Assessment appendix to aid ARCP.

As last year colour coded to ease monitoring of progression

Green = supported with assessments
Orange = supported with assessments but not summative/cbd level when this is required
Yellow = supported with learning modules/reading/regional teaching/reflection
Red = No evidence
Grey = Not required

CONTENTS

PART A

Common competencies
History taking – all mini cex and cbd's used as evidence for level 2+ competency.
Clinical examination as sbove.
Therapeutics and safe prescribing 2 reflections on drug error I made, and 1 on a literature search and help contributing to new prescribing guidance on ondansetron
Time management and decision-making Mostly MSF's and mini-cex in time critical or urgent cases used as evidence here. ACAT's also used as evidence for being able to prioritise and multitask. Reflections on shop floor management and non-technical skills learned from regs.
Decision making and clinical reasoning Most assessments here have a clinical reasoning domain. 2 reflections on my own throught process during arrests. MSFs
The patient as a central focus of care MSFs
Prioritisation of patient safety in clinical practice Reflections on capacity, arrests, prescribing errors.
Team working and patient safety Minicex's for trauma team leading ACATS MSFS
Principles of quality and safety improvement Audit abstracts Work on prescribing changes
Infection control DOPS for invasive procedures
Managing long term conditions and promoting patient self-care CBD – injury with complex social issues
Relationships with patients and communication within a consultation CBDs – "difficult communication case" ACATs MSFs
Breaking bad news Reflections
Complaints and medical error Major incident reflection Prescribing error reflection
Communication with colleagues and cooperation MiniCEX ACATs MSF Reflections on ROSC, shop floor management, major incident management
Health promotion and public health Difficult to show evidence for this
Principles of medical ethics and confidentiality

Have had interactions with caldicott guardian in old job
Valid consent DOPS for invasvice procedures and fracture reduction/joint reductions – valid consent
Legal framework for practice Have reported cases to coroner, have written police reports – meets criteria for level 3 competency
Ethical Research Literature review on ondansetron ASME abstract CDR paper
Evidence and guidelines Literature review on ondansetron Work for enlightenme on feverish illness in childhood
Audit Asthma audit NOF audit Fever audit
Teaching and training ALS instructor
Personal behaviour MSFS
Management and NHS structure Major incident reflections

CT3 Major Presentations C3AP1a-e
C3AP1a Chest injury Paediatric chest contusion –mini CEX DOPS for Trauma Chest Drain – 18/1/2013 ACAT 28/3/13 Summative assessment awaited from Dr P Morgan
C3AP1b Abdominal trauma CBD 21/5/2013
C3AP1c Major trauma- Spine ACAT 20/3/2013 ACAT30/04/2013 Summative assessment awaited from Dr A Webster
C3AP1d Major trauma- Maxillo-facial CBD 21/5/2013
C3AP1e Major trauma- Burns CEX 23/1/13 Paeds Burn

All CT3 MPSs should be completed using a summative mini-CEX or CBD with a consultant or associate specialist.

CT3 additional Acute Presentations C3AP2-9	
C3AP2a Trauma- lower limbs	ACAT 28/3/13
C3AP2b Trauma Upper limbs	ACAT 28/3/13 CBD 4/3/13
C3AP3 Abnormal ABG	ACAT 30/04/2013
C3AP4 Abnormal blood glucose	ACAT 30/04/2013
C3AP5 Dysuria Teaching 22/5/13	
C3AP6 Emergency Airway management DOPS 11/4/13	
C3AP7 Needlestick injury Teaching 22/5/13	
C3AP8 Testicular pain Teaching 22/5/13	
C3AP9 Urinary retention Teaching 22/5/13	

CT3 trainees should have completed 4/9 acute presentations using ACAT-EM/ Mini-Cex/CBD
Remaining 5/9 can be sampled using ACAT EM, reflective entries, e-modules, teaching and audit

CT3 PMP [APLS completed 2010]
PMP1 Anaphylaxis Mini Cex 17/9/2012
PMP2 Apnoea, Stridor, Airway obstruction Mini-CEX – Asthma 28/08/2012 MiniCEX 13/4/13
PMP3 Cardiorespiratory arrest Helped at 3 cardiorespiratory arrest pre-alerts. "Found" and escalated 2 respiratory arrests Mini-CEX – Neonatal emergency 13/4/2013
PMP4 Major Trauma – Children Completed DOPS and miniiCEX for 6yo in RTA hit and run with lung contusion. MiniCEX for Paeds BURNS 23/1/13
PMP5 Shocked Child Formative Mini-Cex 24/1/2013
PMP 6 Unconscious child CBD for febrile convulsion/status 9/10/2012 and 23/10/12

CT3 PAP
PAP1 Abdominal pain CBD 5/2/13
PAP2 Accidental poisoning, poisoning and self-harm+ *Min-CEX28/02/13* *Regional Teaching 19/12/12*
PAP3 Acute life-threatening event (ALTE) **Mini-CEX – Neonatal emergency 13/4/2013**
PAP4 Blood disorders Regional Teaching CBD – Presentations of leukaemia. 23/08/2012
PAP5 Breathing difficulties - recognise the critically ill and those who will need intubation and ventilation* **Regional Teaching 10/10/12** **Mini-CEX – Asthma 28/08/2012** **Mini-CEX – Neonatal emergency 13/4/2013**
PAP6 Concerning presentations + *CBD formative – 9/10/12* *Regional teaching 3/10/12 and 19/12/12*
PAP7 Dehydration secondary to diarrhoea and vomiting Mini CEx 24/1/2013
PAP8 Dental problems

No longer seems to exist
PAP9 ENT Regional Teaching 16/1/12
PAP10 Fever in all age groups* **Febrile convulsion CBD 16/10/12** **CBD 23/10/12** **CBD 9/10/12** **Regional Teaching 3/10/12**
PAP11 Floppy child CBD 9/10/12 Regional Teaching 3/10/12
PAP12 Gastro-intestinal bleeding GI.docx
PAP13 Headache Regional Teaching 16/1/13
PAP14 Neonatal presentations CEX – 16/04/2013
PAP15 O&G Own learning – Paediatric gynecology.docx
PAP16 Ophthalmology Regional Teaching 16/1/13
PAP17 Pain in children* - CEX 30/12/12
PAP18 Painful limbs – atraumatic+ *Minicex 24/1/13 and 11/1/13 [these are both formative]* *Regional Teaching 16/1/13*
PAP19 Painful limbs- traumatic CEX – 22/4/13
PAP20 Rashes in children+ *Regional Teaching 3/10/12* *Summative CBD 28/2/13*
PAP21 Sore throat+ *CBD 16/10/12*

***these APs need to be undertaken as summative assessments with a consultant or associate specialist**

+ these need to be undertaken as a formative CBD/mini-cex or ACAT.

Remaining 12 should be sampled using ACAT EM, reflective entries, e-modules, teaching

PEM CT3 Practical procedures
1.Venous access in children DOPS 25/9/2012
2. Airway assessment and maintenance, Aseessment 19/9/12, MiniCex 23/1/13, and CBD 23/1/12 CEX and DOPS 15/4/2013
3. Safe sedation in children, *NO LONGER PART OF CURRICULUM (informed at CT3 PEM Symposium had been moved to ST4-6) by CEM PEM lead.*
4. Paediatric equipment and Guidelines in the resuscitation room. *DOPS 11/1/13 and 12/12/12*
5. Primary survey in a child

DOPS. 9/8/12 20/8/12 23/8/12

5/5 should be assessed using DOPS

Trainees are also expected to demonstrate evidence of the following:

- MCEM B&C – COMPLETED 2012
- 1 X MSF per year minimum, preferably 1 per placement - COMPLETED
- Completed all three life support courses APLS(EPLS)/ ALS/ATLS - COMPLETED
- Minimum number of consultant assessments = 12 – COMPLETED [have 25 as of 4/2/12]
- Clinical governance activity: - Minimum of 1 X Audit per year
    - COMPLETE – NICE FEVER CEM AUDIT
    - Attended Clinical Governmence meeting 25/10/12 – Gave presentation
- Level 1&2 child protection – certificate on e-portfolio – COMPLETED – See Screen Grab called child protection evidence 2013.
- 30 e-learning modules from CEM Hub- certificates uploaded to e-portfolio - COMPLETED
- Should see > 750 children/yr - COMPLETED please see count.xlsx in personal library my number is 3520
- 20 paeds resuscitations – COMPLETED (see LOG)#

- Receipt of completing the deanery end of placement questionnaire (one for each placement) http://www.yorksandhumberdeanery.nhs.uk/placement_feedback/
    - Uploaded to e-portfolio. – currently unavailable 6/5/13
- Receipt of completing the GMC/PMETB survey if open before ARCP date.
    - **COMPLETETION CODE 1-29W8-3100**

PART B

Paeds Resus Log (Children who I have assessed/helped assess in Resus bay). Not exhaustive.				
No.	Age and Sex Date	Injuries/Illness	Actions	Outcome
1	12 yo M Day shift/	Isolated head injury from 2m onto face.	Primary and secondary survey. Cleared C-spine and arranged CT head	Overnight observation
2	12 yo F Late shift	SVT	Gave adenosine	Overnight observation
3	7 yo M Late shift	RTC, hit and run, unwitnessed.	Primary and secondary survey. Failed line. CT showed pelvic free fluid, no injury, and lung contusion	Admitted for further observation
4	8/52 M Late shift	Unwell. Mother had GBS Respiratory arrest, sepsis, and fits	Held airway. Called for help. Arranged CT head. Helped with ventilation.	Admitted to PICU
5	24 day M Day shift	Unwell. Increased RR, and WOB. Diagnosis: Bronchiolitis.	Identified unwell child. Saline nebs. Alerted Paeds team. Identified high risk baby (prem, lung and heart dx).	Admitted to HDU ward
6	11month M Night shift	Meningococcal Septicaemia and arrest	Acted as team member.	Unsuccessful
7	2 y o M Night shift	Increased SOB, probably pneumonia	Cannulated, gave IV ABx, anti-pyretics.	Went to CAT
8	15 y o M	Trauma. Unrestrained FSP	Did primary survey. Liased	Went to ward. Learning point = JUST CALL

	Day Shift	MVC. Bullseye injury	with speicialities. Had trauma CT	TRAUMA TEAM
9	2 yo F Day Shift	Febrile convlusion +/- hypoglycaemia	Cannualted. Liased with paeds. Sent hypoglycaemia screen	Admitted to CAT
10	2 yo M Night Shift	Croup. With Resp distress.	Cannulated. Gave Dex, gave adrenaline neb.	Admitted to ward.
11	6 yo M Night Shift	Moderate Asthma	Cannulated. Gave B2B Nebs, Steroid etc	Admitted to ward.
12	3 yo M Day Shift	Febrile convlusion -> Status	Held airway. Moved down algoryhthm	PICU – TUBE – CT head - Ward
13	O M Night	Neonatal pre-alert.	Did CPR, helped with airway.	Unsuccessful
14	4 y o F Day	Trauma Pneumothorax, pulmonary contusion ?brachial plexus inj, liver lac	Ran Trauma. Arranged scan. Took to scan. Gave 2 fluid bolus,when became unstable.	Ward for observation.
15	1 yo M Day	Fever. BM1.0 D+V, poor feeding	Access via IO, too shut down.	Ward
16	2 y o F Day	Chest sepsis Fever	Access, Iv ABX, Bloods, fluids	Ward
17	10 mth F Mid	Meningococcal Sepsis	Acces, Iv ABX, Fluid bolus,	Ward
18	22mth F Mid	Chest Sepsis	IV Acces, IV ABx, Diagnosis	Ward
19	7 yo F Mid	30% Burns to chest, arms and legs	IV Access, IV fluid, Pain refief, Refferal and	Manchester Burns Unit

			transfer	
20	13 y o M	Abdominal pain following assault by fellow pupil. Perforation	IV access, analgesia, IV fluids, CT Abdo	Urgent lapartomy
21	13 y o M	Trauma 13 yo struck by car 30mph Pubic Rami #	Led Trauma Team	Ward
22	5 yo M	Fractured femur	Cannulated Did FNB Thomas Splint	Ortho Ward
23	4/12 M	OOA	Got IO access Gave adrenaline Gave boluses ROSC	PICU
24	4/12 M	OOA:	Failed IO access Gave adrenaline and boluses Decision to stop	Pinderfields/Manchester for PM
25	0 YO M	Apnoes. Poor respiratory effort. Bradycardias	Discovered patient, moved to Resus, enlisted help. Held airway, bagged.	PICU
26	5/12 Y O M	Anaphylaxis	Made diagnosis Gave IM adrenaline	Child went to ward
27	8 yo M	Abdominal/Groin wound	Managed wound appropraitley. ATLS approach.	Child went to theatre.
28	11 y F	Chest Sepsis complicated case – sickle cell, CP,	Iv Access using USS, bloods, initial resus and	HDU

		seizure disorder, HIV+VE	Rc	

Procedural Sedation Log (only recorded if I am the "seditionist")				
	Age and Sex Date	Injuries/Illness	Actions	Outcome
1	52 yo M Late shift/	Volar angulated distal radius #	Propofol 1% sedation. Gave 160mg over 10 mins.	Nice reduction.
2	36 y o F Late shift	Dorsal angulated distal radius	Propofol 1% sedation. With 100mcg Fentanyl Gave 120mg over 10 mins.	Good reduction
3	39 y o M	Distal tibial shaft #	Propofol 1% with Fentanyl	Cast applied, no worse, no better.
4	22 y o M	Ant Shoulder disloc	Propofol 1% Morphine prior	Polysling F/U with shoulder surgeon
5	54 y o M Mid	Distal radius #	Fentanyl and Propofol	# clinic
6	26 y o M Mid shift	Weber C #	Propofol	Admitted
7	24 y o FMid Shift	Weber C #	Propofol	Admitted

Adult Resus Log (Adults I have seen in RESUS – also not exhaustive)				
	Age and Sex	Injuries/Illness	Actions	Outcome
1	28 M Day	RTC Left pneumothorax Left liver lac, left	Trauma drain! RSI CT head chest	Went to ICU for further Rx and to be woken up.

		renal lac, left sided pelvic brim #	pelvis	
2	84 F	FOF 16 hour lie ?Fell down stairs ➔ Problems from long lie and problems causing fall.	Access Bloods – renal Fx, Fluids CT Head Xrays	CofE' ?GI Bleed
3	57 M Mid	New onset Fast AF	Access Bloods Beta blockade	Cardiology
4	90 M Mid	Right CVA	CT Scan Access Diagnosis	Admission to stroke unit
5	83 F Mid	ARF	Arranged Dialysis Art line	Arranged transfer
6	48 F Mid	Left Anterior Shoulder dislocation	Relocated Spazzo and modified Kocher	Fracture clinic
7	24 M	Trauma Traumatic amputation of 2nd and 3rd digits. 2nd 2nd and 3rd MT #	Led Trauma team Liased with plastics	Theatre
8	49 M	Post-arrest Anterior lead changes	Led arrest team	Primary PCI
9	52 M	Left evolving CVA	Diagnosis	Angiography for thrombectomy
10	22 M	Trauma. RTC. Passenger Died on arrival.	Led trauma team. No injuries	CDU for observation.

11	21F	Right sided pneumothorax.	Sited drain	Referred to Resp
12	48M	Angle grinder wound to face.	Tacked closed. Sent to Max fax	Theatre
13	54F	Fall Distal Radius #	Reduced Haematoma block	# clinic
14	46F	Fall Left Trimalleolar # dislocation	Reduced/	Admitted to ortho ward for fixation
15	26 M	Trauma Jump from 2 story window #disloc right ankle	Ketamine for sedation. Trauma Scan.	Orthopedics
16	Day shift 30M	Trauma 30m fall. Open # disloc left ankle (including talus) Disloc right ankle Right pneumothorax 3 liver lac #pelvis	Team member Trauma chest Drain Applied pelvic binder	Radiology for embolisation then theatre then ICU. *NB – need to improve communication skills with consultants from other specialities*
17	Day shift 65M	Respiratory Arrest Tubed by paramedics PEA then ROSC	Switched to ventilator. Gained IV access, art access. Got anaesthetic help. Started propofol	CT PA then ICU for cooling.
18	Day shift 28M	Open # disloc radius and ulnar left arm.	Arranged urgent review gave ABX, tetanus.	Transferred to ward for surgery later that day.

19	Day shift 60M	VF OOA: ROSC Evolving lateral ischaemia	Packaged for PCI	PCI
20	Day shift 48M	Cyclist Vs Car. 15mph through windscreen of car.	Trauma scan.	CDU for observation. Had # ribs.
21	Day shift 22M	Rugby player #disloc ankle: obvious	Reduced under procedural sedation prior to Xray	Ortho Ward
22	Day shift 85M	Distal radius # left arm non-dominant.	Improved dorsal angulation.	# clinic.
23	Mid-shift 54M	Anterior shoulder disloc	Reduced with consultants help	# clinic
24	Mid shift 43 M	Maisoneuf #	Reduced	Ortho ward
25	Mid Shift 89 F	SVT – pacemaker problem, chest pain		Cardiology
26	Mid shift 16 F	Acetone poisoning	Initial management ABGs, fluid, HDU and referral	HDU
27	Mid Shift 56 M	VF Arrest 1 shock ROSC	Identified anteriolateral ischaemia	Cath lab
28	Mid Shift 26 M	Mid shaft tibial #	Reduced	Ortho ward
29	Mid shift 22M	Ant Shouder disloc	Procedural sedation	Ortho f/u
30	Mid Shift 20 yo M	Reaccumulated spontaneous pneumothorax	Seldinger Chest Drain	Respiratory
31	Day Shift 22y o F	RTC – unrestrained passenger with open TIB fib/Pelvic #, and lung contusion	Led Trauma Team [Major incident]	Theatre Trauma ward

32	Mid shift 64 y o M	VT with ID, arranged cardiology and anaesthesia input	Led team. Arranged definitive management.	CCU
33	mid shift 88 yo F	Sepsis with AF and acute LVF	Fluid management	CCU
34	mid shift 15 yo M	Anterior shoulder disloc (right)	Reduced under entonox.	# clinic
35	mid shift 26 y o M	Weber C #	Reduced medial shift. Ortho not happy, so did sedation for their attempt (no better than mine!)	Ortho ward

PART C

Level	**CT1**	**CT2**	**CT3**
Job 1	**14**	**34**	**31**
Job 2	**24**	**15**	**6**
Total	**38**	**49**	**37**
			124