Assessment Descriptors for Emergency Care Advanced Clinical Practitioners Supplement to the EC-ACP curriculum June 2018

Mini-CEX Descriptors

This table of satisfactory and unsatisfactory indicators is provided to support feedback and development. It can be contextualized for most presentations and not all descriptors are expected to be demonstrated for every presentation.

Dimension	Descriptor of satisfactory performance	Descriptor of unsatisfactory performance
History taking	 Engages with the patient Clear and focused history taking Recognises the critical symptoms/symptom patterns Obtained all the important information from the patient, not missing important points Elicits the history in difficult circumstances, copes with the challenge of noise, distractions, high workload 	 History taking was not focused Did not recognise the critical symptoms, symptom patterns Failed to gather all the important information from the patient, missing important points Did not engage with the patient Was unable to elicit the history in difficult circumstances-busy, noisy, multiple demands
Physical examination	 Detects /elicits and interprets important physical signs. Maintains dignity and privacy 	 Failed to detect /elicit and interpret important physical signs Did not maintain dignity and privacy
Communication	 Communication skills with colleagues Listens to other views Involves the whole team in discussions Respected the lead of others when appropriate Considerate and polite to colleagues Able to give clear and timely instructions Clear referral discussion-whether for opinion, advice, or admission Communication with patients Responsive to the concerns of the patient, their understanding of their illness and what they expect Sensitive and responsive to patients unarticulated fears Ensured carers/patients informed and given adequate information and education Encourages patient involvement/ partnership in decision making 	 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

Dimension	Descriptor of satisfactory performance	Descriptor of unsatisfactory performance
Clinical judgment- clinical decision making	 Identifies the most likely diagnosis in a given situation Appropriately judicial in the use of diagnostic tests Able to construct a comprehensive and likely differential diagnosis Able to correctly identify those who need admission and those who can be safely discharged. Recognised atypical presentation Able to recognise the urgency of the case Able to select the most effective treatments Made decisions in a timely fashion Decisions reflected clear understanding of underlying principles Reassessed the patient Anticipated interventions and responded with alacrity Reviewed the effect of interventions and took appropriate action 	 Did not identify the most likely diagnosis in a given situation Was not discriminatory in the use of diagnostic tests Did not construct a comprehensive and likely differential diagnosis Did not correctly identify those who need admission and those who can be safely discharged. Did not recognise atypical presentation Did not recognise the urgency of the case Did not select the most effective treatments Did not make decisions in a timely fashion Decisions did not reflect clear understanding of underlying principles Did not reassess the patient Did not review effect of interventions
Professionalism	 Respected confidentiality Protect the patients dignity Sensitive and respectful of patients opinions/hopes/fears Explained plan and risks in a way the patient could understand 	 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	Demonstrated efficiency in progressing the case	 Was slow to progress the case
Overall care	 Ensure patient was in a safe monitored environment Anticipated or recognised complications Focused sufficiently on safe practice Was aware of and followed published standards guidelines or protocols Follow infection control measures Safe Prescription and provision of therapeutics 	 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/provide therapeutics

Mini-CEX Summative Descriptors for Major Presentations

1 Anaphylaxis	
	Expected behaviours
Initial approach	 ABCD approach, including GCS Asks for vital signs including SPaO2, blood sugar Requests monitoring Recognises physiological abnormalities Looks for obvious cause of shock (e.g. bleeding) Secures iv access
History	 Obtains targeted history from patient Obtains collateral history form friends, family, paramedics- cover PMH Recognises the importance of treatment before necessarily getting all information Obtains previous notes
Examination	Detailed physical examination which must include physical signs that would differentiate between haemorrhagic, hypovolaemic , cardiogenic and septic causes for shock
Investigation	 Asks for appropriate tests- arterial blood gas or venous gas and lactate FBC, U&Es, clotting studies, LFTs, toxicology, Cross match as indicated blood and urine culture, CK and troponin, ECG, CXR, Familiar with use of US to look for IVC compression and cardiac tamponade
Clinical decision making and judgement	 Forms diagnosis and differential diagnosis including: Trauma-haemorrhagic, blood loss control form direct pressure, pelvic splintage, emergency surgery or interventional radiology Gastrointestinal - upper and lower GI bleed, or fluid loss form 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
Communication	Effectively communicates with both patient and colleagues
Organisation and efficiency	 Manages time well – does not appear rushed but completes critical tasks in a timely way. Uses staff and delegates appropriately
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 Unconscious/altered Mental Status	
	Expected behaviour
Initial approach	 ABCD approach, including GCS Asks for vital signs including SPaO2, blood sugar Secures iv access Looks for lateralising signs, pin point pupils, signs of trauma, considers neck injury Considers opiate OD, alcoholism, anticoagulation
History	 Obtains history- friends, family, paramedics- cover PMH, previous ODs etc Obtains previous notes
Examination	Detailed physical examination including fundoscopy
Investigation	Asks for appropriate tests arterial blood gas FBC U&Es clotting studies LFTs, toxicology blood and urine culture CK and troponin HbCO ECG CXR CT
Clinical decision making and judgement	 Forms diagnosis and differential diagnosis including: Trauma- SAH, Epidural and subdural Neurovascular- stroke, hypertensive encephalopathy Cardiovascular- dysrhythmia, hypotension Neuro- 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

3 Shock	
	Expected behaviour
Initial approach	 ABCD approach, including GCS Asks for vital signs including SPaO2, blood sugar Requests monitoring Recognises physiological abnormalities Looks for obvious cause of shock e.g. bleeding Secures iv access
History	 Obtains targeted history from patient Obtains collateral history form friends, family, paramedics- cover 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 different between haemorragic, hypovolaemic , cardiogenic and septic causes for shock
Investigation	Asks for appropriate tests Arterial blood gas or venous gas and lactate FBC U&Es clotting studies LFTs, toxicology Cross match as indicated blood and urine culture CK and troponin ECG CXR Familiar with use of US to look for IVC compression and cardiac tamponade
Clinical decision making and judgement	 Forms diagnosis and differential diagnosis including: Trauma-haemorrhagic, blood loss control form direct pressure, pelvic splintage, emergency surgery or interventional radiology Gastrointestinal - upper and lower GI bleed, or fluid loss form 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
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

4 Major Trauma	
	Expected behaviour
Initial approach	 Knows when to activate the trauma team (based on local guidelines) Able to perform a rapid primary survey, including care of the c spine and oxygen delivery Can safely log roll patient off spinal board Able to assess disability, using AVPU or GCS Asks for vital signs Able to request imaging at end of primary survey Knows when to request specialty opinion and/or further imaging
History	 Obtains history of mechanism of injury from paramedics Able to use AMPLE history
Examination	After completing a primary survey is able to perform detailed secondary survey
Investigation	Asks for appropriate tests Primary survey films CT imaging arterial blood gas FBC U&Es clotting studies PT toxicology ECG FAST UO by catheterisation Appropriate use of NG
Clinical decision making and judgement	 Forms differential diagnosis and management plan based on: Able to identify and mange life threatening injuries as part of primary survey Able to identify the airway that may be at risk Can identify shock, know it classification and treatment Safely prescribes fluids, blood products and drugs. Can identify those patients who need urgent interventions or surgery before imaging or secondary survey Can safely interpret imaging and test results Demonstrates safe disposition of trauma patient after secondary survey Able to identify those patients that be safely discharged home
Communication	Effectively communicates with both patient and other members of the trauma team
Overall plan	Identifies immediate life threats and readily reversible causes. Stabilises and prepares for further investigation, treatment and admission
Professionalism	Behaves in a professional manner

5 Sepsis	
	Expected behaviour
Initial approach	 Initial approach based on ABCD system- ensuring early monitoring of vital signs including temperature,SPaO2, blood sugar Can interpret early warning medical score as indicators of sepsis (EMEWS or similar) Aware of systemic inflammatory response criteria (SIRS), and that 2 or more may indicate sepsis T>38 or < 36 HR > 90 RR > 20 WCC > 12 or < 4
History	 Obtains history of symptoms leading up to illness Able to take a collateral history, form paramedics, friends and family Able to use AMPLE history Looks specifically for conditions causing immunocompromise
Examination	Able to perform a competent examination looking for 1. Possible source of infection 2. Secondary organ failure
Investig a tion	Asks for appropriate tests FBC U&Es clotting studies ABGs or VBGs Lactate, ScVo2 Blood cultures ECG CXR Urinalysis +/- catheterisation Other interventions which may help find source of sepsis Swabs PCR PUS Considers need for further imaging

Clinical decision making andjudgement	 Form a management plan with initial interventions being: Oxygen therapy Fluid bolus, starting with 20 mls/Kg IV Antibiotics, based on likely source of infection Documentation of a physiological score, which can be repeated Be able to reassess Recognises and is able to support physiological markers of organ dysfunction, such as:- Systolic BP < 90 mm Hg PaO2 < 8 Kpa Lactate > 5 Reduced GCS Urine output < 30 mls/hr Demonstrates when to use invasive monitoring, specifically CVP line Arterial line Demonstrates when to start inotropes, Noradrenaline v dopamine Demonstrates how to set up an inotrope infusion
Communication	Effectively communicates with both patient and other members of the acute care team
Overall plan	Identifies sepsis Implements sepsis bundle Stabilises patient, reassesses and able to inform and/or hand over to critical care team
Professionalism	Behaves in a professional manner

Mini-CEX Summative Descriptors for Acute Presentations

1 Chest Pain	
	Expected behaviours
Initial approach	 Ensures monitoring, i.v. access and defibrillator nearby. Ensures vital signs are measured including SpO₂
History	 Takes focused history (having established conscious with patent airway) of chest pain including site severity onset nature radiation duration frequency precipitating and relieving factors Previous similar pains and associated symptoms Systematically explores for symptoms of life threatening chest pain Assesses ACS risk factors Specifically asks about previous medication and past medical history Seeks information from paramedics, relatives and past medical notes including previous ECGs
Examination	On examination has ABCD approach with detailed cardiovascular and respiratory examination including detection of peripheral pulses, blood pressure measurement in both arms, elevated JVP, palpation of apex beat, auscultation e.g. for aortic stenosis and incompetence, pericardial rub, signs of cardiac failure, and pleural rubs
Investigation	 Ensures appropriate investigation ECG (serial) ABG FBC, U&Es troponin and d dimer if indicated Chest x-ray
Communication	Effectively communicates with both patient and colleagues
Prescribing	Able to relieve pain by appropriate prescription
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case.
Overall plan	Stabilises and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

2 Abdominal Pain	
	Expected behaviours
Initial approach	 Ensures appropriate monitoring in place and iv access Establishes that vital signs measured
History	 Takes focused history of abdominal pain including site severity onset nature radiation duration frequency precipitating and relieving factors previous similar pains and associated symptoms Systematically explores for symptoms of life threatening abdominal pain Specifically asks about previous abdominal operations Considers non abdominal causes- MI, pneumonia, DKA, hypercalcaemia, sickle, porphyria Seeks information from paramedics, relatives and past medical notes
Examination	 Able to undertake detailed examination for abdominal pain (ensuring adequate exposure and examining for the respiratory causes of abdominal pain) including 1. Inspection, palpation, auscultation and percussion of the abdomen 2. Looks for herniae and scars 3. Examines loins, genitalia and back 4. Undertakes appropriate rectal examination
Investigation	 Ensures appropriate investigation- ECG ABG FBC U&Es LFTs amylase erect chest x-ray and abdominal x-rays if obstruction or perforation suspected
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case
Communication	Effectively communicates with both patient and colleagues
Prescribing	Able to relieve pain by appropriate prescription
Overall plan	Stabilises (if appropriate) and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

3 Breathlessness	
	Expected behaviours
Initial approach	 Ensures monitoring, iv access gained, O2 therapy Ensures vital signs are measured including Spa O2
History	 If patient able, trainee takes focused history of breathlessness including onset, severity duration frequency precipitating and relieving factors previous similar episodes associated symptoms Systematically explores for symptoms of life threatening causes of breathlessness Takes detailed respiratory history Specifically asks about medication and past medical history Seeks information from paramedics, relatives and past medical notes including previous chest x-rays and blood gases
Examination	On examination has ABCD approach with detailed cardiovascular and
	 respiratory examination including, work of breathing, signs of respiratory distress detection of wheeze crepitations effusions areas of consolidation
Investigation	 Ensures appropriate investigation ECG ABG FBC U&Es troponin and d dimer if indicated Chest x-ray Able to interpret chest x-ray correctly
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case Knows BTS guidelines for treatment of Asthma and PE
Communication	Effectively communicates with both patient and colleagues
Prescribing	 Able to prescribe appropriate medication including oxygen therapy, bronchodilators, GTN, diuretics Able to identify which patients would benefit from NIV
Overall plan	Stabilises and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

4 Mental Health

Mental health issues are a common problem within the ED (typically combinations of overdose, DSH, suicidal ideation but also psychotic patients). Selection of patients suitable for min-CEX assessment must be undertaken thoughtfully.

	Expected behaviours
Initial approach	Ensures assessment takes place in a safe environment.
History	History taking covers presenting complaint, past psychiatric history, family history, work history,
	 sexual/marital history, substance misuse, forensic history, social circumstances, personality.
	 Undertakes mental state examination covering: appearance and behaviour speech mood thought abnormalities
	 hallucinations cognitive function using the mini mental state examination insight Elicits history sympathetically, is unhurried Searches for collateral history- friends and relatives, general practitioner, past medical notes, mental health workers
Examination	Ensures vital signs are measured Undertakes physical examination looks for physical causes of psychiatric symptoms- head injury, substance withdrawal, thyroid disease, intoxication, and hypoglycaemia
Investigation	Ensures appropriate tests U&E FBC CXR CT toxicology
Clinical decision making and judgement	Ensures no organic cause for symptoms Forms working diagnosis and assessment of risk- specifically of suicide and toxicological risk in those with overdoses
Communication	Effectively communicates with both patient and colleagues
Prescribing	Knows safe indications, routes of administration of common drugs for chemical sedation
Overall plan	Identifies appropriately those who will need further help as an inpatient and who can be followed up as an out patient Is able to assess capacity Have strategies for those who refuse assessment or treatment or who abscond
Professionalism	Behaves in a professional manner

5 Head Injury	
	Expected behaviours
Initial approach	Ensures ABC is adequate and that neck is immobilised in the unconscious patient and those with neck pain. Ensures BM done
History	 Establishes history- mechanism of injury any loss of consciousness and duration duration of any amnesia headache vomiting associated injuries especially facial and ocular Establishes if condition is worsening Gains collateral history from paramedics, witnesses, friends/relatives and medical notes Establishes if taking anticoagulants, is epileptic
Examination	 After ABC undertakes systematic neuro examination including GCS papillary reactions and size cranial nerve and peripheral neurological examination and seeks any cerebellar signs Looks for signs of basal skull fracture Examines scalp Looks for associated injuries- neck, facial bones including jaw Actively seeks injuries elsewhere
Investigation	Is able to identify the correct imaging protocol for those with potentially significant injury -specifically the NICE guidelines
Clinical decision making and judgement	Is able to refer appropriately with comprehensive and succinct summary Knows which patients should be referred to N/surgery Is able to identify those patients suitable for discharge and ensures safe discharge.
Communication	Effectively communicates with both patient and colleagues
Prescribing	Able to safely relieve pain in the head injured patient
Overall plan	Stabilises and safely prepares the patient for further treatment and investigation or safely discharges patient
Professionalism	Behaves in a professional manner

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

Practical Procedures DOPs Descriptors

1 Basic airway management including adjuncts e.g. BVM, oxygen delivery	
Observed behaviour	Task Completed
1. Is able to assess the adult airway and in the obstructed patient provide a patent airway by simple manoeuvres and the use of adjuncts and suction.	
2. Undertakes this in a timely and systematic way.	
3. Assesses depth of respiration and need for BVM.	
4. Can successfully BVM.	
5. Knows and can show how to deliver high flow 02	
 Knows other O2 delivery systems typically in ED- fixed concentration masks, nasal specs, Mapleson C circuits. 	
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 identified 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 accessX2		
6. If shocked looks for potential sites of blood loss- abdomen, pelvis and limbs.		
7. Can formulate differential 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. Ensured 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
 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.	

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 clinician to assist.	
 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 clinician 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, pop correct patient, taken relevant history, and consented 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.	

ACAT-EM Descriptors

ACAT –EM	
Assessment Domains	Description
Clinical assessment and clinical topics covered	Quality of history and examination to arrive at appropriate diagnosis- made by direct observation in different areas especially in the resuscitation room.
	No more than 5 AP should be covered in each ACAT and this should involve a review of the notes and management plan of the patient.
Medical record keeping	Quality of recording of patient encounters including drug and fluid prescriptions
Investigations and referrals	Quality of trainees choice of investigations and referrals
Management of patients	Quality of treatment given (assessment, investigation, urgent treatment given involvement of seniors)
Time management	Prioritisation of cases
Management of take/team working	Appropriate relationship with and involvement of other health professionals
Clinical leadership	Appropriate delegation and supervision of junior staff
Handover	Quality of handover of care of patients between EM and in patient teams and in house handover including obs/CDU ward
Patient safety	Able to recognise effects of systems, process, environment and staffing on patient safety issues
Overall clinical judgement	Quality of trainees integrated thinking based on clinical assessment, investigations and referrals. safe and appropriate management, use of resources sensibly

Instructions for Use of ACAT-EM

This tool works best if:

1. The assessment is best conducted over more than one shift (typically 2-3) as not all the domains may be observed by the assessor in one shift. The assessor should ensure that as many domains are covered as possible

2. The assessor should seek the views of other members of the ED team when judging performance

3. The clinical notes and drug prescriptions should be reviewed especially relating to patients cared for in the resuscitation room.

4. The ACAT can be used to confirm knowledge, skills and attitudes for the cases reviewed by the assessor

5. The ACAT can be used in a variety of setting within the ED- cdu ward rounds, clinics as well as major/minor/resuscitation and paediatric areas

Mini-CEX Summative Descriptors for PEM EC-ACP

1 Abdominal pai	n
	Expected behaviour
Initial approach	ABCD approachAsks for vital signs
History	 Obtains history-patient, friends, family, paramedics- cover PMH Obtains previous notes
Examination	 General appearance – listlessness, features of dehydration and shock Detailed physical examination including assessment of dehydration Abdominal examination for guarding and distention Inguinal and testicular examination
Investigation	 Asks for appropriate tests FBC, U&Es, LFTs, blood and urine culture Abdominal x-ray for those with? obstruction
Clinical decision making and judgement	Forms diagnosis and differential diagnosis for D&V including: Intussusception Bacterial and viral gastroenteritis Food poisoning Pyelonephritiss for abdominal pain hernia, intussusception, pyloric stenosis, appendicitis, UTI, viral URTI, lower lobe pneumonia
Communication	Effectively communicates with both patient and colleagues
Overall plan	 identifies immediate life threats and readily reversible causes Able to classify degree of dehydration and prescribe appropriately Stabilises and prepares for further investigation, treatment and admission. Identifies which patients can be safely discharged
Professionalism	Behaves in a professional manner

2 Assessment of	of the febrile child
	Expected behaviour
Initial approach	 ABCD approach, including GCS Asks for vital signs including SPaO2, temperature, blood sugar. Identifies patient that needs resuscitation
History	 Obtains history- parents, friends, paramedics- cover PMH, Obtains previous notes Identifies if immune deficient/ high risk-sickle, DM, CSF shunts, cardiac patients
Examination	 General appearance Detailed physical examination focus on looking for causes of fever- ENT, neck stiffness, chest for resp and cardiac causes, abdomen, CNS, joints, Skin/rash
Investigation	Asks for appropriate tests arterial blood gas FBC,U&Es, clotting studies, LFTs, toxicology, blood and urine culture Appropriate imaging including Chest x-ray
Clinical decision making and judgement	Forms diagnosis and differential diagnosis including: Infection Bacterial otitis media, UTI, pneumonia, meningitis, cellulitis, joint infection, appendicitis Viral chickenpox, gastroenteritis Others neoplastic, salicylates, hyperthyroidism Demonstrates knowledge of NICE guidelines for management of febrile child
Communication	Effectively communicates with both child, parents and colleagues
Overall plan	Stabilizes and prepares for further investigation, treatment and admission
Professionalism	Behaves in a professional manner

3 Assessment of t	he breathless child
	Expected behaviour
Initial approach	 ABCD approach focusing on airway patency, effort and efficacy of breathing, o effects of inadequate respiration o and cardiovascular status. Ensures patent airway and high flow oxygen. Ensures monitoring
History	Obtains history- parents, paramedics
Examination	 General appearance Detailed physical examination with detection of stridor & wheeze, Signs of heart failure
Investigation	 Asks for appropriate tests- arterial blood as, FBC, U&Es, clotting studies, blood and urine culture, blood sugar Appropriate imaging Cxray
Clinical decision making and judgement	 Forms diagnosis and differential diagnosis including: Stridor: croup/epiglottitis Wheeze: asthma/bronchiolitis Fever :pneumonia Demonstrates knowledge of guidelines e.g. NICE for management of asthma. Knows of croup scoring system
Communication	Effectively communicates with both child, parents and colleagues
Overall plan	Stabilises and prepares for further investigation, treatment and admission. Seeks senior help early and appropriately
Professionalism	Behaves in a professional manner

4 Assessment of the	4 Assessment of the child in pain	
	Expected behaviour	
Initial approach	Recognises child in pain including behavioural and physiological changes	
History	 Obtains history of the condition causing pain Elicits past history of painful experiences and successful relieving measures 	
Examination	 Able to determine the cause of pain Able to undertake pain assessment including the use of pain ladder and faces scale 	
Investigation	Appropriate to the presentation	
Clinical decision making and judgement	 Ensures parent involvement Selects most appropriate analgesic and route of administration Demonstrates comprehensive knowledge of drugs and dosages Calculates dosage correctly Considers use of distractive techniques 	
Communication	Communicates effectively to both the child and parents. Sensitive and reassuring	
Overall plan	Ensures effective analgesia by repeated assessment and additional treatment if needed	
Professionalism	Behaves in a professional manner	

Paediatric Practical Procedures DOPs Descriptors

1 Venous access in children Trainee should identify suitable sites for cannulation in a child-specifically
Trainee should identify suitable sites for cannulation in a child, specifically
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the dorsum of the hand and foot,
cubital fossae,
external jugular,
scalp veins,
femoral vein,
• IO.
S/he should select appropriate route depending on the clinical case
For the fully conscious patient:
 Should ensure adequate pain relief if appropriate- using topical anaesthetic
Should ensure clean site and use aseptic technique
Prepares equipment- cannulae, connections, steristrips, flush and blood collection
bottles
 Immobilisation of limb using other members of staff
Gains access, takes samples, connects, secures and flushes to ensure correct position
Splints limb
For those undergoing resuscitation (this DOPs will be unplanned but should not stop this valuable
learning opportunity from being missed)
a. femoral vein cannulation
 Demonstrates correct anatomy and proposed site of puncture
 Should ensure clean site and use aseptic technique
 Prepares equipment- cannulae, connections, steristrips, flush and blood collection bottles
 Immobilisation of limb using other members of staff
 Gains access, takes samples, connects, secures and flushes to ensure correct position
b. Intraosseous insertion using either IO needle or EZ drill
Should ensure clean site and use aseptic technique
 Prepares equipment- IO needle, connections, flush and syringe for collection of
marrow blood
 Successfully inserts, confirms secure and patent. Connects to giving set and three way
tap, and gives fluid bolus
 Knows complications of IO insertion

Basic airway manoevers in children

- Preparation- can size nasophrayngeal and oral airways
- Can select appropriate BVM
- On arrival assesses airway for patency
- Established if obstructed or not.
- Uses suction, adjuncts and positioning appropriately
- Ensures patent airway
- Administers high flow oxygen with appropriate mask
- Supports ventilation with BVM
- Ensures concurrent monitoring including SpAO2, ECG
- Correctly identifies those that will need intubation
- Works effectively with medical and nursing colleagues to deliver effective care

3 Equipment and guidelines in the resuscitation room.

This is designed to ensure the trainee is familiar with and can access important paediatric resuscitation information and equipment

The trainee must demonstrate that:

- Can calculate the child's weight, defibrillation energy, ETT size, fluid bolus, dose of adrenaline, dose of 10% dextrose to correct hypoglycaemia
- · Can attach paediatric defibrillation paddles to adult paddles
- Can size and use o/p, n/p airways and use BVM
- They can find IO needle set
- That they know/ can find the normal range of physiological variables
- Can immediately access and know the common paediatric protocols- for cardiac arrest, seizures and anaphylaxis
- They can interpret limb x-rays- specifically recognise epiphyses, joint effusions.
- That they can interpret lat cspine (age <10)
- That they recognise the normal paediatric ECG and how it changes

4 Perform a primary survey in a child			
	Expected behaviour		
Preparation phase	 Has calculated weight – prepared – defibrillation charge, ETT, fluid bolus, and dextrose (10%) Has Broselow tape and knows how to use it 		
Transfer	Ensures safe transfer of patient onto ED trolley		
Examination	 Assesses airway, establishes if obstructed, corrects and ensures delivery of 100%O2. Appropriate use and correct sizing of airway adjuncts Concurrently ensures cervical spine immoblisation (using collar, sandbags and tape)- able to select and apply correct collar Exposes chest identified 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 Examines for signs of shock, ensures monitoring established and has gained iv accessX2 If shocked looks for potential sites of blood loss- abdomen, pelvis and limbs. Can formulate differential for shocked patient Knows protocol for fluid administration for the shocked child Establishes level of consciousness and seeks lateralising signs Uses paediatric GCS scale Examines limbs, spine and rectum (if unconscious or spinal injury suspected) ensuring safe log roll. BM done for those with altered level of consciousness Will baye identified and scarebod for potential life threatoning problems 		
Monitoring and interventions	 Ensured appropriate monitoring Will have placed lines, catheter and NG tubes as appropriate 		
Investigations	 Ensured appropriate blood testing (including cross match). Plain radiology trauma series undertaken 		
Prescribing	g Ensures adequate and safe pain relief		
Clinical decision making and judgement	 Directs team appropriately Liaises with and involves parents 		
Overall plan	Notes of primary survey are clear and legible		
Professionalism	ssionalism Behaves in a professional manner		

		ESLE descriptors	
		Examples of good behaviour	Example of poor behaviour
Management & Supervision	Standards	 Notices doctor's illegible notes and explains the value of good note keeping Explains importance of ensuring sick patient is stable prior to transfer Ensures clinical guidelines are followed and appropriate pro forma is complete 	 Fails to write contemporaneous notes Does not wash hands (or use alcohol gel) after reviewing patient Fails to adhere to clinical safety procedures
	Workload Management	 Sees a doctor has spent a long time with a patient and ascertains the reason Ensures both themselves and other team members take appropriate breaks Deals with interruptions effectively 	 Fails to act when a junior is overloaded and patient care is compromised Focuses on one particular patient and loses control of the department Fails to escalate appropriately when overloaded
		 Gives constructive criticism to team member Takes the opportunity to teach whilst reviewing patient with junior doctor Gives positive feedback to junior doctor who has made a difficult diagnosis Leads team through appropriate debrief after resuscitation 	 Criticises a colleague in front of the team Does not adequately supervise junior doctor with a sick patient Fails to ask if junior doctor is confident doing a practical procedure unsupervised
k & ion	Team Building	 Even when busy, reacts positively to a junior doctor asking for help Says thank you at end of a difficult shift Motivates team, especially during stressful periods 	 Harasses team members rather than giving assistance or advice Speaks abruptly to colleague who asks for help Impolite when speaking to nursing staff
Teamwork & Cooperation	•••••••••	 Gives an accurate and succinct handover of the department Ensures important message is heard correctly Gives clear referral to specialty doctor with reason for admission (e.g. SBAR) 	 Uses unfamiliar abbreviations that require clarification Repeatedly interrupts doctor who is presenting a patient's history Gives ambiguous instructions
	Assertiveness	 Uses appropriate degree of assertiveness when inpatient doctor refuses referral Willing to speak up to senior staff when concerned Remains calm under pressure 	 Fails to persevere when inpatient doctor refuses appropriate referral Shouts instructions to staff members when under pressure Appears panicked and stressed

	Option	Seeks help when unsure	Does not look at previous ED notes/ old ECGs when necessary
	Generation	Goes to see patient to get more information when junior is unclear abou	
		history	• Fails to ensure all relevant information is available when advising
		Encourages team members' input	referral
bu	Selecting &	Verbalises consideration of risk when sending home patient	 Uses CDU to avoid making treatment decisions
aki	Communicating	Discusses the contribution of false positive and false negative test result	Alters junior doctor's treatment plan without explanation
making	Options	Decisive when giving advice to junior doctors	 Forgets to notify nurse-in-charge of admission
uo			
cisio	Outcome Review	Reviews impact of treatment given to acutely sick patient	 Fails to establish referral outcome of complicated patient
ec		Follows up with doctor to see if provisional plan needs revising	 Sticks rigidly to plan despite availability of new information
		Ensures priority treatment has been given to patient	 Fails to check that delegated task has been done
	Gathering	Uses Patient Tracking System appropriately to monitor state of the	 Fails to notice that patient is about to breach and no plan has been
	Information	department	made
		'Eyeballs' patients during long wait times to identify anyone who looks	 Ignores patient alarm alerting deterioration of vital signs
		unwell	 Fails to notice that CDU is full when arranging new transfers
ŝ		Notices doctor has not turned up for shift	
ness	Anticipating	Identifies busy triage area and anticipates increased demand	• Fails to anticipate and prepare for difficulties or complications during a
e e		• Discusses contingencies with nurse-in-charge during periods of	practical procedure
Awai		overcrowding	• Fails to ensure that breaks are planned to maintain safe staffing levels
Ā		Prepares trauma team for arrival of emergency patient	Fails to anticipate and plan for clinical deterioration during patient
na	Lindoting the		transfer
tio	Updating the	Updates team about new issues such as bed availability or staff	Notices the long wait but fails to check the rest of the team is aware Sile to inform team and the provide the rest of the team is aware
Situati	Team	shortages	Fails to inform team members when going on a break
Sit		Keeps nurse-in-charge up to date with plans for patients	
		Communicates a change in patient status to relevant inpatient team	