INTERCOLLEGIATE BOARD FOR TRAINING IN INTENSIVE CARE MEDICINE (IBTICM)

THE CURRICULUM FOR THE CCT IN INTENSIVE CARE MEDICINE

COMPETENCY-BASED TRAINING AND ASSESSMENT

PART III

Assessment of Competence in ICM at Basic Level and in Complementary Specialties

Name: _____

Module Dates: _____

CONTENTS

Terminology and scope of these documents:
The term ‘intensive care’ in this document is synonymous with ‘critical care’ or ‘intensive therapy’. ‘Intensive care unit (ICU)’ is synonymous with critical care unit or ‘intensive therapy unit (ITU)’. High dependency, step-down and outreach care are also considered in these documents.

DOCUMENTATION OF COMPETENCE IN ICM AT BASIC LEVEL AND THE COMPLEMENTARY SPECIALITIES (ANAESTHESIA AND INTERNAL MEDICINE) OR DURING FOUNDATION YEAR TRAINING

This section contains the forms, which must be completed by trainers and trainee to confirm that the trainee has satisfactorily met the minimum standards required for achieving competence at Basic level in each of the three elements

1. normally three months of intensive care medicine, and
2. four to eight months in the complementary specialty of anaesthesia (normally six months)
3. four to eight months in the complementary specialty of medicine (normally six months)

These periods are now indicative, and whilst it is recognised that trainees will normally need at least 4 months to acquire the necessary competences, it is nevertheless the demonstration of competences rather than the duration of training which will now become the mechanism for establishing appropriateness to enter later stages of training. The complementary specialty competences may be acquired before, or after, appointment to a ST post in ICM. Consequently, and given that the three elements of training may be undertaken in different hospitals at widely separate times, particular effort must be made to ensure that trainees plan ahead and maintain these records of competency assessment.

Trainers should ensure that trainees have retained these skills if they were acquired before starting an ICM training post.

When considering 'Medicine' as a complementary specialty it is understood that competences may be gained in any attachment to a medical training programme with a component of unselected take. This may be in acute medicine, or an acute medical specialty. Up to one half of this indicative period may be spent in Emergency Medicine.

Assessments should be performed by, or with the approval of, the Intercollegiate Board Tutor (Board Tutor) or relevant College Tutor, or other designated consultants who meet the criteria to be trainers[1]. The precise way in which the assessments are conducted will depend on circumstances and local practice. Guidance is given in Part I of these documents. It will usually be possible for assessments to take place during routine clinical work and for different elements to have been assessed by a number of appropriate assessors at varying times during clinical attachments'. However, the assessments must include all the items listed in the following forms, and two consultant assessors, who confirm that the trainee has achieved those competences, must have assessed each competency grouping. The assessments must be signed by both assessors and by the trainee. Copies of the outcome of these assessments must be held by the trainee, the Board Tutor, and the base specialty College Tutor.

Assessments of a more general nature should be carried out using a multi-source feedback (MSF) process at least once during each component of Basic training. If deficits in attitudes and inter-personal skills are demonstrated by these MSFs it may be necessary to carry out more than one iteration. The clinical assessments should use Direct Observation of Procedural Skills (DOPS), Mini-Clinical Evaluation Exercises (mini-CEX) and Case Based Discussions (CBD) as the fundamental tools, but this does not exclude the use of other tools appropriate to the curriculum and attachment.

The trainee will be assessed in the following areas:

3.1: During training in anaesthesia:

[1] A trainer is defined in Part I of this series of documents *A Reference Manual for Trainees and Trainers*

a) Preoperative assessment.
b) General anaesthesia for ASA I or II patients (including equipment and anaesthetic machine check)
c) Rapid sequence induction
d) CPR skills
e) Clinical judgement, attitudes and behaviour
f) Confirmation of satisfactory completion of training in anaesthetic module

3.2: During training in medicine:

a) General aspects of clinical history taking, examination and investigation of patients
b) Initial assessment of competence in the management of the acutely ill patient (also 3.iii.c)
c) CPR skills (if not already assessed in anaesthetic or intensive care modules or no ALS course in preceding 12 months)
d) Clinical judgement, attitudes and behaviour

3.3: During training in intensive care medicine:

a) CPR skills (if not already assessed in anaesthetic or internal medicine modules or no ALS course has been successfully completed in the preceding 12 months)
b) Either:
    i) Airway management skills, or
    ii) Rapid sequence induction and tracheal intubation (assessed in anaesthetic module)
c) Initial assessment of competence in the management of the acutely ill patient (also 3.2(b))
d) Organ support and practical procedures
e) Communication skills, clinical judgement, attitudes and behaviour

3.1: ASSESSMENT OF COMPETENCE OF ICM TRAINEES UNDERTAKING THE COMPLEMENTARY SPECIALTY TRAINING MODULE IN ANAESTHESIA

This will be conducted using the Initial Test of Competence in Anaesthesia developed by the Royal College of Anaesthetists. The test, the assessment forms, and the explanatory notes are reproduced here in full (with minor modification to include confirmation of duration of complementary specialty training). It should be noted that the assessments of rapid sequence induction and CPR could be assessed during the Basic intensive care medicine module and that CPR could also be assessed during the internal medicine module.

1. Before being permitted to practice anaesthesia without direct clinical supervision[2] all trainees must achieve a satisfactory standard in an initial assessment of competency involving at least two consultant anaesthetists who meet the criteria to be trainers[2]. This applies to new trainees and to more experienced trainees working in the United Kingdom for the first time. Although the assessment process is the responsibility of the College Tutor, it can be delegated to other trainers, as appropriate. This initial assessment is designed to demonstrate the possession of basic key components of knowledge, skills and attitudes necessary to progress in the specialty.

Until the Initial Assessment of Competency has been completed successfully, the trainee must not deliver anaesthesia *at any time* without direct supervision.

2. It is intended that this assessment should be completed by a typical trainee after approximately 3 months of full-time training in anaesthesia, but the exact timing will need to be determined on an individual basis. More experienced trainees who are working in the United Kingdom for the first time, whatever their grade, could be assessed much earlier than 3 months, after a period of familiarisation and direct clinical supervision.

3. The initial assessment should comprise a recorded consensus view of the trainers who have supervised the trainee including a workplace assessment covering:
   - preoperative assessment;
   - general anaesthesia for ASA I or II patients (including equipment and anaesthetic machine check);
   - general anaesthesia with spontaneous respiration;
   - general anaesthesia with endotracheal intubation;
   - rapid sequence induction and failed intubation routine;
   - CPR skills; and
   - clinical judgement, attitudes and behaviour.

4. The knowledge, skills and attitudes expected and the assessment details are given in Appendix 1. The patients seen by trainees will need to be selected so as to be appropriate to the trainees' limited exposure within the specialty and should always be of ASA I or II.

These assessments will be formal. Both the assessment and its outcome must be recorded in departmental records and in the trainee's personal record. Should a trainee be assessed as unsatisfactory in any area, and thus be referred for further closely supervised training, the reasons for this referral must be recorded. The names of assessors must be legible, as must any additional comments.

[2] Levels of supervision and the criteria for trainers are defined in *The CCT in Anaesthesia I: General Principles*, sections 4 and 5.

5. Following the Initial Assessment of Competency:

- Satisfactory assessment: After a satisfactory assessment trainees may begin to undertake uncomplicated general anaesthesia cases and peripheral nerve blocks delegated to them, without direct supervision and may be given increased clinical responsibility (for example by working on the 'on-call' rota with indirect {local or distant} supervision[8]).

- Unsatisfactory assessment: After an unsatisfactory assessment trainees will need targeted instruction and a re-assessment. Whether the whole assessment is to be repeated or targeted at deficient areas is a decision to be taken locally, with regard to individual circumstances, and is left to the discretion of the assessors.

- Compulsory reassessment after repeated failure: Repeated failure by a novice trainee to achieve the prescribed standard after 6 months of full-time training will call into question the trainee's suitability for a career in anaesthesia and should lead to an immediate, compulsory reassessment. Failure at this assessment will normally result in the trainee being asked to leave the specialty.

THE INITIAL TEST OF COMPETENCY: SYLLABUS

The principles of this Initial Test of Competency can be found in Section 2.

This test is in 5 parts:

a) Preoperative assessment
b) General anaesthesia for ASA I or II patients (including equipment and anaesthetic machine checks)
1. General anaesthesia with spontaneous respiration
2. General anaesthesia with endotracheal intubation
c) Rapid sequence induction and failed intubation routine
d) CPR skills
e) Clinical judgement, attitudes and behaviour

If a trainee has successfully completed an ALS course within the last 12 months (d) can be omitted.

Only after this test has been satisfactorily completed can a trainee progress beyond direct supervision.

Each of the 5 parts of the test (a – e, above) can be assessed by one (or more) trainers, but not all 5 parts can be "signed off" by the same single trainer. At least two trainers must be involved in the overall assessment.

What follows is the syllabus for each of the five parts together with the assessment sheets for each part.

3.1(a) Pre-operative assessment

Clinical skills:

Is able to:

1. demonstrate satisfactory communication with staff and patients
2. in a manner appropriate to the patient, to take a relevant history, explain the necessary aspects of anaesthesia, and answer any questions in a manner appropriate to the patient
3. assess the airway
4. recognise potential problems requiring senior help
5. explain the management of post-operative pain and symptom control in a manner appropriate to the patient
6. interpret basic investigations (FBC, U & Es, chest x ray, ECG)
7. choose and prescribe an appropriate pre-medication

Knowledge:

1. The American Society of Anesthesiologists (ASA) scale of fitness
2. The relevance of common inter-current diseases to anaesthesia and surgery
3. Consent for anaesthesia
4. Predictors of difficult intubation

Setting:

Patients: All appropriate patients aged 16 and over
Location: Wards
Situation: Supervised ward round

Assessments:

* A ward-based demonstration of practical skills
* Simultaneous oral confirmation of understanding

Guidance:

This is an early test to ensure that the trainee communicates adequately and understands the broad outline of anaesthetic assessment. After about three months of training the trainee should be expected to identify patients who are low risk from the anaesthetist's point of view. There is no expectation of the trainee being able to determine the fitness of patients for operation who are severely ill or who have inter-current disease. The expectation is that they will know which cases to refer to or discuss with senior colleagues. The trainee should have an understanding of whatever premedication he or she intends to use.

INITIAL ASSESSMENT OF COMPETENCY:

a) Pre-operative assessment of patients

The trainee must be accompanied on a pre-operative round of patients.

Name of trainee……

The Trainee:

Communicates in a satisfactory manner with patients	☐
Obtains relevant history	☐
Undertakes any physical examination (if indicated)	☐
Assesses the airway	☐
Understands the pre-operative investigations	☐
Explains anaesthesia clearly	☐
Discusses pain and explains post-operative analgesia clearly	☐
Prescribes pre-operative medication as needed	☐
Understands the ASA classification	☐
Understands consent for anaesthesia and procedure	☐

This assessment was completed satisfactorily
IF NO, GIVE REASONS:

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.1(b) Administration of a safe general anaesthetic to an ASA I or II patient

Clinical skills:

1. Explanation of the anaesthetic procedure(s) and surgery to the patient
2. Appropriate choice of anaesthetic technique
3. Pre-use equipment checks
4. Proper placement of intravenous cannulae
5. Attachment of monitoring (including ECG) before induction of anaesthesia
6. Measures blood pressure non-invasively
7. Pre-oxygenation
8. Satisfactory induction techniques
9. Appropriate management of the airway
10. Maintenance of anaesthesia
11. Knowledge of the concept of 'awareness' under anaesthesia, and methods of prevention
12. Appropriate perioperative monitoring and its interpretation
13. Recognition and immediate management of any adverse events which might occur
14. Proper measures during emergence from general anaesthesia, including extubation.
15. Satisfactory hand over to recovery staff
16. Accurate completion of anaesthetic and other records
17. Prescription of appropriate post-operative analgesia and anti-emetics
18. Choice of post operative oxygen therapy
19. Instructions for continued intravenous therapies (if relevant)

Knowledge:

1. The effects of anaesthetic induction on cardiac and respiratory function
2. The rationale for pre-oxygenation
3. Methods available for the detection of misplaced ET tubes, including capnography
4. Common causes of arterial desaturation (cyanosis) occurring during induction, maintenance and recovery
5. Common causes and management of intra-operative hypertension and hypotension
6. The immediate management only of cyanosis, apnoea, inability to ventilate, aspiration, bronchospasm, anaphylaxis and malignant hyperpyrexia
7. Trainees must demonstrate an adequate, basic, practical knowledge of anaesthetic pharmacology to support their practice, for example, know about: 2 induction agents, 2 volatile agents, 2 opioids, suxamethonium and 1 competitive relaxant

Setting:

Patients: ASA I and II patients age 16 years and over requiring uncomplicated surgery in the supine position e.g. hernia, varicose veins, hysterectomy, arthroscopy
Location: Operating theatre
Situations: Supervised theatre practice

Assessments:

* A theatre-based demonstration of practical skills
* Simultaneous oral case discussion of understanding

Guidance:

The trainee should be observed undertaking a number of cases using facemask and airway, and/or laryngeal mask and/or endotracheal tube. Care should be taken to ensure that the trainee is skilled in use of bag and mask and does not always rely on the laryngeal mask. Whilst ensuring patient safety the assessor should let the trainee proceed largely without interference and note problems of technique. This should be combined with a question and answer session covering the underlying comprehension of the trainee. The level of knowledge expected is that of a trainee who has been working in anaesthesia for 3 months and should be sufficient to support the specified clinical skills. Exclusions are specialised surgery, rapid sequence induction (see Section c) and children under the age of 16 years.

3.1(b) Ability to administer a general anaesthetic competently to an elective ASA I or II patient

Part 1 General anaesthesia with spontaneous respiration

Name of trainee ………

The Trainee:

Properly prepares the anaesthetic room and operating theatre	☐
Satisfactorily conducts a pre-operative equipment check (including the anaesthetic machine and breathing system)	☐
Has properly prepared and assessed the patient for surgery	☐
Chooses an appropriate anaesthetic technique	☐
Establishes IV access	☐
Establishes ECG and pulse oximetry in the anaesthetic room	☐
Measures the patient's blood pressure prior to induction	☐
Pre-oxygenates as necessary	☐
Induces anaesthesia satisfactorily	☐
Manages airway competently	☐
I) Face mask (+/-) airway	☐
II) LMA	☐
Makes satisfactory transfer to operating theatre	☐
Positions patient safely	☐
Maintains and monitors anaesthesia satisfactorily	☐
Conducts emergence and recovery safely	☐
Keeps an appropriate and legible anaesthetic record	☐
Prescribes analgesia appropriately	☐
Properly supervises discharge of patient from recovery	☐
Understands the need for oxygen therapy	☐

This assessment was completed satisfactorily
IF NO, GIVE REASONS:

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.1(b) Ability to administer a general anaesthetic competently to an elective ASA I or II patient

Part 2 General anaesthesia with endotracheal intubation

Name of trainee ……

In addition to the assessment in Part 1, the trainee must demonstrate the following:

Assesses the airway properly	☐
Knowledge of factors which may make intubation difficult	☐
Satisfactory use of laryngoscope	☐
Correct placement of endotracheal tube*	☐
Confirming the position of endotracheal tube by	☐
(i) observation	☐
(ii) auscultation	☐
(iii) capnography	☐
Knowledge of how to recognise incorrect placement of endotracheal tube	☐
Knowledge of how to maintain oxygenation in the event of failed intubation	☐
Manages extubation competently	☐

This assessment was completed satisfactorily
IF NO, GIVE REASONS:

Signed …….. Print name…… …….. .Date …..……..

Appointment ……..……..

Signed …… Print name ……..... Date……..……

Appointment……

*If intubation is not possible, the trainee should maintain the airway and allow the assessor to intubate the patient.

3.1(c) Rapid Sequence Induction for an ASA I or II patient and failed intubation routine

Clinical skills:

1. Detection of risk factors relating to slow gastric emptying, regurgitation and aspiration
2. Use of drugs (antacids, H_2 receptor antagonists, proton pump inhibitors etc.) in the management of the patient at risk of aspiration
3. Explanation of pre-oxygenation to the patient
4. Proper explanation of rapid sequence induction (RSI) to patient
5. Proper demonstration of cricoid pressure to the patient and assistant
6. Demonstration of the use of:
    a) tipping trolley
    b) suction
    c) oxygen flush
7. Appropriate choice of induction and relaxant drugs
8. Attachment of ECG, pulse oximeter and measurement of BP before induction
9. Pre-oxygenation
10. Satisfactory rapid sequence induction technique
11. Demonstration of proper measures to minimise aspiration risk during emergence from anaesthesia
12. Failed intubation drill, emergency airway management (this may be manikin based)

Knowledge:

1. Risk factors causing regurgitation and aspiration.
2. Factors influencing gastric emptying, especially trauma and opioids
3. Fasting periods in relation to urgency of surgery
4. Reduction of the risks of regurgitation
5. Failed intubation drill, emergency airway management
6. The emergency treatment of aspiration of gastric contents
7. Basic pharmacology of suxamethonium and repeated doses

Setting:

Patients: Starved ASA I and II patients aged 16 and over having uncomplicated elective or urgent surgery with normal upper airway anatomy.
Location: Operating theatre.
Situations: Supervised theatre practice.

Assessments:

* A test of failed intubation drill (this may be manikin based)
* A theatre based demonstration of practical skills
* Simultaneous oral test of understanding.

Guidance:

This test should ensure competent management of the airway during straightforward urgent surgery. The test must be done on a patient who is adequately starved prior to induction of anaesthesia. The patient may, or may not be, an urgent case. The trainee should be able to discuss methods of prediction of the difficult airway and of difficult intubation. They should be able to explain and if possible demonstrate on a manikin the failed intubation drill, and the immediate management of the patient who aspirates gastric contents.

3.1(c) Rapid Sequence Induction (RSI) and failed intubation routine

Name of trainee……

The Trainee has satisfactorily demonstrated:

Preparation of the anaesthetic room and operating theatre	
Satisfactorily checking of the anaesthetic machine, suction etc.	
Preparation of the patient (information and positioning)	
An understanding of the mandatory periods for pre-operative fasting	
An understanding of the indications for RSI	
An adequate explanation of RSI to the patient, including cricoid pressure	
To the assistant how to apply cricoid pressure	
Proper pre-oxygenation of the patient	
The undertaking of a RSI	
Recognition of correct placement of tracheal tube	
Knowledge of failed intubation drill	
Practical application of failed intubation drill (this may be manikin based)	
Proper extubation when the stomach may not be empty	

This assessment was completed satisfactorily
IF NO, GIVE REASONS:

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.1(d) Cardiopulmonary resuscitation (CPR)

3.1(d) Assessment of Cardiopulmonary resuscitation

The sections on notes and assessment for cardiopulmonary resuscitation form Part VI of the Curriculum and have been moved to there in recognition of the fact that they form a guide for many others than those undertaking a CCT in ICM. Their easy accessibility is therefore important. The appropriate assessment for CCT should be carried out at the different stages of training using Part VI documentation

3.1(e): Clinical judgement, attitudes and behaviour

At Basic level all that is required is confirmation of the statements below:

Name of trainee _____

To the best of my knowledge and belief this trainee has

1. Shown care and respect for patients
2. Demonstrated a willingness to learn
3. Asked for help appropriately
4. Appeared reliable and trustworthy

Signed …….. Print name…… ……..…… Date ……

Appointment ……..……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..……..

3.1(f) Confirmation of satisfactory acquisition of competences for complementary module in anaesthesia

Name of trainee: _____

Period of anaesthetic training and hospital placements (list below):

Dates: Place:

I confirm that this trainee has satisfactorily completed the complementary module in anaesthesia, or its equivalent

Signed …….. Print name…… ……..…… Date ……..……..……..

Appointment ……..……..

Signed …….. Print name…… ……..…… Date ……..……..……..

Appointment ……..……..

3.2: ASSESSMENT OF COMPETENCE OF TRAINEES UNDERTAKING THE COMPLEMENTARY SPECIALTY TRAINING MODULE IN MEDICINE

Trainees will be expected to demonstrate sufficient knowledge and skills to permit them to initiate appropriate acute management of patients with common medical disorders. This includes the initial test of competence in management of the acutely ill patient (3.1(b)). This initial test of competence may be undertaken during Foundation Year training, during training in medicine or in ICM. **Trainers should ensure that trainees have retained these skills if they were acquired before starting an ICM training post.**

The trainee will be assessed in the following:

a) General aspects of clinical history taking, examination and investigation of patients
b) Initial test of competence in the management of the acutely ill patient
c) CPR skills (if not already assessed in anaesthetic or intensive care modules or no ALS course in preceding 12 months)-
d) Clinical judgement, attitudes and behaviour

Settings:

The assessments will be conducted in the workplace during delivery of care to all appropriate hospitalised patients aged 16 and over in the clinic, wards, emergency departments or ICUs.

Clinical Skills to be assessed in 3.2(a) and 3.2(b):

- Identify acutely abnormal physiology and initiate prompt and appropriate resuscitation
- Establish venous access with attention to infection control measures
- Deliver a fluid challenge safely to acutely ill patients to optimise cardiac output
- Safely administer drug treatment including oxygen therapy
- Take an arterial blood sample for blood gas analysis
- Reassess acutely ill patients within an appropriate period following initiation of treatment
- Undertake a focussed history and examination to establish a differential diagnosis
- Demonstrates satisfactory communication with patients, relatives and colleagues
- Identify common abnormalities from ECGs, chest X-rays and arterial blood gas analyses
- Form a reasonable initial differential diagnosis
- Propose appropriate treatment plans
- Correctly prepare drugs for administration
- Request senior/more experienced help when appropriate
- Manage patients with impaired consciousness including seizure activity
- Determine need for “nil by mouth” status
- Insert a naso-gastric tube
- Identify concurrent co-morbid diseases and their relevance to the acute illness
- Select, prescribe and monitor safe and effective analgesia for patients with acute pain
- Initiate resuscitation and safe defibrillation in the event of a cardiorespiratory arrest

Knowledge to be assessed in 3.2(a) and 3.2(b):

- Presenting features of common acute medical conditions including breathlessness, hypoxaemia, hypotension, oliguria, chest pain, nausea, vomiting, and confusion or coma
- Clinical interpretation of acutely abnormal physiology
- Causes of impaired level of consciousness including seizures / seizure activity
- Causes of acute abdominal pain
- Risk factors precipitating the acute presentation of these conditions
- Common treatment algorithms (e.g.: myocardial infarction, asthma, COPD, diabetic ketoacidosis)

- Deliberate self-harm: modes of presentation, causation, initial treatment for most common forms of self-poisoning, psychological support
- Indications, contraindications, doses, routes of administration, and complications of drugs used
- Clinical and laboratory measures of acuity and severity of disease
- Safe and effective oxygen therapy
- Safe use of analgesic drugs; routes and methods of administration
- Acute confusional states including acute psychosis: causes and initial management
- Resuscitation protocols to Intermediate Life Support level (by the end of Foundation Year 1)
- Resuscitation protocols to Advanced Life Support level (by end of Foundation Year 2)

3.2(a) Assessment of general aspects of clinical history taking, examination and investigation of patients

The trainee must have been observed delivering care to patients.

Name of trainee…….

The Trainee:

	Assessor
Communicates in a satisfactory manner with patients	
Obtains relevant history	
Undertakes physical examination correctly and with consideration	
Identifies main abnormalities on examination	
Forms an initial differential diagnosis	
Proposes appropriate investigations	
Interprets results of investigations	
Forms a definitive diagnosis	
Proposes an appropriate management plan	
Describes how to convey information to the patient	
These assessments were completed satisfactorily IF NO, GIVE REASONS:	

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.2(b) INITIAL ASSESSMENT OF COMPETENCE IN THE MANAGEMENT OF THE ACUTELY ILL PATIENT (also evaluated in 3.3(c))

These competences may already have been assessed during training in GIM. The competences are specifically directed at the care of the acutely ill patient, and must be assessed in addition to generic skills in patient care such as history taking and clinical examination. The assessments will be conducted in acute care environments, which may include the wards, medical admissions units, accident and emergency departments, postoperative recovery areas, and intensive care units. Assessments will normally be undertaken when suitable opportunities arise, and will usually be performed by different assessors at different times.

Name of trainee: _____

The Trainee:	Assessor
Promptly assesses airway, breathing, circulation in the collapsed patient	
Identifies and responds to acutely abnormal physiology	
Establishes venous access with attention to infection control measures	
Delivers a fluid challenge safely to an acutely ill patient	
Reassesses acutely ill patients promptly following initiation of treatment	
Requests senior or more experienced help when appropriate	
Undertakes a secondary survey to establish a differential diagnosis	
Obtains an arterial blood gas sample safely, interprets results correctly	
Manages patients with impaired consciousness including fits	
Describes safe and effective use of common analgesic drugs	
Explains the principles of managing a patient following self-poisoning	
Describes the management of a patient with an acute psychosis	
Knows and applies local protocols for acute medical conditions	
Ensures safe continuing care of patients between shifts/on call staff	
Considers appropriateness of interventions according to patients' wishes	

Comments, or advice given by supervisors:

I confirm that this record is accurate (Local Training Supervisors/College Tutor)

Signed …….. Print name…… ……..... Date ……

Appointment ……..

Signed …….. Print name…… ……..... Date ……

Appointment ……..

3.2(c) Cardiopulmonary resuscitation assessment: See section 3.1(d)

The sections on notes and assessment for cardiopulmonary resuscitation form Part VI of the Curriculum and have been moved to there in recognition of the fact that they form a guide for many others than those undertaking a CCT in ICM. Their easy accessibility is therefore important. The appropriate assessment for CCT should be carried out at the different stages of training using Part VI documentation

If within the last 12 months the trainee has been assessed as competent in CPR in either the anaesthetic or the intensive care modules, or has successfully undertaken an ALS course, this section can be omitted. If not, then the assessment must be performed using the forms in Part IV.

3.2(d) Clinical judgement, attitudes and behaviour

During complementary specialty training all that is required is confirmation of the statements below:

Name of trainee _____

To the best of my knowledge and belief, during internal medicine training this trainee has:

- Shown care and respect for patients
- Demonstrated a willingness to learn
- Asked for help appropriately
- Appeared reliable and trustworthy

Signed …….. Print name…… ……..…. .Date …..……..

Appointment ……..……..

Signed …… Print name ……..... Date……..……

Appointment…….

3.3: ASSESSMENT OF COMPETENCE OF ICM TRAINEES UNDERTAKING BASIC TRAINING IN INTENSIVE CARE MEDICINE

Trainees will be expected to demonstrate a level of knowledge and skills which permit them to identify acutely ill patients, initiate appropriate emergency management, stabilise them for transfer, plan their care for the first hour in the ICU, and identify serious complications which may arise during intensive care.

The assessments will be conducted in the workplace, usually during the third month.

The trainee will be assessed in the following:

a) CPR skills (if not already assessed in anaesthetic or internal medicine modules, or no ALS course in preceding 12 months)
b) Either:
    i. Airway management, *or*
    ii. Rapid sequence induction and tracheal intubation (3.1(c), in anaesthetic module)
c) Initial assessment of competence in the management of the acutely ill patient
d) Organ support and practical procedures
e) Communication skills, clinical judgement, attitudes and behaviour

Notes and guidance:

3.3(a) Cardiopulmonary resuscitation assessment: See section 3.1(d) and Part IV
If within the last 12 months the trainee has been assessed as competent in CPR in either the anaesthetic or the intensive care modules, or has successfully undertaken an ALS course, this section can be omitted. If not, then the assessment must be performed using the forms in Part IV.

3.3(b) Airway management, or Rapid Sequence Induction and tracheal intubation: (See also section 3.1(c)
These assessments may be omitted if the trainee has already successfully completed section 3.i.c (in the anaesthetic module). If not, then the airway management competences must be assessed. These assessments may be conducted either in the intensive care unit (if a suitable opportunity arises) or in theatres, whichever is the most appropriate. Patient safety must be assured at all times.

3.3(c) and 3.3(d)

Clinical skills and Knowledge:
The clinical skills that are to be assessed must be supported by knowledge of the presentation, identification and management of common medical and surgical conditions which may result in critical illness. The focus is on first-point-of-contact, and the initial stabilisation of a sick patient. This will include knowledge of applied physiology and pharmacology, and an understanding of appropriate methods for basic organ system support and their potential complications.

Setting:
Patients: Patients receiving intensive and high dependency care or acute care
Location: Intensive or high dependency care units, wards and Emergency Departments (ED) and other clinical areas caring for acutely ill patients
Situations: Supervised delivery of patient care

Assessments:

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..

Guidance:

The trainee should be observed performing procedures and delivering patient care. The assessor should let the trainee proceed as far as possible without interference, whilst noting strengths and weaknesses of technique. This should be combined with a concurrent or subsequent discussion of understanding that assesses the underlying comprehension of the trainee. Communication with patient and staff, and personal responsibility for standards of care are all important elements.

3.3(a) Cardiopulmonary resuscitation assessment

The sections on notes and assessment for cardiopulmonary resuscitation form Part VI of the Curriculum and have been moved to there in recognition of the fact that they form a guide for many others than those undertaking a CCT in ICM. Their easy accessibility is therefore important. The appropriate assessment for CCT should be carried out at the different stages of training using Part VI documentation

If within the last 12 months the trainee has been assessed as competent in CPR in either the anaesthetic or the intensive care modules, or has successfully undertaken an ALS course, this section can be omitted. If not, then the assessment must be performed using the forms in Part IV.

3.3(b) Airway management skills

Object: to ensure that the trainee can manage an airway safely in the obtunded patient.

These assessments may be omitted if the trainee has successfully completed section 3.i.c (in the anaesthetic module). If not, then the airway management competences must be assessed. These may be conducted either in the intensive care unit (if a suitable opportunity arises) or in theatres, whichever is the most appropriate.

In these assessments the trainee demonstrates how to maintain a clear airway in an unconscious or anaesthetised patient by simple positional manoeuvres and the use of Guedel or nasopharyngeal airways; demonstrates or describes the use of the laryngeal mask airway; demonstrates bag and mask ventilation in an unconscious or anaesthetised patient; prepares a ventilator for use, with a basic set of safe settings; selects and prepares appropriate drugs and equipment for intubation of a patient with acute hypoxaemia; describes or demonstrates methods for minimising the risk of aspiration of gastric contents, including safe application of cricoid pressure (Sellick's manoeuvre); describes the actions required in the event of accidental displacement of an oral-tracheal tube and a tracheostomy tube; and demonstrates or describes the procedure for changing a tracheostomy tube, testing for correct placement.

Name of trainee:_____

The Trainee:

	Assessor
Demonstrates how to maintain a clear airway in unconscious patient	
Demonstrates safe use of airway adjuncts	
Demonstrates safe use of the laryngeal mask airway	
Demonstrates effective bag & mask ventilation (patient or mannequin)	
Prepares ventilator for use, with a basic set of safe settings	
Selects, prepares drugs & equipment for intubation in acute hypoxaemia	
Describes, demonstrates methods for minimising gastric aspiration risk	
Describes actions required for accidental displacement of endotracheal tube	
Describes or demonstrates procedure for displacement of, and elective replacement of, a tracheostomy tube	

These assessments were completed satisfactorily

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.3(c) INITIAL ASSESSMENT OF COMPETENCE IN THE MANAGEMENT OF THE ACUTELY ILL PATIENT (form 3.2(b))

Object: to ensure that the trainee can take simple diagnostic steps and safely manage common medical emergencies.

These competences may already have been assessed during Foundation Year training, or during training in GIM. Trainers should ensure that trainees have retained these skills if they were acquired some time before starting an ICM training post. The competences are specifically directed at the care of the acutely ill patient, and must be assessed in addition to generic skills in patient care such as history taking and clinical examination. The assessments will be conducted in acute care environments, which may include the wards, medical admissions units, accident and emergency departments, postoperative recovery areas, and intensive care units. Assessments will normally be undertaken when suitable opportunities arise, and will usually be performed by different assessors at different times.

Name of trainee: _____

The Trainee:	Assessor
Promptly assesses airway, breathing, circulation in the collapsed patient	
Identifies and responds to acutely abnormal physiology	
Establishes venous access with attention to infection control measures	
Delivers a fluid challenge safely to an acutely ill patient	
Reassesses acutely ill patients promptly following initiation of treatment	
Requests senior or more experienced help when appropriate	
Undertakes a secondary survey to establish a differential diagnosis	
Obtains an arterial blood gas sample safely, interprets results correctly	
Manages patients with impaired consciousness including fits	
Describes safe and effective use of common analgesic drugs	
Explains the principles of managing a patient following self-poisoning	
Describes the management of a patient with an acute psychosis	
Knows and applies local protocols for acute medical conditions	
Ensures safe continuing care of patients between shifts/on call staff	
Considers appropriateness of interventions according to patients' wishes	

Comments, or advice given by supervisors:

Assessments:

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..……..

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..……..

3.3(d) Organ support and practical procedures

Object: to ensure that the trainee has developed competence at basic technical skills and understanding of the simpler aspects of organ support.

These assessments will usually be conducted in the ICU and related clinical environments. If individual items are assessed by different assessors at different times, the assessor should indicate that a specific topic has been assessed by entering his or her initials in the relevant box.

Name of trainee:_____

The Trainee:

	Assessor
Demonstrates aseptic peripheral venous cannulation (+ local anaesthetic)	
Demonstrates aseptic arterial cannulation (+ local anaesthetic)	
Discusses indications for and contraindications to arterial cannulation	
Demonstrates aseptic placement of central venous catheter (CVC)	
Discusses indications, contraindications & complications of CVCs	
Connects mechanical ventilator and selects initial settings	
Describes safe use of drugs to facilitate mechanical ventilation	
Describes safe management of a patient 'fighting the ventilator'	
Describes principles of monitoring cardiovascular function	
Describes principles of monitoring respiratory function	
Describes appropriate response to oliguria	
Describes advice for ward staff receiving a patient with a tracheostomy	
Prescribes safe administration of vasoactive drugs, electrolytes	
These assessments were completed satisfactorily IF NO, GIVE REASONS:	

Assessments:

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……

Appointment ……..

3.3(e) Assessment of communication skills, attitudes and behaviour

These assessments will be conducted using the examples below, which are provided for guidance only, and not as prescriptive or exclusive standards. Suboptimal performance must be recognised and discussed with the trainee as early as possible and appropriate remedial action taken. Trainees must not be presented with an adverse assessment at the end of their ICM module without extensive prior warning and attempts to resolve the problem(s) in a supportive and confidential manner.

Attitude or behaviour	Example of minor problem	Example of serious problem
Communication skills (with patients and relatives)	Occasional communication difficulties with patients or relatives have been noticed	Repeated communication difficulties with patients and relatives have been noticed. Others have commented on them.
Communication skills (with staff)	Occasional communication difficulties have been noticed; unsatisfactory transmission of clinical information, e.g.: handovers, ward-round	Repeated communication difficulties with staff have been noticed. Others have commented on them. Fails to pass on important clinical information
Communication skills (sensitivity to needs of others)	On occasions fails to listen to patients or relatives or to respect their wishes. Lacks sensitivity in handling patients occasionally	Appears oblivious to what patients and relatives say, or insensitive to their likely feelings. Fails to understand or respect different cultural and ethical perspectives
Reliability and time-keeping	Isolated episodes of lateness, sometimes fails to warn of problems, tends to need reminding to get things done.	Repeated episodes of lateness, often fails to warn of problems, usually needs reminding to get things done
Control of moods and emotions	Occasionally shows irritability or bad temper with no apparent cause. Although other staff are aware of it, work continues normally.	Is well known for being moody, irritable and bad-tempered. Other staff modify their behaviour to accommodate them. The pattern of work is adversely affected
Personal presentation	When seeing patients, occasionally dresses in an unprofessional way.	Frequently dresses in an unprofessional way when seeing patients who may find this distasteful or upsetting. Other aspects of personal hygiene sometimes cause offence
Social behaviour	Social life occasionally impinges on professional life causing lateness, tiredness at work, and difficulty with studies.	Social life repeatedly affects professional performance, is likely to be causing problems with self-directed learning and affects patient care.
Conscientiousness in safe practice	Usually satisfactory but has occasional lapses (e.g. doesn't sign for drugs ordered, forgets to tidy up own sharps).	More frequent or serious errors, such as failing to check donor blood against transfusion form, errors in prescription, relaxed approach to errors. Doesn't record critical incidents
Initiative	Rather passive. Tends to need pushing when things have to be done. Slower than he/she should be to take responsibility.	Actively avoids taking up challenges and very slow in adopting responsibility as and when problems arise
Over or under assertiveness	(I) May undertake inappropriate procedures because of pressure from others. (II) On occasions insists on a course of action in the face of reasonable advice to the detriment of patients and/or colleagues	(I) Fails to be assertive even when necessary for the patient's well being. Unable to control any situation. (II) Frequently causes problems and offends patients and/or colleagues by insisting on a course of action in the face of reasoned argument.
Over-confidence	Occasionally takes on cases that are beyond level of competence. Occasional clinical crises occur because of lack of proper planning and assessment.	Frequently exhibits lack of care in planning and execution of tasks. Works without concern beyond his/her level of training, knowledge or experience.
Under-confidence	Reluctant to extend clinical experience. Anxious when working alone on clinical cases that should be within his/her competence.	Frequently demonstrates and transmits anxiety to the theatre environment. Is sufficiently stressed by work that symptoms of stress become an issue and affect performance.
Departmental involvement	Participation below the usual expected. Tends not to attend meetings unless he/she has to.	Rarely participates in any departmental activity. Rather isolated socially from other members of the department.
Team working	Doesn't always consider the needs of others. Tends to press ahead with his/her own plan and expects others to adapt around it.	Careless of the needs of others. Often arrogant and thoughtless. Sufficient lack of insight that his/her behaviour frequently causes problems.
Personal organisation	Can be unprepared for the task in hand: sometimes forgets to bring essential items to meetings etc. Can be slow to implement agreed policy changes.	Frequently poorly prepared and disorganised. Unreliable to the extent that other staff are affected. Appears unaware of the impact their behaviour has on the working environment.
Honesty and trustworthiness	Has been found to manipulate the truth to prevent criticism; blames others for own errors and shortcomings	Deliberately misleads staff, patients or trainers by miss-information e.g. fills in logbook with non-existent cases; does not report serious adverse event; alters records after a problem has occurred. Fails to answer patient's/relative's queries honestly
Enthusiasm	Usual response to new opportunities is rather flat. Gives the appearance that work is an onerous duty rather than something to give satisfaction	Negative response to new opportunities. Always places personal convenience before that of patients or colleagues. Never volunteers and is uncooperative in solving departmental problems
Record keeping	Occasionally fails to keep a good record or is rather economical with basic information. Needs reminding to retrieve and document laboratory investigations.	Case notes review demonstrates frequent poor record keeping; key items of information missing, or incorrectly documented. Training record poorly maintained, possibility of falsification of entries

3.3(e) Assessment of communication skills, attitudes and behaviour

Object: These attributes are required to assure good working relationships with colleagues, patients and relatives. They are an essential part of professional practice and must be assessed favourable before the trainee is recommended for progression to the next stage of training.

Please put a tick in the appropriate box. Any 'cause for concern' must be qualified with information. This form should be completed annually or whenever a trainee leaves a hospital or attachment. If difficulties arise, it can be used more frequently. For trainees completing their Basic training the assessments should be made once for each attachment. The preferred method of assessment is multi-source feedback, but the observations made whilst using the other three tools should not be overlooked.

Attitude or behaviour	Satisfactory	Cause for concern	Please give examples of cause for concern, noting date. Expand on a separate sheet if necessary	Initials of assessors (with dates)
Communication Skills (with patients & relatives)				
Communication Skills (with staff)				
Communication Skills (sensitivity to another's needs)				
Reliability and time-keeping				
Control of moods and emotions				
Personal presentation				
Social behaviour				
Conscientiousness in checking				
Initiative				
Over or under assertiveness				
Over-confidence				
Under-confidence				

Departmental involvement				
Team working				
Personal organisation				
Honesty and trustworthiness				
Enthusiasm				
Record keeping (training record, case notes)				

I confirm that any 'causes for concern' have been discussed with the trainee. The outcome of these discussions was as follows:

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……
……

Assessments:

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..

Signed …….. Print name…… ……..…… Date ……..……

Appointment ……..