Patient contacts and how best to use every contact

To successfully credential as an RCEM ACP, the trainee ACP (tACP) needs to see at least 2100 patients across the training period, with at least 20% of these being resus cases for an adult credential and 10% for a children's credential. This can seem like a daunting prospect, especially when you have recently started as a tACP. It may be more helpful to think of this as an average of just 5 patient contacts per shift over the minimum training period of 3 years. Your patient contacts will also likely increase as you progress and become more proficient.

It is important, therefore, that you are gathering patient contact data from the start of your training, both to contribute to the total for credentialing but also to help you understand how you are developing your ability to multi-task and make decisions which are reflected in your numbers. Most departmental IT systems will do this automatically, but the data output is unlikely to be in the format that is required for your credentialing submission. The data should be summarised into a table (a template is available on the RCEM website):

Patient logbook summary table (adults)

Patient logbook summary (adults)		Training year		Period covered	
Name		Registration no.		Hospital site	

Month / year	Patient total	Resus / high acuity	Majors	Ambulatory / minors	Admitted	Discharged	Referred
Totals							

Patient logbook summary table (children)

Patient logbook summary (children)		Training year		Period covered	
Name		Registration no.		Hospital site	

Month / year	Patient total	Age category			Resus / high acuity	Majors	Ambulatory / minors	Admitted	Discharged	Referred
		0 – 1	1 – 5	5+						
Totals										

We would recommend that you do not leave the creation of this table until the end of training; instead monitor your numbers regularly and discuss them with your supervisor. This will help point you to how you might become more efficient or use your time in a different way, as well as showing you how you are progressing. It will also help ensure you are seeing patients across the full breadth of emergency medicine.

The reason that RCEM is looking for sufficient patient contacts lies in the concept of experiential learning. Medicine is not a pure science, and you are unlikely to ever see every single condition in every single context. Rather you need to have encountered a wide range of different presentations, applying principles to each of them but starting to understand how patients differ in their response to pathology and display different signs and symptoms. Only by seeing a lot of patients with chest pain (some of whom will have life threatening conditions some will have low acuity, low importance problems, and some may have no clinical diagnosis) can you quickly and reliably identify those who need immediate or urgent treatment. The minimum number is a ***minimum*** number – many ACPs will see many more patients than this and the more patient contacts you have, the more confident and competent you will become. However, what is really important is to ensure that every patient contact is fully utilised, both for your own development (what can I learn from this patient?) and for the portfolio.

The ACP Credentialing Panel, whilst wanting to know you have reached the required entrustment level, will also want to see evidence of your journey as a developing EM clinician. This can be demonstrated by a sequence of WPBAs which start as formative with lots of action points and end in a final summative assessment by a consultant at the relevant entrustment level. These WPBAs can remain in your portfolio but you should be aware that the limit on the number of items that may be linked to a KC is 7 so, at submission, you will need to select those which are most useful to illustrate the journey.

The other way to "use" patient contacts might be to focus on the clinical presentation and to seek out some e-learning or, in some cases, a particular course. Or you might decide that the patient is so unusual you want to complete a case report, such as a procedural log or reflective practice log. Alternatively, you might decide to teach others - nurses, medical students, peer ACPs - on the topic, and specifically on what you learnt about how you diagnosed and managed the patient. A patient and their pathway might also be a prompt for a QI project to improve that pathway. Remember also that patient feedback is important and so whilst we don't recommend '*targeting'* individual patients, you should remember to periodically and systematically ask your patients for feedback – perhaps all patients in a week every year for example.

Practically you might want to simply keep a list of (or access on the IT system) the patients you saw in a shift and, before you completely switch off, make one or two reflective notes, send a ticket for a WPBA, or find and listen/bookmark a relevant podcast or learning.

Some shifts you won't have any direct supervision and it can seem impossible to think of the learning or make it count in these circumstances. Below are some examples to highlight this.

Example 1: How to choose the most appropriate WPBA in ED where there is direct supervision.

You are asked to see a middle-aged male patient with chest pain by the consultant in charge of majors. The department is running well, and they offer to come and supervise you seeing this patient. This is the optimum result as you can get a consultant MiniCEX. If they can't directly

supervise you, but you present the case to them after your assessment, then you can ask to record that conversation as a CBD, and you could also write a reflection on the patient, focusing either on the clinical component or perhaps a non-clinical component such as your situational awareness. You may also undertake some e-learning related to this case and, from that one patient, you have four pieces of evidence.

Example 2: How to get the most of a patient contact where you have not been observed for a WBPA

You see a patient and present them to a senior and, as part of that, you have some learning points - there is a scoring system to aid with discharge in this group that you weren't aware of before and you were certain the patient was going home. It is very easy to think there is nothing to be gained from that experience in terms of your portfolio, but you will be heading off to read that paper.

As you are taking notes from reading the paper, why not input this into a self-directed learning reflection form and link it to the curriculum and/or clinical syllabus. If you follow up your conversation with the senior with a CBD, you can include your notes as evidence that you have gone away and done the learning and reflection.

Example 3: What patient contacts outside of the ED are useful and how can I use them?

i. *You are spending the day in ICU shadowing an ACCP on the ICU ward round. You assist in an arterial line and then do one yourself, observed by the ACCP. Be sure to ask for a DOPS that you can link to the arterial line procedure. For added evidence here you might reflect on the differences in doing this skill in the controlled ICU environment over ED.*

   ***Please note that this WPBA cannot be included as the mandatory evidence for this procedure** as this requires a consultant summative DOPS. However, the additional evidence and experience will only make it more likely that you can get an assessment of this skill in the ED, as when they ask who can undertake the skill you can completely do this.*

ii. *You are in a cardioversion clinic with an arrhythmia specialist nurse during DC cardioversions of patient in AF. You can get a DOPS for this procedure which will be useful for your credentialing submission providing the specialist nurse is themselves trained in this procedure.*

In summary, every patient, every meeting, every encounter in your working life in ED will likely have some educational benefit and can be used for some production of evidence.