2023

REMEDIAL
PORTFOLIO OF LEARNING

Fellowship

of the

College of Family Physicians of South Africa

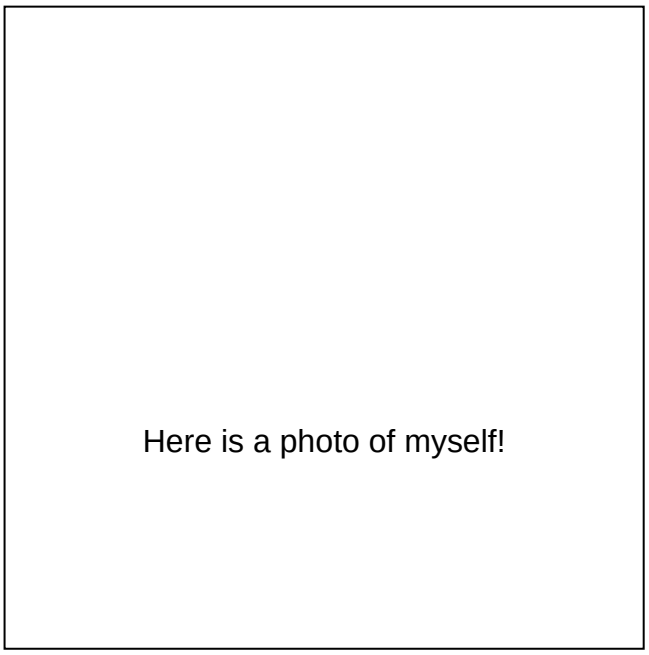
FCFP(SA)

This portfolio of learning belongs to:

……(name and surname printed)

My university student number was……

My HPCSA MP number is …….



I joined the training programme from the …….(date) to the……..(date)

I work as a ……(job classification i.e. medical officer/ clinical manager, etc) in the following district and health facility.
……
I need to submit a remedial portfolio of learning spanning one year, as I exited the registrar training programme more than 36 months ago. I have chosen to be mentored by the following academic department of Family Medicine
…….

REMEDIAL PORTFOLIO OF LEARNING

CONTENTS

SECTION 1

Introduction to the portfolio

Your yearly portfolio of learning is a reflection of your learning and development during the past year. It has a number of learning and assessment tools to help you reflect on your learning and development. You are required to use this remedial portfolio of learning which gives evidence to yourself, your supervisors, the complex coordinator, the programme manager, the head of department, and the College of Family Physicians that your learning has been adequate and you are eligible to sit the CFP examinations.

The value of your portfolio is enhanced through regular reflections around situations you encounter in the workplace, in discussions with your peers and supervisors, and capturing these in your portfolio.
The remedial PoL is only available in hardcopy, but an e-portfolio will eventually replace the hardcopy portfolio.

Your portfolio remains your property. Your university HOD will submit a recommendation and assessment mark to the CMSA, and you must submit your portfolio to the CMSA.

Purpose of the portfolio

In a nutshell, the portfolio serves 2 purposes: Internally, it is part of Clinical Family Medicine, with a formative component (learning between you and your supervisors) and a summative component (towards your year mark). Externally, an acceptable portfolio is necessary to pass the FCFP examinations of the CMSA.

Your portfolio provides evidence of learning and development in the workplace during your time in family medicine. It allows you to demonstrate that you have met the outcomes of the training programme. Many of these outcomes are best assessed in the portfolio. This portfolio document is also available on the CMSA website, which will assist both you and your supervisor with its development.

The learning portfolio for Family Medicine training in South Africa has been developed through an extensive process of consultation and consensus between all the Family Medicine academic departments in the country. In terms of national training outcomes for Family Medicine, 5 unit standards have been agreed upon. Within these 5 unit standards there are 85 more specific training outcomes. The portfolio does not intend to reflect training and learning in all of these, as some outcomes will be assessed through other means. The 50 outcomes that must be reflected in the portfolio are summarised in section 2 and should be constantly referred to and kept in mind as you work and learn in daily practice.

Your portfolio should help you to:

1. Think consciously and objectively about your own training. This is known as *reflective learning*, and is its primary purpose.
2. Document the scope and depth of your training experiences.
3. Provide a record of your progress and personal development as training proceeds.
4. Provide an objective basis for discussing work performance, objectives, and immediate and future educational needs with your supervisors.
5. Provide documented evidence for the CMSA of the quality and intensity of the training that you have undergone as a requirement to sit the Part A examination for the FCFP(SA).

The portfolio is not just a logbook of signed procedures undertaken or witnessed. It should contain your written reflections and systematic documentation of your learning experience. It includes opportunities for you to reflect, explore, form opinions, and identify your strengths and weaknesses. It allows you to follow your own progress; not only concerning the training programme, but also in terms of the learning goals you have set for yourself. In this way, the portfolio provides an opportunity to record and document the subjective aspects of training.

The objectives of your portfolio are to:

- develop a structured learning plan
- identify goals and actions required to achieve them
- record progress in achieving those goals
- document personal strengths
- identify areas needing improvement

Who looks at your Portfolio of Learning?

1. **Trainees, including those who have completed their four years of training**. You should interact regularly with your portfolio to ensure it documents your learning on a continuous basis and stimulates you to reflect on your experiences.
2. **Supervisors**. It would help if you met on a regular basis with your supervisor to develop and reflect on your learning plans, to be observed and reflect on your clinical practice and to have a variety of educational meetings. All these activities should be documented in your portfolio. Your supervisor should also review progress with the portfolio during intermittent evaluations of your progress. In this way the portfolio allows a structuring of the supervision process.
3. **CMSA**. The CMSA requires evidence that learning has taken place as part of a structured programme to sit Part A of the FCFP(SA) examination. The portfolio is an essential piece of evidence for this.

This portfolio is a cumulative record of your personal learning, goals, needs, strategies and activities throughout your training programme. The sections in the portfolio are not exhaustive, but rather an indication of the <u>minimum</u> that you should be doing. You will learn a great deal more than what is contained in your portfolio.

The portfolio does not aim to assess or capture all the competencies needed to be a family physician, nor is it the only way of assessing you. Some competencies or skills will also be tested or validated via other means, e.g. orals, OSCEs, Multiple Choice Questions, assignments and written papers in formal examinations.

The portfolio should not become a big additional burden on you and the supervisor. In many instances, you can include reports from meetings you attend as part of your work (e.g. M&M meetings) that you have done as part of the academic programme for the university(e.g. reflective writing, clinical audits and community projects). These should not be repeated but should simply be incorporated into the portfolio.

The emphasis is on the *process* of completing the portfolio (in a way that encourages *reflection*), and "the learning journey" rather than "something else that must be done and handed in for marks." Be creative, for example you can include photos or video clips of a community project, or letters written as the patient advocate, etc.

You must link all your learning, including course work, on-line learning, and theory with your everyday clinical practice and maintain the continuity over a year of training. For example learning around the consultation, ethics and EBM all speak to each other, and need to be continuously revisited during your training, including during learning around chronic diseases, COPC, research, and FOPC, and also during topics pertaining to teaching, learning, leadership and clinical governance. You need to consider how your training and learning reflects the expected national outcomes, the six roles of the family physician in South Africa, and link with the local district health indicators.

Portfolio Completion Criteria

The Portfolio should always be used in conjunction with the ***Regulations and Syllabus for admission to the Fellowship of the College of Family Physicians of South Africa FCFP(SA)***, as may be amended from time to time. See https://www.cmsa.co.za/view_exam.aspx?QualificationID=9

- Entries must, where indicated, be supported by the required **signatories/validation** of yourself and your supervisors and your assessment **scores**. It is strongly advised that you keep a **backup copy** of all entries (electronic or printed).
- Each clinical allocation must be signed/validated by the relevant supervisor, including the pertinent sections of your logbook.
- The scores in your completed portfolio will be discussed and assessed **at the end of the year** by the university head of department at the contact session at the start of every new year.
- The final portfolio must reach your university head of department ***at least 3 (three) months*** before the commencement of the FCFP(SA) Part A Examination, so the head can submit a report, which will be sent to the Academic Trainee of the CMSA. Failure to submit the portfolio on time will result in the candidate not being invited to the examination.
- The trainee must sign a declaration before submitting the final portfolio to the CMSA at the end of the year of training.

A note to supervisors

As a supervisor, you commit one or more trainees for the period under your supervision. Please plan to meet regularly with your trainee to discuss their learning and development during this time. One-on-one meetings are more valuable than group meetings and should happen at least monthly. A CMSA workshop on assessment (2010) indicated 2 key issues:

- Transfer of theoretical knowledge into clinical practice is a big challenge.
- Trainees want and need feedback on their clinical practice in order to learn.

The portfolio should be the vehicle that facilitates these learning conversations or educational meetings. International literature, local work in SA, and several CMSA workshops also highlighted the importance of the *people* using the portfolio (and various assessment tools). The portfolio per se is a tool, and its quality is determined by the quality of the supervision, the feedback, the context of learning, and the input from the trainee. The portfolio must not be a '(thick) paper exercise', but rather a (lean) way of showing key evidence of learning; indicating continuous reflection on clinical practice and regular interaction between trainees and supervisors.
Since 2013 all trainees in South Africa sit a single exit examination offered by the CMSA. One requirement for entrance to the Part A examination is an acceptable portfolio of learning. This implies that all new trainees who started since 2012 must develop such a portfolio. Therefore in 2012 all the Divisions / Departments of Family Medicine in South Africa have incorporated the learning portfolio into their assessment of training in the MMed (Family Medicine) programme. Students outside South Africa are also expected to complete the same portfolio for their final examination.
The portfolio is assessed by the academic head of department and/or programme manager at the relevant university at the end of every year, assessment process (year mark). A recommendation (satisfactory / not satisfactory) will be given to the CMSA, 3 months prior to applying for the Part A examination, as a pre-requisite to sit the FCFP(SA)/MMed examination.

A large margin of flexibility and local adaptability for each university is accepted, while the general template of the portfolio, including the agreed-upon national training outcomes, are standardised for South Africa as a whole.

National unit standards and expected learning outcomes to be assessed in the portfolio

A national Delphi process (2010) with experts and supervisors in Family Medicine reached consensus on 50 of 85 national learning outcomes to be assessed by the learning portfolio. The Delphi process also asked panel members which assessment methods and tools would be the most appropriate to use in the portfolio. A focus group discussion between the 8 national Family Medicine Head of Departments verified and clarified the new national outcomes and agreed on the final assessment methods to be used for the portfolio. These national training outcomes were reviewed in 2021 and published (Mash, Steinberg, & Naidoo. "Updated programmatic learning outcomes for the training of family physicians in South Africa." *South African Family Practice* [Online], 63.1 (2021): 4 pages), to include 83 revised training outcomes.

It is important to keep the national training outcomes for Family Medicine in mind while you develop your portfolio. The 5 national Family Medicine Training Unit Standards are broken down into a number of outcomes, to be reflected on and assessed in your portfolio. These should help you to develop your personal learning plans.

Preparing a Learning Plan

You must meet with your local supervisor at the beginning and end of every clinical allocation, or at least every 6 months (twice a year) if you are not 'rotating' through different areas in the district hospital, to develop, document and review your learning plan. With your logbook at hand, list the learning objectives you have set for yourself for the duration of that allocation or 6-month period. These should be updated as your allocation progresses.

On completion of the allocation, you must reflect on the progress you made in meeting your objectives, and identify areas in which further learning is needed.
Some tools are useful to help you reflect, e.g. the Case-based discussion, Chart stimulated recall, and Clinical question analysis tools.

Note that this is not an assessment by the supervisor of the trainee's work during the allocation. It is an exploration of the trainee's ***insight*** into the learning appropriate to that allocation and the extent to which it has been achieved.
The Learning Plan includes the following objectives:

- Identification of prior learning
- Identification of current learning needs (objectives)
- Planning of activities to meet these needs
- Timelines and support required to enable these activities
- How learning will be evaluated (with the suggested tools)

You need to be able to adjust your learning plan with each allocation and as you progress in the programme as a whole in order to develop the skill of lifelong learning and personal growth. Learning is best when it is learner-centered and very individual!
You need to keep in mind:

1. The National training outcomes for Family Medicine in SA.
2. Your University's MMed curriculum and its outcomes.
3. Your personal learning needs.
4. The relation of your planned allocations with the health service platform.

When you develop your learning plan you need to simultaneously consider what you will be doing in your academic programme (e.g. modules, assignments), what practical experience you will be receiving in your clinical setting (e.g. your allocations), what PHC clinic has adopted you, what your personal learning needs are, and what the health issues in the local community are. Also include you research thesis as a standing item, and document your progress. Ultimately all of this must contribute towards achieving the outcomes of the programme, your own personal growth, and improving the health of people in families in the local community.

Some tips to help you write your learning plan:

1. Use the 5 national training outcomes as framework.
2. Read your local (Sub) District Health plan, to align your learning plan. For example, if eye care or maternal health or diabetes mellitus is a sub-district priority, your learning plan should include some of these also.
3. Look at your progress overall - you should get to everything over the 4 years.
4. Have 2-3 learning plans per year according to your immediate allocation.
5. Be SMART, flexible, and adapt your learning to the working environment.
6. Discuss your draft learning plan with your supervisor and the clinical manager.
7. Regularly revisit and update your plan with your supervisor - Contract to meet at least twice to review the plan at a fixed time and day of the week.
8. Consider the local team - make visible your plan within the team.
9. Ensure your plan is graded and revisit it together with your reflections and supervisor report, before you draw up your next plan.
10. Transfer your unmet learning needs from the previous year to your first learning plan in the following year.

The discussions you have with your supervisor or mentor and the feedback you get are of much greater value than simply a grade.

Please ensure that your supervisor has assessed and signed every learning plan.

Assessment Methods and Tools

Different assessment methods and tools are available in the literature and used by different Departments of Family Medicine. The portfolio allows for various tools to be used and shared by different medical schools.
The 'bottom line' for whatever method or tool is used is that it should provide clear evidence of learning for one of the expected outcomes. Your university will already have a number of assessment tools in place to monitor your development as a trainee. Make use of whatever relevant methods or tools you have in your programme and add them to your portfolio. For example, if you are doing a relevant written assignment (e.g. COPC project, patient study, practice audit) as part of your academic programme, you should include this, together with the assessment scores you received, in your portfolio.
Examples of the most commonly used tools are included in your portfolio.

If you do not have internet access where you work, then keep some of these copies with you, for immediate use when the opportunity arises. You can also do an audio- or video-clip, for uploading/including in your portfolio later.

Clinical governance activity

Please provide written proof as evidence of learning in any of the following areas:

1. Evidence-based Medicine (e.g. critical appraisal of a journal article, searching for evidence, use of guidelines)
2. Quality improvement cycle/audit
3. Significant event analysis (SEA)
4. Patient safety incidents (PSI)
5. Morbidity and mortality meetings
6. Monitoring and evaluation meetings
7. Community improvement projects

Observations of consultations by supervisor

Your supervisor must directly or indirectly (by use of audio or video tapes) observe you during patient consultations, and during teaching events (where you teach or train others). You must include **at least ten (10) observations** of yourself by your supervisor(s) during the course of one year. One of these observations must be a teaching event, where you show evidence of teaching a group or individual (student, nurse, junior doctor, others). More than 10 is obviously better, but the best 10 will count towards your final year grade. These observations of consultations are assessed via the mini-CEX tool and teaching tools (one for group presentation and one for individual teaching (one-minute preceptor)). Choose different patient complexity levels, in different contexts (hospital, PHC clinic, community) by different supervisors, to increase the entrustability of your performance in the workplace.

The following tools are useful here:
1. Mini-Clinical Evaluation Exercise (Mini-CEX) (for the consultation) is the tool that you will use most often. The idea is that you keep it short (<20 min). You need not be assessed on every aspect of the consultation every time. Use this tool often. The more, the better! Ask for feedback. You should be assessed against the FCFP(SA) exit examination standards (progress test).
Our mini-CEX was adapted from the American Board of Internal Medicine, www.abim.org. Discussed in Norcini JJ, Blank LL, Arnold GK, Kimball HR. The mini-CEX (Clinical Evaluation Exercise): a preliminary investigation. Ann Intern Med 1995;123:795-9.

2. Group teaching tool
3. Bedside teaching tool (1-minute preceptor)

Further references to help you can be found in

- How to communicate effectively in the consultation. South African Family Practice Manual.
- Communication Skills. Handbook of Family Medicine.

Multi-source feedback

A 360 degrees questionnaire is included in the portfolio as another tool to assess your performance and get specific feedback from 10-16 colleagues. If converted into electronic format, e.g. SurveyMonkey® or Google Forms®, it becomes straightforward to complete.

Log book of procedural skills

The logbook captures the number of clinical procedural skills performed and the level of competency achieved. A list of clinical skills that your supervisor should assess during observation in the logbook is included in the portfolio and based on the agreed national list of clinical skills for Family Medicine.
You are expected to have ten procedures directly observed (video or physical) and the scored DOPS tools need to be included in the portfolio of learning. Please ensure that the DOPS covers a range of skills across many domains.

Don't feel confined to the different clinical areas in the logbook, but 'indulge' your logbook and add your skills where-ever you pick them up in the appropriate areas in your logbook. Be honest with yourself, and force your supervisor to score you correctly, as a lower score provides learning and improvement opportunities. If you score very well in a skill, to the point of competence, to perform the skill independently, you need not revisit this skill again and should be teaching others.

The logbook skills list was revised in 2017, and published in the PHCFM journal (Akoojee, Mash). Your portfolio contains the updated list.

How should the trainee be assessed via these assessment tools?

Every item that is entered into your portfolio should be assessed in some way or another by a supervisor in the academic programme. This will assist the end-of-year overall assessment of the portfolio by the head of department or program manager.

The general recommendation by the national panel of experts and supervisors is to use one of two grading methods:

- A Global Rating (e.g. not satisfactory / needs improvement / satisfactory) for the item
- A specific Grade (e.g. percentage).

Many university academic programmes already give a mark for various assignments, which should just be captured in the portfolio, without the need for repeat assessment.

Educational meetings

A useful resource was published in the SA Family Practice Journal during 2010 which describes various learning conversations:
Mash R, Goedhuys J, D'Argent F. Enhancing the educational interaction in family medicine trainee training in the clinical context SA Fam Pract 2010;52(1):51-54:

"The relationship between trainee and trainer functions best when the trainer consciously facilitates the trainee's learning and considers all their interactions as educational opportunities. The trainer's role is more that of an educational guide and less that of an authoritarian expert. The trainee and the trainer should be aware of their own learning styles and how they may be complementary or contradictory. A variety of conversations with different purposes should be structured and planned and not left to chance. Several methods for observing and collecting the trainee's clinical experience should be developed and used regularly. Further attention needs to be paid to the development of useful, reliable and valid portfolios."

Do you know your own learning style?

During the programme, you should meet **individually** with your immediate supervisor and as a group of local trainees. These meetings can be alternated 1-2 weekly (i.e. one week with your supervisor one-on-one and the next week as a group) and be recorded in your portfolio. Your portfolio at the end of the year should demonstrate a

minimum of 2-hours formal tuition per month / 24-hours for the year. However, the aim should be to show engagement well above the minimum standard.

Use the letters below to record the general focus of the meeting and then describe what was done. Over the course of the year we would expect you to shown learning across all of the learning outcomes. The meeting should broadly be located within at least one of the national learning outcomes. Remember the learning outcomes are shown in detail in Section 2 of your portfolio.

A: Leadership and governance: Learning areas include personal or professional development (this includes discussion of your learning plans), teamwork and making sense of the healthcare system. Issues related to clinical (e.g. quality improvement) or corporate governance (e.g. procurement) could be discussed.

B: Clinical care: Learning areas include discussion of actual patients through the use of case-based discussions (This should be the dominant educational meeting that you are having on a regular individual basis with your supervisor), record review, presentation of problem patients (e.g. on ward rounds or in your clinic), or clinical tutorials. Reflect on assessment, management, difficult consultations, the biopsychosocial approach, challenges to communication.

C: Family and community orientated care: Learning areas include the engagement with family as part of clinical care, reflection on home visits, community engagement, community diagnosis, working with community health workers, community interventions.

D: Teaching and training others: Learning areas include your ability to build capability, teach, present or provide clinical training for other healthcare workers or students.

E: Professionalism and ethics: Learning areas include discussion of ethical dilemmas, health and human rights or professional conduct.

F: Other: This category can be used to code educational meetings that address other relevant issues not covered by the options above.

Some tools help to facilitate some of these meetings, for example:

1. Significant event analysis tool
2. Case-based discussion tool
3. Chart stimulated recall tool

Ideally, suppose you are documenting case-based discussions of patients with your supervisor. In that case, you should aim to follow up on several patients over the year to see their progress and development over time, which will be a valuable learning experience. These patients would ideally be seen in your local PHC clinic that has adopted you as their doctor.

Useful references

1. Instruments for Workplace-based Assessment (WBA): Follow link from: www.fdg.unimaas.nl/educ/cees/sa
2. Thistlethwaite JE. How to keep a portfolio. The Clinical Teacher 2006 (3), Issue 2: 118–123.
3. Govaerts MJB, Van der Vleuten CPM, et at. Broadening Perspectives on Clinical Performance Assessment: Rethinking the nature of In-training Assessment. Advances in Health Sciences Education 2007; 12:239-260
4. Akoojee Y, Mash R. Reaching national consensus on the core clinical skill outcomes for family medicine postgraduate training programmes in South Africa. Afr J Prm Health Care Fam Med. 2017;9(1), a1353. https://doi.org/10.4102/ phcfm.v9i1.1353
5. Van Tartwijk J, Driessen EW. Portfolios for assessment and learning: AMEE Guide no. 45. *Med Teach* 2009; 31: 790-801
6. Tochel C, Haig A, Hesketh A, Cadzow A, Beggs K, Colthart I, et al. The effectiveness of portfolios for post-graduate assessment and education: BEME Guide No 12. Med Teach 2009 04;31(4):320-339.
7. Sandars J. The use of reflection in medical education: AMEE guide no. 44. Med Teach 2009, 31(8):685–695.
8. Mash R, Goedhuys J, D'Argent F. Enhancing the educational interaction in family medicine trainee training in the clinical context. SA Fam Pract 2010;52(1):51-54
9. Couper ID, Mash B, Smith S, Schweitzer B: Outcomes for family medicine postgraduate training in South Africa. SA Fam Pract 2012, 54(6):501–506.
10. Jenkins L, Mash B, Derese A. Development of a portfolio of learning for postgraduate family medicine training in South Africa: a Delphi study. BMC Fam Pract. 2012;13:11. http://dx.doi.org/10.1186/1471-2296-13-11
11. Jenkins L, Mash B, Derese A. The national portfolio of learning for postgraduate family medicine training in South Africa: experiences of trainees and supervisors in clinical practice. BMC Medical Education 2013 13:149.
12. Jenkins L, Mash B, Derese A. The national portfolio for postgraduate family medicine training in South Africa: a descriptive study of acceptability, educational impact, and usefulness for assessment. BMC Medical Education. 2013;13:101. http://dx.doi. org/10.1186/1472-6920-13-101.
13. Knight K, Henstridge-Blows J, Stacey H, Knight J. Reflection: how do I do it? Student BMJ 2013;21:f6387. DOI: 10.1136/sbmj.f6387

Divider:

Learning Outcomes

SECTION 2

National Unit Standards and Expected Learning Outcomes to be Assessed in the Portfolio

Look at the summary of the national learning outcomes in this section of your portfolio. To remind you and your supervisor of what has been covered and what still needs to be done and to plan appropriately, it is suggested that you mark off what you have completed using the blocks in the "checklist" column. This will ensure inclusion of all the outcomes in the portfolio over time.

OUTCOMES ASSESSED IN PORTFOLIO	Recommended assessment methods	Suggested frequency of assessment	Checklist
UNIT STANDARD 1 (Revised) Effectively manage him/herself, his/her team and his/her practice, in any sector, with visionary leadership and self-awareness, in order to ensure the provision of high-quality, evidence-based care.			
Develop him or her-self optimally as a leader by: 1. Demonstrating self-awareness and reflection in terms of one's personality, personal values, preferred learning and leadership styles, and learning and development needs. 2. Demonstrating effective methods of self-management and self-care 3. Demonstrating willingness to seek help when necessary 4. Demonstrating an ability for self-growth and personal development	Learning Plan, discussed regularly with and updated and signed by supervisor (Section 3) Continuous assessment form (Section 4)	2X/year End of allocations	
Offer leadership within the healthcare team and district health system by: 1. Communicating and collaborating effectively 2. Demonstrating an ability to build capability, mentor or coach members of the healthcare team 3. Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counseling 4. Working effectively as a member of the sub/district healthcare team			

Describe and contribute to the functioning of the district healthcare system by: 1. Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy 2. Demonstrating an ability to contribute to the management of a facility, sub-district, or district.	Report/minutes of M&E meeting in your facility Continuous assessment form (Section 4) Multi-source feedback (Management module), or continuous assessment form (Section 4)	Once during programme End of allocations or 2X/year	
Lead clinical governance activities by: 1. Demonstrating the ability to lead a quality improvement cycle in practice 2. Demonstrating the ability to build capability through training, teaching and mentoring others in the healthcare team [see unit standard 4] 3. Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub/district 4. Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis) in the sub/district 5. Facilitating the implementation of clinical guidelines in the sub/district 6. Critically reviewing new evidence (e.g. research) and applying the evidence in practice 7. Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process			
Understand and influence corporate governance: 1. Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, grievances) 2. Understand the principles of financial management (e.g. budgets, health economics, financial planning) 3. Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings) 4. Understand the principles of health information and record-keeping systems 5. Understand the principles of rational planning of health services 6. Be able to communicate effectively with those responsible for corporate governance			
UNIT STANDARD 2 Evaluate and manage patients with both undifferentiated and more specific problems cost-effectively according to the bio-psycho-social approach			

Evaluate a patient according to the bio-psycho social approach by: 1. Taking a relevant history in a patient-centred manner, including exploration of the patient's illness experiences and context.	Observation by supervisor.	20 Observations / year	
2. Performing a relevant and accurate examination			
3. Performing appropriate special investigations where indicated, based on current evidence and balancing risks, benefits and costs			
4. Formulating a bio-psycho-social assessment of the patient's problems, informed, amongst others, by clinical judgment, epidemiological principles and the context			
Formulate and execute, in consultation with the patient, a mutually acceptable, cost-effective management plan, evaluating and adjusting elements of the plan as necessary by: 1. Communicating effectively with patients to inform them of the diagnosis or assessment and to seek consensus on a management plan			
2. Establishing priorities for management, based on the patient's perspective, medical urgency and context			
3. Formulating a cost-effective management plan including follow-up arrangements and re-evaluation			
4. Formulating a management plan for patients with family-orientated or other social problems, making appropriate use of family and other social and community supports and resources.			
5. Appling technology cost -effectively and in a manner that balances the needs of the individual patient and the greater good of the community.			
6. Incorporating disease prevention and health promotion.			
7. Effectively managing concurrent, multiple and complex clinical issues, both acute and chronic, often in a context of uncertainty.			
8. Demonstrating a patient centred approach to management using collaborative decision making			
9. Including the family in management and care of patients whenever appropriate			
10. Demonstrates a commitment to building continuity of care and on-going relationships with patients as well as an understanding of the chronic care model			
11. Demonstrates the ability to provide preventive care, using primary, secondary, and tertiary prevention as appropriate, and to promote wellness			
12. Demonstrates the ability to provide holistic palliative and terminal care			
13. Recognising and managing discord in relationships impacting on health, using appropriate tools e.g. genograms, ecomaps where necessary to identify potential problems		Once during programme	
14. Collaborating and consulting with other health professionals as appropriate	Continuous assessment form (Section 4)	End of allocations or 2x/year	
15. Co-ordinating the care of patients with multiple care providers			
16. Demonstrating appropriate record keeping			
17. Performing effectively and safely the technical and surgical skills necessary for functioning as a generalist.	Logbook	Beginning and end of each	

	(Section 8)	allocation or 2x/year	
UNIT STANDARD 3 Facilitate the health and quality of life of the family and community.			
Integrate and co-ordinate the preventive, promotive, curative, rehabilitative and palliative care of the <u>individual</u> in the context of the family and the community by: 1. Knowing the resources available in the community and being able to co-ordinate and integrate team efforts.		Once during programme	
2. Considering the family in assessment and engaging the family in management at an appropriate level			
3. Providing family- and community-oriented care to patients			
4. Conducting home visits when necessary			
Identify and address problems influencing the health and quality of life of the <u>community</u> in which the family physician works, by: 1. Demonstrating an understanding of the concept of and an ability to work in a "community"			
2. Demonstrating the ability to identify community health problems and make a 'community diagnosis'			
Be an advocate for individuals and communities to ensure informed decision making on health matters based on evidence by: 1. Ensuring co-ordination of care and that the holistic needs of a patient are being addressed at any level of care			
UNIT STANDARD 4 Facilitate the learning of others regarding the discipline of family medicine, primary health care, and other health-related matters			
Demonstrate the role of the family physician as a teacher, mentor or supervisor by: 1. Describing relevant principles of adult education and learning theory	Feedback from people who were taught, or Observation by supervisor, or	Yearly	
2. Conducting effective learning conversations in the clinical setting (clinical mentoring)			
3. Using educational technology effectively			
4. Making an effective educational presentation			
UNIT STANDARD 5 Conduct all aspects of health care in an ethical and professional manner			
Demonstrate an awareness of the legal and ethical responsibilities in the provision of care to individuals and populations by: 1. Identifying and defining an ethical dilemma using ethical concepts		Once during programme	
2. Applying a problem solving approach in which the law, ethical principles and theories, medical information, societal and institutional norms and personal value system are reflected			
3. Formulating possible solutions to the ethical dilemma			
4. Implementing these solutions in order to provide health care in an ethical, compassionate and responsible manner that reflects respect for the human rights of patients and colleagues			

SECTION 3

Learning Plans, Reflections, and Allocations Assessments

CUMULATIVE RECORD OF ALLOCATIONS

(minimum of two learning plans for the year)

Start Date	End Date	No. of Months	Facility(s)	Clinical Dept(s) / Type of exposure(s)

Divider: Learning Plans, Reflections, and Allocations Assessments

Summary of supervisor(s) assessments of learning plans and clinical allocations:

First learning plan score		Second learning plan score		Third learning plan score		FINAL AVERAGE (../10):

First allocation report score		Second allocation report score		Third allocation report score		FINAL AVERAGE (../10):

Remember to keep your logbook up to date!

LEARNING PLAN 1

Period: from ……..…… to ……..…….……

Experience expected during this period, e.g. working one day per week in a primary care clinic, doing a home visit, or visiting a palliative care facility, working in the ARV clinic, and/or working in the maternity ward and doing calls in the EC and throughout the district hospital (Keep the 5 national unit standards in mind). Also, who is my local health team?

……
……
……
……
……
……

A. Learning Objectives:

Reflect on your prior learning that is relevant to this next period of training, and write it down here.

……
……
……
……
……
……
……
……
……
……
……

For this period, complete the table below:

National Learning Outcomes	Learning needs/objectives	Planned activities to meet these objectives	Timelines, Support and Resources required to meet these objectives	Evaluation (how will you know if these objectives have been met, suggested tools)
1. Effectively manage him/herself, his/her team and his/her 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 cost-effectively according to the bio-psycho-social approach				
3. Facilitate the health and quality of life of the family and community.				
4. Facilitate the learning of others regarding the discipline of family medicine, primary health care, and other health-related matters				
5. Conduct all aspects of health care in an ethical and professional manner				

B. Supervisor Feedback (meet at least twice)

.....

……

……..

……..

……..

……..

……..

C. Date of next meeting to review progress ……

	Date	Signed trainee	Signed supervisor
Meeting1			
Meeting2			

D. Supervisor Assessment (ringed)

Assessment	2	1	0
1. Drawn up and discussed with supervisor	Within 1st month of new clinical allocation	Beyond 1st month of allocation	Towards the end or not at all
2. Shared within team	Yes, visibly	Mentioned, but not visible	not
3. Revisited and updated	At least twice	At least once	Not at all
4. Takes national outcomes and district health plan into account	Clearly	Partially	Not at all
5. SMART	Clearly (all 5)	Partially (some)	Almost not at all

Grade……/10

REFLECTION ON ALLOCATION 1

Name of allocation(s): _____

Allocation started _____ and ending_____

Name of health facility: _____

Type of health facility (please indicate):
PHC District hospital Regional hospital L3 Hospital Other (e.g. TB/ Psychiatry)
Clinical area(s) covered in this allocation (please tick all that apply):

Adult medicine	☐	Infectious Diseases (HIV/TB)	☐
Women's Health	☐	Surgery	☐
Child Health	☐	Orthopaedics	☐
Anaesthetics	☐	Emergencies	☐
ENT	☐	Eyes	☐
Dermatology	☐	Psychiatry	☐
Other (specify)	☐		

Provide a brief **description** of your duties, patient profile and patient numbers personally managed in this allocation.

Reflect on your **experience** as a trainee working in this facility during this allocation, what worked well and what could be improved?

Reflect on your **learning** during this allocation. What has been learnt? What remains to be learnt? (Refer to the Learning Objectives in your Learning Plan.)

Trainee _____ (Signature) Date: _____	Leave days:

CONTINUOUS ASSESSMENT DURING THIS ALLOCATION BY MY SUPERVISOR

(To be completed by supervisor and discussed with trainee)

Marking scale: 9–10 = excellent; 7–8 = above average; 5–6 = average/satisfactory; 3-4 = below average/unsatisfactory; 1–2 = very weak; N/A = not applicable or don't know

	Score 1 – 10
KNOWLEDGE	
• Clinical medicine	
SKILLS	
• Clinical record-keeping: case-notes, letters, summaries	
• Rational prescribing and use of medication	
• Rational use of diagnostic tests and resources	
• Co-ordination of patient care with multiple providers	
PROFESSIONAL VALUES AND ATTITUDES	
• Approach to ethical and medico-legal issues	
• Punctuality, time keeping and reliability	
• Relationship with other team members	
• Leadership abilities	
• Collaboration or consulting with other health professionals	
OVERALL ASSESSMENT	
• Global rating (Give score for rotation ……/10)	/10

Feedback from supervisor:

Supervisor's name: _____

Signature:_____Date:_____

LEARNING PLAN 2

Period: from ……..…… to ……..…….……

Experience expected during this period, e.g. working one day per week in a primary care clinic, doing a home visit, or visiting a palliative care facility, working in the ARV clinic, and/or working in the maternity ward and doing calls in the EC and throughout the district hospital (Keep the 5 national unit standards in mind). Also, who is my local health team?

……
……
……
……
……
……

A. Learning Objectives:

Reflect on your prior learning that is relevant to this next period of training, and write it down here.

……
……
……
……
……
……
……
……
……
……
……

For this period, complete the table below:

National Learning Outcomes	Learning needs/objectives	Planned activities to meet these objectives	Timelines, Support and Resources required to meet these objectives	Evaluation (how will you know if these objectives have been met, suggested tools)
1. Effectively manage him/herself, his/her team and his/her 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 cost-effectively according to the bio-psycho-social approach				
3. Facilitate the health and quality of life of the family and community.				
4. Facilitate the learning of others regarding the discipline of family medicine, primary health care, and other health-related matters				
5. Conduct all aspects of health care in an ethical and professional manner				

B. Supervisor Feedback (meet at least twice)

.....

……

……..

……..

……..

……..

……..

C. Date of next meeting to review progress ……

	Date	Signed trainee	Signed supervisor
Meeting1			
Meeting2			

D. Supervisor Assessment (ringed)

Assessment	2	1	0
1. Drawn up and discussed with supervisor	Within 1st month of new clinical allocation	Beyond 1st month of allocation	Towards the end or not at all
2. Shared within team	Yes, visibly	Mentioned, but not visible	not
3. Revisited and updated	At least twice	At least once	Not at all
4. Takes national outcomes and district health plan into account	Clearly	Partially	Not at all
5. SMART	Clearly (all 5)	Partially (some)	Almost not at all

Grade……/10

REFLECTION ON ALLOCATION 2

Name of allocation(s): _____

Allocation started _____ and ending_____

Name of health facility: _____

Type of health facility (please indicate):
PHC District hospital Regional hospital L3 Hospital Other (e.g. TB/ Psychiatry)
Clinical area(s) covered in this allocation (please tick all that apply):

Adult medicine	☐	Infectious Diseases (HIV/TB)	☐
Women's Health	☐	Surgery	☐
Child Health	☐	Orthopaedics	☐
Anaesthetics	☐	Emergencies	☐
ENT	☐	Eyes	☐
Dermatology	☐	Psychiatry	☐
Other (specify)	☐		

Provide a brief **description** of your duties, patient profile and patient numbers personally managed in this allocation.

Reflect on your **experience** as a trainee working in this facility during this allocation, what worked well and what could be improved?

Reflect on your **learning** during this allocation. What has been learnt? What remains to be learnt? (Refer to the Learning Objectives in your Learning Plan.)

Trainee _____ (Signature) Date: _____	Leave days:

CONTINUOUS ASSESSMENT DURING THIS ALLOCATION BY MY SUPERVISOR

(To be completed by supervisor and discussed with trainee)

Marking scale: 9–10 = excellent; 7–8 = above average; 5–6 = average/satisfactory; 3-4 = below average/unsatisfactory; 1–2 = very weak; N/A = not applicable or don't know

	Score 1 – 10
KNOWLEDGE	
• Clinical medicine	
SKILLS	
• Clinical record-keeping: case-notes, letters, summaries	
• Rational prescribing and use of medication	
• Rational use of diagnostic tests and resources	
• Co-ordination of patient care with multiple providers	
PROFESSIONAL VALUES AND ATTITUDES	
• Approach to ethical and medico-legal issues	
• Punctuality, time keeping and reliability	
• Relationship with other team members	
• Leadership abilities	
• Collaboration or consulting with other health professionals	
OVERALL ASSESSMENT	
• Global rating (Give score for rotation ……/10)	/10

Feedback from supervisor:

Supervisor's name: _____

Signature:_____Date:_____

SECTION 4

RECORD OF EDUCATIONAL MEETINGS WITH SUPERVISOR

Your portfolio at the end of the year should demonstrate engagement with all of the learning outcomes below and a minimum of 2 hours formal tuition per month / 24-hours for the year. However, the aim should be to show engagement above the minimum standard. One-on-one meetings with your supervisor, reflecting on real patient scenarios, are most meaningful. Try to avoid having mostly group CPD type meetings.

Use the letters below to record the general focus of the meeting and then describe what was done. The meeting should broadly be located within at least one of the national learning outcomes. Remember that the learning outcomes are detailed in Section 2 of your portfolio.

Divider: Educational Meetings

A: Leadership and governance: Learning areas include personal or professional development (this includes a discussion of your learning plans), teamwork and making sense of the healthcare system. Issues related to clinical (e.g. quality improvement) or corporate governance (e.g. procurement) could be discussed.

B: Clinical care: Learning areas include discussion of actual patients through the use of case-based discussions, record review, presentation of problem patients, or clinical tutorials. Reflect on assessment, management, difficult consultations, the biopsychosocial approach, challenges to communication.

C: Family and community orientated care: Learning areas include the engagement with family as part of clinical care, reflection on home visits, community engagement, community diagnosis, working with community health workers, community interventions.

D: Teaching and training others: Learning areas include your ability to build capability, teach, present or provide clinical training for other healthcare workers or students.

E: Professionalism and ethics: Learning areas include discussion of ethical dilemmas, health and human rights or professional conduct.

F: Other: This category can be used to code educational meetings that address other relevant issues not covered by the options above.

Date	Group or individual meeting	Code letter from list of learning outcomes	Duration (hours)	Description of content covered / activities / topics	Signature of supervisor
9/2/2023	Individual	D	1	Last 2 patients seen today in PHC clinic	Example

Date	Group or individual meeting	Code letter from list of learning outcomes	Duration (hours)	Description of content covered / activities / topics	Signature of supervisor

Some tools to facilitate your educational meetings are included here:

1. Case-based Discussion (CbD)
2. Chart stimulated Recall (CSR)
3. Clinical Question Analysis (PAN-PUN-DEN)
4. Significant Event Analysis (SEA)

Case-based Discussion Notes Sheet – to help supervisors and trainees*

<u>Tick</u> those questions you'd like to ask;
add any others not on this sheet but specific to the case under discussion
Stick to the 'there and then'; don't go into the future (i.e. no "what if" questions)

Competence	Proposed Questions	Evidence Obtained
Practising holistically *(physical, psychological, socio-economic and cultural dimensions; patient's feelings and thoughts)*	☐ What do you think was the patient's agenda (her I.C.E.)? How did you elicit this? Why present now? ☐ What effect did the symptoms have on her work, family and other parts of her life? *(illness vs. disease)* ☐ How did the symptoms affect her psychosocially? What phrase(s) did you use? ☐ What prior knowledge of the patient did you have which affected the outcome of your consultation(s)? ☐ Did you identify any ongoing problems which might have affected this particular complaint? ☐ How did you establish the patient's point of view? What consultation skills did you use to do this? <u>Other Qs</u>	**Note:** In general, when asking the trainee to present the case, ask them to also say: 1. what **issues** they felt the case **raised** 2. what **issues** they felt **needed resolving** 3. what bits they found **challenging/difficult** **This will help you focus your questions.** ☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Data gathering and interpretation *(gathering and using data for clinical judgement, the choice of examination and investigations and their interpretation)*	☐ Ask about the specifics of the case and diagnoses eg what biological features of depression did she show? How long did she have it for? etc ☐ What bits of information did you find helpful in this case? Why? How did you phrase that? ☐What other information did you use to help formulate your diagnosis/decision? ☐ Did you refer to any previous investigations to help you? What were they? ☐ What skills did you use to obtain the history? ☐ What examination did you make? ☐ I see from the notes that there is no reference to examining her "chest"; Do you think this might have been helpful? In what way? ☐ Had you gathered any further information about this case from others? ☐ Was there any other information you would have liked? How would that have helped you? <u>Other Qs</u>	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Making diagnoses & decisions *(conscious, structured approach to decision-making)*	*DIAGNOSIS* ☐ What were you particularly worried about in this case? ☐ How did you come to your final diagnosis? Remind me which bits of the history and examination were instrumental in this? ☐ Did you use any tools or guidelines to help you? *TREATMENT* ☐ What were your options? Which did you choose? Why this one? Convince me that you made the right choice. ☐ Did you consider any evidence in your final choice? Tell me about it? ☐ How did the patient feel about your choice of treatment? Did this influence your final decision? ☐ Did you consider the implications of your decision for the relatives/doctor/practice/society? Tell me more about how they might feel? How did this influence your final decision? ☐ Did you use any framework or model to help justify your decision? <u>Other Qs</u>	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Clinical Management *(recognition and management of common medical conditions)*	☐ What made you prescribe xxx? How did you come to choosing that? What does the evidence say about it? ☐ Had you thought of any other options at the time? What were they? Tell me about some of the pros and cons of these options so I can get an idea of why you went for what you did. Do you know the evidence behind any of these? What were your main priorities here? ☐ Why did you do those investigations? What were you looking for? ☐ Why did you make that referral? What worried you that led to that referral? Did you speak to them? What were you hoping the referral might achieve? What did you actually put in the referral letter? ☐ Did you put into place any follow up/review? How long? Why do you want to see her again?	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd

	Other Qs	
Managing medical complexity *(beyond managing straight-forward problems, eg managing co-morbidity, uncertainty & risk, approach to health rather than just illness)*	☐ How did you generally FEEL about this case? ☐ Do you think the patient kind of pushed you into investigation/referral/treatment with abx? How do you feel about this? What have you learned from this case? ☐ What did you do to alter her help seeking behaviour? ☐ Was there a difference of agendas? How did you tackle this? (eg demanding patient, difficult angry patient, overbearing heartsinks etc). Tell me exactly how you managed to merge agendas. ☐ What made this case particularly difficult? How did you resolve that? ☐ Were there any ongoing problems that added to the complexity of this case? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Primary care admin and IMT *(effective recordkeeping and online info to aid patient care)*	☐ Look at the trainee's electronic recording of information. Do you think it was satisfactory? Ask what the trainee thinks on reflection- "Do you think what you have documented is adequate?" Any important negatives left out? The patient's narrative? Concise yet thorough? ☐ Did you use any online information to help you? What? How? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Working with colleagues and in teams *(working effectively; sharing information with colleagues)*	☐ Did you involve anyone else in this case? Why? How did they help? ☐ Did you involve any other organisations in this case? For what purpose? ☐ How did you ensure you had effective communication with others involved in this particular case? ☐ If many people/organisations are involved in the case, ask: "What do you see as your role considering loads of people are involved in this case?" Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Community orientation *(management of health and social care of local community)*	☐ Did you think about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more…OR Is there a potential for harm in the way you approached this case? OR Can you see any ethical dilemmas in this particular case? OR Had you any ethical considerations when dealing with this case? Tell me more. ☐ Had you any thoughts at the time about the cost of treatment/investigation/referral? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Maintaining an ethical approach to practice *(ethical practise, integrity, respect for diversity)*	☐ What ethical principles did you use to inform your choice of treatment? ☐ How did you ensure the patient had an informed choice when it came to management? What are patients' rights? How did this influence your handling of the case? ☐ Sick Notes – individual vs. society thing. Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Fitness to practise *(awareness own performance, conduct or health, or of others; action taken to protect patients)*	☐ Excluding the serious stuff eg What alarm features did you enquire about?; How did you carry out a suicidal risk assessment?; How did you know her headaches are not a result of a brain tumour?; How did you exclude a brain tumour? ☐ Safety Netting – How did you close the consultation? Did you advise on when to come back? What did you say? ☐Are there any other responsibilities you have to patients in general? How do they apply to this case? How did you make sure you observed them? Why are they important? ☐ Did you use a chaperone? ☐ Did you wear a glove before taking blood/doing a PV/PR/giving the injection? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd

* *Developed by Dr. Ramesh Mehay, Programme Director Bradford VTS (Dec 2006)*

UNIVERSITY OF ALBERTA

Department of Family Medicine

Chart Stimulated Recall Instructions

The Chart Stimulated Recall (CSR) worksheet can be used for a variety of teaching opportunities:

1. Post patient encounter teaching session
2. After a resident run clinic, ambulatory clinic or consult
3. As a teaching session to help a learner in difficulty

The CSR can be useful:

1. As a teaching tool; to help structure a teaching session
2. As a tool for providing feedback
3. to improve documentation skills
4. to help demonstrate and evaluate CanMEDS-FM roles and competencies
5. To stimulate reflective practice
6. As a tool for residents in difficulty
    a. To identify gaps in knowledge
    b. To identify critical thinking and reasoning skills

Instructions

1. Prepare the learner by informing them that you will be reviewing a chart note and you would like to discuss the patient encounter. Let the learner know that this is a teaching session and they will receive feedback on their chart note and review of the case.
2. Select a chart note for review. The chart can be electronic or hand written.
3. Review the chart note and write comments for feedback in Box A. Suggestions for comments are included at the top of Box A
4. Select a few Discussion Questions from the list under Box A. The possible questions should help guide your discussion, but not all questions need to be asked.
5. Write comments for feedback on the Case presentation and discussion questions in Box B.
6. Give the learner your feedback Add the CSR to their portfolio, learning file or achievement system.

Dr. S. Schipper - CRS Worksheet Updated July 2009

Adapted from PAR worksheet

University of Alberta
Department of Family Medicine

Chart Stimulated Recall (CSR) Worksheet

Resident or Student:		**Date of CSR:**
Preceptor/Supervisor:	**Chart # or Patient Initials:**	**Date of Visit:**

Box A: Comments and Feedback from the Chart Note	
May include some or all of the following:	
1. Record keeping and legibility	*3. Follow-up documented*
2. Information documented is pertinent and relevant	*4. General comments*

Case Review – Possible Discussion Questions

(note which questions were asked)

1. **General Case Review**
   a. Clinical assessment – **Family Medicine Expert, Communicator**
      i. Can you give me an overview of the case?
      ii. What features of the patient's presentation led you to your top two (or three) diagnoses?
      iii. Did you inquire about the patient's illness experience (feelings, ideas, effect on function and expectations) and what did you learn?
      iv. If there was ambiguity or uncertainty about the case, how did you deal with it?
      v. Is there anything else you wish you would have asked?

   b. Investigations and Referrals – **Collaborator, Manager**
      i. Why did you choose the investigations that you did?

ii. Were there other tests that you thought of but decided against? Why?

iii. How did you decide whether to refer to a health care team member or consultant?

c. Treatment and Management – **Scholar, Communicator**

i. What features led you to choose the treatment that you did?

ii. What were the patient's expectations for treatment?

iii. Do you feel you reached common ground with the patient?

iv. Were there other treatments that you thought of but didn't offer? If so, why did you decide against them?

d. Follow-up

i. What did you decide was appropriate for follow up? Did you document your plans?

ii. What factors influenced your decision?

2. Comprehensive Care – Health Advocate

a. Monitoring Chronic Disease

i. Did you discuss his/her chronic disease/progress?

ii. On reflection, can you think of monitoring strategies that would be appropriate?

b. Health Promotion and Prevention

i. Did you discuss preventive interventions? (e.g. BP, smoking cessation, alcohol use, screening tests, diet, exercise, etc.)

ii. On reflection, do you think there are some interventions should be discussed?

3. Patient Factors – Health Advocate

a. Was there anything special about this patient that influenced your decisions regarding management? (e.g. compliance issues, past medical history, support systems, employment)

b. On reflection, is there anything about this patient you wish you knew more about?

4. Practice or System factors – Collaborator, Manager

a. Is there anything special about your practice setting that influenced your management in this case? (e.g. a nurse educator, Care Network, lack of access services)

b. On reflection, how could you improve health care delivery to this patient?

Box B: Comments and Feedback from the Case Review	
May include some or all of the following:	
1. General comments about case presentation	*5. Demonstrated Patient-Centeredness and CanMeds-FM Competencies*
2. Analysis of information and reasoning skills	*6. Comprehensive care and health promotion*
3. Approach to management and ambiguity	*7. Evidence of reflective practice*
4. Use of evidence-based medicine	

Preceptor or Supervisor Signature: _____

Resident or Student Signature: _____

Date: _____

Dr. S. Schipper - CRS Worksheet Updated July 2009
Adapted from PAR worksheet

Clinical Question Analysis

This sheet should be with you during your practice and act as a guide to ask questions in a moment of reflection alone after the patient consultation. It can also be used to reflect on other challenges or situations that arise in clinical practice.

a. The Situation and/or Patient Actually Met Needs (PAN) at time of consultation

.....

.....

.....

b. The Situational Difficulty and/or Patient Unmet Need (PUN) (on Reflection)

.....

.....

.....

c. MY Problem, difficulty, questions or observations (including my emotional reactions on reflection)

.....

.....

.....

d. MY (Doctor) Educational Need (DEN) (Which aspects of this encounter or situation do I need to find out more about to improve?)

.....

.....

.....

e. How did I close the learning loop i.e. what did I do in my practice differently or implement what I learnt?

.....

.....

.....

Trainee……Signature……Date…….....

Significant Event Analysis (could also be a Morbidity and Mortality [M&M] discussion)

Description of occurrence	Date
What was managed well?	
What did not go well i.e. briefly the identified problem?	

Fishbone (put what you see as causes to this problem as the bones to the arrow pointing to the identified problem)

Identification of main learning needs

Actions	By whom	When

Trainee..... Signature ……

Supervisor……. Signature ……..

Divider: Observations of Performance

SECTION 5

OBSERVATIONS OF THE TRAINEE

This section must include **<u>at least ten (10) observations</u>** of yourself by your supervisor(s) during the year. These must consist of at least 10 observations of consultations (assessed via the mini-CEX tool). One of the 10 observations must include you doing a teaching session, and be captured in one of the two tools, either for a group or an individual teaching session. The group presentation tool and the one-minute preceptor tool (for individual teaching) is included. Several assessment tools are available to help with direct or indirect observation. Please make more copies as you need:

1. Mini-CEX (for consultations)
2. Communication skills observation tool
3. Group presentation tool
4. One-minute preceptor
5. 360 Degrees Questionnaire (Section 6)

Tip: Be very opportunistic, asking your supervisor to observe you whenever you recognize a moment of 'quietness', perhaps first thing in the morning, or a specific day of the week. Keep some of these assessment tools with you.

- During initial training, detailed remediation should take place during the consultation. The trainee should be asked for his/her hypothesis after taking the history. This intervention should decrease as they progress until the consultation is purely observed, unless the patient's welfare is endangered.
- No intervention should take place during formal (summative) assessment.
- During formal assessments, trainees may need help focusing on specific issues in patients with complex problems with limited time.
- Time management is an important skill, but trainees can be assessed out of what was appropriately completed, where there are clear reasons why the consultation could not be finished within the time allowed; assessors may intervene 1 minute before the end, or afterwards, to ask for the trainee's assessment and plan.
- Keep the mini-CEXs short (<20 min), you need not assess everything every time, do this regularly, ask for feedback, assess against FCFP exit exam standard (progress test).

Observations (each scored …../10)	1	2	3	4	5	6	7	8	9	10 Teach	FINAL AVERAGE (……./10)

COMMUNICATION SKILLS OBSERVATION TOOL

Trainee name……. Supervisor ……Date……

Checklist score Each of the items below is an important skill in the consultation and should be rated separately. Rating should be at the performance expected from a family physician.	**Shown (2 points)**	**Partially shown / not sure (1 point)**	**Not shown (zero points)**
Initiating the session			
Makes appropriate greeting / introduction and demonstrates interest and respect Greets patient, obtains name, introduces self, attends to physical comfort of patient, shows interest and respect, establishes initial rapport.			
Identifies and confirms the patient's problem list or issues Gives an opportunity for the patient to list all their issues or problems before exploring the initial problem "So headache, fever - anything else you'd like to talk about?". Summarises and confirms the list with the patient.			
Gathering information			
Encourages patient's contribution / story By use of open as well as closed questions, attentive listening, facilitation skills and summarization and responding to cues. As opposed to cutting off the patient, use of only closed questions in an interrogatory style.			
Makes an attempt to understand the patient's perspective Elicits spontaneously and acknowledges the patient's perspective or uses specific questions– beliefs, concerns, expectations, and feelings.			
Thinks family, and obtains relevant family, social and occupational information Elicits relevant information about the patient's household, family, occupation, and environment.			
Obtains sufficient information to ensure no serious condition is likely to be missed Elicits enough clinical information to establish a working diagnosis and ensure no serious condition is likely to be missed.			
Explanation and planning			
Appears to make a clinically appropriate working diagnosis The apparent diagnosis is clinically appropriate according to the subjective and objective evidence. If necessary the notes in the patients folder can be reviewed later to establish what the doctor was thinking.			
There is a clear explanation of the diagnosis and management plan The explanation is well organized, in small chunks, avoids jargon, where appropriate makes use of visual methods, leaflets, repetition, signposting.			
Gives patient an opportunity to ask for other information and / or seeks to confirm patient's understanding The patient is asked if they would like other information and / or their understanding is checked by reverse summarizing or opportunity to clarify			
The explanation takes account of and relates to the patient's perspective The explanation connects, responds to or takes into account the patient's beliefs, concerns and expectations			
Involves the patient where appropriate in decision making The patient is offered insight into doctor's thought processes, suggestions, options and invited to participate in decision making through use of choice, expression of preferences or ideas. The doctor does not just give orders, directives or instructions of what must be done.			
Chooses an appropriate management plan The management plan is based on scientifically sound evidence and is appropriate for the diagnosis. If necessary the notes in the patients folder can be reviewed later to			

establish what the doctor was thinking.			
Closure			
Closes consultation successfully in the time available Brings the consultation to a conclusion rather than running out of time. Deals with any remaining issues from the patient.			
Provides appropriate safety netting for the patient Shows evidence of having considered how certain they are of the diagnosis, what might go wrong with the treatment, how they will know if things do not go well, side effects occur or more serious sequelae develop. Shows this in an appropriate plan of safety netting with the patient.			
Additional skills – for merit These will not be applicable to all consultations, but will depend on the content of the specific consultation			
Establishes therapeutic rapport / relationship in a patient with a mental or psychosocial problem Shows evidence of basic counseling skills used in a mature and integrated way that offers supportive therapy to the patient: such as empathy, attentive listening, summarizing, unconditional positive regard, facilitative responses.			
Breaks bad news appropriately Shows evidence of structured approach to breaking bad news that includes skills such as: setting the scene by summarizing or discovering where things have reached to date and check patients understanding; warn patient that difficult information is coming; give information clearly, directly and honestly; be sensitive to the emotional reaction from the patient by giving space for it, encourage expression of feelings; allow patient to ask their own questions, express concerns and elicit the type and amount of information they want, make a supportive plan.			
Shows skills in brief motivational interviewing Shows evidence of brief motivational interviewing skills such as: setting an agenda, explores readiness to change, chooses skills appropriate to the patients readiness to change (elicit-provide-elicit, decision balance sheet, brainstorming), rolls with resistance.			
Total Score out of 30 (maximum = 30)			**…/30**
Above Total Score divided by 3			**…/10**

Mini-Clinical Evaluation Exercise (CEX)

Evaluator:_____ **Date:**_____

Trainee:_____**FCFP exam**: yes_____ no _____

Patient Problem/Dx:_____

Setting: **O** Ambulatory **O** In-patient **O** EC **O** Other_____

Patient: Age_____ Sex:_____ **O** New **O** Follow-up

Complexity: **O** Low **O** Moderate **O** High

Focus: **O** Data Gathering **O** Diagnosis **O** Therapy **O** Counselling

1. **Establishes a good doctor-patient relationship** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

2. **Gathering information** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

3. **Physical Examination Skills** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

4. **Clinical Judgement** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

5. **Explaining and Planning** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

6. **Shows a well-organised approach** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

7. **Overall Clinical Competence** (**O** Not Observed)
   1 2 3 4 5 6 7 8 9 10
   UNSATISFACTORY SATISFACTORY SUPERIOR

Mini –CEX Time: **Observing_____Mins** **Providing Feedback:_____Mins**

Total Score by your Supervisor ……../ 70 **Divided by 7 ……../10**

[or divided by total of competencies assessed, e.g. if 5 competencies, then …../50]

Feedback:_____
_____
_____
_____
_____

_____ _____

Trainee Signature Evaluator Signature

DESCRIPTORS OF COMPETENCIES DEMONSTRATED DURING THE MINI-CEX

Establishes a good doctor-patient relationship: Shows genuine respect, compassion, sensitivity, rapport, empathy, establishes trust, and attends to patient's comfort.

Gathering information: Explores the patient's problem(s) by effectively using questions, listening and facilitation skills and obtains sufficient information. Understands the patient's perspective. Understands the patient's context.

Physical examination skills: Performs a competent, focused examination, in an efficient and logical sequence. Elicits the correct and relevant physical signs.

Clinical judgement: Makes a correct, rational and holistic (3-stage) assessment. Chooses an appropriate and evidence-based management plan.

Explaining and planning: Clearly explains the assessment and management plan. Gives the patient an opportunity to ask for information / confirms patient's understanding. Involves the patient where appropriate in decision-making. Provides appropriate counselling when relevant.

Shows a well-organised approach: Ensures a structure and rational flow to the consultation, prioritises, is timely and efficient.

Overall clinical competence: Is the overall competency below, at or above the level expected for this assessment.

[Keep it short (<20 min), need not assess everything every time, do this regularly, ask for feedback, assess against FCFP exit exam standard (progress test)]

Adapted from the American Board of Internal Medicine, www.abim.org. Discussed in Norcini JJ, Blank LL, Arnold GK, Kimball HR. The mini-CEX (Clinical Evaluation Exercise): a preliminary investigation. Ann Intern Med 1995;123:795-9.

Further references: Mash B. How to communicate effectively in the consultation. South African Family Practice Manual (Mash and Blitz, Ed), 3rd ed. 2015: 464-466; and Blitz J. Communication Skills. Handbook of Family Medicine (Mash Ed), 3rd ed. 2011: 67-96.

Marking Sheet for Presentation Skills

Presentation: Structure and organization, formulation, time management, preparation

1-4	5-7	8-10	Mark	Weight	Final
Disorganised, unprepared, fails to complete in time available – unable to demonstrate structure and organization	Finishes on time, mostly organized, structured – maintains good organization throughout most of the consultation	Well organized, equal division of time between sections, content logically connected, good preparation evident – maintains excellent structure and organization		20	

Teaching aids: Readability, functionality, use of media, use effectively

1-4	5-7	8-10	Mark	Weight	Final
Slides have too much information, small fonts, fumble with aids, not able to use the computer, poor coherence	Good layout of slides, uses media with reasonable confidence, deals with hiccups, summarises key messages well	Slides readable, no more than 5 – 7 bullets, no more than 7 words per line, appropriate use of graphics, enhances and complements the verbal presentation		20	

Non-Verbal: posture, positioning, hand movements, nerves, clothing, mannerisms, eye contact

1-4	5-7	8-10	Mark	Weight	Final
Stands with back to audience, inappropriately dressed, fidgets, excessive hand movement, poor eye contact – poor display of non-verbal com	Appears comfortable, uses appropriate hand movements, contains nerves, good eye contact with audience – maintains good non-verbal com	Confident, uses appropriate non-verbal communication, engages with audience – develops and sustains excellent non-verbal communication throughout presentation		20	

Verbal: Accent, volume, speed, enthusiasm, pronunciation

1-4	5-7	8-10	Mark	Weight	Final
Speaks inaudibly, too fast, boring, too loud or too soft – audience loses interest, is unable to understand the content	Speaks at appropriate level, uses language correctly – audience is able to understand all the content	Varies speech, displays enthusiasm for work – audience understands the content and is engaged / stimulated		15	

Rapport with audience: Handling of questions, respectful, engaging

1-4	5-7	8-10	Mark	Weight	Final
Does not build and/or loses rapport with the audience, becomes defensive or aggressive on questions	Develops good rapport with the audience, genuine attempt to understand and appropriately respond to questions	Develops and sustains above average rapport throughout, engages with audience, responds to questions on a higher cognitive level, works with critique not against		15	

Content of presentation

1-4	5-7	8-10	Mark	Weight	Final
Poorly defined aims, poor methodology, unclear results, lack of insight and interpretation, inappropriate and unsubstantiated responses to questions	Clear aims, reasonable methodology, clear results, reasonable interpretation, defends findings appropriately	Scope of research more than expected, makes significant contribution to the discipline, innovative methods, high level of interpretation and responses to questions		10	

The presentation will be marked using the following marking schedule
1-4 - Below standard for a family physician, fail
5-7 - Family physician standard, pass
8-10 - Above standard, exceptional, possible distinction

TOTAL MARK: ……....out of 100 divide by 10 FINALMARK……./10

REGISTRAR NAME:……..……SUPERVISOR:…….……

FEEDBACK:

……

……

……

……

……

Scoring Rubric for WPBA of postgraduate Family Medicine Teaching Skills - One minute Preceptor

Setting: Teaching a: medical student……nurse……..intern…….. medical officer……..other……..

OPD……..EC……..PHC clinic…….hospital ward

1. Getting a commitment

1-4	5-7	8-10	Mark	Weight	Final
Not done. Predominantly gathers further data from Student about the case. Questioning is more in line with own thought process	Gets commitment. Question mostly appropriate to the stage of the learner	Able to get commitment with appropriate question to level/stage of learner. Able to move learner respectfully and collegially beyond their level of comfort.		20	

2. Probing for supporting evidence

1-4	5-7	8-10	Mark	Weight	Final
Passes immediate judgement on the response trough immediate feedback	Probes for rationale for answer but continues to give judgement on the rationale	Probes well for rationale for answer and explores guesses without pronouncing on the response.		20	

3. Reinforcing what was done well

1-4	5-7	8-10	Mark	Weight	Final
Provides generic and general feedback on presentation i.e., “That was a great presentation”	Reinforces well and provides examples	Reinforces well, provides examples, and categorises into skills, attitudes, and behaviours as relevant.		20	

4. Giving guidance about errors and omissions

1-4	5-7	8-10	Mark	Weight	Final
Uses extreme terms, e.g., bad/poor and does not provide balance between constructive criticism and positive feedback	Gives appropriate feedback	Gives focused and appropriate feedback and uses growth-oriented terms e.g., 'could do this even better in future’		20	

5. Teaching a General Principle

1-4	5-7	8-10	Mark	Weight	Final
Too many principles taught, or over generalises	Identifies and explains appropriate principle	Identifies appropriate principle and/or provides strategies for further searches		20	

6. Concluding

1-4	5-7	8-10	Mark	Weight	Final
Does not conclude clearly and next steps not well outlined.	Concludes session and re-directs to the care of the patient.	Concludes respectfully and outlines next steps and own role in the care of the current patient. Probes for feedback on teaching.		10	

The presentation will be marked using the following marking schedule
1-4 - Below standard for a family physician
5-7 - Family physician standard
8-10 - Above standard, exceptional

TOTAL SCORE: (…….....out of 110)x100 divide by 10 FINAL SCORE……./10

REGISTRAR NAME:……..……SUPERVISOR:……..……..

FEEDBACK:

……

……

……

……

……

References:

Primary MO of R, Asheville NCE. The one minute preceptor: 5 microskills for one-on-one teaching. MAHEC Off Reg Prim Care Educ [Internet]. 2006;8. Available from: http://www.oucom.ohiou.edu/fd/monographs/microskills.htm%5CnThe

Neher JO, Gordon KC, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. J Am Board Fam Pract. 1992 Jul-Aug;5(4):419-24. PMID: 1496899.

Divider: Multisource Feedback (360^0)

SECTION 6

MULTI-SOURCE FEEDBACK

A 360 degrees questionnaire is another tool to assess your performance and get specific feedback from colleagues. If converted into electronic format, e.g. SurveyMonkey® or Google Forms®, it becomes very easy to complete. It asks 38 specific questions according to the 5 national unit standards, and elicits free text feedback on what is done well, what could be done even better, and what should be stopped. Ask between 10 and 16 colleagues (nurses, doctors, managers, allied health colleagues, supervisors) to complete the questionnaire anonymously, and give back to you. Ask people who know you, have worked with you, and have observed you in the workplace. You need to document entrustable evidence of your professional activities.

Multisource feedback

Respond to each statement with the level of agreement:

1 Strongly disagree

2 Disagree

3 Unsure

4 Agree

5 Strongly agree

Can also select ‘not applicable’.

Unit standard 1: Leadership and clinical governance

1. Organises their work well. Sets the right priorities.
2. Is capable of keeping a good balance between work and home.
3. Is available and accessible.
4. Shows self-confidence.
5. Shows self-knowledge and self-awareness
6. Can stimulate and motivate others.
7. Communicates effectively and respectfully with colleagues
8. Respects the input and expertise of others
9. Is a good colleague and positively contributes to the functioning of a team.
10. Take initiatives to improve quality in the health facility

Do you have any feedback to the trainee on what they should stop doing, start doing or continue doing in terms of their leadership and clinical governance?

[free text entry]

Unit standard 2: Competent clinician and consultant

1. Independently handles patient problems accurately and at an adequate pace.
2. Masters clinical skills/procedures and apply these adequately.
3. Pays sufficient attention to the psychosocial aspects of disease.
4. Communicates effectively and respectfully with patients/ family (empathic, clear and active listening, discuss)
5. Is open to verbal and non-verbal reactions and emotions of others and responds adequately
6. Is capable of involving the patient actively in improving his/ her health.
7. Is accurate, clear and complete in reporting/ written communication (medical record documentation, letters, instructions).
8. Hands over the care for patients effectively as well as carefully.
9. Weighs costs and benefits for diagnostics, treatments and prevention.
10. Takes a scientific approach and uses evidence-based medicine wherever possible.

Do you have any feedback to the trainee on what they should stop doing, start doing or continue doing in terms of their work as a clinician?

[free text entry]

Unit standard 3: Family and community orientated primary care

1. Pays sufficient attention to the patient's family or household context
2. Uses a wide variety of resources in the community to help patients

3. Builds the capability of community health workers
4. Demonstrates an awareness of the community served and their health needs
5. Helps develop interventions to improve the health of the community

Do you have any feedback to the trainee on what they should stop doing, start doing or continue doing in terms of their work with families or in the community?

[free text entry]

Unit standard 4: Capacity building and clinical training

1. Conducts effective learning conversations in the clinical setting
2. Is willing to and capable of training/ educating others.
3. Is capable of presenting clearly and concisely in front of a group (lecture, review of a clinical topic, handover, big round).
4. Gives specific, sensitive and useful feedback to others on their performance.
5. Is aware of the gaps in their own knowledge / skills and makes a learning plan based on this.

Do you have any feedback to the trainee on what they should stop doing, start doing or continue doing in terms of their ability to capacitate, train or teach other health professionals?

[free text entry]

Unit standard 5: Ethics and professionalism

1. Shows sufficient involvement with the patient and put the patient's interest first.
2. Respects the patient's privacy
3. Is open to feedback and willing to admit mistakes.
4. Is aware of shortcomings and asks for assistance / supervision in time.
5. Functions adequately under stress / time pressure.
6. Is reliable and keep agreements.
7. Acts according to legal and ethical guidelines and regulations
8. Advocates for patient's rights or healthcare needs when necessary

Do you have any feedback to the trainee on what they should stop doing, start doing or continue doing in terms of their ethical or professional behaviour?

[free text entry]

Level

Functions in comparison with other trainees in the same stage of the education:

- Below expected level (0-4)
- At expected level (5-7)
- Above expected level (8-10)

Do you have any other feedback to the trainee on what they should stop doing, start doing or continue doing that has not been given already?

[free text entry]

The feedback and score on each section is used formatively. The final overall assessment ("level") is used for the PAT as a score out of 10.

Divider:

Clinical Governance activity

SECTION 7

CLINICAL GOVERNANCE

Please provide evidence of clinical governance activity performed in the last year. You must submit at least two types of clinical activities from the list below. Each candidate's involvement in clinical governance activity will be scored, and the mean score will be taken for each activity type. i.e. M&Ms only rate as one type of activity. If more than one type of activity, the cumulative mean score will be taken. This section contributes 10% to your portfolio.

This could include copies of

1. Evidence-based Medicine (e.g. critical appraisal of a journal article, searching for evidence, use of guidelines, reviewing and developing protocols for your institution, Leading journal club presentations)
2. Quality improvement projects. Evidence of being part of the team
3. Significant event analysis (SEA)
4. Patient safety incident analysis reports
5. Morbidity and mortality meeting reports
6. Monitoring and evaluation meeting reports

Please provide a short reflection on each of the submitted materials.

Divider:

Logbook

SECTION 8: LOGBOOK OF PROCEDURAL SKILLS

This section must include at least ten (10) observations of yourself by your supervisor(s) during the year. These must consist of at least 10 observations of procedures performed (assessed via the DOPS or C-Section tools). At the end of this section is also included the Minimum Safety Standards for a Safe Caesarean Section. Several assessment tools are available to help with direct or indirect observation. Please make more copies as you need:

1. Direct observation of procedural skills (DOPS)
2. Caesarean section surgical skills assessment
3. Caesarean section anaesthetic skills assessment

Your supervisor should evaluate your competency with your learning plan and clinical allocation assessment **at the beginning and end of the allocation or at least every 6-months (i.e. February and August)**.
It is assumed that while learning these specific skills, you will also be exposed to an appropriate spectrum of patients and will be supervised in the relevant clinical assessment, decision making and management. If some skills are not obtained, reflect on this and indicate the reasons in your portfolio.

NB: Logbook skills will be assessed by a Family Physician only. Each trainee is expected to video record or be directly observed for TEN (10) logbook skills during the year. The skill will be scored using a DOPS tool.

Direct Observation of Procedural Skills TOOL (DOPS)

TEMPLATE FOR PROCEDURAL SKILLS ASSESSMENT

1. PREPARATION OF PATIENT
- Introduces self (if not already known)
- Puts patient at ease
- Explains the procedure to patient
- Explains indications, contraindications, risks and benefits of the procedure as applicable
- Appropriately answers any question(s) the patient might have
- Assures the patient that his/her comfort during the procedure is your priority
- Gets patient's consent

2. PREPARATION FOR PROCEDURE
- Uses appropriate safety measures
- Maintains sterility as required
- Prepares correct anaesthesia/analgesia
- Appropriate choice of needed material or instrument(s)
- Appropriate choice of needed drugs

3. PROCEDURE

- Places patient in correct position for the procedure
- Accurately and comprehensively performs the procedure
- Explains step by step what is being done
- Does not unnecessary hurt the patient
- Critical steps are not omitted

4. POST-PROCEDURE

- Admits patient for observation if needed
- Arranges follow-up of patient
- Refers the patient when indicated
- Educates the patient about the condition
- Provides and/or prescribes analgesia, dressings, other appropriate management Provides preventive measures

5. TEAM WORK

- Works collegially with nursing or medical colleagues in performing the procedure
- Gives appropriate instructions to nursing staff involved
- Ensures proper hand over of patient for ongoing care if required

Direct Observation of Procedural Skills (DOPS) – scoring sheet

TRAINEE:_____ SUPERVISOR:_____

SETTING: ☐ Ambulatory ☐ In-patient ☐ EC/Casualty Other: _____

Patient age: _____ Patient sex: _____ ☐ New ☐ Follow-up

SKILL PERFORMED: _____

Complexity of skill: Low ☐ Medium ☐ High ☐

---

1. PREPARATION OF PATIENT:

1 2 3 4 / 5 6 7 / 8 9 10

UNSATISFACTORY SATISFACTORY EXEMPLARY

---

2. PREPARATION OF EQUIPMENT:

1 2 3 4 / 5 6 7 / 8 9 10

UNSATISFACTORY SATISFACTORY EXEMPLARY

---

3. PROCEDURE:

1 2 3 4 / 5 6 7 / 8 9 10

UNSATISFACTORY SATISFACTORY EXEMPLARY

---

4. POST-PROCEDURE (AFTER CARE):

1 2 3 4 / 5 6 7 / 8 9 10

UNSATISFACTORY SATISFACTORY EXEMPLARY

---

5. TEAM WORK:

1 2 3 4 / 5 6 7 / 8 9 10

UNSATISFACTORY SATISFACTORY EXEMPLARY

TOTAL /50 Divide by 5: Final score /10

Feedback:

.....

.....

.....

Supervisor signature…….....……Date…….....

Additional tools to help during direct observation of procedures (C-sections and Anaesthetics):

Caesarean section

Trainee Name:		Assessor Name:		Date:
Level of training: Grade/Year		Post:		

Clinical details of complexity/difficulty of case	

Item under observation	**Performed independently**	**Needs help**
	PLEASE TICK RELEVANT BOX	
Appropriate skin incision (e.g. length, position)		
Safe entry of peritoneal cavity		
Careful management of bladder		
Appropriate uterine incision (e.g. length, position)		
Safe and systematic delivery of baby		
Appropriate delivery of placenta		
Check uterine cavity (e.g. intact, empty, configuration)		
Safe securing of uterine angles		
Check for ovarian pathology		
Appropriate closure of rectus sheath		
Attention to haemostasis		
Neatness of skin closure		
Comments:		

Levels of complexity for each stage of training:

ST1	First or second caesarean section with longitudinal lie
Core Training	Twins/transverse lie
	Preterm at gestation over 28 weeks
CCT	Preterm less than 28 weeks or grade 4 placenta praevia
	Fibroids in lower uterine segment

	Performed independently	Needs help
	PLEASE TICK RELEVANT BOX	
Item under observation: opening		
Appropriate preoperative preparation: bladder empty, prepare and drape abdomen		
Appropriate skin incision (e.g. length, position) with safe use of surgical knife		
Subcutaneous fascia opened with attention to haemostasis		
Rectus sheath incised either side of linea alba, extended with scissors and dissected off rectus muscle with attention to haemostasis		
Safe entry of peritoneal cavity by either sharp or blunt dissection		
Item under observation: closing		
Identification of peritoneal edge and closure (optional) using appropriate suture material, instruments and technique		
Ensure haemostasis of peritoneum and posterior surface of rectus sheath		
Secure closure of rectus sheath using appropriate suture material, instruments and technique for knot tying and placement of sutures		
Ensure haemostasis before skin closure		
Accurate skin closure using appropriate method, instruments and technique (trainees should demonstrate competence in the full range of closure methods)		
Appropriate and safe use of needle holder: needle loaded correctly, no touch technique, no inappropriate movements		
Comments (please state skin closure method)		

Examples of minimum levels of complexity for each stage of training:

ST1	Patient with no previous lower transverse incision
Intermediate Training	Patient with previous lower transverse incision but without suspicion of severe abdominal adhesions
CCT	Patient with previous abdominal surgery and likely severe abdominal adhesions

GENERIC TECHNICAL SKILLS ASSESSMENT

Assessor, please ring the candidate's performance for each of the following factors:

Respect for tissue	Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments.	Careful handling of tissue but occasionally caused inadvertent damage.	Consistently handled tissues appropriately with minimal damage.
Time, motion and flow of operation and forward planning	Many unnecessary moves. Frequently stopped operating or needed to discuss next move.	Made reasonable progress but some unnecessary moves. Sound knowledge of operation but slightly disjointed at times.	Economy of movement and maximum efficiency. Obviously planned course of operation with effortless flow from one move to the next.
Knowledge and handling of instruments	Lack of knowledge of instruments.	Competent use of instruments but occasionally awkward or tentative.	Obvious familiarity with instruments.
Suturing and knotting skills as appropriate for the procedure	Placed sutures inaccurately or tied knots insecurely and lacked attention to safety.	Knotting and suturing usually reliable but sometimes awkward.	Consistently placed sutures accurately with appropriate and secure knots and with proper attention to safety.
Technical use of assistants Relations with patient and the surgical team	Consistently placed assistants poorly or failed to us assistants. Communicated poorly or frequently showed lack of awareness of the needs of the patient and/or the professional team.	Appropriate use of assistant most of the time. Reasonable communication and awareness of the needs of the patient and/or of the professional team.	Strategically used assistants to the best advantage at all times. Consistently communicated and acted with awareness of the needs of the patient and/or of the professional team.
Insight/attitude	Poor understanding of areas of weakness.	Some understanding of areas of weakness.	Fully understands areas of weakness
	Limited documentation, poorly written.	Adequate documentation but with some omissions or areas that need elaborating.	Comprehensive legible documentation, indicating findings, procedure and postoperative management.

Please complete the relevant box:

Needs further help with:		Competent to perform the entire procedure without the need for supervision	
Date:		Date:	
Signed Trainer		Signed Trainer	
Signed Trainee		Signed Trainee	

Anaesthesia for Caesarean Delivery

Trainee Name:		**Assessor Name and qualification:**		**Date:**
Undergraduate University:		**Duration of Anaesthesia Block Undergrad:**		
Internship Location:		**Duration of Anaesthesia Internship training:**		
Post:				
Details of Case Assessed on				

Item Under Observation	**Performed Independently**	**Needs Help**
	Please Tick Relevant Box	
Preoperative Assessment:		
Physical Examination; identify if patient high risk for PPH		
Airway Examination		
Review for GA or Spinal Contraindications		
Preoperative Equipment Check:		
Anaesthesia Machine Check (See Check List)		
Tilting table with lateral arm supports		
Anaesthetic wedge		
Suction apparatus, suction tubing and Yankhauer nozzles		
Resuscitation Equipment Check:		
Defibrillator		
Ambubag		
Intubation Equipment Check:		
Laryngoscope (Size, ?Operational)		
Stylet/Laryngoscope handle with batteries		
Laryngoscope blades (size 3 and 4)		
Stylet/bougie/introducer		
Magill's forceps		
Cuffed endotracheal tubes (sizes 6.0, 6.5, 7.0, 7.5)		
Syringe to inflate cuff		
Strapping		
Laryngeal mask airways (sizes 3 and 4), or equivalent supraglottic airway		
Stethoscope to confirm intubation		
Cricothyroidotomy set (scalpel handle and blade)		
Preparation Patient:		
Premedication – sodium citrate 30ml orally, 0 - 30 minutes pre-operatively		
Good IV access, with 500ml clear fluid given as preload		
Urinary catheter		
Draw up essential drugs:		
Phenylephrine/ephedrine/etilephrine		
atropine		
suxamethonium		
induction agent		

Item Under Observation	**Performed Independently**	**Needs Help**
Spinal Technique:		
Measure NIBP before starting, and set NIBP to read at 1 minute intervals AND Feel for volume of patient's pulse AND apply pulse oximeter AND apply ECG		
Administer 500ml of Ringer's lactate (or similar) while performing the		

spinal		
Lumbar Puncture technique:		
Appropriate needle insertion technique and direction		
Understanding of spinal anatomy		
Use of Pencil Point Needle and method		
Actions after Spinal administered:		
Wedging		
Head and Shoulders raised		
Monitor NIBP at **one** min intervals		
Communicate with patient		
Continue careful fluid administration		
40% Facemask oxygen		
Rapid administration of reactive vasopressor and/or prophylactic infusion if any sign of hypotension		
Assessment of level of block, knowledge of required level for CD		
Haemorrhage management:		
Understands risk factors for haemorrhage		
Knows when bleeding is excessive e.g. HD compromise, >1L		
Appropriate oxytocic management: (2.5 plus 20 units at 125ml/hr)		
Recovery management		
Understands need for recovery		
Documents level of spinal and completes postoperative charts		
Checks for PPH: haemodynamics and visible bleeding		
Knows discharge criteria after neuraxial anaesthesia		
Knowledge of action if failed spinal:		
Wait at least 20 minutes		
Options:		
Immediate conversion to GA (circumstances favouring this??)		
Supplementation and top up with Local Anaesthesia and Ketamine (circumstances favouring this??)		
Wait and repeat spinal. (NOT advised)		
Abandon Local attempt and refer (circumstances favouring this??)		
General anaesthetic technique		
Monitoring and positioning as with after insertion of spinal		
Intravenous line running, with ringer lactate or equivalent		
Preoxygenation with tight fitting mask, 100 oxygen for 5 vital capacity breaths		
Induction: RSI with sleep dose of induction agent, cricoid pressure and suxamethonium		
Intubate and confirm ETT position		
Maintenance: Volatile with 0.8 MAC of agent in oxygen/air		
Opioids after baby delivered; which one, how much?		
Additional muscle relaxants ?options plus oxytocic management		
Management of Failed intubation		
When to declare (after 2 unsuccessful attempts)		
Inform team and call for help		
Gentle mask ventilation – OXYGENATION		
Supraglottic airway insertion: 2 attempts		
Cannot intubate, cannot ventilate = surgical airway		
When to wake up or proceed		
Knowledge of Action if Cardiac Arrest:		
Informs team and call for help		
Deliver baby urgently (within 4 minutes)		
Immediate chest compression		
Immediate manual displacement of uterus		
BMV airway Mx		
Intubation		
Adrenaline bolus 1 mg/repeated each 3 minutes		
Recovery management		
Assesses level of consciousness		

Assesses adequacy of oxygenation and ventilation		
Check for PPH: haemodynamics and visible bleeding		
Knows discharge criteria after general anaesthesia		

Generic Technical Skills Assessment after **SPINAL and GA**
Assessor Please ring the Candidate's performance for each of the following factors:

Area	**Poor Performance** This is unacceptable as implies failed airway, failed resuscitation	Fair Performance	Good Performance
Preparation and Planning	Not aware of potential complications and failed to prepare	Gaps in Preparation for Potential complications	Careful planning to handle complications
Technical Skills	Poor handling of equipment, clumsy in use of needles, syringes and procedures	Achieves procedures, but lacking in finesse	Slick effective ivi access, lumbar puncture and intubation
Knowledge and handling of equipment	Unable to utilise monitors to assess patient conditions	Unfamiliar and slow in application of Blood Pressure cuff, oximetry and following monitoring	Slick use of monitors to reliably assess physiological condition of patient
Technical Use of Assistants and relations with patient and surgical team	Unable to utilise team members to achieve safe anaesthesia	Preparing the team for actions, instructs them on expected roles (cricoid pressure, assist patient positioning etc.)	Full control of the theatre team to ensure optimal outcome
Insight and attitude	Poor Understanding of areas of Weakness	Some understanding of areas of Weakness	Fully understands areas of weakness and has plans to correct the issues
Documentation	Limited Documentation, poorly written	Adequate documentation but some omissions or areas that need elaborating	Comprehensive legible documentation indicating procedure

Needs Further Help With:	Competent to perform Anaesthesia (spinal and GA) for caesarean Section without the need for further direct supervision.
*	
*	
*	
*	
Date:	Date:
Signed (trainer):	Signed (trainer):
Signed (trainee):	Signed (trainee):

DETAILS OF TRAINER:
Name:
Qualifications:
HPCSA no:

Core skills for the training of family physicians

Assess yourself against the national exit examination expectations for a newly qualified family physician for the skills presented below. Consider if you, your supervisors, and the patients can trust you completely or not quite yet, as you enter your own assessment of every skill.

Self-assess the core skills to help you develop your learning plan using the following assessment guide.

A: Only Theory:

Only theoretical knowledge regarding the skill's principles, indications, contraindications, performance and complications.

B: Seen or have had demonstrated:

Have theoretical knowledge regarding the skill and have seen or observed the skill demonstrated by someone else. Still need direct supervision.

C: Apply/Perform:

Have theoretical knowledge and performed the skill several times. Can be entrusted to perform the skill under indirect supervision.

D: Routine/Independent:

Fully entrusted to perform the skill independently, without supervision.

Clinical area	Skill	Self-assessment of skill
Perform common side-room tests	Use a glucometer	
	Use a haemoglobinometer	
	Perform a pregnancy test	
	Perform urinalysis	
	Venepuncture	
Adult health – General	Femoral vein puncture	
	Lumbar puncture	
	Routine intravenous access in adults	
	Lymph node excision biopsy	
	Perform point-of-care counselling and testing for HIV	
Adults – Musculoskeletal	Measure shortening of the legs	
	Aspirate and inject the knee joint	
	Inject tennis elbow or golfer's elbow	

Clinical area	Skill	Self-assessment of skill
	Interpret radiographs of joints and bones	
	Inject carpal tunnel syndrome	
	Inject De Quervain's tenosynovitis	
	Inject the shoulder and subacromial bursa	
	Inject trochanteric bursitis	
Adults – Abdomen	Incision and drainage of perianal haematoma	
	Interpret the abdominal radiograph in an adult	
	Proctoscopy	
	Interpret barium swallows	
Adults – Chest	Electrocardiogram set up, record and interpret	
	Interpret chest radiograph	
	Measure peak expiratory flow	
	Nebulise a patient	
	Pleural tap	
	Use inhalers and spacers	
	Perform and interpret exercise stress test	
	Perform and interpret office spirometry	
Adults – Urology	Penile block	
	Reduce a paraphimosis	
	Male medical circumcision	
	Drain hydrocele	
	Insert a urinary catheter	
	Insert a suprapubic catheter	
	Interpret intravenous pyelogram	
	Vasectomy	
Eyes	Excision of chalazion	
	Use a Schiotz tonometer	
	Fundoscopy	
	Instil drops or apply ointment	
	Remove foreign body from the eye	
	Test for squint	
	Washout of eyes (chemical burns)	
Ear, nose and throat	Assess hearing loss	
	Reduce a fractured nose	
	Remove a foreign body from ear and nose	
	Syringe, dry swab an ear	
	Take a throat swab	
	Manage epistaxis (cautery, packing)	
	Suture a pinna lobe	
	Drain a peritonsillar abscess	
Skin	Inject keloids	

Clinical area	Skill	Self-assessment of skill
	Phenol ablation of ingrown toenail	
	Excise sebaceous cyst (other lumps, bumps)	
	Apply a compression dressing to venous leg ulcer	
	Cryotherapy or cauterisation	
	Skin biopsy (punch and shave) or skin scrapes	
	Wide-needle aspiration biopsy lymph node	
Pregnancy	Obstetric ultrasound	
	Interpret antenatal growth chart	
	Assess foetal well-being during labour	
	Episiotomy and suturing	
	Examine progress during labour and use partogram	
	Normal vaginal delivery	
	Apply and interpret the cardiotocograph	
	Assess foetal movement and counsel use of kick chart	
	Assisted vaginal delivery (vacuum extraction or forceps)	
	Caesarean section and management of bleeding	
	Evacuation of uterus	
	Manual removal of placenta	
	Repair of third-degree tear	
	Pelvic ultrasound (transvaginal)	
Woman's health	Culdocentesis	
	Hormone implants	
	Laparotomy for ectopic pregnancy	
	Termination of pregnancy (medical and surgical)	
	Insertion of intrauterine contraceptive device	
	Papanicolau smears	
	Dilatation and curettage	
	Drainage/marsupialise Bartholin's abscess or cyst	
	Endometrial biopsy or sampling	
	Fine-needle aspiration biopsy of breast lump	
	Tubal ligation	
	Cervical polyp removal	
Newborn	Assess gestational age at birth	
	Counsel on Kangaroo mother care	
	Resuscitate a newborn	
	Umbilical vein catheterisation	
	Patient-centred consultation	
	Use genogram and eco-map	
	Develop and use flowcharts for chronic care	
	Motivate behaviour change	
	Assess and consult families, couples	

Clinical area	Skill	Self-assessment of skill
	Shared consultation to capacitate nurse practitioner	
	Counselling skills for HIV, termination of pregnancy, sexual assault	
	Break bad news	
	Mini–Mental State Examination	
	Use problem-orientated medical record	
	Conduct a family conference	
	Cope with language barriers	
	Holistic assessment and management	
	Sexual history and counselling	
	Calculate % burn	
	Manage choking	
	Prescribe oxygen using a variety of devices i.e. nasal prongs, face masks, non-invasive CPAP	
	Immobilise the spine using blocks, straps, spinal boards, collars and spider harness	
	Insert an advanced airway i.e. endotracheal tube, laryngeal mask	
	Measure the Glasgow Coma Scale	
	Administer rabies prophylaxis	
	Advanced cardiopulmonary resuscitation – Adult	
	Advanced cardiopulmonary resuscitation – Child	
	Debride wounds or burns	
	Gastric lavage	
	Give a blood transfusion	
	Incision and drainage of abscesses	
	Insert chest drain	
	Insert nasogastric tube	
	Interpret radiographs in trauma	
	Emergency venous access i.e. intravenous cut down, femoral line	
	Manage snake bite	
	Primary survey	
	Relieve tension pneumothorax	
	Remove a foreign body from skin i.e. splinter, fish hook	
	Secondary survey	
	Selecting emergency equipment for doctors bag or emergency tray	
	Debride and suture lacerations	
	Prepare and stabilise a critically ill patient for transport	
	Cricothyroidotomy	
	Insert central line	

Clinical area	Skill	Self-assessment of skill
	Connect a patient to a ventilator and monitor the patient	
	Perform cardiac pacing using chemical or mechanical means	
	Perform synchronised cardio version	
	Perform arterial sampling: adult and child	
	Classify patient according to triage system	
	Apply finger and hand splints	
	Apply casts to upper and lower limb	
	Closed reductions on hand, forearm, tibia, fibula	
	Set up skeletal and skin traction	
	Reduce elbow dislocation	
	Reduce hip dislocation	
	Reduce radial head dislocation	
	Reduce shoulder dislocation	
	Excise ganglion	
	Amputations – fingers	
	Apply club foot cast	
	Debridement of open fractures	
	Emergency fasciotomy	
	Injections – intra-dermal, subcutaneous, intramuscular, deep intramuscular	
	Ring block	
	Check Boyle's machine	
	Control airways with mask	
	General anaesthetic (inhalation and intravenous induction)	
	Intubate and ventilate patient	
	Ketamine anaesthesia	
	Monitor patient during anaesthetic	
	Monitor patient during recovery	
	Reverse muscle relaxation (mixed drugs)	
	Select an appropriate circuit – Magill Circle, T-piece	
	Spinal anaesthetic	
	Ventilate patient using mask and bag	
	Biers block	
	Brachial block	
	Administer conscious sedation and monitor the patient	
	Assess growth and classify malnutrition	
	Capillary blood sampling – finger and heel	
	Assess chest radiograph in child	
	Developmental assessment	
	How to do and interpret Tine and Mantoux tests	

Clinical area	Skill	Self-assessment of skill
	Intraosseous line	
	Intravenous access in a child	
	Lumbar puncture in a child	
	Manage problems using the integrated management of childhood	
	Suprapubic bladder puncture	
	Venepuncture – upper limb and external jugular vein	
	Manage neonatal jaundice with phototherapy	
	Complete sick certificates	
	Complete death certificates	
	Certify patient under Mental Health Care Act	
	Writing appropriate referral letters	
	Managing a clinic for chronic care, for example, HIV and ARVs	
	Perform work assessment and complete disability grant forms	
	Assess, manage and document drunken driving	
	Assess, manage and document interpersonal violence	
	Assess, manage and document sexual assault	
	Complete J-88 form following assault	
	Counselling of a dying patient	
	Hypodermoclysis (subcutaneous infusion)	
	Set up a syringe driver	
	Contribute to the development or revision of guidelines	
	Facilitate the implementation of clinical guidelines within the subdistrict	
	Improve quality of care by facilitating quality improvement cycles (including the audit of clinical care as one step in the cycle)	
	Improve cost-effectiveness through reflection on routinely collected data, particularly rational prescribing and use of investigations	
	Build capability and quality care through teaching, training and mentoring	
	Critically appraise new evidence	
	Appraise the competence of new clinicians and set appropriate levels of independence versus support	
	Evaluate the quality of care in relation to the relevant clinically orientated national core standards	
	Do a home visit	
	Make a community diagnosis, and interpret and prioritise health indicators	

Clinical area	Skill	Self-assessment of skill
	Promote health in communities	
	Plan and implement a teaching or continuing professional development activity	
	Use a portfolio of learning	
	Mentor a colleague	
	Facilitate small group learning	
	Prepare and give a presentation	

Elective skills identified as relevant in some settings to the training of family physicians

Clinical area	Skill	Self-assessment of skill
Perform common side-room tests	Microscopy of vaginal discharge (wet mount, potassium hydroxide)	
	Microscopy of urine	
Adult health – General	Bone marrow puncture technique and smear	
	Microscopy of cerebrospinal fluid	
	Thin and thick smears for malaria	
	Doppler ultrasound – For peripheral vascular disease	
Adults – Abdomen	Abdominal ultrasound	
	Gastroscopy	
	Helicobacter pylori testing	
	Peritoneal dialysis	
	Repair a hernia	
	Sigmoidoscopy	
	Liver biopsy	
	Appendicectomy	
	Injection of haemorrhoids	
	Rubber-banding of haemorrhoids	
Adults – Chest	Echocardiogram	
	Pleural biopsy	
Adults – Urology	Hydrocoelectomy	
	Bilateral capsular orchidectomy	
	Cystoscopy	
	Prostate biopsy	
Eyes	Slit-lamp examination	
ENT	Indirect laryngoscopy	

Clinical area	Skill	Self-assessment of skill
	Tonsillectomy or adenoidectomy	
Skin	Skin patch testing	
Woman's health	Cone biopsy of cervix	
	Colposcopy	
	Hysterectomy	
	Large loop excision of the transformation zone for cervix	
Pregnancy	Amniocentesis	
	Clinical pelvimetry	
Orthopaedics	Open reductions – pins and screws	
Child health	Extradural tap	
Dental	Dental extraction	
	Wiring of teeth for mandibular fracture	
Forensic	Medico legal post-mortem	
Anaesthetics	Epidural	
Emergencies	Perform a focussed assessment sonar for trauma (FAST scan)	

Feedback on skills

Date completed:
Specific feedback on the trainee's performance by supervisor: What was done well…   What could be done even better…   What should be changed/stopped…
Name of supervisor Signature supervisor
Signature trainee

Divider:

Courses,

Congresses,

Workshops, EM

Meds Certificates

SECTION 9

COURSES, CONGRESSES, WORKSHOPS, EM MEDS CERTIFICATES

Attendance at, or own presentations, of post-graduate meetings, lectures, workshops, symposia or congresses relevant to Family Medicine
(Attach *Certificates of Attendance* if applicable)

Date	**Duration (hrs)**	**Presenter** (Self/other)	**Topic**	**Event**

CERTIFICATES of Courses relating to Family Medicine

(Copies of Certificates *must* be attached)

COURSE	**INSTITUTION**	**DATE**	**COURSE DIRECTOR**

ANY OTHER LEARNING EXPERIENCE RELEVANT TO FAMILY MEDICINE, that has not been captured, e.g. journal article publications:

Certificates of Training in Emergency Medicine

Evidence of competency in emergency medicine is a requirement to sit the FCFP (SA) examinations of the CMSA.

Please insert your proof of competency in this section. These will include various ATLS, ACLS, PALS, AMLS, DipPEC, or other courses.

Divider:

Annual Assessment

SECTION 10

Standard National Family Medicine Postgraduate Portfolio Assessment Tool (PAT): Annual assessment

Three satisfactory annual portfolio scores (≥60%) are needed for verification to the CMSA that the candidate is ready for the Final Part A Exam. Numbers 1-6 below add up to 90 points and can be completed by a competent administrative person as the information is already in the portfolio, while the HOD/Program manager completes point 7 (…./10), to give a final score out of 100.

1. A learning plan (section 3) for each allocation undertaken and a minimum of 2 per year. Missing learning plans should be scored as zero. If there are more than two learning plans, but one is not scored, take the average score of those scored. Take the average of each learning plan's scores as the year's score.

Learning plans	First learning plan score	Second learning plan score	Third learning plan score	FINAL AVERAGE (…...../10):

2. Report/Reflection on Allocations (Section 3)**: Portfolio cannot be seen as acceptable overall if a report is missing**. The portfolio has a global assessment out of 10 that can be used as an overall score for the allocation. Take the average of each allocation's scores as the year's score.

Supervisor report	First report score	Second report score	Third report score	FINAL AVERAGE (…...../10):

3. Educational meetings (Section 4): Add up the number of hours recorded (round each meeting to the nearest half hour) (section 4) and divide the total by 4 to give a score for the year. The max score possible is 10. In addition give 2 points for each national outcome addressed if it appears at least once in the portfolio (A, B, C, D, E, F) to a max of 10. Add the two scores together to give a score out of 20. Then divide by 2 to give a final score for the year out of 10.

Educational Meetings	Score for hours (Total hours/4)=	2 Points per outcome A-F	A, B, C, D, E, F Score for categories =	TOTAL (…./10):

4. Observations of consultations presented (section 5): Calculate the average score for the 9 best observations and 1 teaching observation. Each observation should already have been scored out of 10. Missing observations should be counted as zero (if there are less than 10 observations). Add up all the sores and divide by five to give a value out of 20.

Observations (each scored …../20	1	2	3	4	5	6	7	8	9	10	FINAL AVERAGE (……./20)

5. Multi-source Feedback score (Section 6):_____/10

6. Clinical governance activity (Section 7): Rate the quality of the candidates' involvement in clinical governance activity. Must include at least two different types of activities. If only one type of activity is included i.e. M&Ms only rate the one type, take the mean score and divide by two. If more than one type of activity take the mean of each type.

	Activity Type (i.e. M&Ms)	Mean score (10)
Activity 1		
Activity 2		
Activity 3		
Total	Divide the mean score by the number of different activity types	/ 10

*Required by CMSA

7. Logbook (section 8): Score this out of 20 based on the scores obtained for the 10 best observed/video-recorded skills assessed via DOPS.

Total scores for the skills (…./20)		SCORE (……/20):

8. Section 10: The Program Manager will make a global rating of the portfolio (Also using the reflections on learning in section 3, and a Likert scale.)

SCORE SELECTED (……...../10):

1 Poor	2 Barely adequate	3 Average	4 Good	5 Excellent
Reflections on allocations[1]:				
Describes what happened: Only experiences or clinical activities are described.	*Describes one's reactions:* Writing shows self-awareness in terms of one's thoughts, feelings and context.	*Critical analysis of learning:* Writing shows critical analysis with development of more abstract conceptualization of new knowledge, skills and personal growth.	*Critical analysis of learning and learning needs:* Writing also shows critical analysis of what must still be learnt or focused on next.	*Critical analysis of learning, learning needs and practical planning*: Writing also shows how these new learning needs have been translated into future plans.
1 Poor	2 Barely adequate	3 Average	4 Good	5 Excellent
Organization of portfolio:				
Incomplete or many areas disorganized or filled in mostly at the end of the year.	Complete with a few areas disorganized but completed throughout the year.	Complete and organized in a systematic way. Completed throughout the year.	As before but presented in an exemplary way.	As before but with innovative additional evidence such as photos, videos, patient reports.

*[1]Koole et al. BMC Medical Education 2011, 11:104

Year_____

The portfolio is: Poor Barely adequate Average Good Excellent

Portfolio Assessment Tool (PAT) Score ...…….../100

Recommendations:

_____

Signed:_____

HOD/Programme manager name:

_____ Date:_____