Entrustable professional activities for postgraduate Family Medicine training in South Africa

1. Introduction

Entrustable professional activities (EPA) define both learning and assessment in the workplace for registrars in family medicine. Workplace-based learning and assessment requires four essential components:

1. Defined EPAs to guide training, assess progress and structure the decision on whether someone is entrustable as a specialist in Family Medicine.
2. High quality clinical training from family physicians and other supervisors
3. Collecting evidence of learning and entrustability in an electronic portfolio
4. Entrustment committees within training programmes to allow progression and identify registrars in difficulty as well as a national entrustment committee to decide if someone can finally be entrusted as a specialist in family medicine.

This document describes the EPAs that have been defined for Family Medicine.

2. Structure of the EPAs

Each EPA has a standardized structure with eight components:

1. The title.
2. Specifications and limitations.
3. Potential risks in case of failure.
4. Links to the curriculum and roles of the family physician.
5. Required knowledge, skills, attitudes, behaviours, experience and resources.
6. Sources of evidence to support entrustment decisions.
7. Entrustment level expected by end of the program.
8. Expiry date.

A useful reference is the AMEE Guide no.140: Full article: The recommended description of an entrustable professional activity: AMEE Guide No. 140 (tandfonline.com)

Each of these components will be briefly outlined below.

3. The title

The title describes a demarcated aspect of the work expected of a family physician. One can imagine that the title could form part of the job description of a family physician. Training programs need to decide how much supervision a registrar requires to function in this aspect of the work – this is an entrustment decision.

There are 22 EPAs. Together they cover all the work expected of a family physician.

Number	EPA Title
1	Managing women and newborns in the peri-partum period
2	Managing pregnant women
3	Managing women and babies in the postnatal period
4	Managing children with undifferentiated and more specific problems
5	Managing children requiring inpatient care and procedures
6	Providing anaesthesia in the district hospital operating theatre
7	Providing anaesthesia for minor procedures
8	Managing adult and adolescent patients with chronic conditions
9	Managing adult and adolescent patients with undifferentiated problems
10	Managing patients with infectious diseases
11	Managing adults with conditions that may require surgery or procedures
12	Managing patients with mental health disorders
13	Managing patients with emergency conditions
14	Managing patients with forensic problems
15	Managing adults and children with palliative care needs
16	Managing care for older patients
17	Managing patients with impairments & rehabilitation needs
18	Supporting community-based health services
19	Supporting and providing health promotion and disease prevention services
20	Providing training and continuous professional development
21	Leading a clinical team
22	Leading clinical governance activities

4. Specification and limitations

This section specifies the professional work-related activities that are included within this EPA. Some activities during patient care are expected from a family physician for almost all EPAs and should not be repeated in every EPA. Many EPAs relate to National Unit Standard 2 (Clinical Care). To keep the EPA compact and clear, refer to this preamble in the EPA here, and only describe very focused specifications, e.g. Take a sexual history, etc.

It also defines the limits of this EPA and the activities that are not included. This section may also describe the various work settings within which these activities may

take place. In addition, this section may link to other EPAs that contain relevant activities that are not further described here, to avoid duplication.

5. Potential risks in case of failure.

Entrustment decisions are taken on behalf of our patients and the public. Their safety and the quality of their care need to be kept in mind when making entrustment decisions. There is also risk to the health service (e.g. litigation) and to the health profession if a doctor cannot be trusted with a specific activity while engaged with it. There may also be a risk to other health care workers, depending on the activity. This section reminds us of the risks if a registrar has inadequate supervision for their level of competence. Most of the abovementioned risks apply generically to all EPAs and should be kept in mind by the registrar when considering specific EPAs.

6. Links to the curriculum and roles of the family physician.

6.1 Unit standards

The programmatic learning outcomes of the curriculum for the training of family physicians are defined within five unit standards:

1. Effectively manage themselves, their team and their practice, in any sector, with visionary leadership and self-awareness in order to ensure the provision of high-quality, evidence-based care.
2. Evaluate and manage patients with both undifferentiated and more specific problems in a holistic, cost-effective manner.
3. Improve the health and quality of life of the community.
4. Facilitate the learning of others regarding the discipline of family medicine, PHC, and other health-related matters.
5. Conduct all aspects of healthcare in an ethical, legal and professional manner

Each of the EPAs is linked back to the most relevant unit standard. Unit standards are written from an educational perspective and describe what the learner should be able to remember, understand, apply, analyze, evaluate, or create by the end of the programme. A full description of the 5 National Unit Standards can be found at (Insert link here).

EPAs are written from the perspective of the health services and describe the activities that a registrar is expected to perform in the workplace. They are therefore more fit-for-purpose when making entrustment decisions in the workplace and assessing actual competence to do the work.

Many of the EPAs relate to unit standard 2, which focuses on the clinical activities of the registrar. The registrar should keep the generic contents of unit standard 2 in mind as it describes the expected approach to consulting, decision-making and management of patients. These generic expectations are not repeated in the relevant EPAs. They include:

a) Taking a full patient-centred medical history, with a bio-psycho-socio-spiritual approach.
b) Doing a focused clinical examination.
c) Conducting appropriate bedside investigations.
d) Clinical reasoning and appropriate clinical, individual and contextual (family and community) assessments.
e) Interpretation of specific investigations.
f) Discussing the diagnosis with the patient and agreeing on a shared management plan.
g) Recognising conditions that need emergency or urgent care and arranging appropriate management plans and referrals.
h) Outlining and agreeing on appropriate further referrals.
i) Preparing patients for minor procedures (informed consent).
j) Preparing for the minor procedures (equipment and consumables).
k) Performing minor procedures.
l) Providing appropriate post-procedure care.
m) Collaborating with the healthcare team.
n) Aware of the environment and issues of planetary health.

Unit standard 5 focuses on ethical and professional behavior and can be applied to all EPAs. The expectations are further described below.

6.2 Roles of the family physician.

The national position paper on the contribution of family physicians to the health system collates all the activities into three main roles:

- Clinician and consultant: Being a competent clinician and consultant to your healthcare team.
- Capacity builder and clinical training: Building the capacity of the healthcare teams that you work with and training students in the workplace.
- Leader of clinical governance: Developing systems for improving the quality of care and patient safety.
- Champion of community-oriented primary care (COPC).

Often the work of the family physician integrates aspects of these roles in a particular setting. You may be seeing patients, advising team members, building capacity, and trying to improve the quality of care all in a day's work. However, each EPA is linked to the dominant role to which it relates. A useful reference to the nationally agreed roles of the family physician can be found at here: The contribution of family

physicians to district health services in South Africa: A national position paper by the South African Academy of Family Physicians | Family Physicians | South African Family Practice (safpj.co.za)

7. Required knowledge, skills, attitudes, behaviours, experience and resources.

Knowledge and skills

This section describes the specific underlying knowledge, skills, attitudes, behaviours, and the required experience for this EPA. We have combined knowledge and skills into a single list for the sake of simplicity. All skills require underlying knowledge and we have focused more on describing the application of knowledge in specific skills that relate to the EPA.

Attitudes and behaviours.

Many of the expected attitudes and behaviours are generic and described here, because they apply to all EPAs. They do not need to be rewritten into every EPA. Attitudes are internal mindsets that affect how we behave. Behaviour is what is observable by others as an external manifestation of our mindsets.

We expect registrars to embody the key principles of Family Medicine and for these principles to be visible in their behavior.

- Being *person-centred* by seeing the person as a whole and in the context of their family and wider social environment. This perspective should be part of the clinical method and therapeutic approach to all clinical encounters.
- Being able to *comprehensively* deal with illness and disease across the life course, the burden of disease, and from health promotion to palliation.
- Taking *continuity* of responsibility for people's care across many disease episodes and over time.
- *Coordinating* care as needed across organizations within and between health and social care.

We expect registrars to demonstrate an awareness of their legal and ethical responsibilities in the provision of care to individuals and populations as described in unit standard 5.

We expect registrars to demonstrate professional values in relationship to society, interpersonal relationships and personal behavior as described in unit standard 5. Professional behaviors in the workplace that are specifically related to trust, have also been described as making A RICH entrustment decision (Full article: The ingredients of a rich entrustment decision (tandfonline.com):

- Agency: Being proactive towards needs of patients, sharing of relevant information, needs of the team, need for help, own development.
- Reliability: Are conscientious, predictable, accountable and responsible. Do what they said and follow through on assigned tasks.
- Integrity: Are truthful, prioritize patient welfare, are person-centred and ethical.
- Capability: Are competent, have relevant knowledge and skills, efficient, adapt to changing circumstances and new tasks.
- Humility: Knows one's limits, willing to ask for help, receptive to feedback.

Experience

This describes the types of allocations that are expected and which can contribute to learning in the area of this EPA. In addition, this describes the procedural or other skills that one should have the opportunity to perform. The registrar should review the skills logbook in the national portfolio to know which skills pertain to a specific EPA.

Resources

This describes some of the core and specific resources that help learning in this EPA. The following resources are essential and apply to all EPAs. They are therefore not listed in every EPA:

- Mash B, Brits H, Naidoo M, Ras T (Eds). South African Family Practice Manual (4th ed). Cape Town: Van Schaik, 2023.
- Mash B (Ed). Handbook of Family Medicine (4th ed). Cape Town: Oxford University Press Southern Africa, 2017.
- South African Family Practice Journal
- Essential drug list and Standard treatment guidelines for PHC
- Essential drug list and Standard treatment guidelines for hospital care

8. Sources of evidence to support entrustment decisions.

The entrustment committee will decide based on the contents of the portfolio of learning. The level of entrustment for each EPA is assessed based on the available evidence. The levels of entrustment are:

1. Can observe only.
2. Direct supervision (the supervisor must be next to the registrar).
3. Indirect supervision (the supervisor must be available in the facility).
4. Distant supervision (the supervisor can be available off-site at a distance).
5. Supervising others (no supervision is needed).

This assessment may be related to progression in the program, identifying registrars in difficulty or making a final decision on whether this person can be certified as a family physician.

Each form or entry in the portfolio is a potential data point that can be included in such an assessment. Key principles with regard to these data points are:

- Saturation: Are there enough entries in the portfolio or data points to make a decision about this EPA?
- Triangulation: Are there a sufficient variety of data points to make a decision about this EPA? This means from different assessors, from different contexts or settings, and from different types of assessments.
- Aggregation: Are the data points linked to a specific EPA so that the quantitative and qualitative evidence is aggregated to enable a decision?

Each EPA describes potential sources of evidence that can be linked to the EPA. For example:

1. Direct observations
    1. (e.g. mini-CEXs, DOPS, teaching events)
2. Individual discussions
    1. Educational meetings (with the supervisor, others)
3. Longitudinal monitoring
    1. Multi-source feedback (This may include role players specific to an EPA, e.g. the nursing manager of the labour ward, or a forensic or palliative care colleague, or the nursing coordinator of home-based services).
    2. Periodic assessment of performance (of allocation, of last 6-months).
    3. Learning plans (for allocation, for next 6-months).
    4. Registrar reflections (on allocation, of the last 6 months).
    5. Written assignments on workplace based learning and practice.
    6. Record of allocations (relevant experience).
    7. Logbook (relevant opportunity to practice procedural and other skills).
4. Product evaluation
    1. E.g. letters of performance from managers, reports from clinical governance activities, etc.
5. Non-WBA type assessments
    1. Patient complaints/compliments, patient-safety incidents, disciplinaries

<u>A useful reference includes:</u>
Adrian Philipp Marty, Machelle Linsenmeyer, Brian George, John Q. Young, Jan Breckwoldt & Olle ten Cate (2023) Mobile technologies to support workplace-based

assessment for entrustment decisions: Guidelines for programs and educators: AMEE Guide No. 154, Medical Teacher, DOI: 10.1080/0142159X.2023.2168527

The EPA may also define a minimum number of data points that are required to achieve the entrustment level by the end of the programme. For example, a minimum number of direct observations that cover a variety of activities.

9. Entrustment level expected by end of the programme.

This defines the level of entrustment that needs to be obtained by the end of the program for this EPA. For most EPAs this would be level 4.

10. Expiry date

Once a registrar has obtained the expected level of entrustment they do not need to be assessed again before the expiry date. Entrustment, however, does not last forever. This is because health professionals may not continue to perform the necessary skills or engage with the EPA in a way that maintains their competence. This item defines the expiration date for the expected level of entrustment. Once the registrar has obtained the expected level of entrustment it will usually last for the duration of the training program.

EPAs for postgraduate family medicine training in South Africa - 2023

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5	Managing children requiring inpatient care and procedures
6	Providing anaesthesia in the district hospital operating theatre
7	Providing anaesthesia for minor procedures
8	Managing adult and adolescent patients with chronic conditions
9	Managing adult and adolescent patients with undifferentiated problems
10	Managing patients with infectious diseases
11	Managing adults with conditions that may require surgery or procedures
12	Managing patients with mental health disorders
13	Managing patients with emergency conditions
14	Managing patients with forensic problems
15	Managing adults and children with palliative care needs
16	Managing care for older patients
17	Managing patients with impairments & rehabilitation needs
18	Supporting community-based health services
19	Supporting and providing health promotion and disease prevention services
20	Providing training and continuous professional development
21	Leading a clinical team
22	Leading clinical governance activities

EPA 1

1. Title: Managing women and newborns in the peri-partum period

No	**Component**	**Description**	
2.	Specifications and limitations	This EPA includes or may include elements of: a) Activities in primary care facilities and district hospitals. b) Evaluating and managing all stages of labour, the peripartum period and immediate care after delivery. c) Evaluating and managing all aspects of immediate neonatal care at this level d) History, examination and investigations as per unit std 2. e) Recognising conditions that need emergency or urgent care, providing or arranging such care, or referring to the next level of expertise f) Conducting obstetric procedures at primary care facility and district hospital level. <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: ● Conditions that require more specialized care. ● Antenatal care (See EPA 2) ● Postnatal care (See EPA 3)	
3.	Potential risk in case of failure	● Increased morbidity and mortality for the mother – high ● Increased morbidity and mortality for the new-born - high ● Generic risks as outlined in preamble	
4.	Link with most relevant FM Roles and Nat Unit Standards	● <u>Clinician and consultant</u> ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC)	<u>National Unit Standard 2</u>
5.	Required knowledge, skills, attitudes, experience.	**Knowledge and Skills:** An approach to all of the following conditions: ● Intra-partum care ● New-born and immediate post-partum care <u>Intra-partum</u> ● Examine progress during labour and use partogram ● Apply and interpret CTG ● Assess foetal wellbeing during labour ● Normal vaginal delivery ● Breech delivery ● Assisted vaginal delivery/vacuum extraction/forceps ● Caesarean section	

		● Episiotomy and suturing ● Repair of third degree tear ● Manual removal of the placenta ● Massage of atonic uterus ● Abruption of the placenta. ● Placenta praevia. ● Postpartum haemorrhage. ● Amniotic fluid embolism. ● Shoulder dystocia ● Hypertensive disorders of pregnancy (chronic hypertension, gestational hypertension, Pre-eclampsia, Eclampsia, Chronic Kidney Disease) ● Vacuum assisted delivery(?) <u>New-born</u> ● Resuscitation of a new-born ● Umbilical vein catherization ● Assess gestational age at birth ● Well new-born check ● Apgar score interpretation ● Clearing mucus from the baby mouth and throat ● Examination of the new-born baby ● Umbilical cord catheterisation **Attitudes and Behaviour:** ● Refer to the expectations in the EPA preamble ● Attitudes related to task-specific trustworthiness, in addition to task-specific capability: • Integrity (truthful, good intentions, patient-centred) • Reliability (conscientious, predictable, accountable, responsible) • Humility (observing limits, willing to ask for help, receptive to feedback) • Agency (self-confident, proactive toward work, team, and safety) **Experience:** The registrar must be allocated during training to labour ward and theatre in the district hospital and could also spend time at the primary care facility (e.g. MOU). They must be exposed to the management of complications and the conditons typically referred to the family physician at these levels. The skills to which they should be exposed are listed above. **Resources:** ● Guidelines for Maternity Care in SA ● ESMOE guidelines

6.	Sources of information to support entrustment decisions in the portfolio	Entrustment decisions are based on the evidence provided in: 1. At least 6 Direct (or video recorded) observations by: FP supervisors and/or other specialists (e.g. obstetricians) in the hospital or primary care labor ward. At least one must include a C-section. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring 1. Multi-source feedback 2. Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation 3. Learning plans (for allocation, for next 6-months) 4. Registrar reflections (on allocation, of last 6 months) 5. Written assignments 6. Record of allocations (relevant experience) 7. Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinary procedures
7.	Level of supervision	Entrustment level expected at end of programme: Level 4.
8.	Author *Names, university, date.*	Dr M Ramochele, DR K Hlabyago, Prof Mabuza SMU May 2023, Updated June 2023

EPA 2

1. Title: Managing pregnant women

No	**Component**	**Description**	
2.	Specifications and limitations	This EPA includes or may include the following elements: • activities in primary care facilities and district hospitals • Monitoring and assisting pregnant women • Managing antenatal problems • Caring for the pregnant couple <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: ● Conditions that require more specialised levels of care ● Peripartum problems (See EPA 1) ● Gynaecological non-pregnant conditions (See EPA 9) ● Pregnant women with surgical need before 28 weeks (See EPA 11)	
3.	Potential risk in case of failure	• Increased morbidity and mortality for the patient - moderate • Morbidity or mortality for the baby in utero - moderate • Generic risks as outlined in preamble	
4.	Link with most relevant FM Roles and Nat Unit Standard	• **<u>Clinician and consultant</u>** • Clinical trainer & capacity-builder • Leader of clinical governance • Champion of community-oriented primary care (COPC)	National Unit Standard 2
5.	Required knowledge, skills, attitudes, experience.	**Knowledge and Skills:** • Symptoms & signs of pregnancy • Recognizing patients with poor obstetric history • PMTCT • Rhesus incompatibilty • Antenatal growth chart • Extra-uterine pregnancy • Ectopic pregnancy • Anaemia in pregnancy • Infections in pregnancy (UTI, STI, Genital Ulcers) • Antepartum hemorrhage • Hypertensive disorders of pregnancy (Chronic, gestational, pre-eclampsia, eclampsia, HELLP and Chronic Kidney disease) • Gestational diabetes • Miscarriage • Pregnant women with communicable and non-communicable diseases • Clinical pelvimetry • Assess foetal movement/wellbeing • Obstetric ultrasound	

		• Multiple pregnancy
		• Breech presentation
		• Cervical cerclage
		• Culdocentesis
		
		Attitudes and Behaviour:
		• Refer to expectations in EPA Preamble
		• Attitudes related to task-specific trustworthiness, in addition to task-specific capability:
		  • Integrity (truthful, good intentions, patient-centred)
		  • Reliability (conscientious, predictable, accountable, responsible)
		  • Humility (observing limits, willing to ask for help, receptive to feedback)
		  • Agency (self-confident, proactive toward work, team, and safety)
		
		Experience:
		The registrar must be allocated during training to antenatal clinics and be exposed to emergencies in pregnant women. They should be exposed to the typical complications in pregnancy that are referred to the family physician and may be seen in district hospitals and high-risk antenatal clinics. They should have experience of the skills listed above.
		
		Resources:
		• ESMOE Training Manual
		• SA Maternity Care Guidelines

6.	Sources of information to support entrustment decisions in the portfolio	Entrustment decisions are based on the evidence provided in:
		1. At least 6 Direct (or video recorded) observations by: FP supervisors and other specialists (e.g. obstetricians) in hospital ANC/OPDs, maternity wards, High Risk Antenatal Clinics, PHC, EC and during home visits. e.g. mini-CEXs, DOPS, teaching event.
		2. Individual discussions
		  • Educational meetings (with the supervisor, others)
		3. Longitudinal monitoring
		  • Multi-source feedback
		  • Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation
		  • Learning plans (for allocation, for next 6-months)
		  • Registrar reflections (on allocation, of last 6 months)
		  • Written assignments
		  • Record of allocations (relevant experience)
		  • Logbook (relevant opportunity to practice procedural and other skills)
		4. Product evaluation
		  • E.g. letters of performance from managers

		5. Non-WBA type assessments • Patient complaints/compliments, patient-safety incidents, disciplinary procedures
7.	Level of supervision	Entrustment level expected at end of programme: Level 4
8.	Author(s) *Name(s), university, date.*	Dr M Ramochele, Dr K Hlabyago, Prof LH Mabuza. SMU May 2023, updated June 2023

EPA 3

1. Title: Managing women and babies in the postnatal period

No	Component	Description	
2.	Specifications and limitations	This EPA includes or may include elements of: • Activities in primary care facilities and district hospitals • Evaluating and caring for both mother and the newborn baby up to six weeks post-delivery. • Monitoring and promoting health and wellness of the mother-baby • Managing postnatal complications for mother and baby <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: ● Peri-partum care (See EPA 1) ● Conditions that require more specialized levels of care	
3.	Potential risk in case of failure	• Increased morbidity and mortality for the mother • Increased morbidity and mortality for the baby • Generic risks listed in preamble	
4.	Link with most relevant FM Roles and Nat Unit Standard	• **<u>Clinician and consultant</u>** • Clinical trainer and capacity-builder • Leader of clinical governance • Champion of community-oriented primary care (COPC)	National Unit Standard 2
5.	Required knowledge, skills, attitudes, experience.	**Knowledge and Skills:** An approach to all of the following: • Recognition and management of perineal trauma sustained during vaginal delivery • Management of persistent vaginal bleeding post delivery • Skin-to-skin contact for bonding • Breastfeeding • Breast engorgement, infection and abscess • Exercise and nutrition • Bladder and bowel function • Contraception • Sexual health • Immunisation schedule • PMTCT • Postnatal visits • Postpartum depression and psychosis • Common puerperal infections • Management of secondary post-partum haemorrhage • Care of the C-Section wound • Teaching mother mechanical milk expression • Contraceptive implant insertion • IUCD insertion	

		• Umbilical cord toilet
		• Phototherapy
		• Teaching kangaroo mother care
		
		Attitudes and Behaviour:
		
		• Refer to EPA Preamble
		• Attitudes related to task-specific trustworthiness, in addition to task-specific capability:
		  • Integrity (truthful, good intentions, patient-centred)
		  • Reliability (conscientious, predictable, accountable, responsible)
		  • Humility (observing limits, willing to ask for help, receptive to feedback)
		  • Agency (self-confident, proactive toward work, team, and safety)
		
		Experience:
		The registrar should be allocated to the postpartum ward and have opportunity to follow women up in the postnatal services at district hospital or primary care or even community-based services. They should also be allocated to neonatal high-care or neonatal units in the district hospital. They should have opportunity to practice the skills listed above.
		
		Resources:
		• IMCI guidelines
		• PMTCT guidelines
		• SA Maternity Guidelines

6.	Sources of information to support entrustment decisions in the portfolio	Entrustment decisions are based on the evidence provided in:
		  • At least 6 Direct (or video recorded) observations by: FP supervisors and other specialists in hospital OPDs, maternity wards, PHC, EC and during home visits. e.g. mini-CEXs, DOPS, teaching event
		2. Individual discussions
		  • Educational meetings (with the supervisor, others)
		3. Longitudinal monitoring
		  • Multi-source feedback
		  • Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation
		  • Learning plans (for allocation, for next 6-months)
		  • Registrar reflections (on allocation, of last 6 months)
		  • Written assignments
		  • Record of allocations (relevant experience)
		  • Logbook (relevant opportunity to practice procedural and other skills)
		4. Product evaluation
		  • E.g. letters of performance from managers

		5. Non-WBA type assessments • Patient complaints/compliments, patient-safety incidents, disciplinary procedures
7.	Level of supervision	Entrustment level expected at end of programme: Level 4
8.	Author(s) *Name(s), university, date.*	Dr M Ramochele, DR K Hlabyago. Prof LH Mabuza SMU May 2023, Updated June 2023, Reviewed July 2023

EPA 4

Title: Managing children with undifferentiated and more specific problems

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include the following elements: • Activities in the community, primary care facilities and district hospitals • Managing children and infants with undifferentiated and more specific problems. • Counsel and work with caregivers • It includes children up to 12 years of age. • Full patient centered medical history • Appropriate focussed clinical examination • Appropriate bedside investigations • Clinical reasoning and appropriate clinical, individual and contextual assessments • Ordering and interpretation of specific investigations • Discussing the diagnosis with the patient and carer and agreeing on a common management plan • Recognising conditions that need emergency or urgent care and arranging appropriate management plans and referrals • Outlining and agreeing on appropriate further referrals • Preparing patients for minor procedures (informed consent) • Preparing for the minor procedures (equipment and consumables) • Performing minor procedures • Providing appropriate post-procedure care • Collaborating with the healthcare team <u>Limitations</u> **-** A summative entrustment decision for this EPA does not apply for: • Conditions that require more specialised levels of care • Children as in-patients who may need surgical conditions (See EPA 5) • Infectious diseases (See EPA 10) • Children with mental illness (See EPA 12) • Emergency conditions (See EPA 13) • Children needing palliative care (See EPA 15)
3.	Potential risk in case of failure	• Increased morbidity and mortality in children. • Risk of reputational damage - moderate • Litigation risk-moderate • Lifelong disability in surviving children • Impact on under-five mortality and the SDGs • Impact on the family
4.	Link with most relevant FM Roles and Nat Unit Standard	• **<u>Clinician and consultant</u>** • Clinical trainer and capacity-builder • Leader of clinical governance • Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** An approach to all of the common undifferentiated problems in primary care settings. (See Addendum in curriculum)**.** • Respiratory • Gastrointestinal • Neurological • Musculoskeletal • Skin • ENT • Eye

		• Haematological • Endocrine • Congenital • Developmental • Nutritional • Learning disorder • Breaking bad news. • Hearing test • Lumbar puncture • Visual acuity, visual field, fundoscopy, • Skin scraping • FNA • Counsel and work with caregivers **Attitudes and Behaviours:** • Apply HPCSA ethical rules. • Understand and apply appropriate legislation on consent and ascent. • Attitudes related to task-specific trustworthiness, in addition to task-specific Capability: o Integrity (truthful, good intentions, patient-centred) o Reliability (conscientious, predictable, accountable, responsible). o Humility (observing limits, willing to ask for help, receptive to feedback). o Agency (self-confident, proactive toward work, team, safety). **Experience:** Dedicated time in a Children's ward or POPD. **Resources:** 1. A guide to the management of common medical conditions in paediatrics 2. PHC Level EML 3. Hospital level Paediatrics EML 4. Children's ACT 38 of 2005. 5. IMCI
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. Direct (or video recorded) observations by: FP supervisors and other specialists (e.g. paediatricians) in hospital OPDs, wards, PHC, EC and during home visits. 1. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions 1. Educational meetings (with the supervisor, others) 3. Longitudinal monitoring 1. Multi-source feedback 2. Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation 3. Learning plans (for allocation, for next 6-months) 4. Registrar reflections (on allocation, of last 6 months) 5. Written assignments 6. Record of allocations (relevant experience) 7. Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation 1. E.g. letters of performance from managers 5. Non-WBA type assessments 1. Patient complaints/compliments, patient-safety incidents, disciplinaries (All captured in portfolio of learning) Minimum of 6 diverse direct observations of patient consultation in the Wards/ EC/ PHC clinic. At least six written, video or audio evidence of procedures.

7.	Level of supervision	Entrustment level expected at the end of the programme: Level 4 The registrar should attain this competency by Year 3 of the programme. *1. Full direct supervision required* *2. Indirect supervision (close by)* *3. Supervision available if needed (in institution)* *4. Supervision off-site* *5. Teaching others*
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for five years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Authors: *Name(s), university, date.*	Dr Khan University of Limpopo, 02 June 2023.

EPA 5

1. Title: Managing children requiring inpatient care and procedures

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include the following elements: • Managing patients under 13-years of age requiring procedures. • Managing patients under 13-years of age requiring in-patient care. • Diagnosing conditions that are appropriate for procedures at district level. • Procuring informed consent and assent, including collaborating with family. • Administering local or general anaesthetic. • Performing surgical procedures appropriate for district level care. • Providing post-operative care. • Identifying conditions for district level admission or specialised service referral. • Developing, implementing, and monitoring in-patient management plans. • Discharge, referral, and follow-up plans. • Managing emergency situations in the ward or in the peri-operative period. • Stabilise and refer to specialised paediatric services. • Working within a multi-disciplinary team. Limitations – A summative entrustment decision for this EPA does not apply for: • Conditions that require more specialized level of care. • Neonatal care (See EPA 3). • Palliative care (See EPA 15). • Community-oriented care (See EPA 18).
3.	Potential risk in case of failure	• Increased morbidity and mortality in children. • Risk of reputational damage - moderate. • Litigation risk - moderate. • Lifelong disability in surviving children • Impact on under-five mortality and the SDGs • Impact on the family
4.	Link with relevant FM Roles and Nat Unit Standard	• **Clinician and consultant**. • Clinical trainer and capacity-builder. • Leader of clinical governance. • Champion of COPC Unit standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** • Nutritional status. • Infectious diseases: HIV, malaria, gastroenteritis, respiratory, TB, measles, meningitis, endemic diseases (e.g., cholera). • Non-communicable: allergies (anaphylaxis, eczema, asthma) • Local anatomy and pathology • Pathophysiology of common conditions, pharmacology of medications. • Fluid, electrolyte balance, and using blood products. • Identifying child at risk – Children's Act, Sexual Offences Act • Burns (as appropriate): wound management and analgesia • Accidents including poisoning. • Referral criteria: medical and surgical conditions. • Insect stings, animal bites and wound care. • Common orthopaedic and surgical conditions. • Basic surgical skills. • Closed reduction and immobilising common fractures and dislocations. • Reduction of paraphimosis. • Circumcision.

		• Venous and intra-osseous access. • Arterial gasses. • Incision and drainage of abscesses. • Biopsies – fine needle, excision, punch, core. • Removal of foreign bodies – nose, ears, skin, digits. • Debridement and suturing. • Managing epistaxis. • Rational use and interpretation of radiology and laboratory investigations. • Lumbar puncture. • Advanced resuscitation skills. • Administration of oxygen. • Notification of infectious diseases. **Attitude and Behaviours:** • Apply HPCSA ethical rules. • Understand and apply appropriate legislation on consent and ascent. • Attitudes related to the A-RICH acronym (See preamble). **Experience:** The registrar will gain this experience in various setting namely: the PHC attachment, the outpatient department and the children's wards. The current registrar programme makes provision for these allocations, which may vary in length from 6 to 12 months. **Resources:** 1. PHC Level EML 2. Hospital level Paediatrics EML 3. Children's Act 38 of 2005 4. Sexual Offences Act
6.	Sources of information to support entrustment decisions (All captured in portfolio of learning)	Entrustment decisions are based on the evidence provided in: 1. At least 6 Direct (or video recorded) observations by: FP supervisors and/or Paediatricians in hospital OPDs, wards, PHC, EC and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring • Multi-source feedback • Periodic supervisor assessment at end of OPD/PHC/ward allocation • Learning plans (for allocation, for next 6-months) • Registrar reflections (on allocation, of last 6 months) • Written assignments • Record of allocations (relevant experience) • Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation, E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries Appropriate mix of consultations and skills (complexity and multi-morbidity)
7.	Level of supervision	Entrustment level expected at the end of the programme: Level 4 The registrar should attain this competency by Year 3 of the programme.
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for five years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author, university, date	Dr M. Ramavhuya University of Limpopo, 22 June 2023.

EPA 6

Title: Providing anaesthesia in the district hospital operating theatre

No	Component	Description
2.	Specifications and limitations	<u>This EPA includes the following elements:</u> Providing peri-operative care for adult patients classified ASA I and selected ASA II Providing peri-operative care for low risk obstetric patients Activities at primary care level and district hospitals <u>Detailed specifications to be observed:</u> ● Administer General Anaesthesia (GA) or spinal anaesthesia for patients with ASA I and selected ASA II classification ● Administer GA or spinal anaesthesia for low risk obstetric patients ● Assess, identify risk and manage the pre-operative patient ● Assess a patient pre-operatively for performance of spinal anaesthesia ● Consider and prepare essential drugs pre-operatively ● Test and check (general, resuscitation, intubation) equipment pre-operatively ● Manage the regular airway peri-operatively ● Manage the unanticipated difficult airway peri-operatively ● Manage the complications of spinal anaesthesia ● Manage a patient post failed spinal anaesthesia ● Monitor and care for a patient intra-operatively ● Manage cardio-respiratory compromise and arrest ● Consider indications and administer blood transfusions ● Provide post-operative care and management in the recovery room ● Manage post-operative pain or complications ● Stabilise and transfer a ventilated patient <u>Limitations:</u> A summative entrustment decision for this EPA does not apply for<u>:</u> ● Administering spinal or general anaesthesia in children aged younger than 13 years (Level 2 supervision required) ● Providing peri-operative care for selected adult patients with ASA II ● Providing peri-operative care for adult patients with ASA > II ● Providing anaesthesia for high risk obstetric patients including non-obstetric disease indications in pregnancy ● Management of major blood loss
3.	Potential risks in case of failure	● Failed anaesthesia ● Cancellation of surgery ● Postoperative pain ● Patient morbidity ● Patient mortality ● Medico-legal consequences ● Public health consequences (access to care at PHC level)
4.	Link with FM Roles and National Unit Standards)	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2

5.	Required knowledge, skills, attitude / behaviour, experience	**Knowledge and Skills:** (See details in Curriculum addendum) ● Basic sciences, physics and clinical measurement (SI units, humidification, oximetry, measurement of volumes flows pressures, capnography, electrical safety, temperature, fire and explosions) ● Pharmacology of anaesthetic agents ● Monitoring equipment and clinical measurement ● Equipment and apparatus ● Monitoring ● Clinical Management ● Principles of Obstetrics ● Recognition of high-risk obstetric patients, immediate management, and referral ● Neonatal considerations and resuscitation ● Provide safe anaesthesia care and pain management for uncomplicated patients undergoing non-major surgery ● ECG recording and interpretation ● Arterial blood gas collection and interpretation ● Venous access ● Administer oxygen ● Maintenance of an adequate airway (control airway with BVM) ● Rapid sequence induction ● Inhalation induction ● Intravenous induction ● Ketamine anaesthesia ● Intubation ● Ventilation ● Set airflows (Magill, Circle, T-piece) ● Reverse muscle relaxation (mix drugs) ● Advanced Cardiac Life Support ● Lumbar puncture ● Aseptic techniques ● Central venous cannulation ● Sterilise equipment Be familiar with clinical protocols (drills) in the delivery of safe anaesthesia care, and be able to respond accordingly for crisis management, including: ● Airway assessment ● Checking the anaesthesia delivery system (Boyle's machine) ● Pre-operative equipment check (general theatre equipment e.g. table, suction; resuscitation equipment; intubation equipment) ● Pre-operative essential drugs preparation ● Pre-operative patient preparation ● Monitor a patient during anaesthesia ● Monitor and manage a patient in the recovery room ● Identification and management of problems which are commonly acute and may be life- threatening Managing the obstetric patient and neonate peri-operatively ● Resuscitation in obstetric haemorrhage ● Resuscitation in obstetric patient with preeclampsia ● Advanced cardiac life support in the obstetric patient ● Resuscitation of neonate and meconium or pulmonary aspiration **Attitudes and Behaviour:** HPCSA ethical guidelines for good practice in the health care professions Attitudes related to A-RICH acronym (See Preamble)

		Experience: Dedicated allocation / time spent in theatre providing anaesthetic care **Resources:** ● SA Dept of Health National Guidelines for Maternity Care in South Africa ● ESMOE guidelines ● Adult advanced cardiac life support (ACLS) manual and algorithms ● Paediatric advanced life support (PALS) manual and algorithms ● International trauma life support (ITLS) manual and algorithms ● Clinical Anaesthesiology. 5th ed. McGraw Hill Companies. 2013. Morgan GE, Mikhail MS, Murray MJ.
6.	Sources of information to support entrustment decisions	● Direct observations by family physician supervisors, supervising Emergency Medicine consultants in the EC or supervising Anaesthetics consultants in theatre: DOPS including Anaesthesia for Caesarean Section Delivery & Generic technical skills assessment: ● Educational meetings and reports ● Reflections by registrar ● Allocations assessment reports by supervisor ● Skills logbook ● Certificates of training in Emergency Medicine courses All captured in portfolio of learning MINIMUM ENTRUSTMENT REQUIREMENTS ● At least 8 DOPS (4 spinal and4 general anaesthesia DOPS) ● Favourable anaesthetics domain allocation feedback and rating of competency in core clinical skills and performance (>60%) ● Registrar allocation report with evidence of required exposure and experience ● Valid ACLS and PALS certification
7.	Level of supervision	Entrustment level expected at end of programme: ● Level 4 for adults classified ASA I and selected adults classified ASA II
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years.
	Author(s) university, date	Dr Brett van Coppenhagen University of Pretoria June 2023

EPA 7

Title: Providing anaesthesia for minor procedures

No	Component	Description
2.	Specifications and limitations	<u>This EPA includes the following elements:</u> ● Local, regional or conscious (anaesthetic monitored) procedural sedation ● Providing peri-procedural care for patients classified ASA I and selected ASA II ● Providing peri-procedural care for obstetric patients ● Activities at primary care level and district hospitals <u>Detailed specifications to be observed:</u> 1. Assess a patient pre-procedural for performance of appropriate conscious sedation, local anaesthetic technique or selected regional blocks 2. Consider and prepare essential drugs pre-procedural 3. Test and check (general, resuscitation, intubation) equipment pre-procedural. 4. Administer local anaesthetic techniques and selected regional blocks including administration of: ● Topical mucosal/skin anaesthetic EMLA ● Field blocks of lip and ear ● Face (supraorbital, infraorbital, mental) blocks ● Digital nerve "ring" block ● Wrist block ● Colles fracture haematoma block ● Brachial plexus block ● Intercostal nerve block ● Fascia iliaca compartment block ● Femoral nerve leg block ● Ankle block ● WALANT (wide awake local anaesthesia no tourniquet) technique ● IVRA (intravenous regional anaesthesia of the arm) Bier's block ● Epidural 5. Manage the complications of local anaesthetic technique or selected regional block including: ● Local anaesthetic systemic toxicity ● Hypotension ● High or total spinal block ● Nausea and vomiting ● Post-dural puncture headache ● Urinary retention ● Infective complications ● Spinal or epidural haematoma ● Neurological injury ● Opioid side effects 6. Manage a patient post failed conscious sedation, local anaesthetic technique or selected regional block, including: ● Manage cardio-respiratory compromise and arrest ● Stabilise and transfer a ventilated patient ● Providing anaesthesia in the district hospital operating theatre EPA no. 6 7. Provide peri-procedural monitoring, care and pain management including chronic pain management <u>Limitations: A summative entrustment decision for this EPA does not apply for:</u> ● Administering regional blocks in children aged younger than 13 years. ● Providing regional blocks for high risk obstetric patients including non-obstetric disease indications in pregnancy ● Providing peri-procedural care for selected adult patients classified ASA II

		● Providing peri-procedural care for adult patients classified ASA > II ● Providing anaesthesia in the district hospital operating theatre – (See EPA 6)
3.	Potential risks in case of failure	● Failed conscious sedation, partial local or regional anaesthesia ● Cancellation of surgery ● Postoperative pain ● Patient morbidity or mortality ● Medico-legal consequences ● Public health consequences (access to care)
4.	Link with FM Roles and National Unit Standards	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** (See details in addendum to curriculum) ● Basic sciences ● Monitoring equipment and clinical measurement ● Physics and clinical measurement (SI units, humidification, oximetry, measurement of volumes flows pressures, capnography, electrical safety, temperature, fire and explosions) ● Pharmacology: Local anaesthetics pharmacology, properties, mechanism and determinants of action, additives, dosage, potential side-effects and local &systemic toxicity. Understanding the use of vasoconstrictors, adjuvants and other adjunct medications in local anaesthesia ● Anatomy: Knowledge of targeted area for the procedure and anatomical orientation of nerves, blood vessels and other structures in the region ● Utilizing ultrasound (POCUS) and nerve stimulators for selected blocks ● Techniques and approaches to various local anaesthetic techniques, including infiltration anaesthesia, nerve blocks, and other regional anaesthesia approaches. ● Equipment and apparatus ● Monitoring ● Clinical Management ● Management of complications ● Pain management ● Principles of Obstetrics Skills: ● Provide safe anaesthesia care and pain management for uncomplicated patients undergoing minor procedures ● POCUS or nerve stimulator guided technique ● ECG recording and interpretation ● Arterial blood gas collection and interpretation ● Venous access ● Administer oxygen ● Maintenance of an adequate airway (control airway with BVM) ● Rapid sequence induction ● Inhalation induction ● Intravenous induction ● Ketamine anaesthesia ● Advanced Cardiac Life Support ● Aseptic techniques ● Sterilise equipment Be familiar with clinical protocols (drills) in the delivery of safe conscious sedation, and be able to respond accordingly for crisis management, including: ● Airway assessment

		• Checking the anaesthesia delivery systems • Pre-procedural equipment check (general theatre equipment e.g. table, suction; resuscitation equipment; intubation equipment) • Pre-procedural essential drugs preparation • Pre-operative patient preparation • Monitor a patient during sedation • Monitor and manage a patient post procedure • Identification and management of problems which are commonly acute and may be life- threatening **Attitudes and Behaviour:** HPCSA ethical guidelines for good practice in the health care professions. Effective communication skills to explain the procedure, risks, benefits and alternatives The importance of obtaining informed consent before performing conscious sedation, local anaesthesia or regional blocks. Attitudes related to A-RICH acronym (See preamble) **Experience:** Ongoing experience providing anaesthesia for minor procedures in the OPD procedural area, ward, day surgery, theatre or emergency center setting **Resources:** • SA Dept of Health National Guidelines for Maternity Care in South Africa. • ESMOE guidelines. • Adult advanced cardiac life support (ACLS) manual and algorithms • Paediatric advanced life support (PALS) manual and algorithms • International trauma life support (ITLS) manual and algorithms • Clinical Anaesthesiology. 5th ed. McGraw Hill Companies. 2013. Morgan GE, Mikhail MS, Murray MJ. • South African Society of Regional Anaesthesia Guidelines 2016 available at https://www.sasaweb.com/wp-content/uploads/2022/07/SASRA-guidelines-2016.pdf • SA Society of Anaesthesiologists Practice Guidelines 2022 available at https://www.sasaweb.com/resources/ • www.nysora.com (managed by the New York School of Regional Anaesthesia)
6.	Sources of information to support entrustment decisions	• DOPS: Direct observations by supervising family physician, Emergency Medicine registrars/consultants, Anaesthetics registrars or consultants • Educational meetings and report • Assignments • Reflections by registrar • Allocations assessment reports by supervisor • Skills logbook • Certificates of training in Emergency Medicine courses • All captured in portfolio of learning MINIMUM ENTRUSTMENT REQUIREMENTS • At least 10 DOPS in a variety of diverse procedures • Favourable anaesthetics domain allocation feedback and rating of competency in core clinical skills and performance (>60%)
7.	Level of supervision	Entrustment level expected at end of programme: • Level 4 for patients classified ASA I and for selected patients classified ASA II
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years.
	Author, univ., date	Dr B van Coppenhagen University of Pretoria, June 2023

EPA 8

1. Title: Managing adult and adolescent patients with chronic conditions

Number	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Evaluate and manage adult and adolescents with common medical problems in a holistic, cost-effective manner ● Activities in the community, in primary care facilities and in district hospitals (ambulatory and inpatients) To achieve this EPA the following is needed: ● Full patient-centred medical history which may include a sexual history ● Appropriate focussed clinical examination ● Appropriate bedside investigations ● Clinical reasoning and appropriate clinical, individual and contextual assessments ● Ordering and interpretation of specific investigations ● Discussing the ongoing illness with the patient and agreeing on a common management plan, and applying the principles of chronic care ● Outlining and agreeing on appropriate further referrals ● Performing minor procedures appropriate to chronic care ● Collaborating with the family and healthcare team. <u>Limitations</u> – A summative entrustment decision for this EPA does not apply for: ● Conditions that require more specialised services ● Recognising red flags that need emergency or urgent care and arranging appropriate management plans (see EPA 10) ● Most surgical conditions (see EPA 11) ● Managing the palliative needs of the patient (see EPA 15) ● Activities related to disease prevention and treatment (see EPA 19) ● Capacitating nurse practitioners and junior colleagues (see EPA 20) ● Managing a clinical unit (see EPA 21) ● Performing clinical governance activity (see EPA 22)
3.	Potential risk in case of failure	● Increased morbidity and mortality ● Reputational damage – low risk ● Litigation – low risk ● Increased costs associated with tertiary care
4.	Link with most relevant FM Role and national unit standard	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** An approach to all of the following conditions: (See addendum to curriculum) • Non-communicable diseases including multi-morbidity • Organ system failures • Common autoimmune conditions • Common haematological conditions

		• Common neurological conditions • Chronic cardiovascular, renal, gastrointestinal and respiratory conditions • Common cancers • Common male and female sexual disorders • Common endocrine conditions • Administer different modalities of oxygen • Assess and consult families/couples • Collect specimens (blood/urine/pus swab etc) • Complete sick certificates • Demonstrate behaviour change counselling • Demonstrate skills in breaking bad news • Interpret barium swallows • Interpret radiographs CXR/AXR/Back/ Joints • Insert an intercostal chest drain • Measure peak expiratory flow • Nebulise a patient • Perform a pleural tap • Perform a pregnancy test • Perform an exercise stress test • Perform and interpret an electrocardiogram • Perform and interpret office spirometry • Perform fine/ wide needle aspiration biopsy • Perform point-of-care ultrasound • Perform routine intravenous access in adults • Perform urinalysis • Perform venepuncture • Perform work assessment and complete disability grant forms • Perform a femoral vein puncture • Perform a lumbar puncture • Use a glucometer • Use a haemoglobinometer • Use inhalers and spacers • Write letters to make appropriate referrals **Attitudes and Behaviours:** • Apply HPCSA ethical rules • Understand and apply appropriate health legislation • Attitudes related to the A-RICH acronym (see Preamble) **Experience:** The registrar will gain this experience in various setting namely: the PHC attachment, the outpatient department and the medical wards. The current registrar programme makes provision for these rotations, which may vary in length from 6 months to 12 months. **Resources:** ● APC Manual ● Hospital-level adult EML and STG ● General resource – Medscape or UpToDate

6.	Sources of information to support entrustment decisions (All captured in portfolio of learning)	Entrustment decisions are based on the evidence provided in: 1. At least 10 Direct (or video recorded) observations by: FP supervisors and other specialists in hospital OPDs, wards, PHC, EC and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on chronic care ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries Appropriate mix of consultations and skills (complexity and multi-morbidity) Must cover a diverse range of chronic conditions.
7.	Level of supervision	Entrustment level expected at end of programme: • Level 4 The registrar should attain this competency by Year 3 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for 5 years. Once the registrar is entrusted with this EPA, it must not be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Prof Mergan Naidoo UKZN 13 February 2021, Updated 12 May, June 2023

EPA 9

1. Title: Managing adult and adolescent patients with undifferentiated problems

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Evaluate and manage patients with undifferentiated problems in a holistic, cost-effective manner ● activities in the community, in primary care facilities and in district hospitals. ● Includes adolescents from thirteen years of age ● Full patient-centred medical history ● Appropriate focussed clinical examination ● Appropriate bedside investigations ● Clinical reasoning and appropriate clinical, individual and contextual assessments ● Ordering and interpretation of specific investigations ● Discussing the diagnosis with the patient and agreeing on a common management plan ● Outlining and agreeing on appropriate further referrals ● Doing minor procedures ● Collaborating with the healthcare team Limitations - A summative entrustment decision for this EPA does not apply for: ● Managing conditions that require urgent/ emergency care (See EPA 13) ● Managing patients requiring more specialised levels of care ● Activities related to disease prevention and treatment (see EPA 19) ● Capacitating nurse practitioners and junior colleagues (see EPA 20)
3.	Potential risk in case of failure	Increased morbidity and mortality- low risk Reputational damage – low risk Litigation – low risk Increased burden on other health services The increased cost of missing a potentially important condition
4.	Link with relevant FM Roles and Nat Unit Standards	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance Unit standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** An approach to all of the common undifferentiated problems in primary care settings. (See Addendum for Curriculum.) • GI/ respiratory/renal/ cardiovascular/ musculoskeletal/neurological symptoms • Gynaecological/ urogenital symptoms • Symptoms of sexual dysfunction • Non-specific symptoms • Mouth/ENT/ Eye/ Dermatology symptoms ● Assess and consult families/couples ● Collect routine specimens (blood/urine/stool/ pus swab etc) ● Complete sick certificates ● Breaking bad news ● Interpret barium swallows ● Interpret radiographs CXR/AXR/Back/ Joints ● Measure peak expiratory flow

		● Nebulise a patient ● Perform a lumbar puncture ● Perform a pleural tap ● Perform a pregnancy test ● Perform a relevant POCUS ● Perform an exercise stress test ● Perform and electrocardiogram (set up, record and interpretation) ● Perform and interpret office spirometry ● Perform brief behaviour change counselling ● Perform femoral vein puncture ● Perform fine and wide needle aspiration biopsy ● Perform fundoscopy ● Perform urinalysis ● Perform venepuncture ● Perform work assessment and complete disability grant forms ● Set up routine intravenous access in adults and children ● Take a sexual history in different contexts ● Use a glucometer ● Use a haemoglobinometer ● Use inhalers and spacers ● Write letters for appropriate referrals (specialists/investigations/MDT etc) **Behaviours:** • Apply HPCSA ethical rules • Understand and apply appropriate health legislation • Attitudes related to the A-RICH acronym (See Preamble) **Experience:** The registrar will encounter these symptoms during clinical rotations in the PHC clinic, the outpatient departments, the emergency centre and when they are placed in the community. The duration of the rotation may vary from 4 months to one year. Additionally, patients from any clinical domain may present with these symptoms i.e. a surgical patient may present with weakness in the post operative period. **Resources:** ● APC Manual ● PHC EML ● Family Practice Handbook ● Family Practice Manual
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. At least 10 Direct (or video recorded) observations of consultations by: FP supervisors and other specialists in PHC clinics, hospital OPDs, wards, EC and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments

		○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation: E.g. letters of performance from managers 5. Non-WBA type assessments: Patient complaints/compliments, patient-safety incidents, disciplinaries All captured in portfolio of learning. Appropriate mix of consultations and skills (complexity and multi-morbidity) Must cover a diverse range of symptom complexes.
7.	Level of supervision	Entrustment level expected at end of programme: • Level 4 The registrar should attain this competency by Year 3 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Prof Mergan Naidoo UKZN 23 November 2021/ Updated 24 May 2023 / June 2023

EPA 10

1. Title: Managing patients with infectious diseases

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: a) Evaluating and managing adults and children with common infectious diseases b) Activities in the community, primary care facilities and district hospitals. c) Coordinating outbreak responses at facility and community level d) Coordinating active surveillance e) Transversal activities as per preamble and National Unit Standard 2. f) Implementing antimicrobial stewardship (as per EPA 22) g) Screening, preventing disease, and health promotion related to infectious diseases using a COPC approach (More in EPAs 18 and 19) <u>Limitations:</u> A summative entrustment decision for this EPA does not apply for: ● The PMTCT programme and pregnant women (See EPAs 2 and 3) ● Palliative and end-of-life care. (See EPA 15) ● Managing adults and children with advanced, complicated infectious diseases that require more specialised care.
3.	Potential risks in case of failure	Patient suffering morbidity Patient suffering mortality Community placed at risk Generic Risks as outlined in the preamble Health Care workers placed at risk
4.	Link with most relevant FM roles and national unit standard	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National unit standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** (See also addendum to Curriculum) ● Using a COPC principles approach, coordinate active surveillance, contact tracing, and isolation (where appropriate) in community of common category 1 and category 2 notifiable conditions as per addendum list. ● Pre- and post-exposure prophylaxis for common Category 1 and category 2 notifiable conditions in addendum ● Infection Control principles including isolation and quarantine principles. ● Initiating first or second-line ART ● Identifying potential candidates for third-line ART ● Initiating first or second line TB treatment ● Ongoing care for a patient with HIV or TB ● Managing opportunistic infections in HIV ● Diagnosing and coordinating care of cancers in HIV ● Managing adverse effects & complications of treatment in HIV & TB ● Coordinating multidisciplinary team management of MDR-TB ● Managing patients with multi-morbidity ● Managing non-adherence through counselling ● Providing and coordinating initial and ongoing care of common infectious diseases as per addendum

		● Managing patients with fever of unknown origin ● Point of care HIV testing ● Venesection for blood cultures ● Behaviour change counselling ● Sexual history and counselling ● Urine testing for LF-LAM ● Urine testing for Schistosomiasis haematobium ● Thick and Thin Smears for Malaria ● Nasopharyngeal swabbing These skills are used in this EPA, but will be summatively assessed in other EPAs: ● Skin biopsy ● Pus swab ● Lymph node excision biopsy ● Wide needle aspiration biopsy ● Male medical circumcision ● Assess and consult families/couples ● Break bad news ● Counselling skills for HIV ● Assess chest radiograph ● Cervical Smear ● Point of care ultrasound (Splenic micro-abscesses) ● Urine testing for UTI ● Lumbar puncture including measurement of opening pressures [All above skills observed at least twice]. **Attitudes and Behaviours:** ● Apply HPCSA ethical rules ● Understand and apply appropriate health legislation ● Attitudes related to the A-RICH acronym (see Preamble) **Experience**: The registrar will gain/have some of this experience in various settings namely: the community ward-based teams, the PHC attachment, the district hospital outpatient department and the wards. The current registrar programme makes provision for these allocations, which may vary in length from 6 months to 12 months. See logbook where relevant. **Resources:** Treatment For Latent TB Infection In South Africa Guidelines Sept 2019 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates. Nat. DOH. SA National TB Guidelines APC IMCI HPCSA ethical guidelines on HIV and other STIs HPCSA ethical guidelines

		NICD https://www.nicd.ac.za/nmc-overview/notification-process/
6.	Sources of information to support entrustment decisions All captured in portfolio of learning	Entrustment decisions are based on the evidence provided in: 1. Direct observations by FP supervisors, senior medical officers, consultants in Internal Meds and Paediatrics, senior HIV nurses, during consultations in PHC clinics, hospital OPDs, wards, the EC and during home visits (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback (This may include role players specific to an EPA) ○ Periodic assessment of performance (of allocation, of last 6-months) ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on workplace based learning and practice ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers, reports from clinical governance activities, etc. 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries **Minimum Experience required:** Some of the activities must show how experience in TB and HIV have been obtained.
7.	Level of supervision	Entrustment level expected at end of programme: ● Level 5 for adults with uncomplicated disease ● Level 4 for drug resistant HIV TB, severe malaria, hepatitis, and typhoid infections. ● Level 3 for children with HIV and TB
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	LS Jenkins, T Motsohi, B Mash. Stellenbosch University 19 Oct 2021 (updated 19 May 2023, 25 June 2023)

EPA 11

1. Title: Managing adults with conditions that may require surgery or procedures

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include elements of: ● Adults presenting with general surgical, orthopedic, urology, ENT, gynecology and ophthalmology problems ● Setting: Primary care facilities and district hospitals ● Managing patients with undifferentiated non-trauma related surgical symptoms that may require surgery or procedures. ● Managing non-trauma patients with acute conditions needing surgical intervention. ● Providing pre-, intra and post-operative care in primary health care facilities, district hospitals and patient's home. ● Managing patients with ongoing surgical problems. ● Consult and work within a multidisciplinary team. ● Manage the clinical encounter in detail, including taking history, examination, investigations for the purpose of comprehensive assessment and management of common surgical conditions. ● Apply basic surgical techniques in performing basic and common procedures. ● Recognize, stabilize, and manage patients with surgical problems requiring referrals to other levels of care. ● Apply ethical principles in the assessment and management of patients with surgical problems. ● Demonstrate awareness of limit of skills and knowledge and need to seek for help. <u>Limitations</u> **-** A summative entrustment decision for this EPA does not apply for: ● Surgical conditions requiring interventions and procedures at more specialized levels of care. ● Obstetric procedures and surgery (See EPA 1) ● Surgical problems in children (See EPA 5) ● Patients with undifferentiated problems (See EPA 9) ● Managing patients who present with surgical emergencies (See EPA 13)
3.	Potential risk in case of failure	● Missed diagnosis and poor skills resulting in: - increased complications, morbidity, and mortality. - Disruption of Doctor-patient relationship, reputational damage for doctors, patient dissatisfaction. ● Medico-legal implications - moderate ● Deviation from local package of health care services - mild
4.	Link with most relevant Fam Meds roles and Nat Unit Standard	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge,	**Knowledge and skills**

	skills, attitude, experience.	● Understanding and application of the anatomical, pathological, and microbial bases of common surgical problems. ● Knowledge and effective use of relevant surgical instruments and equipment ● Application of basic surgical techniques including haemostasis, surgical dissection, suturing, wound dressing, etc in the management of common surgical conditions encountered in PHC. ● Principles of fluids and electrolyte balance and homeostasis. ● Use of blood and blood products including management of adverse reactions. ● Interpretation of the results of laboratory and radiological investigations. ● Rational use of antimicrobials and stewardship ● Principles of medical ethics. ● Family oriented primary care. ● Communicating bad news ● Prevention and management of medical errors (Procedural skill list aligned to logbook in portfolio) ● Do appropriate surgical procedures in Primary health care (Including CHC and District Hospital level) (Examples superficial abscess I&D versus breast abscess) ● Do appropriate orthopaedic procedures in Primary health care (Including CHC and District Hospital level) (Examples POP application, shoulder dislocation) ● Do appropriate ear nose and throat procedures in Primary health care (Including CHC and District Hospital) (Examples Peritonsillar aspiration, nasal and aural foreign body, epistaxis, ear syringing) ● Do appropriate eye procedures in Primary health care (Including CHC and District Hospital level) ● Do appropriate urological procedures in Primary health care (Including CHC and District Hospital level) (Examples suprapubic catheterisation, urethral catheterisation, hydrocele aspiration) ● Do appropriate gynaecological procedures in Primary health care (Including CHC and District Hospital level) (Examples laparotomy for ectopic pregnancy, dilatation and curettage of uterus, endometrial biopsy, cervical biopsy) **Attitude and Behaviour**: ● HPCSA ethical guidelines for good practice in the health care professions. Cultural and gender sensitivity ● Compassionate approach, treating patients with dignity and respect. ● Advocacy for patient and family-centred care ● Able to practice self-care, reflective behaviour and able to identify transference and counter-transference ● Attitudes related to A-RICH acronym (See Preamble) **Experience**: Dedicated time spent in a district hospital theatre, doing surgical procedures. **Resources**: Family Practice Handbook relevant chapters Family Medicine Manual relevant chapters

6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. Direct observations by family physicians and other senior surgical doctors in district hospitals or CHCs: a minimum of 10 direct observations that are diverse (covering a range of surgical conditions) (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic assessment of performance (of allocation, of last 6-months) ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on workplace-based learning and practice ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers, reports from clinical governance activities, etc. 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries
7	Level of supervision	Entrustment level expected at end of programme: Level 4 for service package at PHC facilities and district hospital. The registrar should attain this competency by end of Year 3 of the programme
8	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years.
	Authors, University, Date	*C Lion-Cachet, M Torlutter, M Petkova, E Wenegieme, N Erumeda, D Pretorius, R Cooke and O Omole* University of the Witwatersrand; June 2023

EPA 12

1. Title: Managing patients with mental health disorders

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Conducting adult mental health-oriented consultations in primary care, emergency centres and in-patient district hospitals; ● Conducting child and adolescent mental health-oriented consultations in primary and emergency care contexts; ● Differentiating between delirium and primary mental health disorders ● Implementing appropriate clinical and ethico-legal decisions and actions when managing mental health users; ● Making biopsychosocial and risk assessments using the mental state examination; ● Creating evidence-based non-pharmacological and pharmacological interventions; ● Implementing family-oriented assessments and interventions; ● Manages own subjectivity using debriefing, reflective skills and asking for help; ● Working within a multi-disciplinary team ● Taking a mental health-specific history ● Doing a mental state examination ● Doing a mental health risk assessment ● Managing adverse effects of psychotropic medications ● Completing MHCA forms as appropriate ● Conducting family meetings to obtain collateral information and plan interventions ● Engaging with members of the multi-disciplinary team <u>Limitations</u> **-** A summative entrustment decision for this EPA does not apply for: ● Managing complex mental health patients needing specialised psychiatric care ● Family and Community oriented primary care (See EPA 18)
3.	Potential risks in case of failure	1. Patient incorrectly and unsafely discharged into the community e.g., suicide/homicide 2. Childhood diagnoses missed impacting on long-term quality of life e.g., school failure; socialisation issues 3. Not recognising the family at risk of perpetuating mental health problems 4. Medico-legal implications of deviating from the MHCA 5. Misdiagnosed organic illness and subsequent incorrect management
4.	Link with most relevant FM Roles and National unit standards	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** ● Common mental health problems in primary care – diagnostic criteria DSM V: mood disorders; substance use disorders; personality disorders; schizophrenia; learning and behavioural disorders in children ● Risk factors for mental health ● Social determinants for mental health ● Mental health manifestations of metabolic/physical disease

		● Referral criteria and pathways ● Family and Community-based resources ● Ethics and Laws pertaining to the mental health user ● History taking and examination in Mental Health ● Manage behaviourally disturbed patients in an emergency setting ● Engaging with adult patients and their families ● Engaging with child and adolescent patients and their families ● Working within a multidisciplinary team ● Managing self and other team members in crisis ● Psychoeducation **Attitudes and Behaviour:** ● Patient-centred, family and community oriented ● Risk-conscious ● Evidence-based ● Ten Cate – A RICH framework **Resources:** ● SA Family Practice Manual latest ed – appropriate chapters (examination and MHCA) ● SA Handbook of FM – appropriate chapters on consultation and FCOPC ● Moodley K. Ethics. Latest edition. Appropriate chapters on ethics, MHCA, Child Act ● EML primary and hospital level (latest editions) ● SAMF latest edition. Appropriate sections on psychopharmacology ● DSM V
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. At least 6 diverse mini-CEX in varied contexts (emergency, in-patient, primary care). 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Record of allocations (relevant experience) 4. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries (All captured in portfolio of learning)
7.	Level of supervision	Entrustment level expected at end of programme: Level 4
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years.
	Author(s) *Name(s), university, date.*	Profs T Ras, K von Pressentin UCT June 2023

EPA 13

Title: Managing patients with emergency conditions

No	Component	Description
2.	Specifications and limitations	This EPA contains the following elements: Adults and children presenting with emergencies including trauma, injury, or accidents; medical emergencies including pregnancy first and second trimester & mental health emergencies, including parasuicide. Activities at district hospitals, community health/day centers or PHC clinics (any setting where a patient is presenting with an emergency). ● Triaging patients on arrival in an emergency centre setting ● Identifying red flags / danger signs and urgently managing threats to life. ● Assessing, examination and managing patients presenting in an emergency setting, including identifying appropriate algorithms to follow ● Performing key surgical procedures required in an emergency setting ● Managing referrals and referral pathways ● Leading the team in resuscitation scenarios ● Mass disaster response: recognising and coordinating the team ● Managing distress in patients and families Limitations: A summative entrustment decision for this EPA does not apply for: ● Emergency pregnancy related presentations from third trimester (see EPA 2) ● Forensic emergencies e.g. drunken driving. (see EPA 14) ● Patients presenting with undifferentiated non-urgent conditions (see EPA 9)
3.	Potential risk in case of failure	● Increased mortality and morbidity and suffering of patients (high risk) ● Increased suffering of families ● Reputational damage (high risk) ● Litigation (high risk)
4.	Link with FM Roles and National Unit Standards	● **Clinician and consultant** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National unit standard 2
5.	Required Knowledge Skills Attitude Experience	**Knowledge and Skills** (See addendum to Curiculum) Trauma, Injuries & Accidents ● Triaging ● Burns ● Bites and stings ● Exposure to poisonous substances ● Chemical substance abuse emergencies ● Eye injuries including chemical burns eyes & blunt/ penetrating foreign bodies. ● Post exposure prophylaxis to occupational and inadvertent (non-occupational) ● Sexual assault including provision of PEP ● Soft tissue injuries. ● Polytrauma including the primary and secondary survey

		● Trauma related hypovolaemic shock ● Severe epistaxis ● Fractures ● Penetrating wounds to the chest, abdomen or head ● Thermoregulatory, near drowning, & diving emergencies Medical emergencies ● Cardiac emergencies ● Respiratory emergencies ● Angioedema and anaphylaxis ● Severely ill, undifferentiated patient in the emergency room ● Endocrine emergencies ● Non-traumatic shock ● Renal & electrolyte emergencies ● Haematological disorders in the emergency setting. ● Gastro-intestinal emergencies ● Neurological emergencies ● Infectious emergencies ● Convulsions Mental health emergencies ● The aggressive / behaviourally disturbed patient ● Neuroleptic malignant syndrome ● Parasuicide and patients with suicidal ideation **<u>Procedures</u>** Trauma, Injuries & Accidents procedures ● Intubate a patient and manage an airway ● Immobilise the spine ● Clean, debride and irrigate wounds. ● Calculate the percentage of burns ● Nasogastric / Orogastric lavage including inserting a nasogastric tube ● Removing a foreign body from an eye ● Suture lacerations ● Removing foreign bodies in ears, nose, bronchus, throat ● Packing a nose (for epistaxis) ● Apply plaster casts and splints and do closed reduction of common limb fractures ● Reduce dislocations of shoulder, elbow and hip ● Inserting an intercostal drain / relieving a tension pneumothorax ● Relieve a cardiac tamponade ● Giving a massive transfusion ● Gaining intravenous access – peripheral line / central venous line ● Interpreting an X-ray in a trauma patient ● Point of care ultrasound to assess a patient with trauma ● Transport a critically ill patient from primary to secondary care ● Remove percutaneous foreign bodies ● Suspected choking / foreign body aspiration in children Medical emergencies procedures

		• Cardio-pulmonary resuscitation including appropriate use of defibrillator • Cricothyroidotomy • Blood gas analysis • Lumbar puncture and measuring IC pressure • Emergency dialysis ?? • Central venous line • Confirmation of death • Intra-osseous line Mental health emergencies procedures • Arrange a 72 hour admission • Risk assessment on a patient with suicidal ideation • Restraining / sedating of the aggressive patient **Attitudes & Behaviours** • Empathic counselling in a patient that has been through sexual assault. • Empathic communication with families of patient with polytrauma • A-RICH approach (Ten Care 2020) • Communicating the death / severe illness / injury of a patient to friends and family **Experiences** • Doing on-calls in an emergency setting / department / EC. • BLS / ACLS / ATLS / PALS or equivalent **Focused resources** • A guide to the management of common medical emergencies in adults, WGJ Kloeck • SATS website: https://emssa.org.za/special-interest-groups/the-south-african-triage-scale-sats/ • Advanced Life Support training manuals
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. Direct observations: a minimum of 10 direct observations that are diverse (covering trauma, medical and mental health emergencies) Mini-CEXs, DOPS, teaching event 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic assessment of performance (of allocation, of last 6-months) ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on workplace-based learning and practice ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers, reports from clinical governance activities, etc. 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries **Minimum experience required**

		● At least 96 on-call shifts in an emergency setting / department
7.	Level of supervision	Level 4 by end of program.
8.	Expiry date	This EPA does not need to be re-assessed before end of programme (4 years)
	Author(s)	Dr Madeleine Muller & Prof Busisiwe Cawe, WSU. June 2023

EPA 14

Title: Managing patients with forensic problems.

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include the following elements: ● Manage patients where different aspects of the law and medicine overlap ● Be able to correctly complete necessary legal documentation ● Comprehensive management of… ● sexual offenses ● child / elderly abuse ● assault and interpersonal violence ● natural and unnatural death processes ● driving under the influence ● other injuries and violence (e.g. road accidents) <u>Limitations</u> - A summative entrustment decision for this EPA does not apply to: ● Procedures & Processes of the Mental Health Care Act (See EPA 12) ● Regulated Medicines and substances ● Malpractice & Negligence Law ● Doing Postmortems
3.	Potential risks in case of failure	Patient suffering morbidity. Moderate risk. Patient can suffer mortality. Partners placed at risk. Moderate risk. Medico-legal consequences.
4.	Link with most relevant FM Roles and Nat Unit Standard.	● **<u>Clinician and Consultant</u>** ● Clinical trainer and Capacity builder ● Leader of Clinical governance ● Champion of COPC Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** Clinical presentation of forensic cases and management protocols Medico-legal terminology Traumatology terminology and management Relevant anatomy and anatomical trauma variations Record keeping and correct medico-legal forms Legal and social processes available in child and elderly abuse Clinical examination of a sexual assault survivor Clinical examination of an abused child or elderly patient Clinical record keeping Training staff in forensic management Communication skills, e.g. negotiating a postmortem for unnatural death Working closely with police, courts, and social workers Competent and professional to testify in court **Attitudes and Behaviours:** HPCSA ethical guidelines on disclosure, consent etc. National unit standard 5 (Ethics and Professionalism) National unit standard 2 some aspects Patient-centered, community minded, etc. Professional behavior: Develop package for all EPAs.

		A-RICH approach as per published article (Ten Cate 2020, DOI: 10.1080/0142159X.2020.1817348) **Experience**: Some exposure to patients with forensic needs, particularly directly being observed managing patients with sexual assault. **Resources:** Handbook of Family Medicine. Mash et al. SA Family Practice Manual. Mash et al. HPCSA ethical guidelines SAFPJ 2 articles on completing the J88 Police form. Maternal deaths National Report (3-yearly)
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: At least 6 Direct (or video recorded) observations by: FP supervisors, senior medical officers, court or police feedback, or senior nurses, during consultations in clinics, hospital OPDs, wards, the EC and Thutuzela centres. (e.g. mini-CEXs, DOPS, teaching event) 1. Individual discussions 2 Educational meetings (with the supervisor, others) 2. Longitudinal monitoring ○ 1 Multi-source feedback evaluation (with at least 1 forensic colleague) ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ 1 Registrar reflection ○ 1 Written assignment ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 3. Product evaluation E.g. letters of performance from managers 4. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries All captured in portfolio of learning
7.	Level of supervision	Entrustment level expected at end of programme: Level 4
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Werner Viljoen, LS Jenkins, T Motsohi, B Mash. Stellenbosch University July 2022 (updated 19 May 2023, June 2023)

EPA 15

1. Title: Managing adults and children with palliative care needs

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include the following elements: ● Evaluate and manage adult and paediatric patients with common palliative problems in a holistic, cost-effective and compassionate manner ● Activities in the community, in primary care facilities and district hospitals. ● Activities related to disease palliation and family care. ● Early identification of patients who require a palliative care approach. ● Full patient and family-centred bio-psychosocial and spiritual assessment ● Appropriate focussed clinical examination ● Appropriate and rational investigations ● Good clinical reasoning and appropriate clinical, individual, spiritual and contextual assessment ● Discussing the diagnosis and prognosis with the patient and family and agreeing on a common management plan and advance care plan ● Recognising conditions that need emergency or urgent care and arranging appropriate management plans and referrals ● Outlining and agreeing on appropriate further referrals, including psychosocial and spiritual management. ● Ensuring available multidisciplinary community and home care ● Providing comprehensive end-of-life care ● Assessing and managing basic bereavement and linking with bereavement care when complicated bereavement is identified ● Identifying & appropriate referral of vulnerable individuals e.g children at risk. ● Enlisting and working within a multidisciplinary team • Breaking bad news • Having a serious illness conversation • Doing Advance Care Planning • Conducting a family meeting • Pain and symptom control • Performing minor procedures e.g. placing a syringe driver • Identifying potential tissue and organ donors and integrating specialist requesting into end-of-life discussions as standard of care • Providing appropriate bereavement care • Collaboration with the healthcare team for the best possible outcome Limitations - A summative entrustment decision for this EPA does not apply for: ● Managing adults with chronic conditions (See EPA 8) ● Recognising conditions that require urgent/ emergency care (See EPA 13) ● Managing care for older patients (See EPA 16) ● Conditions that require more specialised levels (regional/tertiary) of care
3.	Potential risk in case of failure	Increased morbidity and suffering of patients Increased suffering of families Reputational damage Wasteful expenditure Missed opportunities for prevention e.g. tissue donation Litigation

4.	Link with most relevant FM Roles and Nat Unit Standard	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● **<u>Champion of community-oriented primary care (COPC)</u>** Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** An approach to all of the following conditions: ● management of all major malignancies ● End stage renal disease ● End stage heart disease ● End stage respiratory disease ● End stage liver disease ● End stage and untreated infectious diseases ● End stage peripheral vascular disease ● Brain injury or severe trauma clinically deteriorating and no benefit to surgical interventions. ● Progressive neurological conditions ● Dementia care and frailty care ● Pain management in all of the above conditions ● Approach to common symptom management ○ Dyspnoea ○ Constipation ○ Cachexia ○ Delirium ○ Diarrhoea ○ Nausea and/ vomiting ○ Depression and anxiety ○ Common symptoms at the end of life ● Assess, consult and include families ● Break bad news ● Compassionate prognostication ● Serious illness conversation ● Assess organ and tissue donation potential and refer appropriately ● Assess bereavement needs, provide basic bereavement care and refer appropriately ● Assess spirituality and refer appropriately ● Work within a multidisciplinary/ interdisciplinary team ● Advocating for patients and families to other colleagues ● Advocate for palliative care within their own context ● Complete sick certificates ● Appropriate networking with available resources ● Set up a syringe driver ● Ascites and pleural taps **Attitudes and Behaviour:** ● Apply HPCSA ethical rules ● Managing an ethical dilemma

		● Understand and apply appropriate health legislation ● Advocacy for patient and family centred care ● Practicing the principle of non-abandonment ● Able to practice self-care, reflective behaviour and able to identify transference and countertransference ● Attitudes related to the A-RICH acronym (See preamble) **Experiences:** At least 8 supervised activities of direct care of patients and families with palliative care needs before unsupervised practice can be considered. **Resources:** ● Palliative Care guidelines ● Hospital level adult EML ● General resource – Medscape or UpToDate
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. At least 8 direct observations by: FP supervisors who are trained in Pall Care, senior medical officers who are trained in palliative care, consultants in palliative care, hospital OPDs, hospices, wards, the EC and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries (All captured in portfolio of learning)
7.	Level of supervision	Entrustment level expected at end of programme: • Level 4 The registrar should attain this competency by Year 3 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Dr Rene Krause, Dr Jennie Morgan, Dr Maggie De Swardt, Dr David Thomson UCT June 2023

EPA 16

1. Title: Managing care for older patients

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Evaluating and managing elderly patients with common medical, social and psychological problems in a holistic, cost-effective and compassionate manner ● Activities in the community, primary care facilities, and district hospitals. ● Full patient and family-centred bio-psychosocial and spiritual assessment ● Ensuring available community and home care. ● Working within a multidisciplinary team ● ICF: participation restriction and activity limitation ● Identify emergencies that require urgent interventions per patient/family wishes and ethical principles ● Understanding and explaining the normal ageing process e.g., sensory impairment, decreased mobility and immunity, cancers, etc. ● Manage a combination of multiple diseases e.g., diabetes, hypertension, arthritis, dyslipidaemia, stroke, depression/anxiety, and dementia with or without consultation with specialists in the context of elderly care. (Also see EPA8) ● Diagnose and manage frailty, malnutrition, social isolation ● Support or guide the patient and family on appropriate placement options. ● Providing appropriate bereavement care (also see EPA15) <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: ● Activities solely relating to chronic conditions (See EPA 8) ● Activities solely relating to undifferentiated problems (See EPA 9) ● Diagnosis and management of emergency conditions (See EPA 13) ● Palliative care and end-of-life care (see EPA 15) ● Rehabilitation care (see EPA 17) ● Promoting and preventing disease e.g., healthy lifestyle, immunisation, & screening (see EPA19)
3.	Potential risk in case of failure	Increased morbidity and mortality of patients Increased suffering of families Reputational damage Litigation
4.	Link with most relevant FM Roles and Nat Unit Standard	● **<u>Clinician and consultant</u>** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** An approach to all of the following conditions in the elderly: • Renal and urological diseases and their complications, e.g., urinary incontinence, drug contra-indications/ dosage adjustments with kidney impairment • Cardiac disease. E.g., hypertension, ischemic heart disease, chronic cardiac failure • Respiratory disease e.g., pneumonia, COPD, destructive lung disease, TB • Screening, diagnosis, and management of all major malignancies • Frailty, Arthritis and mobility impairment • Malnutrition

		• Stroke, Depression, Dementia and Alzheimer's disease
		• Peripheral vascular disease with or without amputations
		• Medico-legal aspects of caring for the elderly
		
		Procedures / Consultation skills
		● Manage common presenting symptoms
		● Perform procedures to assist with diagnosis e.g., pleural and ascites taps, fine needle aspirations, FAST
		● Interpret special investigations in the context of elderly care
		● Assess and consult families
		● Compassionate prognostication
		● Assess and refer appropriately
		● Work within a multidisciplinary/ interdisciplinary team
		● Advocating for patients and families
		● Appropriate networking with available resources
		● Completion of documentation e.g., old age home application, pension and medical aid forms
		
		Attitudes and Behaviour:
		• Apply HPCSA ethical rules
		• Managing an ethical dilemma
		• Understand and apply appropriate health legislation
		• Compassionate approach, treating patients with dignity and respect.
		• Advocacy for patient and family-centred care
		• Able to practice self-care, reflective behaviour and able to identify transference and countertransference
		• Attitudes related to task-specific trustworthiness, in addition to task-specific capability:
		  • Integrity (truthful, good intentions, patient-centred)
		  • Reliability (conscientious, predictable, accountable, responsible)
		  • Humility (observing limits, willing to ask for help, receptive to feedback)
		  • Agency (self-confident, proactive toward work, team, and safety)
		
		Experience:
		Some activities of direct care of patients and families with geriatric care needs before unsupervised practice can be considered.
		
		Resources:
		● Oxford Handbook of Family Medicine
		● SA Family Practice Manual
		● Hospital-level adult and PHC EML

6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. At least 8 Direct (or video recorded) observations by: FP supervisors and other specialists (e.g. palliative/geriatric care) in hospital OPDs, wards, PHC, EC and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback

	(All captured in portfolio of learning)	○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on elderly care ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation, E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries
7.	Level of supervision	Entrustment level expected at end of the programme: • Level 4 The registrar should attain this competency by Year 3 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Prof Hanneke Brits UFS May 2023, updated June 2023

EPA 17

1. Title: Managing patients with impairments and rehabilitation needs

No	Component	Description
2.	Specifications and limitations	This EPA includes or may include the following elements: • Adult and paediatric patients with impairments or with rehabilitation needs • Identification of physical, psychological or mental impairments in patients • Evaluate and manage common medical, social and psychological problems in patients with impairment in a holistic, cost-effective and compassionate manner • Activities to promote inclusiveness, in the community, in primary care facilities and district hospitals. • Activities supporting the family and care facilities. • Working within a multidisciplinary team, including nursing, medical, including physiotherapists, occupational therapists, speech and audiology therapists, social workers and dieticians. • Assess level of functioning (ICF) – baseline and progress <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: • Impairments due to acute conditions • Palliative care and end-of-life care (See EPA 15) • Managing care for older and frail patients (See EPA 16) • Assessment of patients' needs for rehabilitation services (See EPA19)
3.	Potential risk in case of failure	• Unnecessary suffering, limitation or exclusion for the patient • Avoidable financial and social burden on individuals and families • Reputational damage
4.	Link with relevant FM Role and Nat Unit Standard	• <u>Clinician and consultant</u> • Clinical trainer and capacity-builder • Leader of clinical governance • Champion of community-oriented primary care (COPC) Unit Standard 2
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** • Mechanisms of functions and their limitations in physical and mental impairment • International Classification of Functioning, Disability and Health (ICF) • Approaches to rehabilitation and integration • Typical complications and risks of deterioration in specific conditions of impairment, and ways to identify and manage those. • Pathways of access to rehabilitation and support services. • Medico-legal aspects pertaining to impaired people. • Diagnosis and management of conditions of impairment, including physical, mental, hearing, speech, and visual. • Manage common acute presenting symptoms. • Diagnose and manage chronic medical conditions in the context of impairment • Appropriate clinical physical, psychological and mental assessment skills • Identify and manage patients that need urgent referral • Identify and manage patients that need referral to allied health services • Identify and manage patients that need to obtain assisting devices • Assess and consult families • Compassionate prognostication • Assess and refer appropriately

		● Work within a multidisciplinary/ interdisciplinary team ● Advocating for patients and families ● Early identification of palliative care needs (See EPA15) ● Identify and utilise available community and home-based care ● Appropriate networking with available resources ● Completion of documentation e.g., old age home application, pension and medical aid forms, and insurance claim forms **Attitudes and Behaviour:** ● Show genuine empathy to the patient and family ● Support or guide the patient & family in appropriate placement if the need arises. ● Apply HPCSA ethical rules ● Managing an ethical dilemma ● Understand and apply relevant legislation ● Attitudes related to A-RICH acronym (See preamble) ● Advocacy for patient and family-centred care ● Able to practice self-care, reflective behaviour and able to identify transference and counter-transference **Experience:** At least 8 activities of direct care of patients with impairment and rehabilitative needs and their families before unsupervised practice can be considered. **Resources:** ● Chapter in Family Practice Handbook ● Chapter in SA Family Practice Manual ● Hospital-level adult EML
6.	Sources of information to support entrustment decisions (All captured in portfolio of learning)	Entrustment decisions are based on the evidence provided in: 1. At least 8 Direct (or video recorded) observations by: FP supervisors, senior medical officers, consultants and experienced health professionals from other disciplines in rehabilitation facilities and services in hospital OPDs, wards, PHC, EC, Hospices and during home visits. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback ○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on rehabilitation ○ Record of allocations (relevant experience) ○ Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation, E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries
7.	Level of supervision	Entrustment level expected at end of programme: • Level 4 The registrar should attain this competency by Year 3 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed program.
	Author *Name, university, date.*	Prof Dirk Hagemeister UFS June 2023

EPA 18

1. Title: Supporting community-based health services

No	Component	Description
2.	Specifications and limitations	<u>This EPA includes the following elements:</u> 1. Leading and assisting COPC implementation as a model of care 2. Supporting community based services 3. Care coordination and community engagement <u>Detailed specifications to be observed:</u> 1. Define the community 2. Assess health and care asset base (Local Institutional Support Assessment) 3. Assess and prioritise individual, family and community health problems and needs 4. Conduct home visits with community health care worker CHW teams 5. Facilitate primary health care team members understanding and use of routinely collected health information (e.g. routine DHIS reports, Ideal Clinic or Hospital norms and standards, use of investigations, prescribing of medication, ward based outreach teams / CHW household data) 6. Make a community diagnosis 7. Facilitate reflective action planning using routine data, and shared empirical experiences and observations. 8. Develop adaptive action plans and interventions to improve the health of the community 9. Capacitate (train and support) primary healthcare teams through continuous work integrated learning 10. Partner with identified community oriented health and care programs or projects and support service delivery 11. Coordinate patient / family centered linkage to care between primary health care teams and health, allied or social service providers in clinics, hospitals, private practices, not for profit and community based organizations. 12. Create a monitoring framework for COPC activities and plans <u>Limitations</u>: A summative entrustment decision for this EPA does not apply for any specific activities.

3.	Potential risks in case of failure.	● Public, family and personal health consequences
		● Inability to respond to health-related needs
		● Failure of integrated service delivery
		● No improvement, shift or deterioration in
		  ○ primary health care
		  ○ access to health care
		  ○ health literacy
		  ○ disease burden
		  ○ morbidity and mortality
		● Inability to achieve health care equity

4.	Link with FM Roles and national unit standards	● **<u>Champion of COPC</u>** ● Clinician and consultant ● Clinical trainer and capacity builder ● Leader of Clinical governance National Unit Standard 3
5.	Required knowledge, skills, attitudes/ behaviour, experience	**Knowledge and Skills** ● Define COPC ● Understand the principles of COPC ● Understand COPC practices as stepwise continuous cycles of improvement ● Know the value and goals of home visits ● Understand the purpose and functioning of community-based health care worker CHW teams (ward-based outreach teams WBOT / ward health teams WHT) ● Understand the key elements of effective care coordination ● Be familiar with the purpose and ways to conduct local health assessments and institutional analyses ● Understand and interpret health status, community data and information ● Define and apply comprehensive care o Have an approach to community health promotion o Understand individual, familial, community and population levels of disease prevention ● Understand a capability approach to learning o Know how to develop and build service provider, patient, family and community competencies and capacity. ● Know how to approach and apply COPC as scientifically informed practice o Understand health indicators and their measurement ● Know the main challenges facing healthcare in South Africa ● Know the main challenges facing healthcare in your defined community ● Define inter-disciplinary and multi-professional practice ● Understand service integration components of person centred healthcare, (people & practitioners in partnerships and continuity of care) ● Understand the concepts and difference between horizontal/vertical equity and equality ● Know and practice cultural safety in all communities o Cross-cultural knowledge o Identify, understand, accept, respect and take account of relevant cultural or religious beliefs and practices (such as diet, burial practices or processes) for decision making. ● Know Batho Pele Principles and public service complaints and compliments processes ● Know the South African health care system and policy reform initiatives o The organization and the levels of governance o Re-engineering of primary health care o The ideal clinic initiative o Universal health coverage and the NHI Skills applying to COPC practice: Include four main performance areas: 1. Clinical practice (delivering and supporting the delivery of person/family centered primary health care to people in their homes/places of work)

		2. Education and Training (building own and others competencies) in an ingoing integrated way to create capability 3. Information (Gathering, Interpretation, Application for informed Adaptive Planning and Practice) 4. Relationship building (between people, tiers and levels, services and organisations) The clinician is able to: ● Make a community diagnosis ● Develop adaptive action plans to address identified health priorities of the community ● Create a monitoring framework for COPC activities and plans. ● Train and develop capacity ● Apply the principles and approach of COPC practice **Attitudes and Behaviours:** ● **A**ttitudes related to task-specific trustworthiness and capability ● **C**ooperative and collaborative practice ● **H**umility (observing limits, willing to ask help, receptive to feedback) ● **A**gency (self-confident, proactive toward work, team, safety) ● **I**nformed (apply scientific, policy and Batho-Pele-Principles appropriately) ● **I**ntegrity (truthful, good intentions, patient-centred, continuously learning) ● **R**eliability (conscientious, predictable, accountable, responsible HPCSA ethical guidelines for good practice in the health care professions **Experience**: ● Dedicated time spent in the community supporting community-based services (eg substance use program, feeding schemes, home based care, hospice) **Resources:** ● The contribution of family physicians and primary care doctors to community-orientated primary care. Mash R, Gaede B, Hugo JF. S Afr Fam Pract. 2021;63(1): e1–e5. https://doi.org/10.4102/safp.v63i1.5281 ● Marcus TS. COPC - A Practical Guide. 2018. Department of Family Medicine, University of Pretoria. Available at: https://www.researchgate.net/publication/327495860_COPC-_A_Practical_Guide ● NHI White Paper and Policy Available at: https://www.gov.za/about-government/government-programmes/national-health-insurance-0 ● Ideal Clinic South Africa norms and standards. Website: https://www.idealhealthfacility.org.za
6.	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. Direct observations by: FP supervisors, Senior Nurses in PHC clinics, Hospital OPDs, Wards, Teams and Community Workers in the Extended Community and during at least TWO home visits, and patient and family feedback - at least TWO teaching/training observations 2. Individual discussions Educational meetings (with the supervisor, others) 3. Longitudinal monitoring ○ Multi-source feedback

	All captured in portfolio of learning	○ Periodic supervisor assessment at end of OPD/PHC/ward attachment allocation ○ Learning plans (for allocation, for next 6-months) ○ Registrar reflections (on allocation, of last 6 months) ○ Written assignments on COPC (scored >60%) ○ Record of allocations (with relevant COPC experience) ○ Logbook (relevant opportunity to practice skills) 4. Product evaluation E.g. letters of performance from managers 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries
7.	Level of supervision	Entrustment level expected at end of programme: Level 4
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year training program.
	Author(s) university, date	Prof T Marcus, Dr B van Coppenhagen University of Pretoria June 2023

EPA 19

1. Title: Supporting and providing health promotion and disease prevention services

No	Component	Description
2.	Specifications and limitations	This EPA contain the following elements: ● Takes place at: district hospital, community health / day centre, primary health care and at community level. ● Providing primary preventative services, which includes lifestyle modification and immunisations including recognising preventative measures and opportunistic health promotion needed in different age groups and populations. ● Implementing preventative care for different key populations & improving access to care ● Providing family planning and contraception ● Supporting school health initiatives including oral health, vision screening etc ● Providing secondary prevention (early detection of disease or precursors to disease) including cancer screening ● Setting up and overseeing a health prevention program. ● Providing linkages to rehabilitation of those with established disease (Quaternary prevention) Limitations**:** A summative entrustment decision for this EPA does not apply for: ● Maternal health (See EPA 2) ● Tertiary prevention (manage established disease to minimise disability) (see EPA 8) ● Preventing infectious diseases such as HIV, Hep B (see EPA 10) ● Sexual assault (See EPA 14) ● Supporting community-based health services (see EPA 18)
3.	Potential risk in case of failure	● Increased incidence of preventable illness / cancer / non-communicable diseases (moderate risks) ● Decreased access to care (high risk) ● Increased cost of healthcare (moderate risk)
4.	Link with FM Roles and National unit standards	● **Clinician and consultant** ● Clinical trainer and capacity-builder ● Leader of clinical governance ● Champion of community-oriented primary care (COPC) National Unit standard 2
5.	Required Knowledge Skills Attitude Experience	**Knowledge and Skills** (See addendum in Curriculum) Providing primary preventative services ● Implementing and overseeing a childhood immunisation program ● Identifying relevant individuals (adults) for vaccinations ● Sexual health – STI & HIV prevention ● Oral Health ● School Health ● Health promotion interventions across for key target audiences across the lifecycle including ○ Children <5 years ○ Women of child bearing age ○ Men ○ Youth

- Older people
- Marginalised populations

Providing secondary prevention

- Evaluation of screening tests, and case finding
- Screening and appropriate referral for cancer
- Identifying healthy patients that may have an increased cardiovascular risk
- Screening for non-communicable disease
- Risk assessment in elderly patients
- Health promotion.

Providing linkages to rehabilitation of those with established disease (Quaternary prevention)

- Understanding the roles of rehabilitation clinicians
- Identifying patients with rehabilitation needs for early referral

- Managing adverse events following immunisation, including reporting (AEFI)
- Cervical examination, taking of a cervical smear and interpreting results
- Digital Rectal Examination for prostate screening
- Breast examination / teach a breast examination
- Examining moles and screen for suspicious lesions
- Stop smoking counselling session
- Brief behavioural intervention to modify lifestyle in patients with increased cardiovascular risk
- Visual acuity screening in children
- Hearing tests in children
- Neurodevelopmental assessments
- Working with the multidisciplinary team

Procedures

- Inserting IUCDs and implanon and removal
- Medical male circumcision

Attitudes and Behaviours

- Taking a sexual health history (in the prevention setting) – sensitive and appropriate for different populations
- Explaining need for vaccination to a person (including those who is vaccine hesitant)
- Appropriate communication and gender affirmation in transgender and gender diverse people
- Adolescent friendly communication strategies
- Explaining the result of a screening test and how it relates to risk
- Using motivational interviewing techniques to encourage change in behaviour
- Communicating within a multidisciplinary team.

Experience

- Sessions in a cervical screening / colposcopy / VIA clinic
- Courses on motivational interviewing and brief behavioural counselling
- Sessions in child immunisation clinic
- Part of multidisciplinary meetings with rehabilitation staff

Focused Resources

- McWhinney's Textbook of Family Medicine

		● National health promotion policy and strategy 2015-2019, NDOH ● Cervical cancer prevention and control policy ● National cancer strategic framework for South Africa 2017-2022 ● National adolescent and youth health policy ● South Africa's National Sex worker HIV, TB and STI Plan ● HIV Clinician Society Gender Affirming Health Care guidelines
6	Sources of information to support entrustment decisions	Entrustment decisions are based on the evidence provided in: 1. Direct observations: 4 direct observations across primary, secondary and quaternary prevention levels. (e.g. mini-CEXs, DOPS, teaching event) 2. Individual discussions: Educational meetings (with the supervisor, others) 3. Longitudinal monitoring • Multi-source feedback including rehabilitation colleagues and patients • Periodic assessment of performance (of allocation, of last 6-months) • Learning plans (for allocation, for next 6-months) • Registrar reflections (on allocation, of last 6 months) • Written assignments on workplace based learning and practice • Record of allocations (relevant experience) • Logbook (relevant opportunity to practice procedural and other skills) 4. Product evaluation E.g. letters of performance from managers, reports from clinical governance activities, etc. 5. Non-WBA type assessments Patient complaints/compliments, patient-safety incidents, disciplinaries **Minimum Experience required:** • Sessions in a family planning clinic • Sessions in an immunisation clinic
7.	Level of supervision	Level 4 by end of programme
8.	Expiry date	This EPA does not need to be re-assessed before end of programme (4 years)
	Author(s), University, Date	Dr Madeleine Muller & Prof Busisiwe Cawe WSU. June 2023

EPA 20

1. EPA Title: Providing training and continuous professional development

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: a) Developing own teaching and mentoring skills to educate and support healthcare professionals b) Contributing to the educational process, facilitation of learning and promotion of the development of other healthcare professionals c) Engaging in ongoing learning and continuous professional development (CPD) activities to enhance and maintain growth, clinical knowledge and skills. • Design and plan educational opportunities for health care professionals • Develop and/or implement educational curricula or programs for junior staff • Deliver teaching sessions, including didactic lectures, case-based discussions, workshops and bedside teaching • Constructive feedback and assessment identifying areas for improvement. • Utilising various assessment methods, such as direct observations, case presentations or written evaluations. • Professional behaviour, ethical conduct & communication skills - positive role model • Supervision and guidance to ensure patient safety. • Facilitate progressive independence in clinical decision-making and patient care. • Reflective practice • Facilitate journal clubs and participate in evidence-based discussions • Attend educational courses, workshops, conferences or webinars • Engage in quality improvement initiatives, collaborating with interdisciplinary teams • Academic rounds • Simulation-based training and skills workshops • Manage a learner in difficulty <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: • Leading a team (See EPA 21) • Leading clinical governance (See EPA 22)
3.	Potential risk in case of failure	• Inadequate competency to perform independently with a potential compromise to patient care and safety • Disconnect between training and skills required in the workplace, inability for effective application resulting in poor performance and errors in clinical reasoning and decision making. • Stagnation of professional development impeding the development of new knowledge and skills • Failure to maintain accreditation with the HPCSA
4.	Link with FM roles and National Unit Standards	• Clinician and consultant • **<u>Clinical trainer and capacity-builder</u>** • Leader of clinical governance • Champion of community-oriented primary care (COPC)

		National unit standard 4
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** (Link with addendum in Curriculum) • Principles of adult learning, educational theories, instructional design and assessment methods, including • Differentiating between the scope of WPBA and classroom-based learning and teaching • Familiarity with professional standards, guidelines and statutory requirements for education • Familiarity with current research and evidence-based practices as it pertains to education and professional development (scholarship of teaching and learning) • Design constructively aligned educational activities • Utilise varied teaching strategies • Facilitation and presentation skills to effectively deliver educational content • Facilitation of small group discussions and adapting teaching methods to different learning styles • Designing and implementing assessment methods • Providing constructive feedback • Evaluating learners' progress and competence • "Bedside" teaching and mentoring – learning encounters in the clinical space, linked to patient care **Attitudes and Behaviour:** • Communication and collaboration skills to interact with learners, colleagues and interdisciplinary teams • Commitment to lifelong learning, embracing new knowledge and skills and recognising the need for continuous professional development • Openness to innovation with a willingness to explore innovative teaching methods, technologies and educational approaches • Patient centeredness – keeping the needs of patients at the forefront – ensures training and CPD will contribute to improved patient care • Professionalism upholding values, ethics and standards of conduct in all aspects of teaching and CPD • Empathy, respect and culturally sensitive towards learners, understanding their individual needs, and fostering an inclusive and supportive learning environment **Experiences:** Individual, small group, and larger group teaching events. **Focussed Resources:** • TCT resource materials • African Journal of Health Professions Education • South African Family Practice journal, including Mastering your fellowship (registrar section)

6.	Sources of information to support entrustment decisions (Captured in portfolio of learning)	Ten heterogenous sources, representing both observed activities and evidence of teaching, and balanced between group and individual activities. Observed practice activities include the following: • Scored presentation skills assessment tool Additional evidence of teaching: • Lesson plans, signed attendance registers (students, peers, interns, MDT) • Multi-source feedback (360-degree), including student and learner feedback • Evidence of participating/ facilitating conferences, workshops, and seminars relevant to training and CPD • Evidence of contributing to curriculum and assessment development • Evidence of utilisation of online learning platforms • Evidence of reflective practice and/or position statement as a clinician teacher Video-recording of a range of teaching sessions (group and individual)
7.	Level of supervision	Entrustment level expected at the end of the programme: • Level 4 The registrar should attain this competency by Year 4 of the programme
8.	Expiry date	This EPA should be re-assessed for entrustment if not practised for 5 years. Once the registrar is entrusted with this EPA, it must not be re-assessed during the 4-year MMed program.
	Author(s) *Name(s), university, date.*	Dr S Rangiah (Clive) UKZN 25 June 2023

EPA 21

1. Title: Leading a clinical team

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Leading clinical team activities in the district health services ● Retention and recruitment ● Staff performance management ● Line management duties at the level of the individual employee as well as at the level of the team who report to the family physician ● Shared leadership activities in partnership with the other leaders and managers in the facility and/or sub-district/district ● Overseeing the integration, efficiency and effectiveness of the clinical team ● Coordinating call rosters ● Coordinating leave management in line with the HR policy ● Participating in recruitment and selection process for vacant posts ● Facilitating exit interviews of staff who resign ● Facilitating conflict management and resolution in the workplace ● Identifying and supporting the impaired colleague ● Contributing to a positive institutional culture in the workplace ● Leading and facilitating meetings and team activities in the clinical setting, such as interprofessional ward round <u>Limitations</u> - A summative entrustment decision for this EPA does not apply for: ● Clinical and corporate governance activities (see EPA 22)
3.	Potential risks in case of failure	Low staff morale. Poor team spirit and performance. Conflict within the team and workplace. Medico-legal consequences. Loss of staff/resigning
4.	Link with most relevant FM Roles and Nat Unit Standard	● **<u>Leader of clinical governance</u>** ● Clinician and consultant ● Clinical trainer and capacity-builder ● Champion of community-oriented primary care (COPC) National Unit Standard 1
5.	Required knowledge, skills, attitude, experience	**Knowledge and Skills:** ● Principles of the district health system in the context of existing and developing national legislation and policy ● Principles of human resource management (e.g., labour relations, recruitment, disciplinary procedures, grievances, as well as performance appraisals of staff) ● Self-management and self-care, including implementing and monitoring strategies for self-growth and personal development ● Communicating and collaborating effectively ● Ability to build capability, mentor or coach members of the healthcare team

		● Ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling ● Ability to contribute to the management of a facility, sub-district, or district ● Communicate effectively with those responsible for corporate governance **Attitudes and Behaviour:** ● Self-awareness to develop self optimally as a leader ● Recognize role as a member of the sub/district healthcare team ● Attitudes related to A-RICH acronym (See preamble) **Experience**: Need to at least be part of a specific team, e.g. working as a "FP" - managing a ward, call rosters, dealing with staff absenteeism, dealing with conflict. The registrar should be given these responsibilities from 2nd or 3rd year of the programme. This must be built into the learning plans. **Resources:** ● HPCSA ethical guidelines ● Dept of Health policies regarding people management/HR ● Mash R, Steinberg H, Naidoo M. Updated programmatic learning outcomes for the training of family physicians in South Africa. South African Family Practice. 2021 Sep 6;63(3). ● Mash R, Blitz J, Malan Z, Von Pressentin K. Leadership and governance: learning outcomes and competencies required of the family physician in the district health system. SA Family Practice. 2016 Nov 18;58(6):232-5.
6.	Sources of information to support entrustment decisions All captured in portfolio of learning	Direct observations by: FP supervisors, other senior colleagues and management team members. See evidence of doing a call roster, managing a ward, managing conflict, leading a clinic team meeting. Educational meetings with supervisors Assignments: reflections by the registrar in their role as a team leader in managing an issue, such as an interpersonal conflict in the team Allocations assessment reports by supervisor 360-degree evaluation - NB for this EPA
7.	Level of supervision	Entrustment level expected at end of programme: ● Managing self and immediate team members: level 4 ● Managing others and influencing the organisation: level 3
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years.
	Author(s) *Name(s), university, date.*	Profs K von Pressentin, T Ras University of Cape Town 10 May 2023, updated June 2023

EPA 22

1. Title: Leading clinical governance activities

No	Component	Description
2.	Specifications and limitations	This EPA includes the following elements: ● Leading clinical governance activities to improve quality of care ● Leading clinical governance activities to improve patient safety ● Activities can occur at a district/sub-district level, at the district hospital, at the primary care facility or in the community-based services. ● Leading a quality improvement cycle (audit and feedback) ● Contributing to the development of new protocols or guidelines ● Implementing new protocols or guidelines with the clinical team ● Managing risks to patients through leading morbidity and mortality meetings, reviewing patient safety incidents, coordinating antimicrobial stewardship ward rounds and audits, participating in pharmaceutical or therapeutics committees, and managing patient complaints. ● Assessing level of supervision required by team members. ● Supporting disaster management planning. ● Facilitating reflection of the team on routinely collected health information (e.g. routine DHIS reports, Ideal Clinic or Hospital norms and standards, use of investigations, prescribing of medication, CHW household data, perinatal death review meetings) ● Critically reviewing new evidence/research and advising/ presenting to / discussing with the team ● Leading small-scale applied research projects to create new evidence or evaluate services and cost drivers ● Leading structured reflection, root cause analysis, planning and implementation of changes to clinical practice ● Influence those responsible for corporate governance (HR management, performance appraisal, finances, procurement, infrastructure, health information system) A summative entrustment decision for this EPA does not apply to: ● Clinical teaching and training (see EPA 20) ● Leading the clinical team (see EPA 21)
3.	Potential risks in case of failure	No improvement in the quality of care. Ongoing avoidable risks and harm to patients Poor team functioning Litigation
4.	Link with most relevant FM role and national unit standard.	● **<u>Leader of clinical governance</u>** ● Clinician and consultant ● Clinical trainer and capacity-builder ● Champion of community-oriented primary care (COPC) National Unit Standard 1
5.	Required knowledge, skills, attitudes/ behaviour,	**Knowledge and Skills:** ● Quality improvement cycle (audit and feedback) ● Critical appraisal of research studies ● Applied research methods

	experience, resources	● Rational planning cycle ● Logic models for project implementation and evaluation ● Principles of guideline development, dissemination, and implementation ● Structured approaches to reflection e.g., Gibbs reflection cycle, the 5-whys, root cause analysis, fishbone diagrams ● Batho Pele principles, public service complaints and compliments processes ● Basic principles of disaster management planning ● The I-we-it leadership model ● The district health system ● Leading teams in clinical governance activities ● Implementation of changes to clinical practice ● Facilitation of meetings and small group processes ● Presentations to clinical team ● Data collection, analysis and reporting ● Writing reports ● Searching for new evidence ● Identifying key stakeholders and team members ● Engaging facility and district management teams **Attitudes and behaviour:** See description of family medicine principles as well as expected ethical and professional behaviours in preamble to EPA set. **Experience:** Clinical governance activities are usually integrated into a variety of allocations and do not have their own separate allocation. Often registrars pay additional attention to this EPA as they become more senior and more like apprentice family physicians. Exposure to the following activities is expected: ● Contribute to the development or revision of guidelines or protocols ● Help facilitate the implementation of guidelines or protocols ● Conduct a quality improvement project with the team ● Lead risk assessment and patient safety activities e.g. morbidity and mortality meetings ● Lead reflection with the team on routinely collected data e.g. prescribing or laboratory data ● Critically appraise new evidence for the team ● Assist entrustment decisions for junior colleagues and help determine appropriate levels of supervision ● Evaluate the quality of care with regard to national norms and standards e.g. Ideal Clinic **Focussed Resources:** ● See generic resources, especially the SA Family Practice Manual. ● R Mash, J Blitz, Z Malan & K Von Pressentin (2016): Leadership and governance: learning outcomes and competencies required of the family physician in the district health system, South African Family Practice, DOI: 10.1080/20786190.2016.1148338 ● Ideal Hospital and Ideal Clinic norms and standards ● PHCFM series on primary care research methods 2014

6.	Sources of information to support entrustment decisions Captured in portfolio of learning	● Educational meetings with supervisors ● Written assignments (excluding research assignment that is examined separately in Part B of the FCFP) ● Reflections by registrar ● Allocations assessment reports by supervisor ● 360 degree evaluations ● Logbook ● Additional evidence of involvement in clinical governance e.g. reports of activities from health services
7.	Level of supervision	Entrustment level expected at end of programme: ● Level 4
8.	Expiry date	This EPA should be re-assessed for entrustment if not practiced for 5 years. Once the registrar is entrusted with this EPA, it does not have to be re-assessed during the 4-year MMed programme.
	Author(s), University, date	B Mash, T Motsohi, L Jenkins Stellenbosch University June 2023