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Certificate of Eligibility of Specialist Registration (CESR) Portfolio

Name	
GMC Number	

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Glossary

ACAT	Acute Care Assessment Tool
CbD	Case Based Discussion
RCEM	Royal College of Emergency Medicine
CESR	Certificate of Eligibility of Specialist Registration
CPD	Continuing Professional Development
CTR	Clinical Topic Review
DOPS	Direct Observation of Procedural Skills
IAC	Initial assessment of competence (anaesthetics)
ICM	Intensive Care Medicine
MIMMS	Major Incident Medical Management and Support
Mini-CEX	Mini Clinical Evaluation Exercise
MSF	Multi Source Feedback
RCA	Root Cause Analysis
WBA's	Work-Based Assessments (also called Work placed based assessments

Introduction

The **Certificate of Eligibility of Specialist Registration (CESR)** is a means by which doctors who have not completed an approved deanery training programme can be entered on the Specialist Register. It is a competency-based process where the trainee provides a portfolio of evidence that demonstrates that their training, qualifications and experience meet the requirements of the Emergency Medicine CCT curriculum.

Successful completion of the CESR process results in entry onto the Specialist Register and the doctor will then be able to apply for Emergency Medicine Consultant posts in the traditional way.

The process itself involves collation of a range of evidence covering the four domains as set out by the GMC (covered in more detail in the sections below). The evidence is then reviewed by the GMC and the Royal College of Emergency Medicine CESR panel to ascertain whether there is sufficient evidence for entry onto the Specialist Register.

Background

Royal Derby Hospital Emergency Department has devised tailor-made CESR rotations to facilitate all successful applicants to our programme with the clinical and non-clinical experience/skills required to apply for entry onto the Specialist Register in Emergency Medicine and subsequent eligibility to apply for a consultant post.

Each programme will run over approximately 4 years with each year being loosely equivalent to traditional higher specialty training (HST) years ST3-6, although this time frame can be flexible to meet the individual needs of the CESR trainee. The clinical secondments (Anaesthetics, ITU, Acute Medicine, Paediatrics) will run in parallel with demonstration of the required competencies. These are set out in the sections below with clear guidance as to what is required in each domain.

The rotation will run in parallel with a specifically designed teaching programme matching that of the FCEM curriculum. There will also be focussed teaching on specific areas including OSCE practice, Critical Appraisal teaching and mock viva's on both the CTR and management sections of the FCEM examination. There will be opportunities for collaborative learning and skills development with CESR- training contemporaries across the Derbyshire region.

Each CESR trainee will be assigned a Consultant Educational Supervisor who will provide support throughout the programme. Once you have successfully completed the portfolio and passed the FCEM examination your supervisor will support your application with the GMC and CEM in respect of entry onto the specialist register.

Format of CESR Application

- Application checklist and form (completed by candidate and validated by GMC prior to CEM review)
- Structured Reports (These will be completed by during your annual appraisal with your educational supervisor.)
- Curriculum Vitae
- Domain 1 – Knowledge, Skills and Performance
- Domain 2 - Safety and Quality
- Domain 3 – Communication, Partnership and Teamwork
- Domain 4 – Maintaining Trust

Domain 1 – Knowledge, Skills and Performance

Evidence of competencies in relevant specialty areas:

ACUTE MEDICINE

- 6/12 previous experience with evidence (WBAs) of necessary skills and experience

  OR

- 3/12 secondment during which all WBA's covering the Acute Medicine mandatory presentations and procedures are completed. (see page 13 for further details)

ICM

- 3/12 previous experience as a trainee with evidence (WBAs) of necessary skills and experience AND a logbook of the basic competencies in ICM as set out by RCoA

  OR

- 3/12 secondment during which all WBA's covering the mandatory presentations and procedures must be completed AND completion of a **logbook of basic competencies in ICM as per RCoA (see page 16/17)**

ANAESTHETICS

- 3/12 previous experience as an anaesthetic trainee including the initial assessment of competence

  OR

- 3/12 secondment during which all WBA's covering the mandatory presentations and procedures must be completed AND completion of a logbook of basic competencies in Anaesthetics as per RCoA. (see page 14/15)

PAEDIATRIC EM

- 6/12 in previous Paediatric/ PEM training post with WBA's OR
- 3/12 secondment and WBAs for all paediatric major and acute presentations (see page 20/21)

COMMON COMPETENCIES

During your placements in EM you will need:

1. WBAs to cover the common presentations, procedures and competencies (or equivalent e-learning, teaching or ACAT EM) (see pages 22-24)
2. A minimum of the following:
    - 6 DOPS per year
    - 12 mini CEX in 4 years
    - 12 CbD in 4 years
    - 6 ACAT-EM in 4 years
    - 12 reflective cases in 4 years
    - 2 MSF/ 360 appraisals in 4 years
3. You are encouraged to keep a logbook of evidence (with anonymised patient details) of a range of presentations, diagnoses and any practical procedures undertaken e.g. chest drain insertion/ RSI

ULTRASOUND

- Level 1 signed off + Log Book with 50+ cases OR completion of Level 1 Finishing School.

CPD: (evidenced via CEM ePortfolio)

- Four years of records of CPD (including a minimum of 50 CPD points/ year)
- Evidence of regular (at least twice yearly) appraisal with your educational supervisor

COURSES

- Up-to-date certification in:
    - ALS
    - ATLS
    - APLS (note that EPLS is not a substitute for APLS)
    - HMIMMS (not compulsory)

  You need to be recommended as an instructor for at least one of the above courses

TEACHING AND TRAINING

(you need to keep a record of evidence of all the teaching you have attended and delivered)

- Completion of recognised teaching courses (e.g. ALSG/ ATLS Instructor Course) AND full Instructor Status for one of the above life support courses
- Training the Trainers Course
- Written feedback on teaching delivered
- Evidence of teaching at multiple levels (including students, juniors and peers)

- Presentations given
    - You should aim to present at least one trust wide meeting as well as at regional and national forums such as teaching/ conferences
- Evidence of providing feedback to others (e.g. ePortfolio tickets etc)
- Clinical and Educational Supervision training leading to mentorship/ supervision of e.g. foundation trainees within the ED.

RESEARCH

- Successful completion of a CTR and CTR Viva as part of the FCEM examination.
- Presentations of research at conference
- Publications
- Exams
- You will be supported to work towards completing the FCEM examination during the final year of this programme. (Successful completion of FCEM Examination will make your application of entry onto the specialist register a much more straightforward process)

Annual Review of Competence Progression –Emergency Medicine

(It is expected that the trainee will work towards completion of the following over their time in EM and that progress will be reviewed annually)

Assessments (Mini CEX or CBD) by a CONSULTANT in **2 of the following 6 Major Presentations –** not to be duplicated with those covered elsewhere in the curriculum. *(For full details see Section 6.1 of ACCS Curriculum 2012)* https://www.gmc-uk.org/-/media/documents/accs-curriculum---jan-2018_pdf-73072688.pdf			
	Yes	Date	No
1. CMP1 Anaphylaxis			
2. CMP2 Cardiorespiratory arrest			
3. CMP3 Major Trauma			
4. CMP4 Septic patient			
5. CMP5 Shocked patient			
6. CMP6 Unconscious patient			
ALL 6 of these competencies should be completed across the entire portfolio for completion of CESR Training.			
Summative assessments (Mini CEX or CBD) by a consultant in each of the following 10 Acute/ Major Trauma Presentations. *(Trainees should aim for 2-3 per year)*			
CAP1 Abdominal Pain			
CAP6 Breathlessness			
CAP7 Chest Pain			
CAP18 Head Injury			
CAP30 Mental Health			
C3AP1a Major trauma - Chest injuries			
C3AP1b Major trauma - Abdominal trauma			
C3AP1c Major trauma – Spine			
C3AP1d Major trauma – Maxillofacial			
C3AP1e Major Trauma – Burns			

Assessments by a **consultant** in at least **5 of the 38 Acute Presentations** (see page 24) using **mini CEX, CBD or ACAT** *(see Section 6.2 of ACCS 2012 Curriculum for full details)* https://www.gmc-uk.org/-/media/documents/accs-curriculum---jan-2018_pdf-73072688.pdf			
In addition to this a further **10 Acute Presentations** covered by each of the following assessment modalities:			
• Teaching delivered			
• Audit			
• E-learning modules			
• Reflective practice			
• Additional WPBAs (including ACAT)			
Practical procedures as **DOPS** in **all** of the following:			
• Airway Maintenance			
• Primary Survey			
• Wound Care			
• Fracture/Joint manipulation			
• Any 1 other procedure from the list on page 27-29			
At the completion of CESR Training, and across the whole portfolio, assessments should have been completed for all 44 practical procedures (see page 25-27)			
At the completion of CESR Training, trainees should have evidence of ALL 25 common competences (see page 28)			
At the completion of CESR Training, the trainee should have completed at least 4 MSFs – aim for 1 per year			

ES name, signature & date

Trainee name, signature & date

End of Placement Review of Competence Progression

Acute Medicine

Assessments (Mini CEX or CBD) by a CONSULTANT in **2 of the following 6 Major Presentations –** not to be duplicated with those covered elsewhere in the curriculum: *(For full details see Section 6.1 of ACCS Curriculum 2010)* http://www.accsuk.org.uk/documents/accscurriculum2010.pdf		
	Yes	No
• CMP1 Anaphylaxis		
• CMP2 Cardio-respiratory arrest		
• CMP3 Major Trauma		
• CMP4 Septic patient		
• CMP5 Shocked patient		
• CMP6 Unconscious patient		
Formative assessments by a consultant in at least **10 of the 38 Acute Presentations** (see page 24) using **mini CEX, CBD or ACAT** *(see Section 6.2 of ACCS 2010 Curriculum for full details)* http://www.accsuk.org.uk/documents/accscurriculum2010.pdf		
8 -10 Acute Presentations covered by each of the following assessment modalities:		
• Teaching delivered		
• Audit		
• E-learning modules		
• Reflective practice		
• Additional WPBAs		
DOPs covering **5** of the following **practical procedures,** plus **up to 5** additional practical procedures from the list on page 25-27 – this should not be duplicated with procedures assessed elsewhere in the curriculum. *(See Section 7.0, ACCS Curriculum 2010 for full details)* http://www.accsuk.org.uk/documents/accscurriculum2010.pdf		
Pleural tap & aspiration		

Intercostal drain insertion (Seldinger)		
Ascitic tap		
Abdominal paracentesis		
DC cardioversion		
Knee aspiration		
Temporary pacing (external / wire)		
Lumbar puncture		

ES name, signature & date

Trainee name, signature & date

End of Placement Review of Competence Progression

Initial Anaesthetic Competencies

Formative assessment of **5** Anaesthetic-**CEX**		
	YES	NO
• IAC A01 Preoperative assessment of a patient who is scheduled for a routine operating list (non urgent or emergency)		
• IAC A02 Manage anaesthesia for a patient who is not intubated and is breathing spontaneously		
• IAC A03 Administer Anaesthesia for laparotomy		
• IAC A04 Rapid Sequence Induction		
• IAC A05 Recovery of a patient from Anaesthesia		
Formative assessment of **8** Specific Anaesthetic **CbDs**:		
• IAC C01 Patient identification, operation and side of surgery		
• IAC C02 Discuss how the need to minimise postoperative nausea and vomiting influenced the conduct of the anaesthetic.		
• IAC C03 Discuss airway assessment and how difficult intubation can be predicted.		
• IAC C04 Choice of muscle relaxants & induction agents		
• IAC C05 Post op analgesia		
• IAC C06 Post op oxygen therapy		
• IAC C07 Emergency surgery - problems		
Formative assessment of **6** further anaesthetic **DOPS**:		
• IAC Basic and advanced life support		
• IAC D01 Demonstrate function of anaesthetic machine		
• IAC D02 Transfer and positioning of patient on operating table		
• IAC D03 Demonstrate CPR on a manikin		

• IAC D04 Technique of scrubbing up, gown & gloves		
• IAC D05 Competencies for pain management including PCA		
• IAC D06 Demonstrate failed intubation drill on manikin		
PLUS – WBPAs to confirm the Basis of Anaesthetic Practice		
• A1 Pre-operative assessment - History taking • A1 Pre-operative assessment – Clinical examination • A1 Pre-operative assessment – Anaesthetic evaluation		
• A2 Pre-medication		
• A3 Induction of GA		
• A4 Intra-operative care		
• A5 Post-operative recovery		
• B Management of the airway including in children		
• Management of cardio-respiratory arrest		
• Infection Control		
And a minimum of one of the following modules – sedation, regional block, emergency surgery, transfers		

ES name, signature

Trainee name, signature and date

Note: Incomplete information will be regarded as the relevant outcome having <u>not</u> been achieved

The Royal College of Anaesthetists

Initial Assessment of Competence Certificate

This is to certify that: _____

GMC number ☐☐☐☐☐☐☐ College Reference Number ☐☐☐☐☐☐

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

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

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

Final signoff must be done by two Consultant Anaesthetists

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

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

Hospital or department date stamp

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

End of Placement Review of Competencies

Intensive Care Medicine

Trainees are advised to keep a logbook of their cases whilst working in ITU. A sample logbook as recognised by the RCoA can be found at:

http://www.logbook.org.uk/

Formative assessments in **2** of the following **Major Presentations** (not to be duplicated from elsewhere in the curriculum)		
	Yes	No
• CMP1 Anaphylaxis		
• CMP2 Cardio-respiratory arrest		
• CMP3 Major Trauma		
• CMP4 Septic patient (ideally assessed in ICM)		
• CMP5 Shocked patient		
• CMP6 Unconscious patient		
Formative assessment of **5 Acute Presentations** as per page 18		
Formative assessment of **13 Practical Procedures** as DOPS, (Or Mini-CEX or CBD if indicated) including:		
• ICM 1 Peripheral venous cannulation		
• ICM 2 Arterial cannulation		
• ICM 3 ABG sampling & interpretation		
• ICM 4 Central venous cannulation		
• ICM 5 Connection to ventilator		
• ICM 6 Safe use of drugs to facilitate mechanical ventilation		
• ICM 7 Monitoring respiratory function		
• ICM 8 Managing the patient fighting the ventilator		
• ICM 9 Safe use of vasoactive drugs and electrolytes		
• ICM 10 Fluid challenge in an acutely unwell patient (CBD)		

• ICM 11 Accidental displacement ETT / tracheostomy		
• Plus 2 other DOPS		

Paediatric Competencies

Trainee Name: _____

Summative assessment (**Mini-CEX** or CbD) of 3 of the 6 Major paediatric presentations (or successfully complete APLS/EPLS):	
PMP1 - anaphylaxis PMP2 - Apnoea, stridor and airway obstruction PMP3 - Cardiorespiratory arrest PMP4 - Major trauma PMP5 - Shocked child PMP6 - Unconscious child	Completed at least 3 of 6 **or** APLS/EPLS Yes / No
Summative assessment (Mini-CEX or CbD) in ALL of the following acute presentations in children:	
PAP1 - abdominal pain PAP5 - breathlessness PAP10 - Fever PAP17 - child in pain	Completed all 4 Yes / No
Formative assessment (ACAT-EM, Mini-CEX or CbD) in all of the following acute presentations:	
PAP6 - Concerning presentations in children PAP18 - Limb pain – non-traumatic PAP21 - Sore throat PAP2 - Poisoning PAP20 - Rash	Completed all 5 Yes / No
Remaining 10 acute presentations in children all sampled by successful completion of a combination of the following:	
e-learning teaching and audit assessments self-reflective entries onto ePortfolio	Completed all 10 Yes / No

ACAT-EMs	
Remaining Acute Conditions: PAP3 Acute life-threatening event (ALTE) PAP4 Blood disorders PAP7 Dehydration secondary to D&V PAP9 ENT PAP11 Floppy child PAP12 Gastro-intestinal bleeding PAP13 Headache PAP14 Neonatal presentations PAP16 Ophthalmology PAP19 Painful limbs- traumatic	
Formative assessment (DOPS) of all of the following 5 practical procedures:	
Venous access in children Airway assessment and maintenance Demonstration of the safe use of paediatric equipment and guidelines in the resuscitation room including the Resuscitaire. (Primary survey in an injured child *Safe sedation in children* – these 2 competencies may need to be undertaken during EM placement, rather than whilst on paeds secondment)	Completed all 5 Yes / No
Please detail any further WPAs (e.g. DOPS in addition to those specified above) – note NOT mandatory:	
Have at least 12 (in total) assessments been completed by a Consultant?	Yes / No

NB – as guidance trainees are expected to have seen 200 new cases (ward or CED) during the post.

Clinical Supervisor (Consultant Paediatrician)

Name: _____ Job Title: _____

GMC Number: _____

Email Address: _____

Signed: _____ Date:___/___/___

Educational Supervisor (Consultant in EM)

Name: _____ Job Title: _____

GMC Number: _____

Email Address: _____

Signed: _____ Date:___/___/___

CESR Trainee

Name: _____

Signed: _____ Date:___/___/___

Summary of Presentations, Procedures and Common Competencies

Major Adult Presentations

- Anaphylaxis
- Cardio-respiratory arrest
- Major trauma
- Septic patient
- Shocked patient
- Unconscious patient

Acute Adult Presentations:

Abdominal Pain including loin pain (EM, AM)

Abdominal Swelling, Mass & Constipation (EM, AM)

Acute Back Pain (EM)

Aggressive/disturbed behaviour (EM, AM)

Blackout/Collapse (EM, AM)

Breathlessness (EM, AM)

Chest Pain (EM, AM)

Confusion, Acute/Delirium (EM, AM)

Cough (EM, AM)

Cyanosis (EM, AM)

Diarrhoea (EM, AM)

Dizziness and Vertigo (EM, AM)

Falls (EM, AM)

Fever (EM, AM)

Fits / Seizure (EM, AM)

Hematemesis & Melaena (EM, AM)

Headache (EM, AM)

Head Injury (EM)

Jaundice (EM, AM)

Limb Pain & Swelling – Atraumatic (EM, AM)

Neck pain (EM)

Oliguria patient (EM, AM)

Pain Management (EM, AM)

Painful ear (EM)

Palpitations (EM, AM)

Pelvic pain (EM)

Poisoning (EM, AM)

Rash (EM, AM)

Red eye (EM)

Suicidal ideation (EM)

Sore throat (EM)

Syncope and pre-syncope (EM, AM)

Traumatic limb and joint injuries (EM)

Vaginal bleeding (EM)

Ventilatory Support (EM, ICM)

Vomiting and Nausea (EM, AM)

Weakness and Paralysis (EM, AM)

Wound assessment and management
(EM)

Practical Procedures - ADULT	AM	EM	ICM	Anaesthesia
1. Arterial cannulation				
2. Peripheral venous cannulation				
3. Central venous cannulation				
4. Arterial blood gas sampling				
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				
12. Basic and advanced life support				
13. DC Cardioversion				
14. Knee aspiration				
15. Temporary pacing (external/ wire)				
16. Reduction of dislocation/ fracture				
17. Large joint examination				
18. Wound management				
19. Trauma primary survey				
20. Initial assessment of the acutely unwell				
21. Secondary assessment of the acutely unwell				
22. Connection to a mechanical ventilator				
23. Safe use of drugs to facilitate mechanical ventilation				

24. Managing the patient fighting the ventilator				
25. Monitoring Respiratory function				
Initial Assessment of Competence (IAC) - as listed below from Preoperative assessment to Emergency surgery				
26. Preoperative assessment				
27. Management of spontaneously breathing patient				
28. Administer anaesthesia for laparotomy				
29. Demonstrate RSI				
30. Recover patient from anaesthesia				
31. Demonstrates function of anaesthetic machine				
32. Transfer of patient to operating table				
33. Technique of scrubbing up and donning gown and gloves				
34. Basic competences for pain management				
35. Patient Identification				
36. Post op N&V				
37. Airway assessment				
38. Choice of muscle relaxants and induction agents,				
39. Post op analgesia				
40. Post op oxygen therapy				
41. Emergency surgery				
42. Safe use of vasoactive drugs and electrolytes				
43. Delivers a fluid challenge safely to an acutely unwell patient				
44. Describes actions required for accidental displacement of tracheal tube or tracheostomy				

45. Demonstrate CPR resuscitation on a manikin				

Common Competences:

- History taking
- Clinical examination
- Therapeutics and safe prescribing
- Time management and decision making
- Decision making and clinical reasoning
- The patient as central focus of care
- Prioritisation of patient safety in clinical practice
- Team working and patient safety
- Principles of quality and safety improvement
- Infection control
- Managing long term conditions and promoting patient self care

Relationships with patients and communication within a consultation

- Breaking bad news
- Complaints and medical error
- Communication with colleagues and cooperation
- Health promotion and public health
- Principles of medical ethics and confidentiality
- Valid consent
- Legal framework for practice
- Ethical research
- Evidence and guidelines
- Audit
- Teaching and training
- Personal behaviour
- Management and NHS structure

Domain 2 – Safety and Quality

Audit

- Involvement in at least one audit per year over the four years
- Aim to fully complete at least one audit cycle

Show evidence of working to improve patient care and safety in at least 3 of the following:

- Audit
- Service Improvement Project
- Responding to appraisals
- Performance reviews
- Risk management
- Clinical governance procedures
- Submission of, or response to an IR1
- Risk meetings
- Mortality and morbidity meetings

Service Development

Examples may include:

- Introduction of new guidelines
- Develop new pathways
- Introduce new equipment

Clinical Governance

- Complaints: responses (anonymised)
- Serious Incidents: investigations including RCA’s and action plans

Health and Safety

- Trust Induction
- Annual updates

Domain 3 – Communication, Partnership and Teamwork

Communication with patients:

- Compliments
- Thank you's

Management/Team working

Examples may include:

- Evidence of chairing meeting
- Leading project groups
- Evidence of project management

Relations with Colleagues:

Examples may include:

- Letters of appreciation from colleagues
- Emails
- Other documentation of good relationships

Domain 4 – Maintaining Trust

This domain is designed to show evidence of acting with honesty and integrity

The majority of the evidence for this is obtained as below:

- Evidenced from structured references

- Conflict resolution or other relevant courses

Appendix A: Useful Links

There are useful links on various websites including the Royal College of Emergency Medicine and the GMC.

Most of the requirements should be contained clearly within the portfolio but the most useful links as an adjunct to this are the following:

- Royal College of Emergency Medicine website:
  - Training and Exams - Work Place Based Assessment
  - Training and Exams - Work Place Based Assessment – SAS Doctors
  - Training and Exams - Equivalence

- GMC website:
  - Type “CESR” into search words

Appendix B: Case Based Discussion (CBD)

The Case-based Discussion (CbD) is a structured interview designed to assess your professional judgement in clinical cases

The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of competence: the discussion should not shift into a test of knowledge.

The Consultant will aim to cover as many relevant competences as possible in the time available. It’s unrealistic to expect all competences to be covered in a single CbD, but if there are too few you won’t have sufficient evidence of progress.

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Royal College of Emergency Medicine

Summative Case Based Discussion CbD

Trainee name:			
Assessor:		GMC assessor No:	
Grade of assessor:		Date	/ /
Case discussed (brief description)	Presentation – please see curriculum for number		

	Expected behaviours	Successful	Unsuccessful	Not observed
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			
Overall	Successful Unsuccessful If more than two “not observed” then unsuccessful			

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

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Royal College of Emergency Medicine

Formative Case Based Discussion CbD

Trainee name:			
Assessor:		GMC assessor No:	
Grade of assessor:		Date	/ /
Case discussed (brief description)	Presentation – please see curriculum for number		

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:

Appendix C: Directly Observed Procedural Skills (DOPS)

A DOPS is a structured checklist for assessing both the patient interaction and the ability of the doctor to perform the procedure in question

The process is led by the trainee

Each DOPS should represent a different procedure unless the trainee feels they need additional training/support with a particular area

The DOPS should be matched to the practical procedures required by the Royal College of Emergency Medicine (see Appendix E)

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

Trainee name:			
Assessor:		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:

Appendix D: Mini-Clinical Evaluation Exercise (Mini-CEX)

A Mini-CEX is a structured assessment of an observed clinical encounter

It is a “snapshot” designed to provide feedback on skills essential to the provision of good patient care

The process is led by the trainee who usually chooses the clinical encounter which should be representative of their workload

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Royal College of Emergency Medicine

Summative Mini-Clinical Evaluation Exercise - Mini-CEX

Trainee name:			
Assessor:		Assessor GMC no.	
Grade of assessor:		Date	/ /
Case discussed (brief description)	Presentation – please see curriculum for number		

	Descriptors of poor performance	Successful	unsuccessful
Initial approach			
History and information gathering	• History taking was not focused • Did not recognise the critical symptoms, symptom patterns • Failed to gather all the important information from the patient, missing important points • Did not engage with the patient • Was unable to elicit the history in difficult circumstances- busy, noisy, multiple demands		
Examination	• Failed to detect /elicit and interpret important physical signs • Did not maintain dignity and privacy		
Investigation	• Was not discriminatory in the use of diagnostic tests		
Clinical decision making and judgment	• Did not identify the most likely diagnosis in a given situation • 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		
Communication with patient, relatives, staff	• 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 • Did not respect confidentiality • Did not protect the patient's dignity • Insensitive to patient's opinions/hopes/fears • Did not explain plan and risks in a way the patient could understand		
Overall plan	• Was slow to progress the case		
Professionalism	• 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		
Overall	• Successful • Unsuccessful (this outcome if any one criteria unsuccessful		

Things done particularly well
Learning points
Action points

Assessor Signature:	**Trainee** Signature:

Appendix E: Multi-Source Feedback (MSF)

The Multi-Source Feedback (MSF) tool is used to collect colleagues' opinions on your clinical performance and professional behaviour.

It provides data for reflection on your performance and self-evaluation.

Conducting the MSF

Provide respondents a letter explaining the MSF process and giving the closing date (assistance is usually obtained through the revalidation/workforce team – ask your mentor for advice). Make sure your Consultant supervisor knows which colleagues you've asked to take part.

Using a variety of respondents

It's good practice to get opinions from as many different colleagues as possible.

Using MSF feedback

Your Consultant supervisor will have access to the anonymised results once the MSF closes.

You'll then have a feedback interview (usually timed with an appraisal) and an opportunity to reflect on the results.

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

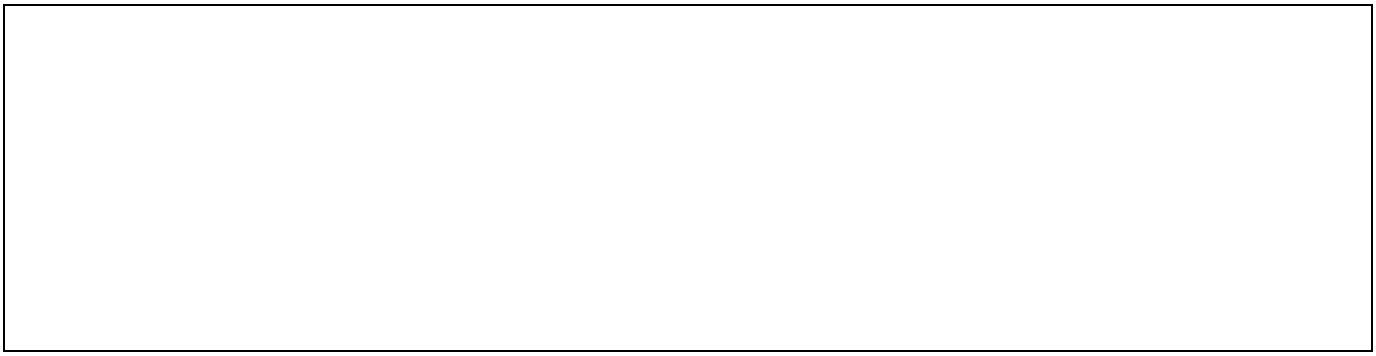
This form is completely anonymous.

Trainee name:					
Grade of assessor:		Date			/ /
UNKNOWN	1	2	3	4	5
Not Observed	Performance **Does Not Meet** Expectations	Performance **Partially Meets** Expectations	Performance Meets Expectations	Performance **Exceeds** Expectations	Performance **Consistently Exceeds** Expectations

	Good Clinical Care	1-5 or UK	Comments
1	Medical knowledge and clinical skills		
2	Problem-solving skills		
3	Note-keeping – clarity; legibility and completeness		
4	Emergency Care skills		
Comments on this doctor's clinical care			
	Relationships with Patients	1-5 or UK	
1	Empathy and sensitivity		

2	Communicates well with all patient groups		
3	Treats patients and relatives with respect		
4	Appreciates the pyscho-social aspects of patient care		
5	Offers explanations		
Comments on this doctor's relationships with patients			
Relationships with Colleagues		1-5 or UK	
1	Is a team-player		
2	Asks for others' point of view and advice		
3	Encourages discussion Empathy and sensitivity		
4	Is clear and precise with instructions		
5	Treats colleagues with respect		
6	Communicates well (incl. non-vernal communication)		
7	Is reliable		
8	Can lead a team well		
9	Takes responsibility		
10	"I like working with this doctor"		
Comments on this doctor's relationships with colleagues			

	Teaching and Training	1-5 or UK	
1	Teaching is structured		
2	Is enthusiastic about teaching		
3	This doctor's teaching sessions are beneficial		
4	Teaching is presented well		
5	Uses varied teaching skills		
Comments on this doctors teaching and training skills			
	Global ratings and concerns	1-5 or UK	
1	Overall how do you rate this Dr compared to other ST1 Drs		
2	How would you rate this trainees performance at **this stage** of training		
3	Do you have any concerns over this Drs probity or health?		
General comments			



Appendix F: Practical Procedures

The Royal College of Emergency Medicine provides an extensive list of required procedures – these are summarised and tabulated earlier in the portfolio.

These should be linked to the evidence provided in the form of Directly Observed Procedural Skills (DOPS)

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Appendix G: CEM Teaching Observation Tool

Providing evidence of the type and quality of teaching (including feedback) is a significant part of the CESR process

Feedback should be sought, wherever possible, from all teaching provided and this evidence retained in your portfolio

Overleaf is a Teaching Observation Tool provided by the Royal College of Emergency Medicine which should be used as the basis for obtaining feedback

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Royal College of Emergency Medicine

Teaching observation tool

Trainee name:			
Assessor:		Assessor GMC no.	
Grade of assessor:	Consultant, SASG, ST4-6	Date	/ /
Learner group		Setting	
Number of learners		Less than 5, 5-15, 16-30, more than 30	
Length of session			
Title of session			
Brief description of session			

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	
Introduction of self					
Gained attention of group					
Gave learning expected learning outcomes					
Key points emphasised					
Good knowledge of subject					
Logical sequence					
Well-paced					
Clear concise delivery					
Good use of tone/voice					

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Resources supported the topic					
Varied the activity					
Involved the group – participation ,					
Effective use of questioning					
Appropriate use of teaching methods					
Appropriate use of assessment techniques					
Used mini-summaries					
Encouraged questions from group					
Dealt with questions appropriately					
Summarised key points at end					
Met learning outcomes					
Kept to time limit					
Overall performance					
Things done particularly well					
Learning points					

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Appendix H: CEM Audit Assessment Tool

Evidence of participation in audit is a required component of the CESR process

Below is an Audit Assessment Tool provided by the Royal College of Emergency Medicine. This should act as the basis from which evidence of participation in audit is recorded in your portfolio.

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Royal College of Emergency Medicine

Audit assessment tool

Trainee name:			
Assessor:		Assessor GMC no.	
Grade of assessor:	Look up table – Consultant, SASG, ST4-6	Date	/ /
Basis of assessment	LUT – presentation, report, both		
Title of audit with brief description			
CEM Audit?	Yes/no		

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	
Audit topic					
Standard chosen					
Audit methodology					
Results and interpretation					
Conclusions					
Recommendations made as a result					
Plan for implementation of change					
Actions undertaken to implement change					
Overall performance					

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Things done particularly well
Learning points

Descriptors

Rating	Description	
Below expected standard	Significant guidance required throughout audit process, inappropriate topic or poor methodology resulting in inappropriate conclusions of limited practical use. Inadequate consideration of future direction of audit. No consideration of how to implement change	
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 and clear achievable plans outlined to implement change	
Exemplary standard of clinical audit	Audit topic related to an important clinical topic, detailed and exhaustive methodology applied, resulting in conclusions with significant clinical importance. Plans for future direction of audit highlighted and evidence of action taken to implement change.	