

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Obtains history: friends, family, paramedics. Covers PMH, previous ODs etc • Obtains previous notes
Examination	Detailed physical examination including fundoscopy
Investigation	Asks for appropriate tests <ul style="list-style-type: none"> • 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	Forms differential diagnosis including: <ul style="list-style-type: none"> • Trauma: SAH, epidural and subdural

judgement	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<p>Asks for appropriate tests</p> <ul style="list-style-type: none"> • 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	<p>Forms differential diagnosis including:</p> <ul style="list-style-type: none"> • Trauma: haemorrhagic. Controls blood loss using direct

judgement	<p>pressure, pelvic splintage, emergency surgery or interventional radiology</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Obtains history of mechanism of injury from paramedics • Able to use AMPLE history
Examination	After completing a primary survey is able to perform <ul style="list-style-type: none"> • detailed secondary survey
Investigation	Asks for appropriate tests <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Ability to identify and manage life threatening injuries as part of primary survey • Able to identify the airway that may be at risk • Can identify shock, know its classification and treatment

	<ul style="list-style-type: none"> • 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	<p>Initial approach based on ABCD system, ensuring early monitoring of vital signs including temperature, SPaO₂, blood sugar</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ T > 38 or < 36 ○ HR > 90 ○ RR > 20 ○ WCC > 12 or < 4
History	<ul style="list-style-type: none"> • 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	<p>Able to perform a competent examination looking for</p> <ul style="list-style-type: none"> • Possible source of infection • Secondary organ failure
Investigation	<p>Asks for appropriate tests</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Swabs

	<ul style="list-style-type: none"> ○ PCR ○ Pus <p>Considers need for further imaging</p>
Clinical decision making and judgement	<p>Form a management plan with initial interventions being:</p> <ul style="list-style-type: none"> • 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 <p>Recognises and is able to support physiological markers of organ dysfunction, such as:-</p> <ul style="list-style-type: none"> • Systolic BP < 90 mm Hg • PaO₂ < 8 KPa • Lactate > 5 • Reduced GCS • Urine output < 30 mls/hr <p>Demonstrates when to use invasive monitoring, specifically</p> <ul style="list-style-type: none"> • CVP line • Arterial line <p>Demonstrates when to start inotropes. Noradrenaline v dopamine</p> <p>Demonstrates how to set up an inotrope infusion</p>
Communication	Effectively communicates with both patient and other members of the acute care team
Overall plan	<p>Identifies sepsis</p> <p>Implements 4 hour sepsis bundle</p> <p>Stabilises patient, reassesses and informs and/or hands over to critical care team</p>
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	<ul style="list-style-type: none"> • Ensures monitoring, i.v. access and defibrillator nearby. • Ensures vital signs are measured including SpO₂
History	<ul style="list-style-type: none"> • Takes focused history (having established conscious with patent airway) of chest pain including: <ul style="list-style-type: none"> ○ 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	<p>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</p>

Investigation	Ensures appropriate investigation <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Ensures appropriate monitoring in place and iv access • Establishes that vital signs measured
History	<ul style="list-style-type: none"> • Takes focused history of abdominal pain including: <ul style="list-style-type: none"> ○ 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	<p>Able to undertake detailed examination for abdominal pain (ensuring adequate exposure and examining for the respiratory causes of abdominal pain) including:</p> <ul style="list-style-type: none"> ○ Inspection, palpation, auscultation and percussion of the abdomen ○ Looks for herniae and scars ○ Examines loins, genitalia and back ○ Undertakes appropriate rectal examination
Investigation	<p>Ensures appropriate investigation-</p> <ul style="list-style-type: none"> ○ ECG ○ ABG ○ FBC ○ U&Es

	<ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> ○ Ensures monitoring, iv access gained, O2 therapy ○ Ensures vital signs are measured including Spa O2
History	<ul style="list-style-type: none"> ○ If patient able, trainee takes focused history of breathlessness including onset, <ul style="list-style-type: none"> ● 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	<p>On examination has ABCD approach with detailed cardiovascular and respiratory examination including, work of breathing, signs of</p> <ul style="list-style-type: none"> ● respiratory distress ● detection of wheeze ● crepitations ● effusions ● areas of consolidation
Investigation	<p>Ensures appropriate investigation</p> <ul style="list-style-type: none"> ● ECG ● ABG ● FBC ● U&Es ● troponin and d dimer if indicated

	<ul style="list-style-type: none"> • Chest x-ray <p>Able to interpret chest x-ray correctly</p>
Clinical decision making and judgement	<p>Able to formulate a full differential diagnosis and the most likely cause in this case</p> <p>Knows BTS guidelines for treatment of Asthma and PE</p>
Communication	Effectively communicates with both patient and colleagues
Prescribing	<ul style="list-style-type: none"> • 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	<p>History taking covers</p> <ul style="list-style-type: none">• presenting complaint• past psychiatric history• family history• work history,• sexual/marital history• substance misuse• forensic history• social circumstances• personality <p>Undertakes mental state examination covering:</p> <ul style="list-style-type: none">• appearance and behaviour• speech• mood• thought abnormalities• hallucinations• cognitive function using the mini mental state examination• insight <p>Elicits history sympathetically. Is unhurried.</p> <p>Searches for collateral history: friends and relatives, general practitioner, past medical notes, mental health workers</p>
Examination	<p>Ensures vital signs are measured</p> <p>Undertakes physical examination looks for physical causes of psychiatric symptoms: head injury, substance withdrawal, thyroid disease, intoxication and hypoglycaemia</p>
Investigation	Considers appropriate tests

	<ul style="list-style-type: none"> • U&E • FBC • CXR • CT • toxicology
Clinical decision making and judgement	<p>Ensures no organic cause for symptoms</p> <p>Forms working diagnosis and assessment of risk- specifically of suicide and toxicological risk in those with overdoses</p>
Communication	Effectively communicates with both patient and colleagues
Prescribing	Knows safe indications, routes of administration of common drugs for chemical sedation
Overall plan	<p>Identifies appropriately those who will need further help as an inpatient and who can be followed up as an out patient</p> <p>Is able to assess capacity</p> <p>Have strategies for those who refuse assessment or treatment or who abscond</p>
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	<ul style="list-style-type: none"> • Establishes history- <ul style="list-style-type: none"> ○ 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	<p>After ABC undertakes systematic neurological examination including</p> <ul style="list-style-type: none"> • 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	<p>Is able to refer appropriately with comprehensive and succinct summary</p> <p>Knows which patients should be referred to Neurosurgery</p> <p>Is able to identify those patients suitable for discharge and ensures safe discharge.</p>

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 O ₂	
6. Knows other O ₂ 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:

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

Name of trainee:		Year of Training:	
Assessor:		GMC No:	
Grade of assessor:		Date	/ /
Case discussed (brief description)		Diagnosis	
Focus of assessment – History	Examination	Diagnoses	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					
Things done particularly well					

Learning points	
Action points	
Assessor Signature:	Trainee Signature:

Dimension	Descriptor of unsatisfactory performance
History taking	<p>History taking was not focused</p> <ul style="list-style-type: none"> • 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	<p>Failed to detect /elicit and interpret important physical signs</p> <p>Did not maintain dignity and privacy</p>
Communication	<p>Communication skills with colleagues</p> <ul style="list-style-type: none"> • 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 <p>Communication with patients</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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