The guide to RCEM Emergency Care
ACP credentialing

November 2018
Preface

In 2016, the Royal College of Emergency Medicine opened a pilot scheme for credentialing Advanced Clinical Practitioners in Emergency Medicine. The pilot completed in summer 2017 and the process is now an accepted part of College activity.

This guide is designed to support the trainee Emergency Care Advanced Clinical Practitioner (EC-ACP), established ACPs who wish to credential, and supervisors who are providing the clinical and educational support for the EC-ACP process. This guide replaces the “guide to Emergency Care EC-ACP Credentialing project” published for the pilot scheme.

The standards and requirements for the EC-ACP are set out in the Emergency Care ACP Curriculum, which is available on the Royal College of Emergency Medicine website. The curriculum has been endorsed by the Royal College of Nursing and the College of Paramedics. A second edition of the Curriculum was approved in October 2017 and has replaced the curriculum in place for the pilot project.

Credentialing windows are anticipated to be open twice a year – in spring and autumn. EC-ACPs planning to apply for credentialing should ensure they are following the curriculum that will be in place at the time of credentialing.

The purpose of the Reference Guide is to assist stakeholders in understanding the process and documentation to be used. The Reference Guide is as the title states, a Guide, and practices, processes and paperwork may be altered at the discretion of the Royal College of Emergency Medicine through the RCEM ACP credentialing committee.

The RCEM would like to thank Health Education England for their support and guidance in the development and implementation of the EC-ACP credentialing process.
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Section 1: Introduction and overview of process

1.1 This Guide sets out the arrangements for the Emergency Care Advanced Clinical Practitioner (EC-ACP) credentialing process as agreed by Royal College of Emergency Medicine (RCEM).

1.2 The credentialing process is a mechanism whereby trainee and established ACPs in Emergency Care will present evidence of their achievements and competences to be evaluated against the RCEM Emergency Care ACP curriculum. A panel of Fellows of the College and senior ACPs will review the evidence and confirm there is appropriate evidence that the standard has been met.

1.3 The standard to be met is that of an ST3/CT3 in Emergency medicine in the relevant curriculum items- and is defined in the Curriculum on the RCEM website.

1.4 The process includes:

Collection of evidence – all within 5 years and the majority within the last 3 years
Completion of a checklist that ensures all evidence is present.
Completion of a structured training report and faculty educational governance statement
Sign off by the local educational supervisor (who must have attended the RCEM training) confirming all evidence is adequate and accurate
Review by two RCEM panel members individually
Discussion and agreement by the panel (six members)- t-ACP in absentia
Confirmation of successful credentialing or indication of what is required to achieve credentialing in future

1.5 It is important that trainee and established ACPs recognise the need for attaining a formal advanced practice qualification at Level 7, minimum of Postgraduate Diploma, before the credentialing process can commence. The advanced practice programme must contain specific modules/sufficient credits for topics of history and examination, diagnostics and clinical reasoning and pharmacology, regardless of the title of the programme. A list of learning outcomes for academic modules is available in appendix seven. From and including the autumn 2019 credentialing window, all applicants will be required to have the independent prescribing qualification.

1.6 Trainee and established ACPs will be required to collect evidence for all areas of the curriculum, through use of the RCEM e-portfolio for ACPs. It is not possible to credential without an RCEM e-portfolio account.

1.7 To access the curriculum, information about e-portfolio access and other information relating to Emergency Care ACP developments, please visit the College EC-ACP section in Exams and Training on the RCEM website here.

1.8 ACPs who successfully credential against the curriculum will be awarded a certificate and their details will be held on a register of successfully credentialed ACPs held by RCEM.

1.9 Individuals interested in applying for the credentialing process, or wishing to join the Emergency Care ACP mailing list should contact acp@rcem.ac.uk, likewise any questions may be sent to this email address.
1.10 All time periods referred to within this document (and other Emergency Care ACP paperwork) are full-time equivalent.

1.11 We would recommend that all ACPs commence a portfolio as soon as they start training – as it allows familiarity with the portfolio and a safe place to collect and store evidence for the future.

Section 2: Utility of the credentialing process

2.1 The credentialing process alone does not confer a license to practice or replace the need for the EC-ACP to maintain their professional registration and to ensure they revalidate for their whole scope of practice. The credential confirms that the EC-ACP has reached a specified standard of clinical care in all areas of the defined curriculum, by the presentation of evidence of delivering that standard in practice.

2.2 It is not essential for an emergency care EC-ACP to have been successfully awarded the RCEM credential for the EC-ACP to practice clinically. The arrangements for appointment and employment of the workforce, as well as the individual scope of practice within a department, is a matter for that department to determine. The credential simply confirms the described standard of practice has been observed and sufficient evidence of that standard provided.

2.3 The Medical Act – it should be remembered that the legal responsibility for the patient care ALWAYS rests with the (medical) Consultant. Therefore, an EC-ACP working alongside a core or Foundation Trainee cannot take delegated responsibility from that Trainee. They may give advice to the junior trainee based on their own experience and their scope of practice, but the final responsibility rests with the Consultant.

Section 3: The experience required for credentialing – working as an EC-ACP

3.1 Emergency Care Advanced Clinical Practitioners may be from a nursing or paramedic background; in future it may be possible for other Allied Healthcare Professionals (AHPs) to be considered for credentialing.

3.2 Advanced practitioners, whether working as a trainee or established EC-ACP, will need to gather evidence for the credentialing process. There is no difference between the evidence required by an EC-ACP who has recently completed training, or an established EC-ACP who wishes to credential other than independent prescribing responsibilities. This will change from (and including) the Autumn 2019 credentialing window when all paramedics will also be required to have independent prescribing rights.

3.3 Trainee ACPs may find it convenient to collect evidence in parallel with the requirements of the Higher Education Institute where they are studying for their postgraduate award. However, they will need to appreciate it is unlikely that they will be at the required standard at the start of the course. Established ACPs may find it more difficult to ring fence time to secure assessments whilst also working full time. It is likely therefore that whilst expressing an intention to credential at the commencement of the academic study is appropriate and starting the portfolio then, the evidence
collected in the first year or two is unlikely (particularly in terms of summative assessments) to be at the required standard and therefore relevant for the final submission.

3.4 The evidence required is substantial. We believe that the experiential learning required to develop the skills to the required standard is a minimum of 3 years in full time clinical practice working as an ACP. We suggest that this is a minimum of 30 hours a week (pro-rata) and – gaining confidence clinically is considerably more difficult if the exposure is less than this (say one or two days a week). Experience in seeing a wide range of cases is required. Therefore it is likely for a new entry to ACP practice, the whole process from start of the Masters to final submission will take longer than three years.

3.5 The ACP is required to upload a current Curriculum Vitae that details the primary qualification, details of the higher education programme and clinical experience as an ACP with dates, working pattern and responsibilities as evidence of at least three years in clinical practice as an ACP (full time equivalent).

3.6 Individuals considering undertaking EC-ACP credentialing should have support from their employers – this process is likely to require considerable time from supervisors, additional time in focused patient contact gaining competences and additional study leave time.

3.7 EC-ACPs are recommended to ensure that their job description and job plan encompasses their entire scope of work. Whilst NHS indemnity provides standard support in the case of litigation, personal support and counselling can be invaluable. Nurses are also able to access support through the RCN https://www.rcn.org.uk/get-help/rcn-advice. Additional personal indemnity is possible through the medical indemnity companies – for example the MDU provides personal indemnity on a bespoke fee (depending on experience). The College recommends that ACPs explore this in addition to vicarious liability offered by their employer. For self-employed/agency ACPs personal indemnity is essential.

Section 4: The evidence required

4.1 Evidence should be collected as per the curriculum requirements; all evidence must be saved on the RCEM e-portfolio. For RCEM e-portfolio technical support, please contact: eportfolio@rcem.ac.uk

4.2 Evidence of successful completion of the PGDip at level 7 with the required modules MUST be included in the portfolio and the academic declaration completed together with the transcripts of the PGDip. Historical (ie before commencing ACP training) pharmacology/prescribing may be at level 6. It may be that the tACP needs to gain additional credits over and above their original PGDip in order to complete modules relevant to the EM curriculum. This should be explored at the beginning of the process. A list of learning outcomes for academic modules is available in appendix seven.

All summative/consultant assessments submitted as formal evidence must be on the RCEM forms even if scanned paper copies are used.

4.3 Other evidence includes teaching plans, feedback from others, e-learning, audit, quality improvement work, reflection on cases. Further details of acceptable evidence are in the RCEM curriculum. Whilst many presentations do not require consultant summative assessments, it is essential there is evidence in the portfolio of other activity in addition to WBAs. This should
demonstrate the journey of the tACP and might include some early formative assessments, some e-learning or study days to consolidate learning – perhaps teaching delivered by the tACP or reflections culminating in another WBA – summative where mandated or formative.

A logbook or record of the case mix and numbers seen in each area (resus, majors, ambulatory) and age (adult / child) and disposition (admitted/discharged) should be provided – if not possible from the hospital system, an overview of the numbers should be provided and verified by the educational supervisor. This should cover at least the last 12 months.

4.4 The checklist for credentialing must be completed legibly and correctly. It should be emailed to the College 8 weeks before credentialing, but also uploaded into the portfolio. It must be countersigned by the Educational Supervisor. It should be noted that the checklist should be the checklist clearly marked on the website for the relevant credentialing window.

4.5. All competences in the curriculum, including the common competences, must have several items of evidence submitted against it. It is therefore important at the point of credentialing that the most appropriate/relevant item is identified on the checklist for consideration- accurately with the correct date and type of evidence.

4.6 ACPs who are already practising in this role will have evidence accumulated in their CPD and professional portfolio. This may be suitable if accompanied by reflection on their current practice and development of expertise since the original evidence was gathered.

4.7 Reflection in this context is based on documenting any discussion with a mentor or supervisor, describing any learning and actions to be taken as a result of the activity. It is expected that the EC-ACP will provide reflection on most elements of evidence. A helpful document on reflection in medical practice can be found at https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/the-reflective-practitioner—guidance-for-doctors-and-medical-students

4.8 In general terms, one piece of evidence can be used for up to 2 competences – occasionally 3, except for the ACAT-EM which can cover up to 5 competences.

4.9 An assessment for a common competence should be exclusively looking at that competence (history taking, safe prescribing etc). For example, it is not appropriate to link a CbD for an acute presentation competence to 2-3 common competences just to attain coverage of the curriculum. ACPs should enter a self assessment narrative of the reasons they believe that they meet the level – for all common competences and the presentations in the curriculum.

4.10 Retrofitting prior experience and evidence is possible but should be limited. ACPs may well have completed their postgraduate qualification some 5 or more years ago- and this is acceptable evidence for this element of the evidence required. Any other evidence older than five years will not be accepted.

Evidence that is older than 3 years old MUST be accompanied by evidence that the learning is refreshed (previous courses for example should have an update) and reflection on what has happened since that course, how their practise has developed, their new skills etc. Any summative consultant assessments required MUST be within the last three years, and on College format forms.
4.11 Summative assessments by consultants for the major and acute presentations can be either on mini-CEX or CbD Format (or ACAT/ESLE). The balance of observed assessments to discussions must be maintained to demonstrate adequate observed practice – hence there should be at least 50% of the WBAs in the mini-CEX format for the consultant assessments.

4.12 ACPs should be reminded that they were unlikely to be at the standard of an ST3 when they entered practice years ago. The development of the competences to the correct standard will take 3 years or more of practice as an EC-ACP in most cases.

4.13 A portfolio is unlikely to be adequate if more than 30% of the evidence is from more than 3 years ago.

4.14 Planning is therefore vital, in the same way as a trainee doctor needs to plan to get all the competences/WBA completed, the EC-ACP will need to plan and anticipate the requirements. The higher education course must also be planned to ensure the academic component is in step with the clinical skills development.

4.15 Simulation courses including life support courses, can be used as evidence where specified. In addition, simulation for some rare competences such as anaphylaxis and temporary pacing is acceptable but the EC-ACP MUST have led the scenario and have a completed Consultant Assessment where relevant. Simulation cannot be accepted for other procedures or presentations where summative consultant assessments are required.

4.16 Collecting evidence in the portfolio is also useful in collecting evidence for the revalidation of the individual practitioner. We therefore recommend the portfolio to ACPs even if they do not intend to credential in the near future.

4.17 ACPs who wish to credential must have a named educational supervisor who is a substantive consultant on the GMC Specialist Register for Emergency Medicine, is a member of RCEM, has undergone RCEM training for ACP supervisors, and who has access to their e-portfolio. It is the EC-ACP responsibility to identify the supervisor and to ensure access is given. This educational supervisor will be responsible for the sign off for the portfolio, the completion of the structured training report, countersigned checklist and for leading the faculty educational governance statement.

4.18 Trainee and established ACPs should review the curriculum and checklist regularly to ensure they understand the requirements, processes and paperwork. Any queries should be directed to acp@rcem.ac.uk

4.19 In summary, the final submission for credentialing must include:

1. A complete checklist that confirms all evidence of competence is present, signed by the educational supervisor who meets the requirements of 4.17. This evidence must include an up to date CV covering all of the applicant’s clinical experience and training.

2. A structured training report which summarises the progress made.

3. A faculty governance statement which summarises the views of the named faculty on the ACP and the standard required.
Section 5: Self evaluation

5.1 The EC-ACP is expected to self evaluate all common competences and presentations. For common competences, the EC-ACP is recommended to read the descriptors as detailed in the document on the RCEM website for each before self evaluation – to ensure they understand the standard required – it is unlikely that the EC-ACP will be at level 3 in more than a few of the common competences.

5.2 Self rating on presentations is critical – the EC-ACP should read the descriptors and judge whether they have achieved them. It is unlikely that the portfolio will be approved and the EC-ACP credentialed if there are significant numbers of presentations where “some experience” is noted. All the major and acute presentations where a consultant summative assessment is required- must be “achieved” with a description of why the evidence presented shows that level.

5.3 With regard to life support courses, the EC-ACP should reflect on how the course relates to their practice.

Section 6: Educational Supervisor guidance

6.1 At least one individual involved in assessing trainee and established EC-ACPs at the Trust must have completed the RCEM mandatory Emergency Care ACP supervisor training. Dates are on the RCEM website.

6.2 The local individual who has had the mandatory supervisor training will be responsible for ensuring other colleagues involved in assessing the trainee EC-ACP understand the requirements including the standard expected.

6.3 Other supervisors and assessors who are responsible for assessing the EC-ACP in other placements for example acute medicine, ambulatory care, anaesthetics, should be made aware of the process, the standard, and given some information about the process and aims of credentialing, as well as being familiar with the tools used.

6.4 Each EC-ACP MUST have a named educational supervisor for the final sign off who meets the requirements of 4.17 – for the final sign off the ES must have attended the supervisor training. This trained educational supervisor is confirming, by countersigning the checklist, that they understand the standard, that they have examined all the evidence and believe it is complete as required by the credentialing process.

6.5 As of 2018, not all Educational supervisors actively supporting EC-ACPs will have been able to attend the supervisor training, and in addition paediatric EDs may not have someone who meets the requirements of 4.17 in their consultant body. These departments can continue to provide educational supervision, mentoring and support whilst the EC-ACP is training even if the supervisor is not eligible at that time to complete final sign off. However, the ES must liaise directly with a trained EM supervisor on the standards expected until they can be trained and, in the case of paediatric departments – for the foreseeable future.

6.6 The Educational supervisor will be responsible for meeting regularly with the EC-ACP to review progress against the curriculum and undertake some of the mandatory assessments.
6.7 The final sign off (STR and checklist) must be countersigned by the consultant who meets the requirements of 4.17 even if they have not been the direct educational supervisor during the training years.

6.8 As well as the Structured training report (STR), the Educational Supervisor will be expected to complete the logbook output to rate the EC-ACP on all of the competences. This allows the RCEM to be assured that the ES has confirmed the EC-ACP is competent in all competences. The EC-ACP should be at least level 2 on all common competences and have achieved the majority of presentations – equivalent to the level of an ST3 doctor at the end of that year.

6.9 Educational supervision of an EC-ACP preparing to credential is likely to take as much time if not more than an EM trainee. The College recommends 0.25PA per EC-ACP supervised within the consultant job plan.

6.10 All consultant educational supervisors should be approved supervisors under the GMC approval process for educational and clinical supervision.

6.11 All educational and clinical supervisors should participate in the Faculty governance statement – this includes consultant practitioners, senior ACPs and consultants in other specialties. This is a critical part of the confirmation of the standard reached and constitutes important evidence to be considered in the process.

6.12 Non-medical assessors who carry out workplace based assessments (WBA) should complete local training on the use of WBA and familiarise themselves with the curriculum. There are also many free e-learning tools for preparing to undertake the WBA available on the internet (i.e. http://www.faculty.londondeanery.ac.uk/e-learning).

6.13 The assessment tools are expected to be used in a productive, developmental way. For that reason, the interaction between the assessor and the EC-ACP should be interrogative, not simply confirmatory. For example, the assessor is expected to ask questions such as “what if” and “why” when discussing a case in a CbD and in the MiniCEX and DOPs, there should be enquiry as to why they undertook the procedure, elicited the history or made the diagnosis. Similarly, there should be enquiry as to why the clinical signs were evident (or not) and the use of the investigations.

6.14 For further information about the role of the educational supervisor, clinical supervisors etc and eligibility for the roles please see the Emergency care-ACP curriculum on the RCEM website.

**Guidance for the supervisor in working with the tACP**

6.15 It is your name (and GMC number) that is on the STR – confirming the ACP is working at the equivalent of ST3 level in the relevant competences. This means that you should be confident that your assessment is accurate and that you have sought the opinion of others in the faculty.

6.16 It is your responsibility to ensure that other consultants who have signed off the summative assessments understand the standard required and the evidence needed. We recommend that you discuss this with them before they work with the ACP and are familiar with the credentialing principles.

6.17 Consultant supervisors who sign off summative assessments must be substantive EM consultants who are accredited with the GMC for educational supervision. The exception is where relevant consultants in other specialties are summatively assessing areas of their expertise ie
anaesthetics, ICU, Paeds and acute medicine. They will need to be substantive and accredited by the GMC – you may have to ask them! When you confirm the evidence is appropriate you are also saying you are confident the regulations around sign off for credentialing have been followed.

6.18 You should meet regularly with the tACP and check that they are both collecting and labelling evidence correctly – this is particularly important in the library where documents must be saved as WHOLE documents, not single pages or GIF/BMP and the title must be understandable. In addition the mandatory consultant WBAs should be a minimum of 50% directly observed assessments – not all CBDs.

6.19 In reviewing the portfolio – remember that you can make comments on the competences in the curriculum that can be helpful to the panel (demonstrating formative feedback and progression) or can be removed (if it is a comment to say – “you need more evidence” for example) at a future date. This regular review and communication is part of the formative support and on-going supervision.

6.20 Faculty meetings are critical – to discuss problems and to ensure colleagues are understanding the process.

Support for the tACP in Preparing for the Panel

6.21 Remember the panel are taking time out to review a significant number of portfolios. This time currently is 4-5 hours per applicant. If you as the educational supervisor are NOT spending at least that time in checking the evidence before signing – then you will inevitably miss crucial elements and the tACP will be unsuccessful.

6.22 The checklist is the key – if the checklist is not provided, the tACP is ineligible. The checklist must be fully completed legibly and correctly. You should be confident you have found the evidence and it does demonstrate THAT competence – an anaesthetic competence instead of sedation will be unacceptable, a DOPS instead of a CBD will be unacceptable even if the WBA says the candidate is at the standard. The panel will only look at the item suggested for the competence – and if it is not acceptable, then the application will be unsuccessful.

6.23 Check that the checklist is correct – the website has a link to the correct checklist for that panel – the checklist does change from time to time.

6.24 The STR – a checklist for reviewing the portfolio, completing the STR and feedback that you will receive on your supervision is included in appendix 2 and 3. Please check that you understand the purpose and required content of the STR and of the faculty governance statement.

Supervision explained

The table below describes the activities of supervision and who is eligible to undertake them:

1. Final sign off for the portfolio (logbook output and STR completion) –

   • is a member of the RCEM in good standing
   • on the specialist register in Emergency Medicine
   • employed as a substantive consultant
   • completed training and recognised by the GMC as a supervisor

2. Educational supervision and educational meetings
• as above
  or
• employed as a substantive consultant in EM or Paeds EM
• completed training and recognised by the GMC as a supervisor

3. Clinical supervision and sign off for summative consultant assessments

• as above
  or
• employed as a substantive consultant in EM or a relevant specialty
• completed training and recognised by the GMC as a supervisor
  or
• member of the RCEM in good standing
• On the specialist register
• Employed as a locum consultant in EM

4. assessment of non-consultant mandatory WBAs

• as above
  or

• expert in the procedure
• substantive employee in the Trust
• confirmed as understanding the standard by the ES and identified as suitable for assessment

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<tr>
<th></th>
<th>Meets the requirements of 4.17</th>
<th>Substantive consultant in other specialty</th>
<th>Non-medical consultant or senior ACP</th>
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<tr>
<td>Educational supervision with Final sign off on the portfolio and the STR completion</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Educational supervision – ongoing meetings and discussion</td>
<td>X</td>
<td>X (PEM only)</td>
<td></td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessments summative</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assessments non summative</td>
<td>X</td>
<td>X</td>
<td>X</td>
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Section 7: The credentialing panel

7.1 The evidence presented is considered by a panel of consultants (RCEM Fellows) and senior ACPs/consultant practitioners.

7.2 The EC-ACP is not present at the panel - hence the importance of the completed checklist

7.3 All credentialing panel members will be appointed and trained by the Royal College of Emergency Medicine.

7.4 The credentialing panel will be responsible for reviewing the evidence presented in the e-portfolio and agreeing an outcome.

7.5 A Panel will normally consist of 6 assessors, with a minimum of 2 Fellows in good standing with the RCEM.

7.6 Applicants will be required to ensure their evidence is complete 8 weeks prior to the credentialing panel date. Any evidence submitted after this 8 week window will not be considered except in exceptional circumstances.

7.7 Applicants will be required to include a completed checklist in their portfolio, countersigned by their supervisor at this 8 week window.

7.8 There are two possible outcomes at the credentialing panel: Successful – credential OR Further evidence required (see Appendix – Credentialing Outcome Form).

7.9 Outcomes will be recorded on a Credentialing Outcome Form (Appendix). Those who have successfully met the curriculum requirements will receive a certificate and will be added to the register of credentialed Emergency Care ACPs.

7.10 The credentialing panel members will provide feedback to trainee ACPs via the Credentialing Feedback Form (Appendix). For those who have not met the requirements, detailed feedback, including potential timescales for re-submission, will be provided.

7.11 There is an appeals process - details on the RCEM website.

7.12 ACPs who have successfully credentialed will be invited to the annual RCEM diploma ceremony.

7.13 At the Credentialing Assessment, the only question for the Panel is whether the evidence is sufficient. The panel are unable to assess the competence of the EC-ACP hence the need for the ES to be closely involved in the assessments, to undertake many themselves, and to ensure assessors understand the standard required.

Section 8: The standard

8.1 The standard required is that of the Core Trainee at the end of CT3/ST3 in all competences described in the EC-ACP curriculum.

8.2 This standard can be described as the practitioner able to look after the majority of the cases in the Emergency Department, albeit they will require support and guidance on a significant number of cases and for most of the cases in the resuscitation room.

8.3 All common competences and presentations must be signed off by the EC-ACP and the supervisor.
8.4 In the portfolio, the EC-ACP and their educational supervisor are able to identify themselves as having had “some experience” of presentations. Since we are expecting the EC-ACP to have adequate experience in the whole EC-ACP curriculum in order to be credentialed, use of this should be limited. “Some experience” would normally signify that the EC-ACP does understand the presentation or procedure but that they have not personally undertaken the procedure but only supported/assisted and discussed in CbD. This description will only be accepted in one or two presentations - and not in any of the Major presentations or those requiring consultant assessment.

8.5 In terms of procedures, selection of “some experience” will only be accepted for those where CBD is acceptable.

8.6 All common competences must be at level 2 - it is unlikely the EC-ACP will be at a higher level in more than a few common competences.

Section 9: Gaining the required experience

9.1 Many ACPs are very experienced. For new ACPs who are experienced nurses or paramedics, the shift to the clinician medical model may be a challenge. The same standard as seen in a medical trainee of cognitive reasoning, diagnostic skills and decision making must be demonstrated. The RCEM recognises that the case mix in many departments is varied and getting exposure to the full range of case mix might be challenging for some ACPs, including the paediatric experience or acute medical related cases/skills.

9.2 For EM trainees this is overcome by the acute medicine and paediatric attachments in the ACCS programme. For ACPs therefore a secondment or placement in acute medicine, or ambulatory medicine may support the development of some skills. Time focused on paediatric competences may also be useful to those who wish to credential across adults and children. See 9.6)

9.3 Much of the anaesthetic and ITU competences for the ACCS trainees are not required for ACPs. However, there are some critical skills that are included in the curriculum and the EC-ACP must be able to demonstrate a working knowledge of those skills even if they do not themselves regularly carry out that procedure. These competences are mostly acquired by spending time in the resuscitation room or with ACCS trainees as a short secondment.

9.4 Life support courses – these are specified for each curriculum – it should be noted that not all ATLS courses take non-medics as full participants – but the RCS England is helpful in identifying courses that will. In practice it may be easier to find an ETC course than an ATLS course that accepts non-medics. Note that the Paediatric EC-ACP must also do a trauma course – either ATLS or ETC.

9.5 If a trainee is a life support instructor, the same standard of evidence is required – the scanned instructor card and evidence of teaching within the last three years with the programme and feedback included.

9.6 Adult nurses who trained since project 2000 will not have had any paediatric experience in their training. If they wish to work in paediatrics as an ACP then the local employer will need to determine the requirements for additional training that must be demonstrated. To credential as an adult and paediatric ACP we would expect some evidence of additional paediatric training for these adult trained nurses as well as the full evidence of competences signed off in the curriculum. In many
ways, these adult nurses will need additional experience/exposure to children to gain the recommended competences and this may take additional time in the children’s department.

Section 10: Working in the department
10.1 We would recommend that EC-ACPs are given titles such as Trainee, Junior and Senior as they progress. This helps to define their level of independence and will support, particularly in the early years, their designation as still learning. This is particularly important to avoid them being pulled into nursing duties or non-practitioner roles when the staffing gets tough.

10.2 There is no stipulation of the nature of the working pattern required – or where the EC-ACP should work. However, since the EC-ACP role is anticipated to be 24/7, we would recommend that the EC-ACP participates in a 24/7 rota including night shifts and the impact of this pattern of working on the individual is discussed and clarified from the start. This is a matter for local negotiation and discussion.

10.3 We would recommend that trainee EC-ACPs are employed solely in that role. Departments have employed trainee EC-ACPs in dual roles, such as Senior Sister 50% and Trainee EC-ACP 50%, and subsequently found trainees struggle to progress.

10.4 The EC-ACP may benefit from having specific shifts identified as “credentialing shifts” where it is made clear to the team that the EC-ACP will be working on their assessments and competences. Likewise, where feasible in the consultant team, a shift for a named consultant to perform WBAs is helpful covering both medical trainees and ACPs.

Section 11: Top Tips for developing a programme for EC-ACP development and workforce (also useful for EC-ACPs to read!)
This section is developed from top tips from supervisors who have had extensive experience in supervising and running EC-ACP development programmes. We are keen to receive other tips from other colleagues, please send to ACP@rcem.ac.ukk.

11.1 ACPs can form an important part of your substantive and permanent workforce. They are valuable! In order to attract and support ACPs, paying for MSc and/or life support courses in return for commitment to work for 3 years in the department is a fair agreement.

11.2 Developing a cohort of ACPs will take time – it is not likely that there will be large numbers of credentialed ACPs locally available for some years. Therefore a medium to long term strategy and business case will be required to develop that cohort. The department must therefore commit to the development of this workforce and the benefits that will accompany the investment. Resources required include:

Cost of the HEI postgraduate course

Back fill for the staff during the academic component

Backfill for supervised practice at least at first
Time for consultant educational supervision and formal workplace based assessments including ESLEs

Time for formal education for the tACPs and their teachers

11.3 Having a learning agreement with the EC-ACP is critical, this should define how many WBAs can be expected over a given period, how often the ES and EC-ACP will meet as well as the objectives for the next period of practice.

11.4 Joint appointments (recruitment and appraisal) with the HEI can be extremely useful in supporting the ongoing development and identifying any learners who may be struggling with the academic or clinical components. Triangulation of performance across the academic path and clinical experience is crucial.

11.5 A learning agreement can be translated into a “learning menu”, a document which others can access that lists what the EC-ACP still has outstanding, this helps to focus shop floor experience and access to WBAs.

11.6 The MSF can be really useful for the EC-ACP. This will both highlight how their new role is developing and be important as a positive reinforcement but may also shed light if the EC-ACP is struggling with how to present themselves/manage the interaction with other specialties or the ED doctors. This may however need a robust discussion in terms of how to guide and direct future performance.

11.7 Some skills may be better achieved by attendance at clinics – for example cardiology defibrillation clinics, neurology ambulatory care for LPs. This will need exploring locally.

11.8 Rotations across regions may support development of some competences – or allow access to a different case mix. Shared induction, HR processes and teaching programmes spread the burden of work.

11.9 Consideration of how to make a shift positive for all learners – so identifying with the doctors and tACPs who needs what assessments and their focused training needs – and at the end of a shift – a learning debrief – what have we learnt, what will we refresh/review for next time. This takes thought and preparation but will benefit both medical and EC-ACP learners and develop an educational culture.

The burden of supervision is critical – it may be that whilst your department would benefit from ACPs, the amount of supervision on the shop floor by including tACPs will be too great and will jeopardise the supervision of all learners. A critical review of your total supervision burden is critical before starting a programme.

11.10 ACPs must be seen to be progressing. For many new ACPs the role is challenging as they go from being an experienced leader in their previous role to being new and challenged by the alternative approach to diagnosis, the decision making required and the need to develop independence. Being an EC-ACP is not for everyone and the role of the ES is to manage training performance. There should be milestones and achievements built into the initial contract with the EC-ACP which detail progression including success in the higher education programme as well as the achievement of the WBAs. Credentialing is the apex of achievement but supporting the development of the skills and ability to be safe and effective on the shop floor is the core business for the ES.
11.11 The RCEM does not mandate a formal ARCP (annual review of competence progression) but we believe there are benefits in running such a process. This can be run alongside the appraisal process as a personal development and performance review. An example of a form that can be used is included in the appendices of this document.

11.12 An ES who is a recently appointed Consultant may be the perfect ES for the EC-ACP. They will be very familiar with the RCEM portfolio having used it themselves recently and will be able to support and direct the easiest ways to link, navigate and save items.

11.13 The EC-ACP will have a personal library. This, as with the trainees, quickly becomes unmanageable unless properly archived. We would recommend folder structures which for trainee ACPs may be usefully split into years, and should include folders for e-learning, for teaching, courses etc. A useful outline structure is included in the appendices of this document.

11.14 Evidence that is scanned in must be saved as documents/PDFs not JPEGs (which are too large). They should be named logically with the type of document, the competence covered number and text and date of achievement (not date of scanning). The document must be scanned as a single document, not a page per document.

11.15 Previous evidence can be helpful. However, for many ACPs it is easier just to collect new evidence than to try to find the old evidence and update with notes and reflection.

11.16 Clinical supervision is key and the department must determine that there is sufficient capacity for clinical supervision of the EC-ACP as well as the foundation, core and higher trainees. Trainee ACPs may benefit from a non-medical supervisor in addition to their Education Supervisor. This person may be an established EC-ACP who is able to support and guide the trainee in their role transition.

11.17 The ACPs should be clearly visible on the rota alongside the medical trainees. This allows the total number of trainees requiring supervision on any individual shift to be known and catered for. Supervising a large number of trainees with one consultant will result in a poor experience for everyone involved including the patients.

11.18 Every time evidence is uploaded – it must be linked. A library full of evidence is not useful if it is not linked. However, linking one item to more than 3 competences is unlikely to be appropriate.

11.19 Similarly, the educational supervision does take the entire proposed tariff of 0.25 PA per week, perhaps even more so than doctor supervisees. The team job plan should reflect the total time needed for the supervision of all trainees of all professions.

11.20 Sign off on the portfolio includes the “red man/blue man” where the EC-ACP rates themselves and the supervisor confirms that level. This must be done for all common competences and the rest of the clinical competences. It is useful to discuss this face to face – as to why the EC-ACP believes they are at that level and why the supervisor agrees or not. This is designed to be an interactive constructive process of developmental conversation.

11.21 Some departments have developed a “breakfast club” process of early morning meeting as a group and peer discussion and learning. This enables frank discussions of problems, peer tutoring and coaching and a sense of team development.
11.22 In the portfolio, when you send a “ticket” for an assessment (see the portfolio user guide) then it is useful to put your learning outcomes in the description section of the ticket to allow the supervisor to confirm you met the learning outcomes.

11.23 Avoid peak times for medics – ie when the FY2s or core trainees change over – as the consultants will be doing lots of assessments for them.

11.24 Plan the academic education into the programme – when will the prescribing module be, try to get the history and examination module first to allow the EC-ACP to get on with practise.

11.25 The departmental middle grade and nursing staff must understand what the programme is trying to achieve and who the EC-ACPs are and their requirements. Otherwise there will be confusion of roles and expectations.

11.26 The whole or part of the portfolio can be downloaded into a PDF to be used for the academic component with the university – or for your revalidation portfolio

11.27 Specific presentations may need different evidence. Sometimes a department might not see significant numbers of major trauma and so a major trauma case for miniCEX is difficult – but a minor trauma which is dealt with and then a formal discussion about what would have been different if there were significant injuries is appropriate. Whilst the ETC does not substitute for the consultant summative assessment required it does help some triangulation of competence.

11.28 In some cases a sim may be used for a miniCEX providing the trainee notes this is a simulation at the beginning of the description and why that is being used.
Appendix one: Credentialing Feedback and Outcome Form

Emergency Care Advanced Clinical Practitioner
Credentialing feedback and Outcome Form

<table>
<thead>
<tr>
<th>Forename:</th>
<th>Surname:</th>
<th>Regulatory Body and Membership Number:</th>
</tr>
</thead>
</table>

Primary Qualification (Institution and year awarded):

Master’s Degree (Institution and year awarded):

Time spent in Advanced Clinical practice (WTE):

Date of Credentialing Assessment:

<table>
<thead>
<tr>
<th>List all panel members</th>
<th>1.</th>
<th>2.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.</td>
<td>4.</td>
</tr>
<tr>
<td></td>
<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

Location of training/working

<table>
<thead>
<tr>
<th>From: (insert dates)</th>
<th>To: (insert dates)</th>
</tr>
</thead>
</table>

Evidence considered by the panel and known to the trainee

<table>
<thead>
<tr>
<th>1. ePortfolio</th>
<th>2. Structured Training Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Checklist of evidence</td>
<td>4. FGS</td>
</tr>
<tr>
<td>5. CV</td>
<td>6. Academic declaration</td>
</tr>
</tbody>
</table>

Panel feedback
### Panel Outcome

<table>
<thead>
<tr>
<th><strong>Successful - Credential</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of all curriculum requirements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Further evidence required</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Further evidence is required, see additional feedback form.</td>
<td></td>
</tr>
</tbody>
</table>

**If further evidence is required:**

Recommended time required to achieve outstanding objectives (whole time equivalent) following discussion:

________________________________________________________________________________

**Chair of Panel's signature:** | **Date:**

By signing this form the Chair of the panel is confirming that fitness to any practice issues have been considered. This document should be scanned and saved in the trainee EC-ACP’s ePortfolio. This information will also be recorded at the Royal College of Emergency Medicine. By signing the form, the EC-ACP is indicating that they understand and agree that the information will be shared with other parties involved in their training as outlined above. The EC-ACP signature on the form indicates that they understand the recommendations arising from the credentialing assessment. It does not imply they accept or agree with the outcome.
## Appendix two: Checklist for the ES in signing the STR

<table>
<thead>
<tr>
<th>Overview</th>
<th>Is it the correct Checklist?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic</strong></td>
<td>Are the academic declaration and transcripts completed – are they all level 7 and are all modules correct?</td>
</tr>
<tr>
<td><strong>CV</strong></td>
<td>Does the CV clearly show 3 years of full time ACP practice – and their previous experience, if not is there an explanation?</td>
</tr>
</tbody>
</table>
| **Progression** | Are there FGS for more than one year, is there an STR for every year of training and if not what is the explanation?  
Does the most recent FGS – preferably within a month of submission – specifically state that the TACP is ready to credential and is practising at St3 level in the opinion of all the consultants present? |
| **Work** | Is there a log book and evidence of adequate clinical contact and experience? |
| **Logbook output (red man blue man)** | Have you reviewed all evidence and does it confirm you think they are at the correct level?  
Have you read the CC descriptors to see what a level 2 needs to include – and have you commented on why the evidence does or doesn’t support your assertion of level 2 (or higher)?  
Why have you said this person is higher than level 2 (if you have)?  
Is there a comment on all competences in the main curriculum to demonstrate you have seen the evidence and believe it confirms the standard? |
| **Mandated assessments** | Are all the mandated assessments completed on the correct form and by the correct assessor – describing the right discussion for that presentation/competence? |
| **Procedures** | Where required are these done on DOPS forms, and are the assessors eligible to sign them off – is the evidence the right type of evidence? |
| **Consultant assessors** | Do you know all the assessors – have you explained to them the level required particularly if they are not EM consultants? Are they all eligible to be assessors? |
| **Other elements** | For elements such as QIP /audit etc – are you satisfied that the evidence supports the level required and the descriptors in the curriculum? Is the audit loop closed, or the QIP have 2-3 PDSA cycles? |
| **General comments** | • Are there too many items of evidence for each competence or too little- we recommend about 5? Does one WBA get linked to more than 3 competences – if so then there needs to be some tidying before submission and then reassess?  
• Are WBAs simply tick boxed rather than any learning points or note of discussion? The WBAs need to be rich in information and show the depth and breadth of knowledge.  
• Are all the WBAs filled in during a short period – suggesting a retrospective filling in of forms? Whilst practically this may be necessary – it reduces the validity of the evidence unless there |
are contemporaneous reflections by the trainee on the case – demonstrating their learning points. Having the majority of the evidence completed in a short window, say two weeks, raises concerns in the panel.

<table>
<thead>
<tr>
<th>Other evidence</th>
<th>Is there sufficient evidence of other activity – demonstrating a commitment to life-long learning and helping others as well as reflection?</th>
</tr>
</thead>
</table>
| STR completion | • Have you made comments on the assessments – summarising or explaining any exceptions, unsatisfactory?  
• Have you referenced the previous STR and/or learning objectives and how they have been met in this period?  
• Be clear about additional achievements that demonstrate competence particularly for Common competences.  
• If there are areas needing development be clear if these mean the individual is not operating at St3 level or just part of on-going professional development – and what they will be doing about it.  
• Be clear that the tACP is ready for credentialing and has reached and demonstrated the standard. |
Appendix three: Feedback for supervisor

This is the form we will use to give you feedback on your tACP portfolio submitted for credentialing.

<table>
<thead>
<tr>
<th>tACP name:</th>
<th>Curriculum followed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational supervisor:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome of panel:</th>
<th>Date of panel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area of supervision</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBAs</td>
<td>This will include comments on the content, applicability of the case to the presentation/competence and the level of the assessor – it will include comments on the MSF</td>
</tr>
<tr>
<td>Completion of STR</td>
<td>This will comment on utility of the comments in the STR</td>
</tr>
<tr>
<td>Completion of FGS</td>
<td>This will comment on the utility and membership of the FGC</td>
</tr>
<tr>
<td>Evidence provided of supervision and meetings</td>
<td>This will make suggestions or comments on the frequency and content of your meetings recorded in the portfolio</td>
</tr>
<tr>
<td>Advice to supervisor</td>
<td>This will include constructive suggestions for what others have found helpful, to support the tACP and supervisor – particularly where the ACP is unsuccessful</td>
</tr>
</tbody>
</table>
Appendix four: RCEM EC-ACP Academic Component - Credentialing Declaration

<table>
<thead>
<tr>
<th>EC-ACP name:</th>
<th>NMC/HCPC No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of academic programme: (e.g. Advanced Clinical Practice)</td>
<td></td>
</tr>
<tr>
<td>Awarding institution:</td>
<td></td>
</tr>
<tr>
<td>Academic award: (i.e. PGDip/MSc/Doctorate)</td>
<td></td>
</tr>
<tr>
<td>Modules studied (names):</td>
<td>Academic Credits:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing award (For professions who can prescribe)</td>
<td>Academic Level 7 (if taken before entering the Masters programme a level 6 will be accepted)</td>
</tr>
<tr>
<td>Additional info: (if required)</td>
<td></td>
</tr>
</tbody>
</table>

Your programme may not have modules with the titles below. In order to ensure you have achieved level 7 academic learning in these areas you **must** attach the learning outcomes/objectives and credits earned within your programme which you believe covers the following areas *(they may be in different modules on your course)*:

- History taking and physical assessment
- Pharmacology
- Clinical decision making and diagnostics

Please ensure a copy of any certificates and transcripts are clearly labelled and uploaded to a folder in your portfolio title ‘Academic Award’.
Appendix five: Organisation of the Personal Library in the e-Portfolio

The eportfolio has a number of ways in which one can store documents and allow others to read evidence of your progression. The structure is such that if the curriculum links are used appropriately – there is little that needs to be accessed through the personal library.

However, the panel may wish to browse or find documents in your library and you will need to have organised it appropriately to facilitate the finding of specific documents.

The library has 400MB of space, this should be more than enough unless you upload videos or other space hungry items such as JPEGs.

We recommend you create the structure of your library by creating folders before you upload anything – so that it is easy to save them in the right place.

Some top tips on using the library are as follows:

- **Name the items carefully** – try to put the nature of the item (e-learning, programme of a course, notes from a meeting) in the title, as well as the presentation it relates to (if relevant) and the date. For example: notes from a teaching session you went to on 12th Jan 2016 on non-invasive ventilation might be “CAP35 lesson notes 12.01.16”.
- **Put only the evidence that you need to present in the library** – big presentations you have given to prove you have taught are not necessary. Instead use the lesson plan and feedback from the learners.
- **Think about who will access the library and what they are looking for** – will they need to see everything or just specific documents not seen elsewhere? If you have linked appropriately in your curriculum, any individual item will be visible from the link within the curriculum.
- **Documents not linked to the curriculum are important for others to be able to locate in your library** – these should be in top level folders clearly marked e.g. Masters certificates, appraisal forms, etc.

Certificates and exams

This section in the portfolio should be for only mandatory courses (life support and safeguarding). All other certificates are better being kept in the library rather than having multiple “other” in the certificates and exams section.

Recommended structure of the library folders:

Please note that RCEM has now uploaded a template for the library section in the e-portfolio for new starters. Please use the RCEM format to file your documents. For those with old format e-portfolio the following structure may be useful

- **Other Qualifications/Certificates**
  - Primary qualification, other exams,
- Up to date CV,
  - NMC/HCPC certificate, professional indemnity certificate

- Prixes, awards, grants
  - Credentialing checklists – checklists, Progression forms for each year if present,

- Casemix and logbook - excel spreadsheet of patients seen, one for each attachment/year and separate log of procedures for each year /placement

- E-learning certificates
  - Organised by types - common competences, major presentations, acute presentations, paediatric presentations, management topics, academic topics

- Teaching delivered
  - Organised by year delivered

- External courses - other than Life support courses

- CPD – formal training attended

- Audits undertaken – each in one folder with proposal, results, report, presentation if relevant

- Quality improvement documents

- Complaints and incidents involved in:
  - Organised by folder for each
  - Remember to anonymise the original document, statement, response
  - If relevant - note if a reflection made (saved in reflections)
Appendix six: EXAMPLE Annual progression form for trainee ACPs from a nursing background

this is not mandatory but is included for information

Name:                        Date:

NMC:

Year of training EC-ACP: 1 2 3 N/A

Revalidation Date:

Panel:

Current Educational Supervisor:

(Evidence of progression towards revalidation for nurses)

| 450 practice hours or 900 if revalidating as both a nurse and midwife |
| 35 hours CPD including 20 hours participatory learning |
| Five pieces of practice related feedback |
| Five written reflective accounts |
| Reflective discussion |
| Health and character declaration |
| Professional indemnity arrangements |

Trust appraisal requirements (modify as required):

| Appraisal form self-assessment section completed? |
| YES/NO |

(should be submitted with portfolio of evidence 3-weeks prior to the meeting)

Trust appraisal doc also completed so all done in same meeting
Emergency Directorate: *this can be altered to site /Trust specific requirements*

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health statements</td>
<td></td>
</tr>
<tr>
<td>Probity statement</td>
<td></td>
</tr>
<tr>
<td>Mandatory training (up to date)</td>
<td></td>
</tr>
<tr>
<td>Medical devices self-assessment form</td>
<td></td>
</tr>
<tr>
<td>Mentoring or training courses (up-to-date minimum 3 yearly face-to-face)</td>
<td></td>
</tr>
<tr>
<td>Radiation protection/IRMER certificates</td>
<td>*(completion of on-line e-LfH modules <a href="http://www.e-lfh.org.uk/home/">http://www.e-lfh.org.uk/home/</a>)</td>
</tr>
<tr>
<td>Non-medical prescribing – <em>evidence of refresher-review</em></td>
<td></td>
</tr>
<tr>
<td>Patient feedback survey</td>
<td><em>(once as a trainee and then every 3 years)</em></td>
</tr>
<tr>
<td>Multi source feedback (360)</td>
<td><em>(Yearly for trainees/once every 3 years for non-trainees)</em></td>
</tr>
<tr>
<td>Date and copy of MSF summary</td>
<td></td>
</tr>
<tr>
<td>Educational supervision meetings</td>
<td><em>(Evidence of engagement x 3 annually)</em></td>
</tr>
<tr>
<td>ETC/ATLS (or equivalency) provider/instructor dates completed</td>
<td></td>
</tr>
<tr>
<td>Dates of courses taught on</td>
<td></td>
</tr>
<tr>
<td>APLS/EPLS (or equivalency) provider/instructor dates completed</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Dates of courses taught on</td>
<td></td>
</tr>
<tr>
<td>ALS (or equivalency) provider/instructor dates completed</td>
<td></td>
</tr>
<tr>
<td>Dates of courses taught on</td>
<td></td>
</tr>
<tr>
<td>Registered on RCEM e-portfolio</td>
<td></td>
</tr>
<tr>
<td>Number and type of WPBA performed during appraisal year</td>
<td></td>
</tr>
<tr>
<td>Documents/pathways/service development</td>
<td></td>
</tr>
<tr>
<td>Conferences attended (title and date)</td>
<td></td>
</tr>
<tr>
<td>Posters/ Publications</td>
<td></td>
</tr>
<tr>
<td>Risky business articles etc</td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td></td>
</tr>
<tr>
<td>Courses attended (title and date)</td>
<td></td>
</tr>
<tr>
<td>Teaching and associated feedback</td>
<td></td>
</tr>
<tr>
<td>Challenges and associated reflection</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Thank yous/compliments</td>
<td></td>
</tr>
<tr>
<td>Complaints and incidents – reflection and learning points</td>
<td></td>
</tr>
<tr>
<td>Strengths</td>
<td></td>
</tr>
<tr>
<td>Areas for development</td>
<td></td>
</tr>
<tr>
<td>Personal Development plan (PDP)</td>
<td>Evidence of progression towards previous years PDP</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Personal development plan</td>
<td>Objectives set for the next 12 months that should look to meet gaps, areas for further development, specific training needs etc?</td>
</tr>
</tbody>
</table>
Appendix seven: Learning outcomes for academic modules (EC-ACP)

**History taking and physical assessment**
- Elicit a focused history to establish the possible cause of the presentation in all ages
- Establish relevant previous history including drug history and social elements that may contribute to a presentation
- Gather relevant information from a range of other sources including relatives, carers and medical records particularly where this may be sensitive information
- Recognise the challenges of gathering complex and sensitive information
- Demonstrate an accurate physical examination of all body systems in simple and complex situations in all ages and consider the findings in the context of the patient presentation
- Synthesise the findings of the history and examination to make a differential diagnosis and formulate a management plan
- Demonstrate judgement in communication and data gathering within the patient encounter and make appropriate recordings
- Distinguish and articulate the difference between normal and abnormal in the context of the patient presentation
- Ensure patient privacy, dignity and confidentiality is maintained throughout the clinical assessment
- Critically consider the place of the skills of history taking and physical examination within the context of advanced clinical practice

**Pharmacology**
- Demonstrate a comprehensive knowledge of the cellular mechanisms of drug action and physiologic outcomes
- Describe the mechanisms of absorption distribution, metabolism and excretion of drugs and the relevance of this to medicines management in the clinical setting
- Demonstrate a knowledge of the clinical use of drugs in the diagnosis, prevention and treatment of disease in all ages
- Critically evaluated the effectiveness of drug actions and demonstrate expertise in applying this to the management of patients of all ages
- Appraise comprehensive sources of information, advice and decision support in medicines management

**Clinical decision making and diagnostics**
- Demonstrate an understanding of the decision making process in advanced clinical practice
- Utilise a range of sources of knowledge and information as well as decision support tools to come to a sound clinical judgement
- Critically evaluate decision support tools in the clinical context to support rapid decision making and resuscitation in all ages
- Manage uncertainty and the associated risks in the diagnostic process and communicate this appropriately with the patient
• Engage the patient in shared decision making providing sufficient and clear information to support the decision making

• Communicate and record the rationale for decision making to others when making a decision and the importance of that record

• Evaluate decisions in the light of the clinical outcome

• Critically evaluate the contribution of clinical tests (laboratory, imaging and near patient testing) to the clinical decision making in the light of accuracy and cost of those clinical tests as well as the epidemiology of the condition

• Utilise clinical tests in an effective manner to supplement the clinical assessment. This will require reviewing the risks of over or under utilisation of investigations, statistical utility of investigations balancing the cost with benefit to maximise the impact on patient care