ACUTE CARE COMMON STEM

CORE TRAINING PROGRAMME

Curriculum and Assessment System

April 2012

Preface

The purpose of the Acute Care Common Stem (ACCS) programme is to provide trainees with a broad range of knowledge skills and attitudes so as to be able to:

- assess any acutely ill patient and commence resuscitation if necessary.
- diagnose the most likely underlying problem.
- initiate appropriate investigations, commence appropriate immediate treatment and identify and liaise with the in-patient teams to ensure appropriate definitive care.

Uniquely, the ACCS programme delivers the training and experience needed for this by enabling the trainee to work and learn in the four areas most closely concerned with the acutely ill patient – General Internal Medicine (GIM), Anaesthesia (AN), Intensive Care Medicine (ICM) and Emergency Medicine (EM).

The knowledge base and skill set of these specialties are closely related. These specialties interface in the care of every acutely ill patient. By working in these specialties, the ACCS trainee will become familiar with the common acute and life threatening presentations, their rapid initial assessment and treatment and how to determine what definitive care will be needed and where it should best be provided.

The understanding and thorough grounding in these four specialties delivered by ACCS training will enable the doctor to work effectively both individually and as part of a team in the care of the acutely ill patient and develop a firm foundation for their future chosen specialty.

This document describes the curricular and assessment systems for Acute Care Common Stem core training. It is published by the College of Emergency Medicine (CEM), the Royal College of Anaesthetists (RCoA), the Federation of Royal Colleges of Physicians (FedRCP) and the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM); which together form the Intercollegiate Committee for ACCS Training (ICACCST).

The curriculum and assessment system has been written following consultation between CEM, the RCoA, FedRCP, IBTICM, Heads of Specialty Schools, Programme Directors, individual consultants, trainees and lay people. This feedback was reviewed and developed by the ICACCST and approved by the three Colleges and the IBTICM.

The ICACCST will be pleased to receive comments on this document from both trainers and trainees. These should be addressed to ICACCST at:

The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London
WC1R 4SG
E-mail: accs@rcoa.ac.uk

The document is reviewed regularly with an implementation date for any changes being not less than 6 months after the publication date. Amended pages are sent to Dean Directors, Heads of Specialty Schools, Regional Advisors and Programme Directors for the specialties concerned. An updated version of the manual is maintained on the relevant College and IBTICM websites.

Occasionally, queries arise that affect the immediate interpretation or application of specific areas within this document. Answers to these will be published on the relevant College and IBTICM websites and, if

necessary, earlier by e-mail to all Dean Directors, Heads of Specialty Schools, Regional Advisors and Programme Directors.

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Glossary of terms

Clinical terms

AAA	Abdominal aortic aneurysm
ALS	Advanced life support
APLS	Advanced paediatric life support
ASD	Arial sepal defect
BE	Base excess
BIS	Inspectoral index
BP	Blood pressure
BMI	Body mass index
BNF	British National Formulary
CFAM	Cerebral function analysis monitor
CFM	Cerebral function monitor
CO_2	Carbon dioxide
COPD	Chronic obstructive pulmonary disease
CPEX	Cardiopulmonary exercise testing
CSF	Cerebrospinal fluid
CT	Computerised tomography
CVP	Central venous pressure
DVT	Deep vein thrombosis
ECG	Electrocardiogram
EMG	Electromyogram
ENT	Ear, Nose and Throat
GCS	Glasgow Coma Score
GHB	Gamma hydroxybutyrate
GMC	General Medical Council
GU	Genitourinary
Hb	Haemoglobin
IAC	Initial assessment of competence
IPPV	Intermittent positive pressure ventilation
IRMER	Ionisation Radiation (Medical Exposure) Regulations
IT	Information technology
LiDCO™	Lithium indicator dilution cardiac output
MAC	Minimum alveolar concentration
MH	Malignant hyperpyrexia
MRI	Magnetic resonance imaging
NO	Nitric oxide
NSAID	Non-steroidal anti-inflammatory drug
PE	Pulmonary embolus
PFO	Patent foramen ovale
PONV	Postoperative nausea and vomiting
PSI	Pounds per square inch
Ref.	Reference
ROSC	Return of spontaneous circulation
RS	Respiratory system
RSI	Rapid sequence induction
SpO_2	Saturation of haemoglobin with oxygen

SSRI	Selective serotonin receptor inhibitor
SVP	Saturated vapour pressure
VSD	Ventricular septal defect
WCC	White cell count

Educational and organisational terms

ACCS	Acute Care Common Stem
AIM	Acute Internal Medicine
AM	Acute medicine
AN	Anaesthetics
ASA	American Society of Anesthesiologists
BTS	British Thoracic Society
CCT	Certificate of completion of training
CEM	College of Emergency Medicine
CPD	Continuing professional development
CSM	Committee on Safety of Medicines
ED	Emergency Department
EM	Emergency Medicine
GIM	General Internal Medicine
GMC	General Medical Council
GMP	Good medical Practice
GIM(Acute)	That part of GIM associated with the acute medical take
ICACCST	Inter Collegiate Committee for Acute Care Common Stem Training
ICM	intensive care medicine
JRCPTD	Joint Royal College of Physicians Training board
LAT	Locum appointment for training
LTFT	Less than full time training
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NICE	National Institute for Health and Clinical Excellence
RCP	Royal College of Physicians
RCoA	Royal college of Anaesthetists
SAS	Staff and associate specialist
STC	Specialty Training Committee

Curriculum sections and Assessment Method Glossary

AA	Audit Assessment
ACAT	Acute Care Assessment Tool
ACAT- EM	Acute Care assessment tool (EM)
ARCP	Annual Review of Competence Progression
CBD	Case Based Discussion (CBD)
CAP	Core Acute Presentations
CMP	Core Major Presentations
D	Direct observation of procedural skills (DOPS)
E	Examination
FRCA	Fellowship of the Royal College of Anaesthetists
IAC	Initial Assessment of Competence

L	Life support course
Mi or A	Mini- clinical evaluation exercise or anaesthesia clinical evaluation exercise (Mini-CEX or Anaes-CEX)
M	Multisource feedback
MCEM	Membership of the College of Emergency Medicine
MRCP	Membership of the Royal College of Physicians
PP	Practical Procedures
PS	Patient Survey
S	Simulation
TO	Teaching Observation
WPBA	Work Place Based Assessments

GMP domain headings

GMP 1	Knowledge, skills and performance
GMP 2	Safety and quality
GMP 3	Communication, partnership and teamwork
GMP 4	Maintaining trust

Executive Summary

ACCS is a 3 year core training programme that normally follows Foundation Year 2. It is the only core training programme for trainees wishing to enter higher specialty training in Emergency Medicine. It is an alternative core training programme for trainees wishing to enter higher specialty training in General Internal Medicine (GIM), Acute Internal Medicine (AIM) or Anaesthetics. It will deliver all elements of the specialty specific core training curricula, with additional augmented outcomes i.e. competences beyond those areas covered by GIM and anaesthetics. The first two years are spent rotating through Emergency Medicine (EM), General Internal Medicine, Anaesthetics and Intensive Care Medicine (ICM). The third year is spent providing training that will ensure the trainee meets the minimum requirements for entry into higher specialty training in their parent specialty (EM, GIM/AIM, Anaesthetics and also ICM). For trainees entering the specialities defined by the JRCPTB the competences required are defined within the General Internal Medicine (2009) curriculum for those following the core medical training programme.

Aim The aim of ACCS training is to produce multi-competent junior doctors able to recognise and manage the sick patient, who can define the nature of the specialist intervention required and who have complementary specialty training.

Objectives Within the overall aim, each specialty has a specific objective for ACCS training:

- ***Emergency Medicine*** To provide training that delivers the first three years of the CCT in Emergency Medicine in a pre-planned and structured manner.

- ***General Internal Medicine(Acute)*** To produce a cohort of trainees with all the competences delivered in Core Medical Training (CMT), with augmented outcomes and more broadly based experience. For the purposes of this training programme trainees must obtain significant experience in the acute medical take during the 6 months of medicine as this defines the term GIM(Acute

- ***Anaesthetics*** To produce a cohort of trainees with more broadly based experience than is available solely within the Anaesthetics CCT programme and to allow those who want to obtain a joint CCT in Anaesthetics and ICM to obtain the complementary competences in a pre-planned and structured manner.

- ***Intensive Care Medicine (ICM)*** To allow trainees who want to obtain a joint CCT in ICM to obtain the competences of the complementary specialties in a pre-planned and structured manner.

The programme consists of:

- 6 months of Emergency Medicine
- 6 months of GIM(Acute)
- 1 year of Anaesthetics + ICM (with a minimum period of 3 months in either discipline).
- 1 further year in the chosen parent specialty

The programme is a competency based programme; nevertheless, minimum required periods of time are specified to allow acquisition of competences and for administrative reasons to ease the organisation of rotations.,

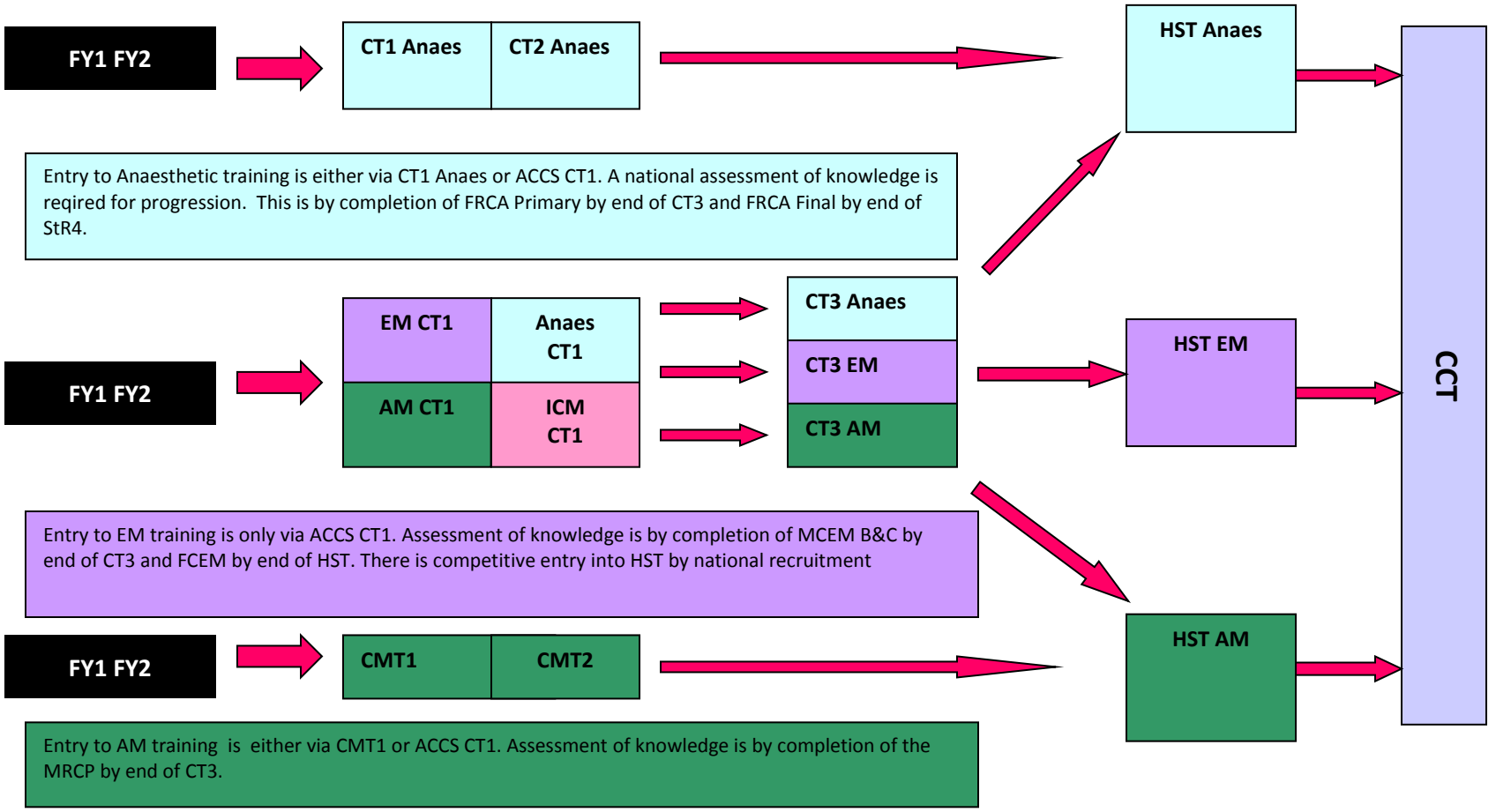
Application by trainees will normally be for ACCS training, but some Deaneries will have specialty specific or indicative recruitment whereby trainees will have to state at application or interview a preference for the specialty programme they wish to follow on completion of ACCS training. This will enable appropriate posts to be made available at CT3 (for Anaesthetics) and at CT3 for Emergency Medicine and General or Acute(Internal) Medicine.

Selection will normally be made by a panel with representatives from all four disciplines. Record of In Training Assessment (ARCP) panels should also have representatives from all disciplines being reviewed by the panel.

Assessment

All ACCS trainees will be assessed using the proscribed tools and against the criteria specified in Section 8 of this curriculum. Satisfactory performance in the specified assessments (including relevant postgraduate examinations) is required before progression to higher specialty training.

ACCS routes of entry and training pathways



Assessment of competence is shown using WPBA tools such as Mini-CEX, CbD, DOPs, ACAT and MSF. In Anaes and EM some of these WPBA tools are summative and are therefore required for progression at ARCP. The overall assessment process combines the relevant college examination as the primary assessment of knowledge with the workplace based assessments, which are designed to monitor how that knowledge is applied in clinical practice. It is necessary for trainees to engage fully with the assessment process to ensure that an evidence base of competence is accrued.

1.0 Introduction

1.1 What is ACCS?

ACCS is a new concept in medical training. Designed to attract doctors with an interest in the acute medical specialties, the three year ACCS programme will develop the skills, knowledge and attitudes required to enter higher training in Emergency Medicine (EM), GIM/AIM, Anaesthetics, and also Intensive Care Medicine (ICM).

On completion of Foundation Training, many trainees recognise that they find working with the sickest patients in the hospital stimulating; they enjoy the challenges faced in the acute situation, and are rewarded by the improvements they see as their treatments take effect. The specialties EM, GIM(Acute), Anaesthetics, and ICM all play their part in the management of such patients. In ACCS, time is spent training in each of these four disciplines.

ACCS provides the core competences for progression to higher specialty training in EM, GIM(Acute) and Anaesthetics, along with the complementary specialty requirements required if the trainee's ambitions are to achieve dual CCT training in ICM.

ACCS is designed to deliver the competencies common to the acute specialties, and help develop in trainees an acute care 'language'. It will not only improve knowledge and practical competences, but also provide essential communication and networking skills essential to the effective practice of an acute care physician. On completion of ACCS, doctors will have the necessary skills required to pursue a career in the acute specialty of their choice.

1.2 Aim of ACCS

ACCS delivers training in the core skills required in each of the component specialties (EM, GIM(Acute), Anaesthetics and ICM): a junior doctor deciding on a career in ***any*** of these specialties is trained in the core skills required for ***all*** of them.

ACCS will provide multi-competent junior doctors who will be not only be able to recognise and manage the acutely unwell patient, but will be competent to define the nature of the specialist intervention required, and be able to initiate emergent or urgent treatment, until specialist or more senior help arrives.

1.3 Objectives of ACCS

ACCS has a common aim, but each specialty has specific objectives for ACCS training:

Emergency Medicine

ACCS constitutes the first three years of the CCT in EM in a pre-planned and structured manner. The first two years of ACCS training (EM, GIM(Acute), Anaesthetics and ICM) are followed by a further year gaining additional competences in adult EM (including musculoskeletal emergencies) and Paediatric Emergency Medicine; thus fulfilling the requirements to progress to higher training in EM.

General (Internal) Medicine

ACCS is one of the training options available for delivering the core competences required for a CCT in GIM, AIM or one of the acute medical specialties in a pre-planned and structured manner. The first two years of ACCS training (GIM(Acute), EM, Anaesthetics and ICM) are followed by a further year in GIM(Acute). The trainee should take part in at least 4 shifts of acute medical take per month during the 6 month period of training in medicine. This three year training programme fulfils the requirements for progression to higher training in GIM, AIM or an acute medical specialty.

Anaesthetics

Anaesthetics offers career opportunities in a wide range of subspecialty areas all of which can be achieved by direct entry to a Core Anaesthetic CCT (CAT) programme. However, those Anaesthetic trainees with an interest in the 'acute' end of the Anaesthetic spectrum will find ACCS an ideal career starting point. It provides trainees with more widely based experience than is available solely within the CAT programme. The first two years of ACCS training (GIM(Acute), EM, Anaesthetics and ICM) are followed by a third year spent gaining additional competences in Anaesthetics.

It is widely acknowledged that the broader range of competences achieved by those on an ACCS programme, compared to those pursuing CAT, enhances patient care particularly in the provision of emergency out-of-hours work. This enables supervisors more discretion in the deployment of trainees with wider-ranging skillsets. For example the additional knowledge and skills gained within the ACCS programme may enable trainees to work with lower supervision levels where appropriate, in areas such as perioperative medicine, trauma management and critical care. In addition, the skills gained as part of this 3 year training programme are transferable to training in ICM, either as part of a single or dual programme.

Dual CCT in Intensive Care Medicine (ICM)

ACCS allows trainees who wish to obtain dual CCT in Acute Medicine & ICM, Anaesthetics & ICM or Emergency Medicine & ICM, to obtain the competences of the complementary specialties in a pre-planned and structured manner.

1.4 ACCS & the academic trainee

Trainees joining the ACCS programme may wish to pursue an academic career and have the opportunity to compete for Academic training posts. This gives the successful trainee the opportunity to undertake an additional year of training specifically to prepare them for research. This will enable them to submit a research proposal which, if successful, will provide the funding to support their research before they enter higher specialist training. When this year is undertaken will be determined locally and will typically involve attendance at taught courses covering such areas as critical analysis of scientific literature, information management, study design, basic statistical analysis, fraud, ethics and plagiarism, presentation skills, scientific writing and publishing skills. Trainees may have the opportunity to complete a Masters programme in research.

The three years of clinical training within the ACCS programme has to be completed by these trainees. The clinical component is demanding and experience has shown that trainees need all this time to gain the knowledge skills and attitudes required and to be successful in the summative assessments. The overall clinical training time for these trainees should not be shortened.

1.5 Further advice about ACCS

The first point of contact for information concerning an individual's training is this document. Most questions can be answered by reference to this document, all of which is available widely in electronic format.

The next point of contact should be the ACCS Tutor or the specialty College Tutor in the hospital or department in which the trainee is currently based.

If the College Tutor is unable to give the necessary guidance, the Deaneries' ACCS or Core Training Programme Directors (TPD) or the relevant Head of Specialty School can be asked for advice.

Trainees should only contact the ICACCST for advice if the above named Trainers have been unable to

help. The ICACCST will inevitably find providing individual advice difficult, as it will have no knowledge of the trainee's particular circumstances, and have no detailed understanding of local delivery of ACCS training.

2.0 Principles of the first two years of ACCS training

2.1 Introduction

The first 2 years of ACCS training forms part of the core training programmes for Emergency Medicine, those Medical specialties with an emphasis on acute management and Anaesthetics.

The components of training, which can rotate in any order, are:

- 1 year Emergency Medicine + GIM(Acute) (6 months each)
- 1 year Anaesthetics + Intensive Care Medicine (minimum 3 months, maximum 9 months in each)

The training will be provided in posts and programmes approved by GMC. Departments in which training occurs must comply with the regulations and recommendations of the relevant national Departments of Health, GMC and the ICACCST. Doctors responsible for training are expected to comply with the regulations and recommendations of the GMC.

2.2 Administration of ACCS training

The intention is that all hospitals in the UK that provide ACCS training will be managed by Specialty Schools. ACCS Schools may be developed once the training is established and the best forms of delivery have been identified. Until then most ACCS programmes are managed by Specialty Schools with some sort of overarching cross-specialty Training infrastructure.

Hospitals within a School will generally be expected to offer experience and training in at least two of the specialties and preferably all four.

A key appointment in each ACCS School will be the Deanery appointed Training Programme Directors who will have responsibility for organising the rotations to ensure that all the aspects of training are covered.

It will be the responsibility of each Deanery to appoint ACCS Specialty Training Committees (STCs). The constitution of each STC in ACCS will be subject to local Deanery considerations. One or more Training Programme Directors should be appointed according to local process and the STC should also have, as a minimum, trainee and educational representation.

Guidance for Deans

Guidance for Deans on the implementation of ACCS training is contained in Appendix B.

2.3 Responsibility for training in the workplace

Competency based training relies on assessments made during clinical service. The responsibility for the organisation, monitoring and efficacy of this training and assessment is shared by a variety of authorities:

- GMC is responsible for approving posts and programmes for training.

- The ICACCST is responsible for:
  - Developing the curriculum including determining the learning objectives and competences of training; and
  - Advising GMC and Postgraduate Deans on the arrangements for organising and monitoring in-service training.
- The Postgraduate Dean is responsible:
  - For selecting trainees in accordance with nationally agreed procedures
  - To GMC for the quality management of training
  - For organising the Annual Review of Competence Progression (ARCP) for each trainee
  - For the overall training arrangements in each hospital; the Clinical Tutor or Director of Education acts as the Dean's officer within the hospital and is responsible for the educational environment and in some cases, aspects of generic training
- The local Specialty Training Committee:
  - Reports to the Postgraduate Dean and is responsible for local arrangements for in-service training.
  - Has responsibility for deciding what evidence of progress in training will be reviewed at appraisal and evaluated at the ARCP.
- Programme Directors organise the rotations to ensure that the curricula are covered and that remedial training is implemented if required.
- The Clinical Directorates for each specialty within a hospital are responsible for delivering in service training in accordance with the principles adopted by GMC, the ICACCST, the Postgraduate Dean and the ACCS Training Committees.
- When they are established ACCS Schools will take on responsibility for organising and monitoring the training scheme and individual trainees; in the meantime ARCP panels should include representatives from all component specialties being reviewed by the panel.

2.4 Modules and units of training

ACCS training is described under the headings of:

1. Common Competencies
2. Major Presentations
3. Acute Presentations
4. Anaesthesia in ACCS

Each area is described in terms of:

- the subject area;
- the required knowledge;
- the required skills;
- the required attitudes and behaviour;
- the range of possible assessment methods that could be used
- mapping to the GMP headings.

2.5 Appraisal and assessment

Each trainee must complete an educational agreement with their supervisor within two weeks of the start of each placement. This should clearly establish the training goals of the placement and forms part of the basis of subsequent review.

There will be regular appraisal and assessment during ACCS training. Progression is dependent on successful assessment. The timing and format of appraisal and assessment is indicated in section 8.0 and the additional specialty specific appendices.

Every trainee must have a formal appraisal at the end of the period with each specialty.

Examinations of knowledge Are one of several assessment methods used within the programme e.g. MCEM (Part A) for Emergency Medicine, the MRCP Part 1 Examination for GIM(Acute), the FRCA Primary MCQ Examination for Anaesthetics. The syllabi for these examinations of basic level knowledge are contained in the individual specialty CCT programmes.

Portfolio: Every ACCS trainee must maintain a training portfolio.

ARCP The ARCP is the process whereby all assessments of a trainee's knowledge, skills and attitudes throughout the year come together for review at Deanery level. The STC works with the Postgraduate Deans in conducting the ARCP to provide a composite picture of the trainee's achievements, shortcomings and consequent future training needs. ARCP panels should include representatives from all component specialties under review

2.6 Supervision

ACCS teaching and learning require that consultants and trainees work together in clinical practice. The detailed requirements of clinical supervision will vary between the four ACCS specialties and are described in the relevant CCT programmes.

Clinical supervision Every trainee must at all times be responsible to a named consultant. That consultant must be available to advise and assist the trainee as appropriate. Sometimes this will require the consultant's immediate presence but on many occasions less direct involvement will be acceptable. All operating lists and clinical sessions involving a trainee should be under the supervision of a named consultant or SAS grade doctor. It is accepted that absences (holiday, study leave, professional leave or sickness) will occur. However, when such absences happen and a trainee undertakes clinical work, there must be an arrangement to provide appropriate direct or indirect consultant supervision for the trainee.

Supervision is a professional function of consultants and they will be able to decide what is appropriate for each circumstance in consultation with the trainee. The safety of an individual hospital's supervision arrangements is the concern of the departmental and hospital management and it is necessary for them to agree local standards and protocols that take account of their particular circumstances. Clinical supervision for each specialty module will be in accordance with the procedures contained in the relevant CCT programme. At all times the needs of patient safety must govern the level of supervision available.

Educational supervision Every trainee must have a nominated educational supervisor to oversee individual learning.

Clinical supervision by SAS grades When clinical supervision of a trainee is being provided by a SAS grade doctor, the trainee must always have unimpeded access to a named consultant.

Clinical supervision of one trainee by another Clinical supervision of one trainee by another occurs and senior trainees must learn how to do this safely and effectively. A junior trainee may refer to a more senior trainee as the first line of advice and assistance. However, both trainees must be subject to supervision from a designated consultant.

Clinical teaching The placement of a trainee with a consultant is always a teaching opportunity even if it is primarily required for patient safety. Consultants must work with trainees both to teach them and to assess their competence on a daily basis. This experience is best described as clinical teaching to

distinguish it from pairings that occur for reasons of safety (clinical supervision) though all direct clinical supervision is also clinical teaching.

2.7 Out of hours cover for emergency services

Out of hours work for trainees largely involves providing services for emergencies. Such out of hours work makes different demands upon the trainee. Whenever trainees are learning new aspects of emergency work they must have close clinical supervision.

The service requirements of hospitals, however, may necessitate trainees undertaking more out of hours emergency cover than is needed for their training. A balance therefore must be maintained between the service and training requirements of out of hours work; service must not undermine the necessity for training out of hours. This must be reviewed by evaluating the whole training scheme; out of hours emergency work must not prevent the trainee from meeting the standards of the agreed competences on schedule. Out of hours duties apply *pro rata* (weekdays and weekends) to flexible trainees.

Each component specialty module is distinct and there is no place for moving out of the designated specialty module to provide service work in another area.

2.8 Simulators

The ICACCST encourages the use of simulators for relevant aspects of postgraduate training in acute care especially for events of high importance but infrequent occurrence, for situations where there might be a high risk to patients and for team building and working under pressure.

3.0 Entry and progression through ACCS training

3.1 Entry to ACCS core training

Entry to ACCS training will be by competitive application under nationally agreed arrangements. The interview panels will comprise representatives of all four specialties that comprise ACCS training. Before entering the ACCS programme trainees will usually be asked to specify the specialty they want to pursue for a CCT.

Routes of entry into ACCS

There are several routes of entry into ACCS - the most frequent being:

- Entry into ACCS Year 1 from F2
- Entry into ACCS for trainees with a combined total of less than 18 months experience in any of the four ACCS component specialties at SHO/CT1/CT2 level
- Entry into ACCS from Core/Higher Training in a non-ACCS specialty.

Nomination of Specialty

- During the selection process trainees will usually have to declare which one of the three specialties (Emergency Medicine, GIM(Acute) or Anaesthetics) they intend to follow during the third ACCS year. Allocation into Anaesthetics CT3, Emergency Medicine CT3 or a CT3 year in GIM(Acute) will be dependent on this declaration.
- Flexibility over exit Specialty e.g. switching from Anaesthetics to Emergency Medicine might be possible if the programmes locally can accommodate the change and there is agreement of the Training Programme Directors. The GMC has approved such transfers between specialties, with trainees entering their new specialty training programme at a level commensurate with their previous experience.

Appointment process

- ACCS appointment panels should consist of trainers from each of the constituent specialties of ACCS training.
- No trainee should be appointed to a training post in a specialty not represented on the appointment panel. The only exception to this could be if the prospective written agreement of the absent specialty programme director was made available to the panel at the structured interview.

3.2 Progression through the ACCS programme

Duration

The indicative duration of ACCS training is three years.

The order in which the modules are completed does not matter and will be determined by local arrangements. The *preferred* order of elements is Emergency Medicine and Acute Medicine in CT1 with Anaesthetics and ICM in CT2.

Exit from ACCS training

On completion of the first two years of ACCS training a trainee's next step will depend on the specialty CCT programme to which they have applied.

Emergency medicine

On completion of the first two years of ACCS training, trainees will join the Emergency Medicine programme at the start of CT3.

- WPBAs. Trainees will be expected to have acquired the requisite number and type of WPBAs (see section 8.0 and appendices 8.1-8.5 for the first 2 years of ACCS).
- Examinations. EM trainees will normally be expected to have completed MCEM Part A before entering the CT3 year and must pass MCEM B and C by the end of CT3.

General (Internal) Medicine

On completion of 3 years of ACCS training, trainees will be eligible for appointment to the GIM, AIM or acute medical specialty CCT programme at the start of ST3.

- WPBAs. Trainees will be expected to have acquired the requisite number and type of WPBAs (see section 8.0 and appendices 8.1-8.5 for the first 2 years of ACCS).
- Exams. AM trainees will normally be expected to have completed MRCP 1 before entering CT3 and to have passed MRCP2 & PACES by the end of CT3. The requirement for acquisition of MRCP(UK) prior to entry to ST3 is likely to become mandatory in 2010.

Anaesthetics

- On completion of the first two years of ACCS training, trainees will join the Anaesthetics programme at an appropriate point in CT3. Uncoupling and fixed entry dates for ST3 will mean that most trainees will undertake the entire CT3 year in Anaesthetics.
- Trainees are not eligible for appointment to ST3 (Anaesthetics) until they have obtained the **Basic Level Training Certificate** i.e. have achieved all the basic competencies for Anaesthetics and ICM. ACCS trainees must have undertaken a minimum of 18 months training in Anaesthetics by the end of CT3.
- If a trainee does more than 3 months ICM in ACCS the second three months of ICM does not contribute to intermediate levels of competence because trainees will not have the wider experience that underpins intermediate level assessment standards. This will also usually mean that such a trainee will not have achieved all the necessary anaesthetic competences delivered in the 21 months of Anaesthetics in CT1/2 of the Anaesthetics programme. The missing competences and the "additional" ICM competences will be recorded on his/her Basic Level Training Certificate and the missing competences will have to be achieved within an agreed time frame.
- WPBAs. Trainees will be expected to have acquired the requisite number and type of WPBAs (see section 8.0 and appendices 8.1-8.5 for the first 2 years of ACCS).
- Exams. Trainees moving from ACCS training will normally be expected to have passed the FRCA Primary MCQ assessment of knowledge before entering CT3 Anaesthetics.

ICM

Because there is no stand-alone CCT programme in ICM, trainees wishing to obtain a joint CCT in ICM must complete one of the CCT programmes listed above or a surgical specialty CCT programme.

- WPBAs. Trainees will be expected to have acquired the requisite number and type of WPBAs (see section 8.0 and appendices 8.1-8.5 for the first 2 years of ACCS).

3.3 Principles for calculating training time

Less than full-time (LTFT) trainees

The European Medical Directive states that:

> *"Part-time training shall meet the same requirements as full-time training, which shall differ only in the possibility of limited participation in medical duties to a period of at least half that of full-time trainees, including on-call duties."*

This is interpreted to mean that flexible trainees should, pro rata, undertake the same out-of-hours work as full-time trainees, including weekend and shift duties. General advice on LTFT training is contained in the "Gold Guide".

Locum Appointment for Training (LAT)

Trainees who have completed LAT posts in ACCS may apply for direct entry into year 2 of ACCS core training for training in the other ACCS modules. The exact content of training will be decided on an individual basis.

If a trainee holding a LAT post in ACCS successfully applies for an NTN in one of the component specialty CCT programmes, full credit will be given for competences acquired, assessed and recorded during the LAT.

Sickness, parental and maternity leave

In a competency based programme trainees are to be assessed and signed off on the basis of competences achieved not the time taken to obtain them. Thus, normally, periods of absence due to sickness, parental or maternity leave are irrelevant. In the event of prolonged absence a period of reorientation may be needed before further competences can be taught and assessed.

Military service

Absence on military operations by full time or reserve members of the Defence Medical Services will be treated in the same way as for absence due to sickness. It is theoretically possible that with careful planning such trainees may be able to acquire and be assessed for competences whilst on military duty. Retrospective recognition is not given for training obtained outside the European Economic Area (EEA).

Training year

The date an individual's indicative training year starts is determined by the local Specialty Training Committee, and is not necessarily the chronological date from the beginning of training.

4.0 The delivery of training and education

The ICACCST supports the GMC's view that all doctors have a professional obligation to contribute to the education and training of other doctors. The instruction of trainees can be undertaken by consultants, SAS grade doctors and other trainees. Trainees may teach other trainees both formally in tutorials etc. and in clinical situations where this is agreed by their supervising consultant. Clinical teaching situations will often involve the senior trainee in supervising the junior but the overall responsibility must rest with the nominated consultant supervisor (see Section 2.6). In addition there may be contributions from other health care professionals e.g. nurses, physiotherapists, pharmacists, basic scientists and health care managers.

4.1 Principles of delivering training and education

It is intended that trainees should be totally immersed in each specialty module during their attachment to it. It is not intended that trainees should be taken away for centralised generic training, with the exception of mandatory training. The Common Competences in ACCS (5.0) must be delivered within the specialty modules.

The ICACCST recognises that the example of trainers and teachers has a powerful influence upon the standards of conduct and practice of every trainee, whether an undergraduate or a qualified doctor in training. It follows that all those involved in training and teaching should recognise and meet their responsibilities. In particular:

- Any consultant or SAS grade doctor who is involved in the training or education of trainees should themselves be aware of the educational objectives of the training programme and participate actively in the optimal construction and delivery of the programme.
- Consultants, SAS grade doctors and others involved in teaching must fulfil the CPD requirements for the clinical appraisal process and to the satisfaction of the relevant medical Royal College.
- Trainers and teachers should take the necessary steps to acquire the skills of a competent teacher.

4.2 The organisation of training and education

The primary responsibility for learning lies with the trainee. The infrastructure of training and education is there to facilitate this.

Educational Supervisor

Every trainee must have an Educational Supervisor - defined by GMC as a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's educational agreement. The Educational Supervisor's role is to help the trainee to plan their training and reach personal and institutional objectives. In some clinical departments the College or Board Tutor may be the Educational Supervisor for all the trainees. If this is the case they must ensure that they have sufficient time and resources to undertake the duty in accordance with accepted good practice in educational supervision.

Clinical Supervisor

Every trainee must have a Clinical Supervisor. GMC defines a Clinical Supervisor as a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged

4.3 The "Lead" Educational Supervisor / "Track Lead"

It is recognised that in co-ordinating the ACCS training within Hospitals and Deaneries different models have evolved. The organisation of training in Hospitals may be co-ordinated by College Tutors / Educational Supervisors from an individual trainee's nominated CCT specialty, for example during the Anaesthetic block of training this would be the RCoA College Tutor. Alternately one Educational Supervisor may have overarching responsibility for the delivery of ACCS training within the Hospital and will co-ordinate the efforts of the other Educational Supervisors. During each speciality attachment the Educational Supervisor for that speciality will be responsible for the trainee. However, one of the Educational Supervisors may take on the role of Hospital "Lead" and in Deaneries with established ACCS Speciality Training Committees sit on the STC. For trainees in LAT positions the local mechanism will be identical.

The "Lead" Educational Supervisor is not expected to deliver personally all aspects of training and supervision that are listed below; the intention is that the "Lead" will ensure that training is properly organised, delivered, and is accessible to the trainees. The "Lead" should act as an organiser and coordinator of training. Specific tasks can be delegated by the "Lead" Educational Supervisor and individual speciality Educational Supervisors to other members of the department. The delivery of high quality training requires contributions from all consultants and not just the Educational Supervisors although they remain the prime point of contact for the trainees. In addition to acting as an important role model and general adviser to all trainees in the relevant specialty, the responsibilities of the "Lead" Educational Supervisor and individual speciality Educational Supervisors include:

- organisation of teaching / training
- organising workplace assessments
- keeping records of the progress of trainees through acquisition of competences and liaising with service rota-makers
- examination preparation for trainees
- professional development / career advice for trainees
- liaison with the Postgraduate Dean and Training Programme Director
- sitting on the Specialty Training Committee for the individual discipline and/or the ACCS Speciality Training Committee or School Board
- representing the ICACCST on training matters affecting their specialty
- advising ICACCST on matters of general and individual concern
- audit of clinical supervision arrangements

4.4 SAS grade doctors and senior trainees as trainers

The ICACCST recognises that SAS grade doctors and senior trainees have a valuable role in training. To be a trainer SAS grades must fulfil their College's CPD requirements; this is essential for those areas where they have clinical and on-call responsibilities. The ICACCST encourages College Tutors and Educational Supervisors to identify those SAS grades with aptitude and to nominate them to the ACCS Specialty Training Committee specifying the areas in which they have appropriate expertise. The specific areas in which SAS grades train are best identified at local level. SAS grades who undertake training must have the opportunity to acquire the skills of a competent trainer. For senior trainees, learning to train others is part of their curriculum. When being taught by a SAS grade or a senior trainee, trainees must at all times have unimpeded access to named consultants for advice.

4.5 Workplace based learning

To complete ACCS core training satisfactorily, the trainee must demonstrate to the satisfaction of the trainers the competences specified for the sections:

1. Common Competencies,
2. Major Presentations,
3. Acute Presentations
4. Anaesthesia in ACCS

The proportion of time the trainee spends being directly taught in the workplace will vary throughout training depending on the requirements of the individual specialty modules, the trainee's seniority and the nature of the clinical work. There may be variation from week to week depending on local work patterns. As trainees become more experienced they may have the opportunity to work without direct clinical supervision but the majority of their duties should include direct clinical teaching by consultants and other senior members of the team. This does not obviate the need for appropriate educational and clinical supervision at all times.

4.6 Workplace based assessment

The ACCS programme uses shared tools for workplace based assessment, but documentation may differ and other formats are explicitly required such as the Initial Assessment of Competency in Anaesthetics or the Acute Care Assessment Tool (ACAT) in GIM (Acute) and EM. The tools used are:

- Multi-Source Feedback (MSF)
- Mini-Clinical Evaluation Exercise (or Anaes-CEX)
- Direct Observation of Procedural Skills (DOPS); and
- Case Based Discussion (CbD)

Trainees will be expected to complete workplace based assessments during each specialty module. The WPBA required for the first two years are described in section 8.0 and appendices 8.1-8.4

During the ACCS programme the trainee should ideally complete at least one Multi-Source Feedback each year, but preferably one per specialty placement.

4.7 Clinical knowledge

To complete ACCS core training successfully, the trainee must satisfactorily complete an assessment of knowledge appropriate to the requirements of their chosen CCT specialty i.e. the FRCA Primary, MRCP or MCEM.

4.8 Formal education

Within departments there should be arrangements for formal, educational and Clinical Governance meetings. Although it is accepted that not all consultants can always be present at such educational meetings, it is expected that consultants will participate whenever possible. It is expected that all trainees will participate in this process. This time should be 'ring fenced' such that trainees are not required to cover service commitments during this period except in exceptional circumstances. Attending group educational activity in hospitals is part of the professionalism of good doctors. Attendance at departmental clinical meetings should be one of the forms of evidence of progress presented at appraisal and for ARCPs. Local Specialty Training Committees should determine what level of participation should be mandatory for progress.

Trainees must have a meeting with their Educational Supervisor (or a representative) at least three-monthly, to discuss their progress, outstanding learning needs and how to meet them.

4.9 Professional knowledge, skills, attitudes and behaviour

Professional attitudes and behaviour

- Problems with professional and clinical attitudes and behaviour in the workplace are a major factor in the genesis of major critical incidents. Difficulties with professional behaviour and communication are a common cause of problems in training and of disciplinary procedures. Such behaviours depend in part upon the character traits of the individual but to a great extent suitable behaviour can be learned. Learning what is acceptable behaviour requires that acceptable standards are clearly described to the trainee.
- Trainees will be expected to develop their professional attitudes and behaviours throughout their training. They can expect to be assessed regularly. Section 5.0 includes guidance on required standards. The trainee's behaviour must be compared with these standards and records of good and bad performance should be kept as part of the assessment process.

Professional knowledge and skills

- The requirement for teaching and assessing professional knowledge and skills is generic to all four component specialties. It is essential for all the acute care specialties that those taking up consultant posts should be able to play a full part in the running of the NHS. Throughout their training, therefore, all trainees are required to acquire and develop professional knowledge, skills and attitudes at a level and pace appropriate to their stage of training, including the following subjects:
- The Responsibilities of Professional Life
- Teaching and Medical Education
- Health Care Management
- Information Technology
- Medical Ethics and Law

For some aspects, trainees may take study leave and attend specific courses. Alternatively, much can be achieved by taking advantage of what is available locally, for instance Deanery or ACCS Specialty based courses or departmental training sessions. Whichever way the training is delivered records of achievement must be maintained as part of the trainee's portfolio for presentation at the annual appraisal and for the ARCP.

Child protection

The Children Act 1989 is the legislative authority for child welfare and protecting children from abuse. Sections 27 and 47 of the Act place duties on various agencies to assist social services departments in actual or suspected cases of child abuse. Child Protection Training may be delivered as part of mandatory training in host Hospitals.

Equality and Diversity

The ICACCST conforms to the view that equality of opportunity is fundamental to the selection, training and assessment of doctors. It seeks to recruit trainees regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation. Patients, trainees and trainers and all others amongst whom interactions occur have a right to be treated with fairness and transparency in all circumstances and at all times. Equality characterises a society in which everyone has the opportunity to fulfil his or her potential. Diversity addresses the recognition and valuation of the differences between and amongst individuals. Promoting equality and valuing diversity are central to the curriculum.

The importance of Equality and Diversity in the NHS has been addressed by the Department of Health in England in 'The Vital Connection' in Scotland in 'Our National Health: A Plan for Action, A Plan for Change' and in Wales by the establishment of the NHS Wales Equality Unit. These themes must therefore be considered an integral part of the NHS commitment to patients and employees alike. The theme was developed in the particular instance of the medical workforce in 'Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce'. Furthermore, Equality and Diversity are enshrined in legislation enacted in both the United Kingdom and the European Union. Prominent among the relevant items of legislation are:

- Equal Pay Act 1970
- Sex Discrimination Acts 1975 and 1986
- Indirect Discrimination and Burden of Proof Regulations 2001
- Race Relations Act 1976 and Race Relations (Amendment) Act 2000
- Disability Discrimination Act 1995
- Employment Rights Act 1996
- Human Rights Act 1998
- Employment Relations Act 1999
- Maternity and Paternity Leave Regulations 1999
- Part Time Workers Regulations 2000
- Employment Act 2002
- European Union Employment Directive and European Union Race and Ethnic Origin Directive
- Age Discrimination Act 2006

It is therefore considered essential that all persons involved in the management of training (Board, Tutors, and Training Programme Directors et al) are trained and well versed in the tenets of Equality and Diversity and it is expected that all trainers should be trained in Equality and Diversity.

As part of their professional development trainees will be expected to receive appropriate training in Equality and Diversity to the standards specified by GMC and to apply those principles to every aspect of all their relationships. The delivery of this training is the responsibility of the Postgraduate Dean. A record of completion of this training must be held in the trainee's portfolio. The benefits of this training are:

- To educate the trainee in the issues in relation to patients, carers and colleagues and others whom they may meet in a professional context
- To inform the trainee of his or her reasonable expectations from the training programme
- To advise what redress may be available if the principles of the legislation are breached

Communication skills

Communication skills are developed both formally and informally.

There should be formal training in presentation skills. Inter-personal communication skills should be included in assessments provided by individual consultant supervisors and remedial training should be devised and provided to meet individual needs.

Team working and leadership

Doctors in the acute care specialties have to work as part of a wider team and are expected to demonstrate leadership. Formal training in these areas is not built into this curriculum, but the absence of these qualities should be commented on in workplace based assessments and discussed at appraisals. Remedial training should be devised and provided to meet individual needs.

4.10 Training accommodation

Any hospital with trainees must have appropriate accommodation to support their training and education; this may be within an appropriate department(s) or elsewhere in the hospital e.g. the Postgraduate Teaching Centre. This accommodation should include:

- a focal point for the ACCS faculty and trainees so that effective service and training can be co-ordinated and optimal opportunities provided for gaining experience and teaching
- adequate accommodation for trainers and teachers in which to prepare their work
- a private area where confidential activities such as assessment, appraisal, counselling and mentoring can occur
- a secure storage facility for confidential training records
- a reference library where trainees have ready access to bench books (or an electronic equivalent) and where they can access information at any time
- access for trainees to IT equipment such that they can carry out basic tasks on a computer including the preparation of audio-visual presentations. Access to the internet is recognised as an essential adjunct to learning
- a suitably equipped teaching area
- a private study area
- an appropriate rest area whilst on duty

5.0 ACCS Common Competences

The common competences are those that should be acquired by all doctors during their training period starting within the undergraduate career and developed throughout the postgraduate career.

Assessment of acquisition of the common competences:

For ACCS trainees competence to at least level 2 descriptors will be expected prior to progression into specialty training. Further assessment will be undertaken as outlined by the various workplace-based assessments listed.

The first three common competences cover the simple principles of history taking clinical examination and therapeutics and prescribing. These are competences with which the specialist trainee should be well acquainted from Foundation training. It is vital that these competences are practised to a high level by all specialty trainees who should be able to achieve competences to the highest descriptor level early in their specialty training career.

History taking

To progressively develop the ability to obtain a relevant focussed history from increasingly complex patients and challenging circumstances. To record accurately and synthesise history with clinical examination and formulation of management plan according to likely clinical evolution		
Knowledge	Assessment Methods	GMP Domains
Recognise the importance of different elements of history	E, Mi	1
Recognise the importance of clinical, psychological, social, cultural and nutritional factors particularly those relating to ethnicity, race, cultural or religious beliefs and preferences, sexual orientation, gender and disability	Mi	1
Recognise that patients do not present history in structured fashion	E, Mi, ACAT	1, 3
Know likely causes and risk factors for conditions relevant to mode of presentation	E, Mi, C, ACAT	1
Recognise that history should inform examination, investigation and management	E, Mi, C, ACAT	1
Skills		
Identify and overcome possible barriers to effective communication	Mi, C, ACAT	1, 3
Manage time and draw consultation to a close appropriately	Mi, C, ACAT	1, 3
Supplement history with standardised instruments or questionnaires when relevant	Mi, C, ACAT	1
Manage alternative and conflicting views from family, carers and friends	Mi, C, ACAT	1, 3

Assimilate history from the available information from patient and other sources	Mi, C, ACAT	1, 3
Recognise and interpret the use of non verbal communication from patients and carers	Mi, C, ACAT	1, 3
Focus on relevant aspects of history	Mi, C, ACAT	1, 3
Behaviours		
Show respect and behave in accordance with Good Medical Practice	Mi, C, ACAT	3, 4

Level Descriptor	
1	Obtains, records and presents accurate clinical history relevant to the clinical presentation Elicits most important positive and negative indicators of diagnosis Starts to ignore irrelevant information
2	Demonstrates ability to obtain relevant focussed clinical history in the context of limited time e.g. outpatients, ward referral Demonstrates ability to target history to discriminate between likely clinical diagnoses Records information in most informative fashion
3	Demonstrates ability to rapidly obtain relevant history in context of severely ill patients Demonstrates ability to obtain history in difficult circumstances e.g. from angry or distressed patient / relatives Demonstrates ability to keep interview focussed on most important clinical issues
4	Able to quickly focus questioning to establish working diagnosis and relate to relevant examination, investigation and management plan in most acute and common chronic conditions in almost any environment

Clinical examination

To progressively develop the ability to perform focussed and accurate clinical examination in increasingly complex patients and challenging circumstances

To relate physical findings to history in order to establish diagnosis and formulate a management plan

Knowledge	Assessment Methods	GMP Domains
Understand the need for a valid clinical examination	E, Mi, C, ACAT	1
Understand the basis for clinical signs and the relevance of positive and negative physical signs	E, Mi, C, ACAT	1
Recognise constraints to performing physical examination and strategies that may be used to overcome them	E, Mi, C, ACAT	1
Recognise the limitations of physical examination and the need for adjunctive forms of assessment to confirm diagnosis	E, Mi, C, ACAT	1
Skills		
Perform an examination relevant to the presentation and risk factors that is valid, targeted and time efficient	E, Mi, C, ACAT	1
Recognise the possibility of deliberate harm in vulnerable patients and report to appropriate agencies	E, Mi, C, ACAT	1, 2
Interpret findings from the history, physical examination and mental state examination, appreciating the importance of clinical, psychological, religious, social and cultural factors	Mi, C	1
Actively elicit important clinical findings	E, Mi, C, ACAT	1
Perform relevant adjunctive examinations	E, Mi, C, ACAT	1
Behaviours		
Show respect and behaves in accordance with Good Medical Practice	Mi. C, M	1, 4

Level Descriptor	
1	Performs, accurately records and describes findings from basic physical examination Elicits most important physical signs Uses and interprets findings adjuncts to basic examination e.g. internal examination, blood pressure measurement, pulse oximetry, peak flow
2	Performs focussed clinical examination directed to presenting complaint e.g. cardio-respiratory, abdominal pain Actively seeks and elicits relevant positive and negative signs

	Uses and interprets findings adjuncts to basic examination e.g. electrocardiography, spirometry, ankle brachial pressure index, fundoscopy
3	Performs and interprets relevance advanced focussed clinical examination e.g. assessment of less common joints, neurological examination Elicits subtle findings Uses and interprets findings of advanced adjuncts to basic examination e.g. sigmoidoscopy, FAST ultrasound, echocardiography
4	Rapidly and accurately performs and interprets focussed clinical examination in challenging circumstances e.g. acute medical or surgical emergency

Therapeutics and safe prescribing

To progressively develop your ability to prescribe, review and monitor appropriate medication relevant to clinical practice including therapeutic and preventative indications		
Knowledge	Assessment Methods	GMP Domains
Recall indications, contraindications, side effects, drug interactions and dosage of commonly used drugs	E, Mi, C, ACAT	1
Recall range of adverse drug reactions to commonly used drugs, including complementary medicines	E, Mi, C, ACAT	1
Recall drugs requiring therapeutic drug monitoring and interpret results	E, Mi, C, ACAT	1
Outline tools to promote patient safety and prescribing, including IT systems	Mi, C, ACAT	1, 2
Define the effects of age, body size, organ dysfunction and concurrent illness on drug distribution and metabolism relevant to the trainees practice	E, Mi, C, ACAT	1, 2
Recognise the roles of regulatory agencies involved in drug use, monitoring and licensing (e.g. National Institute for Clinical Excellence (NICE), Committee on Safety of Medicines (CSM), and Healthcare Products Regulatory Agency and hospital formulary committees	Mi, C, ACAT	1, 2
Skills		
Review the continuing need for long term medications relevant to the trainees clinical practice	E, Mi, C, ACAT	1, 2
Anticipate and avoid defined drug interactions, including complementary medicines	E, Mi, C, ACAT	1
Advise patients (and carers) about important interactions and adverse drug effects	E, Mi, C, ACAT	1, 3

Make appropriate dose adjustments following therapeutic drug monitoring, or physiological change (e.g. deteriorating renal function)	E, Mi, C, ACAT	1
Use IT prescribing tools where available to improve safety	E, Mi, C, ACAT	1, 2
Employ validated methods to improve patient concordance with prescribed medication	E, Mi, C, ACAT	1, 3
Provide comprehensible explanations to the patient, and carers when relevant, for the use of medicines	E, Mi, C, ACAT	1, 3
Behaviours		
Recognise the benefit of minimising number of medications taken by a patient	Mi, C, ACAT	1
Appreciate the role of non-medical prescribers	Mi, C, ACAT	1, 3
Remain open to advice from other health professionals on medication issues	Mi, C, ACAT	1, 3
Recognise the importance of resources when prescribing, including the role of a Drug Formulary	Mi, C, ACAT	1, 2
Ensure prescribing information is shared promptly and accurately between a patient's health providers, including between primary and secondary care	C, ACAT	1, 3
Remain up to date with therapeutic alerts, and respond appropriately	C, ACAT	1

Level Descriptor	
1	Understands the importance of patient compliance with prescribed medication Outlines the adverse effects of commonly prescribed medicines Uses reference works to ensure accurate, precise prescribing
2	Takes advice on the most appropriate medicine in all but the most common situations Makes sure an accurate record of prescribed medication is transmitted promptly to relevant others involved in an individual's care Knows indications for commonly used drugs that require monitoring to avoid adverse effects Modifies patient's prescriptions to ensure the most appropriate medicines are used for any specific condition Maximises patient compliance by minimising the number of medicines required that is compatible with optimal patient care Maximises patient compliance by providing full explanations of the need for the medicines prescribed Is aware of the precise indications, dosages, adverse effects and modes of administration of the drugs used commonly within their specialty Uses databases and other reference works to ensure knowledge of new therapies and adverse effects is up to date Knows how to report adverse effects and take part in this mechanism
3/4	Is aware of the regulatory bodies relevant to prescribed medicines both locally and nationally Ensures that resources are used in the most effective way for patient benefit

This part of the generic competences relate to direct clinical practise; the importance of patient needs at the centre of care and of promotion of patient safety, team working, and high quality infection control. Furthermore, the prevalence of long term conditions in patient presentation to general internal medicine means that specific competences have been defined that are mandated in the management of this group of patients. Many of these competences will have been acquired during the Foundation programme and core training but as part of the maturation process for the physician these competences will become more finely honed and all trainees should be able to demonstrate the competences as described by the highest level descriptors by the time of their CCT.

Time management and decision making

To become increasingly able to prioritise and organise clinical and clerical duties in order to optimise patient care. To become increasingly able to make appropriate clinical and clerical decisions in order to optimise the effectiveness of the clinical team resource		
Knowledge	Assessment Methods	GMP Domains
Understand that organisation is key to time management	C, ACAT	1
Understand that some tasks are more urgent or more important than others	E, Mi, C, ACAT	1
Understand the need to prioritise work according to urgency and importance	E, Mi, C, ACAT	1
Understand that some tasks may have to wait or be delegated to others	C, ACAT	1
Outline techniques for improving time management	C, ACAT	1
Understand the importance of prompt investigation, diagnosis and treatment in disease management	E, Mi, C, ACAT	1, 2
Skills		
Identify clinical and clerical tasks requiring attention or predicted to arise	Mi, C, ACAT	1, 2
Estimate the time likely to be required for essential tasks and plan accordingly	Mi, C, ACAT	1
Group together tasks when this will be the most effective way of working	Mi, C, ACAT	1
Recognise the most urgent / important tasks and ensure that they are managed expediently	Mi, C, ACAT	1
Regularly review and re-prioritise personal and team work load	Mi, C, ACAT	1

Organise and manage workload effectively	Mi, C, ACAT	1
Behaviours		
Ability to work flexibly and deal with tasks in an effective fashion	ACAT, C, M	3
Recognise when you or others are falling behind and take steps to rectify the situation	ACAT, C, M	3
Communicate changes in priority to others	ACAT, M	1
Remain calm in stressful or high pressure situations and adopt a timely, rational approach	ACAT, M	1

Level Descriptor	
1	Recognises the need to identify work and compiles a list of tasks Works systematically through tasks with little attempt to prioritise Needs direction to identify most important tasks Sometimes slow to perform important work Does not use other members of the clinical team Finds high workload very stressful
2	Organises work appropriately but does not always respond to or anticipate when priorities should be changed Starting to recognise which tasks are most urgent Starting to utilise other members of the clinical team but not yet able to organise their work Requires some direction to ensure that all tasks completed in a timely fashion
3	Recognises the most important tasks and responds appropriately Anticipates when priorities should be changed Starting to lead and direct the clinical team in effective fashion Supports others who are falling behind Requires minimal organisational supervision
4	Automatically prioritises and manages workload in most effective fashion Communicates and delegates rapidly and clearly Automatically responsible for organising the clinical team Calm leadership in stressful situations

Decision making and clinical reasoning

To progressively develop the ability to formulate a diagnostic and therapeutic plan for a patient according to the clinical information available

To progressively develop the ability to prioritise the diagnostic and therapeutic plan To be able to communicate the diagnostic and therapeutic plan appropriately		
Knowledge	Assessment Methods	GMP Domains
Define the steps of diagnostic reasoning:	Mi, C, ACAT	1
Interpret history and clinical signs	E, Mi, C, ACAT	1
Conceptualise clinical problem	E, Mi, C, ACAT	1
Generate hypothesis within context of clinical likelihood	E, Mi, C, ACAT	1
Test, refine and verify hypotheses	E, Mi, C, ACAT	1
Develop problem list and action plan	Mi, C, ACAT	1
Recognise how to use expert advice, clinical guidelines and algorithms	E, Mi, C, ACAT	1
Recognises the need to determine the best value and most effective treatment both for the individual patient and for a patient cohort	E, Mi, C, ACAT	1, 2
Define the concepts of disease natural history and assessment of risk	E, Mi, C, ACAT	1
Recall methods and associated problems of quantifying risk e.g. cohort studies	E, Mi, C, ACAT	1
Outline the concepts and drawbacks of quantitative assessment of risk or benefit e.g. numbers needed to treat	E, Mi, C, ACAT	1
Describe commonly used statistical methodology	E, Mi, C, ACAT	1
Know how relative and absolute risks are derived and the meaning of the terms predictive value, sensitivity and specificity in relation to diagnostic tests	E, Mi, C, ACAT	1
Skills		
Interpret clinical features, their reliability and relevance to clinical scenarios including recognition of the breadth of presentation of common disorders	C, ACAT	1
Recognise critical illness and respond with due urgency	C, ACAT	1
Generate plausible hypothesis(es) following patient assessment	C, ACAT	1
Construct a concise and applicable problem list using available information	C, ACAT	1
Construct an appropriate management plan and communicate this effectively to the patient, parents and carers where relevant	C, ACAT	1, 3, 4

Define the relevance of an estimated risk of a future event to an individual patient	C, ACAT	1
Use risk calculators appropriately	C, ACAT	1
Apply quantitative data of risks and benefits of therapeutic intervention to an individual patient	C, ACAT	1
Search and comprehend medical literature to guide reasoning	AA, C	1
Behaviours		
Recognise the difficulties in predicting occurrence of future events	E, C, Mi, ACAT	1
Show willingness to discuss intelligibly with a patient the notion and difficulties of prediction of future events, and benefit/risk balance of therapeutic intervention	E, ACAT, C, Mi	3
Be willing to facilitate patient choice	E, C, Mi, ACAT	3
Show willingness to search for evidence to support clinical decision making	E, C, Mi, ACAT	1, 4
Demonstrate ability to identify one's own biases and inconsistencies in clinical reasoning	E, C, Mi, ACAT	1, 3

Level Descriptor	
1	In a straightforward clinical case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patient's wishes
2	In a difficult clinical case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patient's wishes
3	In a complex, non-emergency case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan

	Seeks appropriate support from others Takes account of the patient's wishes
4	In a complex, non-emergency case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patient's wishes and records them accurately and succinctly

The patient as central focus of care

Prioritises the patient's wishes encompassing their beliefs, concerns expectations and needs		
Knowledge	Assessment Methods	GMP Domains
Recall health needs of particular populations e.g. ethnic minorities and recognise the impact of culture and ethnicity in presentations of physical and psychological conditions	E, C, Mi, ACAT	1
Skills		
Give adequate time for patients to express ideas, concerns and expectations	E, C, ACAT	1, 3, 4
Respond to questions honestly and seek advice if unable to answer	E, C, ACAT	3
Encourage the health care team to respect the philosophy of patient focussed care	E, C, ACAT	3
Develop a self-management plan including investigation, treatments and requests/instructions to other healthcare professionals, in partnership with the patient	E, C, ACAT	1,3
Support patients, parents and carers where relevant to comply with management plans	E, C, ACAT, PS	3
Encourage patients to voice their preferences and personal choices about their care	E, C, ACAT, PS	3
Behaviours		
Support patient self-management	Mi, C, ACAT, PS	3
Recognise the duty of the medical professional to act as patient advocate	Mi, C, ACAT, PS	3, 4

Level Descriptor	
1	Responds honestly and promptly to patient questions but knows when to refer for senior help Recognises the need for disparate approaches to individual patients
2	Recognises more complex situations of communication, accommodates disparate needs and develops strategies to cope
3	Deals rapidly with more complex situations, promotes patients self care and ensures all opportunities are outlined
4	Is able to deal with all cases to outline patient self care and to promote the provision of this when it is not readily available

Prioritisation of patient safety in clinical practice

To understand that patient safety depends on the organisation of care and health care staff working well together To never compromise patient safety To understand the risks of treatments and to discuss these honestly and openly with patients so that patients are able to make decisions about risks Ensure that all staff are aware of risks and work together to minimise risk		
Knowledge	Assessment Methods	GMP Domains
Outline the features of a safe working environment	Mi, C, ACAT	1
Outline the hazards of medical equipment in common use	Mi, C, ACAT	1
Recall side effects and contraindications of medications prescribed	E, Mi, C, ACAT	1
Recall principles of risk assessment and management	C	1
Recall the components of safe working practice in the personal, clinical and organisational settings	C, ACAT	1
Recall local procedures for optimal practice e.g. GI bleed protocol, safe prescribing	Mi, C, ACAT	1
Skills		
Recognise when a patient is not responding to treatment, reassess the situation, and encourage others to do so	Mi, C, ACAT	1
Ensure the correct and safe use of medical equipment, ensuring faulty equipment is reported appropriately	Mi, C, ACAT	1
Improve patients' and colleagues' understanding of the side effects and contraindications of therapeutic intervention	Mi, C, ACAT	1, 3
Sensitively counsel a colleague following a significant event, or near incident, to encourage improvement in practice of individual and unit	C, ACAT	3
Recognise and respond to the manifestations of a patient's deterioration (symptoms, signs, observations, and laboratory results) and support other members of the team to act similarly	Mi, C, ACAT, M	1
Behaviours		

Continue to maintain a high level of safety awareness and consciousness at all times	Mi, C, ACAT	2
Encourage feedback from all members of the team on safety issues	Mi, C, ACAT, M	3
Show willingness to take action when concerns are raised about performance of members of the healthcare team, and act appropriately when these concerns are voiced to you by others	Mi, C, ACAT M	3
Continue to be aware of one's own limitations, and operate within them competently	Mi, C, ACAT	1

Level Descriptor	
1	Discusses risks of treatments with patients and is able to help patients make decisions about their treatment Does not hurry patients into decisions Promotes patients safety to more junior colleagues Always ensures the safe use of equipment. Follows guidelines unless there is a clear reason for doing otherwise Acts promptly when a patient's condition deteriorates Recognises untoward or significant events and always reports these Leads discussion of causes of clinical incidents with staff and enables them to reflect on the causes Able to undertake a root cause analysis
2	Demonstrates ability to lead team discussion on risk assessment and risk management and to work with the team to make organisational changes that will reduce risk and improve safety
3	Able to assess the risks across the system of care and to work with colleagues from different department or sectors to ensure safety across the health care system
4	Shows support for junior colleagues who are involved in untoward events Is fastidious about following safety protocols and encourages junior colleagues to do the same

Team working and patient safety

To develop the ability to work well in a variety of different teams – for example the ward team and the infection control team - and to contribute to discussion on the team's role in patient safety To develop the leadership skills necessary to lead teams so that they are more effective and able to deliver better safer care		
Knowledge	Assessment Methods	GMP Domains

Outline the components of effective collaboration	C, ACAT	1
Describe the roles and responsibilities of members of the healthcare team	C, ACAT	1
Outline factors adversely affecting a doctor's performance and methods to rectify these	C	1
Skills		
Practise with attention to the important steps of providing good continuity of care	Mi, C, ACAT	1,3.4
Accurate attributable note-keeping	Mi, C, ACAT	1, 3
Preparation of patient lists with clarification of problems and ongoing care plan	Mi, C, ACAT. M	1
Detailed hand over between shifts and areas of care	Mi, C, ACAT, M	1, 3
Demonstrate leadership and management in the following areas: Education and training, Deteriorating performance of colleagues (e.g. stress, fatigue), High quality care, Effective handover of care between shifts and teams	Mi, C, ACAT	1, 2, 3
Lead and participate in interdisciplinary team meetings	Mi, C, ACAT	3
Provide appropriate supervision to less experienced colleagues	Mi, C, ACAT, M	3
Behaviours		
Encourage an open environment to foster concerns and issues about the functioning and safety of team working	Mi, C, ACAT, M	3
Recognise and respect the request for a second opinion	Mi, C, ACAT, M	3
Recognise the importance of induction for new members of a team	Mi, C, ACAT, M	3
Recognise the importance of prompt and accurate information sharing with Primary Care team following hospital discharge	Mi, C, ACAT, M	3

Level Descriptor	
1	Works well within the multidisciplinary team and recognises when assistance is required from the relevant team member Demonstrates awareness of own contribution to patient safety within a team and is able to outline the roles of other team members Keeps records up-to-date and legible and relevant to the safe progress of the patient Hands over care in a precise, timely and effective manner
2	Demonstrates ability to discuss problems within a team to senior colleagues. Provides an analysis and plan for change

	Demonstrates ability to work with the virtual team to develop the ability to work well in a variety of different teams – for example the ward team and the infection control team - and to contribute to discussion on the team's role in patient safety To develop the leadership skills necessary to lead teams so that they are more effective and able to deliver better safer care
3	Leads multidisciplinary team meetings but promotes contribution from all team members Recognises need for optimal team dynamics and promotes conflict resolution Demonstrates ability to convey to patients after a handover of care that although there is a different team, the care is continuous
4	Leads multi-disciplinary team meetings allowing all voices to be heard and considered. Fosters an atmosphere of collaboration Demonstrates ability to work with the virtual team Ensures that team functioning is maintained at all times Promotes rapid conflict resolution

Principles of quality and safety improvement

To recognise the desirability of monitoring performance, learning from mistakes and adopting no blame culture in order to ensure high standards of care and optimise patient safety		
Knowledge	Assessment Methods	GMP Domains
Understand the elements of clinical governance	C, M	1
Recognise that governance safeguards high standards of care and facilitates the development of improved clinical services	C, M	1, 2
Define local and national significant event reporting systems relevant to specialty	Mi, C, ACAT,	1
Recognise importance of evidence-based practice in relation to clinical effectiveness	E, C	1
Outline local health and safety protocols (fire, manual handling etc)	C	1
Understand risk associated with the trainee's specialty work including biohazards and mechanisms to reduce risk	C	1
Outline the use of patient early warning systems to detect clinical deterioration where relevant to the trainees clinical specialty	Mi, C, ACAT,	1
Keep abreast of national patient safety initiatives including National Patient Safety Agency , NCEPOD reports, NICE guidelines etc	Mi, C, ACAT,	1
Skills		
Adopt strategies to reduce risk e.g. surgical pause	ACAT, C	1, 2
Contribute to quality improvement processes e.g. Audit of personal and departmental performance Errors / discrepancy meetings Critical incident reporting Unit morbidity and mortality meetings Local and national databases	AA, C	2
Maintain a folder of information and evidence, drawn from your medical practice	C	2
Reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation	AA	1, 2, 3, 4
Behaviours		

Show willingness to participate in safety improvement strategies such as critical incident reporting	C, M	3
Engage with an open no blame culture	C, M	3
Respond positively to outcomes of audit and quality improvement	C, M	1, 3
Co-operate with changes necessary to improve service quality and safety	C, M	1, 2

Level Descriptor	
1	Understands that clinical governance is the over-arching framework that unites a range of quality improvement activities. This safeguards high standards of care and facilitates the development of improved clinical services Maintains personal portfolio
2	Able to define key elements of clinical governance Engages in audit
3	Demonstrates personal and service performance Designs audit protocols and completes audit loop
4	Leads in review of patient safety issues Implements change to improve service Engages and guides others to embrace governance

Infection control

To develop the ability to manage and control infection in patients. Including controlling the risk of cross-infection, appropriately managing infection in individual patients, and working appropriately within the wider community to manage the risk posed by communicable diseases		
Knowledge	Assessment Methods	GMP Domains
Understand the principles of infection control as defined by the GMC	E, Mi, C, ACAT	1
Understand the principles of preventing infection in high risk groups (e.g. managing antibiotic use to prevent Clostridium difficile) including understanding the local antibiotic prescribing policy	E, Mi, C, ACAT	1
Understand the role of Notification within the UK and identify the principle notifiable diseases for UK and international purposes	E, Mi, C, ACAT	1
Understand the role of the Health Protection Agency and Consultants in Health Protection (previously Consultants in Communicable Disease Control – CCDC)	C, ACAT	1
Understand the role of the local authority in relation to infection control	ACAT, C, Mi	1
Skills		
Recognise the potential for infection within patients being cared for	E, Mi, C, ACAT	1, 2
Counsel patients on matters of infection risk, transmission and control	E, Mi, C, ACAT, PS	2, 3
Actively engage in local infection control procedures	ACAT, C	1
Actively engage in local infection control monitoring and reporting processes	ACAT, C	1, 2
Prescribe antibiotics according to local antibiotic guidelines	ACAT, C, Mi	1
Recognise potential for cross-infection in clinical settings	E, ACAT, C, Mi	1, 2
Practice aseptic technique whenever relevant	D	1
Behaviours		
Encourage all staff, patients and relatives to observe infection control principles	E, ACAT, C, M	1, 3
Level Descriptor		

1	Always follows local infection control protocols. Including washing hands before and after seeing all patients Is able to explain infection control protocols to students and to patients and their relatives. Always defers to the nursing team about matters of ward management Aware of infections of concern – including MRSA and C. difficile Aware of the risks of nosocomial infections Understands the links between antibiotic prescription and the development of nosocomial infections Always discusses antibiotic use with a more senior colleague
2	Demonstrate ability to perform simple clinical procedures utilising aseptic technique Manages simple common infections in patients using first-line treatments. Communicating effectively to the patient the need for treatment and any prevention messages to prevent re-infection or spread Liaise with diagnostic departments in relation to appropriate investigations and tests
3	Demonstrate an ability to perform more complex clinical procedures whilst maintaining aseptic technique throughout Identify potential for infection amongst high risk patients obtaining appropriate investigations and considering the use of second line therapies Communicate effectively to patients and their relatives with regard to the infection, the need for treatment and any associated risks of therapy Work effectively with diagnostic departments in relation to identifying appropriate investigations and monitoring therapy Working in collaboration with external agencies in relation to reporting common notifiable diseases, and collaborating over any appropriate investigation or management
4	Demonstrates an ability to perform most complex clinical procedures whilst maintaining full aseptic precautions, including those procedures which require multiple staff in order to perform the procedure satisfactorily Identify the possibility of unusual and uncommon infections and the potential for atypical presentation of more frequent infections. Managing these cases effectively with potential use of tertiary treatments being undertaken in collaboration with infection control specialists Work in collaboration with diagnostic departments to investigate and manage the most complex types of infection including those potentially requiring isolation facilities Work in collaboration with external agencies to manage the potential for infection control within the wider community including communicating effectively with the general public and liaising with regional and national bodies where appropriate

Managing long term conditions and promoting patient self-care

Knowledge	Assessment Methods	GMP Domains

Recall the natural history of diseases that run a chronic course	E, C, Mi, ACAT	1
Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care	E, C, Mi, ACAT	1
Outline the concept of quality of life and how this can be measured	C	1
Outline the concept of patient self-care	C, Mi	1
Know, understand and be able to compare medical and social models of disability	C	1
Understand the relationship between local health, educational and social service provision including the voluntary sector	C	1
Skills		
Develop and agree a management plan with the patient (and carers), ensuring comprehension to maximise self-care within care pathways when relevant	E, C, Mi, ACAT	1, 3
Develop and sustain supportive relationships with patients with whom care will be prolonged	C, Mi	1, 4
Provide effective patient education, with support of the multi-disciplinary team	E, C, Mi, ACAT	1, 3, 4
Promote and encourage involvement of patients in appropriate support networks, both to receive support and to give support to others	E, C, PS	1, 3
Encourage and support patients in accessing appropriate information	E, C, PS	1, 3
Provide the relevant and evidence based information in an appropriate medium to enable sufficient choice, when possible	E, C, PS	1, 3
Behaviours		
Show willingness to act as a patient advocate	E, C, Mi, ACAT	3, 4
Recognise the impact of long term conditions on the patient, family and friends	E, C, Mi, ACAT	1
Ensure equipment and devices relevant to the patient's care are discussed	C, Mi, ACAT	1
Put patients in touch with the relevant agency including the voluntary sector from where they can procure the items as appropriate	ACAT, C, Mi	1, 3
Provide the relevant tools and devices when possible	ACAT, C ,Mi	1, 2

Show willingness to facilitate access to the appropriate training and skills in order to develop the patient's confidence and competence to self care	ACAT, C, Mi, PS	1, 3,4
Show willingness to maintain a close working relationship with other members of the multi-disciplinary team, primary and community care	ACAT, C, MI, M	3
Recognise and respect the role of family, friends and carers in the management of the patient with a long term condition	ACAT, C, Mi, PS	1,3

Level Descriptor	
1	Describes relevant long term conditions Understands the meaning of quality of life Is aware of the need for promotion of patient self care Helps the patient with an understanding of their condition and how they can promote self management
2	Demonstrates awareness of management of relevant long term conditions Is aware of the tools and devices that can be used in long term conditions Is aware of external agencies that can improve patient care Teaches the patient and within the team to promote excellent patient care
3	Develops management plans in partnership with the patient that are pertinent to the patients long term condition Can use relevant tools and devices in improving patient care Engages with relevant external agencies to promote patient care
4	Provides leadership within the multidisciplinary team that is responsible for management of patients with long term conditions Helps the patient networks develop and strengthen

Issues of communication both with patients and carers and within the healthcare team are often causes of complaint and inadequate communication can lead to poorer standards of patient care. Specific issues are highlighted within this section to promote better communication generally and within certain situations

Relationships with patients and communication within a consultation

Communicate effectively and sensitively with patients, relatives and carers		
Knowledge	Assessment Methods	GMP Domains

Structure an interview appropriately	E, ACAT, C, Mi, PS	1
Understand the importance of the patient's background, culture, education and preconceptions (ideas, concerns, expectations) to the process	ACAT, C, Mi, PS	1
Skills		
Establish a rapport with the patient and any relevant others (e.g. carers)	E, ACAT, C, Mi, PS	1, 3
Listen actively and question sensitively to guide the patient and to clarify information	E, ACAT, C, Mi, PS	1, 3
Identify and manage communication barriers, tailoring language to the individual patient and using interpreters when indicated	E, ACAT, C, Mi, PS	1, 3
Deliver information compassionately, being alert to and managing their and your emotional response (anxiety, antipathy etc)	E, ACAT, C, Mi	1, 3,4
Use, and refer patients to, appropriate written and other information sources	E, ACAT, C, Mi	1, 3
Check the patient's/carer's understanding, ensuring that all their concerns/questions have been covered	E, ACAT, C, Mi	1, 3
Indicate when the interview is nearing its end and conclude with a summary	E, ACAT, C, Mi	1, 3
Make accurate contemporaneous records of the discussion	ACAT, C, Mi	1, 3
Manage follow-up effectively	ACAT, C, Mi	1
Behaviours		
Approach the situation with courtesy, empathy, compassion and professionalism, especially by appropriate body language - act as an equal not a superior	E, ACAT, C, Mi, M, PS	1, 3, 4
Ensure that the approach is inclusive and patient centred and respect the diversity of values in patients, carers and colleagues	E, ACAT, C, Mi, M, PS	1, 3
Be willing to provide patients with a second opinion	E, ACAT, C, Mi, M, PS	1, 3
Use different methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved	E, ACAT, C, Mi, M	1, 3
Be confident and positive in one’s own values	E, ACAT, C, Mi	1, 3

Level Descriptor	
1	Conducts simple interviews with due empathy and sensitivity and writes accurate records thereof
2	Conducts interviews on complex concepts satisfactorily, confirming that accurate two-way communication has occurred
3	Handles communication difficulties appropriately, involving others as necessary; establishes excellent rapport
4	Shows mastery of patient communication in all situations, anticipating and managing any difficulties which may occur

Breaking bad news

To recognise the fundamental importance of breaking bad news. To develop strategies for skilled delivery of bad news according to the needs of individual patients and their relatives / carers		
Knowledge	Assessment Methods	GMP Domains
Recognise that the way in which bad news is delivered irretrievably affects the subsequent relationship with the patient	E, ACAT, C, Mi, M, PS	1
Recognise that every patient may desire different levels of explanation and have different responses to bad news	E, ACAT, C, Mi, M, PS	1, 4
Recognise that bad news is confidential but the patient may wish to be accompanied	E, ACAT, C, Mi, M, PS	1
Recognise that breaking bad news can be extremely stressful for the doctor or professional involved	E, ACAT, C, Mi, M	1, 3
Understand that the interview may be an educational opportunity	E, ACAT, C, Mi, M	1
Recognise the importance of preparation when breaking bad news by: Setting aside sufficient uninterrupted time Choosing an appropriate private environment Having sufficient information regarding prognosis and treatment Structuring the interview Being honest, factual, realistic and empathic Being aware of relevant guidance documents	E, ACAT, C, Mi	1, 3
Understand that “bad news” may be expected or unexpected	E, ACAT, C, Mi	1
Recognise that sensitive communication of bad news is an essential part of professional practice	E, ACAT, C, Mi	1
Understand that “bad news” has different connotations depending on the context, individual, social and cultural circumstances	E, ACAT, C, Mi, M	1
Recall that a post mortem examination may be required and understand what this involves	E, ACAT, C, Mi, M, PS	1
Recall the local organ retrieval process	ACAT, C, Mi	1
Skills		
Demonstrate to others good practice in breaking bad news	E, C, D, M	1, 3
Involve patients and carers in decisions regarding their future management	E, C, D, M	1, 3, 4

Encourage questioning and ensure comprehension	E, C, D, M	1, 3
Respond to verbal and visual cues from patients and relatives	E, C, D, M	1, 3
Act with empathy, honesty and sensitivity avoiding undue optimism or pessimism	E, C, D, M	1, 3
Structure the interview e.g. Set the scene, Establish understanding, Discuss; diagnosis, implications, treatment, prognosis and subsequent care	E, C, D, M	1, 3
Behaviours		
Take leadership in breaking bad news	C, D, M	1
Respect the different ways people react to bad news	C, D, M	1

Level Descriptor	
1	Recognises when bad news must be imparted Recognises the need to develop specific skills Requires guidance to deal with most cases
2	Able to break bad news in planned settings Prepares well for interview Prepares patient to receive bad news Responsive to patient reactions
3	Able to break bad news in unexpected and planned settings Clear structure to interview Establishes what patient wants to know and ensures understanding Able to conclude interview
4	Skilfully delivers bad news in any circumstance including adverse events Arranges follow up as appropriate Able to teach others how to break bad news

Complaints and medical error

Knowledge	Assessment Methods	GMP Domains
Basic consultation techniques and skills described for Foundation programme and to include: Define the local complaints procedure Recognise factors likely to lead to complaints (poor communication, dishonesty etc) Adopt behaviour likely to prevent complaints Dealing with dissatisfied patients or relatives Recognise when something has gone wrong and identify appropriate staff to communicate this with Act with honesty and sensitivity in a non-confrontational manner	C, D, M	1
Outline the principles of an effective apology	C, D, M	1
Identify sources of help and support when a complaint is made about yourself or a colleague	C, D, M	1
Skills		
Contribute to processes whereby complaints are reviewed and learned from	C, D, M	1
Explain comprehensibly to the patient the events leading up to a medical error	C, D, M	1, 3
Deliver an appropriate apology	C, D, M	1, 3, 4
Distinguish between system and individual errors	C, D, M	1
Show an ability to learn from previous error	C, D, M	1
Behaviours		
Take leadership over complaint issues	C, D, M	1
Recognise the impact of complaints and medical error on staff, patients, and the National Health Service	C, D, M	1, 3
Contribute to a fair and transparent culture around complaints and errors	C, D, M	1
Recognise the rights of patients, family members and carers to make a complaint	C, D, M	1, 4
Level Descriptor		
1	Defines the local complaints procedure	

	Recognises need for honesty in management of complaints Responds promptly to concerns that have been raised Understands the importance of an effective apology Learns from errors
2	Manages conflict without confrontation Recognises and responds to the difference between system failure and individual error
3	Recognises and manages the effects of any complaint within members of the team
4	Provides timely accurate written responses to complaints when required Provides leadership in the management of complaints

Communication with colleagues and cooperation

Recognise and accept the responsibilities and role of the doctor in relation to other healthcare professionals. Communicate succinctly and effectively with other professionals as appropriate		
Knowledge	Assessment Methods	GMP Domains
Understand the section in "Good Medical Practice" on Working with Colleagues, in particular:	C, M	1
The roles played by all members of a multi-disciplinary team	C, M	1
The features of good team dynamics	C, M	1
The principles of effective inter-professional collaboration to optimise patient, or population, care	C, M	1
Skills		
Communicate accurately, clearly, promptly and comprehensively with relevant colleagues by means appropriate to the urgency of a situation (telephone, email, letter etc), especially where responsibility for a patient's care is transferred	ACAT, C, Mi	1, 3
Utilise the expertise of the whole multi-disciplinary team as appropriate, ensuring when delegating responsibility that appropriate supervision is maintained	ACAT, C, Mi, M	1, 3
Participate in, and co-ordinate, an effective hospital at night team when relevant	ACAT, C, Mi, M	1
Communicate effectively with administrative bodies and support organisations	C, Mi, M	1, 3

Employ behavioural management skills with colleagues to prevent and resolve conflict	ACAT, C, Mi, M	1, 3
Behaviours		
Be aware of the importance of, and take part in, multi-disciplinary work, including adoption of a leadership role when appropriate	ACAT, C, Mi, M	3
Foster a supportive and respectful environment where there is open and transparent communication between all team members	ACAT, C, Mi, M	1, 3
Ensure appropriate confidentiality is maintained during communication with any member of the team	ACAT, C, Mi, M	1, 3
Recognise the need for a healthy work/life balance for the whole team, including yourself, but take any leave yourself only after giving appropriate notice to ensure that cover is in place	C, Mi, M	1
Be prepared to accept additional duties in situations of unavoidable and unpredictable absence of colleagues	C, M	1

Level Descriptor	
1	Accepts his/her role in the healthcare team and communicates appropriately with all relevant members thereof
2	Fully recognises the role of, and communicates appropriately with, all relevant potential team members (individual and corporate)
3	Able to predict and manage conflict between members of the healthcare team
4	Able to take a leadership role as appropriate, fully respecting the skills, responsibilities and viewpoints of all team members

For all hospital based physicians there is a need to be aware of public health issues and health promotion. Competences that promote this awareness are defined in the next section

Health promotion and public health

To progressively develop the ability to work with individuals and communities to reduce levels of ill health, remove inequalities in healthcare provision and improve the general health of a community.		
Knowledge	Assessment Methods	GMP Domains
Understand the factors which influence the incidence of and prevalence of common conditions	E, C, Mi	1
Understand the factors which influence health – psychological, biological, social, cultural and economic especially poverty	E, C, Mi	1
Understand the influence of lifestyle on health and the factors that influence an individual to change their lifestyle	E, C, Mi	1
Understand the purpose of screening programmes and know in outline the common programmes available within the UK	E, C, Mi	1
Understand the relationship between the health of an individual and that of a community	E, C, Mi	1
Know the key local concerns about health of communities such as smoking and obesity	E, C, Mi	1
Understand the role of other agencies and factors including the impact of globalisation in protecting and promoting health	E, C, Mi	1
Demonstrate knowledge of the determinants of health worldwide and strategies to influence policy relating to health issues including the impact of the developed world strategies on the third world	E, C, Mi	1
Outline the major causes of global morbidity and mortality and effective, affordable interventions to reduce these	E, C, Mi	1
Recall the effect of addictive behaviours, especially substance misuse and gambling, on health and poverty	E, C, Mi	1
Skills		
Identify opportunities to prevent ill health and disease in patients	E, C, Mi, PS	1, 2
Identify opportunities to promote changes in lifestyle and other actions which will positively improve health	E, C, Mi	1, 2
Identify the interaction between mental, physical and social wellbeing in relation to health	E, C, Mi	1
Counsel patients appropriately on the benefits and risks of screening	E, C, Mi PS	1, 3

Work collaboratively with other agencies to improve the health of communities		E, C, Mi	1
Behaviours			
Engage in effective team-working around the improvement of health		C, M	1, 3
Encourage where appropriate screening to facilitate early intervention		C	1
Level Descriptor			
1	Discuss with patients and others factors which could influence their personal health Maintains own health is aware of own responsibility as a doctor for promoting healthy approach to life		
2	Communicate to an individual, information about the factors which influence their personal health Support an individual in a simple health promotion activity (e.g. smoking cessation)		
3	Communicate to an individual and their relatives, information about the factors which influence their personal health Support small groups in a simple health promotion activity (e.g. smoking cessation) Provide information to an individual about a screening programme and offer information about its risks and benefits		
4	Discuss with small groups the factors that have an influence on their health and describe initiatives they can undertake to address these Provide information to an individual about a screening programme offering specific guidance in relation to their personal health and circumstances concerning the factors that would affect the risks and benefits of screening to them as an individual Engage with local or regional initiatives to improve individual health and reduce inequalities in health between communities		

The legal and ethical framework associated with healthcare must be a vital part of the practitioner's competences if safe practice is to be sustained. Within this the ethical aspects of research must be considered. The competences associated with these areas of practice are defined in the following section.

Principles of medical ethics and confidentiality

To know, understand and apply appropriately the principles, guidance and laws regarding medical ethics and confidentiality		
Knowledge	Assessment Methods	GMP Domains
Demonstrate knowledge of the principles of medical ethics	E, ACAT, C, Mi	1
Outline and follow the guidance given by the GMC on confidentiality	E, ACAT, C, Mi	1
Define the provisions of the Data Protection Act and Freedom of Information Act	E, ACAT, C, Mi	1
Define the role of the Caldicott Guardian within an institution, and outline the process of attaining Caldicott approval for audit or research	E, ACAT, C, Mi	1, 4
Outline situations where patient consent, while desirable, is not required for disclosure e.g. communicable diseases, public interest	E, ACAT, C, Mi	1, 4
Outline the procedures for seeking a patient's consent for disclosure of identifiable information	E, ACAT, C, Mi	1
Recall the obligations for confidentiality following a patient's death	E, ACAT, C, Mi	1, 4
Recognise the problems posed by disclosure in the public interest, without patient's consent	E, ACAT, C, Mi	1, 4
Recognise the factors influencing ethical decision making: religion, moral beliefs, cultural practices	ACAT, C, Mi	1
Do not resuscitate: Define the standards of practice defined by the GMC when deciding to withhold or withdraw life-prolonging treatment	ACAT, C, Mi	1
Outline the principles of the Mental Capacity Act	ACAT, C, Mi	1
Skills		
Use and share information with the highest regard for confidentiality, and encourage such behaviour in other members of the team	ACAT, C, Mi, M	1, 2,3

Use and promote strategies to ensure confidentiality is maintained e.g. anonymisation	C	1
Counsel patients on the need for information distribution within members of the immediate healthcare team	E, ACAT, C, M	1, 3
Counsel patients, family, carers and advocates tactfully and effectively when making decisions about resuscitation status, and withholding or withdrawing treatment	E, ACAT, C, M PS	1, 3
Behaviours		
Encourage ethical reflection in others	ACAT, C, M	1
Show willingness to seek advice of peers, legal bodies, and the GMC in the event of ethical dilemmas over disclosure and confidentiality	E, ACAT, C, M	1
Respect patient's requests for information not to be shared, unless this puts the patient, or others, at risk of harm	E, ACAT, C, M, PS	1, 4
Show willingness to share information about their care with patients, unless they have expressed a wish not to receive such information	ACAT, C, M	1, 3
Show willingness to seek the opinion of others when making decisions about resuscitation status, and withholding or withdrawing treatment	ACAT, C, M, MSF	1, 3

Level Descriptor	
1	Use and share information with the highest regard for confidentiality adhering to the Data Protection Act and Freedom of Information Act in addition to guidance given by the GMC Familiarity with the principles of the Mental Capacity Act Participate in decisions about resuscitation status and withholding or withdrawing treatment
2	Counsel patients on the need for information distribution within members of the immediate healthcare team and seek patients' consent for disclosure of identifiable information
3	Define the role of the Caldicott Guardian within an institution, and outline the process of attaining Caldicott approval for audit or research
4	Able to assume a full role in making and implementing decisions about resuscitation status and withholding or withdrawing treatment

Valid consent

To obtain valid consent from the patient		
Knowledge	Assessment Methods	GMP Domains
Outline the guidance given by the GMC on consent, in particular:	C, D, M	1

Understand that consent is a process that may culminate in, but is not limited to, the completion of a consent form Understand the particular importance of considering the patient's level of understanding and mental state (and also that of the parents, relatives or carers when appropriate) and how this may impair their capacity for informed consent		
Skills		
Present all information to patients (and carers) in a format they understand, allowing time for reflection on the decision to give consent	E, ACAT, C, Mi, PS	1, 3
Provide a balanced view of all care options	E, ACAT, C, Mi, PS	1, 3, 4
Behaviours		
Respect a patient's rights of autonomy even in situations where their decision might put them at risk of harm	E, ACAT, C, Mi, PS	1
Avoid exceeding the scope of authority given by a patient	E, ACAT, C, Mi, PS	1
Avoid withholding information relevant to proposed care or treatment in a competent adult	E, ACAT, C, Mi, PS	1, 3, 4
Show willingness to seek advance directives	E, ACAT, C, Mi, PS	1, 3
Show willingness to obtain a second opinion, senior opinion, and legal advice in difficult situations of consent or capacity	E, ACAT, C, Mi, PS	1, 3
Inform a patient and seek alternative care where personal, moral or religious belief prevents a usual professional action	E, ACAT, C, Mi, PS	1, 3, 4

Level Descriptor	
1	Obtains consent for straightforward treatments with appropriate regard for patient's autonomy
2	Able to explain complex treatments meaningfully in layman's terms and thereby to obtain appropriate consent
3	Obtains consent in "grey-area" situations where the best option for the patient is not clear
4	Obtains consent in all situations even when there are problems of communication and capacity

Legal framework for practice

To understand the legal framework within which healthcare is provided in the UK in order to ensure that personal clinical practice is always provided in line with this legal framework

Knowledge	Assessment Methods	GMP Domains
All decisions and actions must be in the best interests of the patient	E, ACAT, C, Mi	1
Understand the legislative framework within which healthcare is provided in the UK – in particular death certification and the role of the Coroner/Procurator Fiscal; child protection legislation; mental health legislation (including powers to detain a patient and giving emergency treatment against a patient's will under common law); advanced directives and living Wills; withdrawing and withholding treatment; decisions regarding resuscitation of patients; surrogate decision making; organ donation and retention; communicable disease notification; medical risk and driving; Data Protection and Freedom of Information Acts; provision of continuing care and community nursing care by a local authorities	ACAT, C, Mi	1, 2
Understand the differences between legislation in the four countries of the UK	C	1
Understand sources of medical legal information	ACAT, C, Mi	1
Understand disciplinary processes in relation to medical malpractice	ACAT, C, Mi, M	1
Understand the role of the medical practitioner in relation to personal health and substance misuse, including understanding the procedure to be followed when such abuse is suspected	ACAT, C, Mi, M	1
Skills		
Ability to cooperate with other agencies with regard to legal requirements – including reporting to the Coroner's Officer or the proper officer of the local authority in relevant circumstances	ACAT, C, Mi	1
Ability to prepare appropriate medical legal statements for submission to the Coroner's Court, Procurator Fiscal, Fatal Accident Inquiry and other legal proceedings	C, M	1
Be prepared to present such material in Court	C, Mi	1
Incorporate legal principles into day to day practice	ACAT, C, Mi	1
Practice and promote accurate documentation within clinical practice	ACAT, C, Mi	1, 3
Behaviours		
Show willingness to seek advice from the Healthcare Trust, legal bodies (including defence unions), and the GMC on medico-legal matters	ACAT, C, Mi, M	1
Promote reflection on legal issues by members of the team	ACAT, C, Mi, M	1, 3

Level Descriptor	
1	Demonstrates knowledge of the legal framework associated with medical qualification and medical practice and the responsibilities of registration with the GMC. Demonstrates knowledge of the limits to professional capabilities - particularly those of pre-registration doctors.
2	Identify with Senior Team Members cases which should be reported to external bodies and where appropriate and initiate that report. Identify with Senior Members of the Clinical Team situations where you feel consideration of medical legal matters may be of benefit. Be aware of local Hospital procedures around substance abuse and clinical malpractice.
3	Work with external strategy bodies around cases that should be reported to them. Collaborating with them on complex cases preparing brief statements and reports as required. Actively promote discussion on medical legal aspects of cases within the clinical environment. Participate in decision making with regard to resuscitation decisions and around decisions related to driving discussing the issues openly but sensitively with patients and relatives
4	Work with external strategy bodies around cases that should be reported to them. Collaborating with them on complex cases providing full medical legal statements as required and present material in Court where necessary Lead the clinical team in ensuring that medical legal factors are considered openly and consistently wherever appropriate in the care of a patient. Ensuring that patients and relatives are involved openly in all such decisions.

Ethical research

To ensure that research is undertaken using relevant ethical guidelines		
Knowledge	Assessment Methods	GMP Domains
Outline the GMC guidance on good practice in research	ACAT, C	1
Outline the differences between audit and research	AA, C, Mi	1
Describe how clinical guidelines are produced	C	1
Demonstrate a knowledge of research principles	C, Mi	1
Outline the principles of formulating a research question and designing a project	C, Mi	1
Comprehend principal qualitative, quantitative, bio-statistical and epidemiological research methods	C	1
Outline sources of research funding	C	1

Skills		
Develop critical appraisal skills and apply these when reading literature	C	1
Demonstrate the ability to write a scientific paper	C	1
Apply for appropriate ethical research approval	C	1
Demonstrate the use of literature databases	C	1
Demonstrate good verbal and written presentations skills	C, D	1
Understand the difference between population-based assessment and unit-based studies and be able to evaluate outcomes for epidemiological work	C	1
Behaviours		
Recognise the ethical responsibilities to conduct research with honesty and integrity, safeguarding the interests of the patient and obtaining ethical approval when appropriate	C, M	1
Follow guidelines on ethical conduct in research and consent for research	C	1
Show willingness to the promotion of involvement in research	C	1

Level Descriptor	
1	Defines ethical research and demonstrates awareness of GMC guidelines Differentiates audit and research Knows how to use databases
2	Demonstrates ability to write a scientific paper Demonstrates critical appraisal skills
3	Demonstrates ability to apply for appropriate ethical research approval Demonstrates knowledge of research funding sources Demonstrates good presentation and writing skills
4	Provides leadership in research Promotes research activity Formulates and develops research pathways

It is the responsibility of each practitioner to ensure that they are aware of relevant developments in clinical care and also ensure that their practice conforms to the highest standards of practice that may be possible. An awareness of the evidence base behind current practice and a need to audit one's own practice is vital for the physician training in general internal medicine

Evidence and guidelines

To progressively develop the ability to make the optimal use of current best evidence in making decisions about the care of patients To progressively develop the ability to construct evidence based guidelines in relation to medical practise		
Knowledge	Assessment Methods	GMP Domains
Understands of the application of statistics in scientific medical practice	E, C	1
Understand the advantages and disadvantages of different study methodologies (randomised control trials, case controlled cohort etc)	E, C	1
Understand the principles of critical appraisal	C	1
Understand levels of evidence and quality of evidence	E, C	1
Understand the role and limitations of evidence in the development of clinical guidelines	E, C	1
Understand the advantages and disadvantages of guidelines	C	1
Understand the processes that result in nationally applicable guidelines (e.g. NICE and SIGN)	C	1
Skills		
Ability to search the medical literature including use of PubMed, Medline, Cochrane reviews and the internet	C	1
Appraise retrieved evidence to address a clinical question	C	1
Apply conclusions from critical appraisal into clinical care	E, C	1
Identify the limitations of research	C	1
Contribute to the construction, review and updating of local (and national) guidelines of good practice using the principles of evidence based medicine	C	1
Behaviours		
Keep up to date with national reviews and guidelines of practice (e.g. NICE and SIGN)	E, C	1

Aim for best clinical practice (clinical effectiveness) at all times, responding to evidence based medicine	ACAT, C, Mi	1
Recognise the occasional need to practise outside clinical guidelines	ACAT, C, Mi	1
Encourage discussion amongst colleagues on evidence-based practice	ACAT, C, Mi, M	1

Level Descriptor	
1	Participate in departmental or other local journal club Critically review an article to identify the level of evidence
2	Lead in a departmental or other local journal club Undertake a literature review in relation to a clinical problem or topic
3	Produce a review article on a clinical topic, having reviewed and appraised the relevant literature
4	Perform a systematic review of the medical literature Contribute to the development of local or national clinical guidelines

Audit

To progressively develop the ability to perform an audit of clinical practice and to apply the findings appropriately		
Knowledge	Assessment Methods	GMP Domains
Understand the different methods of obtaining data for audit including patient feedback questionnaires, hospital sources and national reference data	AA, C	1
Understand the role of audit (developing patient care, risk management etc)	AA, C	1
Understand the steps involved in completing the audit cycle	AA, C	1
Understands the working and uses of national and local databases used for audit such as specialty data collection systems, cancer registries etc. The working and uses of local and national systems available for reporting and learning from clinical incidents and near misses in the UK	AA, C	1
Skills		
Design, implement and complete audit cycles	AA, C	1, 2
Contribute to local and national audit projects as appropriate (e.g. NCEPOD, SASM)	AA, C	1, 2
Support audit by junior medical trainees and within the multi-disciplinary team	AA, C	1, 2
Behaviours		
Recognise the need for audit in clinical practice to promote standard setting and quality assurance	AA, C	1, 2

Level Descriptor	
1	Attendance at departmental audit meetings Contribute data to a local or national audit
2	Identify a problem and develop standards for a local audit
3	Compare the results of an audit with criteria or standards to reach conclusions Use the findings of an audit to develop and implement change Organise or lead a departmental audit meeting
4	Lead a complete clinical audit cycle including development of conclusions, implementation of findings and re-audit to assess the effectiveness of the changes Become audit lead for an institution or organisation

A good physician will ensure that the knowledge possessed is communicated effectively. In the formal setting of teaching and training specific competences will have to be acquired to ensure that the practitioner recognises the best practise and techniques

Teaching and training

To progressively develop the ability to teach to a variety of different audiences in a variety of different ways To progressively be able to assess the quality of the teaching To progressively be able to train a variety of different trainees in a variety of different ways To progressively be able to plan and deliver a training programme with appropriate assessments		
Knowledge	Assessment Methods	GMP Domains
Outline adult learning principles relevant to medical education:	C, TO	1
Identification of learning methods and effective learning environments	C, TO	1
Construction of educational objectives	C, TO	1
Use of effective questioning techniques	C, TO	1
Varying teaching format and stimulus	C, TO	1
Demonstrate knowledge of relevant literature relevant to developments in medical education	C, TO	1
Outline the structure of the effective appraisal interview	C, TO	1
Define the roles to the various bodies involved in medical education	C, TO	1
Differentiate between appraisal and assessment and aware of the need for both	C, TO	1
Outline the workplace-based assessments in use and the appropriateness of each	C, TO	1
Demonstrate the definition of learning objectives and outcomes	C, TO	1
Outline the appropriate local course of action to assist the failing trainee	C, TO	1
Skills		
Vary teaching format and stimulus, appropriate to situation and subject	C, TO	1
Provide effective feedback after teaching, and promote learner reflection	C, M, TO	1
Conduct effective appraisal	C, M, TO	1

Demonstrate effective lecture, presentation, small group and bed side teaching sessions	C, M, TO	1, 3
Provide appropriate career advice, or refer trainee to an alternative effective source of career information	C, M, TO	1, 3
Participate in strategies aimed at improving patient education e.g. talking at support group meetings	C, M, TO	1
Be able to lead departmental teaching programmes including journal clubs	C, TO	1
Recognise the failing trainee	C, TO	1
Behaviours		
In discharging educational duties acts to maintain the dignity and safety of patients at all times	C, M, TO	1, 4
Recognise the importance of the role of the physician as an educator within the multi-professional healthcare team and uses medical education to enhance the care of patients	C, M, TO	1
Balances the needs of service delivery with the educational imperative	C, M, TO	1
Demonstrate willingness to teach trainees and other health and social workers in a variety of settings to maximise effective communication and practical skills	C, M, TO	1
Encourage discussions in the clinical settings to colleagues to share knowledge and understanding	C, M, TO	1, 3
Maintain honesty and objectivity during appraisal and assessment	C, M, TO	1
Show willingness to participate in workplace-based assessments	C, M, TO	1
Show willingness to take up formal tuition in medical education and respond to feedback obtained after teaching sessions	C, M, TO	1, 3
Demonstrates a willingness to become involved in the wider medical education activities and fosters an enthusiasm for medical education activity in others	C, M, TO	1
Recognise the importance of personal development as a role model to guide trainees in aspects of good professional behaviour	C, M, TO	1
Demonstrates consideration for learners including their emotional, physical and psychological well being with their development needs	C, M, TO	1

Level Descriptor	
1	Develops basic PowerPoint presentation to support educational activity Delivers small group teaching to medical students, nurses or colleagues

	Able to seek and interpret simple feedback following teaching
2	Able to supervise a medical student, nurse or colleague through a procedure Able to perform a workplace based assessment including being able to give effective feedback
3	Able to devise a variety of different assessments (e.g. multiple choice questions, work place based assessments) Able to appraise a medical student, nurse or colleague Able to act as a mentor to a medical student, nurses or colleague
4	Able to plan, develop and deliver educational activities with clear objectives and outcomes Able to plan, develop and deliver an assessment programme to support educational activities

The individual practitioner has to have appropriate attitudes and behaviours that help deal with complex situations and to work effectively providing leadership and working as part of the healthcare team

Personal behaviour

To develop the behaviours that will enable the doctor to become a senior leader able to deal with complex situations and difficult behaviours and attitudes. To work increasingly effectively with many teams and to be known to put the quality and safety of patient care as a prime objective To develop the attributes of someone who is trusted to be able to manage complex human, legal and ethical problem. To become someone who is trusted and is known to act fairly in all situations		
Knowledge	Assessment Methods	GMP Domains
Recall and build upon the competences defined in the Foundation Programme: Deal with inappropriate patient and family behaviour Respect the rights of children, elderly, people with physical, mental, learning or communication difficulties Adopt an approach to eliminate discrimination against patients from diverse backgrounds including age, gender, race, culture, disability, spirituality and sexuality Place needs of patients above own convenience Behave with honesty and probity Act with honesty and sensitivity in a non-confrontational manner	ACAT, C, Mi, M, PS	1, 2, 3, 4

The main methods of ethical reasoning: casuistry, ontology and consequentialist The overall approach of value based practice and how this relates to ethics, law and decision-making		
Define the concept of modern medical professionalism	C	1
Outline the relevance of professional bodies (Royal Colleges, JRCPTB, GMC, Postgraduate Dean, BMA, specialist societies, medical defence organisations)	C	1
Skills		
Practise with: integrity compassion altruism continuous improvement excellence respect of cultural and ethnic diversity regard to the principles of equity	ACAT, C, Mi, M, PS	1, 2, 3, 4
Work in partnership with members of the wider healthcare team	ACAT, C, Mi, M	3
Liaise with colleagues to plan and implement work rotas	ACAT, M	3
Promote awareness of the doctor's role in utilising healthcare resources optimally	ACAT, C, Mi, M	1, 3
Recognise and respond appropriately to unprofessional behaviour in other	E, ACAT, C	1
Be able to provide specialist support to hospital and community based services	ACAT, C, M	1
Be able to handle enquiries from the press and other media effectively	C, D	1, 3
Behaviours		
Recognise personal beliefs and biases and understand their impact on the delivery of health services	ACAT, C, Mi, M	1
Recognise the need to use all healthcare resources prudently and appropriately	ACAT, C, Mi	1, 2
Recognise the need to improve clinical leadership and management skill	ACAT, C, Mi	1
Recognise situations when it is appropriate to involve professional and regulatory bodies	ACAT, CbD, Mini-CEX	1

Show willingness to act as a mentor, educator and role model	ACAT, C, Mi, M	1
Be willing to accept mentoring as a positive contribution to promote personal professional development	ACAT, CbD, Mini-CEX	1
Participate in professional regulation and professional development	C, Mi, M	1
Takes part in 360 degree feedback as part of appraisal	C, M	1, 2, 4
Recognise the right for equity of access to healthcare	ACAT, C, Mi,	1
Recognise need for reliability and accessibility throughout the healthcare team	ACAT, C, Mi, M	1

Level Descriptor	
1	Works work well within the context of multi-professional teams. Listens well to others and takes other viewpoints into consideration. Supports patients and relatives at times of difficulty e.g. after receiving difficult news. Is polite and calm when called or asked to help
2	Responds to criticism positively and seeks to understand its origins and works to improve. Praises staff when they have done well and where there are failings in delivery of care provides constructive feedback. To wherever possible involve patients in decision making
3	Recognises when other staff are under stress and not performing as expected and provides appropriate support for them. Takes action necessary to ensure that patient safety is not compromised
4	Helps patients who show anger or aggression with staff or with their care or situation and works with them to find an approach to manage their problem
5	Is able to engender trust so that staff feel confident about sharing difficult problems and feel able to pointing out deficiencies in care at an early stage

Working within the health service there is a need to understand and work within the organisational structures that are set. A significant knowledge of leadership principles and practice as defined in the Medical Leadership Competence Framework is an important part of this competence

Management and NHS structure

To understand the structure of the NHS and the management of local healthcare systems in order to be able to participate fully in managing healthcare provision		
Knowledge	Assessment Methods	GMP Domains
Understand the guidance given on management and doctors by the GMC	C	1
Understand the local structure of NHS systems in your locality recognising the potential differences between the four countries of the UK	ACAT, CbD	1
Understand the structure and function of healthcare systems as they apply to your specialty	ACAT, C	1
Understand the consistent debates and changes that occur in the NHS including the political, social, technical, economic, organisational and professional aspects that can impact on provision of service	C	1
Understand the importance of local demographic, socio-economic and health data and the use to improve system performance	C	1
Understand the principles of: Clinical coding European Working Time Regulations National Service Frameworks Health regulatory agencies (e.g., NICE, Scottish Government) NHS Structure and relationships NHS finance and budgeting Consultant contract and the contracting process Resource allocation The role of the Independent sector as providers of healthcare	ACAT, C, Mi	1
Understand the principles of recruitment and appointment procedures	C	1
Skills		

Participate in managerial meetings	ACAT, C	1
Take an active role in promoting the best use of healthcare resources	ACAT, C, Mi	1
Work with stakeholders to create and sustain a patient-centred service	ACAT, C, Mi	1
Employ new technologies appropriately, including information technology	ACAT, C, Mi	1
Conduct an assessment of the community needs for specific health improvement measures	C, Mi	1
Behaviours		
Recognise the importance of just allocation of healthcare resources	C	1, 2
Recognise the role of doctors as active participants in healthcare systems	ACAT, C, Mi	1, 2
Respond appropriately to health service targets and take part in the development of services	ACAT, C, Mi	1, 2
Recognise the role of patients and carers as active participants in healthcare systems and service planning	ACAT, C, Mi, PS	1, 2, 3
Show willingness to improve managerial skills (e.g. management courses) and engage in management of the service	C, M	1

Level Descriptor	
1	Describes in outline the roles of primary care, including general practice, public health, community, mental health, secondary and tertiary care services within healthcare. Describes the roles of members of the clinical team and the relationships between those roles. Participates fully in clinical coding arrangements and other relevant local activities.
2	Can describe in outline the roles of primary care, community and secondary care services within healthcare. Can describe the roles of members of the clinical team and the relationships between those roles. Participates fully in clinical coding arrangements and other relevant local activities.
3	Can describe the relationship between PCTs/Health Boards, General Practice and Trusts including relationships with local authorities and social services. Participate in team and clinical directorate meetings including discussions around service development. Discuss the most recent guidance from the relevant health regulatory agencies in relation to the specialty.

4	Describe the local structure for health services and how they relate to regional or devolved administration structures. Be able to discuss funding allocation processes from central government in outline and how that might impact on the local health organisation. Participate fully in clinical directorate meetings and other appropriate local management structures in planning and delivering healthcare within the specialty. Participate as appropriate in staff recruitment processes in order to deliver an effective clinical team. Within the Directorate collaborate with other stake holders to ensure that their needs and views are considered in managing services.

6.0 ACCS Introduction to clinical presentations

The curriculum is designed to reflect real practice and the focus of the first two years of ACCS is on:

- The major presentations of patients who will need resuscitation (6.1)
- The key acute presentations of patients who are seen in a variety of settings: the Emergency Department, Intensive Care Unit, the Acute Medical Ward and those areas where anaesthetics are given (6.2).
- The management of the airway is a key skill of the ACCS trainee and the period of training within anaesthesia will give the grounding needed to look after the airway safely and effectively during ACCS and in the trainee's subsequent practice (6.3).

6.1 ACCS Major Presentations

Anaphylaxis

The trainee will be able to identify patients with anaphylactic shock, assess their clinical state, produce a list of appropriate differential diagnoses, initiate immediate resuscitation and management and organise further investigations		
Knowledge	**Assessment Methods**	**GMP Domains**
Identify physiological perturbations causing anaphylactic shock	E, C, Mi, ACAT	1
Recognise clinical manifestations of anaphylactic shock	E, C, Mi, ACAT	1
Elucidate causes of anaphylactic shock	E, C, Mi, ACAT	1
Know anaphylaxis guidelines	E, C, Mi, ACAT	1
Define follow-up pathways after acute resuscitation	E, C, Mi, ACAT	1
Skills		
Recognise clinical consequences of acute anaphylaxis	Mi, C, S	1
Perform immediate physical assessment (laryngeal oedema, bronchospasm, hypotension)	Mi, C, D, S	1
Institute resuscitation (adrenaline/epinephrine), oxygen, IV access, fluids)	Mi, C, D, S	1
Arrange monitoring of relevant indices	Mi, C, S	1
Order, interpret and act on initial investigations (tryptase, C1 esterase inhibitor etc.)	Mi, C	1
Be an ALS provider	L	1
Behaviour		
Exhibit a calm and methodical approach	ACAT, C, Mi, S	3
Adopt leadership role where appropriate	ACAT, C, Mi, S	2,4
Involve senior and specialist allergy services promptly	ACAT, C, Mi, S	2, 3

Cardio-Respiratory Arrest

The trainee will have full competence in the assessment and resuscitation of the patient who has suffered a cardio-respiratory arrest, as defined by the UK Resuscitation Council		
Knowledge	**Assessment Methods**	**GMP Domains**
Demonstrate knowledge of the causes of cardiac arrest including special situations, e.g. hypothermia, trauma, overdose. Be able to identify and correct reversible causes. Demonstrate knowledge of the outcomes of pre-hospital and in hospital arrest	E, C, Mi, ACAT	1
Demonstrate familiarity with the ALS and APLS algorithms and pharmacology.	E, C, Mi, ACAT	1
Outline indication and safe delivery of drugs used as per ALS and APLS algorithm	E, C, Mi, ACAT	1
Know how to manage the patient post arrest with ROSC Be able to diagnose and treat peri-arrest arrhythmias and know the indication, contraindications and side effects of the drugs used.	E, C, Mi, ACAT	1
Know of tissue and organ donation	E, C, Mi, ACAT	1
Skills		
Rapidly assess the collapsed patient in terms of ABC, airway, breathing and circulation	Mi, D, L	1
Perform Basic Life Support competently as defined by Resuscitation Council (UK): effective chest compressions, airway manoeuvres, bag and mask ventilation	Mi, D, L	1
Competently perform further steps in advanced life support: IV drugs; safe DC shocks when indicated; central line insertion, external pacing, endotracheal drug administration, identification and rectification of reversible causes of cardiac arrest	Mi, D, L	1
Break bad news appropriately (see generic curriculum)	Mi, C, M	3, 4
Behaviour		
Recognise and intervene in critical illness promptly to prevent cardiac arrest such as peri-arrest arrhythmias, hypoxia	ACAT, AA, C, Mi	1
Maintain safety of environment for patient and health workers	ACAT, C, Mi	2, 4
Hold a valid ALS certificate (MANDATORY REQUIREMENT)	ACAT, AA C, Mi	1

Demonstrate ability to work in a team and succinctly present clinical details of situation to senior doctor	ACAT, C, Mi	3
Demonstrate ability to consult with a senior, seek anaesthetic team support and to act as the patient's advocate when continued critical care input is needed	ACAT, C, Mi	2, 4
Recognise importance of sensitively breaking bad news to family	ACAT, C, Mi	3, 4

Major Trauma

To assess the trauma victim using a systematic prioritized approach, be able to resuscitate, identifying life threatening conditions and stabilize the patient		
Knowledge	**Assessment Methods**	**GMP Domains**
Be able to perform and interpret the primary and secondary survey	E, C, Mi, ACAT, L	1
Undertake emergency airway management including how to perform a cricothyroidotomy and protect the cervical spine,	E, C, Mi, ACAT, L	1
Know how to establish IV access including intraosseous, central venous access and arterial pressure monitoring	E, C, Mi, ACAT, L	1
Be able to identify of life threatening injury especially thoracic and abdominal trauma and know how to undertake needle thoracocentesis and intercostal drain insertion To identify those with aortic injury, diaphragmatic rupture and pulmonary contusion, myocardial contusion, oesophageal rupture, tracheo-bronchial injury, rib and sternal fracture	E, C, Mi, ACAT, L	1
Be able to recognise and manage hypovolaemic shock	E, C, Mi, ACAT, L	1
Understand the uses of peritoneal lavage and FAST scanning	E, C, Mi, ACAT, L	1
Know the principles of management of head injury and the mechanism and effects of raised intracranial pressure, and methods of preventing secondary brain injury	E, C, Mi, ACAT, L	1
Know the principles of anaesthesia in the presence of head injury and major trauma	E, C, Mi, ACAT, L	1
Know the initial management of cervical spine injury	E, C, Mi, ACAT, L	1
Skills		
Be able to assess and immediately manage a trauma patient: perform and interpret primary and secondary survey.	Mi, C, S, D, L	1
Provide emergency airway management oxygen therapy and ventilation.	Mi, C, S, D, L	1
Be part of the airway team undertaking rapid sequence intubation of the injured patient.	Mi, C, S, D, L	1
Be able to provide cervical spine immobilization and log rolling.	Mi, C, S, D, L	1
Assess and manage hypovolaemic shock. Be able to cannulate major vessel for resuscitation and monitoring.	Mi, C, S, D, L	1

Undertake needle thoracocentesis and intercostal drain insertion. Be able to identify and treat tension pneumothorax	Mi, C, S, D, L	1
Be able to assess the patient using the Glasgow Coma Scale	Mi, C, S, D, L	1
Undertake initial appropriate investigations e.g. x-match chest x-ray, and be able to interpret them	Mi, C, S, L	1
To provide pain relief for the trauma victim	Mi, C, S, L	1
Be able to undertake Safe urinary catheterisation and NG tube insertion	Mi, C, S, D, L	1
Behaviour		
Prompt attendance; focus on resuscitation and life threatening conditions, good communication and team work.	ACAT, C, Mi, L	2, 3
Exhibit a calm methodical approach and be able to prioritise care	ACAT, C, Mi, L	3
Adopt leadership role where appropriate and be able to take over when appropriate	ACAT, C, Mi, L	2,4
Involve senior and specialist services early for those patients with life or limb threatening injuries	ACAT, C, Mi, L	2, 3

Septic Patient

The trainee will have full competence in the assessment and resuscitation of the patient presenting with severe sepsis or septic shock		
Knowledge	**Assessment Methods**	**GMP Domains**
Demonstrate knowledge of the definitions of the systemic inflammatory response syndrome (SIRS), severe sepsis and septic shock. Knowledge of the outcomes of SIRS, septic shock and multiple organ failure	E, C, Mi, ACAT	1
Knowledge of common gram negative and gram positive organisms producing sepsis. Knowledge of special situations not limited to but including infection with toxin producing bacteria Invasive Group A Streptococcus Fungal organisms	C, ACAT	1
Lists components of current "care bundles" (e.g. The Surviving Sepsis Campaign 6 hour bundle)	E, C, Mi, ACAT	1
Outline indication and safe delivery of fluids and vasoactive drugs to haemodynamic endpoints. Understanding of Early Goal Directed Therapy.	E, C, Mi, ACAT	1
Demonstrate knowledge of first line empiric antibiotic therapy for common sepsis presentations. Understanding of the Hospital Antimicrobial Formulary.	E, C, Mi, ACAT	1
Knowledge of the pharmacology of: Vasoactive drugs used in sepsis Adjunctive drugs used in sepsis And the rationale for their use.	E, C, Mi, ACAT	1
Knowledge of ventilatory strategies used in septic shock including lung protective ventilation	E, C, Mi, ACAT, AA	1
Understanding of the use of Renal Replacement Therapies in sepsis and septic shock	E, C, Mi, ACAT	1
Skills		
Rapidly assess the shocked patient in terms of ABC, airway, breathing and circulation	Mi, C, S, D, L	1

Administers oxygen, establishes intravenous access, takes blood cultures and administers antibiotics and intravenous fluids in accordance with 6 hour sepsis bundle.	Mi, C, S, D, L	1
Competently perform further steps in resuscitation: Arterial and central line insertion: drug assisted endotracheal intubation and safe selection of initial ventilator settings.	Mi, C, S, D, L	1
Organises and interprets initial investigations: arterial blood gases lactate central venous oxygen saturation. Organises microbiological investigations not limited to but including relevant cultures, blood cultures and urinary antigens	E, Mi, C, S, D, L	1
Break bad news appropriately (see common competencies curriculum)	Mi, C, S, L	3
Behaviour		
Recognise and intervene in critical illness promptly to prevent deterioration and the development of multiple organ failure	ACAT, C, Mi	1
Maintain safety of environment for patient and health workers	ACAT, C, Mi	2
Demonstrate ability to work in a team and succinctly present clinical details of situation to senior doctor	ACAT, C, Mi	3
Demonstrate ability to consult with a senior, seek anaesthetic team support in airway management and liaise with parent team and with microbiologists.	ACAT, C, Mi	2
Recognise importance of sensitively breaking bad news to family	ACAT, C, Mi	3

Shocked Patient

The trainee will be able to identify a shocked patient, assess their clinical state, produce a list of appropriate differential diagnoses and initiate immediate management		
Knowledge	**Assessment Methods**	**GMP Domains**
Identify physiological perturbations that define shock and understand the pathophysiology of its cause	E, C, Mi, ACAT	1
Identify principle categories of shock	E, C, Mi, ACAT	1
Elucidate main causes of shock in each category (e.g. MI, heart failure, PE, blood loss, sepsis)	E, C, Mi, ACAT	1
Demonstrate knowledge of sepsis syndromes	E, C, Mi, ACAT	1
Demonstrate a knowledge of the roles and the different types of monitoring required for the shocked patient	E, C, Mi, ACAT	1
Understand the role of imaging in the diagnosis of shock e.g. FAST scan, CT etc and be able to interpret the fundamentals of this imaging	E, C, Mi, ACAT	1
Demonstrate a knowledge of the different fluids and drugs e.g. inotropes used in the treatment of shock	E, C, Mi, ACAT	1
Skills		
Recognise significance of major physiological perturbations	Mi, D, L	1
Perform immediate (physical) assessment (A,B,C)	Mi, D, L	1
Institute immediate, simple resuscitation (oxygen, iv access, fluid resuscitation)	Mi, D, L	1
Arrange simple monitoring of relevant indices (oximetry, arterial gas analysis) and vital signs (BP, pulse & respiratory rate, temp, urine output)	Mi, D, L	1
To be able to gain vascular access in the shocked patient, including central venous (using Ultrasound), arterial line, intra-osseous and cut down techniques	Mi, D, L	1
Order, interpret and act on initial investigations appropriately: ECG, blood cultures, blood count, electrolytes, CVP measurements	Mi, D, L	1
Recognition of the need for urgent surgical intervention	Mi, D, L	1
Behaviour		

Exhibit calm and methodical approach to assessing critically ill patient	ACAT, C, Mi	3
Adopt leadership role where appropriate	ACAT, C, Mi, M	2,3
Involve senior and specialist (e.g. critical care outreach) services promptly	ACAT, C, Mi	2

Unconscious Patient

The trainee will be able to promptly assess the unconscious patient to produce a differential diagnosis, establish safe monitoring, investigate appropriately and formulate an initial management plan, including recognising situations in which emergency specialist investigation or referral is required		
Knowledge	**Assessment Methods**	**GMP Domains**
Identify the principal causes of unconsciousness (metabolic, neurological)	E, C, Mi, ACAT	1
Recognise the principal sub causes (drugs, hypoglycaemia, hypoxia; trauma, infection, vascular, epilepsy, raised intra-cranial pressure, reduced cerebral blood flow, endocrine)	E, C, Mi, ACAT	1
List appropriate investigations for each	E, C, Mi, ACAT	1
Outline immediate management options	E, C, Mi, ACAT	1
Skills		
Make a rapid and immediate assessment including examination of coverings of nervous system (head, neck, spine) and Glasgow Coma Score	Mi, D	1
Initiate appropriate immediate management (A,B,C, cervical collar, administer glucose)	Mi, C	1
Take simple history from witnesses when patient has stabilised	Mi, C	1
Prioritise, order, interpret and act on simple investigations appropriately	Mi, C	1
Initiate early (critical) management (e.g. control fits, manage poisoning) including requesting safe monitoring	Mi, C	1
Behaviour		
Recognise need for immediate assessment and resuscitation	ACAT, C, Mi	1
Assume leadership role where appropriate	ACAT, C, Mi	2,3
Involve appropriate specialists to facilitate immediate assessment and management (e.g. imaging, intensive care, neurosurgeons)	ACAT, C, Mi	3
Involve appropriate specialists to facilitate immediate assessment and management (e.g. imaging, intensive care, neurosurgeons)	ACAT, C, Mi	3

6.2 ACCS Acute Presentations

Abdominal Pain including loin pain

The trainee will be able to assess a patient presenting with abdominal pain and loin pain to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
To outline the different classes of abdominal pain and how the history and clinical findings differ between the causes	E, C, Mi, ACAT	1
To identify the possible surgical causes of abdominal pain, depending on site, details of history, acute or chronic including but not limited to peptic ulcer disease, pancreatitis, cholecystitis, cholangitis, biliary colic, bowel obstruction, diverticular disease, viscus perforation, acute appendicitis and ischaemic colitis, AAA, hernias, renal calculi, pyelonephritis, chronic inflammatory bowel disease, and volvulus	E, C, Mi, ACAT	1
Know the common and serious causes of loin pain including renal colic, infection and obstruction of the urinary tract, abdominal aortic aneurysm	E, C, Mi, ACAT	1
Know the medical causes of abdominal pain	E, C, Mi, ACAT	1
To define the situations in which urgent surgical, urological or gynaecological opinion should be sought evaluation	E, C, Mi, ACAT	1
Determine which first line investigations are required, depending on the likely diagnoses following evaluation using ECG, plain radiology, CT, ultrasound and blood tests.	E, C, Mi, ACAT	1
Define the indications and contraindications for specialist investigation: ultrasound, CT, CT KUB,MRI, endoscopy, and IVU	E, C, Mi, ACAT	1
Skills		
To have an A, B, C, D approach ensuring identification of critical or life threatening illness	Mi, C, D	1
Elicit signs of tenderness, guarding, and rebound tenderness and interpret appropriately	Mi, C, D	1
Order, interpret and act on initial investigations appropriately: blood tests, x-rays, ECG and microbiology investigations,	Mi, C	1
Initiate first line management: including effective fluid resuscitation, pain relief antibiotics and appropriate use of a nasogastric tube	Mi, C	1
Interpret gross pathology on CT, CT KUB, IVU, including liver metastases and obstructed ureters with hydronephrosis	Mi, C	1

Be able to identify those that require admission and those who may be safely discharged	Mi, C	1
Behaviour		
Exhibit timely intervention when abdominal pain is the manifestation of critical illness or is life-threatening, in conjunction with senior and appropriate specialists	ACAT, C, Mi	1
Recognise the importance of a multi-disciplinary approach including early surgical/urological assessment when appropriate	ACAT, C, Mi, M	2, 3
Display sympathy to physical and mental responses to pain	ACAT, C, Mi, M	3, 4
Involve other specialties promptly when required	ACAT, C, Mi	2, 3

Abdominal Swelling, Mass & Constipation

The trainee will be able to undertake assessment of a patient presenting with abdominal swelling, mass or constipation to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Define the different types of abdominal mass in terms of site, aetiology and clinical characteristics	E, C, Mi, ACAT	1
Recall the preponderance of functional causes of constipation including constipation with overflow and the investigation and management of faecal incontinence	E, C, Mi, ACAT	1
Describe the appropriate investigations- radiological, surgical, endoscopy.	E, C, Mi, ACAT	1
Identify the causes of hepatomegaly and splenomegaly, abdominal swelling and constipation	E, C, Mi, ACAT	1
Recall abdominal wall pathology as possible causes of distension, including divarification of the recti	E, C, Mi, ACAT	1
Know the pathophysiology of portal hypertension and bowel obstruction.	E, C, Mi, ACAT	1
Know the important steps in diagnosing the cause of ascites, including imaging and the diagnosis of spontaneous bacterial peritonitis and malignancy	E, C, Mi, ACAT	1
Skills		
Elicit associated symptoms and risk factors for the presence of diseases presenting with abdominal mass, ascites and co existing signs. Elicit and interpret important physical findings to establish likely nature.	Mi, C, D	1
Order and interpret appropriate diagnostic tests	Mi, C	1
Practise safe management of ascites:, including the use of diuretics, fluid and salt restriction, and ascitic tap	Mi, C, D	1
Select appropriate second line investigations of constipation when indicated: including blood tests imaging and endoscopy	Mi, C	2
Following diagnosis of the cause of constipation prescribe bulk or osmotic laxatives or motility stimulants as necessary	Mi, C	1
Provide review of medications in patients with constipation in the context of multisystem disease.	Mi, C	1

Behaviour		
Involve specialists promptly when appropriate: surgery, gastroenterology, radiology, palliative care	ACAT, C, Mi	3
Discuss with patient likely outcomes and prognosis of condition	ACAT, C, Mi	3, 4

Acute Back Pain

The trainee will be able to assess a patient with a new presentation of back pain to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the causes of acute back pain including but not limited to – malignant, septic, musculoskeletal, urological, neurological, AAA. Be able to outline features that raise concerns as to a sinister cause (red flags) and those that lead to a consideration of chronic causes (yellow flags). Understand and recognise the Cauda Equina Syndrome.	E, C, Mi, ACAT	1
Specify abdominal pathology that may present with back pain	E, C, Mi, ACAT	1
Recall the indications of an urgent MRI of spine	E, C, Mi, ACAT	1
Outline indications for hospital admission	E, C, Mi, ACAT	1
Outline secondary prevention measures in osteoporosis	E, C, Mi, ACAT	1
Skills		
Perform examination and elicit signs of spinal cord/cauda equina compromise	Mi, C, D	1
Practise safe prescribing of analgesics/anxiolytics to provide symptomatic relief	Mi, C	1
Order, interpret and act on initial investigations appropriately: blood tests and x-rays	Mi, C	1
Behaviour		
Involve neurosurgical unit promptly in event of neurological symptoms or signs	ACAT, C, Mi	2
Ask for senior help when critical abdominal pathology is suspected	ACAT, C, Mi	2, 3
Recognise the socio-economic impact of chronic lower back pain	ACAT, C, Mi	2, 3
Participate in multi-disciplinary approach: physio, OT	C, M	3, 4
Recognise impact of osteoporosis and encourage bone protection in all patients at risk	C	1

Aggressive/disturbed behaviour

The trainee will be competent in predicting and preventing aggressive and disturbed behaviour, use safe physical restraint and chemical sedation, investigate appropriately and liaise with the mental health team.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the factors that predict aggressive behaviour: personal history, alcohol and substance abuse, delirium.	E, C, Mi, ACAT	1
Define and characterize psychosis and know the common causes	E, C, Mi, ACAT	1
Know the indications, contraindications and side effects of tranquillisers. Know de-escalation techniques that can be used o prevent violent behaviour	E, C, Mi, ACAT	1
Know the legal framework for authorizing interventions in the management of the disturbed or violent patient.	E, C, Mi, ACAT	1
Skills		
Ensure appropriate environment and support staff.	C	1
Assess fully including mental state examination and produce valid differential diagnosis	Mi, C, D	1
Undertake and interpret appropriate investigations.	C	1
Produce safe rapid tranquillisation if indicated as defined in national guidelines with appropriate monitoring.	Mi, C	1
Behaviour		
Treat acutely disturbed patient with respect and the dignity they deserve	ACAT, M	2, 4
Liaise promptly with psychiatric services	ACAT, M	3

Blackout/Collapse

The trainee will be able to assess a patient presenting with a collapse to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan (see also 'Syncope' and 'Falls')		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the causes for blackout and collapse (including syncopal causes vasovagal, cough, effort, micturition, carotid sinus hypersensitivity).	E, C, Mi, ACAT	1
Differentiate the causes depending on the situation of blackout +/or collapse, associated symptoms and signs, and eye witness reports	E, C, Mi, ACAT	1
Outline the indications for temporary and permanent pacing systems	E, C, Mi, ACAT	1
Define indications for investigations: ECHO, ambulatory ECG monitoring, neuroimaging	E, C, Mi, ACAT	1
Skills		
Elucidate history to establish whether event was LOC, fall without LOC, vertigo (with eye witness account if possible)	Mi, C	1
Assess patient in terms of ABC and degree of consciousness and manage appropriately	Mi, C, D	1
Perform examination to elicit signs of cardiovascular or neurological disease and to distinguish epileptic disorder from other causes	Mi, C, D	1
Order, interpret and act on initial investigations appropriately: ECG, blood tests inc. glucose, brain imaging (CT and MRI)	Mi. C	1
Manage arrhythmias appropriately as per ALS guidelines	C, L	1
Detect orthostatic hypotension	Mi, C, D	1
Institute external pacing systems when appropriate	Mi, C, D, L	1
Behaviour		
Ensures the follow up pathways for these patients e.g. syncope clinics, falls clinics	ACAT, C	2,3
Recognise impact episodes can have on lifestyle particularly in the elderly	ACAT, C	2, 3
Recognise recommendations regarding fitness to drive in relation to undiagnosed blackouts	ACAT, C	2, 3

Breathlessness

The trainee will be able to assess a patient presenting with breathlessness to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the common and/or important cardio-respiratory conditions that present with breathlessness	E, C, Mi, ACAT	1
Differentiate orthopnoea and paroxysmal nocturnal dyspnoea	E, C, Mi, ACAT	1
Identify non cardio-respiratory factors that can contribute to or present with breathlessness e.g. acidosis	E, C, Mi, ACAT	1
Define basic pathophysiology of breathlessness	E, C, Mi, ACAT	1
List the causes of wheeze and stridor	E, C, Mi, ACAT	1
Demonstrate knowledge of the indications, contraindications and adverse effects of the drugs used to treat the causes of breathlessness	E, C	1
Outline indications for CT chest, CT pulmonary angiography, spirometry	E, C, Mi, ACAT	1
Skills		
Interpret history and clinical signs to list appropriate differential diagnoses: including but not limited to pneumonia, COPD, PE, pulmonary oedema, pneumothorax, asthma. Know the relevant BTS guidelines for these conditions	Mi, C, L	1
Differentiate between stridor and wheeze	Mi, C	1
Order, interpret and act on initial investigations appropriately: routine blood tests, oxygen saturation, arterial blood gases, chest x-rays, ECG, Peak flow test, spirometry	Mi, C	1
Initiate treatment in relation to diagnosis, including safe oxygen therapy, early antibiotics for pneumonia	Mi, C	1
Perform chest aspiration and chest drain insertion	D, L	1
Recognise disproportionate dyspnoea and hyperventilation	Mi, C	1
Practice appropriate management of wheeze and stridor	Mi, C	1
Evaluate and advise on good inhaler technique	Mi, C, D	1

Recognise indications & contraindications for non-invasive ventilation (NIV), and the indications and contraindications for intubation and invasive ventilatory support	Mi, C	1
Behaviour		
Exhibit timely assessment and treatment in the acute phase	ACAT, C	1
Recognise the distress caused by breathlessness and discuss with patient and carers	ACAT, C	2, 3
Recognise the impact of long term illness	ACAT, C	2
Consult senior when respiratory distress is evident	ACAT, C	2, 3
Involve Critical Care team promptly when indicated and recognise the need for care in an appropriate environment	ACAT, C	2
Exhibit non-judgemental attitudes to patients with a smoking history	ACAT, C, M	3, 4

Chest Pain

The trainee will be able to assess a patient with chest pain to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Characterise the different types of chest pain, and outline other symptoms that may be present	E, C, Mi, ACAT	1
List and distinguish between the common causes for each category of chest pain and associated features: cardio-respiratory, musculoskeletal, upper GI	E, C, Mi, ACAT	1
Define the pathophysiology of acute coronary syndrome and pulmonary embolus	E, C, Mi, ACAT	1
Identify the indications for PCI and thrombolysis in ACS	E, C, Mi, ACAT	1
Identify the indications and limitations of cardiac biomarkers, d-dimer analysis, CTPA and V/Q scanning	E, C, Mi, ACAT	1
Know emergency treatments for PE, ACS and aortic dissection	E, C, Mi, ACAT	1
Outline the indications for further investigation in chest pain syndromes: CTPA, trans-oesophageal echocardiography and tread mill (stress) testing	E, C, Mi, ACAT	1
Skills		
Interpret history and clinical signs to list appropriate differential diagnoses: esp. for cardiac pain & pleuritic pain	Mi, C	1
Order, interpret and act on initial investigations in the context of chest pain appropriately: such as ECG, blood gas analysis, blood tests, chest radiograph, cardiac biomarkers	Mi, C	1
Commence initial emergency treatment including that for coronary syndromes, pulmonary embolus and aortic dissection	Mi, C, D	1
Elect appropriate arena of care and degree of monitoring	Mi, C	2
Formulate initial discharge plan	ACAT, C, AA	1
Behaviour		
Perform timely assessment and treatment of patients presenting with chest pain	ACAT, C	1
Involve senior when chest pain heralds critical illness or when cause of chest pain is unclear	ACAT, C	3

Recognise the contribution and expertise of specialist cardiology nurses and technicians	ACAT, C	3
Recommend appropriate secondary prevention treatments and lifestyle changes on discharge	ACAT, C	2, 3
Communicate in a timely and thoughtful way with patients and relatives	ACAT, C, M	3, 4

Confusion, Acute/Delirium

The trainee will be able to assess an acutely confused/delirious patient to formulate a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
List the common and serious causes for acute confusion/delirium	E, C, Mi, ACAT	1
Outline important initial investigations, including electrolytes, cultures, full blood count, ECG, blood gases, thyroid function tests	E, C, Mi, ACAT	1
Recognise the factors that can exacerbate acute confusion/delirium e.g. change in environment, infection	E, C, Mi, ACAT	1
List the pre-existing factors that pre-dispose to acute confusion/delirium	E, C, Mi, ACAT	1
Outline indications for further investigation including head CT, lumbar puncture. Describe the indications, contraindications and side effects of drugs used in acute psychosis including, but not limited to: Haloperidol, Benzodiazepines, Clonidine	E, C, Mi, ACAT	1
Skills		
Examine to elicit cause of acute confusion/delirium	Mi, D	1
Perform mental state examinations (abbreviated mental test and mini-mental test and Confusional Assessment method for ICU (CAM-ICU)) to assess severity and progress of cognitive impairment	Mi, C, D	1
Recognise pre-disposing factors: cognitive impairment, psychiatric disease	C	1
Understand and act on the results of initial investigations e.g. CT head, LP	E, C	1
Interpret and recognise pathology evident on CT head/MRI Brain	E, C	1
Behaviour		
Recognise that the cause of acute confusion/delirium is often multi-factorial	ACAT, C	2, 3
Contributes to multidisciplinary team management including appropriate use of local physical restraint policy	ACAT, C, M	3, 4
Recognise the effects of acutely confused/delirious patient on other patients and staff in the ward environment	ACAT, C	2, 3

Cough

The trainee will be able to assess a patient presenting with cough to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
List the common and serious causes of cough	E, C, Mi, ACAT	1
Identify risk factors relevant to each aetiology including precipitating drugs	E, C, Mi, ACAT	1
Outline the different classes of cough and how the history and clinical findings differ between them	E, C, Mi, ACAT	1
State which first line investigations are required, depending on the likely diagnoses following evaluation	E, C, Mi, ACAT	1
Skills		
Order, interpret and act on initial investigations appropriately: blood tests, chest x-rays and PFT's	E, C	1
Awareness of management for common causes of cough	E, C	1
Behaviour		
Contribute to patients understanding of their illness	ACAT, C	3, 4
Exhibit non-judgmental attitudes to patients with a history of smoking	ACAT, C, M	3, 4
Consult seniors promptly when indicated	ACAT, C	2, 3
Recognise the importance of a multi-disciplinary approach	ACAT, C, M	2

Cyanosis

The trainee will be able to assess a patient presenting with cyanosis to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the causes of cyanosis, cardiac & respiratory	E, C, Mi, ACAT	1
Know how to formulate a differential diagnosis and be able to differentiate from methaemaglobinaemia	E, C, Mi, ACAT	1
Skills		
Perform a full clinical examination differentiating between the various causes of cyanosis	E, C, D	1
Be able to perform and interpret the appropriate tests, e.g. x-rays and ECG	E, C, D	1
Understand the safe prescribing of oxygen therapy	E, C	1
Behaviour		
Involve senior promptly in event of significant airway compromise	ACAT, C	2
Involve specialist team as appropriate	ACAT, C	2

Diarrhoea

The trainee will be able to assess a patient presenting with diarrhoea to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Specify the causes of diarrhoea	E, C, Mi, ACAT	1
Correlate presentation with other symptoms: such as abdominal pain, rectal bleeding, weight loss	E, C, Mi, ACAT	1
Recall the pathophysiology of diarrhoea for each aetiology	E, C, Mi, ACAT	1
Describe the investigations necessary to arrive at a diagnosis	E, C, Mi, ACAT	1
Identify the indications for urgent surgical review in patients presenting with diarrhoea	E, C, Mi, ACAT	1
Recall the presentation, investigations, prevention and treatment of C. difficile associated diarrhoea	E, C, Mi, ACAT	1
Demonstrate knowledge of infection control procedures Demonstrate knowledge of bowel management systems	E, C, Mi, ACAT	1
Skills		
Evaluate nutritional and hydration status of the patient	Mi, C	1
Assess whether patient requires hospital admission	Mi, C	1
Perform rectal examination as part of physical examination	Mi, C, D	1
Initiate and interpret investigations: blood tests, stool examination, endoscopy and radiology as appropriate (AXR and CT – intestinal obstruction, toxic dilatation)	E, C, D	1
Behaviour		
Seek a surgical and senior opinion when required	ACAT, C	3
Exhibit sympathy and empathy when considering the distress associated with diarrhoea and incontinence	ACAT, C	3, 4

Dizziness and Vertigo

The trainee will be able to evaluate the patient who presents with dizziness or vertigo to produce a valid differential diagnosis, appropriate investigation and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the neuroanatomy and physiology relevant to balance, coordination and movement	E, C, Mi, ACAT	1
Define and differentiate the different types of vertigo and ataxia and their causes	E, C, Mi, ACAT	1
Skills		
Take history from patient and attempt to define complaint as either pre-syncope, dizziness or vertigo	Mi, C, D	1
Perform full physical examination to elicit signs of neurological, inner ear or cardiovascular disease including orthostatic hypotension	Mi, C, D	1
Recognise when to request additional tests such as CT scan	E, C	1
Know when to use drugs for dizziness and vertigo and understand their limitations and side effects	E, C	1
Behaviour		
Recognise patient distress when presenting with dizziness and vertigo	ACAT, C	2
Know when to refer to specialist services such as ENT	ACAT, C	3

Falls

The trainee will be able to assess a patient presenting with a fall and produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan (see also 'Syncope' and 'Blackout/Collapse')		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall causes of falls and risk factors for falls	E, C, Mi, ACAT	1
Outline a comprehensive assessment of a patient following a fall and give a differential diagnosis	E, C, Mi, ACAT	1
Recall the relationship between falls risk and fractures	E, C, Mi, ACAT	1
Recall consequences of falls, such as loss of confidence, infection	E, C, Mi, ACAT	1
State how to distinguish between syncope and fall	E, C, Mi, ACAT	1
Skills		
Define the adverse features of a fall, which investigations are needed, and identify those who need admission and those who can be safely discharged with follow up in a falls clinic	E, Mi, C	1
Demonstrates awareness of implications of falls and secondary complications of falls, including rhabdomyolysis following a 'long lie'.	Mi, C	1
Commence appropriate treatment including pain relief	Mi, C	1
Behaviour		
Recognise the psychological impact to an older person and their carer after a fall	ACAT, C	2, 3
Contribute to the patients understanding as to the reason for their fall	ACAT, C, PS	2, 3
Discuss with seniors promptly and appropriately	ACAT, C	2, 3
Ensure appropriate referral to a falls clinic	ACAT, C, AA	2,3
Relate the possible reasons for the fall and the management plan to patient and carers	ACAT, C, PS	3, 4

Fever

The trainee will be able to assess a patient presenting with fever to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the pathophysiology of developing a fever and relevant use of anti-pyretics	E, C, Mi, ACAT	1
Recall the underlying causes of fever: infection, malignancy, inflammation	E, C, Mi, ACAT	1
Recall guidelines with regard to antibiotic prophylaxis	E, C, Mi, ACAT	1
Differentiate features of viral and bacterial infection	E, C, Mi, ACAT	1
Outline indications and contraindications for LP in context of fever	E, C, Mi, ACAT	1
Recognition and awareness of management of neutropenic sepsis	E, C, Mi, ACAT	1
Skills		
Recognise the presence of sepsis syndrome in a patient, commence resuscitation and liaise with senior colleagues promptly	E, Mi, C, D, S	1
Order, interpret and act on initial investigations appropriately: blood tests, cultures, CXR	Mi, C	1
Be able to perform a Lumbar puncture and interpret the result of CSF analysis	D	1
Identify the risk factors in the history that may indicate an infectious disease e.g. travel, sexual history, IV drug use, animal contact, drug therapy , implanted medical devices/prostheses.	E, Mi, C	1
Commence empirical antibiotics when an infective source of fever is deemed likely in accordance with local prescribing policy	E, Mi , C	1
Commence anti-pyretics as indicated	Mi, C	1
Behaviour		
Adhere to local antibiotic prescribing policies	ACAT, C, AA	2
Highlight the importance of early cultures and prompt administration of antibiotics.	ACAT, C, AA	2
Highlight importance of nosocomial infection and principles for infection control	ACAT, C	2

Consult senior in event of septic syndrome	ACAT, C	2, 3
Discuss with senior colleagues and follow local guidelines in the management of the immunosuppressed e.g. HIV, neutropenia	ACAT, C	2, 3
Promote communicable disease prevention: e.g. immunisations, antimalarials, safe sexual practices	ACAT, C	3, 4

Fits / Seizure

The trainee will be able to assess a patient presenting with a fit, stabilise promptly, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the causes for seizure	E, C, Mi, ACAT	1
Recall the common epileptic syndromes	E, C, Mi, ACAT	1
Recall the essential initial investigations following a 'first fit'	E, C, Mi, ACAT	1
Recall the indications for a CT head	E, C, Mi, ACAT	1
Know an algorithm for the management of status epilepticus including the indications for general anaesthesia and airway protection.	E, C, Mi, ACAT	1
Describe the indications, contraindications and side effects of the commonly used anti-convulsants	E, C, Mi, ACAT	1
Be able to differentiate seizure from pseudo seizures and other causes of collapse	E, C, Mi, ACAT	1
Skills		
Outline immediate management options in the management of the patient presenting in status epilepticus, including but not limited to: Resuscitation and treatment Further investigations Transfer to an appropriate area of the hospital	Mi, C	1
Obtain collateral history from witness	Mi, C	3
Promptly recognise and treat precipitating causes: metabolic, infective, malignancy, traumatic	Mi. C	4
Be able to differentiate seizure from other causes of collapse using history and examination	Mi, C	1
Behaviour		
Recognise the need for urgent referral in case of the uncontrolled recurrent loss of consciousness or seizures	ACAT, C	1
Recognise the principles of safe discharge, after discussion with senior colleague	ACAT, C	1, 2

Recognise importance of Epilepsy Nurse Specialists	ACAT, C	1, 2
Recognise the psychological and social consequences of epilepsy	ACAT, C	1

Haematemesis & Melaena

The trainee will be able to assess a patient with an upper GI haemorrhage to determine significance; resuscitate appropriately; and liaise with endoscopist effectively		
Knowledge	**Assessment Methods**	**GMP Domains**
Specify the causes of upper GI bleeding, with associated risk factors including but not limited to coagulopathy and use of NSAIDs/ASA/anticoagulants	E, C, Mi, ACAT	1
Recall scoring systems used to assess the significance and prognosis of an upper GI bleed	E, C, Mi, ACAT	1
Recall the principles of choice of IV access including central line insertion, fluid choice and speed of fluid administration	E, C, Mi, ACAT	1
Recall common important measures to be carried out after endoscopy, including helicobacter eradication, acid suppression	E, C, Mi, ACAT	1
Skills		
Recognise shock or impending shock and resuscitate rapidly and assess need for higher level of care.	Mi, C	1
Distinguish between upper and lower GI bleeding	Mi, C	1
Demonstrate ability to secure appropriate venous access	D	1
Safely prescribe drugs indicated in event of an established upper GI bleed using the current evidence base	Mi, C	2
Behaviour		
Seek senior help and endoscopy or surgical input in event of significant GI bleed	ACAT, Mi	3
Observe safe practices in the prescription of blood products	ACAT, Mi	2

Headache

The trainee will be able to assess a patient presenting with headache to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the presentation of the common and life threatening causes of new onset headache	E, C, Mi, ACAT	1
Understand the pathophysiology of headache	E, C, Mi, ACAT	1
Recall the indications for urgent CT/MRI scanning in the context of headache	E, C, Mi, ACAT	1
Recall clinical features of raised intra-cranial pressure	E, C, Mi, ACAT	1
Demonstrate knowledge of different treatments for suspected migraine	E, C, Mi, ACAT	1
Skills		
Recognise important diagnostic features in history	E, Mi, C	1
Perform a comprehensive neurological examination, including eliciting signs of papilloedema, temporal arteritis, meningism and head trauma	E, D	1
Order, interpret and act on initial investigations	Mi, C	2
Perform a successful lumbar puncture when indicated with minimal discomfort to patient observing full aseptic technique	D	1
Interpret basic CSF analysis: cell count, protein, bilirubin, Gram stain and glucose	E, Mi, C	2
Initiate prompt treatment when indicated: appropriate analgesia; antibiotics; antivirals; corticosteroids	Mi, C	1
Behaviour		
Recognise the nature of headaches that may have a sinister cause and assess and treat urgently	ACAT, C	1
Liaise with senior doctor promptly when sinister cause is suspected	ACAT, C	3
Involve neurosurgical team promptly when appropriate	ACAT, C	2, 3

Head Injury

The trainee will be able to evaluate the patient who presents with a traumatic head injury, stabilize, assess, appropriate investigate and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the anatomy of the scalp, skull and brain, the pathophysiology of head injury (primary and secondary injury) and the symptoms and signs.	E, C, Mi, ACAT	1
Know the indications for urgent CT scanning (national guidelines for CT imaging in head injury). Know the appearances of the common head injuries	E, C, Mi, ACAT	1
Know the indications for admission following head injury.	E, C, Mi, ACAT	1
Know which patients can be safely discharged.	E, C, Mi, ACAT	1
Skills		
Be able to use the ABC approach to the management of a head injury patient, with cervical spine immobilisation.	E, D	1
Be able to demonstrate to use of the GCS and ability to identify those who will need intubation and ventilation.	E, MI, ACAT	1
Elicit the important facts from the history and undertake a full neurological exam to elicit signs of head injury and neurological deficit.	E, Mi, C	1
Recognise and initially manage the secondary consequences of head injury (e.g. loss of airway patency, seizures, raised ICP).	Mi, S, D	1
Behaviour		
Know when to seek senior and anaesthetic, neurosurgical support.	ACAT, C	2
Optimise team working between critical care, neurosurgery, emergency and acute medicine.	ACAT, C	2

Jaundice

The trainee will be able to assess a patient presenting with jaundice to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the pathophysiology of jaundice in terms of pre-hepatic, hepatic, and post-hepatic causes	E, C, Mi, ACAT	1
Recall causes for each category of jaundice with associated risk factors	E, C, Mi, ACAT	1
Recall issues of prescribing in patients with significant liver disease	E, C, Mi, ACAT	1
Recall basic investigations to establish aetiology	E, C, Mi, ACAT	1
Demonstrate knowledge of common treatments of jaundice	E, C, Mi, ACAT	1
Skills		
Take a thorough history and examination to arrive at a valid differential diagnosis	E, Mi, C	1
Recognise the presence of chronic liver disease or fulminant liver failure	Mi, C	1
Interpret results of basic investigations to establish aetiology	E, Mi, C	1
Recognise complications of jaundice	E, Mi, C	
Recognise and initially manage complicating factors: coagulopathy, sepsis, GI bleed, alcohol withdrawal, electrolyte disturbance	E, C	1
Behaviour		
Exhibit non-judgmental attitudes to patients with a history of alcoholism or substance abuse	ACAT, C, M	4
Consult seniors and gastroenterologists promptly when indicated	ACAT, C	3
Contribute to the patient's understanding of their illness	ACAT, PS	4
Recognise the importance of a multi-disciplinary approach	ACAT, C, M	3

Limb Pain & Swelling - Atraumatic

The trainee will be able to assess a patient presenting with atraumatic limb pain or swelling to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the causes of unilateral and bilateral limb swelling in terms of acute and chronic presentation	E, C, Mi, ACAT	1
Recall the different causes of limb pain. Recall the pathophysiology for pitting oedema, non-pitting oedema, thrombosis and peripheral ischemia	E, C, Mi, ACAT	1
Recall the risk factors for the development of thrombosis and recognised risk scoring systems	E, C, Mi, ACAT	1
Recall the indications, contraindications and side effects of diuretics and anti-coagulants	E, C, Mi, ACAT	1
Demonstrate awareness of the longer term management of DVT	E, C, Mi, ACAT	1
Differentiate the features of limb pain and/or swelling pain due to cellulitis, varicose eczema, critical ischaemia and DVT	E, C, Mi, ACAT	1
Skills		
Perform a full and relevant examination including assessment of viability and perfusion of limb and differentiate pitting oedema; cellulitis; venous thrombosis; compartment syndrome	E, D	1
Recognise compartment syndrome and critical ischaemia and take appropriate timely action	E, Mi, C	2
Order, interpret and act on initial investigations appropriately: blood tests, Doppler studies, urine protein	E, Mi, C	2
Practise safe prescribing of initial treatment as appropriate (anti-coagulation therapy, antibiotics etc)	Mi, C	2
Prescribe appropriate analgesia	MI, C, AA	2
Behaviour		
Liaise promptly with surgical colleagues in event of circulatory compromise (e.g. compartment syndrome)	ACAT, C	3
Recognise importance of thromboprophylaxis in high risk groups	ACAT, C, AA	2

Neck pain

The trainee will be able to evaluate the patient who presents with neck pain, produce a valid differential diagnosis, appropriate investigation and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Outline the common and serious causes of neck pain including meningeal irritation, trauma, musculoskeletal inflammation, local infection and vascular causes.	E, C, Mi, ACAT	1
Understand the investigations required to make a diagnosis	E, C, Mi, ACAT	1
Skills		
Take a full history including recent trauma and appropriate physical examination.	E, Mi, D	1
Identify those patients with meningism and consult senior early.	Mi, C	1
Order, Interpret and act on initial tests	Mi, C	1
Be able to prescribe appropriate analgesia and antibiotics	Mi, C, AA	1
Behaviour		
Ask for senior advice appropriately	ACAT, C	2

Oliguric patient

The trainee will be able to produce a differential diagnosis, establish safe monitoring, investigate appropriately and formulate an initial management plan when assessing a patient with a low urine output.		
Knowledge	**Assessment Methods**	**GMP Domains**
Understand the principal causes of a low urine output in the critically ill patient, and be able to identify the principal sub causes (pre-renal, renal and post renal), including but not limited to: hypotension and inadequate renal perfusion renal tract obstruction nephrotoxic drugs and contrast media	E, C, Mi, ACAT	1
Understand current terminology and classification of acute kidney injury	E, C, Mi, ACAT	1
Understand appropriate monitoring of the patient with a low urine output, including but not limited to: clinical assessment Urinary catheterisation cardiovascular monitoring including pressure and flow monitoring techniques (see principles of monitoring cardiac output) arterial blood gases	E, C, Mi, ACAT	1
Understand the methods of assessment of renal function including but not limited to: blood tests assessment of renal excretion. Imaging of the GU tract	E, C, Mi, ACAT	1
Outline immediate management options including but not limited to: Fluid resuscitation Increased cardiovascular monitoring Administration of vasoactive drugs and inotropes The role of diuretics	E, C, Mi, ACAT	1
Understand the role of renal replacement therapy in the oliguric patient	E, C, Mi, ACAT	1
Be able to safely prescribe for patients in renal failure	E,C, Mi, ACAT	1
Skills		
Make a rapid and immediate assessment including appropriate clinical examination	Mi, C	1
Initiate appropriate immediate management	MI, C	1
Prioritise, order, interpret and act on simple investigations appropriately	Mi, C	1
Initiate early (critical) management (e.g. fluid administration) including requesting safe monitoring	Mi, C	1
Behaviour		

Recognise need for immediate assessment and resuscitation	ACAT, C	1
Assume leadership role where appropriate	ACAT, C	2,3
Involve appropriate senior help to facilitate immediate assessment and management	ACAT, C	3
Involve appropriate specialists to facilitate immediate assessment and management or decreased renal function (e.g. imaging, intensive care, surgeons, renal physicians)	ACAT, C	3

Pain Management

The trainee will be able to use analgesic drugs safely and appropriately in the acutely ill patient.		
Knowledge	**Assessment Methods**	**GMP Domains**
Demonstrates an understanding of the need for effective management of pain in the acutely unwell patient, including, but not limited to:	E, C, Mi, ACAT	1
Describes how to assess the severity of acute pain including scoring systems such as the Visual Analogue Scale and Verbal Rating Scale.	E, C, Mi, ACAT	1
Describes the use of multimodal therapy and the 'analgesic ladder'	E, C, Mi, ACAT	1
How emotions contribute to pain	E, C, Mi, ACAT	1
Identification of appropriate analgesic regimes including types of drugs and doses	E, C, Mi, ACAT	1
The use of 'rescue analgesia' for the patient with severe pain	E, C, Mi, ACAT	1
Understands the pharmacology of commonly used analgesics including but not limited to: Indications and contraindications, Side effects, Safety profile, Drug interactions	E, C, Mi, ACAT	1
Demonstrates knowledge of commonly used local anaesthetic blocks including peripheral nerve blockade used in the Emergency Department and major conduction blockade as seen in Critical Care.	E, C, Mi, ACAT	1
Lists complications of regional anaesthesia and outlines their treatment including that of local anaesthetic toxicity and respiratory depression due to centrally administered opiates.	E, C, Mi, ACAT	1
Skills		
Is able to discuss options for pain relief with the patient and obtain informed consent.	Mi, C, D, ACAT	1
Safely prescribes analgesia for the acutely ill patient in pain.	Mi, C, ACAT	1
Safely titrates analgesia against level of pain	Mi, C, ACAT	1
Able to programme locally used analgesic devices	Mi, C, D, ACAT	1
To be able to undertake the peripheral nerve blocks including but not limited to, digital, wrist (ulna, median, radial), femoral, facial (auricular, supra-trochlear, supra-orbital), ankle, Biers Block and know their contraindications.	Mi, C, D, ACAT	1
Makes clear and concise record of interventions in patient notes	Mi, C , ACAT	1

Behaviour		
Recognises the place of input from specialists in the management of analgesia (e.g. the acute pain team, anaesthesia).	Mi, C, ACAT	2, 3
Ensures safety	Mi, C, ACAT	2
To ensure effectiveness and to seek help if pain is not relieved or is disproportionate	Mi, C, ACAT	2, 3
Works to local and national policies in issuing, handling and disposal of controlled drugs	Mi, C, ACAT	2

Painful ear

The trainee will be able to evaluate the patient who presents with painful ears produce a valid differential diagnosis, appropriate investigation and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the anatomy of the ear	E, C, Mi, ACAT	1
Understand the common causes of ear pain	E, C, Mi, ACAT	1
Understand the common treatments for ear pain	E, C, Mi, ACAT	1
Skills		
Be able to undertake a full exam of the ear	E, D	1
Demonstrate the use of an otoscope	E, D	1
Behaviour		
Know when to refer a patient to ENT for continued care	ACAT, C	2

Palpitations

The trainee will be able to assess a patient presenting with palpitations to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall cardiac electrophysiology relevant to ECG interpretation	E, C, Mi, ACAT	1
Recall common causes of palpitations	E, C, Mi, ACAT	1
Recall the categories of arrhythmia	E, C, Mi, ACAT	1
Recall common arrhythmogenic factors including drugs	E, C, Mi, ACAT	1
Recall the indications, contraindications and side effects of the commonly used anti-arrhythmic medications and indications for pacing	E, C, Mi, ACAT	1
Demonstrate knowledge of the management of Atrial Fibrillation (NICE guidelines)	E, C, Mi, ACAT	1
Skills		
Elucidate nature of patient's complaint	Mi, C	1
Order, interpret and act on initial investigations appropriately: ECG, blood tests	Mi, C	1
Recognise and commence initial treatment of arrhythmias being poorly tolerated by patient (peri-arrest arrhythmias) as per UK Resuscitation Council Guidelines	Mi, C	1
Be able to perform carotid sinus massage, DC cardioversion and external pacing safely	D	1
Ensure appropriate monitoring of patient on ward	Mi, C	2
Management of newly presented non compromised patients with arrhythmias	Mi, C	1
Behaviour		
Consult senior colleagues promptly when required	ACAT, C	3
Advise on lifestyle measures to prevent palpitations when appropriate	ACAT, C, PS	3

Pelvic pain

The trainee will be able to evaluate the patient who presents with pelvic pain, produce a valid differential diagnosis, appropriate investigation and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the causes of pelvic pain and understand when to refer to a surgeon, gynaecologist or GUM specialist	E, C, Mi, ACAT	1
Know the anatomical relationships of the organs in the pelvis	E, C, Mi, ACAT	1
Know how to prescribe safely for a patient with pelvis pain	E, C, Mi, ACAT	1
Skills		
Be able to undertake a full examination for a patient with pelvic pain	E, Mi, C	1
Be able to demonstrate a bimanual pelvic examination and use of a speculum and take microbiological swabs	E, D	1
Know how to order and interpret appropriate tests	Mi, E, C	1
Behaviour		
Recognise the need for chaperone	ACAT, C, M	1
Know when to refer to the appropriate specialist.	ACAT, C	2

Poisoning

The trainee will be able to assess promptly a patient presenting with deliberate or accidental poisoning, initiate urgent treatment, ensure appropriate monitoring and recognise the importance of psychiatric assessment in episodes of self harm		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall indications for activated charcoal and whole bowel irrigation	E, C, Mi, ACAT	1
Know the important symptoms, signs and tests to establish the type of poisoning i.e. to be able to recognize the common toxidromes Know the presentations of carbon monoxide poisoning	E, C, Mi, ACAT	1
Know the pharmacology and management of poisoning of the following (but not limited to): paracetamol, salicylate, beta blockers, opiates, alcohol, anti-coagulants, benzodiazepines, carbon monoxide, antidepressants, SSRIs, amphetamine, cocaine	E, C, Mi, ACAT	1
Understand the role of antidotes and demonstrates knowledge of specific therapies in poisoning including but not limited to: ▪ activated charcoal, ▪ acetyl-cysteine, ▪ bicarbonate hyperbaric oxygen	E, C, Mi, ACAT	1
Demonstrates understanding of the role of drug testing/screening and of drug levels	E, C, Mi, ACAT	1
Recognise importance of accessing TOXBASE and National Poisons Information Service and the use of the information so obtained	E, C, Mi, ACAT	1
Understand the psychological and physiological and socioeconomic effect of alcohol misuse and illicit drug use – opioids, amphetamines, ecstasy, cocaine, GHB. Understand addiction, dependence and withdrawal syndromes	E, C, Mi, ACAT	1
Skills		
Recognise critically ill overdose patient and resuscitate as appropriate	Mi, C	1
Take a full history of event, including a collateral history if possible	Mi, C	1
Examine to determine the nature and effects of poisoning	Mi, C	1

Demonstrate the ability to actively manage the acutely poisoned patient, including but not limited to: ▪ Accessing information required (e.g. Toxbase) ▪ Use of specific antidotes and antitoxins ▪ Use of 'generic' control measures such as activated charcoal and alkalinisation of urine Use of renal replacement methods	Mi, C	2
Order, interpret and act on initial investigations appropriately: biochemistry, arterial blood gas, glucose, ECG, and drug concentrations	E, MI, C	1
Ensure appropriate monitoring in acute period of care (Toxbase)	Mi, C	1
Perform mental state examination	E. D	1
Practice safe prescribing of sedatives for withdrawal symptoms. Ensures correction of malnutrition including vitamin and mineral supplementation	Mi, C, AA	1
Behaviour		
Contact senior promptly in event of critical illness or patient refusing treatment	ACAT, C	3
Recognise the details of poisoning event given by patient may be inaccurate	ACAT, C	2
Show compassion and patience in the assessment and management of those who have self-harmed	ACAT, C, M	4

Rash

The trainee will be able assess a patient presenting with an acute-onset skin rash and common skin problems to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the characteristic lesions found in the acute presentation of common skin diseases e.g. cellulitis, erysipelas, impetigo, cutaneous drug reactions, purpuric rashes, skin malignancies	E, C, Mi, ACAT	1
To be able to identify the life threatening dermatological emergencies, know their causes and emergency management including but not limited to: toxic epidermal necrolysis, Stevens Johnson syndrome, erythroderma, necrotizing fasciitis.	E, C, Mi, ACAT	1
Know the common and serious causes of skin and mouth ulceration.	E, C, Mi, ACAT	1
Know the causes of and treatments for pruritus	E, C, Mi, ACAT	1
Recall basic investigations to establish aetiology	E, C, Mi, ACAT	1
Recall risk factors, particularly drugs, infectious agents and allergens	E, C, Mi, ACAT	1
Recall possible medical treatments	E, C, Mi, ACAT	1
Skills		
Take a thorough focussed history & conduct a detailed examination, including the nails, scalp and mucosa to arrive at appropriate differential diagnoses	E, Mi, C	1
Recognise the importance of a detailed drug history	E, Mi, C	1
Recognise likely skin and oral malignancy	E, Mi	1
Recognise that anaphylaxis may be a cause of an acute skin rash	Mi, C	1
Order, interpret and act on initial investigations appropriately to establish aetiology	E, Mi, C	1
Implement acute medical care when indicated by patient presentation / initial investigations Identify those patients who are systemically unwell and require admission.	Mi, C	1
Behaviour		
Demonstrate sympathy and understanding of patients‘ concerns due to the cosmetic impact of skin disease	ACAT, C	4

Engage the patient in the management of their condition particularly with regard to topical treatments	ACAT, C	3, 4
Reassure the patient about the long term prognosis and lack of transmissibility of most skin diseases	ACAT, C	3
Know when to liaise with dermatological specialists early for serious conditions	ACAT, C	2, 3

Red eye

The trainee will be able to evaluate the patient who presents with a painful red eye, produce a valid differential diagnosis, appropriate investigation and implement a management		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the basic anatomy and physiology of the eye and visual pathways	E, C, Mi, ACAT	1
Know the causes of painful red eye including orbital cellulitis.	E, C, Mi, ACAT	1
Understand the investigations required to make differential diagnosis of acute red eye including the importance of measuring visual acuity	E, C, Mi, ACAT	1
Know the common treatments of acute red eye	E, C, Mi, ACAT	1
Skills		
Perform full examination including acuity, ocular movements, visual fields, related cranial nerves and adjacent structures.	E, D	1
Formulate differential diagnosis	Mi, C	1
Demonstrate the use of a slit lamp, fundoscopy and lid eversion	E, D	1
Demonstrate removal of a foreign body	D	1
Demonstrate the use of fluorescein	D	1
Behaviour		
Know when to refer patient on for a specialist opinion who present with red eye	ACAT, C	2, 3

Suicidal ideation

The trainee will be able to evaluate the patient who presents with suicidal ideation, assess risk and formulate appropriate management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Outline the risk factors for a suicidal attempt. Know the national guidelines for self harm	E, C, Mi, ACAT	1
Outline the common co existing psychiatric pathologies that may precipitate suicidal ideation.	E, C, Mi, ACAT	1
Outline the indications, contraindications and side effects of the major groups of psychomotor medications.	E, C, Mi, ACAT	1
Outline the powers that enable assessment and treatment of patients following self harm or suicidal ideation as defined in the Mental Health act	E, C, Mi, ACAT	1
Skills		
Take a competent psychiatric history and be familiar with scoring tools used to assess risk of further harm (e.g. Becks score, SAD persons)	E, D, Mi, C	1
Elicit symptoms of major psychiatric disturbance	E, Mi, C	1
Obtain collateral history when possible.	Mi, C	1
Recognise and manage anxiety and aggression appropriately	Mi, C	1
Behaviour		
Liaise promptly with psychiatric services if in doubt or high risk of repeat self harm is suspected	ACAT, C	2
Recognise the role of the Self harm team and continued community care.	ACAT, C	2
Show compassion and patience in the assessment and management of those who have suicidal intent	ACAT, C, M	4

Sore throat

The trainee will be able to evaluate the patient who presents with a sore throat produce a valid differential diagnosis, appropriate investigation and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the causes of a sore throat, and provide a differential diagnosis	E, C, Mi, ACAT	1
Outline the necessary investigations	E, C, Mi, ACAT	1
Know how to prescribe safely	E, C, Mi, ACAT	1
Skills		
Take a full history including associated symptoms such as joint pain, dysphasia etc	E, Mi, C	1
Perform full exam including examination of the neck and lymph nodes	E, Mi, C	1
Recognise when the airway is at risk and manage appropriately	Mi, C	1
Know when antibiotics are indicated	E, Mi, C	1
Behaviour		
Know when to refer to an ENT specialist for admission of follow up	ACAT, C	2

Syncope and pre-syncope

The trainee will be able to assess a patient presenting with syncope to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the definition and common causes of syncope and pre syncope	E, C, Mi, ACAT	1
Outline the pathophysiology of syncope depending on situation- including but not limited to vasovagal, cough, effort, micturition, carotid sinus hypersensitivity.	E, C, Mi, ACAT	1
Differentiate from other causes of collapse in terms of associated symptoms and signs and eye witness reports	E, C, Mi, ACAT	1
Outline the indications for hospital admission	E, C, Mi, ACAT	1
Outline the indications for cardiac monitoring	E, C, Mi, ACAT	1
Define the recommendations concerning fitness to drive	E, C, Mi, ACAT	1
Skills		
Take thorough history from patient and witness to elucidate episode	E, Mi, C	1
Differentiate pre-syncope from other causes of 'dizziness'	E, C	1
Assess patient in terms of ABC and degree of consciousness and manage appropriately	Mi, C	1
Perform examination to elicit signs of cardiovascular disease	E, D	1
Order, interpret and act on initial investigations appropriately: blood tests ECG	E, Mi, C	1
Behaviour		
Recognise impact episodes can have on lifestyle particularly in the elderly	ACAT, C	2
Recognise recommendations regarding fitness to drive in relation to syncope	ACAT, C	2

Traumatic limb and joint injuries

The trainee will be able to evaluate the patient who presents with a traumatic limb or joint injury produce a valid differential diagnosis, appropriate investigation and implement a management		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the anatomy of the axial skeleton and joints	E, C, Mi, ACAT	1
Outline the treatment options for common fractures and joint injuries	E, C, Mi, ACAT	1
Understand the pathophysiology behind complications like compartment syndrome	E, C, Mi, ACAT	1
Know how to prescribe safely for traumatic limb pain	E, C, Mi, ACAT	1
Skills		
Be able to recognise life threatening trauma	Mi. C, L, S	1
Be able to recognise limb threatening trauma	Mi, C, L	1
Be able to demonstrate assessment of limb function, detect neurological and vascular compromise	E, D	1
Demonstrate common techniques for joint and fracture reduction	D	1
Behaviour		
Know when to seek senior advice in the management of limb and joint trauma	ACAT, C	2

Vaginal bleeding

The trainee will be able to evaluate the patient who presents with vaginal bleeding, produce a valid differential diagnosis, appropriate investigation and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know the causes for vaginal bleeding in different age groups, pre menopausal, post menopausal and pregnant women	E, C, Mi, ACAT	1
Understand the early complications of pregnancy and the pathophysiology of an ectopic pregnancy	E, C, Mi, ACAT	1
Know what investigations are required	E, C, Mi, ACAT	1
Understand what drugs (including anti-D immunoglobulin)can be safely prescribed for each cause	E, C, Mi, ACAT	1
Skills		
Be able to demonstrate a full examination	E, D	1
Be able to demonstrate resuscitative procedures for heavy bleeding or cervical shock	Mi, C	1
Behaviour		
Recognise the need for chaperone	ACAT, C	1, 2
Know when to involve a senior	ACAT, C	2
Know which patient can be discharged safely	ACAT, C	2

Ventilatory Support

The trainee will describe or demonstrate their approach to the patient requiring ventilatory support.		
Knowledge	**Assessment Methods**	**GMP Domains**
Recalls and understands the principles of ventilatory support strategies and local protocols, including but not limited to: Oxygen therapy, CPAP, NIV, IPPV	E, C, Mi, ACAT	1
Knowledge of the conditions which may require ventilatory support in the critically ill, including but not limited to: acute respiratory distress syndrome (ARDS)/acute lung injury, exacerbation of airflow obstruction, infection, trauma	E, C, Mi, ACAT	1
Understands the concepts of oxygen delivery and utilisation and work of breathing.	E, C, Mi, ACAT	1
Recalls appropriate monitoring and investigation of the patient with a requiring ventilatory support, including but not limited to: Clinical assessment, Arterial blood gases, Blood tests, Radiography	E, C, Mi, ACAT	1
Central venous pressure monitoring and more advanced haemodynamic monitoring	E, C, Mi, ACAT	1
Outline immediate management options including: Increasing inspired oxygen fraction, Increased respiratory monitoring, Initiation of non-invasive ventilation or CPAP, Role of invasive mechanical ventilation.	E, C, Mi, ACAT	1
Knowledge of problems associated with ventilatory support (e.g. ventilator associated pneumonia, ventilator associated lung injury), and strategies available to limit such problems	E, C, Mi, ACAT	1
Skills		
Makes a rapid and appropriate assessment, including: Clinical assessment, Use of simple airway manoeuvres to restore a patent airway, Use of airway adjuncts to restore a patent airway, Selection of appropriate oxygen delivery devices	Mi, C, ACAT	1
Initiates appropriate immediate management and performs appropriate further management of the critically ill patient competently.	Mi, C, ACAT, D	1
Demonstrates safe use of local ventilators including: Selects appropriate initial ventilator settings, Selects 100% oxygen	Mi, C, ACAT	1
Prioritise, order, interpret and act on simple investigations appropriately	Mi, C, ACAT	1

Behaviour		
Recognise need for immediate assessment and resuscitation	Mi, C, ACAT	1
Assume leadership role where appropriate	Mi, C, ACAT	3
Communicates effectively with patient, relatives nursing and other staff, during the assessment and the ordering of additional tests and treatment plans.	Mi, C, ACAT	2,4
Involves senior and specialist services appropriately	Mi, C, ACAT	2,3

Vomiting and Nausea

The trainee will be able to assess a patient with vomiting and nausea to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan		
Knowledge	**Assessment Methods**	**GMP Domains**
Recall the causes and pathophysiology of nausea and vomiting	E, C, Mi, ACAT	1
Recall the use and adverse effects of commonly used anti-emetics and differentiate the indications for each and the value of combination therapy.	E, C, Mi, ACAT	1
Recall 'red flag' features that make a diagnosis of upper GI malignancy possible	E, C, Mi, ACAT	1
Know the indications for urgent surgical review	E, C, Mi, ACAT	1
Skills		
Elicit signs of dehydration and take steps to rectify this	Mi, C	1
Recognise and treat suspected GI obstruction appropriately: nil by mouth, NG tube, IV fluids	Mi, C	1
Practise safe prescribing of anti-emetics	Mi, C, AA	2
Order, interpret and act on initial investigations appropriately: including but not limited to blood tests, x-rays, CT scans and endoscopy	E, Mi, C	1
Behaviour		
Involve surgical team promptly in event of GI obstruction	ACAT, C	3
Respect the impact of nausea and vomiting in the terminally ill and involve palliative care services appropriately	ACAT, C	4

Weakness and Paralysis

The trainee will be able to assess a patient presenting with motor weakness to produce a valid differential diagnosis, investigate appropriately, formulate and implement a management plan (see also 'Speech Disturbance' and 'Abnormal Sensation (Paraesthesia and Numbness)')		
Knowledge	**Assessment Methods**	**GMP Domains**
Broadly outline the physiology and neuroanatomy of the components of the motor system	E, C, Mi, ACAT	1
Recall the myotomal distribution of nerve roots, peripheral nerves, and tendon reflexes	E, C, Mi, ACAT	1
Recall the clinical features of upper and lower motor neurone, neuromuscular junction and muscular lesions	E, C, Mi, ACAT	1
Recall the common and important causes for lesions at the sites listed above	E, C, Mi, ACAT	1
Recall tools for the classification of stroke, and prognosis	E, C, Mi, ACAT	1
Recognise the systemic implications of muscular weakness involving the respiratory and bulbar muscles, including need for airway protection and ventilatory support.	E, C, Mi, ACAT	1
Demonstrate knowledge of investigations for acute presentation, including indications for urgent head CT and stroke thrombolysis	E, C, Mi, ACAT	1
Know national guidelines for the management of stroke and TIA.	E, C, Mi, ACAT	1
Recognise acquired ICU paresis and understand its implications for ongoing care.	E, C, Mi, ACAT	1
Skills		
Elucidate speed of onset and risk factors for neurological dysfunction	E, Mi, C	1
Perform full examination to elicit signs of systemic disease and neurological dysfunction and identify associated deficits	E, D	1
Describe likely site of lesion in motor system and produce differential diagnosis	E, Mi, C	1
Order, interpret and act on initial investigations for motor weakness appropriately	E, Mi, C	1
Recognise when swallowing may be unsafe and manage appropriately	Mi, C	1
Detect spinal cord compromise and investigate promptly	Mi, C	1

Perform tests on respiratory function and inform seniors and specialists appropriately	E, D	1
Ensure appropriate care: thromboprophylaxis, pressure areas,	Mi, C, AA	1
Behaviour		
Recognise importance of timely assessment and treatment of patients presenting with acute motor weakness	ACAT, C	2
Consult senior and acute stroke service, if available, as appropriate	ACAT, C	3
Recognise patient and carers distress when presenting with acute motor weakness	ACAT, C, PS	2
Consult senior when rapid progressive motor weakness or impaired consciousness is present	ACAT, C	3
Involve speech and language therapists appropriately	ACAT, C	3
Contribute to multi-disciplinary approach	ACAT, C	3, 4

Wound assessment and management

The trainee will be able to evaluate the patient who presents with a wound and implement a management plan.		
Knowledge	**Assessment Methods**	**GMP Domains**
Know how to assess a wound in terms of mechanism of injury, underlying structures and, complications.	E, C, Mi, ACAT	1
Know the anatomy of the underlying structures especially hand wrist and face.	E, C, Mi, ACAT	1
Know of special types of wound- puncture, bites, amputation de-gloving and presence of foreign bodies.	E, C, Mi, ACAT	1
Be able to classify and describe wounds	E, C, Mi, ACAT	1
Know how to manage wounds in the immunocompromised patient	E, C, Mi, ACAT	1
Know how to use local anaesthetic techniques to produce pain free wounds	E, C, Mi, ACAT	1
Know the indications for tetanus prophylaxis	E, C, Mi, ACAT	1
Know different closure techniques Know the indications for delayed closure of wounds and antibiotic treatment	E, C, Mi, ACAT	1
Understand the principals of asepsis	E, C, Mi, ACAT	1
Skills		
Be able to demonstrate the ability to explore a wound and recognise injury to structures	D	1
Be able to demonstrate the technique of wound toilet including removal of foreign bodies	D	1
Demonstrate wound closure, dressings	E, D	1
Know when to review a wound and make the appropriate arrangements	Mi, C	1
Behaviour		
Recognise when to refer a complex would for further care	ACAT, C	2

6.3 Anaesthetics within ACCS

Introduction

The anaesthetic section of the ACCS curriculum is taken directly from CCT curriculum in Anaesthetics (annex B). As ACCS trainees normally spend between three and nine months in anaesthetics, only certain elements of the anaesthetic curriculum can be achieved and clearly this will vary depending on the individuals' exposure.

All ACCS trainees completing a three month anaesthetic placement must complete, ***as a minimum***, the Initial Assessment of Competence (IAC), and the associated learning outcomes. If this is not completed during this period, then time during the ICU placement should be allowed to enable the trainee to complete their anaesthesia competencies. Without the IAC it will not be possible to achieve an 'outcome 1' at ARCP.

Trainees spending 6 months or longer must complete, in addition to the IAC, the modules listed under the 'Basis of anaesthetic practice', and all the associated learning outcomes. The requirements should be identical to those of the CT anaesthetic trainees within an individual school and again this will be a minimum ARCP requirement;

Basis of anaesthetic practice

- Preoperative assessment
- Premedication
- Induction of general anaesthesia
- Intra-operative care
- Postoperative and recovery room care
- Management of respiratory and cardiac arrest
- Control of infection
- Introduction to anaesthesia for emergency surgery

There are a number of modules within anaesthetic core training, but not part of the 'basis' section, which are of added interest to the ACCS trainee. These include the following modules listed under 'Basic anaesthesia';

1. Airway management
2. Sedation
3. Transfer Medicine
4. Critical incidents

Elements within all these modules are included in the IAC and Basis section. It is suggested that, where possible, the learning outcomes of 1 to 3 above are also addressed during the anaesthetic training and that, in those undertaking a nine month block, this will be the norm.

Trainees who will be pursuing anaesthetic training after completion of ACCS may also wish to complete addition elements of core training and this should be discussed with individuals' educational supervisors.

There are 30 'Critical Incidents' listed in this module. Many are generic and will have been addressed in other parts of ACCS training. Others will be covered in the routine course of anaesthetic training. Trainees should be aware of this list and ensure they have addressed those of direct relevance during their ACCS training.

For trainees following the anaesthesia pathway, those competencies marked with an 'E' as an assessment method may be examined in the FRCA primary examination. A blueprint of the basic level units against the FRCA primary examination is available in Annex B of the Curriculum for a CCT in Anaesthetics.

A Basis of anaesthetic practice

Preoperative Assessment

Preoperative assessment

Core clinical learning outcomes:

- Is able to perform a structured preoperative anaesthetic assessment of a patient prior to surgery and recognise when further assessment/optimisation is required prior to commencing anaesthesia/surgery
- To be able to explain options and risks of routine anaesthesia to patients, in a way they understand, and obtain their consent for anaesthesia

A) History Taking

This training will:

- Develop the ability to elicit a relevant structured history from patients
- Ensure the history obtained is recorded accurately
- Ensure the history is synthesised with the relevant clinical examination

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
HT_BK_01	Recognises the importance of different elements of history	A,C,E	1
HT_BK_02	Recognises that patients do not always present history in a structured fashion	A,C,E	1
HT_BK_03	Knows the likely causes and risk factors for conditions relevant to mode of presentation	A,C,E	1
HT_BK_04	Recognises that the patient's agenda and the history should inform examination, investigation and management	A,C,E	1

Skills

Competence	*Description*	*Assessment Method*	*GMP*
HT_BS_01	Identifies and overcomes possible barriers to effective communication	A,D	3,4
HT_BS_02	Manages time and draws consultation to a close appropriately	A,D	1,3
HT_BS_03	Recognises that effective history taking in non-urgent cases may require several discussions with the patient and other parties, over time	A,C	1
HT_BS_04	Supplements history with standardised instruments or questionnaires when relevant	A,C	3
HT_BS_05	Manages alternative and conflicting views from family, carers, friends and members of the multi-professional team	C,M	3,4
HT_BS_06	Assimilates history from the available information from the patient and other sources including members of the multi-professional team	A,C,M	1,3
HT_BS_07	Recognises and interprets appropriately the use of non verbal communication from patients and carers	A,D	3,4

HT_BS_08	Focuses on relevant aspects of history and maintains focus despite multiple and often conflicting agendas	A,D	1

B) Clinical Examination

This training will enable the learner to:

- Develop the ability to perform focused, relevant and accurate clinical examination in patients with increasingly complex issues and in increasingly challenging circumstances
- Develop the ability to relate physical findings to history in order to establish diagnosis[es] and formulate management plan[s]

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
CE_BK_01	Understands the need for a targeted and relevant clinical examination	A,C,E	1
CE_BK_02	Understands the basis for clinical signs and the relevance of positive and negative physical signs	A,C,E	1
CE_BK_03	Recognises constraints to performing physical examination and strategies that may be used to overcome them	A,C	1
CE_BK_04	Recognises the limitations of physical examination and the need for adjunctive forms of assessment to confirm diagnosis.	A,C	1
CE_BK_05	Recognises when the offer/ use of a chaperone is appropriate or required.	A,C	3,4

Skills

Competence	*Description*	*Assessment Methods*	*GMP*
CE_BS_01	Performs an examination relevant to the presentation and risk factors that is valid, targeted and time efficient	A,D	1
CE_BS_02	Recognises the possibility of deliberate harm [both self harm and harm by others] in vulnerable patients and report to appropriate agencies	A,C,D	2,4
CE_BS_03	Actively elicits important clinical findings	D	1
CE_BS_04	Performs relevant adjunctive examinations	A,D	1

c) Specific Anaesthetic Evaluation

This training will:

- Develop the ability to establish a problem list
- Develop the ability to judge whether the patient is fit for and optimally prepared for the proposed intervention
- Develop the ability to plan anaesthesia and postoperative care for common surgical procedures
- Develop the ability to recognise the trainees limitations and reliably determine the level of supervision they will need
- Ensure trainees can explain options and risks of routine anaesthesia to patients, in a way they understand, and obtain their consent for anaesthesia

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
OA_BK_01	Knows the methods of anaesthesia that are suitable for common operations in the surgical specialties for which they have anaesthetised. Typical experience at this early stage of training will be in: General surgery, Gynaecology, Urology, Orthopaedic surgery, ENT, Dental	A,C,E	1,2
OA_BK_02	Describes the ASA and NCEPOD classifications and their implications in preparing for and planning anaesthesia	A,C,E	1
OA_BK_03	Explains the indications for and interpretation of preoperative investigations	A,C,E	1
OA_BK_04	Lists the indications for preoperative fasting and understand appropriate regimens	A,C,E	1
OA_BK_05	Explains the methods commonly used for assessing the airway to predict difficulty with tracheal intubation	A,C,E	1,2
OA_BK_06	Discusses the indications for RSI	A,C,D,E	1,2
OA_BK_07	Gives examples of how common co-existing diseases affect anaesthesia and surgery including but not exclusively: obesity; diabetes; asthma; ischaemic heart disease; hypertension and rheumatoid disease; epilepsy	A,C,E	1
OA_BK_08	Discusses how to manage drug therapy for co-existing disease in the peri-operative period including, but not exclusively: obesity; diabetic treatment; steroids; anti-coagulants; cardiovascular medication; epilepsy	A,C,E	1
OA_BK_09	Explains the available methods to minimise the risk of thromboembolic disease following surgery	A,C,E	1,2
OA_BK_10	Knows about the complications of anaesthetic drugs [including anaphylaxis, suxamethonium apnoea and malignant hyperpyrexia]	A,C,E	1,2

	and how to predict patients who are at increased risk of these complications		
OA_BK_11	Identifies the principles of consent for surgery and anaesthesia, including the issue of competence	A,C,E	3,4
OA_BK_12	Explains the guidance given by the GMC on consent, in particular: • Understands that consent is a process that may culminate in, but is not limited to, the completion of a consent form • Understands the particular importance of considering the patient's level of understanding and mental state [and also that of the parents, relatives or carers when appropriate] and how this may impair their capacity for consent	A,C,E	3,4
OA_BK_13	Summarises the factors determining a patient's suitability for treatment as an ambulant or day-stay patient	A,C,E	1
OA_BK_14	Recalls/lists the factors that affect the risk of a patient suffering PONV	A,C,E	1
Skills			
Competence	*Description*	*Assessment Method*	*GMP*
OA_BS_01	Demonstrates satisfactory proficiency in obtaining a history specifically relevant to the planned anaesthesia and surgery including: • A history of the presenting complaint for surgery • A systematic comprehensive relevant medical history • Information about current and past medication • Drug allergy and intolerance • Information about previous anaesthetics and relevant family history	A,D,E	1
OA_BS_02	Demonstrates satisfactory proficiency in performing a relevant clinical examination including when appropriate: • Cardiovascular system • Respiratory system • Central and peripheral nervous system: GCS, peripheral deficit • Musculoskeletal system: patient positioning, neck stability/movement, anatomy for regional blockade • Other: nutrition, anaemia, jaundice • Airway assessment/dentition	A,D,E	1

OA_BS_03	Demonstrates understanding of clinical data including, but not exclusively: Patient clinical case notes and associated records Clinical parameters such as: • BP, Pulse, CVP • BMI • Fluid balance • Physiological investigations such as: • ECGs • Echocardiography and stress testing • Pulmonary function tests	A,C,E	1
OA_BS_04	Demonstrates understanding of clinical laboratory data including: • Haematology such as o Routine report of Hb, WBC, haematocrit etc • Biochemistry such as o Arterial blood gases/acid-base balance • Urea and electrolytes • Liver function • Thyroid function	A,C,E	1
OA_BS_05	Identifies normal appearances and significant abnormalities in radiographs including: • Chest X-rays • Trauma films – cervical spine, chest, pelvis, long bones • Head CT and MRI showing clear abnormalities	A,C,E	1
OA_BS_06	Makes appropriate plans for surgery: • Manages co-existing medicines in the peri-operative period • Plans an appropriate anaesthetic technique[s] • Secures consent for anaesthesia • Recognises the need for additional work-ups and acts accordingly • Discusses issues of concern with relevant members of the team • Reliably predicts the level of supervision they will require	A,C,E	1

OA_BS_07	Presents all information to patients [and carers] in a format they understand, checking understanding and allowing time for reflection on the decision to give consent	A,M	3,4
OA_BS_08	Provides a balanced view of all care options	A,C,E,M	2,3

Premedication

Premedication

Note: This forms part of the comprehensive pre-assessment of patients. Assessment is best included as part of the overall assessment of this process.

Learning outcomes:

- Understands the issues of preoperative anxiety and the ways to alleviate it
- Understands that the majority of patients do not require pre-medication
- Understands the use of preoperative medications in connection with anaesthesia and surgery

Core clinical learning outcome:

- Is able to prescribe premedication as and when indicated, especially for the high risk population

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
PD_BK_01	Summarises the value of appropriate explanations and reassurance in alleviating the patients anxiety	A,C,E	1,3
PD_BK_02	Lists basic indications for prescription of premedicant drugs	A,C,E	1
PD_BK_03	Explains how to select appropriate sedative or anxiolytic agents	A,C,E	1
PD_BK_04	Discusses the applied pharmacology of these drugs	A,C,E	1
PD_BK_05	Recalls/lists the factors that influence the risk of patients at increased risk of gastric reflux/aspiration and understands strategies to reduce it	A,C,D,E	1,2
PD_BK_06	Recalls/describes the applied pharmacology of pro-kinetic and antacids including simple alkalis, H_2 and Proton Pump antagonists	A,C,E	2
PD_BK_07	Identifies local/national guidelines on management of thromboembolic risk and how to apply them	A,C,E	1,2
PD_BK_08	Explains the principles and practice of using prophylactic antibiotics	A,C,E	1

Skills

Competence	*Description*	*Assessment Method*	*GMP*
PD_BS_01	Selects and prescribes appropriate agents to reduce the risk of regurgitation and aspiration, in timeframe available	A,C,D,E	1,2
PD_BS_02	Explains, in a way the patient understands, the benefits and possible risks of sedative premedication	A,E,M	3,4
PD_BS_03	Selects and prescribes appropriate anxiolytic/sedative premedication when indicated	A,C,E	1

Induction of general anaesthesia

Induction of general anaesthesia

The use of simulators may assist in the teaching and assessment of some aspects of this section e.g. failed intubation drill

Learning outcomes:

- The ability to conduct safe induction of anaesthesia in ASA grade 1-2 patients confidently
- The ability to recognise and treat immediate complications of induction, including tracheal tube misplacement and adverse drug reactions
- The ability to manage the effects of common co-morbidities on the induction process

Core clinical learning outcomes:

- Demonstrates correct pre-anaesthetic check of all equipment required ensuring its safe functioning [including the anaesthetic machine/ventilator in both the anaesthetic room and theatre if necessary]
- Demonstrates safe induction of anaesthesia, using preoperative knowledge of individual patients co-morbidity to influence appropriate induction technique; shows awareness of the potential complications of process and how to identify and manage them

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
IG_BK_01	In respect of the drugs used for the induction of anaesthesia: Recalls/summarises the pharmacology and pharmacokinetics, including doses, interactions and significant side effects of: Induction agents, Muscle relaxants, Analgesics, Inhalational agents including side effects, interactions and doses, Identifies about the factors that contribute to drug errors in anaesthesia and the systems to reduce them	A,C,D,E	1
IG_BK_02	In respect of the equipment in the operating environment: Describes the basic function of monitors and knows what monitoring is appropriate for induction including consensus minimum monitoring standards and the indications for additional monitoring Explains the function of the anaesthetic machine including: The basic functions of gas flow, Pre-use checking of the anaesthetic machine, The structural features of the anaesthetic machine that minimise errors, The operation of the anaesthetic ventilator, The function of the anaesthetic vaporizers, The operation of any monitoring equipment that is integral with the anaesthetic machine, Knows how to replenish anaesthetic vaporizer	A,C,D,E	1,2
IG_BK_03	In respect of the induction of anaesthesia:	A,C,D,E	1,2

	• Describes the effect of pre-oxygenation and knows the correct technique for its use • Explains the techniques of intravenous and inhalational induction and understands the advantages and disadvantages of both techniques. • Knows about the common intravenous induction agents and their pharmacology • Knows the physiological effects of intravenous induction including the differences between agents • Recalls/explains how to recognise the intra-arterial injection of a harmful substance and its appropriate management • Describes the features of anaphylactic reactions and understands the appropriate management including follow up and patient information • Knows the factors influencing the choice between agents for inhalational induction of anaesthesia • Discusses the additional hazards associated with induction of anaesthesia in unusual places [e.g. Emergency Room] and in special circumstances including but not exclusively: brain injury; full stomach; sepsis; upper airway obstruction • Identifies the special problems of induction associated with cardiac disease, respiratory disease, musculoskeletal disease, obesity and those at risk of regurgitation/pulmonary aspiration.		
IG_BK_04	Describes the principles of management of the airway including: Techniques to keep the airway open and the use of facemasks, oral and nasopharyngeal airways and laryngeal mask airways	A,C,D,E	1,2
IG_BK_05	In respect of tracheal intubation: • Lists its indications • Lists the available types of tracheal tube and identifies their applications • Explains how to choose the correct size and length of tracheal tube • Explains the advantages/disadvantages of different types the laryngoscopes and blades including, but not exclusively, the Macintosh and McCoy • Outlines how to confirm correct placement of an tracheal tube and knows how to identify the complications of intubation including endobronchial and oesophageal intubation	A,C,D,E	1,2

	• Discusses the methods available to manage difficult intubation and failed intubation • Explains how to identify patients who are at increased risk of regurgitation and pulmonary aspiration and knows the measures that minimise the risk • Categorises the signs of pulmonary aspiration and the methods for its emergency management		
IG_BK_06	Explains the importance of maintaining the principles of aseptic practice and minimising the risks of hospital acquired infection	A,C,D,E	2

Skills			
Competence	*Description*	*Assessment Methods*	*GMP*
IG_BS_01	Demonstrates safe practice in checking the patient in the anaesthetic room	A,D	1,2
IG_BS_02	Demonstrates appropriate checking of equipment prior to induction, including equipment for emergency use	A,D	1,2
IG_BK_03	In respect of the equipment in the operating environment: • Demonstrates understanding of the function of the anaesthetic machine including ○ Performing proper pre-use checks ○ Changing/checking the breathing system ○ Replenishing the vaporizer ○ Changing the vaporizer	D	1,2
IG_BS_04	Demonstrates safe practice in selecting, checking, drawing up, diluting, labelling and administering of drugs	A,D	1,2,3
IG_BS_05	In respect of intravenous cannulation: • Obtains intravascular access using appropriate size cannulae in appropriate anatomical location • Demonstrates rigorous aseptic technique when inserting a cannula	D	1
IG_BS_06	In respect of monitoring: • Demonstrates appropriate placement of monitoring, including ECG electrodes and NIBP cuff • Manages monitors appropriately e.g. set alarms; start automatic blood pressure • Demonstrates proficiency in the Interpretation of monitors	A,D	1

IG_BS_07	Demonstrates effective pre-oxygenation, including correct use of the mask, head position and clear explanation to the patient	A,D	1,2,3
IG_BS_08	In respect of intravenous induction: • Makes necessary explanations to the patient • Demonstrates satisfactory practice in preparing drugs for the induction of anaesthesia • Demonstrates proper technique in injecting drugs at induction of anaesthesia • Manages the cardiovascular and respiratory changes associated with induction of general anaesthesia	A,D	1,2,3
IG_BS_09	In respect of inhalational induction of anaesthesia: • Satisfactorily communicates with the patient during induction • Satisfactorily conducts induction	A,D	1,2,3
IG_BS_10	In respect of airway management: • Demonstrates optimal patient position for airway management • Manages airway with mask and oral/nasopharyngeal airways • Demonstrates hand ventilation with bag and mask • Able to insert and confirm placement of a Laryngeal Mask Airway • Demonstrates correct head positioning, direct laryngoscopy and successful nasal/oral intubation techniques and confirms correct tracheal tube placement • Demonstrates proper use of bougies • Demonstrates correct securing and protection of LMAs/tracheal tubes during movement, positioning and transfer • Correctly conducts RSI sequence • Correctly demonstrates the technique of cricoid pressure	A,D	1,2,3
IG_BS_11	Demonstrates correct use of oropharyngeal, laryngeal and tracheal suctioning	A,D	1,2
IG_BS_12	Demonstrates failed intubation drill	D,S	1,2

Intra-operative care

Intra-operative care

Learning outcomes:

- The ability to maintain anaesthesia for surgery
- The ability to use the anaesthesia monitoring systems to guide the progress of the patient and ensure safety
- Understanding the importance of taking account of the effects that co-existing diseases and planned surgery may have on the progress of anaesthesia
- Recognise the importance of working as a member of the theatre team

Core clinical learning outcome:

- Demonstrates safe maintenance of anaesthesia and shows awareness of the potential complications and how to identify and manage them

Skills

Competence	*Description*	*Assessment Method*	*GMP*
IO_BS_01	Demonstrates how to direct the team to safely transfer the patient and position of patient on the operating table and is aware of the potential hazards including, but not exclusively, nerve injury, pressure points, ophthalmic injuries	A,D	1,2,3
IO_BS_02	Manages the intra-operative progress of spontaneously breathing and ventilated patients	A,D	1
IO_BS_03	Demonstrates the ability to maintain anaesthesia with a face mask in the spontaneously breathing patient	A,D	1,2
IO_BS_04	Demonstrates the use of a nerve stimulator to assess the level of neuromuscular blockade	A,D	1
IO_BS_05	Manages the sedated patient for surgery	A,D	1,3
IO_BS_06	Maintains accurate, detailed, legible anaesthetic records and relevant documentation	A,C	1
IO_BS_07	Demonstrates role as team player and when appropriate leader in the intra-operative environment	A,D,M	2,3
IO_BS_08	Communicates with the theatre team in a clear unambiguous style	A,D,M	3
IO_BS_09	Able to respond in a timely and appropriate manner to events that may affect the safety of patients [e.g. hypotension, massive haemorrhage] [S]	A,C,D,E,M,S	1,2

IO_BS_10	Manages common co-existing medical problems [with appropriate supervision] including but not exclusively: • Diabetes • Hypertension • Ischaemic Heart Disease • Asthma and COPD • Patients on steroids	A,C,D	1,2

Post-operative and recovery room care

Postoperative and recovery room care

Learning outcomes:

- The ability to manage the recovery of patients from general anaesthesia
- Understanding the organisation and requirements of a safe recovery room
- The ability to identify and manage common postoperative complications in patients with a variety of co-morbidities
- The ability to manage postoperative pain and nausea
- The ability to manage postoperative fluid therapy

Core clinical learning outcomes:

- Safely manage emergence from anaesthesia and extubation
- Shows awareness of common immediate postoperative complications and how to manage them
- Prescribes appropriate postoperative fluid and analgesic regimes and assessment and treatment of PONV

Knowledge

Competence	*Description*	*Assessment Method*	*GMP*
PO_BK_01	Lists the equipment required in the recovery unit	A,C,E	1
PO_BK_02	Lists the types of monitoring and the appropriate frequency of observations required for patients having undergone different types of surgery	A,C,E	1
PO_BK_03	Describes the care of an unconscious patient in the recovery room, including safe positioning	A,C,D,E	1,2
PO_BK_04	In respect of restoring spontaneous respiration and maintaining the airway at the end of surgery: • Explains how to remove the tracheal tube and describes the associated problems and complications • Recalls/describes how to manage laryngospasm at extubation	A,C,E	1

	• Recalls/lists the reasons why the patient may not breathe adequately at the end of surgery • Recalls/identifies how to distinguish between the possible causes of apnoea • Lists the possible causes of postoperative cyanosis • Understands how to evaluate neuromuscular block with the nerve stimulator		
PO_BK_05	With respect to oxygen therapy: • Lists its indications • Knows the techniques for oxygen therapy and the performance characteristics of available devices • Recalls/explains the causes and management of stridor	A,C,E	1,2
PO_BK_06	Outlines/recalls the principles of appropriate post operative fluid regimes including volumes, types of fluids and monitoring of fluid balance including indications for urethral catheterisation	A,C,E	1
PO_BK_07	In respect of postoperative pain: • Describes how to assess the severity of acute pain • Knows the 'analgesic ladder" • Discusses how emotions contribute to pain • Identifies appropriate post operative analgesic regimes including types of drugs and doses • Explains how to manage 'rescue analgesia' for the patient with severe pain • Lists the complications of analgesic drugs	A,C,E	1
PO_BK_08	In respect of PONV: • Accepts fully how distressing this symptom is • Recalls/lists the factors that predispose to PONV • Recalls/describes the basic pharmacology of anti-emetic drugs • Describes appropriate regimes for PONV	A,C,E	1
PO_BK_09	Recalls/lists the possible causes and management of post operative confusion	A,C,E	1
PO_BK_10	Knows the causes and describes the management of post operative hypotension and hypertension	A,C,E	1
PO_BK_11	Identifies the special precautions necessary for the postoperative management of patients with co-existing diseases including cardiac disease, respiratory disease,	A,C,E	1,2

	metabolic disease, musculoskeletal disease, obesity and those at risk of regurgitation/pulmonary aspiration		
PO_BK_12	Explains the prevention, diagnosis and management of postoperative pulmonary atelectasis	A,C,E	1
PO_BK_13	Lists the appropriate discharge criteria for day stay patients to go home and for patients leaving the recovery room to go to the ward	A,C,E	1
PO_BK_14	Explains the importance of following up patients in the ward after surgery	A,C,E	1,2,3
Skills			
Competence	*Description*	*Assessment Method*	*GMP*
PO_BS_01	Demonstrate appropriate management of tracheal extubation, including; • Assessment of return of protective reflexes • Assessment of adequacy of ventilation • Safe practice in the presence of a potentially full stomach	A,D	1
PO_BS_02	Evaluates partial reversal of neuromuscular blockade, including the use of a nerve stimulator	A,D	1,2
PO_BS_03	Demonstrates the safe transfer of the unconscious patient from the operating theatre to the recovery room	A,C,D	1,2
PO_BS_04	Demonstrates how to turn a patient into the recovery position	A,D	1
PO_BS_05	Makes a clear handover to recovery staff of perioperative management and the postoperative plan	A,D,M	1,3
PO_BS_06	Prescribes appropriate postoperative fluid regimes	A,C	1
PO_BS_07	Demonstrates the assessment of postoperative pain and prescribes appropriate postoperative analgesia regimes	A,C,D	1,3
PO_BS_08	Demonstrates the assessment and management of postoperative nausea and vomiting	A,C	1
PO_BS_09	Demonstrates the assessment and management of postoperative confusion	A,C	1
PO_BS_10	Recognises when discharge criteria have been met for patients going home or to the ward	A,C,D	1,2,3

PO_BS_11	Undertakes follow-up visits to patients after surgery on the ward	A,C,D	1

Management of Respiratory and cardiac arrest

Management of respiratory and cardiac arrest

For those who have not completed an ALS/APLS/EPLS course successfully, simulation may be used to assist in the teaching and assessment of these competencies.

Learning outcomes:

- To have gained a thorough understanding of the pathophysiology of respiratory and cardiac arrest and the skills required to resuscitate patients
- Understand the ethics associated with resuscitation

Core clinical learning outcomes:

- Be able to resuscitate a patient in accordance with the latest Resuscitation Council (UK) guidelines. [Any trainee who has successfully completed RC(UK) ALS course in the previous year, or who is an ALS Instructor/Instructor candidate, may be assumed to have achieved this outcome]

Knowledge

Competence	*Description*	*Assessment Method*	*GMP*
RC_BK_01	Recalls/lists the causes of a respiratory arrest, including but not limited to: • Drugs, toxins • Trauma • Pulmonary infection • Neurological disorders • Muscular disorders	C,E,S	1
RC_BK_02	Identifies the causes of cardiac arrest, including but limited to: • Ischaemic heart disease • Valvular heart disease • Drugs • Hereditary cardiac disease • Cardiac conduction abnormalities • Electrolyte abnormalities • Electrocution • Trauma	C,E,S	1

	• Thromboembolism		
RC_BK_03	Demonstrates an understanding of the basic principles of the ECG, and the ability to recognise arrhythmias including but not exclusively: • Ventricular fibrillation • Ventricular tachycardia • Asystole • Rhythms associated with pulseless electrical activity [PEA]	C,E,S	1
RC_BK_04	Discuss the mode of action of drugs used in the management of respiratory and cardiac arrest in adults and children including but not limited to: • Adrenaline • Atropine • Amiodarone • Lidocaine • Magnesium sulphate • Naloxone	C,E,S	1
RC_BK_05	Identifies the doses of drugs, routes given [including potential difficulty with gaining intravenous access and how this is managed] and frequency, during resuscitation from a respiratory or cardiac arrest	C,E,S	1
RC_BK_06	Explains the physiology underpinning expired air ventilation and external chest compressions	C,E,S	1
RC_BK_07	Explains the need for supplementary oxygen during resuscitation from a respiratory or cardiac arrest in adults and children	C,E,S	1
RC_BK_08	Lists advantages and disadvantages of different techniques for airway management during resuscitation of adults and children, including but not limited to: • Oro and nasopharyngeal airways • Laryngeal Mask type supraglottic airways including but not limited to: LMA, Proseal, LMA supreme, iGel • Tracheal intubation	A,C,E,S	1
RC_BK_09	Explains the reasons for avoiding hyperventilation during resuscitation	C,E	1

RC_BK_10	Compares the methods by which ventilation can be maintained in a patient suffering a respiratory or cardiac arrest, using: • Mouth to mask • Self inflating bag • Anaesthetic circuit • Mechanical ventilator	A,C,E,S	1
RC_BK_11	Recalls/explains the mechanism of defibrillation and the factors influencing the success of defibrillation	C,E,S	1
RC_BK_12	Identifies the energies used to defibrillate a patient	C,E,S	1
RC_BK_13	Recalls/discusses the principles of safely and effectively delivering a shock using both manual and automated defibrillator	C,E,S	1,2
RC_BK_14	Explains the need for continuous chest compressions during resuscitation from cardiac arrest once the trachea is intubated	C,E,S	1
RC_BK_15	Explains the need for minimising interruptions to chest compressions	C,E,S	1
RC_BK_16	Recalls/discusses the reversible causes of cardiac arrest and their treatment, including but not limited to: • Hypoxia • Hypotension • Electrolyte and metabolic disorders • Hypothermia • Tension pneumothorax • Cardiac tamponade • Drugs and toxins • Coronary or pulmonary thrombosis	C,E,S	1
RC_BK_17	Recalls/describes the Adult and Paediatric Advanced Life Support algorithms	C,E,S	1
RC_BK_18	Discusses the specific actions required when managing a cardiac arrest due to: • Poisoning • Electrolyte disorders • Hypo/hyperthermia • Drowning	C,E,S	1

	• Anaphylaxis • Asthma • Trauma • Pregnancy [including peri-mortem Caesarean Section] • Electrocution		
RC_BK_19	Identifies the signs indicating return of a spontaneous circulation	A,C,E,S	1
RC_BK_20	Recalls/lists the investigations needed after recovery from a respiratory or cardiac arrest and describes the potential difficulties with obtaining arterial blood samples and how this may be overcome in these patients.	C,E,S	1
RC_BK_21	Discusses the principles of care required immediately after successful resuscitation from a respiratory or cardiac arrest	C,E,S	1,3,4
RC_BK_22	Discusses the importance of respecting the wishes of patients regarding end of life decisions	C,E,S	1,3,4
RC_BK_23	Outlines who might benefit from resuscitation attempts and the importance of knowing/accepting when to stop	C,E,S	1,3,4
RC_BK_24	Discusses the importance of respecting the wishes of relatives to be present during a resuscitation attempt	C,E,S	3,4
RC_BK_25	Describes the value of debriefing meetings and the importance of active participation	C,S	3,4
Skills			
Competence	*Description*	*Assessment method*	GMP
RC_BS_01	Uses and ABCDE approach to diagnose and commence management of respiratory and cardiac arrest in adults and children	D,S	1
RC_BS_02	Demonstrates correct interpretation of the signs of respiratory and cardiac arrest	S	1,2
RC_BS_03	Maintains a clear airway using basic techniques with or without simple adjuncts: • Head tilt • Chin lift • Jaw thrust • Oro- and nasopharyngeal airways	D,S	1,2

RC_BS_04	Demonstrates correct use of advanced airway techniques including: • Supraglottic devices, including but not limited to LMA, Proseal, LMA supreme, iGel • Tracheal intubation	D,S	1,2
RC_BS_05	Maintain ventilation using: • Expired air via a pocket mask • Self-inflating bag via facemask, or advanced airway • Mechanical ventilator	D,S	1,2
RC_BS_06	Performs external cardiac compression	D,S	1,2
RC_BS_07	Monitor cardiac rhythm using defibrillator pads, paddles or ECG lead	D,S	1,2
RC_BS_08	Uses a manual or automated defibrillator to safely defibrillate a patient	D,S	1,2
RC_BS_09	Turn a patient into the recovery position	D	1,2
RC_BS_10	Prepare a patient for transfer to a higher level of care	A,M	1,2
RC_BS_11	Maintains accurate records of all resuscitation events	A,M	1,2

Control of infection

Control of infection

Learning outcomes:

- To understand the need for infection control processes
- To understand types of possible infections contractible by patients in the clinical setting
- To understand and apply most appropriate treatment for contracted infection
- To understand the risks of infection and be able to apply mitigation policies and strategies

Core clinical learning outcomes:

- The acquisition of good working practices in the use of aseptic techniques

Knowledge

Competence	*Description*	*Assessment Method*	*GMP*
IF_BK_01	Identifies the universal precautions and good working practices for the control of infection including but not limited to:	A,C,D,E	1,2

	• Decontaminate hands before treating patients; when soap and water hand wash is appropriate; when alcohol gel decontamination is appropriate • The use of gloves • The use of sterilised equipment • The disposal of used clinical consumables [single use and reusable]		
IF_BK_02	List the types and treatment of infections contracted by patients usually in the ward and ITU, including but not limited to: • MRSA • C Diff	C,E	1
IF_BK_03	Recalls/discusses the concept of cross infection including: • modes of cross infection • Common cross infection agents	A,C,E	1
IF_BK_04	Recalls/explains the dynamics of bacterial and viral strain mutation and the resulting resistance to antibiotic treatment	C,E	1
IF_BK_05	Explains the need for antibiotic policies in hospitals	C,E	1,2
IF_BK_06	Recalls/discusses the cause and treatment of common surgical infections during the use of but not limited to: • Antibiotics • Prophylaxis	C,E	1
IF_BK_07	Recalls/lists the types of infection transmitted through contaminated blood including but not limited to: • HIV • Hepatitis B and C	C,E	1
IF_BK_08	Discusses the need for, and application of, hospital immunisation policies	C,E	1
IF_BK_09	Recalls/explains the need for, and methods of, sterilisation	C,E	1
IF_BK_10	Explains the Trust's decontamination policy and their application	C	1
Skills			
Competence	*Description*	*Assessment method*	*GMP*

IF_BS_01	Identifies patients at risk of infection and applies an infection mitigation strategy	A,D	1
IF_BS_02	Identifies and appropriately treats the immunocompromised patients	A,C	1,4
IF_BS_03	Be able to administer IV antibiotics taking into account and not limited to: • Risk of allergy • Anaphylaxis	A,D	1,2
IF_BS_04	Demonstrates good working practices, following local infection control protocols and the use of aseptic techniques	A,D,M	1,2
IF_BS_05	Demonstrates the correct use of disposable filters and breathing systems	A,D,M	1
IF_BS_06	Demonstrates the correct use and disposal of protective clothing items including but not limited to: • Surgical scrubs • Masks • Gloves	A,D,M	1,2
IF_BS_07	Demonstrates the correct disposal of clinical consumable items [single use and reusable]	A,D,M	1,2

Introduction to anaesthesia for emergency surgery

Introduction to anaesthesia for emergency surgery

Learning outcomes:

- Undertake anaesthesia for ASA 1E and 2E patients requiring emergency surgery for common conditions
- Undertake anaesthesia for sick patients and patients with major co-existing diseases, under the supervision of a more senior colleague

Core clinical learning outcome:

- Delivers safe perioperative anaesthetic care to adult ASA 1E and/or 2E patients requiring uncomplicated emergency surgery [e.g. uncomplicated appendicectomy or manipulation of forearm fracture/uncomplicated open reduction and internal fixation] with local supervision

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
ES_BK_01	Discusses the special problems encountered in patients requiring emergency surgery and how these may be managed including:	A,C,E	1,2,3,4

	• Knowing that patients may be very frightened and how this should be managed • Recognising that the patient may have severe pain which needs immediate treatment • Understanding that patients presenting for emergency surgery are more likely to have inadequately treated co-existing disease • Understanding how to decide on the severity of illness in the frightened apprehensive emergency patient • Understanding the pathophysiological changes and organ dysfunction associated with acute illness • How to recognise that the patient may be dehydrated or hypovolaemic and understanding the importance of preoperative resuscitation		
ES_BK_02	In respect of the preparation of acutely ill patients for emergency surgery discusses: • How to resuscitate the patient with respect to hypovolaemia and electrolyte abnormalities • The fact that patients may be inadequately fasted and how this problem is managed • The importance of dealing with acute preoperative pain and how this should be managed	A,C,E	1
ES_BK_03	Describes how to recognise the 'sick' patient [including sepsis], their appropriate management and the increased risks associated with surgery	A,C,E	1,2
ES_BK_04	Understands the airway management in a patient with acute illness who is at risk of gastric reflux	A,C,E	1
Skills			
Competence	*Description*	*Assessment Methods*	*GMP*
ES_BS_01	Manages preoperative assessment and resuscitation/optimisation of acutely ill patients correctly	A,C,D	1,2,3,4
ES_BS_02	Demonstrates safe perioperative management of ASA 1 and 2 patients requiring emergency surgery	A,C,D,M	1,2,3,4
ES_BS_03	Manages rapid sequence induction in the high risk situation of emergency surgery for the acutely ill patient	A,D	1

Additional units of training

Airway Management

Airway Management **Core clinical learning outcomes:** • Able to predict difficulty with an airway at preoperative assessment and obtain appropriate help • Able to maintain an airway and provide definitive airway management as part of emergency resuscitation • Demonstrates the safe management of the '"can't intubate, can't ventilate" scenario • Maintains anaesthesia in a spontaneously breathing patient via a facemask for a short surgical procedure [less than 30 mins]			
Knowledge			
Competence	*Description*	*Assessment Methods*	*GMP*
AM_BK_01	Explains the methods commonly used for assessing the airway to predict difficulty with tracheal intubation	A,C,E	1,2
AM_BK_02	Describes the effect of pre-oxygenation and knows the correct technique for its use	A,C,D,E	1,2
AM_BK_03	Describes the principles of management of the airway including techniques to keep the airway open and the use of facemasks, oral and nasopharyngeal airways and laryngeal mask airways	A,C,D,E	1,2
AM_BK_04	Explains the technique of inhalational induction and describes the advantages and disadvantages of the technique.	A,C,D,E	1,2
AM_BK_05	Knows the factors influencing the choice between agents for inhalational induction of anaesthesia	A,C,D,E	1,2
AM_BK_06	In respect of tracheal intubation: • Lists its indications • Lists the available types of tracheal tube and identifies their applications • Explains how to choose the correct size and length of tracheal tube • Explains the advantages/disadvantages of different types the laryngoscopes and blades including, but not exclusively, the Macintosh and McCoy • Outlines how to confirm correct placement of a tracheal tube and knows how to identify the complications of intubation including endobronchial and oesophageal intubation	A,C,D,E	1,2

	• Discusses the methods available to manage difficult intubation and failed intubation • Explains how to identify patients who are at increased risk of regurgitation and pulmonary aspiration and knows the measures that minimise the risk • Understands the airway management in a patient with acute illness who is at risk of gastric reflux • Categorises the signs of pulmonary aspiration and the methods for its emergency management		
AM_BK_07	In respect of restoring spontaneous respiration and maintaining the airway at the end of surgery: • Explains how to remove the tracheal tube and describes the associated problems and complications • Recalls/describes how to manage laryngospasm at extubation • Recalls/lists the reasons why the patient may not breathe adequately at the end of surgery • Recalls/identifies how to distinguish between the possible causes of apnoea • Lists the possible causes of postoperative cyanosis • Understands how to evaluate neuromuscular block with the nerve stimulator	A,C,E	1
AM_BK_08	With respect to oxygen therapy: • Lists its indications • Knows the techniques for oxygen therapy and the performance characteristics of available devices • Describes the correct prescribing of oxygen • Recalls/explains the causes and management of stridor	A,C,E	1,2
AM_BK_09	Discusses the indications for RSI	A,C,D,E	1,2
AM_BK_10	Describes the care of the airway in an unconscious patient in the recovery room, including safe positioning	A,C,D,E	1,2
AM_BK_11	Lists advantages and disadvantages of different techniques for airway management during resuscitation, including but not limited to: • Oro and nasopharyngeal airways • Laryngeal Mask type supraglottic airways including but not limited to: LMA, Proseal, LMA supreme, iGel • Tracheal intubation	A,C,E,S	1

AM_BK_12	Compares the methods by which ventilation can be maintained in a patient suffering a respiratory or cardiac arrest, using: • Mouth to mask • Self-inflating bag • Anaesthetic breathing system • Mechanical ventilator	A,C,E,S	1
AM_BK_13	Discusses the different types of laryngoscope blades available in routine practice and the indications for their use	A,C,E	1
AM_BK_14	Outlines the advantages/disadvantages and reasons for development of new laryngoscopes [e.g. glidescope]	A,C,E	1
AM_BK_15	Outlines the indications for fibre-optic intubation and how awake intubation may be achieved	A,C,E	1,2
AM_BK_16	Describes the management of the 'can't intubate, can't ventilate' scenario	A,C,E	1,2
AM_BK_17	Describes the principles of, and indications for, the use of needle cricothyrotomy and manual jet ventilation	A,C,E	1,2
Skills			
Competence	*Description*	*Assessment Methods*	*GMP*
AM_BS_01	Demonstrates satisfactory proficiency in performing a relevant clinical examination and assessment of the airway and dentition	A,D,E	1
AM_BS_02	Identifies normal appearances and significant abnormalities in radiographs including: • Cervical spine, chest • Head CT and MRI showing clear abnormalities relevant to the airway	A,C,E	1
AM_BS_03	Reliably predicts the level of supervision they will require	A, C,E	1
AM_BS_04	Demonstrates effective pre-oxygenation, including correct use of the mask, head position and clear explanation to the patient	A,D	1,2,3
AM_BS_05	In respect of airway management: • Demonstrates optimal patient position for airway management, including head tilt, chin lift, jaw thrust • Manages airway with mask and oral/nasopharyngeal airways • Demonstrates hand ventilation with bag and mask [including self- inflating bag]	A,D	1,2,3

	• Able to insert and confirm placement of a Laryngeal Mask Airway • Demonstrates correct head positioning, direct laryngoscopy and successful nasal/oral intubation techniques and confirms correct tracheal tube placement • Demonstrates proper use of bougies • Demonstrates correct securing and protection of LMAs/tracheal tubes during movement, positioning and transfer • Correctly conducts RSI sequence • Correctly demonstrates the technique of cricoid pressure		
AM_BS_06	Demonstrates correct use of advanced airway techniques including but not limited to Proseal, LMA supreme, iGel	D,S	1,2
AM_BS_07	In respect of inhalational induction of anaesthesia: • Satisfactorily communicates with the patient during induction • Chooses appropriate agent • Satisfactorily conducts induction	A,D	1,2,3
AM_BS_08	Demonstrates the ability to maintain anaesthesia with a face mask in the spontaneously breathing patient	A,D	1,2
AM_BS_09	Demonstrates failed intubation drill	D,S	1,2
AM_BS_10	Demonstrates management of 'can't intubate, can't ventilate' scenario	D,S	1,2
AM_BS_11	Demonstrates correct use of oropharyngeal, laryngeal and tracheal suctioning	A,D	1,2
AM_BS_12	Demonstrate appropriate management of tracheal extubation, including; • Assessment of return of protective reflexes • Assessment of adequacy of ventilation • Safe practice in the presence of a potentially full stomach	A,D	1
AM_BS_13	Demonstrates how to turn a patient into the recovery position	A,D	1
AM_BS_14	Demonstrates small and large bore needle cricothyrotomy and manual jet ventilation	D,S	1,2
AM_BS_15	Demonstrates surgical cricothyrotomy	D,S	1,2

Procedural Sedation

03 Sedation

Learning outcomes:

- To be able to safely deliver pharmacological sedation to appropriate patients

Core clinical learning outcome:

- Provision of safe and effective sedation to ASA 1 and 2 adult patients, aged less than 80 years of age using a maximum of two short acting agents

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
CS_BK_01	Can explain • What is meant by conscious sedation and why understanding the definition is crucial to patient safety • The differences between conscious sedation and deep sedation and general anaesthesia • The fundamental difference in techniques/drugs used/patient safety • That the significant risks to patient safety associated with sedation technique requires meticulous attention to detail, the continuous presence of a suitably trained individual with responsibility for patient safety, safe monitoring and contemporaneous record keeping	A,D,E	1,2,3
CS_BK_02	Describes the pharmacology of drugs commonly used to produce sedation	A,C,E	1
CS_BK_07	Can explain the minimal monitoring required during pharmacological sedation	A,C,E	1
CS_BK_08	Describes the indications for the use of conscious sedation	A,C,E	1,2
CS_BK_10	Can explain the use of single drug, multiple drug and inhalation techniques	A,C,E	1,2
CS_BK_11	Describes the particular risks of multiple drug sedation techniques	A,C,E	1,2,3
CS_BK_12	Outlines the unpredictable nature of sedation techniques in children	A,C,E	1,2,3

Skills

Competence	*Description*	*Assessment Method*	*GMP*

CS_BS_01	Demonstrates the ability to select patients for whom sedation is appropriate part of clinical management	A,C,D	1,2,3
CS_BS_02	Demonstrates the ability to explain sedation to patients and to obtain consent	A,D	1,2,3
CS_BS_03	Demonstrates the ability to administer and monitor inhalational sedation to patients for clinical procedures	A,D	1,2,3
CS_BS_04	Demonstrates the ability to administer and monitor intravenous sedation to patients for clinical procedures	A,D	1,2,3
CS_BS_05	Demonstrates the ability to recognise and manage the complications of sedation techniques appropriately including recognition and correct management of loss of verbal responsiveness	A,D	1,2,3

Transfer Medicine

02 Transfer Medicine: Basis of Anaesthetic Practice and Basic

Learning outcomes:

- Correctly assesses the clinical status of patients and decides whether they are in a suitably stable condition to allow **intra-hospital transfer [only]**
- Gains understanding of the associated risks and ensures they can put all possible measures in place to minimise these risks

Core clinical learning outcome

- Safely manages the intra-hospital transfer of the critically ill but stable adult patient for the purposes of investigations or further treatment [breathing spontaneously or with artificial ventilation] with distant supervision

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
TF_BK_01	Explains the importance of ensuring the patients clinical condition is optimised and stable prior to transfer	A,C,E	1,2
TF_BK_02	Explains the risks/benefits on intra-hospital transfer	A,C,E	1,2,
TF_BK_03	Recalls/describes the minimal monitoring requirements for transfer	A,C,E	1,2,3
TF_BK_04	Lists the equipment [and back up equipment] that is required for intra-hospital transfer	A,C,E	1,2
TF_BK_05	Outlines the physical hazards associated with intra-hospital transfer	A,C,E	1,2

TF_BK_06	Explains the problems caused by complications arising during transfer and the measures necessary to minimise and pre-empt difficulties	A,C,E	1,
TF_BK_07	Outlines the basic principles of how the ventilators used for transfer function	A,C,E	1
TF_BK_08	Indicates the lines of responsibility that should be followed during transfer	A,C,E	1,2,3
TF_BK_09	Outlines the consent requirements and the need to brief patients in transfer situations	A,C,E	1,2,3,4
TF_BK_10	Outlines the issues surrounding the carrying/recording of controlled drugs during transfer	A,C,E	1,2,3
TF_BK_11	Describes the importance of keeping records during transfer	A,C,E	1
TF_BK_12	Outlines the problem of infection and contamination risks when moving an infected patient	A,C,E	1,2
TF_BK_13	Explains how to assess and manage an uncooperative and aggressive patient during transfer	A,C,E	1,2,3,4
TF_BK_14	Understands hospital protocols governing transfer patients between departments	A,C,E	1
TF_BK_15	Outlines the importance of maintaining communication, when appropriate with the patient and members of the transfer team	A,C,E	1,2
Skills			
Competence	*Description*	*Assessment Methods*	*GMP*
TF_BS_01	Demonstrates the necessary organisational and communication skills to plan, manage and lead an intra-hospital transfer of a stable patient	A,M	1,2,3,4
TF_BS_02	Demonstrates how to set up the ventilator and confirm correct functioning prior to commencing transfer	A,D	1,2
TF_BS_03	Demonstrates safety in securing the tracheal tube securely prior to commencing the movement/transfer	A,D	1,2
TF_BS_04	Demonstrates the ability to calculate oxygen and power requirements for the journey	A,D	1,2
TF_BS_05	Demonstrates safety in securing patient, monitoring and therapeutics before transfer	A,D	1,2,3,4

TF_BK_06	Demonstrates how to check the functioning of drug delivery systems	A,D	2,3
TF_BS_07	Demonstrates appropriate choices of sedation, muscle relaxation and analgesia to maintain the patient's clinical status during transfer	A,C,D,M	1,2
TF_BS_08	Demonstrates the ability to maintain monitoring of vital signs throughout transfer	A,D	1,2
TF_BS_09	Demonstrates the ability to maintain clinical case recording during transfer	C,M	1

Critical Incidents

Critical incidents

Many of the critical incidents listed in this section are also in the basic level sections of the curriculum to which they relate. Given the importance of the recognition and management of critical incidents, they are all included under this one heading for clarity.

Whilst trainees may come across the critical incidents listed below during the course of clinical practice, it is anticipated that many will not be encountered in this way and as a result, the use of simulation to assist teaching and assessment is expected.

Core clinical learning outcomes:

- To gain knowledge of the principle causes, detection and management of critical incidents that can occur in theatre
- To be able to recognise critical incidents early and mange them with appropriate supervision
- To learn how to follow through a critical incident with reporting, presentation at audit meetings, and discussions with patients
- To recognise the importance of personal non-technical skills and the use of simulation in reducing the potential harm caused by critical incidents.

Knowledge

Competence	*Description*	*Assessment Methods*	*GMP*
Recall/describes the causes, detection and management of the following airway and respiratory/ventilation incidents:			
CI_BK_01	Cardiac and/or respiratory arrest	A,C,E,S	1
CI_BK_02	Unexpected fall in SpO_2 with or without cyanosis	A,C,E,S	1
CI_BK_03	Unexpected increase in peak airway pressure	A,C,E,S	1
CI_BK_04	Progressive fall in minute volume during spontaneous ventilation or IPPV	A,C,E,S	1

CI_BK_05	Fall in end tidal CO_2	A,C,E,S	1
CI_BK_06	Rise in end tidal CO_2	A,C,E,S	1
CI_BK_07	Rise in inspired CO_2	A,C,E,S	1
CI_BK_08	Unexpected hypotension	A,C,E,S	1
CI_BK_09	Unexpected hypertension	A,C,E,S	1
CI_BK_10	Sinus tachycardia	A,C,E,S	1
CI_BK_11	Arrhythmias: • ST segment changes • Sudden tachyarrhythmias • Sudden bradycardia • Ventricular ectopics • Broad complex tachycardia • Atrial fibrillation • Ventricular fibrillation • Pulseless electrical activity (PEA)	A,C,E,S	1
CI_BK_12	Convulsions	A,C,E,S	1
Recalls/describes the causes, detection and management of the following specific conditions:			
CI_BK_13	Difficult/failed mask ventilation	A,C,E,S	1
CI_BK_14	Failed intubation	A,C,E,S	1
CI_BK_15	Can't intubate, can't ventilate	A,C,E,S	1
CI_BK_16	Regurgitation/aspiration of stomach contents	A,C,E,S	1
CI_BK_17	Laryngospasm	A,C,E,S	1
CI_BK_18	Difficulty with IPPV, sudden or progressive loss of minute volume	A,C,E,S	1
CI_BK_19	Bronchospasm	A,C,E,S	1
CI_BK_20	Pneumothorax and tension pneumothorax	A,C,E,S	1
CI_BK_21	Gas/fat/pulmonary embolis	A,C,E,S	1
CI_BK_22	Adverse drug reaction	A,C,E	1
CI_BK_23	Anaphylaxis	A,C,E	1

CI_BK_24	Transfusion reactions, transfusions of mis-matched blood or blood products	A,C,E	1
CI_BK_25	Inadvertent intra-arterial injection of irritant fluids	A,C,E	1
CI_BK_26	High spinal block	A,C,E,S	1,
CI_BK_27	Local anaesthesia toxicity	A,C,E	1
CI_BK_28	Accidental decannulation of tracheostomy	A,C,E	1
CI_BK_29	Coning due to increases in intracranial pressure	A,C,E	1
CI_BK_30	Malignant hyperpyrexia	A,C,E,S	1
Discuss the importance of understanding the need for the following attitudes and behaviours			
CI_BK_31	Awareness of human factors concepts and terminology and the importance of non-technical skills in achieving consistently high performance such as: effective communication, team working, leadership, decision making and maintenance of situational awareness	A,C,E	1,2,3,4
CI_BK_32	Awareness of the importance of the process of critical incident reporting	A,C,E,S	1,2,3,4
CI_BK_33	Acceptance that it can happen to you; the unexpected can happen to anyone	A,C,E,S	1,2,3,4
CI_BK_34	To practice response protocols in resuscitation room or in simulation with other healthcare professionals as appropriate	C,D,S	1,2,3,4
CI_BK_35	The need to follow through a critical incident with proper reporting, presentation at morbidity meetings and warning flags as necessary, with appropriate supervision	A,C,E,S	1, 2,3,4
CI-BK_36	The provision of information to the patient and where necessary ensuring they get the appropriate counselling and advice, with appropriate supervision	A,C,E,S	1,2,3,4
Skills			
Competence	*Description*	*Assessment Methods*	*GMP*
CI_BS_01	Demonstrate good non-technical skills such as: effective communication, team working, leadership, decision making and maintenance of high situational awareness	A,C,D,S	1,2,3,4
CI_BS_02	Demonstrates the ability to recognise early a deteriorating situation by careful monitoring	A,C,D,S	1,2,3,4

CI_BS_03	Demonstrates the ability to respond appropriately to each incident listed above	A,C,D,S	1,2,3,4
CI_BS_04	Shows how to initiate management of each incident listed above	A,C,D,S	1,2,3,4
CI_BS_05	Demonstrates ability to recognise when a crisis is occurring	A,C,D,S	1,2,3,4
CI_BS_06	Demonstrates how to obtain the attention of others and obtain appropriate help when a crisis is occurring	A,C,D,S	1, 2,3,4

A.2 Speciality specific assessments for Anaesthesia

A.2.1. Assessment for the initial assessment of competence (IAC)

A.2.2. The assessments listed below.

Section 1. The ACCS trainee must successfully complete all of the following summative WPBAs:

A-CEX	
Assessment Code	*Assessment*
IAC_A01	Preoperative assessment of a patient who is scheduled for a routine operating list [not urgent or emergency] [0-3 months]
IAC_A02	Manage anaesthesia for a patient who is not intubated and is breathing spontaneously [0-3 months]
IAC_A03	Administer anaesthesia for acute abdominal surgery [0-3 months]
IAC_A04	Demonstrate Rapid Sequence Induction [0-3 months]
IAC_A05	Recover a patient from anaesthesia [0-3 months]

DOPS	
Assessment Code	*Assessment*
IAC_D01	Demonstrate functions of the anaesthetic machine [0-3 months]
IAC_D02	Transfer a patient onto the operating table and position them for surgery [lateral, Lloyd Davis or lithotomy position] [0-3 months]
IAC_D03	Demonstrate cardio-pulmonary resuscitation on a manikin. [0-3 months]
IAC_D04	Demonstrates technique of scrubbing up and donning gown and gloves. [0-3 months]
IAC_D05	Basic Competencies for Pain Management – manages PCA including prescription and adjustment of machinery [0-3 months]
IAC_D06	Demonstrates the routine for dealing with failed intubation on a manikin.

CBD	
Examine the case-notes. Discuss how the anaesthetic plan was developed. Ask the trainee to explain their approach to pre-op preparation, choice of induction, maintenance, post op care. Select one of the following topics and discuss the trainees understanding of the issues in context.	
Assessment Code	*Assessment*
IAC_C01	Discuss the steps taken to ensure correct identification of the patient, the operation and the side of operation
IAC_C02	Discuss how the need to minimise postoperative nausea and vomiting influenced the conduct of the anaesthetic
IAC_C03	Discuss how the airway was assessed and how difficult intubation can be predicted
IAC_C04	Discuss how the choice of muscle relaxants and induction agents was made
IAC_C05	Discuss how the trainee's choice of post-operative analgesics was made

IAC_C06	Discuss how the trainee's choice of post-operative oxygen therapy was made
IAC_C07	Discuss the problems emergency intra-abdominal surgery causes for the anaesthetist and how the trainee dealt with these
IAC_C08	Discuss the routine to be followed in the case of failed intubation.

The Initial Assessment of Competence Certificate is available for download from the secure area of the College website.

A2.2. For rotations of 6 – 9 months when completing options.

For rotations of between 6 and 9 months, trainees must complete the IAC assessments defined in A2.1 plus the additional WPBAs listed below.

Optional Unit	A-CEX	DOPS	CBD
Airway Management	1	1	1
Sedation	1	1	1
Transfer Medicine	1	1	1
Critical Incidents	1	1	1

6.4 ICM within ACCS

It is expected that all ACCS trainees will achieve Basic Level Competence as outlined by IBTICM during ACCS training. Used alongside the rest of the ACCS Curriculum, these ICM specialty specific competencies are designed to inform the IBTICM Basic Level Training Competency Document (Part 3). Assessment should be made using the work place based assessment tools described, as part of the overall process used to complete this documentation.

ICM Competency: Demonstrates aseptic peripheral venous cannulation

The trainee will be able to establish venous access a peripheral route (SEE ALSO: ICM Competencies: Establishes Venous Access with Attention to infection control Measures)		
Knowledge	Assessment Methods	GMP Domains
Demonstrates knowledge of venous anatomy and surface anatomy	D	1
To demonstrate an understanding of the need for using appropriate infection control measures when establishing venous access, including but not limited to:	D	1
Understanding of aseptic no touch technique (ANTT) of venous cannulation	D	1
Understanding of sterile techniques of venous cannulation	D	1
Establishing venous access in an appropriate environment and use of appropriate equipment in an aseptic or sterile way appropriate to the procedure	D	1
Use of appropriate skin cleaning methods and the currently recommended cleaning agents	D	1
Skills		
Demonstrate the ability to establish peripheral venous cannulation using an appropriate technique, demonstrating effective infection control measures and proper regard for patient safety and well being.	D	1
Behaviour		
Obtains Consent wherever possible	D	2, 4
Demonstrate the ability to communicate effectively with the patient and other staff when establishing venous access.	D, ACAT	2
Maintain safety of environment for patient and health workers including safe sharps disposal	ACAT, D	2

Adequately documents procedures including date labelling of peripheral cannulae and completion of departmental audit databases	D, Mi, AA	1
Demonstrate ability to consult with a senior, seek appropriate team support	ACAT, AA, C, Mi	2

ICM Competency: Demonstrates aseptic arterial cannulation (+ local anaesthetic)

The trainee discusses indications and contraindications to arterial cannulation and demonstrates aseptic placement of an arterial cannula, using local anaesthesia where appropriate.		
Knowledge	Assessment Methods	GMP Domains
Demonstrates knowledge of Anatomy of radial, femoral and brachial arteries and relevant surface anatomy and demonstrates knowledge of Allen's test and its limitations	Mi, C	1
Demonstrates knowledge of indications and contraindications of arterial cannulation	Mi, C	1
Demonstrates knowledge of local anaesthetic pharmacology	Mi, C	1
Demonstrates knowledge of equipment used in arterial cannulation including but not limited to: "Flowswitch" and Seldinger Cannulae, Disposable transducers, Multi-channel monitors including invasive channel "zeroing"	Mi, C	1
Skills		
The trainee demonstrates the ability to run-through a disposable transducer system	E, D	1
The trainee performs arterial cannulation using the transfixion or Seldinger technique.	E, D	1
The trainee demonstrates the ability to attach transducer system and zero the transducer	E, D	1
Behaviour		
Seeks consent wherever possible	ACAT, C, Mi	2, 4
Demonstrate the ability to communicate effectively with the patient and other staff when establishing venous access.	ACAT, C, Mi	2, 4
Maintain safety of environment for patient and health workers including safe sharps disposal	ACAT, C, Mi	2, 4
Seeks senior help when appropriate	ACAT, C, Mi	2, 4

ICM Competency: Obtains an arterial blood gas sample safely, interprets results correctly

The trainee will be able to obtain an arterial blood gas safely and correctly interpret the results.		
Knowledge	Assessment Methods	GMP Domains
Demonstrates knowledge of • the surface anatomy of the radial and femoral arteries • use of appropriate skin cleaning methods and the currently recommended cleaning agents • use of appropriate sterile techniques • the requirement for heparinised syringes and transport of samples on ice	E, C, M, ACAT,	1
Demonstrates knowledge of normal values of pH, PaO_2, $PaCO_2$, standard bicarbonate or base excess and lactate.	E, C, M, ACAT,	1
Demonstrates understanding of common blood gas derangements including but not limited to: • Hypoxia • Hypercapnia • Metabolic acidosis and lactic acidosis • Metabolic alkalosis	E, C, M, ACAT,	1
Is able to calculate the anion gap and recall causes of increased and decreased anion gap.	E, C, M, ACAT,	1
Demonstrate an understanding of the need for appropriate communication with the patient arterial blood gas sampling, including but not limited to: ▪ Appropriate explanation to the patient ▪ Obtaining implied or explicit consent	E, C, M, ACAT,	1
Skills		
The trainee is able to safely obtain an arterial blood gas sample using either the radial or femoral route.	D	1
Demonstrates rigorous aseptic technique when obtaining blood gas sample Compresses artery following sampling Correctly interprets results Records the results in the patient record	D	1
Behaviour		

Follows local protocols in use of near patient testing versus laboratory testing	ACAT, C, Mi	1
Demonstrates the ability to effectively communicate the procedure with nursing and other staff.	ACAT, C, Mi	1

ICM Competency: Demonstrates aseptic placement of central venous catheter

The trainee will be able to discuss indications, contraindications and complications of Central Venous Catheters (CVC's). The trainee describes indications and contraindications of the Internal Jugular, Subclavian and Femoral route. The trainee can describe the advantages and disadvantages of Peripherally Inserted Central Venous Catheters (PICC lines). The trainee demonstrates aseptic placement of a CVC by the above routes.		
Knowledge	Assessment Methods	GMP Domains
Demonstrates knowledge of the anatomy of the anterior triangle of the neck, the subclavian region and the groin	C, Mi	1
Knowledge of ultrasound anatomy of the anterior triangle of the neck and the groin	E, C, Mi	
Discusses Indications for CVC insertion in the critically ill patient Demonstrates and understanding of the specific risks and benefits of selected insertion sites including but not limited to: ▪ Arterial puncture ▪ Arterio-venous fistulae ▪ Cranial Nerve damage ▪ Pneumothorax ▪ Infection. Understands relative and absolute contra-indications	C, Mi, ACAT	1
Knowledge of local anaesthetic pharmacology	E, C	1
Demonstrates knowledge of equipment used for central venous catheterisation including but not limited to: Seldinger technique, Multi-lumen catheters, ultrasound systems, transducer systems	C, Mi, ACAT	1
Demonstrates knowledge of the correct positioning of central venous catheters on the supine CXR. Knowledge of complications of CVC insertion	C, Mi, ACAT	1
Skills		
The trainee can set up the ultrasound machine, select appropriate depth and gain and apply a sterility sheath	D	1

The trainee safely and aseptically performs placement of CVC's using the: • Internal Jugular approach • Subclavian approach • Femoral approach	D, C	1
The trainee correctly interprets the post-procedure CXR, confirming correct positioning and excluding major complications.	D, Mi, ACAT	1
Behaviour		
Obtains consent where possible	ACAT, C, Mi	(3,6,7)
Uses sedation and local anaesthesia appropriately	D	(3,6,7)
Observes local infection control procedures including ANTT and local "High Impact Intervention" central line "Care Bundle"	D, C	
Maintain safety of environment for patient and health workers including safe sharps disposal	ACAT, C, Mi	2
Adequately documents procedures including date labelling of peripheral cannulae and completion of departmental audit databases	D, Mi	
Demonstrate the ability to work as a part of a team and succinctly present clinical details of the situation to senior doctor	ACAT, C, Mi	3
Demonstrate ability to consult with a senior, seek appropriate team support	ACAT, AA, C, Mi,	2

ICM Competency: Connects mechanical ventilator and selects initial settings

Knowledge	Assessment Methods	GMP Domains
Lists the indications for mechanical ventilation including but not limited to: • Respiratory disease (differentiating Types 1 and 2) • Chest wall disease • Neuromuscular disease • Central Nervous system impairment • Cardiovascular disease • Postoperative management	E, C, Mi, ACAT	1
Demonstrates knowledge of the modes of mechanical ventilation including • Volume controlled and pressure controlled ventilation • Timing windows and the use of SIMV • The use of pressure supported breaths	C, Mi, ACAT, AA	1

• The rationale for the use of PEEP • Rationale and use of inverse ratio ventilation • The causes and detection of "auto-PEEP"		
Demonstrates knowledge of a lung protective ventilator strategy including • Volume and pressure limitation • The use of permissive hypercapnia and its side effects • Contraindications to lung protective ventilation	C, Mi, ACAT, AA	1
Demonstrates knowledge of the "Ventilator Care Bundle"	C, Mi, ACAT, AA	1
Skills		
Sets up and performs circuit check and safety check of the relevant ventilator	D	1
Sets appropriate settings including • Peak inspiratory pressure or tidal volume • i:e ratio • PEEP	D, C, ACAT	1
Behaviour		
Ensures patient safety throughout	C, Mi, ACAT	2, 4
Uses appropriate monitoring including pulse oximetry and capnography	C, Mi, ACAT	1
Communicates target values and parameters to other members of the team and ensures appropriate documentation.	C, Mi, ACAT	1
Sets appropriate alarms	C, Mi, ACAT	1

ICM Competency: Describes Safe Use of Drugs to Facilitate Mechanical Ventilation

The trainee will be able to describe the use of drugs to facilitate mechanical ventilation, the safe and appropriate use of sedative drugs, analgesics and paralytic agents, appropriate methods of administration and problems associated with use of such agents.		
Knowledge	Assessment Methods	GMP Domains
Demonstrate knowledge of drugs which can be used to induce anaesthesia and facilitate tracheal intubation.	C, Mi	1
Demonstrate knowledge of drugs which can be used to sedate patients during mechanical ventilation, and the advantages and disadvantages of these drugs. Demonstrate an understanding of how using combinations of sedative agents may be preferable to use of single agents	C, Mi	1

Outlines rational for use of neuromuscular blocking drugs during mechanical ventilation and appropriate pharmacology	C, Mi	1
Demonstrate an understanding of the role of regular 'sedation interruptions' in the management of the critically ill patient.	C, Mi	
Outline problems associated with the use of sedation to facilitate ventilation in the critically ill.	C, Mi	
Skills		
The trainee will be able to demonstrate the safe handling of equipment used to deliver sedative agents used during mechanical ventilation, including appropriate use of syringe drivers.	D	1
Demonstrate the ability to effectively used appropriate scoring systems to assess level of sedation	D, Mi	1
Practice safe prescribing of all agents used to facilitate mechanical ventilation.	D, C, Mi	1
Behaviour		
Demonstrate the ability to communicate the sedation requirements of a patient to the critical care team.	C, Mi, ACAT	1
Demonstrate the ability to work as a part of a team and succinctly present clinical details of the situation to senior doctor	C, Mi, ACAT	3
Demonstrate ability to consult with a senior, seek appropriate team support	C, Mi, ACAT, AA	2

ICM Competency: Describes Principles of Monitoring Respiratory Function

The trainee will describe methods used to monitor respiratory function		
Knowledge	Assessment Methods	GMP Domains
Demonstrate an ability to perform an effective evaluation of respiratory function in the critically ill patient, including but not limited to: ▪ Clinical evaluation of the respiratory system ▪ Use of respiratory parameters monitored by artificial ventilators, including airway pressure, tidal volumes, minute ventilation, respiratory rates and spirometry	C, D, Mi	1
Skills		
Perform immediate (physical) assessment of the respiratory system	ACAT, D, C, Mi	1
Be able to order and interpret and act on investigations appropriately, including but not limited to: ▪ CXR	C, Mi	1

▪ CT scans ▪ USS		
Demonstrate ability to interpret capnograph waveforms and pressure volume loops during mechanical ventilation.	D, Mi, C. ACAT, E	1
Behaviour		
Exhibit calm and methodical approach to assessing critically ill patient	ACAT, AA, C, Mi	1
Adopt leadership role where appropriate	ACAT, AA, C, Mi	2
Involve senior and specialist (e.g. radiology) services promptly	ACAT, AA, C, Mi	2

ICM Competency: Describes the Assessment of the patient with poor compliance during Ventilatory Support ('fighting the ventilator')

The trainee will be able to describe the assessment of the patient showing poor compliance with mechanical ventilation, and an understanding of the steps which may be used to improve compliance.		
Knowledge	Assessment Methods	GMP Domains
Demonstrates knowledge of conditions which may require ventilatory support, including but not limited to: ▪ Infection ▪ Acute Respiratory Distress Syndrome (ARDS) ▪ Cardiac Failure ▪ Obstructive Airways disease (acute and chronic)	C, Mi	1
Demonstrate knowledge of the different requirements and modes of respiratory support, including but not limited to: ▪ Continuous mandatory ventilation / Assist Control ventilation ▪ Intermittent mandatory ventilation ▪ Pressure support ventilation ▪ PEEP/CPAP	C, Mi	1
Be able to describe the possible causes of poor compliance with respiratory support, including but not limited to: ▪ Airway obstruction or other mechanical problems ▪ Altered clinical condition ▪ Altered sedation requirements ▪ Selection of inappropriate mode of ventilatory support	C, Mi, D	1
Be aware of the role drugs and combinations of drugs in the facilitation of mechanical ventilation, including but not limited to:	C, Mi	1

• Sedative agents • Drugs with respiratory depressant effects • Drugs with neuromuscular blocking actions		
Demonstration of understanding of the need for prompt and appropriate action to prevent hypoxia and respiratory distress when faced with the patient who is not complaint with ventilation, including but not limited to: ▪ Increasing inspired oxygen fraction ▪ Use of manual ventilation techniques when required	C, Mi	1
Skills		
Be able to demonstrate appropriate rapid assessment of the patient who is non-complaint with ventilation, and to institute appropriate life-saving measures until help arrives, including increasing the inspired oxygen settings.	D, Mi	1
Demonstrate the ability to effectively decide when manual ventilation techniques should be used until experienced help arrives.	D, Mi	1
Demonstrate the ability to order appropriate tests and investigations including but not limited to: ▪ Chest radiography ▪ Arterial blood gas analysis	D, ACAT, C, Mi	1
Behaviour		
Demonstrate the ability to communicate the ventilatory requirements of a patient to the critical care team.	ACAT, C, Mi	1
Maintain safety of environment for patient and health workers	ACAT, C, Mi	2
Demonstrate the ability to work as a part of a team and succinctly present clinical details of the situation to senior doctor	ACAT, C, Mi	3
Demonstrate ability to consult with a senior, seek appropriate team support	ACAT, C, Mi	2

ICM Competency: Prescribes safe use of vasoactive drugs and electrolytes

The trainee will recognise understand the use of electrolyte containing solutions and vasopressor in the critically ill patient, and be able to prescribe such agents safely.		
Knowledge	Assessment Methods	GMP Domains
List physiological electrolyte requirements in health and in the critically ill patient, and list common causes of electrolyte disturbances in the critically ill, including but not limited to: ▪ Altered cardiovascular, respiratory and renal function ▪ Altered metabolic processes ▪ Iatrogenic causes of electrolyte imbalance	C, Mi	1
Demonstrate knowledge of commonly available electrolyte solutions, and the advantages and disadvantages of using such solutions.	ACAT, AA, C, Mi	1
Demonstrate knowledge of the use of potassium containing solutions including but not limited to: • Clinical situations where such solutions may be required • Problems associated with the use of K + solutions • Precautions and safety measures required • Appropriate monitoring and assessment during administration	ACAT, C, Mi	1
Demonstrate knowledge of pharmacology of commonly used vasoactive agents	Mi, C, ACAT, E	1
Demonstrate knowledge of the use of vasopressors including but not limited to: ▪ Clinical situations when vasopressor agents may be used ▪ Problems associated with the use of vasopressor ▪ Appropriate levels of monitoring and assessment during the administration of vasopressor ▪ Venous access required for the safe administration of vasopressor	Mi, C, ACAT	1
Skills		
Perform safe prescription of electrolyte solutions and vasoactive agents.	ACAT, AA, C, Mi	1
Arrange monitoring of relevant indices	ACAT, AA, C, Mi	1
Order, interpret and act on initial investigations	ACAT, AA, C, Mi	1
Behaviour		
Exhibit a calm and methodical approach to the critically ill patient	ACAT, AA, C, Mi	3

Adopt leadership role where appropriate	ACAT, AA,C, ACAT	2,4
Involve senior and specialist services appropriately	ACAT, AA, C, Mi	2, 3

ICM Competency: Delivers a fluid challenge safely to an acutely unwell patient.

The trainee will demonstrate an understanding of the need to the ability to assess the fluid status of an acutely unwell patient, the ability to do so using clinical and other means, and to safely administer an appropriate fluid bolus to such a patient.		
Knowledge	Assessment Methods	GMP Domains
Demonstrates an understanding of need to assess the fluid status of the acutely unwell patient, when such assessment is necessary, and the need for reassessment and additional monitoring.	C, Mi	1
Lists methods available to assess fluid status of the acutely unwell patient, including but not limited to: Clinical assessment Use of monitoring devices (for example, central venous pressure and saturation, oesophageal Doppler)	ACAT, C, Mi	1
Outlines advantages and disadvantages of the different fluids which can be used for administration during the management of the acutely unwell patient, including but not limited to: ▪ Crystalloid solutions ▪ Colloids ▪ Blood products	ACAT, Mi, C	1
Skills		
Appropriately assesses and establishes the need for a fluid bolus during to an acutely unwell patient.	ACAT, Mi, C, D	1
Selects appropriate fluid and prescribes appropriate volumes during administration of a fluid bolus	ACAT, C, Mi	1
Effectively assesses the response to a fluid bolus, and makes appropriate clinical decisions based on this response.	ACAT, Mi, C, D	1
Completes adequate documentation of fluids prescribed and documents the response to any fluid challenge administered.	ACAT, C, Mi	1
Behaviour		
Demonstrate the ability to communicate effectively with the patient and other staff when delivering a fluid bolus.	ACAT, C, Mi	3
Demonstrates the ability to effectively communicate the procedure with nursing and other staff.	ACAT, C, Mi	2,4
Involve senior and specialist services appropriately.	ACAT, C, Mi	2,3

ICM Competency: Describes actions required for accidental displacement of tracheal tube or tracheostomy

The trainee will describe or demonstrate their approach to the management of a displaced endotracheal or tracheostomy tube.		
Knowledge	Assessment Methods	GMP Domains
To demonstrate an understanding of the need for immediate assessment of the patient with a suspected airway problem.	C, Mi	1
Outlines immediate airway management appropriate to the patients needs, including but not limited to: Simple airway manoeuvres Use of airway adjuncts Delivery of 'high-flow' oxygen using appropriate devices Re-establishing a definitive airway (re-intubation). Use of bag, valve mask ventilation to assist ventilation	ACAT, C, Mi	1
Lists the drugs which may be required to re-establish endotracheal intubation, including but not limited to: Sedative agents Analgesic agents Neuromuscular blocking agents	ACAT, C, Mi	1
To demonstrate an understanding of the need for continued or additional monitoring including but not limited to: Pulse-oximetry Capnography	ACAT, C, Mi	1
Skills		
Performs an effective, organised and airway assessment including but not limited to: Use of simple airway manoeuvres to restore a patent airway Use of airway adjuncts to restore a patent airway Selection of appropriate oxygen delivery devices Use of bag, valve mask ventilation to assist ventilation The need for rapid assessment of circulatory status Appropriate use of crystalloid or other fluids for volume resuscitation where required	ACAT, C, Mi, D	1
Completes adequate documentation and communicates effectively with medical and other ward staff.	ACAT, C, Mi	1

Behaviour		
Demonstrate the ability to lead a full, prompt assessment of a patient with a compromised airway.	ACAT, C, Mi	3
Demonstrates the ability to communicate effectively with both the patient and their relatives	ACAT, C, Mi	2
Demonstrates the ability to effectively communicate with nursing and other staff	ACAT, C, Mi	2,4
Involves senior and specialist services appropriately	ACAT, C, Mi	2,3

7.0 Practical procedures within ACCS

Below are listed the practical procedures the trainee would be expected to undertake during ACCS programme. Those that must be assessed during the first two years by a particular specialty are indicated in the filled boxes in the table below. Those boxes that are unfilled are also important: these assessments can be undertaken in a number of different ACCS settings.

Some of the items listed below as practical procedures may be assessed by means other than DOPS and these are indicated. For convenience all of the anaesthetic assessments including initial assessment of competence are included in this table. All procedures (including the anaesthetic assessments) and related competencies are to be covered by the trainee over a three year period.

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

18. Wound management		**D**		
19. Trauma primary survey		**D**		
20. Initial assessment of the acutely unwell				
21. Secondary assessment of the acutely unwell				
22. Connection to a mechanical ventilator			**D**	
23. Safe use of drugs to facilitate mechanical ventilation			**C**	
24. Managing the patient fighting the ventilator			**C**	
25. Monitoring Respiratory function			**C**	
Initial Assessment of Competence (IAC) - as listed below from Preoperative assessment to Emergency surgery				
26. Preoperative assessment				**A**
27. Management of spontaneously breathing patient				**A**
28. Administer anaesthesia for laparotomy				**A**
29. Demonstrate RSI				**A**
30. Recover patient from anaesthesia				**A**
31. Demonstrates function of anaesthetic machine				**D**
32. Transfer of patient to operating table				**D**
33. Technique of scrubbing up and donning gown and gloves				**D**
34. Basic competences for pain management				**D**
35. Patient Identification				**C**

36. Post op N&V				**C**
37. Airway assessment				**C**
38. Choice of muscle relaxants and induction agents,				**C**
39. Post op analgesia				**C**
40. Post op oxygen therapy				**C**
41. Emergency surgery				**C**
42. Safe use of vasoactive drugs and electrolytes			**Mi, C**	
43. Delivers a fluid challenge safely to an acutely unwell patient			**C**	
44. Describes actions required for accidental displacement of tracheal tube or tracheostomy			**C**	
45. Demonstrate CPR resuscitation on a manikin				**D**

Mi, A = (Anaesthetic) Mini-CEX, D = DOPs, C = CBD

8.0 The ACCS Assessment System

Summary

- Workplace based assessments are trainee driven.
- The minimum number of assessments to be undertaken in each specialty and their type are indicated for the first two years in the table below.
- Given the overlap between the ACCS specialties, assessment of the same presentation (major or acute) or procedure can occur in a variety of settings (ICU, Acute Medical Ward, ED, within anaesthetic training).
- A small number of assessments have been identified as specialty specific and must be undertaken whilst working within that specialty. **However this in no way restricts these assessments to that specialty, as assessments of the same topic in different settings is beneficial (see appendices A.1-A.4).**
- Trainees must have an electronic portfolio (e-portfolio) if available, which can only be arranged by registration with their parent College. Currently the RCoA does not have an e-portfolio.
- All assessment forms included in this curriculum are examples only. All up to date versions can be found on college websites.

Although the assessments are based on clinical topics, they provide an opportunity to cover the common competency domains which are integral to good clinical practice.

The ACCS Workplace-based assessments (WPBA's) are made up of

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

A description of these tools is given below and further information is available in the e-portfolio trainee section. These WPBA's should be recorded in the trainee's e- portfolio.
It is agreed that the generic tools of the trainee's host college can be used across all settings. This enables the majority of assessments to be performed using documentation specific to the parent college of the trainee, i.e. trainees destined for HST in EM will use EM specific tools for the majority of assessments, even when working in AM, ICM or anaesthetics.
However, all specialties have some specific documentation to be used while trainees work in that specialty, regardless of HST destination. This documentation is available on the parent college websites, the ACCSUK website and within the CEM e-portfolio.
This can provide a hard copy of the assessment which can be stored in the trainee's portfolio so that it can be shared with the Educational Supervisor.

Generic workplace-based assessment forms for Mini-CEX, DOPS and CbD are available in appendix A.5

The workplace-based assessment methods include feedback opportunities as an integral part of the assessment process. This feedback stimulates learning and it is expected that trainees will repeat WPBA to show sustained improvement and not cram all assessments in at the end of a placement.

Some assessments within EM and anaesthesia are summative. For those presentations to be assessed by EM, clear descriptors of a trainee's performance have been provided for successful completion.

Trainees may complete a number of formative assessments before they present themselves for summative sign off.

Multi-source feedback (M or MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides objective systematic collation and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works and includes doctors, administration staff, and other allied professionals. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Mini-Clinical Evaluation Exercise (Mi or mini-CEX, A or Anaes-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Direct Observation of Procedural Skills (D or DOPS)
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

Case based Discussion (C or CbD)
The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record such as patients' written case notes.

Acute Care Assessment Tool (ACAT (GIM), ACAT (EM))
The ACAT is designed to assess and facilitate feedback on a doctor's performance across a number of domains. The ACAT (GIM) is designed for use during over an Acute Medical Take. Any doctor who has been responsible for the supervision of the Acute Medical Take can be the assessor for an ACAT. The ACAT (EM) is a modified version designed for use across shifts worked in the Emergency department. The ACAT tool on any one occasion can be used to cover a number of acute presentations.

Patient Survey (PS)
A Patient Survey identifies issues including behaviour of the doctor and effectiveness of the consultation which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

Audit Assessment Tool (AA)
The Audit Assessment Tool is designed to assess a trainee's competence in completing an audit. The Audit Assessment can be based on review of audit documentation OR on a presentation of the audit at a meeting. If possible the trainee should be assessed on the same audit by more than one assessor.

Teaching Observation (TO)
The Teaching Observation tool is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation can be based on any instance of formalised teaching by the trainee, which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors). The assessment form for TO is available in the e-portfolio.

Frequency of assessments

The suggested assessment methods relevant to each presentation are shown in the assessment methods column of this curriculum. It is not expected that all competences will be assessed and that, where they are assessed, not every method will be used. Given the overlap between the ACCS specialties assessment of the same topic can occur in a variety of settings. A small number of assessments have been identified as specialty specific and **must be** undertaken whilst working within that specialty. **However this in no way restricts these assessments to that placement, as multiple assessments of competence in dealing with the same presentation in different settings is beneficial** (see Appendix A).

The Mini-CEX, DOPS and CBD can be used either formatively or summatively. When they should be used summatively this is clearly indicated, and clear descriptors of trainee's performance are available in the EM and anaesthetic assessment appendices.

It is expected that trainees over the first two years will have a recorded assessment for all 6 of the 'Major presentations' and at least 20 of the 38 'Acute presentations'.

The minimum number of assessments in each part of the 2 year rotation is as follows:

Specialty	Mini-CEX	DOPS	CbD	ACAT
Anaesthesia (3-6 months)	5	6	8	-
Anaesthesia (6-9 months)	6	7	9	-
Acute Medicine	3	5	3	3
Emergency Medicine	4	5	3	1
ICM	3	6	4	

Total sampling of the curriculum

Most major and acute presentations would normally be encountered and therefore assessed while working in AM, EM and ICM. The anaesthetic assessments are clearly centred on the anaesthesia part of the curriculum but opportunities to cover major and acute presentations whilst undergoing anaesthetic training should also be used.

At the beginning and end of each part of the rotation the trainee and their educational supervisor should review the outstanding assessments and plan how they will be covered as the setting of some assessment may vary based on local variations in practice.

Work place based assessments

Which assessment tool?

The number, frequency and relevant tools for assessments for anaesthesia are described in Appendix A.2.

For the remaining specialties the assessment tools of Mini-CEX (Mi), DOPs (D), CBD (C) and ACAT, which involve direct interaction with the trainer, can be used. The ACCS trainee at the end of the first two years will have used one or more of these tools for assessment of the 6 major presentations, 20 of the 38 acute presentations and 39 of the 44 practical procedures.

The trainee will need to submit themselves to assessment regularly, typically once per week, if they are to meet the minimum assessment requirements.

Most of the assessments are not summative, i.e. they are formative and are intended to provide feedback in a non judgemental way.

ACCS CT1-2

Any specialty can assess a major or acute presentation. The identification of a presentation for assessment by a specialty simply means **that specialty must undertake** that assessment, but this does not prevent that presentation being assessed again by another speciality. For example a trainee MUST have a miniCEX or CbD on two major presentations during the EM attachment but could repeat the assessment on those presentations during the AM attachment.

	Major Presentations (MP) 6	**Acute Presentations (AP) 38**	**Practical Procedures (PP)44**
CT1 EM	**Summative** 2 of the 6 MPs will be completed in EM, using a summative tool i.e. the Mini-CEX descriptor tool or a pass/fail CbD Summative tools are available for • Major trauma • Shock • Altered level of consciousness • Sepsis Note – suggested that for: • Anaphylaxis in adults and children this could be covered regionally using simulation • Cardio respiratory arrest could be covered either by ALS or sign off by anaesthesia	**Summative** 5 of the 38 APs must be completed using a summative tool i.e. the Mini-CEX descriptor tool or a pass/fail CbD The CEM suggest coverage of the following acute presentations, for which detailed descriptors are provided • Chest pain • Abdominal pain • Breathlessness • Mental health • Head injury **Formative** • An additional 5 acute presentations must be covered using x1 ACAT • It is also recommended during this time that trainees also aim to cover an additional 10 acute presentations using a combination of ACATS, e learning, reflective entries,	**Formative** 5 of the 44 PP must be completed using DOPs The CEM suggests coverage during EM of • Airway, • Primary survey • wound care • Fracture /joint reduction. • Plus one other from the PP list not covered by another specialty

		teaching and audit assessments	
CT1 AM	**Formative** 2 of the 6 MPs	**Formative** • 10 of the 38 APs using Mini-CEX, CbD or ACAT • The 8-10 remaining AP can be covered using a combination of ACATS, e learning, reflective entries, teaching and audit	**Formative** 5 of the 44 PP Using DOPs
CT2 ICM	**Formative** 2 of the 6 MPs • Ideally sepsis should be covered in ICM • Plus any remaining MPs if not already covered.	**Formative** Any AP that occurs in an ICM setting and not already covered using appropriate tool.	**Formative** 13 of the 44 PP, Using DOPs and other tools
CT2 ANAESTHESIA	**Summative** • Basic and advanced life support assessment • Plus anaesthesia assessments		**Summative** 16 separate Anaesthesia related topics including initial assessment of competence

Appendix A

A.1 Specialty Specific Assessments for Emergency Medicine

The CEM wishes to use assessments in the following ways:

1. To facilitate learning by fostering trainer/trainee interaction
2. To provide meaningful feedback to the trainee so that areas for improvement are clearly identified.
3. To assess that a trainee is safe and competent. For this reason CEM has identified a **limited** number of key presentations for which it wishes summative assessments to be made. This should be undertaken using either:
    a. Mini-CEX tool for which there are detailed descriptors for these presentations of what is expected. These are available to trainees (see below). It is intended that by providing clarity as to what is expected of the trainee, consistency in assessment and accurate feedback will be facilitated.
    b. CbD, for which there are descriptors of satisfactory performance in each of the domains (see below)

    If the trainee is judged unsatisfactory for any of these summative assessments the trainee should repeat the assessment
4. DOPs assessments are not summative, but detailed descriptors of those procedures for which EM is responsible have been provided to help with consistency and feedback
5. To encourage coverage of the curricula content and thereby help examination preparation

A.1.2 Assessment tools

Summative assessment tools

Mini-CEX

In order to facilitate assessment the CEM has:

a. Provided descriptors for **satisfactory performance** in the Mini-CEX for each area chosen for assessment. These detailed descriptors are attached at the end of this appendix. It is important that trainees always systematically develop a full differential diagnosis and always consider the potentially life threatening conditions and not list by probability alone. Clearly for each presentation there is a spectrum of severity and underlying causes and the assessment will need to be tailored to the clinical situation. The Mini-CEX examples at the end of the appendix have deliberately included the whole patient encounter and not simply examination. This reflects the reality of practice.
b. Provided descriptors of **unsatisfactory performance** that can be used in feeding back to the trainee. These are included in the table on page 198
c. Summative and formative tools have been provided, and may be specific or generic in their descriptors.

Case Based Discussions (CbD)

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

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

For each domain (descriptions of expected behaviour given below) the assessor should rate the trainee as below, at, or above the expected level for their grade and experience and make an overall satisfactory/unsatisfactory judgement. Summative assessments must be completed by EM consultants or equivalent e.g. an associate specialist who has completed assessment training as defined by GMC.

Domain descriptor	Expected behaviour
Record keeping	Records should be structured, legible and signed. Should include provisional and differential diagnoses, initial investigations and a 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 trainee's interpretation
Diagnosis	The correct differential diagnosis was reached. Were any important conditions omitted?
Treatment	Emergency treatment was correct and response recorded. Subsequent treatments appropriate and comprehensive
Planning for subsequent care (in-patient or discharged patients)	Clear plan demonstrating expected clinical course, recognition of and planning for possible complications and instructions to patient (if appropriate)
Patient safety issues	Able to recognise effects of systems, process, environment and staffing on patient safety issues
Clinical reasoning	Able to integrate the history, examination and investigative data to arrive at a sensible conclusion and appropriate treatment plan. The patient's co morbidities and social circumstances should be given due consideration.
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 a good overall standard

The CbD form to accompany these descriptors is available at the end of this appendix.

Generic Assessment tools

The generic ACCS EM Workplace-based assessments (WPBA's) are made up of

- Mini-Clinical Evaluation Exercise (Mi or mini-CEX, in anaesthesia A or Anaes-CEX)
- Direct Observation of Procedural Skills (D or DOPS)
- Multi-Source Feedback (M or MSF)

- Case-Based Discussions (C or CbD)
- Patient Survey (PS)
- Acute Care Assessment Tool (ACAT)
- Audit Assessment (AA)
- Teaching Observation (TO)

These are described in the main ACCS curriculum, with some modification for the following assessment tools

ACAT-EM

This tool was originally used by GIM and has been modified for the ED environment. This tool provides the opportunity to assess the trainee working over a longer period of time. It covers a number of important domains; assessing the trainee's interactions with patients and other staff in an ED environment with all that that entails. This tool should only be used formatively.

Testing of this tool in the ED has indicated that:

1. The assessment may take more than one shift as not all the domains may be observed by the assessor in one shift. The assessor should ensure that as many domains are covered as possible
2. That the assessor should seek the views of other members of the ED team when judging performance
3. That the trainee should be aware when the ACAT-EM is being undertaken
4. Each ACAT-EM can be used to assess up to 5 acute presentations. For each acute presentation the case notes and management plan should be reviewed by the clinical supervisor before it is signed off on the ACAT.
5. ACAT-EM can never be used as a summative tool. If the assessor judges the performance to be of concern (i.e. scores 1-3) this acute presentation should be further assessed using Mini-CEX or CbD.
6. ACAT-EM can be used in all areas of the ED including CDU ward rounds and review clinics

ACAT –EM	
Assessment Domains	Description
Clinical assessment and clinical topics covered	Quality of history and examination to arrive at appropriate diagnoses. No more than 5 acute presentations should be covered in each ACAT and this should involve a review of the notes and management plan of the patient.
Medical record keeping	Quality of recording of patient encounters including drug and fluid prescriptions
Investigations and referrals	Quality of trainees choice of investigations and referrals
Management of patients	Quality of treatment given to patients (assessment, investigation and treatment)
Time management	Prioritisation of cases
Management of take/team working	Appropriate relationship with and involvement of other health professionals
Clinical leadership	Appropriate delegation and supervision of junior staff
Handover	Quality of referral to in-patient teams. Quality of in-house handover including observation/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 shop-floor management, use of resources sensibly

The ACAT-EM form which these assessment domains relate to is attached at the end of this appendix.

Practical Procedures

Using a similar approach to Mini-CEX, the CEM has described in more detail the practical skills needed to be demonstrated. These detailed descriptors are attached at the end of this appendix.

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

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

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

A.1.3 Overall assessment structure relating to both core and higher EM training

The assessment regimen described below is new and will be closely monitored by CEM. The ARCP panels, when using the information gathered from these assessments, will need to take into account the feedback from trainers if difficulty in delivery of these assessments is encountered.

For each period of the EM curriculum, i.e. ACCS CT1-2, ACCS CT3, HST4-5 there is clearly defined curricular content and they will be identified and assessed in the following ways:

1. Major and acute presentations that must be assessed summatively using either the EM Mini-CEX or CbD successful/unsuccessful tool

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

3. The remaining acute presentations that may be covered by the trainee using:
   Successful completion of e learning modules
   Reflective diary entries in the e-portfolio (with clear learning outcomes)
   Audit and teaching assessments that relate to acute presentations
   Or additional ACAT-EMs

4. Practical procedures, which are assessed in EM using the DOPs EM tool. These are not summative assessments although descriptors of expected performance are provided in the e-portfolio and CEM web site.

5. The 25 Common competencies, each of which is described by levels 1-4.
   Trainees during CT1-3 should aim to reach level 2 in all areas.
   Trainees by the end of HST should have reached level 4 in all areas.
   Many of these competences are an integral part of clinical practice and as such will be assessed concurrently with the clinical presentations and procedures assessments.
   Trainees should use these assessments to provide evidence that they have achieved the appropriate level.
   For a small number of common competences alternative evidence should be used e.g. assessments of audit and teaching, completion of courses, management portfolio, which can be used to record management & leadership competencies.

A.1.4 ACCS CT1&2 assessments

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

There are 44 items listed under practical procedures (including anaesthesia and ICM items), which should aim to be covered over the first 2 years.

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

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

Core Major Presentations -CMP

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

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

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

Core Acute Presentations -CAP

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

1 Chest pain,
2 Abdominal pain
3 Breathlessness
4 Mental health
5 Head injury

Another 5 APs should be covered non-summatively using x1 ACAT-EM (or individual Mini-CEX or CbD if the opportunity arises).

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

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

During CT1 AM and EM, trainees should be aiming to sample the remaining 18 acute presentations (10 completed in EM, 10 in AM out of total 38).

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

E-learning modules,
Teaching and audit assessments,
Reflective entries that had a recorded learning outcome into the e-portfolio
Or additional ACAT-EMs.

Trainees at the end of their EM training should seek a summary description of the number and location of patients they have seen e.g. total number seen, number aged <16, number seen in resuscitation area, major side, Paeds and injuries. This can be either in a hard copy patient log or electronic version. This patient log will be required for the Structured Training Report.

Practical procedures -PP

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

1 Airway maintenance
2 Primary survey
3 Wound care
4 Fracture/ joint manipulation
5 Plus one other practical procedure from the list

These assessments will be done using the EM DOPs tool but CEM has written detailed descriptors of expected trainee performance to assist in assessment and feedback. Whilst these DOPs are not summative assessments the assessor should indicate whether or not the DOP should be repeated.

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

Common Competences - CC

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

Completed EM WPBA assessment forms will automatically populate the common competences section in the e-portfolio. This will be reviewed during completion of the Structured Training Report, at which time the Educational Supervisor will also be able to sign off additional common competences where additional evidence exists.

A.1.5 Emergency Medicine WPBA assessment tools and forms for ACCS CT1&2

Major Presentation Mini-CEX descriptors

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

1 Unconscious/altered mental status	
	Expected behaviour
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, considers neck injury • Considers opiate OD, alcoholism, anticoagulation
History	• Obtains history: friends, family, paramedics. Covers PMH, previous ODs etc • Obtains previous notes
Examination	Detailed physical examination including fundoscopy
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 • CT brain
Clinical decision making and judgement	Forms differential diagnosis including: • Trauma: SAH, epidural and subdural • Neurovascular: stroke, hypertensive encephalopathy

	• Cardiovascular: dysrhythmia, hypotension • Neurological: 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 and colleagues
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

2 Shock	
	Expected behaviour
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 • Covers PMH • Recognises the importance of treatment before necessarily getting all information • Obtains previous notes
Examination	Detailed physical examination which must include physical signs that would differentiate between haemorrhagic, hypovolaemic , cardiogenic and septic causes for shock
Investigation	Asks for appropriate tests • arterial blood gas • 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 and cardiac tamponade
Clinical decision making and judgement	Forms differential diagnosis including: • Trauma: haemorrhagic. Controls blood loss using direct pressure, pelvic splintage, emergency surgery or interventional radiology • Gastrointestinal: upper and lower GI bleed, or fluid loss from 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 • Obstructive: tension pneumothorax, cardiac tamponade
Communication	Effectively communicates with both patient and colleagues
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 Major trauma	
	Expected behaviour
Initial approach	• Knows when to activate the trauma team (based on local guidelines) • Able to perform a rapid primary survey, including care of the cervical spine and 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 further imaging
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 • clotting studies • toxicology • U&Es • ECG • FAST • UO by catheterisation • Appropriate use of NG
Clinical decision making and judgement	Forms differential diagnosis and management plan based on: • Ability 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

3 Sepsis	
	Expected behaviour

Initial approach	Initial approach based on ABCD system, ensuring early monitoring of vital signs including temperature,SPaO2, blood sugar
	• Can interpret early warning medical score as indicators of sepsis (EMEWS or similar)
	• Aware of systemic inflammatory response criteria (SIRS), and that 2 or more may indicate sepsis
	  ○ T>38 or < 36
	  ○ HR > 90
	  ○ RR > 20
	  ○ WCC > 12 or < 4

History	• Obtains history of symptoms leading up to illness • Able to take a collateral history from paramedics, friends and family • Able to use AMPLE history • Looks specifically for conditions causing immunocompromise
Examination	Able to perform a competent examination looking for • 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
	  ○ Swabs
	  ○ PCR

	○ 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 organ dysfunction, 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 inotrope infusion
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 informs and/or hands over to critical care team
Professionalism	Behaves in a professional manner

ACCS CT1&2

Acute presentation Mini-CEX descriptors

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

1 **Chest pain.**	
	Expected behaviours
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 patent airway) of chest pain including:
	  ○ site
	  ○ severity
	  ○ onset
	  ○ nature
	  ○ radiation
	  ○ duration
	  ○ frequency
	  ○ precipitating and relieving factors
	  ○ previous similar pains and associated symptoms
	• Systematically explores for symptoms of life threatening chest pain
	• Assesses ACS risk factors
	• Specifically asks about previous medication and past medical history
	• Seeks information from paramedics, relatives and past medical notes including previous ECGs

Examination	On examination has ABCD approach with detailed cardiovascular and 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 if indicated
Communication	Effectively communicates with both patient and colleagues
Prescribing	Able to relieve pain by appropriate prescription
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 treatment and investigation
Professionalism	Behaves in a professional manner

2 Abdominal pain	
	Expected behaviours
Initial approach	• Ensures appropriate monitoring in place and iv access • Establishes that vital signs measured

History	• Takes focused history of abdominal pain including:
	  ○ site
	  ○ severity
	  ○ onset
	  ○ nature
	  ○ radiation
	  ○ duration
	  ○ frequency
	  ○ precipitating and relieving factors
	  ○ previous similar pains and associated symptoms
	• Systematically explores for symptoms of life threatening abdominal pain
	• Specifically asks about previous abdominal operations
	• Considers non abdominal causes: MI, pneumonia, DKA, hypercalcaemia, sickle cell disease, 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 of abdominal pain) including: ○ Inspection, palpation, auscultation and percussion of the abdomen ○ Looks for herniae and scars ○ Examines loins, genitalia and back ○ Undertakes appropriate rectal examination
Investigation	Ensures appropriate investigation- ○ ECG ○ ABG ○ FBC ○ U&Es ○ LFTs ○ amylase ○ erect chest x-ray ○ and abdominal x-rays if obstruction or perforation suspected
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 and colleagues
Prescribing	Able to relieve pain by appropriate prescription
Overall plan	Stabilises (if appropriate)and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

3 Breathlessness	
	Expected behaviours
Initial approach	○ Ensures monitoring, iv access gained, O2 therapy ○ Ensures vital signs are measured including Spa O2
History	○ If patient able, trainee takes focused history of breathlessness including onset, • severity • duration • frequency • precipitating and relieving factors • previous similar episodes • associated symptoms ○ Systematically explores for symptoms of life threatening causes of breathlessness ○ Takes detailed respiratory history ○ Specifically asks about medication and past medical history ○ 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 and colleagues
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.	
	Expected behaviours
Initial approach	Ensures assessment takes place in a safe environment.
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 examination covering: • appearance and behaviour • speech • mood • thought abnormalities • hallucinations • cognitive function using the mini mental state examination • insight Elicits history sympathetically. Is unhurried.

	Searches for collateral history: friends and relatives, general practitioner, past medical notes, mental health workers
Examination	Ensures vital signs are measured Undertakes physical examination looks for physical causes of psychiatric symptoms: head injury, substance withdrawal, thyroid disease, intoxication and hypoglycaemia
Investigation	Considers 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 and colleagues
Prescribing	Knows safe indications, routes of administration of common drugs for chemical sedation
Overall plan	Identifies appropriately those who will need further help as an inpatient and who can be followed up as an out patient Is able to assess capacity Have strategies for those who refuse assessment or treatment or who abscond
Professionalism	Behaves in a professional manner

5 Head Injury	
	Expected behaviours
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-
	  ○ mechanism of injury
	  ○ any loss of consciousness and duration
	  ○ duration of any amnesia
	  ○ headache
	  ○ vomiting

	○ 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 or is epileptic
Examination	After ABC undertakes systematic neurological examination including • GCS • pupillary reactions and size • cranial nerve and peripheral neurological examination • 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 Neurosurgery Is able to identify those patients suitable for discharge and ensures safe discharge.
Communication	Effectively communicates with both patient and colleagues
Prescribing	Able to safely relieve pain in the head injured patient
Overall plan	Stabilises and safely prepares the patient for further treatment and investigation or safely discharges patient
Professionalism	Behaves in a professional manner

ACCS CT1&2

Practical procedures DOPs descriptors

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 and suction.	
2. Undertakes this in a timely and systematic way	
3. Assesses depth of respiration and need for BVM	
4. Can successfully BVM	
5. Knows and can show how to deliver high flow 02	
6. Knows other O2 delivery systems typically in ED- fixed concentration masks, nasal specs	
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 ED trolley	
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 identifies raised respiratory rate, chest asymmetry, chest wall bruising, air entry (anteriorly and laterally) and percussion (laterally). Identifies life threatening problems and correctly carries out associated procedures	
5. Examines for signs of shock, ensures monitoring established and has gained iv access X2	
6. If shocked looks for potential sites of blood loss: chest, abdomen, pelvis and limbs.	
7. Can formulate differential diagnoses for shocked patient	
8. Establishes level of consciousness and seeks lateralising signs	
9. Examines limbs, spine and rectum ensuring safe log roll.	
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. Ensures appropriate monitoring 14. Will have placed lines, catheter and NG tubes as appropriate	
15. Ensured appropriate blood testing (including cross match). 16. Plain radiology trauma series undertaken	
17. Ensures adequate and safe pain relief	
18. Directs team appropriately	
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 and irrigation.	
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 to seek help.	

4a Fracture manipulation e.g. Colles fracture	
Observed behaviour	Task Completed
1. Confirms correct patient, takes relevant history, and consents the patient. Explains to patient procedure and anticipated course.	
2. Interprets the x-ray correctly and looks for associated injuries	
3. Ensures appropriate monitoring and resuscitation equipment available and another doctor to assist.	
4. Typically reduction will involve the use of a Biers block (but could use haematoma block)	
5. Patient weighed. Contraindications to Biers known and considered	
6. Biers machine and resuscitation equipment checked	
7. IV access gained both arms if using Bier's block	
8. Correct volume and concentration of local anaesthetic drawn up	

9. Arm raised, padding applied to arm, brachial artery occluded	
10. Cuff inflation to 100mmhg greater than patients systolic BP if using Bier's block	
11. Clock started, anaesthetic given slowly	
12. Ensure anaesthesia of fracture site	
13. Remove cannula from affected side	
14. Ensure counter-traction and traction	
15. Reduce fracture, maintaining reduction and POP applied.	
16. Knows how to size and apply POP	
17. Check x-ray	
18. Release of cuff slowly at 20 minutes post inflation	
19. Continued observation of patient for signs of toxicity- peri oral paraesthesia, hypotension, seizures	
20. Check circulation to limb	
21. Ensures well one hour post procedure, ensures post procedure analgesia and indicates when patient to return and predicted course.	

4b Reduction of a dislocated joint e.g. shoulder, ankle	
Observed behaviour	Task Completed
1. Confirms correct patient, takes focused history and consents the patient	
2. Takes focused history and examination to establish that sedation is safe	
3. Undertakes examination to confirm dislocation and assesses distal neurovascular function	
4. Interprets the x-ray correctly and looks for associated injuries	
5. Ensures appropriate monitoring and resuscitation equipment available and another doctor to assist.	
6. Gains IV access, and has correct volume of opiate, benzodiazepine or other agent e.g. Ketamine, in correctly labelled syringes	
7. Knows the pharmacology of these drugs and their antagonists	
8. Explains to patient procedure and anticipated course	
9. Ensures another doctor present	
10. Gives drugs in controlled way in monitored environment with patient receiving oxygen	
11. Establishes sedated: still responsive to verbal commands.	
12. Undertakes reduction in gentle and controlled manner	
13. Confirms reduction by physical examination and checks distal neurovascular function	
14. Immobilises: sling, takes relevant history, and consents the patient. Explains to patient procedure and anticipated course	
15. Gets check x-ray- checks reduced and no additional fractures detected	
16. Ensures observed and monitored until fully recovered	
17. Rechecks neurovascular function	
18. Ensures well one hour post procedure, ensures post procedure analgesia and indicates when patient to return and predicted course	

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 (brief description)		**Diagnosis**	
Focus of assessment –	**History**	**Examination**	**Diagnosis**	**Management**	**Communication**

Please TICK to indicate the standard of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Initial approach					
History and information gathering					
Examination					
Investigation					
Clinical decision making and judgment					
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:

Formative Mini-Clinical Evaluation Exercise - Mini-CEX

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

Please TICK to indicate the standard of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Initial approach					
History and information gathering					
Examination					
Investigation					
Clinical decision making and judgment					
Communication with patient, relatives, staff					
Overall plan					
Professionalism					

Things done particularly well	
Learning points	
Action points	
Assessor Signature:	**Trainee** Signature:

Dimension	Descriptor of unsatisfactory performance
History taking	History taking was not focused

	• Did not recognise the critical symptoms, symptom patterns • Failed to gather all the important information from the patient, missing important points • Did not engage with the patient • Was unable to elicit the history in difficult circumstances- busy, noisy, multiple demands
Physical examination	Failed to detect /elicit and interpret important physical signs Did not maintain dignity and privacy
Communication	Communication skills with colleagues • Did not listen to other views • Did not discuss issues with the team • Failed to follow the lead of others when appropriate • Rude to colleagues • Did not give clear and timely instructions • Inconsiderate of the rest of the team • Was not clear in referral process- was it for opinion, advice, or admission Communication with patients • Did not elicit the concerns of the patient, their understanding of their illness and what they expect • Did not inform and educate patients/carers • Did not encourage patient involvement/ partnership in decision making
Clinical judgement-clinical decision making	• Did not identify the most likely diagnosis in a given situation • Was not discriminatory in the use of diagnostic tests • Did not construct a comprehensive and likely differential diagnosis • Did not correctly identify those who need admission and those who can be safely discharged. • Did not recognise atypical presentation • Did not recognise the urgency of the case • Did not select the most effective treatments • Did not make decisions in a timely fashion • Decisions did not reflect clear understanding of underlying principles • Did not reassess the patient • Did not anticipate interventions and slow to respond

	• Did not review effect of interventions
Professionalism	• Did not respect confidentiality • Did not protect the patients dignity • Insensitive to patients opinions/hopes/fears • Did not explain plan and risks in a way the patient could understand
Organisation and efficiency	Was slow to progress the case
Overall care	• Did not ensure patient was in a safe monitored environment • Did not anticipate or recognise complications • Did not focus sufficiently on safe practice • Did not follow published standards guidelines or protocols • Did not follow infection control measures • Did not safely prescribe

College of Emergency Medicine
Summative Case Based Discussion CbD

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

Please TICK to indicate the standard of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		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 safety issues					
Overall clinical care					
For summative CbD				**Unsatisfactory**	**Satisfactory**

Things done particularly well
Learning points
Action points

Assessor Signature:	**Trainee** Signature:

College of Emergency Medicine
Formative Case Based Discussion CbD

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

Please TICK to indicate the standard of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		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 safety issues					
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 include provisional 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 trainees interpretation
Diagnosis	The correct diagnosis was achieved with an appropriate differential diagnosis. Were any important conditions omitted?
Treatment	Emergency treatment was correct and response recorded. Subsequent treatments appropriate and comprehensive
Planning for subsequent care (in patient or discharged patients)	Clear plan demonstrating expected clinical course, recognition of and planning for possible complications and instructions to patient (if appropriate)
Clinical reasoning	Able to integrate the history, examination and investigative data to arrive at a logical diagnosis and appropriate treatment plan taking into account the patients co morbidities and social circumstances
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 a good overall standard

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 of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Indication for procedure discussed with assessor					
Obtaining informed consent					
Appropriate preparation including monitoring, analgesia and sedation					
Technical skills and aseptic technique					
Situation awareness and clinical judgement					
Safety, including prevention and management of complications					
Care /investigations immediately post procedure					
Professionalism, communication and consideration for patient, relatives and staff					
Documentation in the notes					
Completed task appropriately					

Things done particularly well
Learning points
Action points

Assessor Signature:	**Trainee** Signature:

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 level of responsibility			
Acute presentations covered (5 max for EM)			

Please TICK to indicate the standard of the trainee's performance in each area	Not observed	Further core learning needed	Demonstrates good practice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Clinical Assessment					
Medical record keeping					
Investigation and treatment of the critically ill patient					
Time management					
Management of the team					
Clinical leadership					
Patient safety					
Handover					
Overall Clinical Judgement					

Which aspects were done well	Learning points
Unsatisfactory AP?	Plan for further AP assessment, specify WPBA tool and review date
Trainees Comments	Action points
Assessors signature	Trainees signature

A.2 Speciality specific assessments for Anaesthesia

A.2.1. For rotations of 3-6 months the assessments listed below

The ACCS trainee must successfully complete all of the following summative WPBAs:

A-CEX	
Assessment Code	*Assessment*
IAC_A01	Preoperative assessment of a patient who is scheduled for a routine operating list [not urgent or emergency] [0-3 months]
IAC_A02	Manage anaesthesia for a patient who is not intubated and is breathing spontaneously [0-3 months]
IAC_A03	Administer anaesthesia for acute abdominal surgery [0-3 months]
IAC_A04	Demonstrate Rapid Sequence Induction [0-3 months]
IAC_A05	Recover a patient from anaesthesia [0-3 months]

DOPS	
Assessment Code	*Assessment*
IAC_D01	Demonstrate functions of the anaesthetic machine [0-3 months]
IAC_D02	Transfer a patient onto the operating table and position them for surgery [lateral, Lloyd Davis or lithotomy position] [0-3 months]
IAC_D03	Demonstrate cardio-pulmonary resuscitation on a manikin. [0-3 months]
IAC_D04	Demonstrates technique of scrubbing up and donning gown and gloves. [0-3 months]
IAC_D05	Basic Competencies for Pain Management – manages PCA including prescription and adjustment of machinery [0-3 months]
IAC_D06	Demonstrates the routine for dealing with failed intubation on a manikin.

CBD	
Examine the case-notes. Discuss how the anaesthetic plan was developed. Ask the trainee to explain their approach to pre-op preparation, choice of induction, maintenance, post op care. Select one of the following topics and discuss the trainees understanding of the issues in context.	
Assessment Code	*Assessment*
IAC_C01	Discuss the steps taken to ensure correct identification of the patient, the operation and the side of operation
IAC_C02	Discuss how the need to minimise postoperative nausea and vomiting influenced the conduct of the anaesthetic
IAC_C03	Discuss how the airway was assessed and how difficult intubation can be predicted
IAC_C04	Discuss how the choice of muscle relaxants and induction agents was made
IAC_C05	Discuss how the trainee's choice of post-operative analgesics was made
IAC_C06	Discuss how the trainee's choice of post-operative oxygen therapy was made
IAC_C07	Discuss the problems emergency intra-abdominal surgery causes for the anaesthetist and how the trainee dealt with these
IAC_C08	Discuss the routine to be followed in the case of failed intubation.

The Royal College of Anaesthetists

Anaesthesia Clinical Evaluation Exercise [A-CEX] Assessment Form

Please complete the question using a cross (x). Please use black ink and CAPITAL LETTERS

Trainee's surname		
Trainee's forename(s)		
GMC number		GMC NUMBER MUST BE COMPLETED

Observation	
Code number	

Observed by		
GMC number		GMC NUMBER MUST BE COMPLETED
Date		

Clinical Setting:

Theatre ☐ ICU ☐ A&E ☐ Delivery Suite ☐ Pain Clinic ☐ Other ☐

Assessment:

	Practice was satisfactory	Assessor's Signature
	Practice was unsatisfactory	Assessor's Signature
If the performance was judged to be unsatisfactory, you must tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.		
Example of good practice were: **Areas of practice requiring improvement were:** **Further learning and experience should focus on:**		

Complete the following if you have marked practice unsatisfactory

	Unacceptable
Did not plan and prepare satisfactorily	
Did not make a clear plan for the patients care	
Is unaware of the particular hazards and problems of this procedure	
Did not consider all the important relevant information or fails to organize additional appropriate investigation.	
Did not modify plans to avoid problems or mitigate their effects.	
Did not prepare necessary drugs and equipment before starting the case	
Did not consider some important management options	
Did not understand the risks of different treatment options	
Did not recognize the signs of potential hazards	
Did not request necessary additional equipment and resources in advance.	
Did not request appropriate assistance	
Did not make satisfactory clinical decisions	
Decisions did not reflect a clear understanding of underlying principles of medical science and practice.	
Did not initiate monitoring and observation appropriate to the clinical situation	
Did not reassess the options as the patient's condition changes	
Did not attend to critical events in the patients progress	
Did not take into account the urgency of the situation in responding to events	
Did not know how to correctly operate the equipment	
Did not anticipate the need for interventions and slow to respond to the need for intervention	
Did not recognise obvious hazards	
Slow to review the effects of interventions	
Did not seek all relevant data before formulating responses	
Did not respond to incipient difficulty by increasing the intensity of monitoring and observation	
Did not focus sufficiently on safe practice	
Careless of patient identification, correct procedure (and site of surgery) and formal record of risk factors.	
Did not abide by published standards, guidelines and protocols.	
Did not abide by protocols for checking drugs and equipment and critical actions	
Breached procedures for avoiding healthcare associated infections	
Did not record having encountered difficulties	
Did not keep timely, accurate comprehensive records	
Exhibited poor standards of professional behaviour	
Insensitive to the patients opinions, hopes and fears	
Did not respect confidentiality	
Did not protect the patients dignity	
Knowledge was below expectation	
Did not clearly explain plans and risks in a way that the patient could understand	
Poor team working was observed	
Did not discuss potential problems with the team	
Did not understand the importance of the concerns expressed by other team members.	
Fails to demonstrate necessary leadership	
Fails to follow the lead of others when appropriate	
Made assumptions about the capability of team members and did not act upon any poor performance	
Acts without consideration of the effects on others and fails to cooperate to achieve joint goals	
Displays panic and anxiety. Did not inspire confidence	
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	

The Royal College of Anaesthetists

Direct Observation of Procedural Skills [DOPS] Assessment Form

Please complete the question using a cross (x). Please use black ink and CAPITAL LETTERS

Trainee's surname		
Trainee's forename(s)		
GMC number		GMC NUMBER MUST BE COMPLETED

Observation	
Code number	

Observed by		
GMC number		GMC NUMBER MUST BE COMPLETED
Date		

Assessment:

	Practice was satisfactory	Assessor's Signature
	Practice was unsatisfactory	Assessors Signature
If the performance was judged to be unsatisfactory, you must tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.		
Example 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		

The Royal College of Anaesthetists

Case Based Discussion [CBD] Assessment Form

Please complete the question using a cross (x). Please use black ink and CAPITAL LETTERS

Trainee's surname		
Trainee's forename(s)		
GMC number		GMC NUMBER MUST BE COMPLETED

Code number or description of case	

Observed by		
GMC number		GMC NUMBER MUST BE COMPLETED
Date		

Clinical setting:
Theatre ☐ ICU ☐ A&E ☐ Delivery Suite ☐ Pain Clinic ☐ Other ☐

Case category:

Elective ☐ Scheduled ☐ Urgent ☐ Emergency ☐

ASA Class: 1 2 3 4 5 ☐☐☐☐☐

Assessment:

	Practice was satisfactory	Assessor's Signature
	Practice was unsatisfactory	Assessor's Signature

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

Example 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.
10. 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***.

A.3 Speciality specific assessments for Intensive Care Medicine

ICM Case- based discussion - CbD

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

Please TICK to indicate the standard of the trainee's performance in each 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 information gathering							
Immediate management and stabilisation							
Further management and decision making							
Safety, including management plan/help							
Communication with patient, relatives and staff							
Documentation in the notes							
OVERALL CLINICAL CARE							

Things done particularly well
Suggested areas for development

Assessor **Trainee**

Signature:	Signature:

ICM 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 of the trainee's performance in each 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 discussed with assessor							
Obtaining informed consent							
Appropriate preparation including monitoring, analgesia and sedation							
Technical skills and aseptic technique							
Situation awareness and clinical judgement							
Safety, including prevention and management of complications							
Care /investigations immediately post procedure							
Professionalism, communication and consideration for with patient, relatives and staff							
Documentation in the notes							
OVERALL CLINICAL CARE							

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

ICM Mini-Clinical Evaluation Exercise - Mini-CEX

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

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

Please TICK to indicate the standard of the trainee's performance in each 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 information gathering							
Immediate management and stabilisation							
Further management and decision making							
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:

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 the trainees' performance.

Please return the form to ----------in the envelope provided by (*add date*)----------.

Thanks you for agreeing to complete this multi-source feedback form.

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 behaviour causing concern • If you want to comment on attitude please provide evidence of behaviour. This should reflect the trainee's behaviour over time – not usually a single incident. • The trainee will receive private feedback, but you will not identified • If enough observers regard a trainee as giving cause for concern they will be offered help and support
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 the standard of the trainee's performance in each area	**Areas of concern**			
	None	**Some**	**Major**	**Cannot comment**
Maintaining trust/professional relationships with patients • Listens • Is polite and caring • Shows respect for patients' opinions, dignity and confidentiality • Is unprejudiced and dresses appropriately				
Verbal communication skills • Gives understandable information • Speaks good English, at an appropriate level for the patient				
Team working/working with colleagues • Respects others' roles and works constructively in the team • Hands over effectively and communicates well. Is unprejudiced, supportive and fair				
Accessibility • Is accessible • Takes proper responsibility • Only delegates appropriately • Does not shirk duty • Responds when called • Arranges cover for absences				

Comments

A.4 Specialty Specific assessments for Acute Medicine

WPBA forms

- Mini-CEX
- CbD
- DOPS
- ACAT
- Audit assessment
- 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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Appendix B

Guidelines for Postgraduate Deans for ACCS training

ACCS is a 3 year programme, which is overseen by the Inter-collegiate committee for ACCS training. The ICACCST is responsible for setting the standards for training, the curriculum and the assessment for ACCS training for the first 2 years. This curriculum has been approved by the GMC. ACCS has the full support of all 3 colleges (CEM, RCoA and JRCPTB) and the inter-collegiate board for ICM training. Administratively the ICBACCST is supported by the RCoA (mhumphrey@rcoa.ac.uk).

Appointments to ACCS posts are currently made by the individual specialties using the HR resources of the regional deaneries.

The first 2 years of ACCS training are generic and follow the same curriculum and assessment system agreed by the ICBACCST. The third year of ACCS is speciality specific and this year follows the curriculum and assessment system laid down by the parent college.

Trainees are expected to nominate their intended specialty on joining the ACCS programme in order to facilitate planning of rotations and training. Those trainees that have successfully completed their first two years and wish to change to a specialty other than their original nomination can seek to do so. GMC have agreed that the competences gained in the first 2 years of training are transferable to all 3 parent specialties. However trainees will have to liaise with the local Deaneries and change will depend on availability of training posts, meeting the relevant entry requirements of that specialty for CT3 and is likely to be competitive. Information from portfolios would need to follow the trainee.

A flow chart of the ACCS route of training is provided in the executive summary (page 10) It is important to note that ACCS provides the only route to HST in EM, whilst entry into AM and anaesthesia can be via other routes (CT1&2 for Anaesthesia and CMT1&2 for AM)

Acute Care Common Stem (ACCS) - generic CT1&2

Most doctors entering ACCS will do so via CT1, unless they are able to enter above CT1 using the CESR CP route. Person specifications, recruitment and selection will be tailored to ensure that the most suitable candidates are appointed into generic ACCS posts.

ACCS requires training and experience for one year in EM and Acute Adult Medicine (AM) and for another year in Anaesthesia and Intensive Care Medicine (ICM) during the first 2 generic training years. Trainees will then enter a third year of specialty specific training, i.e. EM, AM or Anaesthesia.

The first year of ACCS training will usually include 6 months of Emergency Medicine and 6 months of Acute Medicine. In the second year of ACCS there will be a minimum of 3 months in each specialty and there is some flexibility around the amount of time spent in each post. The split within this year should ideally be 6 months and 6 months but could be 3 and 9 and this will vary according to local needs and preferences. Local solutions that work will be an important factor in implementing the acute care common stem e.g. a combined year with a rota that allows the trainee to work between an acute admitting medical assessment unit and ED might be attractive.

Six months' training in anaesthetics is likely to be required in the year split between Anaesthetics and ICM in order to gain the airway and other competences that ACCS trainee's need. A minimum period of 3 months must be spent in each speciality in order to complete the generic 2 years. If an ACCS trainee can only spend 3/12 in anaesthesia the minimum competences required are outlined in the curriculum and

must include the Initial Assessment of Competency (IAC). In this instance (i.e. 3/12 anaesthetic training) it is essential that trainees are given as much time out of their intensive care medicine training as required (which will be 9/12) to ensure they achieve these essential competencies, which are core to patient safety

ACCS CT3 EM: 6/12 PEM and 6/12 EM

The key objective of this year is to achieve the competences required to care for children in the ED as defined in the curriculum. The trainee should also consolidate their EM competences and be able to demonstrate the leadership skills required for entry into ST4.

The preferred model for delivery of paediatric emergency medicine training would comprise 6 months experience in emergency medicine with a paediatric focus, plus additional training in acute general paediatrics/neonates.

- At least 3 months of this training should ideally be in a department recognised for paediatric EM sub-specialty training. The hope is that CT3 trainees could rotate into current middle grade paediatric EM posts for 3 or 6 months, or that one paediatric EM SHO post could be converted to allow 4 CT3 trainees to rotate through for 3 months each per year.

- Where such training opportunities are difficult to access locally the alternative would be that during the 6 months of the CT3 year with a paediatric focus, trainees work for at least 3 months in a general ED. This ED should treat around 16,000 children per year, should have recognised consultant trainer who takes the lead for paediatric issues and who can act as the educational supervisor to the trainee. There needs to be some flexibility in utilising the training opportunities available locally, so for example, where the general EM caseload plus that of a co-located acute paediatric assessment/admission unit is 16,000 per year it is likely that the clinical work will be adequate to train the doctor in an integrated programme between the two departments.

- Where the 6 months of the CT3 year with a paediatric focus is based solely in a general Emergency Department (ED) or in a paediatric ED, there may be a requirement to second the trainee on an individual basis to gain competence and confidence in some procedures such as paediatric airway. This might be arranged by a regular session each week, or by short attachments for focused training.

- The less favoured option would be for 6 months in acute in-patient paediatrics. In this case the trainee would need additional training to gain competence in the surgical and traumatic aspects of paediatric EM. This might be arranged by a regular session in an ED (that meets the requirements described above) each week, or by short block attachments for focused training there. Other sources of relevant training would be for example in paediatric fracture clinics or wards where children with head injuries are cared for.

The remaining 6 months in EM should be used to consolidate the competences acquired in first two years of ACCS and develop the leadership and management skills require for progression through to ST4.

CT3 Anaesthesia

Satisfactory ARCPs at ACCS CT1&2 will allow the Anaesthetic trainee to enter a third year of training, CT3 Anaesthesia. During this year the trainee will be subject to the same curriculum and assessment system as trainees who have entered anaesthesia via the alternative route (see flow chart appendix C).

Trainees will need to pass the part 1 of the FRCA before they are able to enter ST3 together with satisfactory ARCP outcomes.

CT3 Acute Medicine

ACCS trainees who successfully complete ACCS CT1&2 can enter CT3 AM. The focus of this year will be to ensure further experience in acute medical specialties. This should include continued experience in the acute medical take but should also include exposure to medical patients who present with illness managed by the acute medical specialties. Although attachment to an acute medical unit for at least 4 months would be recommended during this year it is recognised that experience in the acute medical take may also be obtained during Hospital at Night experience or by rotation from a medical specialty to the acute take on a rota basis. However achieved, during this year of experience, trainees will have to acquire the competences relating to the acute medicine part of the ACCS curriculum including the defined assessments. All trainees who wish to pursue a career in a medical specialty should pass the MRCP. This will be a mandatory requirement for all entrants to ST3 posts from 2011. Until then entry to ST3 can be achieved if in possession of MRCP part 1. Subsequent progression to ST4 can only be achieved if MRCP has been achieved.

Academic ACCS trainees

A small number of ACCS trainees may wish to develop an academic career by applying for an NTN(A) Details are available at http://www.nccrcd.nhs.uk/intetacatrain

An academic clinical fellowship would under normal circumstances require a year in addition to ACCS CT1 to CT3. The need for this additional year would be the judgement of the local ARCP panel. Academic clinical lectureship would replace ST4 to ST7, leading to appointment to a Senior Lectureship. All appointments to ACF posts are currently run though programmes in the parent specialty and progression is dependant on achieving agreed academic and clinical objectives, which will be reviewed at the ARCP.