Case based discussion (CbD)

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| --- | --- | --- | --- |
| **Trainee name:** |  | **Training Phase:** |  |
| Assessor name: |  | Registration no: |  |
| Grade of assessor:  |  | Date |  |
| **Case discussion** | **Curriculum elements covered** |
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| **Please TICK to indicate the standard of the trainee’s performance in each area**  | *Not observed* | *Further core learning needed* | *Demonstrates good practice* | *Demonstrates excellent practice* |
| *Must address learning* | *Should address learning* |
| Underpinning principles |  |  |  |  |  |
| Safety issues |  |  |  |  |  |
| Record keeping |  |  |  |  |  |
| Team management  |  |  |  |  |  |
| Diagnosis |  |  |  |  |  |
| Treatment |  |  |  |  |  |
| Planning for subsequent care  |  |  |  |  |  |
| Clinical reasoning |  |  |  |  |  |
| Overall clinical care |  |  |  |  |  |
| Adherence to Good Medical Practice  |  |  |  |  |  |

Case based discussion (CbD) (cont.)

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| --- | --- | --- | --- |
| **Trainee name:** |  | **Training Phase:** |  |
| Assessor name: |  | Registration no: |  |
| Grade of assessor:  |  | Date |  |
| **Areas of strength** |
|  |
| **Areas for improvement** |
|  |
| **Action plan** |
|  |
| Assessor Signature: | Trainee Signature: |

**Guidance notes for rating satisfactory or unsatisfactory performance**

**Case Based Discussions (CbD)**

The following table provides descriptors of expected or satisfactory behaviour

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| **Domain** | **Expected behaviour** |
| Record keeping | Records should be legible and signed and dated. Should be structured and include provisional and differential diagnoses, initial clinical findings & monitoring data. |
| Review of clinical findings & monitoring | Undertook appropriate clinical examination & monitoring. Results are recorded and correctly interpreted with appropriate reassessments. |
| Diagnosis | The correct provisional diagnosis was achieved with an appropriate differential diagnosis. Were any important conditions omitted? |
| Treatment | Emergency treatment on scene and during transfer was correct, thoroughly documented and response recorded including adverse events. |
| Planning for subsequent care & handover of care | Clear plan demonstrating expected clinical course, recognition of and planning for possible complications and instructions to team and patient (if appropriate). Evidence of thorough handover to the provider of ongoing care. |
| Clinical reasoning | Able to integrate the history, examination and investigative data to arrive at a logical diagnosis and appropriate treatment plan taking into account the patient’s co-morbidities and any special considerations for the relevant patient group |
| Patient safety issues | Able to recognize effects of systems, process, environment and staffing on patient safety issues |
| Overall clinical care | The case records and the trainees discussion should demonstrate that this episode of clinical care was conducted in accordance with good clinical practice and to a good overall standard |
| Incident debrief | There should be evidence that the incident has been debriefed |

The following table provides descriptors of unsatisfactory behaviour

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| **Observed behaviour** |
| Did not understand the indications and contraindications to the procedure |
| Did not properly explain the procedure to the patient |
| Did not understand relevant anatomy |
| Failed to prepare properly for the procedure |
| Did not communicate appropriately with patient, crew or staff |
| Aseptic precautions were inadequate |
| Did not perform the technical aspect of the procedure correctly |
| Failed to adapt to unexpected problems in the procedure |
| Failed to demonstrate adequate skill and practical fluency |
| Was unable to complete the procedure |
| Did not complete relevant documentation |
| Did not issue clear post procedural instructions to patient, crew or staff |
| Did not maintain an appropriate professional demeanour |