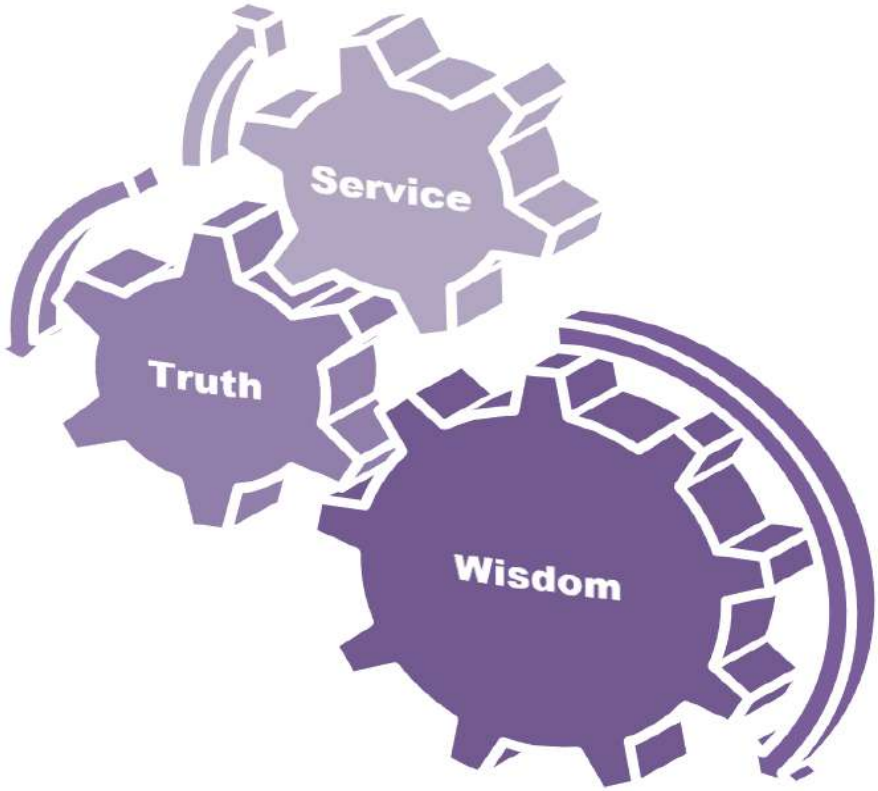
Emergency Medicine Foundation Program

Collaboration of Royal College of Emergency Medicine (UK)

Rawalpindi Medical University

Motto



Vision

- To impart evidence based research oriented medical education
- To provide best possible patient care
- To inculcate the values of mutual respect and ethical practice of medicine

Contribution By

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Message By Vice Chancellor

Emergency medicine is new specialty in Pakistan. Holy family Hospital affiliated with Rawalpindi Medical University is first public sector hospital in Punjab to establish department of emergency medicine. There are few qualified specialists in the field of emergency medicine in Pakistan, a country having a population of over 220 million with extra ordinary burden of both the communicable and non-communicable diseases and trauma cases. Even today, there are only seven hospitals across Pakistan having training opportunity in field of emergency medicine but most of them are private sector hospital.

Realizing importance of emergency medicine, Rawalpindi medical university signed a memorandum of understanding with Royal college of emergency medicine (UK) for starting Emergency medicine foundation program (EMFP). It is a great opportunity to develop a trained workforce for our newly established department of emergency medicine. It will be a milestone in history of emergency medicine in Pakistan. It will help to improve care of patients presenting in emergency department. Curriculum for this training program will cover all important clinical and professional aspects of emergency medicine. Teaching and assessment methodologies for this program will provide great learning opportunity for our trainees to learn according to international standards. Training will be delivered by our faculty under supervision of RCEM. It will provide capacity building for our local faculty. In future this trained faculty will be in better position to develop further training opportunities in this specialty. It will bring great change in knowledge, skills and professional attitude for doctors working in emergency department. Launching this program in Pakistan will also help to create awareness among health processionals regarding importance of Emergency Medicine as a specialty.

Prof. Dr. Muhammad Umar, *Sitara-i-Imtiaz*
MBBS, MCPS, FCPS, FRCP (Glasg), FRCP (London), FACG (USA), AGAF (USA)
Vice Chancellor & Chief Executive
Rawalpindi Medical University / Allied Hospitals Rawalpindi
Chairperson & Professor of Medicine, Rawalpindi Medical College, Rawalpindi Chief Gastroenterology &Hepatology Division, Holy Family Hospital, Rawalpindi

Message By Royal College Of Emergency Medicine

The Royal College of Emergency Medicine (RCEM) is pleased to announce the launch of The Emergency Medicine Foundation Programme and to issue an invitation to international healthcare services to participate in a pilot of this one-year training programme. This new curriculum will provide a quality assured training of key professional and clinical competences in Emergency Medicine at a pre-specialist level. It is aimed at those who have completed residency and wish to develop skills in emergency care, including those who may wish to progress towards further specialist training and membership and fellowship exams. Participation in the pilot of this programme will include delivery of a quality assured training, of key clinical and professional competences, within a structured educational framework that includes supervision from senior clinicians delivered within a local learning hub. Services will have access to a fully developed curriculum, with tools and guidance for training and assessment and associated learning and development resources. This will be complemented by a training programme for clinical and educational supervision. This is an extremely exciting opportunity for both services and clinicians to further develop competence in emergency medicine and standardise care delivery.

Dr Tajek B Hassan, President
Royal College of Emergency Medicine
Medicine

Dr Jason Long, Dean
Royal College of Emergency

Message By Director DME And Program Director

Emergency Medicine Is Rapidly developing specialty in whole of world. It is need of time to promote this specialty in our health system. It is the specialists in emergency medicine who decide what course of action to be followed for a patient reaching hospital in critical condition and if we want to strengthen emergency healthcare, we must produce specialists in EM. In Pakistan we do not have sufficient number of qualified doctors in this specialty. Holy family Hospital is the first public sector hospital in Punjab to have department of emergency medicine. Emergency medicine foundation program (EMFP) is a great opportunity for our university to develop trained faculty in field of emergency medicine. It is the only site in Pakistan for this training Program by Royal College of Emergency Medicine. It will provide training opportunity according to international standards. It has developed a Curriculum covering professional development, trauma care, and resuscitation for acute medical emergencies. This program will provide a foundation to develop future training opportunities in field of emergency medicine and will enable our young doctors to provide best possible care in emergency department according to international standards.

Prof. Rai Muhammad Asghar
Director DME

Prof. Janangir Sarwar Khan
Professor of Surgery & Program Director EMFP

PREFACE

EM is a relatively new specialty, which has evolved just over the last quarter of a century. In fact, EM is the first specialty to develop directly due to demand by the public. Emergency physicians are first contact providers. EM is a specialty of depth and breadth. EM is the medical specialty with the principal mission of evaluating, managing, treating, and preventing unexpected illness and injury. Quality emergency care is a fundamental right and should be available to all who seek it. There is a rapidly growing interest in EM throughout the world.

EM in Pakistan is a new specialty, and in fact, is not an officially designated specialty. EM is an extremely important component of any health care system and provides a vital service to the public. Major clinical problems (all of which are common in Pakistan) that are very well managed by EM include the following: trauma, cardio-respiratory illnesses, toxicology, environmental disorders, and mass casualties from disasters. EM also provides significant benefits to the general public. These include reassurance and confidence, convenience, and ensured access to care. EM also is important for public education in illness and injury prevention, teaching the public how to correctly utilize the health care system. There are significant benefits in developing physician residency training programs in EM.

It is need of the time to introduce specialty of Emergency Medicine in all public sector hospitals of the country as trained personnel can save lives of thousands of patients coming to accident & emergency departments of hospitals in critical condition. It is the specialists in emergency medicine who decide what course of action to be followed for a patient reaching hospital in critical condition and if we want to strengthen emergency healthcare, we must produce specialists in EM.

Scarcity of resources is a limiting factor in establishing EM as a specialty because it requires upgrading of basic infrastructures and adequate training of EM personnel. Lack of trained EM faculty is another limiting factor in Pakistan. Despite obstacles, there is a potential for the development of EM. It is hoped that this relatively new specialty will meet the challenges and will grow with time.

Rawalpindi Medical College was established in 1974. Two years back it was upgraded to Rawalpindi Medical University. Holy Family Hospital, Benazir Butto Hospital and District Headquarter Hospital are tertiary care hospitals affiliated with university as teaching hospitals. All these three hospital have very busy emergency departments. These hospitals are referral centers for upper Punjab, Azad Kashmir and KPK. Due to poor primary and secondary health systems, most of emergency patients are directly referred to these hospitals without proper management.

The Royal College of Emergency Medicine (RCEM) uk is supporting the development of Emergency Medicine at a Global level. As part of this commitment the International Education Committee within the College has developed a training curriculum, aimed at providing registered medical practitioners at pre-specialist level with a demonstrable period of study and training in Emergency Medicine.

The Emergency Medicine Foundation Program (EMFP) will be a one-year course that has a defined and evidence-based curriculum with key competences, both professional and clinical, that support services to provide care that is safe, effective and responsive to population needs. Guidance on methods of learning and assessment will be available, along with additional supportive training tools and resources.

Delivery of training will be with work place-based assessment and online learning. Local supervisors will directly supervise training in coordination with foreign faculty. RCEM will also arrange workshops for training of supervisors.

EMFP is one year certificate course. It will be a joint venture between RMU and RCEM. It will provide a great opportunity to develop a trained staff for working in department of emergency medicine in our hospitals along with trained workforce.

DR USMAN QURESHI
LEAD EDUCATIONAL SUPERVISOR FOR EMFP

EDUCATIONAL SUPERVISORS

Dr. Usman Qurshi
Lead Educational Supervisor

Dr Abdul Naheem

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14	Dr.Sadia Waheed
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16	Dr.Naeem liaguat
17	Dr.Zahid Minhas

FACULTY FOR EMFP
RAWALPINDI MEDICAL UNIVERSITY

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4	Prof Jawad Zaheer	Anesthesia
5	Prof. Imran Saeed	Cardiology
6	Prof. Arshad Sabir	Community Medicine
7	Prof. Shazad Manzoor	G. Medicine
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9	Prof. Naeem Zia	S. Surgery
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11	Prof. Rizwana Chaudary	Gynae/Obs
12	Prof. Seeme Gul	Pharmacology
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14	Dr. Saima Ambreen	G.Medicine
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16	Dr. Abdul Naeem	Emergency Medicine
17	Dr. Muhammad Mujeeb Khan	Dept. of Infectious Diseases
18	Dr. Abeera Zareen	Anaesthesia
19	Dr. Husnain Khan	Plastic Surgery
20	Dr Mehar Bano	Neurology

FACULTY FROM ROYAL COLLEGE OF EMERGENCY MEDICINE

Jason Long (Chair)
Consultant in Emergency Medicine (UK),
Dean at RCEM
Chair of the International Education Sub-Committee

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Consultant in Emergency Medicine (UK)

Emily Beet
Deputy Chief Executive at RCEM (UK)

Victoria De Witt ,
International Officer at RCEM

Emma Fernandez
International Education Project Manager at RCEM

CONTENTS

GLOSSARY OF TERMS

AA	Audit Assessment
ABG	Arterial blood gas
AMPLE	Allergies, Medications, Past illness, Last oral intake, Events leading up to presentation
ACAT-EM	Acute Care Assessment Tool for Emergency Medicine
ATMIST	Age of patient, Time of arrival, Mechanism of injury, Injuries suspected, Signs, Treatment given
AXR	Abdominal X-Ray
BBV	Blood bourne virus
BiPAP	Bilevel Positive Airway Pressure
BVM	Bag Valve Mask
CbD	Case based Discussion
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary resuscitation
CS	Clinical Supervisor
CSF	Cerebrospinal fluid
CTPA	CT Pulmonary Angiography
CXR	Chest X-Ray
CYP	Children and young people
DM	Diabetes Mellitus
DOPs	Direct Observation of Procedures
ED	Emergency Department
eLc	E Learning course
EM	Emergency Medicine
EMFP	Emergency Medicine Foundation Programme
ES	Educational Supervisor
ICP	Intra-cranial pressure
LOC	Level of consciousness
LP	Lumbar Puncture
LS	Life support course
Mi	Mini-Clinical Evaluation Exercise
MSF	Multi-source feedback
PE	Pulmonary embolism
PID	Pelvic inflammatory disease
PMH	Past medical history
PoP	Plaster of Paris
PPI	Proton pump inhibitors
RCEM	Royal College of Emergency Medicine
RL	Reflective log
S	Simulation
TMJ	Temporomandibular Joint
TXA	Tranexamic acid

Introduction

Review of local health and health service needs

It is well known that outcomes for patients presenting with acute emergencies and injuries are linked to the quality of initial clinical assessment and management. This recognition has led to the emergence of Emergency Medicine as a specialty and development of specialist training, especially at higher 'specialty' level aimed at completion of membership exams. However, access to these specialist training courses are limited, and can cost individuals a large amount of personal funds. There is currently a gap in the training programmes of many countries at a pre-specialist or 'core' level after undergraduate training and internship or residency is complete.

The EMFP will enable registered medical practitioners to demonstrate development of core professional and clinical skills in EM, to a measurable and entrustable standard. Development of the medical workforce in EDs will in turn support improved standards of care, especially in areas with high burden of trauma and acute illness, and provide development opportunities for clinicians, who traditionally may have had to seek this outside of the country. In turn completion of this programme can act as a stepping stone to higher specialist training and completing membership exams.

Curriculum purpose

Aim and objectives of curriculum

To develop a curriculum, based at pre-specialist level, that provides key clinical and professional skills in emergency care and ensure health services can provide care that is safe, effective and responsive to population needs.

The following project objectives are key to delivering the above aim:

- A one-year training programme for registered medical practitioners that provides quality assured training in EM at pre-specialist level
- Recruitment to a one-year pilot of the programme in 2019, to develop and adapt the curriculum and training as required
- Education and supervision of trainees by trained clinical and educational supervisors, working within a Learning Hub
- Training of senior clinicians as educational and clinical supervisors
- Development of an array of learning and support tools within RCEM Learning and Eportfolio
- An evaluation of the pilot and effectiveness of the curriculum, followed by wider implementation

Governance and strategic support

Curriculum development and governance process

Initial curriculum development has been by the International Education Committee, utilising current UK Foundation and Core curricula, as well as international best practice and

guidance. The curriculum will be tailored to the trainee level and population needs within pilot countries. The following have been considered when developing the initial pilot curriculum:

- Likely disease prevalence in key non-UK countries
- Potential differences in social determinants of health and acuity or stage of illness of patients presenting to ED
- Wider health service coverage that may impact on patients attending ED
- Potential differences in culture that might impact on health service delivery and health seeking behaviour
- Different training pathways and likely cost to individual of training
- The possible wider role in public health, infection control, mass casualties and disaster preparedness that be required by emergency services in these countries

The programme will not align with one educational provider in any country and will be open to all services who meet criteria. The initial pilot will be limited to India and Pakistan, with the development of a maximum of six learning hubs per country.

Feedback will be actively sought at several points in the pilot process, including on the draft curriculum from learning Hubs prior to pilot. In addition, feedback on the curriculum and evaluation of it's to provide required skills will take place during the pilot, as well as a formal evaluation at the end of the pilot followed by review and revision as required.

Ensuring training and assessment is fair and based on principles of equality and diversity

There are minimal criteria for trainee inclusion within the programme, and services will be responsible for ensuring that recruitment is fair and equitable. Delivery of teaching and assessment of skills and knowledge will be acquired through multiple different techniques, by trained senior clinicians as well as incorporation of feedback from patients and colleagues.

Recruitment, teaching, supervision and assessment by Supervisors and services will be overseen by the Learning Hubs and a faculty.

Trainees should be registered medical practitioners, working within Emergency Medicine and not participating in another formal training programme in order to participate.

Links with other training

Completion of this programme will not automatically enable trainees' entrance to specialist training or the ability to complete membership examinations.

Programme of learning

Outline of training programme delivery

The training is competency based and split into professional, clinical and procedural skills within specific modules. The curriculum covers resuscitation, trauma, acute clinical presentations and core professional competencies and common procedures for this level of trainee. Two of the clinical modules will be decided at a local hub level to allow services to tailor training to local need.

Core Professional Modules

These ensure the trainee has appropriate competence across all professional practice to ensure safe, effective care and good team working. Many of these skills may have been partially or fully achieved before during undergraduate or residency training, but we would expect increased levels of autonomy and maturation in communication skills. The trainee will also be introduced to issues in the context of Emergency Medicine.

These modules do not require separate assessments but cover key areas of professional behaviour and communication that will be assessed within clinical assessments.

Clinical modules

These have been split into resuscitation, trauma and acute presentations and will cover knowledge, skills and behaviours required for common presentations in these areas. Key procedural competences are included within these modules.

In addition to these core modules there are 'Additional' professional and clinical modules. Each Learning Hub will be asked to choose at LEAST 2 modules, prior to the start of the year, that best fit their service and local health needs. These modules will then become part of the local curriculum.

Paediatric specific competencies

Trainees are expected to be able to have some experience with assessment and treatment of children and many modules will have paediatric specific competencies, which should be assessed **in addition to** the competencies listed for adults. One assessment must be a paediatric case as a minimum. It is not expected that trainees will have to show their competence in all the paediatric specific competencies outside of this single assessment.

Entrustable Professional Activities (EPAs)

EPAs constitute the general tasks or work that would or could occur in a day or shift. They are made up of multiple assessable competences and types of competences.

Each module has an indication of the required level of entrustment by completion of assessment of competence. [2,3]

1- Not allowed to practice - clinician is an observer only

2- Direct active – full supervision by a senior clinician, with prompting or verbal and actual guidance and help throughout

3- Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available

4- Passive- full entrustment to carry out competence, no senior support provided

In addition, there is a level 5 -Supervisor- able to supervisor others in EPA. For purposes of this programme we have removed this level as it will be too senior.

The list of competences that must be assessed as fully achieved to allow unsupervised practice will be listed. Assessment may be required several times, for key aspects of

competences as it is anticipated that at start of programme that trainees would be at EPA level 1 or possibly 2. It is not anticipated that trainees would move from level 1 to 4 in a year.

At the start of the year, we would suggest that key EPAs are assessed, and a supervision level assigned. This would need to occur in first few weeks and would then be used to guide educational and overall supervisory requirements for individual trainees.

Entrustment decisions

Some assessments will require summative assessment, but we encourage initial formative assessment which can identify areas for growth. Several formative assessments with evidence of learning in between is of greater evidentiary use and shows better learning than a single summative assessment.

Summative decisions do not necessarily link with duration of programme but change in behaviour and skills e.g. this is competency rather than time-based assessment.

There is no order to which EPA should be completed first or the order in which they be completed, but resuscitation competences should be assessed within first six months.

Appendix 1 has a table of all competencies with expected EPA level by the end of the programme.

Learning outcomes and progression through programme

How to use the syllabus

Each module has clear competencies, some of which must be observed directly in the work place. Trainees must learn the key aspects of the syllabus, so that they can ensure that they arrange adequate supervision and ensure progression with demonstrating achievement of competencies throughout the programme.

Along with competencies within each module there is list of suggested presentations or situations that would be suitable as basis for assessment of different aspects of the syllabus. You may be able to assess aspects of several modules within one assessment, for example as well as completing clinical module ‘Acute Cardiac Presentations’ there may be aspects of professional competencies such as pharmacology, communication with patients and communication with staff that can be assessed at the same time, as well as competency in carrying out certain procedures.

The trainee must therefore have a good working knowledge of the curriculum to make the best use of assessments.

Further detailed information regarding types and number of assessments required, ‘satisfactory/ unsatisfactory’ outcomes for modules and the assessment forms please see: the ‘Curriculum assessment guidance’

Appendix 2 has the Assessment Blueprint outlining the potential assessment tools that can be utilised for each area of professional and clinical practice.

Summative assessment tools

Summative assessments are pass/fail encounters with consultant assessors or via other sources e.g. eLearning modules. These can be carried out after a period of training and can be repeated. There are descriptors of satisfactory versus unsatisfactory progress

Summative clinical assessment tools include:

- Mini- Clinical Evaluation Exercise (Mini-CEX)
- Case-based discussion (CBD)*often more formative from a pragmatic perspective
- Directly Observed Procedure (DOP)
- Life Support course (LS)

Mini-Clinical Evaluation Exercise (Mini-CEX)

Evaluates a clinical encounter with a patient and looks at competence in core skills for good clinical care, including ability to take history and examination and clinical reasoning. Trainee will receive immediate feedback.

Case-based Discussion (CbD)

Assesses performance of trainee in managing patient during presentation and looks at areas such as clinical reasoning, decision making and judgement, application of knowledge in patient care. CbD focuses on a written record of patient's management.

Direct Observation of Procedures (DOPS)

Assessment of skill at a procedure through direct observation and evaluation recorded on tool against a structured checklist. The trainee will receive immediate feedback.

Life Support Course (LS)

This is successful completion of recognised life support course.

Formative assessment tools (both clinical and non-technical)

Formative assessments offer opportunity for reflective practice and form the majority of assessments at this stage of training. These include:

- Mini-CEX
- CBD
- Acute Care Assessment Tool for EM (ACAT-EM)
- Multi-source feedback (MSF)
- Direct observation of procedural skills (DOPS)
- Audit assessment (AA)
- Reflective Log

Acute Care Assessment Tool (ACAT-EM)

Allows for assessment over a period of time and over several different cases and can cover several domains e.g. clinical and professional competences.

The trainee should be aware when the ACAT-EM is being undertaken and it can be used for up 5 different acute presentations, but a minimum of 3.

Multi-Source Feedback (MSF)
Used to assess generic professional skills such as communication, team working, reliability etc

This provides objective systematic collection and feedback of performance, that is derived from a range of colleagues including doctors, nursing and administrative staff, allied health staff. The trainee does not see the individual response

Audit Assessment (AA)
Used to assess competence in completing an audit cycle or one PDSA round of a QI project. Completion of this assessment tool can be based on review of audit or QI documentation or presentation of either at an MDT meeting

Reflective log (RL)

This is an important aspect of formative assessment and allows trainees to show evidence of learning and behaviour change throughout the programme. Further information on reflection is available to trainees within the 'Trainee Reference Guide'.

Timing of assessments

There are a large number of assessments that need to be undertaken and trainees will not be able to complete the curriculum unless they start these straight away. Only the resuscitation modules and the first trauma module require summative assessment, all the rest can be done through formative assessment and reflection of learning.

We anticipate trainees will need to do at least 2-3 assessments per month, in order to demonstrate their competences and show progression through the year. Trainees are responsible for identifying suitable presentations for assessment, but supervisors must be available as much as possible to make the most of these opportunities.

Trainees may find that in some areas their first assessment meets the required level for sign-off but in others they may need to do additional work and have a further assessment. The trainee should ensure that they may need to focus additional effort on those areas where their skills or knowledge are weakest.

It is assumed that trainees will be started at EPA level 1 or 2 (see page 8 for descriptors) and that they will move towards the final EPA level throughout the programme. See Appendix 1 for list of required entrustment levels.

Assessment with paediatric presentations

It is expected that at least one to two of the modules will be assessed in paediatric patients. In general, the competencies laid out in the modules are the same as for adults, but where there are additional paediatric-specific issues to consider, these are added at the end of the module.

Teaching and support

Trainees will be required to attend formal teaching and supervisory meetings throughout the year but are also encouraged to carry out additional reading and online courses to expand their knowledge.

Supervisors will advise trainees where skills, including core professional competences, fall below expected level and a more summative assessment approach may be required. InEMFP Pilot Curriculum general, the main evidence will be integrated with clinical assessment tools and demonstrated in the trainee's reflective log and formative feedback (e.g. MSF). This will be subject to regular educational/clinical supervisor reviews.

Syllabus outline

The modules listed below must be completed by all trainees in all pilot sites. In addition, each Learning Hub must choose AT LEAST TWO additional modules from the list of 10 below, to add to the curriculum.

Generic Modules			
All trainees in all Learning Hubs will be completing these modules. They cover professional, clinical and procedural competencies			
CC	Core Professional Competencies * **Please note, these are NOT assessed separately but must be evidenced through assessment of the clinical modules**	CC1	Clinical decision making and judgement
		CC2	Therapeutics and safe prescribing
		CC3	Assessment and management of pain
		CC4	Infection prevention and control and personal safety
		CC5	Assessing patient capacity and obtaining consent
		CC6	Safeguarding and the vulnerable patient
		CC7	Communication with the patient/relative(s) inc. breaking bad news
		CC8	Communication with colleagues and effective handover
		CC9	Time and workload management
		CC10	Health promotion and public health
R	Resuscitation	R1	Cardiorespiratory, respiratory and peri-arrest
		R2	Shock, anaphylaxis and the septic patient
		R3	The unconscious patient (or deteriorating level of consciousness)
T	Major Trauma	T1	Systematic assessment and initial management of a major trauma presentation
		T2	Major Incident Management: involving large numbers of casualties or a surge of acutely ill patients
A	Acute presentations	A1	Acute cardiac presentations
		A2	Acute respiratory presentations
		A3	Acute abdominal presentations
		A4	Acute presentations involving self-harm and unintentional toxins/poisoning
		A5	Acute neurological, cognitive or affective presentations
		A6	Acute musculoskeletal and atraumatic limb presentations
		A7	Management of burns
Listed below are the practical procedures in which all trainees must complete assessment			
PP	Practical procedures	PP1	Peripheral venous cannulation / emergency intraosseous access
		PP2	Obtaining and interpreting an ABG
		PP3	Obtaining and interpreting an ECG
		PP4	Management of serious haemorrhage (inc. pelvic binder)
		PP5	Basic airway assessment and management
		PP6	Cardio-Pulmonary Resuscitation and safe defibrillation
		PP7	Primary survey of a major trauma patient
		PP8	Initial decompression of a large/tension pneumothorax

		PP9	Local anaesthesia
		PP10	Regional anaesthesia
		PP11	Fracture reduction
		PP12	Dislocation reduction
		PP13	Wound closure and appropriate dressings
		PP14	Limb injury immobilisation including splints/PoP/slings
		PP15	Safe delivery of a fluid challenge

Additional modules

Listed below are a choice of modules. Each Learning Hub will be asked to **add AT LEAST two** of these to their curriculum, which must then be completed by their trainees

O	Options	O1	Principles of quality/safety improvement
		O2	Dermatological presentations
		O3	Infectious and endemic diseases
		O4	Haematological emergencies
		O5	Urological, renal and genitourinary disorders
		O6	‘End-of-life’ and palliative care considerations
		O7	Care of patient with malnutrition, electrolyte or endocrine disorder
		O8	Common ophthalmological presentations
		O9	Common ENT, maxillofacial and dental emergencies
		O10	Common obstetric and gynaecological presentations

A. Core curriculum

CORE PROFESSIONAL COMPETENCES

CC1 Clinical decision making and judgement

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules with appropriate cross-linking. It is important to also consider these competencies within your reflection logs. Colleagues and supervisors may feedback comments on this area within the MSF.

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Defines the steps of diagnostic reasoning
	Conceptualises the clinical problem and generates a differential diagnosis within the context of clinical likelihood. Be able to test, refine and verify hypotheses
	Recognises how to use expert advice, clinical guidelines and algorithms. Can utilise support for decision making in stressful environments
	Recognises the need to determine the best value and most effective treatment both for the individual patient and for a patient cohort
	Defines the concepts of a disease's natural history and assessment of risk
Skills	Is able to judge the severity of a presenting complaint, based on history and examination and determine an appropriate differential diagnosis, investigation and treatment plan
	Is able to recognise signs and symptoms that may indicate a *critical illness* and escalates appropriately
	Constructs an appropriate management plan and communicates this effectively to the patient, parents and carers where relevant
	Can define the relevance of an estimated risk of a future event to an individual patient
	Is able to assess those patients suitable for discharge and provide appropriate treatment and advise
Behaviour	Ensures that patients have an appropriate monitoring plan, including reassessment and identification of the deteriorating patient
	Shows willingness to discuss intelligibly with a patient the notion and difficulties of prediction of future events, and benefit/risk balance of therapeutic intervention
	Recognises personal beliefs and biases and understand their impact on the delivery of health services
	Is willing to facilitate patient choice

	Recognises the need to use all healthcare resources in a discriminatory manner and appropriately

CC2 Therapeutics and safe prescribing

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules with appropriate cross-linking. If further learning is required eLc can be used to support some aspects of this module.

Listed below are *high risk areas* of therapeutics and should be considered opportunities for discussion and assessment:

- Patient requiring a new antibiotic prescription for community acquired infection
- Patient requiring Gentamycin or Vancomycin Monitoring
- Patient with potential toxicity/ overdose or requiring therapeutic levels of:
  - Gentamycin/ Vancomycin
  - Digoxin
  - Lithium
  - Phenytoin/ Carbamazepine/ Sodium Valproate
  - Cyclosporin
  - Sirolimus
  - Tacrolimus
  - Amiodarone
- Patients requiring blood monitoring for potential adverse events:
  - Cytotoxic drugs
  - Antipsychotic drugs o Anticoagulants
  - Amiodarone
- Patient with hepatic impairment, requiring a new medication
- Patient with renal impairment requiring a new medication
- Patient presenting with 5+ regular prescribed medications (polypharmacy)
- Patient requiring opiate analgesic for pain
- Oxygen prescribing in hypercapnic respiratory failure (ABG/SpO2)
- Patient requiring an Insulin Infusion
- Paediatric weight-based calculations for common therapeutics.

Trainees are expected to achieve EPA level 3 (Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Recalls indications, contraindications, side effects, drug interactions and dosage of commonly used drug groups e.g. analgesics, antibiotics, IV fluids

	Recalls a range of adverse drug reactions to commonly used drugs, including analgesics and antibiotics
	Recalls drugs requiring therapeutic drug monitoring and can interpret results
	Can define the effects of age, body size, organ dysfunction and concurrent illness on drug distribution and metabolism relevant to the trainee's practice
	Understands the requirement to adjust the dose for relevant medications in patients with known renal or hepatic impairment
	Understands key issues around prescribing including common errors in medications and safe prescribing, polypharmacy, compliance and resistance (overlapping with health promotion/public health) [antibiotic stewardship – see also IPC/Safety CC3)
Skills	Advises patients (and carers) about important interactions and adverse drug effects
	Is able to safely prescribe 'higher risk' therapeutics (list above)
	Provides comprehensible explanations to the patient, and carers when relevant, on the use of medicines
	Performs dose calculations (e.g. for age/weight) safely and accurately
Behaviour	Improves the patients understanding of diagnosis, investigations and treatments, including side effects and contraindications of medications
	Makes sure an accurate record of prescribed medication is shared with relevant others involved in an individual's care
	Maximises patient compliance by minimising the number of medicines required that is compatible with optimal patient care
	Maximises patient compliance by providing full explanations of the need for the medicines prescribed

CC3 Assessment and management of pain

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules and with appropriate cross-linking.

Patient presentations of particular importance that could be utilised to demonstrate competencies within this module include any patient presenting with moderate to severe pain, issues with regards to analgesia prescriptions such as side effects, exacerbation of existing chronic pain/need for adjuncts, opiate-seeking behaviour, and frequent attenders.

Trainees are expected to achieve EPA level 3 (Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Describes how to assess the severity of acute pain including scoring systems such as the Visual Analogue Scale and Verbal Rating Scale
	Describes the use of multi-modal therapy and the 'analgesic ladder'
	Understands how emotions contribute to pain
	Understands the different treatments of acute and chronic pain, including use of adjunctive therapy e.g. anxiolytics, neuroactive agents
	Understands the pharmacology of commonly used analgesics including but not limited to: Indications and contraindications, Side effects, Safety profile, Drug interactions
	Can list complications of regional anaesthesia and outlines their treatment including that of local anaesthetic toxicity and respiratory depression due to centrally administered opiates
Skills (*see also include PP9 and PP10*)	Is able to discuss options for pain relief with the patient and obtain informed consent
	Uses non-pharmacological as well as pharmacological pain management such as immobilisation, TENS
	Safely prescribes analgesia for the acutely ill patient in pain
	Safely titrates analgesia against level of pain
	Is able to undertake the peripheral nerve blocks including but not limited to: digital, wrist (ulnar, median, radial), femoral, facial (auricular, supra-trochlear, supra-orbital), ankle and know their contraindications
Behaviour	Ensures effectiveness of analgesia provided and seeks help if pain is not relieved or is disproportionate
Paediatric specific competencies	Knows how to assess pain in CYP, the range of options to relieve pain and how to select the best option.
	Knows the range of nonpharmacological and pharmacological - agents, routes of administration, dosage.
	Can explain the management of severe pain including the use of intranasal opiates and intramuscular ketamine
	Knows the safe doses, side effects and toxicity of different agents

CC4 Infection prevention and control and personal safety

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical with appropriate cross-linking.

Assessment of key skills can also be assessed through DOP of aseptic technique, audit of personal/ local practice, MSF plus an eLc.

Potential situations in which Infection control issues could be considered as part of the assessment include the following:

- Patient presenting with suspected infective diarrhoea
- Care of a potentially contaminated patient e.g. chemical, or external haemorrhage with either:
    - history of BBV (HIV/AIDS or Hepatitis B/C)
    - or suspected pulmonary TB or other infectious disease
- Any patient with suspected nosocomial infection e.g. MRSA, C. Difficile
- Notifiable diseases and associated responsibilities
- Neutropenia, immunosuppression or other specific patient risk-factors

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the principles of preventing infection in high risk groups (e.g. antibiotic use to prevent Clostridium difficile) including understanding the local antibiotic prescribing policy
	Knows the role of notification and the role of local authorities in infection control, the principal notifiable diseases and the process for notification
	Is aware of the risks of nosocomial infections. Understands the links between antibiotic prescription and the development of nosocomial infections.
	Understands the principles of risk management of large-scale outbreaks or pandemic infections and initial safe IPC measures to take to limit cross-infection [see also -Mass Casualty T2)
Skills	Uses blood cultures appropriately with good technique and for appropriate indications Starts antibiotics within 1 hour for septic patients
	Manages simple common infections in patients using first-line treatments. Communicating effectively to the patient the need for treatment and any messages to prevent re-infection or spread
	Prescribes antibiotics in accordance with local guidelines, microbiology advice and maintaining stewardship principles
	Practices aseptic technique, even whilst performing clinical procedures
	Identifies the potential for infection amongst high risk patients, including the immunosuppressed, obtaining appropriate investigations and considering the use of second-line therapies
Behaviour	Always follows local infection control protocols. Including washing hands before and after seeing all patients; standard precautions

	Recognises and takes appropriate action in potential infection including use of masks, aprons, closed cubicles (e.g. diarrhoea, haemoptysis) and recognises the risk of cross infection
	Uses gloves in all venepuncture or invasive procedures and goggles as required, safely disposes of all sharps
	Notifies all infectious diseases including common ED presentations (meningococcal, TB, food poisoning)
	Counsels patients on matters of infection risk, transmission and control
	Is able to explain infection control protocols to students and to patients and their relatives.
	Encourages all staff, patients and relatives to observe infection control principles
Paediatric specific competencies	Is able to explain potential risks of common childhood infectious diseases to either immunologically naïve children/adults in close contact, or high-risk groups such as pregnant women or immunosuppressed

CC5 Assessing patient capacity and obtaining consent

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules.

Assessment of key communication skills can also be assessed through DOP of key procedures e.g. fracture reduction or audit of personal/ local practice. Some aspects of knowledge could be obtained through eLc.

Potential situations in which assessment of capacity and consent issues could be considered as part of the overall assessment include the following:

- Patient with dementia/ acute delirium (sufficient to impair capacity) requiring consent for a procedure or treatment
- Adult with learning disability, that impairs capacity, requiring consent for a procedure or treatment
- Patient at risk (or who poses a risk to others) from a mental health presentation
- Assessing cognition and capacity in a patient who is intoxicated
- Obtaining written consent for patient requiring invasive procedure/ treatment: o Reduction of fracture or dislocation
  o Procedural sedation o Cardioversion
  o Excision of abscess
  o Consent for thrombolysis for MI/PE/ Stroke
- Child requiring consent for a procedure
- Adolescent requiring consent for a procedure

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands potential causes of impairment of cognition or capacity e.g. delirium, dementia, severe mental health disorder
	Understands the importance of the patient's background, culture, education and preconceptions (ideas, concerns, expectations) to the consultation process and how it influences communication
	Understands when problems with communication and a patient's mental state may make obtaining consent difficult and the appropriate actions to take
	Understands the law as it applies to healthcare provision, patient consent and capacity and where to find sources of medicolegal information
Skills	Establishes a rapport with the patient and any relevant others (e.g. carers)
	Consents patients verbally and notes the consent for minor procedures such as suturing and abscess drainage
	Can perform a mental state examination and assessment of cognition and capacity
	Gains written consent for procedures requiring sedation or intravenous anaesthesia in line with local departmental protocols e.g. Biers block, conscious sedation for shoulder reduction
	Recognises when consent or refusal is invalid due to lack of capacity and applies principles of 'best interests' and proportionality 'least restriction'; concept and safe use of restraint/deprivation of liberty
	Is able to explain complex treatments meaningfully in layman's terms, to listen actively and question sensitively to guide the patient and to clarify information to assess level of understanding and thereby to obtain appropriate consent
Behaviour	Acts with courtesy, empathy, compassion and professionalism. Ensure that the approach is inclusive, and patient centred and respect the diversity of values in patients, carers
	Checks the patient's/carer's understanding, ensuring that all their concerns/questions have been covered
	Uses different methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved
	Respects a patient's rights of autonomy even in situations where their decision might put them at risk of harm

	Shows a willingness to obtain a second opinion, senior opinion, and legal advice in difficult situations of consent or capacity
	Where communication or capacity is impaired, escalates appropriately to senior colleagues
	Makes accurate contemporaneous records of the discussion
Paediatric specific competencies	Understands the rights of children and adolescents to participate in decisions about their health within their own legal framework
	Is able to discuss treatments requiring consent with patient and family/carer/legal guardian and obtain consent from the appropriate person, dependant on legal age of consent

CC6 Safeguarding and the vulnerable patient

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules with appropriate cross-linking. Some aspects of knowledge could be obtained via eLc.

Potential situations in which safeguarding issues could be considered as part of the overall assessment include the following:

- Elderly patient requiring full care presenting with injuries consistent with abuse
- Female (with or without child dependants) presenting after injury from domestic violence, or vulnerable to gender-based issues e.g. female feticide
- Patient with any presentation who has or is suspected of having alcohol or drug abuse, where care or follow up is impacted
- Patient with any presentation who is homeless, where care or follow up will be impacted
- Patient with any presentation who has learning difficulties or mental health condition and reduced capacity
- Any presentation of vulnerable adult where any abuse type is suspected
- Communication with parents where a risk of harm (such as FGM) or possible exploitation is identified
- Communication with parent of child with suspected non-accidental injury, neglect or other form of abuse

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the signs of physical, emotional, sexual abuse including domestic violence or abuse of elderly and how they may present in ED
	Understands the role of the clinician in identification of dependants potentially at risk due to patient's personal health and substance

	misuse, including understanding the procedure to be followed when abuse is suspected
	Knows the local policies and procedures and clinician responsibilities when suspected abuse is identified in adults or children
Skills	Is able to identify patients and or other family members at risk of gender-based violence or exploitation, including issues such as FGM
	Is able to identify elderly patients at risk of malnutrition, dehydration, susceptibility to extremes in temperature
	Identifies and overcomes possible barriers to effective communication, including seeking translators for patients
	Recognises the possibility of deliberate harm in vulnerable patients and report to appropriate agencies
Behaviour	Records findings, discussions and resultant actions/ referrals carefully in notes
	Recognises the duty of the medical professional to act as patient advocate
Paediatric specific competencies	Understands the ways children might present with all forms of abuse, including neglect and emotional as well as sexual exploitation and relevant tools

CC7 Communication with the patient/relative(s) inc. breaking bad news; confidentiality

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules with appropriate cross-linking. Communication of key information is an important aspect of DOPs.

Key skills and behaviours regarding clarity and effectiveness of communication to be assessed via MSF and as part of reflection.

Potential situations in which communication skills with patients could be included as part of the overall assessment include the following:

- Patient with suspected STI/ HIV requiring sexual health history
- Obtaining a history from patient with acute delirium, dementia
- Communication with family after patient death
- Communication with patient where advising of potential/ suspected bad news dx: STI/ HIV/AIDS/Cancer/MI/Stroke/Major abdominal complaint/ MS/ Potential loss of limb/ Deterioration of disease
- Communication of risk/ advice for patient with alcohol/ drug abuse
- Communication with a victim of sexual assault
- Carrying out history/ examination with patient via translator
- Communicating with any person who is verbally or physically aggressive
- Communicating with a patient who may be at risk of domestic or gender-based violence
- Obtaining history from patient in severe pain

Trainees are expected to achieve EPA level 3 (Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands how the patient's background, culture, education and preconceptions may impact communication with patient and their understanding
	Understands communication factors that may lead to dissatisfaction of the care that was delivered
	Recognises that the way in which any information is delivered significantly affects the subsequent relationship with the patient
	Recognises that every patient may desire different levels of explanation and have different responses to information provided
	Recognises that personal information is private or confidential (within the relevant legal context of that country) but the patient may wish to be accompanied or request information to be shared with another individual or representative; and that this is handled sensitively
	Is able to discuss the role of the coroner or other legal representative (such as Police) in an unexpected death including the need for a post-mortem or similar investigation or examination
Skills	Establishes a rapport with the patient and any relevant others (e.g. carers/relatives/advocates)
	Listens actively and questions sensitively to guide the patient and to clarify information
	Prepares patient/relative to receive bad news and responsive to their reactions and offer appropriate time and space to absorb information
	Structures the interview e.g. set the scene, establish understanding, Discuss: diagnosis, implications, treatment, prognosis and subsequent care
	Encourages questioning and ensures comprehension from patients and or family/ carers
	Responds to verbal and visual cues from patients and relatives
	Can communicate complex information with support of translator when patient speaks a different language
	Can discuss decisions regarding resuscitation, with patients and family/carers (within the relevant legal context of that country)
Behaviours	Introduces themselves to patient/carer/ relative stating name and role
	Can communicate complex information in a clear manner
	Recognises the importance of preparation when breaking bad news by:

	Setting aside sufficient uninterrupted time Choosing an appropriate private environment Having sufficient information regarding prognosis and treatment Structuring the interview Being honest, factual, realistic and empathic
	Is able to discuss life-threatening conditions with patient with realistic presentation of risks and likely outcomes
	Acts with empathy, honesty and sensitivity avoiding undue optimism or pessimism. Respect the different ways people react to bad news
	Involves patients and carers in decisions regarding care
Paediatric specific competencies	Is able to establish a rapport with CYP and their families
	Understands the developmental stage in CYP when communicating and particular issues related to communicating with adolescents and young people

Additional/complementary competencies- EPA Level 1 or 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Paediatric specific competencies	Under supervision; observes or is involved in providing difficult information to parents related to the care of their child

CC8 Communication with colleagues and effective handover/continuity of care

Assessment of these competencies to be integrated during Mini-CEX, ACAT-EM or CbD of clinical modules with appropriate cross-linking.

Key skills and behaviours regarding clarity and effectiveness of communication to be assessed via MSF and during some of the DOPs e.g. CPR. In addition, these skills should be reviewed within the RL.

Potential situations in which communication competencies with colleagues could be included as part of the overall assessment include the following:

- Taking part in or undertaking transfer of patient from one clinical team/site to another
- Giving clinical management advice to a remote lay person, first responder or other healthcare professional
- Receiving or delivering handover from pre-hospital team in trauma or resus situations
- Handover patient with unstable/ deteriorating condition at end of shift to colleague or handover via group meeting

- Communication with specialist or general practitioner with regards to patient-where require follow up care
- Communication with team during trauma and or resus call

Trainees are expected to achieve EPA level 3 (Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the role played by all members of a multi-disciplinary team, good team dynamics and how these positively impact on patient care and safety
	Understands the principles of good communication and communication techniques e.g. SBAR
	Understands the structured communication requirements of handover and potential harm from poor handover communication
	Understands the principles of best practice in handover
Skills	Communicates accurately, clearly, promptly and comprehensively with relevant colleagues by means appropriate to the urgency of a situation (telephone, email, letter etc), especially where responsibility for a patient's care is transferred
	Is able to tell the named nurse and/or nurse in charge (or other relevant clinical lead) the patient plan and communicate key requirements for treatment and monitoring with nursing staff
	Recognises when a patient is not responding to treatment, reassesses the situation and escalates appropriately
	Ensures effective handover of patients to other doctor at end of shift, including overall care plan for patients, acuity and tasks not yet completed and priority of tasks
	Ensures effective handover of key information, when transferring care to other teams e.g. at referral
Behaviour	Recognises role of nursing staffing, lead registrar and consultant Appreciates vital role of all members of team including administrative and portering staff
	Identifies problems for next shift/ team and takes pre-emptive action where required
	When communicating with other team members, especially regarding clinically unstable patients, communicates the patient acuity clearly e.g. using a red-amber-green assessment
	Encourages an open environment with regards to safety, issues of performance and team working

	Ensure appropriate confidentiality is maintained during communication with any member of the team
	Handover of patients at end of shift is given in appropriate environment and manner and is comprehensive and efficient
	Ensures accurate contemporaneous note keeping inc. referral/discharge documentation and record of handover

Additional/complementary competencies- EPA Level 1 or 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skill	Giving clinical management advice to a remote lay person, first responder or other healthcare professional

CC9 Time and workload management

Assessment of this module can be carried out as part of clinical workplace assessments or ACAT-EM; appropriately cross-linked, and with aspects included from MSF summary.

Alternatively, it can be assessed via separate AA or reflective log.

Potential situations that would be suitable for assessment of these competencies include prioritisation of the management of more than one severely unwell patient presenting at once.

Trainees are expected to achieve EPA level 3 (Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands that some tasks are more urgent or more important than others, prioritises care
	Understands the need to prioritise work according to urgency and importance, prioritises resources and delegate appropriately
	Outlines techniques for improving time management
	Understands the importance of prompt investigation, diagnosis and treatment in disease management as key to reducing morbidity and mortality
Skills	Identifies clinical and clerical tasks requiring attention or predicted to arise with minimal organisational supervision
	Recognises the most urgent / important tasks and ensure that they are managed expediently

	Estimates the time likely to be required for essential tasks and plan accordingly
	Groups together tasks when this will be the most effective way of working
	Recognises and appreciates the knowledge and skills of other team members in order to delegate tasks
	Knows when to ask for senior assistance or additional support
Behaviour	Ensures that tasks are prioritised according to importance and completes appropriately. Anticipates when priorities should be changed
	Is able to work flexibly and deal with tasks in an effective fashion
	Ensures all discharge summaries/diagnoses are completed during the shift
Paediatric specific competencies	No additional competences

CC10 Health promotion and public health

Assessment of this module can be carried out as part of clinical workplace assessments using CbD or ACAT-EM or may be included within MSF. Alternatively, it can be assessed via separate AA or some of the competencies can be obtained through completion of an eLc.

Potential situations in which health promotion competencies could be included as part of the overall assessment include the following:

- Patient attending with presenting complaint related to alcohol or drug misuse
- Patient attending with any presentation who are morbidly obese or suffer from malnutrition
- Patients requiring advice on weight loss, alcohol intake, exercise etc as result of diagnosis e.g. ACS and smoking
- Patients attending with suspected sexually transmitted disease
- Patient presenting with a potentially notifiable disease

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies, unless indicated separately in specific clinical modules.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the factors which influence health – psychological, biological, social, cultural and economic (especially poverty)
	Understands the factors which influence the incidence and prevalence of common conditions, including the influence of

	lifestyle on health and factors that may influence an individual to change
	Where relevant, according to local/national policy or service delivery –understands the purpose and principles of screening programmes
	Knows the key local concerns about health of communities such as smoking and alcohol/ drug misuse and available cessation support
	Knows the safe drinking limits for alcohol in females and males and how to assess patients for dependency or harmful drinking
	Knows the impact of obesity and malnutrition on overall health and cognitive ability. Understand how these might occur at the same time
	Understands issues surrounding other determinants of health such as occupation, exercise and sexual health
	Understands issues relating to social and family contacts with suspected malaria, TB, Hepatitis B/C, HIV/AIDS
Skills	Identifies opportunities to prevent ill health and disease in patients and communicates these to an individual and their relatives,
	Takes a drug, alcohol and smoking history in all relevant patients
	Counsels patients appropriately on the benefits and risks of screening and sign-post patients to appropriate services
	Counsels patients on reducing risk of common infections, diseases e.g. malaria, HIV
	Supports an individual in a simple health promotion activity (e.g. smoking cessation)
Behaviour	Engages in effective team-working around the improvement of health
	Encourages, where appropriate, screening to facilitate early intervention
Paediatric specific competencies	Is aware of risk-taking behaviour in adolescents and young adults and this impact on choices with regard to sexual behaviour, use of alcohol, illicit drugs and tobacco

RESUSCITATION

Trainees must complete an assessment of ALL of the following:

- R 1 Cardiorespiratory, respiratory and peri-arrest
- R 2 Shock, anaphylaxis and the septic patient
- R 3 Unconscious patient (or deteriorating level of consciousness)

R1 Cardiorespiratory, respiratory and peri-arrest

Assessment of these competencies is via Mini-CEX, with final summative Mini-CEX to be completed by the end of the programme. If the trainee has evidence of ALS certification valid up to the time of end of programme review this can be used as evidence of completion of some of the relevant knowledge, skills and behaviours within this module.

In addition, key DOPs should be carried out as part of this module including Basic airway management (PP5) and CPR (PP6) unless holding valid BLS training certification within the last 12 months.

Potential situations in which these competencies could be assessed include the following:

- Any adult presentation where resuscitation is instigated, and resus team or team support is required for management
- Patient in respiratory distress requiring airway adjuncts and or additional ventilatory support requiring resus, anaesthetic or team-based support
- Patient presenting with deteriorating cardiac or respiratory presentation requiring escalation of support and management by team e.g. post MI, pericardial effusion with tamponade, asthmatic requiring ventilation, major embolic event, acute LVF

Core competencies to achieve with adult patients, are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available). Paediatric competencies are to be assessed to EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout)

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Demonstrates knowledge of the causes of respiratory and cardiac arrest including special situations (such as drowning, electrical incident) and reversible causes in both adults and children e.g. hypothermia, trauma, overdose (“4 H’s / T’s”).
	Recalls/explains the mechanism of defibrillation, energy used to defibrillate and the factors influencing the success of defibrillation
	Demonstrates familiarity with the ALS and APLS algorithms and can outline indications, mode of action and safe use of relevant drugs in the management of respiratory and cardiac arrest in adults and children

	Is able to identify and discuss the use of resuscitation equipment, including basic and advanced airway adjuncts, monitoring, near-patient testing, defibrillators and automated compression devices
	Demonstrates knowledge of the indications for central venous catheterisation and relevant aftercare
	Demonstrates knowledge of post-arrest care and appropriate critical care involvement where necessary
Skills- History	Demonstrates the ability to obtain a targeted history from patient or collateral history from friends, family, paramedics- inc. relevant past medical history and comorbidities, medications and quality of life factors
	Focuses on relevant aspects of history and maintains focus despite multiple and often conflicting agendas
Skills – Examination	Can rapidly assess the patient systematically, following the ABCDE approach, correctly interpret signs and be able to safely initiate resuscitation in respiratory and cardiac arrest in adults and children
	Demonstrates an ability to perform an effective evaluation of respiratory function in the critically ill patient, including assessment of airway – particularly obstructive problems
Skills- investigation and treatment	Is able to obtain and interpret an ABG and recognise electrolyte and acid-base balance disturbances in the context of a patient with peri-arrest/cardiac arrest [see also – PP2)
	Is able to obtain and interpret ECG and recognise arrhythmias, asystole, rhythms associated with pulseless electrical activity [PEA], etc. in the context of peri-arrest/cardiac arrest [see also – PP3)
	Is able to maintain a clear airway using basic techniques with or without simple adjuncts, deliver oxygen and maintain ventilation using: • Expired air via a pocket mask • Self-inflating bag via facemask • Advanced airway techniques – such as LMA or endotracheal tube
	Performs basic life support competently as defined by The International Liaison Committee on Resuscitation (ILCOR): effective chest compressions with minimum interruption, airway manoeuvres and coordinated bag and mask ventilation
	Can deliver safe DC shocks when indicated (using an automated or manual defibrillator), including cardioversion, according to ALS protocols
	Understands the process of, and delivery of, external pacing and when it would be indicated
	Is able to order and interpret and act on further investigations appropriately, such as blood tests, chest x-ray, transthoracic ultrasound

Skills- Clinical decision making, judgement and planning *[in addition to CC1]*	Can elicit signs of patients who are peri-arrest and intervene in critical illness promptly to prevent respiratory and cardiac arrest (e.g. peri-arrest arrhythmias, hypoxia)
	Can identify those patients with respiratory compromise who may require non-invasive (CPAP/BiPAP) or invasive respiratory support and escalate appropriately
Behaviour- Communication & professionalism [*In addition to CC7& CC8]*	Demonstrates leadership, team-working and professionalism when working within a team managing a resuscitation
	Can utilise team strengths, recognising weaknesses and delegating tasks appropriately
	Maintains situational awareness, asking for vital signs and monitoring according to ALS algorithms and ensuring timely intervention
	Involves other members of team in important resuscitation decision-making such as when to cease CPR
	Involves family members in important resuscitation decision-making if they wish to be present, and ensuring information is provided in a sensitive and clear manner
Paediatric specific competencies*	Knows the infective, allergic and obstructive causes of airway obstruction in children including epiglottitis and post-tonsillectomy bleeding
	Is able to recognise signs of airway obstruction and initiate basic life support, including use of airway adjuncts and oxygen delivery
	Must be familiar with the paediatric equipment and guidelines in the resuscitation room

*Valid APLS certification can be used as evidence of paediatric specific competencies.

Additional optional competencies- EPA 1 or 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills- investigation and treatment	Familiar with use of transthoracic US to look for IVC compression and cardiac tamponade or right-side dilatation
	Insertion intraosseous device for drug / fluid administration
	Insertion of an arterial line for invasive BP monitoring
	Insertion of a central line for access / vasoactive drug administration
	Initiation of general anaesthesia / paralysis, endotracheal intubation (RSI) and formal invasive ventilation for post-arrest critical care
	Initiation of non-invasive ventilation in appropriate patients

R2 Shock, anaphylaxis and the septic patient

Assessment of these competencies via Mini-CEX, with final summative Mini-CEX to be completed by the end of the programme.

In addition, key DOPs could be carried out as part of this module including Peripheral line insertion (PP1), ABG (PP2), IV fluid bolus administration (PP15).

Potential situations in which these competencies could be assessed include the following:

- Any patient presenting with significant allergic response/ anaphylaxis to an allergen or toxin e.g. insect bite, snake/ insect bite, nut allergy
- Any patient presenting with signs of shock, whatever the cause e.g. major blood loss, cardiac event, neurogenic shock, shock secondary to major sepsis
- Any patient presenting with fever and signs of significant systemic sepsis: malaria, pneumonia, peritonitis, meningitis, encephalitis, pyelonephritis
- Any patient presenting with fever and signs of significant sepsis with an indwelling catheter, central line or permanent venous portal
- Any immunocompromised patient presenting with sepsis

Core competencies to achieve with adult patients, are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available). Paediatric competencies are to be assessed to EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout)

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Demonstrates knowledge of the definitions of sepsis and septic shock and understand the patho-physiology, presentation and assessment of other causes of shock including cardiogenic, hypovolaemic and neurogenic shock
	Demonstrates knowledge of common bacterial (gram negative and gram-positive organisms) / vector bourne diseases producing sepsis
	Is able to differentiate features of different infection types
	Demonstrates knowledge of special situations not limited to but including infection with: • Toxin producing bacteria • Invasive Group A Streptococcus • Fungal organisms • Vector bourne infections e.g. malaria • Multi-drug resistant organisms e.g. MDR-TB • Infectious presentations in the immunocompromised • Infection amenable to source control e.g. abscess, infected device
	Elucidates causes of anaphylactic shock and demonstrates knowledge of treatment and follow up required, based on best

	practice guidance e.g. World Allergy Organisation Guidelines for the Assessment and Management of Anaphylaxis
	Recognises and can initiate management of neutropenic sepsis (see also IPC – CC3)
	Demonstrates knowledge of the pharmacology and rationale for the use of the following in sepsis management: • Renal replacement therapy • Vasoactive drugs • Adjunctive drugs
	Demonstrates understanding of indications for antibiotic prophylaxis with different infections; drugs required, for whom and for how long
Skills- History	Obtains a targeted history from patient, even in difficult circumstances including appropriate symptom patterns and potential triggers
	Obtains a collateral history from friends, family, paramedics- incl. PMH and hospital notes
	Identifies the risk factors in the history that may indicate an infectious disease e.g. travel, sexual history, IV drug use, animal contact, drug therapy, implanted medical devices/prostheses
Skills – Examination	Performs a rapid systematic clinical assessment using ABCDE approach (and using ALS algorithm where appropriate)
	Is able to perform a competent examination looking for possible source of infection and signs of secondary organ failure
	Recognises signs of other potential causes for shock such as trauma, particularly in the frail/elderly
Skills- investigation and treatment	Initiates immediate, simple resuscitation (oxygen, iv access, fluid resuscitation), takes appropriate investigations and administers first line treatment, including antibiotics and intravenous fluids in accordance with local guidance [Sepsis Six / Bundle]
	Demonstrates an understanding of the need to assess the fluid status of the acutely unwell patient, when such assessment is necessary, and the need for reassessment and additional monitoring
	Orders, interprets and acts on initial investigations appropriately: ECG, blood cultures, blood count, electrolytes, CVP measurements
	When meningitis/encephalitis is suspected, can outline the indications for lumbar puncture and when this should precede antibiotic therapy; and subsequently interpret CSF laboratory analysis results
	Demonstrates an understanding of the use of glucose control, pressure area care, renal replacement therapies, thromboprophylaxis, gastrointestinal homeostasis and nutrition in all critically ill patients
	Identifies immediate life threats and readily reversible causes, recognising the need to initiate key treatment at the same time as carrying out history and examination

Skills- Clinical decision making, judgement *[in addition to CC1]*	Effectively assesses the response to a fluid bolus (PP15), and makes appropriate clinical decisions based on this response (urine output)
	Arranges suitable monitoring of relevant indices (oximetry, arterial gas analysis) and vital signs (BP, pulse & respiratory rate, temp, urine output) and communicates this to wider team
	Forms a diagnosis and differential diagnosis including: - including those that require critical care escalation, atypical presentations
	Escalates and calls for senior and or specialist help as appropriate
Behaviour- Communication & professionalism *[in addition to CC7 & CC8]*	Adopts a leadership role and demonstrates effective teamwork and communication with a calm, methodical approach
	Is able to communicate effectively and sympathetically with patient, understanding they may be extremely distressed or agitated
	Behaves in a professional manner, respects confidentiality, protects dignity of patients, remains sensitive to patients' opinions/ hopes/fears; explains plan and risk
Paediatric specific competences	Is able to recognise the child in shock and formulate a differential diagnosis and initiate immediate resuscitation
	Is able to recognise and institute treatment for life-threatening complications, including raised intracranial pressure

Additional optional competencies- EPA 1 or 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills- investigation and treatment	Familiar with use of transthoracic US to look for IVC compression and cardiac tamponade or right-side dilatation
	Insertion of an arterial line for invasive BP monitoring
	Insertion of a central line for access / vasoactive drug administration
	imitation of general anaesthesia / paralysis, endotracheal intubation (RSI) and formal invasive ventilation for post-arrest critical care
	Initiation of non-invasive ventilation in appropriate patients

R3 The unconscious patient (or deteriorating level of consciousness)

Assessment of these competencies via Mini-CEX, with final summative Mini-CEX to be completed by the end of the programme.

Potential situations in which these competencies could be assessed include the following:

• Loss of consciousness or deteriorating LOC following head injury •

Suspected overdose of drugs or alcohol with impaired LOC • Sudden

loss of consciousness, unknown cause

• Deteriorating level of consciousness, unknown cause •

Status epilepticus

Core competencies to achieve with adult patients, are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available). Paediatric competencies are to be assessed to EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout)

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Identifies the principal causes of unconsciousness (metabolic, drug and/or alcohol intoxication, neurological, head injury)
	Knows the indications for urgent CT scanning (national guidelines for CT imaging in head injury) and recognises significant abnormalities that may require urgent neurosurgical intervention.
	Knows an algorithm for the management of status epilepticus including the indications for general anaesthesia and airway protection
	Knows the principles of management of head injury and the mechanism and effects of raised intracranial pressure, and methods of preventing secondary brain injury
Skills- History	If head injury suspected: explores mechanism of injury, any loss of consciousness and duration, duration of any amnesia, headache, vomiting, associated injuries, currently taking anticoagulation
	Ensures patient is checked for medical alert bracelets or other warning items (e.g. therapy/medical card) in property
	Gains collateral history from paramedics, witnesses, friends/relatives and medical notes including relevant preceding symptoms (such as severe headache) or past medical history (such as epilepsy)
Skills – Examination	Makes a rapid systematic clinical assessment using ABCDE approach including a full neurological examination, with cervical spine immobilisation where necessary, and actively seeks injuries elsewhere particularly with distracting symptoms
	Is able to assess the Glasgow Coma Score (‘AVPU’ as alternative)
	Ensures the glucose level has been checked
Skills- investigation and treatment	Initiates appropriate immediate management – ensuring airway protected and adequate ventilation, supported if necessary; cardiovascular support; potential toxic/drug-related causes are considered (e.g. opiates: naloxone)
	Initiates early management (e.g. medication to control seizures) with close monitoring in cases of epilepsy / status

Skills- Clinical decision making, judgement *[in addition to CC1]*	Recognises and initiates management for the secondary consequences of head injury (e.g. loss of airway patency, seizures, raised ICP)
	Involves appropriate specialists to facilitate immediate assessment and management (e.g. imaging, intensive care, neurosurgeons)
	Is able to safely relieve pain in the head injured patient
Behaviour- Communication & professionalism *[in addition to CC7 & CC8]*	Adopts a leadership role and demonstrates effective teamwork and communication with a calm, methodical approach
	Is able to communicate effectively and sympathetically with the patient, understanding they may be extremely distressed or agitated
	Behaves in a professional manner, respects confidentiality, protects dignity of patients, remains sensitive to patients' opinions/ hopes/fears; explains plan and risk
Paediatric specific competencies	Is able to assess level of consciousness in CYP using a recognised score e.g. Paediatric GCS
	Understands potential causes of an unconsciousness in a chid and can initiate immediate management – including:

Additional optional competencies- EPA 1 or 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills- investigation/ treatment	Is able to interpret a CT head and C-spine for haemorrhage, ischaemia, space occupying lesion, intracranial pressure rise, skull vault/base of skull fracture, cervical spine injury

Major Trauma

T1. Systematic assessment and initial management of a major trauma presentation

Assessment of these competencies via Mini-CEX, with final summative Mini-CEX to be completed by the end of the programme. If the trainee has evidence of ATLS certification valid up to the time of end of programme review this can be used as evidence of completion of relevant knowledge within this module.

In addition, key DOPs should be carried out as part of this module including Primary survey, spinal protection measures, pelvic stabilisation techniques

Potential situations in which these competencies could be assessed include any presentation that is likely to be classified as major trauma using the Injury Severity Score (ISS ≥15) and could include the following:

- Any patient with penetrating injuries to neck, head, abdomen, thorax or pelvis
- Suspected open or depressed skull fracture
- Traumatic amputation
- Polytrauma involving multiple areas (Moderate to severe Injury to head/neck or thorax/ abdomen plus /-limb)
- Fall from height with injuries to head + 1 other area
- Fall from standing in the frail elderly with injuries to multiple areas

Core competencies to achieve with adult patients, are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available). Paediatric competencies are to be assessed to EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout)

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Is able to demonstrate knowledge of mechanisms of common major injuries (blunt and penetrating) to head/neck and spine, limbs and within chest, abdomen and pelvis in trauma, their pathophysiology and initial recognition
	Understands the concept of damage control resuscitation and surgery
	Understands the principles of haemorrhage control and haemostatic resuscitation
	Understands the principles of spinal protection and appropriate immobilisation
	Knows the principles of management of head injury and prevention of secondary brain injury in the context of the major trauma patient
	Appreciates the relevant anatomy and the effects of energy transfer from common injury mechanisms; including falls from height,

	ballistic and blast, penetrating trauma (stabbing weapons) and high energy blunt trauma (e.g. vehicle collisions with pedestrian)
	Recognises the potential for serious injury from falls from standing in frail and older persons
Skills- History	Is able to obtain a relevant history/hand-over from pre-hospital responders including mechanism, injuries seen and suspected, signs and symptoms, and treatment provided (ATMIST approach)
	Is able to establish an 'AMPLE' history
Skills – Examination	Is able to conduct a primary survey in a trauma patient (adult and children) utilising the principles of ATLS/APLS and communicate/record these as appropriate
	Can safely remove a patient from immobilisation/spinal board while continuing to provide effective spinal protection
	Is able to identify those patients with potentially life-threatening cranial/maxilla-facial injury leading to airway compromise
	Is able to identify airway/respiratory compromise from burns affecting the head/face or from exposure to hot gases/products of combustion in an enclosed space; to appreciate the potential risk from this early during the care of the patient
	Is able to identify those patients with potentially life-threatening thoracic injuries such as aortic injury, tension pneumothorax, diaphragmatic rupture, oesophageal rupture, massive pneumo-/haemo-thorax, flail chest or cardiac tamponade
	Is able to identify those patients with potentially life-threatening abdominal and pelvic injuries such as major vessel injury and bleeding, blunt or penetrating visceral injury such as liver or spleen, or severe pelvic fractures
	Is able to recognise critical limb injury, such as open fractures with ischaemia, and ensure prompt initial treatment and specialist opinion
	Is able to recognise significant traumatic brain injury and spinal cord injury and the need to involve specialist care urgently
	Be able to initiate a systematic secondary survey in a trauma patient (adult and children) utilising the principles of ATLS/APLS and communicate/record these as appropriate (e.g. against checklist)
Skills- investigation and treatment	Appreciates the priority of early control of severe external haemorrhage and undertaking appropriate control measures such as direct pressure, limb elevation or tourniquet, according to local policy
	Is able to initiate emergency airway management, oxygen therapy and identify patients in need of urgent endotracheal intubation and mechanical ventilation, particularly to facilitate safe transfer.
	Is able to manage a tension pneumothorax or massive pneumo-/haemothorax with an initial emergency decompression procedure

	and identify the need for open thoracostomy, thoracotomy and subsequent chest drain insertion as require (PP8)
	Is able to obtain appropriate intravenous or intraosseous access in a major trauma patient (PP1)
	Can manage haemorrhagic/hypovolaemic shock with appropriate blood products, intravenous fluids and therapeutics (such as TXA) according to local resources and policy
	Is able to provide safe and effective analgesia.
	Is able to plan initial radiological investigations such as CT scan, ultrasound and plain radiographs in a safe and timely manner
	Is able to safely interpret plain films for CXR, pelvis and C-spine
	Carries out and interprets initial appropriate laboratory investigations
Skills- Clinical decision making, judgement *[in addition to CC1]*	Knows how and when to activate the trauma team (based on local resources and policy) with pre-alert information or on patient reception
	Recognises when to request more senior or specialty opinion during the course of the patients care
	Is able to manage ongoing trauma care based upon clinical, radiological and laboratory findings including appropriate location for observation and monitoring the patient's response to treatment
	Is able to detect the deteriorating patient and escalate treatment appropriately, including identification of those patients that may need referral/transfer to a specialist care centre
Behaviour- Communication & professionalism *[in addition to CC7 & CC8]*	Attends promptly when required, understands roles and responsibilities in the trauma team and demonstrates effective communication and team work; taking initial leadership role where required to initiate life-saving measures in a timely manner
	Communicates in a calm and reassuring manner with conscious patients, recognising the potential for disorientation and discomfort
	Communicates effectively with seniors and specialist teams, including when inter-hospital transfer is required (referral/hand-over)
	Is able to reflect on the process and outcomes of trauma care after delivery and be able to identify potential areas for individual or team improvement – participation in team debrief
Paediatric	Recognises important differences in anatomical and physiological terms of response to trauma, therapeutics, radiological imaging and support to parents/family and subsequent psychological impact on team members

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	Detail of competency
Skills- Examination	Is able to identify and initially manage nasal, LeFort, mandibular, orbital and zygomatic fractures and TMJ dislocation. Be able to identify and initially manage dental fractures, tooth avulsion
Skills- investigation and treatment	Is able to initiate management of torrential nasopharyngeal bleeding by the use of Foley catheters and reduction of mid-face fractures
	Is able to provide monitoring and resuscitative support to patients during interhospital transfer
Skills- Clinical decision making, judgement	Recognises the burns patient who has an airway at risk and needs early intubation

T2 Major Incident Management: involving large numbers of casualties or a surge of acutely ill patients

Assessment can be carried out via CbD or reflective diary after mass casualty event or practice or simulation exercise. Alternatively, completion of an appropriate course such as Hospital MIMMS (ALSG).

Evidence of completion of key online training can also form part of this module.

Competencies are to be assessed to EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout)

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Is able to define a major incident in healthcare terms, understand a typical major incident plan and the integration/coordination between relevant organisations
	Understands the features of, and specific risks from, different kinds of incidents including mass transportation, mass gathering, industrial, acts of terrorism or CBRN and how this may impact on the hospital response
	Understands local job action roles and responsibilities, and reporting chain/hierarchy, including the security requirements and importance of staff safety
	Understands the management of large numbers of patients that may occur as a result of a significant or prolonged incident.
	Can demonstrate knowledge of predetermined procedures to generate hospital capacity, manage resources and prioritise patient care (including triage)
	Understands the key elements of effective major incident management including command and control, communication, coordination and information management (including documentation)

	Is aware of the need for ensuring the security and safety for staff and patients during such an incident
	Understands the principles of decontamination and prevention of cross-contamination; when it is required, how it is performed and by whom
	Has an awareness of the need to preserve forensic integrity (e.g. patient personal items and clothing) and maintain the chain of evidence
Skills	Is familiar with personal protective equipment and how to use it
	Is able to accurately triage multiple casualties if required to do so
Behaviours- Communication & professionalism *[In addition to CC7& CC8]*	Communicates calmly and effectively and is able to share information within, and between, teams and key command/coordination individuals
	Shows willingness to participate in emergency training exercises/ drills and work in required capacity, dependant on skills and ability
	Maintains documentation and personal log of actions appropriately
	Does not attempt to act outside of prescribed role.
	Participates in post incident debriefing and reflects on learning
Paediatric	No additional competences

Acute Presentations

A1 Acute cardiac presentations

Assessment of these competencies via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

In addition, key DOPs should be carried out as part of this module.

Potential presentations in which these competencies could be assessed include the following:

- Chest pain with suspected cardiac features such as sweating/nausea
- SOB and/or cyanosis in a patient with known cardiac history or suspicion of acute heart failure
- Acute palpitations
- Sudden blackouts/syncope
- Any presentation of child with known congenital heart defect, where management is impacted by this condition

Core competencies to achieve with adult patients, are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Can list and distinguish between, the common causes of **chest pain** their associated features and pathophysiology.
	Can list and distinguish between, the common arrhythmias and their causes, with associated features and pathophysiology
	Can list and distinguish between, the common causes of **syncope and pre-syncope**, with associated symptoms and pathophysiology
	Can list the common causes of sudden worsening of pulmonary and or peripheral oedema related to cardiac function
	Recalls cardiac electrophysiology relevant to ECG interpretation
	Recalls the indications, contraindications and side effects of the commonly used cardiac medications
	Recalls the indications for cardioversion and cardiac pacing
	Outlines the indications for thrombolysis and angioplasty in ACS
	Outline indications for non-invasive ventilation for heart failure
	Outlines the indications for further investigation of chest pain including CTPA or V/Q scan; echocardiography; cardiac stress testing
Skills- History	Interprets history and clinical signs to ascertain features that suggest a cardiac cause including relevant risk factors
	Differentiates pre-syncope from other causes of ‘dizziness’
Skills – Examination	Performs examination to elicit signs of cardiovascular disease, including bruits/murmurs, signs of endocarditis

	Is able to elicit signs of life threatening/ critical presentations e.g. aortic dissection
Skills- investigation and treatment	Conducts a systematic assessment (ABCDE approach) and manages emergent issues appropriately and in a timely manner
	Recognises features of conditions requiring urgent investigation and treatment including acute coronary syndrome, pulmonary embolus, aortic dissection, shock or impending shock, severe arrhythmias, new murmur or severe heart failure
	Orders, interprets and acts on initial investigations in the context of chest pain, arrhythmias and syncope appropriately such as ECG, blood gas analysis, laboratory tests (including cardiac enzymes), chest radiograph, microbiology (e.g. for suspected infective endocarditis)
Skills- Clinical decision making, judgement [*in addition to CC1*]	Elects appropriate arena of care and degree of monitoring
	Involves senior/specialist provider when patient is critically ill with chest pain, arrhythmia, or if the cause is unclear
	Recognises when patients present with either non-cardiac conditions or stable cardiac conditions that can be safely discharged with initial treatment, advice and appropriate follow-up
Behaviour- Communication & professionalism	No additional competencies in addition to CC7 &CC8
Paediatric	No additional competencies

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skill	Participation in cardioversion/external pacing and thrombolysis
	Participation/observation of initiation of non-invasive ventilation for heart failure
	Observing internal pacing/angioplasty (PCI)/pericardiocentesis
	Observing echocardiography/exercise stress testing/CTCA

A2 Acute respiratory presentations

Assessment of these competencies via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

In addition, key DOPs could be carried out as part of this module, including PP2 Obtaining and interpreting an ABG, PP5 Basic airway assessment and management and PP8 Initial decompression of a large / tension pneumothorax.

Potential presentations in which these competencies could be assessed include the following:

- Sudden onset chest pain and SOB (suspicion of pulmonary embolism)
- Acute exacerbation in patient with known COPD or bronchiectasis
- Patient with new onset fever, productive cough +/- haemoptysis (suspicion of pneumonia)
- Any acute SOB with new oxygen requirement
- Acute wheeze with respiratory compromise (e.g. severe asthma)
- Acute stridor with respiratory compromise (e.g. severe croup)
- Other causes of acute respiratory compromise such as sickle cell crisis

Core competencies to achieve (for all patients) are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Defines common causes of **Breathlessness** (including non-cardiorespiratory) and their patho-physiology [to ensure causes of acidosis are not overlooked; e.g. DKA]
	Is able to describe the physiology of oxygen delivery, oxygen cascade and effects on work of breathing; definitions/causes of respiratory failure (type 1/type 2)
	Is able to define common causes and pathophysiology of **cough, cyanosis** [consider endemic pathogens/ environmental/ occupational causes]; **haemoptysis, wheeze, pleuritic chest pain, orthopnoea, dyspnoea, pleural effusion**
	Is able to differentiate upper and lower respiratory features of obstructive or restrictive conditions, inspiratory or expiratory phase e.g. stridor vs. wheeze, croup (laryngotracheobronchitis) vs. epiglottitis or foreign body obstruction
	Outlines relevant indications for, and limitations of, investigations including CXR; transthoracic ultrasound, Computed Tomography Pulmonary Angiography; spirometry; ECG; cardiac biomarkers; d-dimer; microscopy; Ventilation/Perfusion (V/Q) Scan; ABG [*note: PP2 for interpretation of ABG*]
	Recalls/understands principles of ventilatory support strategies including prescribing and administration of oxygen therapy, types of delivery and appropriate monitoring of effectiveness of ventilatory support
	Outlines the indications/contraindications for, and limits of, non-invasive and invasive ventilatory support
Skills- History	Takes a history that captures symptoms, timeline and relevant past medical, pharmaceutical, environmental or behavioural issues and risk factors that may support development of a differential diagnosis

	Elicits issues within the history that would identify high risk patients e.g. those likely to deteriorate, require admission, require ventilatory support or escalation to higher level care
	Is able to elucidate normal degree of activity/ functioning prior to current presentation and establish any predetermined limits of escalation, such as an 'advance directive' (or similar)
Skills – Examination	Uses a systematic (ABCDE) approach with an appropriately detailed cardiovascular and respiratory examination identifying important features to support a differential diagnosis
	Is able to differentiate between stridor and wheeze
	Recognises where respiratory effort is disproportionate due to hyperventilation from anxiety rather than a metabolic or cardiorespiratory disorder
Skills- investigation and treatment	Orders, interprets, prioritises relevant initial investigations including: routine blood tests, D-dimer and cardiac enzymes, ABG [note: PP2], CXR, ECG, peak flow, spirometry, CTPA, laboratory analysis pleural drain/tap sample
	Interprets ABG results in context of clinical condition [note: PP2]
	Initiates initial treatment specific to suspected cause (e.g. safe oxygen prescribing, early antibiotics, bronchodilator therapy)
	Interprets CXR to recognise/differentiate features including pleural effusion, pneumothorax, pneumonia, cardiac size, pulmonary mass/hilar enlargement; recognise the need for further investigations or intervention as necessary (e.g. pleural effusion drain/'tap').
	Makes a rapid and appropriate assessment and provides simple airway manoeuvres, airway adjuncts, selection of oxygen delivery device
Skills- Clinical decision making, judgement [*in addition to CC1*]	Makes an appropriate assessment of ongoing oxygen delivery and support, monitoring and decision when to escalate with initial ventilation [BVM] or ventilatory support if required for more severe or deteriorating respiratory compromise and/or to a higher level/arena of care
Behaviour- Communication & professionalism [*in addition to CC7/CC8*]	Recognises the distress caused by breathlessness and discuss with patient and carers
	Ensures appropriate documentation and sharing of information regarding an infectious disease/communicable disease (such as notifiable disease reporting process) according to local/national policy
Paediatric	Is able to identify and treat common respiratory conditions of childhood e.g. pertussis, croup, induced bronchospasm (viral URTI-related); recognising features of respiratory compromise e.g.

	intercostal/sub-costal recession, accessory muscle use, work and effectiveness of breathing
	Appreciates parental concerns and previous history or preceding pattern of illness in context of the acute presentation; offering appropriate counselling and advice e.g. inhaler medication administration using a spacer device
	~~Is aware of the importance of establishing a vaccination history as part~~ of consultation
	~~Is aware of the risks that some childhood illnesses may present to the~~ immunocompromised or other family members e.g. pregnant females.

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
	Participation/observation of initiation of non-invasive or invasive ventilation strategies, including emergency RSI/endotracheal intubation.
	Participation/observation of pleural effusion 'tap' and/or chest drain insertion; pleural aspiration/insertion of chest drain for spontaneous pneumothorax
	Discuss the impact of long-term respiratory illness and potential limits of escalation according to patients specified wishes or best interests' documentation of appropriate limits of escalation and end of life/palliative care.
	Exhibit non-judgemental attitudes and take opportunity to provide health education including inhaler technique, smoking cessation, lifestyle changes, environmental aspects (solid fuel fires) and information about continuity of care for chronic respiratory conditions.

A3 Acute abdominal presentations

Assessment of these competencies via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations (EXCLUDING clear/established specific O&G causes e.g. ectopic pregnancy) in which these competencies could be assessed include the following:

- Abdominal pain (inc. origin/radiation to loin/groin/back) +/- collapse/syncope
- Abdominal/inguinal/groin lumps/masses (e.g. herniae)
- Obstructive features e.g. abdominal distention/vomiting/'overflow' diarrhoea

- Jaundice/hepatic dysfunction (including hepatitis, alcoholic liver disease or poisoning) +/- ascites
- Abdominal signs or symptoms secondary to infectious disease e.g. Schistosomiasis, Helminths, Cryptosporidium, HIV/AIDs
- Gastrointestinal bleeding (upper or lower)
- Vomiting/diarrhoea suggestive of severe infectious gastroenteritis (esp. bloody or profuse diarrhoea)
- Acute exacerbation of known conditions such as diverticulitis, chronic pancreatitis, inflammatory bowel disease, cholecystitis
- Fresh bleeding PR
- Nutritional or mal-absorptive conditions where this may relate to a gastrointestinal disorder or infection

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Recalls the anatomical relationships of the organs in the abdomen and pelvis
	Outlines the different causes of **abdominal pain** (including surgical causes) and how the history and clinical findings differ between the causes, across all age groups depending on site, details of history, acute or chronic nature
	Outlines possible causes of **abdominal distension**
	Defines the different types of **abdominal mass** in terms of site, aetiology and clinical characteristics
	Outlines common causes and presentations of **upper and lower gastrointestinal bleeding**
	Specifies the causes of **nausea and vomiting, diarrhoea, constipation, jaundice and hepatic dysfunction** {pre- hepatic, hepatic, and post-hepatic causes}, **splenomegaly, hepatomegaly, abdominal swelling, portal hypertension and bowel obstruction** and recall the pathophysiology for each aetiology and associated risk factors
	Knows the common and serious causes of **loin pain** including renal colic, infection and obstruction of the urinary tract
	Describes features of rupture/leaking abdominal aortic aneurysm as a potential presentation with abdominal pain, especially with radiation to the back or involving collapse/syncope with evidence of shock and/or peripheral vascular compromise
	Can list and define gastrointestinal conditions and aetiology associated with acute abdominal presentation including colitis, gastroenteritis (infectious or non-infectious), hepatitis, cholecystitis,

	ascending cholangitis, gastrointestinal ulceration, pancreatitis, diverticulitis, bowel ischaemia or obstruction, irritable bowel syndrome and other functional bowel syndromes, chronic constipation
	Can list and differentiate non-abdominal (medical) causes of abdominal pain such as myocardial infarction, pneumonia, diabetic ketoacidosis, hypercalcaemia, sickle cell crisis, cystic fibrosis
	Considers potential obstetric/gynaecological causes of abdominal pain/presentations and differentiating these (e.g. symptoms of PV bleeding) such as ectopic pregnancy, endometriosis, placental abruption, etc
Skills- History	Takes a focused history of abdominal symptoms including: • Clarification of features of pain, especially any symptoms of immediately life-threatening abdominal conditions such as ruptured AAA, perforation and/or peritonitis, ischaemic bowel • Clarification of features and timelines for other symptoms and signs e.g. passing of flatus, bowel habit, vomiting, diarrhoea, bleeding • Specifically identifies potential pregnancy or gynaecological causes • Identifies any 'red flag' features of serious illness e.g. potential malignancy, liver failure • Obtains relevant past medical and surgical history including diet history, alcohol history, use of medications
Skills - Examination	Is able to undertake a detailed examination of abdomen, loin and pelvis/back as appropriate, eliciting any signs of tenderness, guarding, rebound tenderness, identify an intra-abdominal mass, ascites and interpret these findings appropriately
	Performs a rectal examination as part of physical examination where appropriate
	Elicits and interprets important systemic physical signs, associated symptoms and risk factors for the presence of diseases presenting with abdominal mass, ascites, splenomegaly, hepatomegaly, jaundice
	Evaluates nutritional and hydration status of the patient
Skills- investigation and treatment	Uses a systematic (ABCDE) approach ensuring identification and initiation of timely management of critical or life-threatening illness, including active haemorrhage and sepsis
	Orders, interprets and acts on initial investigations appropriately to establish/confirm aetiology: blood tests, urinalysis (including pregnancy test in females of child-bearing age), ECG and microbiology investigations, stool examination, consideration of urgent endoscopy (e.g. for upper GI bleed) as appropriate

	Orders appropriate radiological investigations including plain films, CT abdomen and be able to interpret CXR and AXR to identify air under diaphragm or other signs of obstruction or perforation
	Initiates first-line management including appropriate fluid resuscitation (including safe prescription/administration of blood products where indicated), pain relief, antibiotics, additional therapeutics e.g. PPI
	Ensures there is appropriate monitoring and observation including the use of a nasogastric tube and/or urinary catheter.
Skills- Clinical decision making, judgement [*in addition to CC1*]	Makes appropriate decisions regarding nutritional status and feeding e.g. 'nil by mouth'
	Prioritises surgical intervention vs. physiological optimisation (often in discussion with surgical and anaesthetic team); prioritising order of surgical procedures in several patients
	Recognises and initially manages complicating factors including coagulopathy, sepsis, alcohol withdrawal, electrolyte disturbance
	Considers the need for other interventions such as use of specific blood products, TXA, reversal of anticoagulation, vasopressor therapy, intra-luminal tamponade devices (e.g. Sengstaken-Blakemore tube)
Behaviour-Communication & professionalism [*in addition to CC7/CC8*]	Recognises the distress caused by, and often frequent attendance that results from, chronic abdominal pain and discusses appropriate strategies with patient and carers
	Ensures appropriate documentation and sharing of information regarding an infectious disease/communicable disease (such as notifiable disease reporting process) according to local/national policy
	Takes the opportunity at first attendance to offer appropriate advice and counselling, and signpost patient to further support services, for alcohol dependency
	Recognises the need for a chaperone
	Exhibits a non-judgmental attitude to patients with a history of alcoholism or substance abuse
Paediatric	Is aware of the specific paediatric abdominal/surgical emergencies including intussusception, pyloric stenosis or nutritional/mal-absorptive disorders, GI infection (including helminths, malaria) and constipation
	Appreciates parental concerns and previous history or preceding patterns of illness in the context of the acute presentation; offering appropriate counselling and advice e.g. for chronic constipation
	Appreciates the potential for fabricated or functional disorder, Munchausen's by proxy; non-accidental/neglect; psychological /psycho-social issues

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	Detail of competency
Skills- examination	Where suspicion of pelvic cause of an acute abdominal presentation in a female patient is able to undertake an appropriate bimanual pelvic examination, use of a speculum +/- microbiological swabs
Skills- investigation and treatment	Interprets gross pathology on CT abdomen, CT KUB, IVU, including identifying liver metastases, ureteric calculi +/- obstruction/dilatation +/-hydronephrosis; focussed abdominal ultrasound (for AAA)
	Demonstrates appropriate technique in carrying out an ascitic tap +/- ascitic drain
	Trans-urethral/transcutaneous suprapubic bladder catherisation

A4 Acute presentations involving self-harm and unintentional toxins/poisoning

This module covers the systemic consequences of intentional/unintentional toxin/poison and, where relevant, mental health aetiology/risk assessment. Assessment of these competencies via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations in which these competencies could be assessed include the following:

- Patient with drug or alcohol dependency presenting with issue related to dependency
- Injury or wound or other presentation as a result of self-harm or suicide attempt
- Unintentional overdose, accidental poisoning, envenomation/exposure
- Intentional overdose or poisoning
- Snakebite or another toxin
- Risk assessment for suicidal ideation/self-harm/harm to others.
- Adult/Child safeguarding/protection related to supervision/parental presentations.

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Is able to recognise features of a presentation that may represent a risk to yourself or others, e.g. from contamination by harmful materials, and the measures (such as decontamination) required to ensure safety before providing further medical care

	Can outline potential routes of exposure, animal vectors (locally prevalent venomous snake/spider species) and the specific signs and symptoms of poisoning from common toxic agents or drugs
	Is able to recognize the common toxidromes (e.g. nerve/organophosphate, opiates, carbon monoxide)
	Can outline initial investigation and management of the following overdose; paracetamol, salicylate, beta blockers, opiates, alcohol, anti- coagulants, benzodiazepines, antidepressants, SSRIs, amphetamine, cocaine, carbon monoxide
	Is able to describe how to obtain information about the recognition, diagnosis and management of specific poisons and toxins depending upon location/environment
	Demonstrates an understanding of drug testing/screening, measurement of drug levels and its limitations/application
	Outlines the immediate measures that should be taken and initial clinical management of severe envenomation/poisoning including use of antivenoms, antidotes and other countermeasures (e.g. activated charcoal, acetylcysteine, bicarbonate)
	Outlines the risk factors for a suicidal attempt
	Understands the common co-existing psychiatric pathologies and psychosocial factors that may precipitate suicide or self-harm
	Understands addiction, dependence and withdrawal syndromes, and how these are initially managed (specific therapeutics such as benzodiazepines and nutritional support for alcohol withdrawal)
	Describes the relevant health legislation/legal framework with regard to the assessment and treatment of patients following a presentation involving self-harm or suicidal ideation including the provision of medical treatment against the patient's will
	Describes the relevant health legislation/legal framework with regard to the sharing of confidential patient information following a presentation involving self-harm or suicidal ideation
Skills-History	Where relevant, takes a competent psychiatric history, including a collateral history (friends, relatives, first responders, mental healthcare providers)
	In the self-harm patient, demonstrates how to assess risk of further harm, which may involve the use of an established scoring tool (e.g. SADPERSONS)
	Is able to recognise a critically ill overdose/self-harm or poisoned patient and initiate resuscitation as appropriate
Skills - Examination	Examines to determine the nature and effects of poisoning
	Is able to perform a mental state examination
	Examines for signs of systemic and/or severe local envenomation and be able to assess a bite to determine the likelihood that envenomation has occurred

	Undertakes a clinical examination looking for signs of the physical complications of alcohol or drug dependency
Skills- investigation and treatment	Orders, interprets and acts on initial investigations appropriately e.g. biochemistry, arterial blood gas, ECG, drug concentrations
	Is able to provide initial resuscitative care for a significantly unwell patient suffering from poisoning/toxin exposure including the safe administration of oxygen (and contraindications such as paraquat poisoning), adrenaline, intravenous fluids, direct drug antidotes such as naloxone for opiate toxicity
	Is able to actively manage the acutely poisoned patient, including but not limited to: the use of specific antidotes and antitoxins, use of control/counter-measures such as activated charcoal or bicarbonate, and indications for renal replacement therapy
	In the case of severe envenomation, ensures that adrenaline and antivenom are delivered rapidly once recognised, and ensure measures are immediately available to manage a potential anaphylactic response to this treatment
	If suspected self-harm, always investigates for overdose by common medications and can initiate treatment as appropriate
	For suspected envenomation ensures suitable monitoring is instigated to identify any signs of neurological deterioration, secondary organ failure and haemostatic dysfunction
Skills- Clinical decision making, judgement *(in addition to CC1)*	Ensures assessment of patient with disturbed behaviour takes place in a safe environment and ensures the safety of both staff and patient
	Forms a working diagnosis and assessment of risk of further harm to themselves or others, or potentially life-threatening presentations
	Is able to assess patient capacity to make decisions regarding their care at the time of presentation
	Is able to assess the likelihood of type and severity of potential envenomation, and relative risks involved in delivering antivenom
	Is able to recognise those patients at sufficient risk that they require immediate ongoing specialist mental health care
Behaviour- Communication & professionalism *(in addition to CC7& CC8])*	Is able to communicate and develop a rapport with patient, family and carers and sympathetically elicit history in patients with suspected self-harm
	Is able to communicate calmly with aggressive or angry individuals
	Can outline strategies for management of those who refuse assessment or treatment or who abscond and are at risk
	Is able to provide advice on reducing risk of further snake/ other animal bites whether inside house or external environment
Paediatric	Demonstrates knowledge of the major types of poison/toxin ingestion by age

	Recognises self-harm as an expression of distress in children and adolescents

A5 Acute neurological, cognitive or affective presentations

This module covers primary disorders of brain/brain function – organic or psychiatric in nature.

Assessment of these competencies via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through PS and MSF

Potential presentations in which these competencies could be assessed include the following:

- Sudden onset weakness, slurring of speech, confusion or change in conscious level
- Acute onset dizziness and vertigo
- 'First Fit' or status epilepticus
- Isolated head injury
- Meningitis/encephalitis
- Acute onset unilateral weakness or loss of sensation
- Severe headache with red flag signs or symptoms
- Acute presentation in patient with multiple sclerosis
- Psychiatric (inc. neuropsychiatric)/affective (such as agitation, severe acute anxiety, mania, hallucinations or psychotic symptoms
- Delirium/dementia (cognitive dysfunction) and mental state examination

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge- Organic conditions	Recalls the common epileptic syndromes, causes and treatments for seizures; including relevant indications for investigations for a 'first fit'
	Recognises status epilepticus in the spectrum of seizure disorder and the priorities for immediate medical care
	Is able to describe the basic neuro-anatomy of the brain, relevant central neurological/sensory functions and how these may be affected by disease or injury
	Is able to describe the neuro-anatomy and physiology relevant to balance, coordination and movement; differentiate the different types of vertigo and ataxia and their causes
	Can outline the neuro-anatomy and physiology of the components of the motor system, including differentiation of upper and lower motor neurone conditions

	Outlines the neuro-anatomy and physiology of sensation (especially pain) and the causes of abnormal sensation and likely site of lesion
	Outlines common causes and treatment of primary headache disorders and be able to differentiate between these and secondary headache
	Outlines common and life-threatening causes of acute new secondary headache, including 'red flag' signs and symptoms and indications for urgent neuro-imaging
	Outlines the classification of stroke and its link to prognosis
	Is able to describe the signs and symptoms of infections affecting central or peripheral neurological function, including but not limited to meningitis, encephalitis, spinal abscess
	Knows the anatomy of the scalp, skull and brain, the pathophysiology of head injury (primary and secondary brain injury)
	Outlines the definitions of traumatic brain injury and identify features that may require radiological imaging and/or further intervention or specialist follow-up
Knowledge-Psychiatric	Defines and characterizes the common types of psychiatric conditions and manner these may present in an emergency, and potential side effects of the major groups of psychomotor medications
	Describes the indications, contraindications and side effects of drugs used in acute psychosis including, but not limited to: haloperidol, benzodiazepines, clozapine
	Lists the common and serious causes for acute confusion/delirium and is able to differentiate between delirium and dementia
	Recognises the factors that can exacerbate acute confusion/delirium (e.g. a change in social environment or acute infection) and can list the pre-existing factors that may pre-dispose to acute confusion/delirium
	Is able to describe the factors that predict aggressive behaviour: personal history, alcohol and substance abuse, delirium
	Is able to describe the legal framework for authorizing interventions in the management of the disturbed or violent patient
	Is able to outline potential physical health and socioeconomic impacts of chronic mental illness
Skills-History	Where required, is able to take a full psychiatric history, obtaining the required information regarding: • presenting complaint • past psychiatric history • family history • work history • sexual/marital history • substance misuse

	• forensic history • social circumstances
	Elucidates a clear timeline and history of neurological symptoms e.g. change to bladder control, recent or past relevant medical history, history of treatment, medications, alcohol/drug misuse
	Obtains a corroborating history from witnesses where possible, especially with head injury and fits
	Is able to recognise symptoms that may indicate raised intracranial pressure ('red flag' features) and corroborates with examination
Skills - Examination	Is able to undertake an appropriate and focussed neurological examination, including cranial nerve examination, assessment of level of consciousness, assessment of power, tone, sensation and reflexes, to support development of a differential diagnosis
	Can differentiate epileptic seizure from non-epileptic (pseudo)-seizures
	Is able to elicit signs of raised intracranial pressure
	Is able to establish the level of a lesion causing changes to motor or sensory function
	Is able to elicit specific signs of conditions such as temporal arteritis, meningism, myasthenia gravis, Parkinson's
	Is able to conduct a mental state examination including: • appearance and behaviour (including clothing) • speech: quality and content • mood and affect • thought abnormalities; insight/rationalisation • hallucinations/delusions • cognitive function e.g. using the mini mental test score
	Undertakes a physical examination that looks for physical causes of psychiatric symptoms and delirium such as head injury, sepsis, substance withdrawal, thyroid disease, intoxication, and hypoglycaemia
Skills-investigation and treatment	Remembers to maintain a systematic approach to assessment (ABCDE) as first principle
	Is able to select appropriate investigations for a suspected traumatic, pharmaceutical or other organic cause of behavioural disturbance; interpret and act on results of investigations: e.g. ECG, blood laboratory tests inc. glucose, brain imaging (CT and MRI)
	Safely sedates patient when appropriate, including monitoring requirements and reassessment as required
	If required, is able to initiate treatment for patient dependant on differential diagnosis e.g. acute anxiety, acute agitation, signs/ symptoms of drug/ alcohol withdrawal
	Is able to identify and initiate radiological investigations for suspected stroke and acute severe headache including indications

	for urgent head CT and stroke thrombolysis or neurosurgical /neuro-radiological intervention
	Knows the indications for LP and how to interpret basic CSF analysis: cell count, protein, bilirubin, gram stain and glucose
Skills- Clinical decision making, judgement *(in addition to CC1)*	Following initiation of immediate resuscitative treatment, expedites the care of patients requiring more specialist immediate treatment e.g. stroke thrombolysis, anaesthesia for status epilepticus
	Knows when it may be appropriate to safely discharge patients presenting with a 'first fit'
	Knows when it may be appropriate to safely discharge patients presenting with headache
Behaviour- Communication & professionalism *(in addition to CC7 & CC8)*	Shows compassion and patience in the assessment and management of those with mental health conditions
	Demonstrates safety awareness of the situation and environment to avoid risk from violent behaviour against themselves or other staff
	Is able to safely evade physical assault using appropriate de-escalation and/or escape techniques
	Is able to use safe and proportional restraint methods (e.g. sedation and/or physical) to manage a violent/aggressive patient who is without capacity and at risk of causing/suffering harm
	Can provide explanations and plan for future care for those with non-serious headaches
Paediatric competencies	Is able to differentiate between febrile convulsion and epilepsy and be able to investigate and treat accordingly
	Is able to reassure parents/ family after child presents with febrile convulsion
	Is able to identify children with head injury which may result from non-accidental injury
	Is able to recognise children/young patients presenting with anxiety-related disorders, signs of post-traumatic stress disorder and other forms of distress and can share relevant information or escalate appropriately; ensure safeguarding and support measures are put in place or signposted

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills- Investigation and treatment	Is able to perform a diagnostic lumbar puncture
	Initiates measures to reduce intracranial pressure, such as intubation/hyperventilation, sedation and paralysis, use of hypertonic saline/mannitol, cooling measures, posture

A6 Acute musculoskeletal and atraumatic limb presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through MSF.

In addition, key DOPs can be carried out as part of this module including PP9 Local and regional analgesia, procedural sedation, PP11 fracture reduction, PP12 dislocation reduction, PP13 simple wound closure and appropriate dressings, PP14 Limb immobilisation inc. splints/ POP/slings

Potential presentations in which these competencies could be assessed include the following:

- Acutely painful/swollen limb or joint: traumatic or non-traumatic
- Immediate management of closed or open fracture of limb
- Management of dislocation of joint (with/without associated fracture)
- Acute back or neck pain: traumatic or non-traumatic
- Complex wound affecting muscle/ tendon/nerve or vascular structure
- Acute musculoskeletal manifestations of known systemic disease, nutritional disorder or hereditary condition (including children presenting with developmental abnormality)
- Child with a limp

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Is able to demonstrate knowledge of bony/joint anatomy with relevant radiological appearances in the clinical context
	Demonstrates knowledge of types, mechanisms/patterns of injury, clinical and radiological presentations and initial treatment of: - common fractures (neck of femur/femur, ankle, wrist, hand) - common joint dislocations (hip, shoulder, ankle, patella) - musculo-tendinous injuries (e.g. Achilles rupture) - traumatic musculoskeletal back/neck pain - swollen/hot joint – inflammation or infection - spontaneously painful limb (e.g. ischaemia)
	Outlines the serious alternative causes of acute back pain such as malignancy, urological, spinal cord compression, AAA rupture
	Outlines the serious alternative causes of acute neck pain such as meningeal irritation, local infection and vascular causes
	With reference to back/neck pain: identifies features that raise concerns as to a more sinister cause (“red flags”) and those that lead to a consideration of a chronic cause (“yellow flags”)

	Knows the likely/ potential immediate, intermediate or long-term secondary issues related to injuries such as fractures e.g. nerve damage, compartment syndrome, wound management
	Demonstrates an awareness of the role of nutrition and degenerative conditions on bony metabolism and density with its effects on function and resilience in different patient groups
	Is able to describe and differentiate causes of limb pain such as ischaemia, venous thromboembolism, infection, inflammation, radiculopathy (nerve root compression/ infection e.g. shingles)
	Recalls the risk factors for the development of thrombosis and recognised risk scoring systems
	Can differentiate between mono and polyarthropathies, and their disease associations
Skills- History	Is able to take a full history including relevant details of mechanism of injury, including the forces/energy involved and circumstances such as protection e.g. clothing/helmet/seat-belt/air bag
	Establishes important details regarding occupational and activity-related (e.g. sport or musical instrument) dexterity and lateral dominancy when presenting with limb injuries
	Establishes relevant past medical history especially in terms of previous joint or limb pain/swelling
	Correlates acute joint or limb pain/swelling with systemic signs or symptoms and/or multiple joint involvement
Skills - Examination	Is able to demonstrate assessment of limb and joint function, including detection of neurological and vascular compromise
	Can examine joints and spine to elicit any signs of swelling, pain or deformity, including range of movement
	Can elicit signs of meningeal irritation when assessing neck pain
	Can elicit signs of spinal cord compression/cauda equina syndrome when assessing patients with acute back pain
	Can assess the viability and perfusion of limb and differentiate pitting oedema; cellulitis; venous thrombosis; compartment syndrome; critical limb ischaemia
Skills- investigation and treatment (*in addition to PP9, PP10, PP11, PP12, PP13, PP14*)	Orders, interprets and acts on initial investigations appropriately: e.g. radiological, blood tests, Doppler studies, urine protein
	Is able to demonstrate the common techniques for joint and fracture immobilisation, including: • local and regional anaesthesia (PP9, PP10) • fracture manipulation (PP11) e.g. Colles/distal radius • reduction of dislocated joint (PP12) e.g. glenohumeral joint • wound care/coverage (PP13) • splintage/application of POP or sling (PP14)
	Is able to prescribe appropriate analgesia/muscle relaxants for acute joint/limb or neck/back pain

	Recognises the need for serological investigations such as joint aspiration (recognising that local practice may vary as to where this occurs)
Skills- Clinical decision making, judgement and planning *(in addition to CC1)*	Recognises the time-critical nature of a potential cauda equina syndrome or limb ischaemia, the need for urgent investigations and senior/specialist intervention
	Can assess a wound for contamination and foreign body (e.g. glass) and risk of infection, including tetanus; offers appropriate prophylaxis (including immunoglobulin/vaccination) (see also PP13)
	Appropriately identifies more complex wounds that may require irrigation/debridement, tendon, vascular or nerve repair, delayed primary closure and longer-term aftercare e.g. antibiotic therapy or secondary wound surgical care (graft/tissue transfers)
	Assesses and provides mobility aids including occupational therapy intervention in the case of older/frail patients
Behaviour- Communication & communications *(in addition to CC7& CC8)*	Provides wound care management advice and information regarding removal of sutures/dressings at appropriate time (see also PP13)
	Offers appropriate routine musculoskeletal self-care advice e.g. Pain relief/Rest/Ice/Compression/Elevation (PRICE) guidance
	Arranges appropriate outpatient clinic/follow-up for review of fractures, dislocations or wounds
Paediatric	Is able to identify a 'pulled elbow' and its treatment
	Is able to identify fractures or other musculoskeletal injuries that may indicate non-accidental injury, particularly in association with age/developmental stage or historical inconsistency
	Appreciates radiological variations due to age (bony epiphyses, association with Salter-Harris fracture patterns)
	Is able to examine gait, posture and hip joints of all age groups and appropriate to developmental stage
	Understands the differential diagnosis of limp in a child
	Septic arthritis: Is able to suspect this in different age groups

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills	Aspiration of a large joint e.g. knee
	Management of a compartment syndrome; may involve observation of fasciotomy

A7. Management of burns

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations in which these competencies could be assessed include the following:

- Thermal burns
- Chemical (caustic) burns
- Electrical burns
- Burn injuries of any type to face, including to eyes
- Circumferential burns or those to more sensitive/vital areas (e.g. genitals/hands)

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Is able to understand the pathophysiology of different burns (thermal, chemical, electrical and radiation)
	Is able to outline how to carry out an initial assessment, resuscitation and management of burns and the potential long-term impact on patient
	Recognises the risks to the upper and lower airway from heat and inhalation injury
	Recognises the importance of burns in special areas (face, joints, perineum) and circumferential burns
	Is able to explain the different dressing types used in burns, how they act and indications for their use
Skills- History	Is able to carry out an appropriate history, eliciting the mechanism of injury and any potential underlying causes e.g. fit or faint or signs of non-accidental injury
Skills - Examination	Carries out a systematic primary survey, with particular initial emphasis on airway and breathing
	Is able to assess airway, initiate initial management including oxygen therapy and be ready to assist ventilation if required;
	Recognise when emergency airway management is needed, such as surgical airway or endotracheal intubation
	Is able to assess the effects of severe burns to the head/neck/torso on respiratory function, including recognising the need for emergency escharotomies
	Is able to assess burns for sensation and capillary refill time
	Is able to identify electrical entry/exit burn wounds and the relevance of location to risk of cardiac and/or neurological injury and dysfunction

	Is able to assess the size and depth of burn and calculate the fluid requirements in adults and children using appropriate protocols/evidence-based guidance
Skills- investigation and treatment	Can provide effective multimodal pain relief for burns, appropriate initial coverage (if appropriate) and intravenous fluids
	Is able to irrigate chemical burns, including to eyes
	Recognises electrical burns and the need for ECG assessment and monitoring; appreciates the risk of cardiac or neurological complications, delayed signs of tissue injury (rhabdomyolysis)
	Is able to assess patients with thermal burns for potential carbon monoxide or cyanide poisoning
	Recognises and escalates care of severe chemical burns especially involving hydrofluoric acid and similar compounds
	Is able to manage minor burns and wounds, application of simple dressings and arranging appropriate follow-up care
Skills- Clinical decision making and judgement *(in addition to CC1)*	Recognises the burns patient who has the potential for delayed airway compromise and may require intubation later; ensure appropriate monitoring and observation in a suitable location for ongoing care
	Knows the criteria for referral to a burn's specialist and or other specialists e.g. critical care centre (dependent upon local/regional policy/resources)
Behaviour- Communication & professionalism *(in addition to CC7& CC8)*	Is able to assess and manage pain and distress from burns – particularly in children; appreciates the different options e.g. IM ketamine, IN diamorphine, sedation
	Is able to communicate the necessary information and initial self-care burn advice for patients who can be safely discharged
	Escalates and/or refers to senior or specialist care appropriately, providing clear and succinct details regarding injury mechanism and calculated burn extent, depth and associated factors such as airway/respiratory involvement, complex burns involving chemical agents, electrical burns
Paediatric	Is able to communicate sympathetically with the child/young person and their family when child presents with a burn
	Is alert to burns presenting as potential non-accidental injury or feature of neglect, including delay in seeking medical advice or historical inconsistency, or inconsistent location/pattern of burn for the described mechanism

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**	
Skills	Is able to carry out escharotomy or fasciotomy if there are signs of ischaemia to limbs or difficulty breathing	
	Management of complex caustic chemical burns e.g. management with calcium chelation for HF exposure	

Procedures

Listed below are practical procedures in ADULTS that trainees will have to show competency in by the end of their training period. Most of these procedures can be assessed as part of assessment of clinical modules.

Key aspects of Core Professional Competencies can be assessed at the same time as procedures, including communication skills, consent, infection prevention and control.

For each procedure the trainee should know the indications/ contraindications and be able to:

- Explain the procedure to the patient and obtain verbal or written consent, as required
- Follow infection control procedures and aseptic technique
- Prescribe associated analgesia / administer if required
- Recognise and be able to undertake emergency management of common complications
- Safely dispose of all sharps
- Document the procedure, including labelling samples and giving instructions for aftercare

Procedure		EPA level
PP1	Peripheral venous cannulation/ emergency intraosseous access	4/3
PP2	Obtaining and interpreting an ABG	4
PP3	Obtaining and interpreting an ECG	4
PP4	Management of serious haemorrhage (inc. pelvic binders)	3
PP5	Basic airway assessment and management	4
PP6	Cardio-Pulmonary Resuscitation (CPR) and safe defibrillation	4
PP7	Primary survey	4
PP8	Initial decompression of a large or tension pneumothorax	3
PP9	Local analgesia	3
PP10	Regional analgesia	3
PP11	Fracture reduction	3
PP12	Dislocation reduction	3
PP13	Simple wound closure and appropriate dressings	4
PP14	Limb injury immobilisation inc. splints/POP/slings	4
PP15	Safe delivery of a fluid challenge	4

Optional procedures where competence could be demonstrated, but are NOT a mandatory requirement include:

- Lumbar Puncture
- Urethral and suprapubic catheters
- Endotracheal Intubation
- Point of care ultrasound

B. Additional module options

The Learning Hubs will identify their choice **of AT LEAST 2** additional modules from the list below, based on service and population requirements. These will then become part of the overall trainee curriculum.

O1. Principles of quality/safety improvement

Assessment of this module can be carried as online learning and reflection or through submission of a project report.

Any online training must be from approved provider and have been completed in last 6 months.

Other actions that can support completion of this module include written reflection after completion of quality improvement or audit project, active participation in national or large audit, research or change project as part of project team or as result of serious untoward incident

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies,

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the principles of quality improvement, audit and learning from safety incidents in the healthcare environment
	Understands the role of human factors in safety, adverse events and near misses
	Recognises the importance of evidence-based practice in relation to clinical effectiveness and can outline the ways in which clinical guidelines can be developed
	Outlines local health and safety protocols (fire, manual handling etc)
	Understands risks associated with the trainee's specialty work including biohazards, hazards related to medical equipment and mechanisms to reduce risk
	Outlines the use of patient early warning systems to detect clinical deterioration where relevant to the trainee's clinical specialty
Skills	Adopts strategies to reduce risk e.g. surgical pause safety checklist
	Contributes to local quality improvement processes – for example; Audit of personal and departmental performance Errors / discrepancy meetings, Critical incident reporting, Unit morbidity and mortality meetings, quality improvement project
Behaviour-communication & professionalism	Engages with an open no-blame culture and shows willingness to act on concerns
	Communicates honestly with patients after an adverse event
	Encourages feedback from other team members on safety issues and events

Paediatric	Co-operates with changes necessary to improve service quality and safety No additional competences
specific competencies	

O2 Dermatological presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations in which these competencies could be assessed include the following:

- Child/ Adult with pruritic rash
- Life threatening rashes e.g. meningococcal septicaemia
- Leg ulcer +/- infection or thrombophlebitis
- Skin rash soon after starting new drug treatment- allergic reactions
- Red, hot skin lesion, tracking e.g. cellulitis
- Abscess
- Bites and infestations
- Surgical wound infection

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Can outline the structure and function of skin, hair and nails
	Recalls the characteristic lesions found in the acute presentation of common skin diseases e.g. cellulitis, erysipelas, impetigo, cutaneous drug reactions, purpuric rashes, skin malignancies
	Is able to identify the life-threatening dermatological emergencies, know their causes and emergency management including but not limited to: toxic epidermal necrolysis, Stevens-Johnson syndrome, erythroderma, necrotizing fasciitis
	Can outline the common causes of skin and mucosal ulceration and outline the classification of skin ulcers by cause
	Understands the aetiology by age and pathophysiology of bites and infestations
	Can outline possible complications that may present with a surgical wound and the type of infections that may occur
Skills- History	Is able to take a detailed history including systemic disease, drug and allergen history and development of skin lesion
	Is able to take detailed history of timeline and evolution of skin signs and symptoms

Skills - Examination	Conducts a detailed examination, including the nails, scalp and mucosae to arrive at appropriate differential diagnoses
	Accurately describes skin lesions following assessment, including any signs of secondary infection
	Is able to identify potential systemic disease with skin presentations
	Documents any early signs of pressure ulcers and identify those patients at risk of skin breakdown
Skills- investigation and treatment	Orders, interprets and acts on initial investigations appropriately to establish aetiology
	Can prescribe appropriate topical and oral treatments for common skin presentations
Skills- Clinical decision making and judgement (*in addition to CC1*)	Identifies those patients who are systemically unwell and require admission
	Recognises life threatening skin rashes and commences treatment and escalates care accordingly
	Ensures those patients who are at high risk for pressure ulcers are identified
Behaviour- communication & professionalism *(In addition to CC7 & CC8)*	Engages the patient in the management of their condition particularly with regard to topical treatments
	Recognises the importance of prevention of pressure ulcers and diabetic ulcers
	Demonstrates sympathy and understanding of patients 'concerns due to the cosmetic impact of skin disease
Paediatric	Understands the common dermatological presentations in children and is able to differentiate the life-threatening presentations

Additional optional competencies- EPA 1

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skills	Carries out a punch or other skin biopsy
	Debridement of wound
Behaviour	Is able to provide advice on managing open wounds, including dressings.

O3 Infectious and endemic diseases

Learning Hubs will be asked to define the most common/ debilitating or clinically important infectious/ endemic diseases that pertain to their service or local population. Assessment of this module should use the generic competencies listed below with particular emphasis on the chosen diseases.

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations / common infectious diseases that could be chosen by local Hub as priority for this module

- Meningitis, acute encephalitis syndrome/ Japanese Encephalitis
- TB
- Malaria
- Influenza
- Diarrhoeal diseases and food poisoning
- Hep B, Hep C, Hep E- acute and chronic
- HIV/AIDS
- Rabies
- Syphilis
- Ascariasis
- Leishmaniasis
- Tetanus
- Viral haemorrhagic fever, Kyasanur forest disease virus and Dengue
- Measles, Mumps, Rubella
- Vaccine preventable diseases e.g. polio, bacterial disease in children
- Schistosomiasis
- Food-bourne trematodes, nematodes

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Can outline the natural history of the common infectious diseases for the local population
	Can outline the common presentations and pathogenesis of infectious diseases that impact on mortality in your region, including meningitis, malaria, TB, HIV/AIDS, Hepatitis, genitourinary infections, schistosomiasis, leishmaniasis, Influenza
	Can outline the pathogenesis of food-bourne diseases, food poisoning and acute diarrhoeal diseases
	Can outline the different typical/ atypical infective presentations common to local area
	Can outline the pathological causes of typical/ atypical infective presentations, and treatments

	Can outline those infections requiring notification to authorities and the process for doing notification
Skills- History	Is able to obtain a detailed history and understand the importance of even generic symptoms e.g. fever with no identifiable cause
	Is able to identify risk factors for development of an infectious disease, including contacts, travel, animal contact and sexual history
Skills - Examination	Is able to identify signs of severe infection including change to LOC, metabolic acidosis, severe anaemia, hypoglycaemia, acute renal impairment, acute pulmonary oedema
	Is able to identify signs of acute encephalitis and those patients with cardiorespiratory impairment requiring rapid resuscitation
Skills- investigation and treatment	Identifies appropriate investigations and treatment, based on the differential diagnosis, clinical presentation, age and presence of pregnancy
	Is able to start empirical treatment for the most likely causes of encephalitis / meningitis presentations and instigate supportive treatment- glycaemic control, hydration, oxygenation
Skills- Clinical decision making and judgement *(in addition to CC1)*	Has a low index of suspicion for common presentations to local area in any patient with fever and no obvious septic loci
	Is able to identify patients at particular risk from seasonal influenza and advise on vaccination
	Is able to identify those patients at greater risk from infectious disease e.g. immunocompromised, elderly, very young, pregnancy
Behaviour- Communication & professionalism *(In addition to CC7 & CC8)*	Is able to advise patients and family members, when prophylaxis is required for an infectious disease e.g. young children and pulmonary TB, pregnant women in endemic malaria areas
Paediatric	Understands the risk diarrhoeal disease presents to those less than 5 years of age and can instigate safe and effective oral rehydration therapy, zinc supplementation and provide advice on breast feeding during acute episodes
	Can outline presentations and pathogenesis of common childhood infections e.g. measles, mumps, rubella
	Can outline the role of prevention in infectious diseases and be able to provide families with advice on contact tracing, prophylactic treatment, vaccinations

O4. Haematological emergencies

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log.

Potential presentations in which these competencies could be assessed include the following:

- Severe pain or breathlessness in patient with known Sickle cell disease, thalassaemia or other haematological disease e.g. Hodgkin's disease
- Acute widespread purpura/ bruising
- Any presentation of patient with ß Thalassaemia Major or Sickle Cell- where care may be impacted by disease
- Sepsis in patient receiving chemotherapy/ immunosuppressives
- Patient with acutely swollen leg and suspected DVT or chest pain and suspected PE

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Understands the pathophysiology and likely presentations of acute haematological emergencies e.g. disseminated intravascular coagulation
	Is able to outline common acute presentations of sickle cell and ß Thalassaemic major/ minor disease, including acute painful crises, osteomyelitis/ avascular necrosis, acute infections, anaemia, acute chest syndrome, stroke and thromboembolic events
	Understands the types of infection likely to present in a patient with sickle cell or thalassaemia
	Is able to diagnose, organise follow- up and explain types of thrombocytopenia
	Knows the causes and initial investigation of patients presenting with bruising and spontaneous bleeding, including over-anticoagulation and its reversal (in life threatening situations)
Skills- History	Obtains a detailed history of sickle cell and thalassaemic disease including of current treatment/ transfusion regimen, treatment of previous episodes, any concerns they may have about current episode
Skills - Examination	Rapidly and systematically assesses the patient in terms of ABCDE, and temperature
	Is able to differentiate different types of rash e.g. purpura
	Is able to assess pain, use the appropriate pain score for age and institute analgesia using an analgesic ladder

Skills- investigation and treatment	Administers oxygen, establishes intravenous access, takes blood cultures and administers antibiotics and intravenous fluids and pain relief
	Organises, interprets and acts on initial investigations including bloods, ABGs, blood cultures
	Is able to initiate management of life- threatening causes of purpura and bruising
Skills- Clinical decision making and judgement *(In addition to CC1)*	Elects the appropriate arena of care and degree of monitoring for patients with an acute haematological emergency
	Refers to appropriate specialist and seeks senior support in timely manner
Behaviour- communication & professionalism *(In addition to CC7 & CC8)*	Understands the patient's expertise in their own condition of sickle cell or thalassaemia
Paediatric	No additional competences

O5 Urological, renal and genitourinary presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through the MSF.

Potential presentations in which these competencies could be assessed include the following:

- Dysuria +/- flank pain and signs of sepsis
- Acutely swollen testis
- Urinary retention
- Severe dehydration with reduced urine production secondary to shock or sepsis
- Acute macro or micro haematuria
- Severe acute flank pain, suspected renal calculi
- Suspected uraemia
- Any presentation where patient has chronic moderate/ severe renal impairment, where management of presentation may be impacted
- Suspected genital ulceration or discharge plus orchiditis

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Knows the common causes of acute urinary retention, urinary tract infections, haematuria and scrotal pain or injury including their pathophysiology
	Understands the principal causes of a low urine output in the critically ill patient, and can identify the principal sub-causes (pre-renal, renal and post-renal), including but not limited to: • hypotension and inadequate renal perfusion • renal tract obstruction • nephrotoxic drugs and contrast media
	Understands the methods of assessment of renal function including but not limited to: blood tests, assessment of renal excretion, imaging of the genitourinary tract
	Outlines the immediate management options for low urine output including but not limited to: fluid resuscitation, increased cardiovascular monitoring, administration of vasoactive drugs and inotropes, the role of diuretics
	Understands the role of renal replacement therapy in the oliguric patient
	Describes common causes of chronic renal disease, their presentation and complications
Skills- History	Takes an accurate history of past treatment for chronic renal disease, history of other systemic disease that may impact renal function and drug treatments
Skills - Examination	Makes a rapid and systematic assessment using an ABCDE approach, of the patient with suspected uraemia, renal calculi, renal sepsis including appropriate clinical examination
	Identifies and refers those patients with testicular torsion promptly
	Is able to elicit signs of severe dehydration that may impair renal function
Skills- investigation and treatment	Is able to relieve symptoms of urinary retention by passage of a urethral catheter
	Is able to order and correctly interpret tests for urinary tract infection, renal calculi, scrotal disorders, including radiographic tests
	Is able to establish the underlying cause and search for the complications of urinary tract infections e.g. pyelonephritis
	Is able to safely prescribe for patients in renal failure
	Initiates early (critical) management of acute kidney injury (e.g. fluid administration) including requesting safe monitoring and identification of hyperkalaemia
	Ensures appropriate tests undertaken and treatment started, including any required swabs for genitourinary infection

Skills- Clinical decision making and judgement *(In addition to CC1)*	Is able to plan and communicate to the wider team appropriate monitoring requirements of the patient with a low urine output
	Involves appropriate senior and specialist support to facilitate immediate assessment and management of those with decreased renal function (e.g. imaging, intensive care, surgeons, renal physicians)
	Identifies those patients that need referral for admission and or emergency renal replacement therapy
Behaviour- Communication & Professionalism *(In addition to CC7 & CC8)*	Is able to reassure patients with severe pain or distress
	Is able to counsel patients on the safe use of medication in renal impairment
	Is able to counsel patients on follow up and contact tracing with suspected genitourinary infection
	Seeks support from specialists early when patient has severe derangement of renal function
Paediatric	Knows the principles of monitoring urine output in infants
	Is able to rationalise and manage the acute causes of testicular pain in children

Additional optional competencies- EPA 1 to 2

Knowledge/ Skill/ Behaviour	**Detail of competency**
Skill- examination	Examination for suspected STD, obtaining microbiological samples via urine or swab
Skill- Investigation & treatment	Examination of CT with contrast for renal calculi
	Supra-pubic catheterisation
Behaviour	Counselling prior to HIV testing
	Communication of positive HIV or STD result

O6 'End of life' and palliative care considerations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through MSF.

Potential presentations in which these competencies could be assessed include the following:

- End stage cancer or disease
- Care of dying patient requiring symptom control

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Is able to explain signs of a patient who is dying and common emergency presentations, including pain, nausea and vomiting, hypercalcaemia, bleeding, seizures, spinal cord compression
	Can outline the management of common symptoms of patients presenting towards end of life or dying including nausea & vomiting, anorexia, breathlessness, pain, psychological distress, incontinence, oral health care
Skills- History	Understands the importance of taking an accurate history of medications and issues that may arise from polypharmacy
	Is able to assess patients and identify those towards the end of life. Understand the importance of assessment of social, psychological and spiritual requirements
Skills - Examination	Carries out full examination, including assessment of mental state, nutritional and hydration status
	Is able to carry out an assessment and implement management of pain, including in patients with cognitive impairment, utilising pain scores and analgesic ladder
Skills- investigation and treatment	Initiates investigations and management, taking into account appropriateness of invasive investigations and treatments in the dying patient
Skills- Clinical decision making and judgement *(In addition to CC1)*	Discusses the patients' needs and preferences regarding care in the last days of life, including preferred place of death, investigations and treatments and resuscitation orders
Behaviour- Communication & professionalism *(In addition to CC7 & CC8)*	Is able to sensitively communicate with patients and family/carers who present in last days of life, to elicit preferences for care and wishes in terms of treatment
	Is able to explain issues, symptoms that may arise towards the end of life for the frail and unwell and can to explain these to patient and carers and outline management plans
	Is able to listen with sympathy and understanding to concerns of family / carers and patient
	Is able to communicate with other clinicians and act as an advocate for patient who is frail or dying
Paediatric competencies	No additional competencies

O7 Malnutrition, electrolyte and endocrine presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through MSF.

Potential presentations in which these competencies could be assessed include the following:

- Any patient with chronic and or severe diarrhoea e.g. Crohns
- Any patient with end stage chronic disease e.g. End stage renal failure or acute renal impairment secondary to sepsis/ medication
- Patient requiring additional support to feed +/- enteral feeding e.g. PEG feeding
- Elderly frail who may have poor nutrition
- Patient with known metastatic cancer and onset of confusion, dehydration, or other signs of hypercalcaemia
- Patients with chronic alcohol dependency and poor nutrition
- Child with severe acute diarrhoea
- Confusion, sweating or decreased LOC in a known diabetic
- SOB, dehydration, fever, in patient with Type 1 DM
- Very high glucose in patient without known DM
- Patient with sepsis and Type 1/II Diabetes
- Suspected new diagnosis of Type 1 Diabetes
- Dehydration, confusion (Hypercalcaemia (non-cancer))
- Tachycardia, anxiety, diarrhoea, weight loss (Thyrotoxicosis)
- Fatigue, bradycardia, weight gain (Myxoedema)

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Knows the aetiology, pathophysiology and presentation of dehydration. Is able to recognise the life-threatening complications of dehydration
	Is able to outline the common causes of malnutrition in adults and children
	Is able to anticipate common problems an adult/ child with severe malnutrition may present with including; hypoglycaemia, hypothermia, sepsis, dehydration and electrolyte imbalance, mineral and vitamin deficiencies

	Can outline the identification and management of common vitamin and mineral deficiencies
	Knows the diagnostic criteria for diabetes and glucose intolerance
	Describes the pathophysiology and likely presentation of common diabetic emergencies e.g. diabetic ketoacidosis
	Outlines the management and pathophysiology of common metabolic and endocrine emergency presentations
	Outlines the impact Type 2 DM may have on life expectancy, risks associated with DM and other health issues/ behaviours and potential long-term complications
	Is able to outline common insulin regimes for Type 1 DM
	Is able to outline common pharmacological and non-pharmacological treatments for Type 2 DM
Skills- History	Is able to screen for potential malnutrition
	Is able to identify patients with poor absorptive capacity e.g. acute colitis
	Is able to take an appropriate detailed history to identify precipitating causes of diabetic ketoacidosis, hyperosmolar non-ketotic coma and hypoglycaemia
	In a patient with suspected new type 2 DM is able to elicit symptoms such as polydipsia, polyuria, repeated skin infections, recent weight loss
	Is able to elicit potential causes for life threatening metabolic or endocrine presentations
Skills - Examination	Can elicit signs of dehydration e.g. dry mucosae, reduced skin turgor
	Is able to elicit signs of common vitamin and mineral deficiencies and any life-threatening complications
	Can elicit signs related to sepsis in a diabetic
	Is able to elicit signs of complications of Type 2 DM
Skills- investigation and treatment	Appropriately assesses and establishes the need for a fluid bolus in an acutely unwell patient
	Administers intravenous glucose and glucagon safely and rapidly to reverse hypoglycaemia
	Prescribes intravenous fluids, insulin and potassium safely for the hyperglycaemic patient
	Can safely correct severe hypo/hyper -natraemia, -kalaemia, -calcaemia
Skills- Clinical decision making and judgement *(In addition to CC1)*	Identifies those patients that will need critical care and intensive monitoring
	Demonstrates an understanding of the need to assess the fluid status of the acutely unwell patient, when such assessment is necessary, and the need for reassessment and additional monitoring

	Understands and can implement changes to diabetic treatment, including insulin in diabetic patient with concomitant illness
Behaviour-Communication & professionalism *(In addition to CC7 & CC8)*	Is able to advise patients on requirements for changes to treatment for diabetes in presence of other illness e.g. sepsis
	Is able to elicit when malnutrition (+/- dehydration) may result from self-neglect
Paediatric	Is able to calculate and prescribe fluid replacement, maintenance fluids and replacement for ongoing losses as per APLS protocols
	Is able to outline different causes and pathophysiology of acute versus chronic malnutrition, especially in children
	Understands how behavioural issues in adolescents and young adults may impact on their diabetic care
	Can identify where malnutrition may be a sign of neglect in a child

O8. Common ophthalmological presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through the MSF.

Potential presentations in which these competencies could be assessed include the following:

- Sudden loss of vision, diplopia or blurring of vision
- Acute red eye
- Foreign body in eye
- Infection eye or orbital region
- Change to visual field

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Knows the pathophysiology and presentations of common acute eye presentations e.g. acute glaucoma, conjunctivitis, foreign body in eye, detached retina, loss of vision or visual field defects, orbital factures
	Knows the optical signs of detached retina, papilloedema
	Can outline common eye presentations associated with systemic disease
Skills- History	Can obtain the timeline of symptoms and any relevant injuries to the eye, past surgery or ophthalmic conditions

Skills - Examination	Is able to fully examine an eye, including use of eye drops to dilate the pupils and staining for foreign bodies
	Is able to test for visual acuity
	Is able to examine the eye, including use of ophthalmoscope and slit lamp
	Is able to assess eye movements and visual fields
Skills- investigation and treatment	Knows how to review an x-ray for penetrating eye injuries
Skills- Clinical decision making, judgement *(In addition to CC1)*	Correctly identifies the underlying pathology and ensures prompt ophthalmic referral for those patients who need admission and those that can be managed with outpatient follow-up
	Is able to identify and referral urgently those with critical eye conditions e.g. ophthalmic zoster, acute angle glaucoma, SOLs
Behaviour- Communication & professionalism	No additional competences
Paediatric	No additional competences

O9. Common ENT and maxillofacial/dental presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through MSF.

Potential presentations in which these competencies could be assessed include the following:

- Severe epistaxis
- Severe acute sore throat
- Foreign body in ear or nose
- Painful locked jaw
- Potential fracture of jaw
- Loss of tooth
- Dental abscess
- Vertigo +/- loss of balance

Core competencies to achieve (for all patients), are EPA level 3 (Indirect active-partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor immediately available).

Knowledge/ Skill/ Behaviour	Detail of competency
Knowledge	Knows the anatomy of the ear, nose and throat
	Knows the common causes of pain in ear and throat and their initial management
	Knows the presentation of dental abscess, teeth avulsion and TMJ dislocation
	Knows the causes of epistaxis including trauma and medication
Skills- History	Is able to establish the timeline of presentation and associated symptoms e.g. dysphagia, joint pain in sore throat as well as any previous presentations and treatments
Skills - Examination	Is able to carry out a full examination of external and internal ear, including use of an Otoscope
	Is able to carry out a full examination of the neck and throat and adjacent lymph nodes
	Is able to identify patient with upper airway obstruction, including stridor
Skills- investigation and treatment	Is able to derive a differential diagnosis and initiate treatment for most likely cause of presentation
	Knows when antibiotics are indicated for sore throats or ear infections
	Is able to undertake anterior nasal packing /use nasal tampon in epistaxis
Skills- Clinical decision making and judgement	Knows when to refer a patient to ENT for specialist assessment, admission or follow up
Behaviour- Communication & professionalism	No additional competences
Paediatric specific	Outline common life-threatening ENT/ maxillofacial presentations in paediatric age group e.g. epiglottitis, quinsy

O10. Common obstetric and gynaecological presentations

Assessment of these competencies is via Mini-CEX, CbD (formative or summative) or ACAT-EM and a reflective log. In addition, key aspects of communication and professionalism can be captured through MSF.

Potential presentations in which these competencies could be assessed include the following:

- Abdominal pain or shock in early pregnancy
- Bleeding in early or late pregnancy

- Female with fever, abdominal pain- suspected pelvic inflammatory disease
- Late pregnancy complications e.g. preeclampsia/ eclampsia

Trainees are expected to achieve EPA level 2 (Direct active – full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout) in these competencies.

Knowledge/ Skill/ Behaviour	**Detail of competency**
Knowledge	Knows the causes of pelvic pain, vaginal discharge and bleeding in women of all ages, including pregnancy
	Knows the normal physiological changes of pregnancy
	Knows the early complications of pregnancy and their pathophysiology
	Knows the complications of middle, late pregnancy, their presentations and pathophysiology
	Knows the pharmacology of drug metabolism at different trimesters of pregnancy and safe prescribing
	Knows the common presentations, systemic manifestations, pathogens and appropriate initial investigation for potential PID
	Knows the common post-partum life threatening presentations e.g. bleeding, PE
Skills- History	Is able to elicit a full sexual and reproductive history
	Is able to take an obstetric history
Skills - Examination	Is able to undertake a full examination of a patient with pelvic pain
	Is able to demonstrate a bimanual pelvic examination, use of speculum and obtain microbiological swabs when appropriate
	Is able to examine the foetus in pregnancy, including cardiac sounds, presentation, size
	In a patient that is bleeding, is able to examine using systematic ABCDE approach and assess requirements for resuscitation
	Is able to investigate suspected preeclampsia
Skills- investigation and treatment	Can explain the rationale for investigations and commence the appropriate treatment
Skills- Clinical decision making and judgement *(In addition to CC1)*	In the acutely unwell patient, bleeding or sepsis, is able to carry out initial assessment and initiate resuscitation and refer appropriately
	Recognises life threatening presentations such as eclampsia, PE, massive haemorrhage
Behaviour- communication	Is able to communicate the need for the examination and explain to the patient throughout examination
	Recognises the need for a chaperone

& professionalism (In addition to CC7 & CC8)	
Paediatric	No additional competences

Appendices

Appendix 1 EMFP curriculum and expected attainment in EPAs by end of programme year

1	Not allowed to practice independently, observer only
2	Direct active- full supervision by senior clinician, with prompting/ verbal and actual guidance and help throughout
3	Indirect active- partial supervision by senior clinician, no prompting or help provided, direct line of vision or supervisor is immediately available
4	Passive- full entrustment to carry out competence, no senior support provided

Curriculum modules				**EPA level at start**	**EPA level at end**	
					Adult patients	**Paediatric patients**
CC	Core Professional Competencies * **Please note, these are NOT assessed separately but must be evidenced through assessment of the clinical modules**	CC1	Clinical decision making and judgement	1	2	2
		CC2	Therapeutics and safe prescribing	1/2	3	3
		CC3	Assessment and management of pain	1/2	3	3
		CC4	Infection Prevention and Control (IPC); personal safety (PPE)	1	2	2
		CC5	Assessing patient capacity and obtaining consent	1	2	2
		CC6	Safeguarding and the vulnerable patient	1	2	2
		CC7	Communication with the patient/relative(s) inc. breaking bad news	1/2	3	2
		CC8	Communication with colleagues and effective handover	1/2	3	3
		CC9	Time and workload management	1/2	3	3
		CC10	Health promotion and public health	1/2	2	2
R	Resuscitation	R1	Cardiorespiratory, respiratory and peri-arrest	1/2	3	2
		R2	Shock, anaphylaxis and the septic patient	1/2	3	2

Curriculum modules				EPA level at start	EPA level at end	
					Adult patients	Paediatric patients
		R3	The unconscious patient (or deteriorating level of consciousness)	1/2	3	2
T	Major Trauma	T1	Systematic assessment and initial management of a major trauma presentation	1/2	3	2
		T2	Major Incident Management: involving large numbers of casualties or a surge of acutely ill patients	1	2	2
A	Acute presentations	A1	Acute cardiac presentations	1/2	3	3
		A2	Acute respiratory presentations	1/2	3	3
		A3	Acute abdominal presentations	1/2	3	3
		A4	Acute presentations involving self-harm and unintentional toxins/poisoning	1/2	3	3
		A5	Acute neurological, cognitive or affective presentations	1/2	3	3
		A6	Acute musculoskeletal presentations	1/2	3	3
		A7	Management of burns	1/2	3	3
PP	Practical procedures	PP1	Peripheral venous cannulation / emergency intraosseous access	1/2	3	-
		PP2	Obtaining and interpreting an ABG	1/2	3	-
		PP3	Obtaining and interpreting an ECG	1/2	3	-
		PP4	Management of serious haemorrhage (inc. pelvic binder)	1/2	3	-
		PP5	Basic airway assessment and management	1/2	4	-
		PP6	Cardio-Pulmonary Resuscitation (CPR) and safe defibrillation	1/2	4	-
		PP7	Primary survey of a major trauma patient	1/2	4	-
		PP8	Initial management of a tension pneumothorax	1/2	4	-
		PP9	Local anaesthesia	1/2	3	-

Curriculum modules				EPA level at start	EPA level at end	
					Adult patients	Paediatric patients
		PP10	Regional anaesthesia	1/2	3	-
		PP11	Fracture reduction	1/2	3	-
		PP12	Dislocation reduction	1/2	3	-
		PP13	Simple wound closure and appropriate dressings	1/2	4	-
		PP14	Limb injury immobilisation including splints/POP/slings	1/2	4	-
		PP15	Safe delivery of a fluid challenge	2	4	-
O	Additional modules *** Please note the Learning Hub will choose 2 to be included within the curriculum**	O1	Principles of quality/safety improvement	1	2	2
		O2	Dermatological presentations	1	2	2
		O3	Infectious and endemic diseases	1	2	2
		O4	Haematological emergencies	1	2	2
		O5	Urological, renal and genitourinary disorders	1/2	3	3
		O6	'End-of-life' and palliative care considerations	1	2	-
		O7	Care of patient with malnutrition, electrolyte or endocrine disorder	1	2	2
		O8	Common ophthalmological presentations	1	2	2
		O9	Common ENT, maxillofacial and dental emergencies	1	2	2
		O10	Common obstetric and gynaecological presentations	1	2	-

Appendix 2 Assessment blueprint

Listed below are the curriculums with the suitable assessment tools. It is suggested all modules have initial formative assessments, followed by additional formative or summative assessment as outlined below. Please note, although summative eLc alone cannot be used to sign off a module by itself, although it can be used as additional evidence alongside an ACAT-EM or CbD.

Curriculum modules		Formative							Summative				
		Mini-CEX	CbD	ACAT-EM	MSF	AA	RL	S	Mini-CEX	CbD	DOPs	LS	eLc
CC1	Clinical decision making and judgement	*	*	*	*		*		*	*			
CC2	Therapeutics and safe prescribing	*	*	*									*
CC3	Assessment and management of pain	*	*	*							*		
CC4	Infection Prevention and Control (IPC); personal safety (PPE)	*	*	*	*	*					*		*
CC5	Assessing patient capacity and obtaining consent	*	*	*		*					*		*
CC6	Safeguarding and the vulnerable patient	*	*	*									*
CC7	Communication with the patient/relative(s) inc. breaking bad news	*	*	*	*		*				*		
CC8	Communication with colleagues and effective handover	*	*	*	*		*				*		
CC9	Time and workload management			*	*	*	*						
CC10	Health promotion and public health		*	*		*	*						*
R1	Cardiorespiratory, respiratory and peri-arrest	*					*		*		*	*	
R2	Shock, anaphylaxis and the septic patient	*					*		*		*		
R3	The unconscious patient (or deteriorating level of consciousness)	*					*		*				
T1	Systematic assessment and initial management of a major trauma presentation	*					*		*		*	*	
T2	Major Incident Management: involving large numbers of casualties or a surge of acutely ill patients		*				*	*				*	*

Curriculum modules		Formative							Summative				
		Mini-CEX	CbD	ACAT-EM	MSF	AA	RL	S	Mini-CEX	CbD	DOPs	LS	eLc
A1	Acute cardiac presentations	*	*	*			*		*	*	*		
A2	Acute respiratory presentations	*	*	*			*		*	*	*		
A3	Acute abdominal presentations	*	*	*			*		*	*			
A4	Acute presentations involving self-harm and unintentional toxins/poisoning	*	*	*			*		*	*			
A5	Acute neurological, cognitive or affective presentations	*	*	*			*		*	*			
A6	Acute musculoskeletal presentations	*	*	*			*		*	*	*		
A7	Management of burns	*	*	*			*		*	*			
PP1	Peripheral venous cannulation / emergency intraosseous access										*		
PP2	Obtaining and interpreting an ABG										*		
PP3	Obtaining and interpreting an ECG										*		
PP4	Management of serious haemorrhage (inc. pelvic binder)										*		
PP5	Basic airway assessment and management										*		
PP6	Cardio-Pulmonary Resuscitation (CPR) and safe defibrillation										*		
PP7	Primary survey of a major trauma patient										*		
PP8	Initial management of a tension pneumothorax										*		
PP9	Local anaesthesia										*		
PP10	Regional anaesthesia										*		
PP11	Fracture reduction										*		
PP12	Dislocation reduction										*		

Curriculum modules		Formative							Summative				
		Mini-CEX	CbD	ACAT-EM	MSF	AA	RL	S	Mini-CEX	CbD	DOPs	LS	eLc
PP13	Simple wound closure and appropriate dressings										*		
PP14	Limb injury immobilisation including splints/POP/slings										*		
PP15	Safe delivery of a fluid challenge										*		
O1	Principles of quality/safety improvement					*	*					*	*
O2	Dermatological presentations	*	*	*			*						*
O3	Infectious and endemic diseases	*	*	*			*						*
O4	Haematological emergencies	*	*	*			*						*
O5	Urological, renal and genitourinary disorders	*	*	*			*						*
O6	'End-of-life' and palliative care considerations	*	*	*			*						*
O7	Care of patient with malnutrition, electrolyte or endocrine disorder	*	*	*			*						*
O8	Common ophthalmological presentations	*	*	*			*						*
O9	Common ENT, maxillofacial and dental emergencies	*	*	*			*						*
O10	Common obstetric and gynaecological presentations	*	*	*			*						*