2022 Curriculum ST5 Palliative Medicine pre-ARCP checklist

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| Trainee Name:  | Date of ARCP:  |
| Training start date:  | Number of months of ST5 completed |
| Year of training:  | FT or LTFT:  |
| Date of completion of current ST year:  | Predicted CCT date:  |
| Curriculum: 2022 | Date of last ARCP:  |
| Educational Supervisor(s):  | Clinical Supervisor(s): |
|  |
|  | Present | Not present | Comments |
| Form R Annual leave record |  |  |  |
| Form R Sick leave record |  |  |  |
| Form R Other leave record, including maternity leave |  |  |  |

# Generic Capabilities in Practice

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| Generic CiPSES to confirm trainee meets expectations for level of training | ST5- Level descriptors B = Below expectations for this year of training; may not meet the requirements for critical progression pointM = Meeting expectations for this year of training; expected to progress to next stage of trainingA = Above expectations for this year of training; expected to progress to next stage of training |
| Able to function successfully within NHS organisational and management systems |  |
| Able to deal with ethical and legal issues related to clinical practice |  |
| Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement |  |
| Is focussed on patient safety and delivers effective quality improvement in patient care |  |
| Carrying out research and managing data appropriately |  |
| Acting as a clinical teacher and clinical supervisor |  |

# Palliative Medicine

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| Evidence of learning required by end of ST5 |
| Measure | Present/Absent/Issues or Comments |
| ES ReportConfirms meeting or exceeding expectations and no concerns |  |
| What Palliative Medicine care settings have been experienced? |  |
| **Palliative Medicine CiP**ES to confirm trainee is performing at or above the level expected for all CiPs | **ST5 Level descriptors** Level 1: Entrusted to observe only – no clinical careLevel 2: Entrusted to act with direct supervisionLevel 3: Entrusted to act with indirect supervision Level 4: Entrusted to act unsupervised |
| Managing patients with life limiting conditions across all care settings | (2) |
| Ability to manage complex pain in people with life limiting conditions across all care settings | (3) |
| Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings | (3) |
| Ability to demonstrate effective advanced communication skills with patients, those close to them and colleagues across all care settings | (3) |
| Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings | (3) |
| Manages delivery of holistic psychosocial care including religious, cultural and spiritual care across all care settings across all care settings | (3) |
| Demonstrates the ability to lead a palliative care service in any setting, including those in the third sector | (2) |

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| Measure | Present/Absent/Issues or Comments |
| MCRs in Palliative Medicine2 |  |
| MSF1 |  |
| ACATs in Palliative Medicine2 |  |
| CBD or mini-CEX in Palliative Medicine4  |  |
| RRP2 |  |
| SCE in Palliative MedicineNot required |  |
| ALSValid |  |
| Quality ImprovementEvidence of supervision of an audit or QIP with major involvement in design, implementation, analysis and presentation of the findings, including development of an action planQIPAT required by end of ST5 |  |
| Communication SkillsEvidence of completion of locally approved advanced communication skills training by the end of training |  |
| Patient SurveyCompletion of one satisfactory patient survey by end of training, with indicative minimum 15 respondents (including patients seen during IM training) |  |
| TeachingEvidence of participation in and evaluation of teaching medical students, junior doctors, nurses and AHPs1 teaching observation |  |
| Clinical ManagementEvidence of participation in and awareness of some aspects of management, e.g. designing rotas; organising and leading teams; organising teaching sessions or journal clubs1 LEADER completed by the end of ST5 |  |

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| Directly Observed Procedural Skills (DOPS)1 by end of ST5 | If DOPs done, minimum standard expected at ST5LS (f) = Limited supervision (formative)SL/LS (f) = Skills lab or satisfactory supervised practice (formative)CI (s) = Competent to set up independently (summative DOPS)CS (s) = Competent in simulated setting (summative DOPS)CCA (s) = Competent to manage complications and advise patients re: management (summative DOPS) |
| Total Requirement | 0/1 |
| Syringe pump set up\* | LS (f) |
| NIV | SL/LS (f) |
| Spinal Lines | SL/LS (f) |
| Tracheostomy Care | SL/LS (f) |
| Indwelling Pleural/Peritoneal Catheter | SL/LS (f) |

\* Trainees need to demonstrate sustained competence for the syringe pump DOPS, which must therefore be repeated three times during training in a range of clinical settings and with different assessors by the end of training.

## Supplementary guidance for Palliative Medicine ARCP decision aid – 2022 Curriculum

Events giving concern:

The following events occurring at any time may trigger review of trainee’s progress and possible remedial training: issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; issues arising from supervisor report; issues of patient safety

Summary of Clinical Activity

Trainees are expected to record the range of clinical experience relevant to the portfolio using the summary of clinical activity forms. These are not meant to be onerous but to allow the trainee to demonstrate the range of activities undertaken to support the ES report and ARCP panel. Examples include:

* Out of hours: including details of all on-call /out of hours clinical activity, e.g. emergency admissions, routine and unplanned follow ups, telephone advice across all clinical settings
* Hospital, palliative care inpatient/hospice and community: number and range of patients seen in different settings to evidence sampling across range of curriculum. The majority of ST4 trainees will benefit from starting their specialty training in an inpatient unit, to provide the foundation stone for developing the core skills that are then transferrable to hospital and community settings.



Study leave:

* list of courses attended, use of CPD diary

Teenagers and Young Adults:

* please reference JRCPTB guidance and target workplace based assessments as outlined in the JRCPTB guidance on training in Adolescent and Young Adult Health Care (Curriculum Extract, pages 7-8)1

Evidence to support experience across settings and specialty on call

To aid evaluation of progression, trainees will be encouraged to keep a summary log of experience across different care settings and including specialty on call, to demonstrate that they have the range of experience required as outlined in the curriculum. Educational supervisors will be asked to comment on these areas in the educational supervisor reports and these areas will be reviewed at the time of PYR, to help identify any gaps in training.

# Internal Medicine

Progression through training is by acquisition of capabilities.

All times (e.g. days, months, years) and numbers (e.g. of patients, of clinics, of assessments) are to be understood as ‘indicative’.

This means that the view of the JRCPTB is that the time or number specified is that required by most trainees to acquire and demonstrate the capability and for there to be adequate evidence to allow an Educational Supervisor (ES) to make a judgement about their trainee’s performance.

ARCP panels will make decisions based on holistic review of the trainee’s progress and be proportionate in their requirements, e.g. if the only IM training that a trainee undertakes in a particular year is in outpatients, they should only require evidence related to Clinical CiP4 (managing patients in an outpatient clinic).

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| Measure | Present/Absent/Issues or Comments |
| ES ReportConfirms meeting or exceeding expectations and no concerns |  |
| What Internal Medicine care settings have been experienced? |  |

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| **Report/SLE** | **ST4** | **ST5** | **ST6** | **ST7** |
| Clinical Activity – Outpatients*(can include community experience, virtual clinics and work in Ambulatory settings)* | Number of outpatient clinics in specialties other than PM | Number of outpatient clinics in specialties other than PM | Number of outpatient clinics in specialties other than PM | Indicative minimum of 20 clinics in specialties other than PM by the end of IMS2 |
| Clinical Activity: Acute unselected take | Record estimate of number of patients presenting with acute medical problems with active involvement | Record estimate of number of patients presenting with acute medical problems with active involvement | Record estimate of number of patients presenting with acute medical problems with active involvement | Active involvement in the care of 750 patients presenting with acute medical problems by the end of IMS2, with 100 patients in the final year of training |
| Clinical Activity: Continuing ward care of patients admitted with acute medical problems | Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems\* | Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems\* | Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems\* | 12 months of experience and training in continuing ward care of patients admitted with acute medical problems by end of IMS2, including 3 months in final year of IMS2 training |

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| Measure | Present/Absent/Issues or Comments |
| Multiple consultant reports (MCR) in IM(IM/Specialty Consultants, if IM training has happened in this year) | 0/2 |
| Multiple Source Feedback (MSF) in IM(covers both PM & IM, if IM training has happened in this year) | 0/1 |
| Acute care assessment tool (ACAT) Included within IMS2 requirements of four per year – aim for at least one IM ACAT to reflect palliative care work, either ward round or on call experience | 0/4 |
| Case Based Discussions (CBD), or Mini-Clinical Evaluation Exercise (mini-CEX) in IM | 0/3 |
| QIPAT Aim to lead minimum of one audit/QIP, covers both PM and IM |  |
| Patient SurveyCompletion of one satisfactory patient survey by end of training, with indicative minimum 15 respondents (patient or those close to them; can include patients seen in IM). One survey will meet the requirements of the Palliative Medicine and IM curricula |  |

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| **Report/SLE** | **ST4** | **ST5** | **ST6** | **ST7** |
| Simulation | Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM | Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM | Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM | At least 12 hours of simulation training to include recognition of human factor in interactions during IMS2, including at least 4 hours in the final year of IMS2 training |
| Study Leave  | Record number of hours of recognised IM study leave (CPD points and/or Deanery organised) | Record number of hours of recognised IM study leave (CPD points and/or Deanery organised) | Record number of hours of recognised IM study leave (CPD points and/or Deanery organised) | 75 hours of recognised IM study leave (CPD pointsand/or Deanery organised) by end of IMS2, including 20 hours in final year of IMS2 training |
| Teaching experience |  |  |  | At least one Teaching Observation to be completed by end of IMS2 (can draw on PM TOs) |

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| **Directly Observed Procedural Skills (DOPS)** | **Minimum level of competence required in IMS2** |
| Advanced cardiopulmonary resuscitation (CPR) | Leadership of CPR team |
| Ascitic tap | Competent to perform unsupervised |
| Direct current (DC) cardioversion  | Competent to perform unsupervised |
| Lumbar puncture | Competent to perform unsupervised |
| Nasogastric (NG) tube | Competent to perform unsupervised |
| Pleural aspiration for fluid (diagnostic) | Skills lab or satisfactory supervised practice |
| Abdominal paracentesis | Skills lab or satisfactory supervised practice |
| Access to circulation for resuscitation (femoral vein or intraosseous)  | Skills lab or satisfactory supervised practice |
| Central venous cannulation (internal jugular or subclavian)  | Skills lab or satisfactory supervised practice |
| Intercostal drain for effusion | Skills lab or satisfactory supervised practice |
| Intercostal drain for pneumothorax | Skills lab or satisfactory supervised practice |
| Temporary cardiac pacing using an external device  | Skills lab or satisfactory supervised practice |

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| **Internal Medicine CiP**Level 1: Entrusted to observe only – no clinical careLevel 2: Entrusted to act with direct supervisionLevel 3: Entrusted to act with indirect supervision Level 4: Entrusted to act unsupervised | **ST4** | **ST5** | **ST6** | **ST7** |
| Managing an acute unselected take | (3) | (3) | (3) | (4) |
| Managing the acute care of patients within a medical specialty service | (2) | (3) | (3) | (4) |
| Providing continuity of care to medical inpatients | (3) | (3) | (3) | (4) |
| Managing outpatients with long term conditions | (3) | (3) | (3) | (4) |
| Managing medical problems in patients in other specialties and special cases | (3) | (3) | (3) | (4) |
| Managing an MDT including discharge planning | (3) | (3) | (3) | (4) |
| Delivering effective resuscitation and managing the deteriorating patient | (4) | (4) | (4) | (4) |
| Managing end of life and applying palliative care skills | (3) | (3) | (3) | (4) |