National Prevocational Framework Review

Draft consultation documents - Attachment A

TRAINING & ASSESSMENT

TRAINING AND ASSESSMENT REQUIREMENTS FOR PREVOCATIONAL (PGY1 & PGY2) TRAINING PROGRAMS

Contents

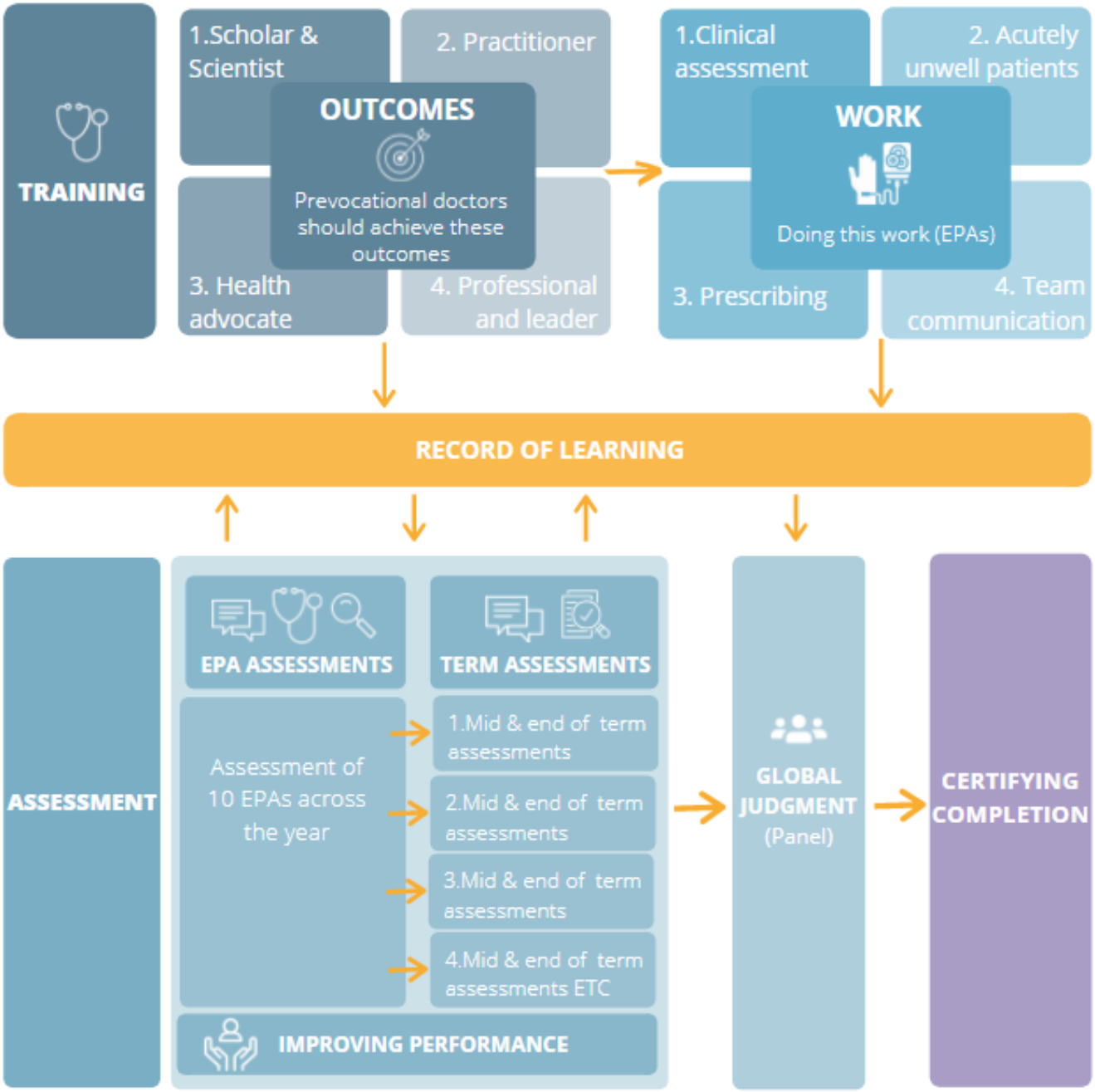
1. About this document

This document contains the Draft Training and Assessment requirements for Prevocational doctors (PGY1 and PGY2) that forms part of the National Framework for Prevocational Medical Training. The following provides a summary of the areas for consultation in this document.

Summary of areas for consultation

Component	Section	Status in review
Training	2A. Outcome statements	Draft revised document consulted on in September – November 2020 and March – April 2021. This draft includes feedback and changes made in response to previous consultation as well as new outcomes related to Aboriginal and Torres Strait Islander health.
	2B. Entrustable professional activities	Initial draft document consulted on in September – November 2020. Draft revised document consulted on in March – April 2021. This draft includes feedback and changes made in response to previous consultation and new behaviour descriptors related to Aboriginal and Torres Strait Islander patients.
	2C. Record of learning	Draft outline was consulted on in March – April 2021. No new major changes
Assessment	3A-C. Assessment process	Draft revised document consulted on in March – April 2021. This draft includes changes made in response to feedback in the previous consultation as well as processes for assessing Aboriginal and Torres Strait Islander outcomes.
	3D. Forms – Term assessment form	The initial revisions to the term assessment form were included in the March-April 2021 consultation. This draft includes changes made in response to feedback in the previous consultation and has no new major changes.
	3E. Forms – EPA assessment form	The first draft of the EPA form was included in the March-April 2021 consultation. This draft includes changes made in response to feedback in the previous consultation and has no new major changes.

Diagram summarising components



2. Prevocational training

A. Draft revised - Prevocational Outcome statements

Introduction

Update since last consultation

Stakeholder feedback	Response
Feedback on revisions to the outcome statements were broadly supportive and feedback detailed mostly minor revisions to wording in the domains.	Further minor adjustments made to wording in response to March – April 2021 stakeholder feedback in green text.
Stakeholder feedback was broadly supportive of an individualised procedural list captured in the e-portfolio.	The AMC has confirmed that there will be a learner-centred list, captured in the e-portfolio which will include a basic list as a drop-down menu and free text spaces for additional procedures.
There was emphasis on the importance of consulting with Aboriginal and Torres Strait Islander stakeholders for relevant domains.	A Sub Group of the AMC Aboriginal, Torres Strait Islander and Māori Committee has drafted relevant outcomes for broader consultation. Consultation will include targeted workshops with Aboriginal and Torres Strait Islander organisations.
Stakeholders mentioned the increasing impacts of climate change on health, and the importance of addressing environmentally sustainable healthcare within the domains.	Additional text has been added to the introduction to Domain 3 to include reference to the impact of broader systemic issues on health. The introductory text of Domain 4 has been adjusted to emphasise the importance of system "stewardship".

Green text highlights changes made in response to April 2021 consultation feedback.

Revised text	Notes on changes
These outcome statements state the broad and significant capabilities that prevocational doctors should achieve by the end of their two-year prevocational programs. The high-level statements are applicable at completion of postgraduate year 1 (PGY1) and postgraduate year two (PGY2), though the level of expectation, responsibility, supervision, and entrustability of the outcomes will be different between the two years. The outcome statements form part of the two-year Training and Assessment framework for prevocational doctors. The statements, describing the capabilities of a prevocational doctor, are complemented by entrustable professional activities, which describe the characteristics of the work of prevocational doctors. Prevocational training providers are responsible for designing learning and assessment programs that will enable prevocational doctors to achieve these outcomes. The outcome statements provide clinical supervisors and training directors with clear criteria for determining progress and completion. It should be noted that achievement of the outcomes is a requirement of PGY1, with General Registration remaining at the end PGY1. The process for certifying completion at the end of PGY2 will include achievement of the outcomes and meeting the requirements of the	Introduction expanded to include postgraduate year two (PGY2) and to note the Medical Board of Australia's CPD requirements for PGY2. Areas relevant across all outcomes have been raised from the Domains into the introduction: • Importance of quality and safety • Good Medical Practice – not an outcome but an expectation of practice.

Medical Board of Australia's Registration Standard: Continuing Professional Development. It is assumed throughout this document that prevocational doctors are working within their scope of practice. Safe and high-quality practice is an expectation of all practitioners, at all stages of training, and all healthcare and training providers. Accordingly, prevocational training programs and prevocational doctors should take account of the work of the Australian Commission on Safety and Quality in Health Care; the National Safety and Quality Health Service (NSQHS) Standards and the NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health. All doctors should practice according to the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia.*	Based on stakeholder feedback, added statement on scope of practice. Additional document reference to emphasise the importance of quality and safety specific to the Aboriginal and Torres Strait Islander context.

The outcome statements are:

1 set within four domains[1].
2 to be achieved by the end of prevocational years (PGY1 and PGY2).
3 work-based, person-centred, and take account of the prevocational doctor's increasing responsibility for patient care under supervision.
4 designed to be sufficiently generic to cover a range of learning environments.

[1] The same four domains are used in the graduate outcome statements for medical students, and can be found in *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* [Internet]. Canberra: Australian Medical Council; 2012 [cited 2013 Sep 23]. Available from: http://www.amc.org.au/index.php/ar/bme/standards.

Domain 1: The prevocational doctor as scientist and scholar

This Domain is about the doctor who applies and expands their medical knowledge and evaluates and applies relevant evidence to their clinical practice. The doctor who recognises the importance of research and quality improvement and assurance to clinical practice and the broader healthcare system.

On completing training, Australian prevocational doctors are able to:

Original statement	Revised statement	Notes on change
1.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations at all stages of life.	1.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.	Changes to improve clinical relevance of Domain 1 and to reflect that paediatric exposure may not be guaranteed in all programs. Minor change in line with feedback.
New statement	1.2 Access, critically appraise and apply evidence from the medical and scientific literature to clinical and professional practice.	Changes to improve clinical relevance of Domain 1. Included 1.4 from graduate outcomes with edits. Based on stakeholder feedback, added in "professional".
Moved previous statement 1.3 Participate in quality assurance and quality improvement activities such as risk management and incident reporting.	1.3 Participate in quality assurance and quality improvement activities such as, peer review of performance, clinical audit, risk management, incident reporting and reflective practice.	Statement moved from Domain 3 with edits. Revised based on feedback. Also, to further align with CPD requirements. Based on stakeholder feedback, added in "reflective practice".
New statement	1.4 Demonstrate a knowledge of evidence informed medicine that supports and advances Aboriginal and Torres Strait Islander health.	In line with confirmed scope to strengthen Aboriginal and Torres Strait Islander health. New statement developed by the AMC Aboriginal, Torres Strait Islander and Māori Committee Sub Group.

Domain 2: The prevocational doctor as practitioner

This Domain describes the work expected of prevocational doctors in assessing and caring for patients including appropriately communicating, documenting, prescribing, ordering investigations, and transferring. It is expected that prevocational training will equip doctors with the broad skills they need to continue their education and practice in a range of settings.

On completing training, Australian prevocational doctors are able to:

Original statement	Revised statement	Notes on change
2.1 Place the needs and safety of patients at the centre of the care process. Demonstrate safety skills including effective clinical handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting.	2.1 Place the needs and safety of patients at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective clinical handover, graded assertiveness, delegation	Second sentence removed, captured in EPAs. Based on stakeholder feedback, added examples back in and strengthened emphasis on legal requirements. No further changes. Considered escalation within skills covered in 4.4.

	and escalation, infection control, and adverse event reporting.	
2.2 Communicate clearly, sensitively and effectively with patients, their family/carers, doctors and other health professionals.	2.2 Communicate sensitively and effectively with patients, their family/carers, and health professionals applying the principles of shared–decision making and informed consent.	Minor wording changes. Revised based on stakeholder feedback. Noted feedback regarding shared - decision making. Statement added to introduction about the expectation that prevocational doctors are working within their scope.
New statement	2.3 Demonstrate effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework, inclusive of Indigenous knowledges of well-being and health models to support Aboriginal and Torres Strait Islander patient care.	In line with confirmed scope to strengthen Aboriginal and Torres Strait Islander health. New statement developed by the AMC Aboriginal, Torres Strait Islander and Māori Committee Sub Group
2.3 Perform and document a patient assessment, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis.	2.4 Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and summary of the patients' health issues.	Original: Minor wording changes. Revised based on stakeholder feedback.
2.4 Arrange common, relevant and cost-effective investigations, and interpret their results accurately.	2.5 Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of cost-effectiveness.	Wording changes to improve clarity. Revised based on stakeholder feedback. Considered environmental sustainability might be outside prevocational doctor's scope in this outcome statement but considered in relation to system stewardship in Domain 3.
2.5 Safely perform a range of common procedural skills required for work as an intern.	2.6 Safely perform a range of common procedural skills required for work as a PGY1 or PGY2 doctor.	Minor wording changes. Determined not to create a generalised procedural list. Intend that the e-portfolio will capture individualised procedural lists. Common procedures will vary based on teams and experiences. Based on stakeholder feedback, procedural list will remain learner-centred though a drop down of examples of common procedures will be provided in addition to free text.
2.6 Make evidence-based management decisions in	2.7 Make evidence-informed management decisions and referrals using principles of	Made change based on stakeholder feedback, also to

conjunction with patients and others in the healthcare team.	shared decision-making with patients, carers and the healthcare team.	encompass allied health treatments. Note change made to introduction regarding scope of practice.
2.7 Prescribe medications safely, effectively and economically, including fluid, electrolytes, blood products and selected inhalational agents.	2.8 Prescribe therapies and other products including drugs, fluid, electrolytes, and blood products safely, effectively and economically.	Change to include allied health treatments. Moved allied health reference to 2.6 to recognise role in referral not prescribing. Practicing within scope covered in introduction. Feedback regarding environmental impact to be considered as part of system stewardship in separate domain.
2.8 Recognise and assess deteriorating and critically unwell patients who require immediate care. Perform basic emergency and life support procedures, including caring for the unconscious patient and cardiopulmonary resuscitation.	2.9 Recognise, assess, communicate and escalate as required, and provide immediate management to deteriorating and critically unwell patients.	Removed detail. Removed detail, current wording about deteriorating patient recognises broader than physical, encompasses mental health. Made change based on stakeholder feedback. Basic life support covered in EPAs.
2.9 Retrieve, interpret and record information effectively in clinical data systems (both paper and electronic).	2.10 Appropriately utilises and adapts to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making.	Expanded from previous statement to encompass flexible and adaptive practice in context of changing systems and technology. Revised wording based on feedback. The previous attribute was focused on information management; this has now been incorporated in 2.3.

Domain 3: The prevocational doctor as a health advocate

This Domain describes the doctor who applies whole of person care and partners with their patients in their care. Whole of person care includes consideration of all dimensions of a person that can affect their overall health. These dimensions include but are not limited to, an individual's geographical location, culture, sexual orientation, gender identity and any disabilities. Recognising the broader determinants of health have tangible effects on their patients and considering their context as well as broader systemic issues. Including understanding and considering how these factors influence a patient's symptoms, interpretation, presentation and behaviours. Behaviour as an advocate occurs as a response to acknowledgment of the disempowerment that patients may experience as they access the health system. As a health practitioner, the prevocational doctor will consider their own biases and reflect on their impact on their practice. [Added in response to feedback]

On completing training, Australian prevocational doctors are able to:

Original statements	Revised statements	Notes on change
3.1 Apply knowledge of population health, including issues relating to health inequities and inequalities; diversity of cultural, spiritual	3.1 Incorporate disease prevention, relevant health promotion and health surveillance into interactions with individual patients. Including screening for common diseases, chronic	Made more relevant to PGY1/PGY2 level interactions with patients and separated statements to

and community values; and socio-economic and physical environment factors. 3.3 Demonstrate ability to screen patients for common diseases, provide care for common chronic conditions, and effectively discuss healthcare behaviours with patients.	conditions, and discuss healthcare behaviours with patients. 3.2 Apply whole of person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs. Acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources. 3.3 Demonstrate culturally safe practice with ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.	clarify meaning: 1. Population health (includes screening for common diseases) 2. Whole of person care 3. Culturally safe care (aligned with AHPRA definition). Made revisions based on feedback. Removed "appropriate" based on stakeholder feedback. Feedback suggesting geographic location added. Considered covered in 'social' context. Added in broader issues of discrimination.
3.2 Apply knowledge of the culture, spirituality and relationship to land of Aboriginal and Torres Strait Islander peoples to clinical practice and advocacy.	3.4 Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander Peoples. This includes understanding current evidence around systemic bias as a determinant of health and how these biases maintain health inequity. 3.5 Demonstrate knowledge of the ongoing impact of colonisation and racism on the health and wellbeing of Aboriginal and Torres Strait Islander Peoples.	Consulting separately on this outcome statement with Aboriginal and Torres Strait Islander groups. Feedback received from first consultation suggesting two statements required to a) recognise the impact of colonisation and systemic racism and b) more broadly address cultural safety. This will be reviewed as part of further targeted consultation. In line with confirmed scope to strengthen Aboriginal and Torres Strait Islander health. New statement developed by the AMC Aboriginal, Torres Strait Islander and Māori Committee Sub Group.
New statement	3.6 Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare system. Where relevant, this should include communicating with caregivers and other health professionals.	New outcome on the patient's journey in the broader healthcare system. No new revisions.
3.4 Participate in quality assurance, quality improvement, risk management processes, and incident reporting.	Statement moved.	Moved to Domain 1 and revised.
New statement		
New statement		

Domain 4: The prevocational doctor as a professional and leader

[New text added to describe the broad intent of each Domain] This Domain describes the professional dimension of the doctor. The importance of ethical behaviours, professional values, optimising wellbeing, lifelong learning and teamwork. Responsibilities of the doctor also include supporting the health and well-being of individuals, communities and populations now and for future generations and taking responsibility for the sustainability of the healthcare system.

On completing training, Australian prevocational doctors are able to:

Original statement	Revised statement	Notes on change
4.1 Provide care to all patients according to *Good Medical Practice: A Code of Conduct for Doctors in Australia*, and demonstrate ethical behaviours and professional values including integrity; compassion; empathy; and respect for all patients, society and the profession.	4.1 Demonstrate ethical behaviours and professional values including integrity; compassion; self-awareness, empathy; patient confidentiality and respect for all.	Reference to Good Medical Practice moved to introduction as a requirement from the beginning not an outcome. Made revisions based on feedback.
4.2 Optimise their personal health and wellbeing, including responding to fatigue, managing stress and adhering to infection control to mitigate health risks of professional practice.	4.2. Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.	Minor wording changes. Revisions made in response to stakeholder feedback.
4.3 Self-evaluate their professional practice, demonstrate lifelong learning behaviours, and participate in educating colleagues.	4.3 Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback.	Minor wording changes. Added "and feedback" in response to feedback.
4.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.	4.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.	Minor wording changes. No new revisions.
4.5 Respect the roles and expertise of other healthcare professionals, learn and work effectively as a member or leader of an inter-professional team, and make appropriate referrals.	4.5 Respect the roles and expertise of healthcare professionals, learn and work collaboratively as a member of an inter-professional team.	Minor wording changes. No new revisions.
New statement	4.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.	New statement to support safe work environments for self and others. Revised to clarify.
New statement	4.7 Critically evaluate cultural and clinical competencies to improve culturally safe practice and create culturally safe environments for Indigenous communities. Incorporate into the learning plan strategies to	

	address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care.	
4.6 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.	4.8 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.	Minor wording changes. No new revisions.

B. Draft revised - Entrustable professional activities

Note: The draft EPAS have been developed using the Royal Australasian College of Physician Basic Training Curriculum EPA structure and content, with permission.

Summary

Please see consultation papers for details regarding the development of the EPAS.

The AMC has drafted four entrustable professional activities (EPAs) as part of the revised two-year framework. The EPAs aim to describe the key work of PGY1 and PGY2 doctors, providing clarity around the most important work and learning activities. Anchored to the prevocational outcome statements, the EPAs help to align the role, outcomes and assessment of PGY1 and PGY2 doctors. The assessment of EPAs will increase structured opportunities for observation, feedback and learning and inform global judgements at the end of terms/ years.

The AMC's thinking on the EPAs in the prevocational context is as follows:

- An EPA is a description of work: This contrasts with outcomes or capabilities which describe characteristics of the doctor.
- An EPA is not an assessment tool, but performance of an EPA can be assessed. The assessment of EPAs will include judgements about entrustability, the level of supervision required for the junior doctor to perform this work safely.
- While the same EPAs will be assessed for PGY1 and PGY2 doctors, they will be assessed at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work.
- Note: Information about the assessment of EPAS is detailed in SECTION 3 of this document.

Update since last consultation: The EPAs were reviewed in response to stakeholder feedback provided during the March – April formal consultation period.

Stakeholder feedback	Response
Overall, there was support for revisions made to the EPAs and the changes appear to have responded to earlier feedback.	Additional minor revisions that have been made in green text.
Requested specific EPAs or components of EPAs (e.g. mental health).	The EPAs are intended to include mental health presentations. Additional text has been added to EPA 2 to indicate that the EPA includes recognition and care of a rapid decline in mental health.

Green text highlights changes made in response to April 2021 consultation feedback.

Overview of the EPAs:

EPA	Summary
EPA 1: Clinical assessment	Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan. (Based on RACP's EPA 1)
EPA 2: Recognition and care of the acutely unwell patient	Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (Based on RACP's EPA 7)
EPA 3: Prescribing	Appropriately prescribe therapies (drugs, fluids, blood products, inhalational therapies including oxygen) tailored to patients' needs and conditions, either in response to a request by the treating team or self-initiated. (Based on RACP's EPA 4)

EPA 4: Team Communication – documentation, handover and referrals	Communication about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral. (Based on combining RACP's EPA 3 (documentation) and 5 (transfer of care))

Structure of the EPAS:

Component	Description
Theme	Identifies the activity.
Title	Provides brief summary of the activity.
Focus and context	Describes central aspects of the activity and in what clinical context it might apply.
Description	Provides overview of the key tasks involved in the activity.
Behaviours	Describes behaviours that could be observed and would support the supervisor to make judgments about the level of performance. The behaviours are anchored to the prevocational outcome statements and purposefully out of order to reflect the order of the activity. Sub points are included to provide further detail, where required, in an electronic format these could be minimised.

EPA 1

Theme: Clinical assessment

Title: Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan including appropriate investigations.

Focus and context: This EPA applies in admission, reviewing patient on request of particular concern, ward call tasks, ward round, lower acuity ED presentations, general practice consultations or outpatient clinical attendance.

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, where appropriate or possible:

1. if clinical assessment requested by a team member, clarify the concern(s) with them
2. identify pertinent information in the patient record
3. obtain consent from the patient
4. obtain history
5. examine patient
6. consider and integrate information from patient record, clinical assessments, and relevant ward protocols/ guidelines/ literature
7. develop provisional and differential diagnoses and/or problem lists
8. produce a management plan, confirm with senior colleague as appropriate, and communicate with relevant team members and the patient
9. implement management plan, initiate or perform appropriate investigations and procedures, document assessment and next steps, including indications for follow up

Behaviours:

Outcome	**Requires minimal supervision** *(I trust the prevocational doctor to complete the task, I need to be contactable/ in the building and able to provide general overview of work)* Examples of behaviours of a prevocational doctor who can perform this activity with minimal supervision.	**Requires direct supervision** *(I need to be there to observe the interactions and review the work)* Examples of behaviours of a prevocational doctor who requires direct supervision to perform this activity.
Domain 2: Practitioner	**Patient assessment** – history • Obtains person-centred histories tailored to the clinical situation in a culturally safe and appropriate way Sub-points • Reviews and identifies pertinent information in the patient's record to locate the problem in that patient journey • Identifies and uses collateral sources of information to obtain history when needed, such as family members, carers, and other health professionals **Aboriginal and Torres Strait Islander health** • Demonstrates cultural competence in working alongside Aboriginal and	**Patient assessment –** history • Exhaustively gathers information not pertinent to the presenting problem while missing necessary points. • Uses jargon and/or inappropriate acronyms • Does not listen to the patient effectively or give them space to speak. **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate their ability to: follow processes to routinely ask patients if

	Torres Strait Islander Peoples (patients and colleagues), and actively supports cultural safety within the clinical environment. **Patient assessment** - physical examination • Performs accurate, appropriate and person-centred physical examination and/or mental state exam **Patient assessment** – clinical reasoning • Filters, prioritises, and synthesises pertinent information for clinical problem solving <u>Sub -points</u> • Recognises and correctly interprets normal and abnormal findings • Formulates appropriate problem lists or differential diagnosis **Patient management** • Produces and implements appropriate management plan • Initiates appropriate, focused and basic investigations • Safely performs common procedures, where relevant <u>Sub- points</u> • Identifies patients' preferences regarding management and assesses the role of families in decision making **Communication** • Communicates accurately and effectively with the patient, carers, and team members <u>Sub points</u> • Clarifies the task or problem with the team member/s • Communication includes anticipating, reading, and responding to verbal and non-verbal cues • Demonstrates active listening skills	they identify as being of Aboriginal and/or Torres Strait Islander origin, and include; current Indigenous health evidence, exposure to the determinants of health and Indigenous health models within their practice. **Patient assessment** - physical examination • Performs inadequate physical examinations • Does not respect patient privacy, comfort and safety **Patient assessment** – clinical reasoning • Reaches conclusions unsupported by data or evidence such as history and examination findings • Unable to synthesise relevant information • Differential diagnosis is unsafe, unprioritised and/ or not contextualised • Develops a minimal list of potential problems with pertinent, major problems missed. **Patient management** • Unable to produce a basic management plan • Produces a management plan which does not address issues relevant to the patient • Does not confirm management plan with supervisor when appropriate **Communication** • When communicating with patient, carers or team members may do one or more of the following: ○ does not introduce themselves ○ does not listen carefully, ○ does not clarify ○ uses jargon ○ does not summarise to ensure shared understanding
Domain 4: Professional & leader	**Professionalism** • Demonstrates professional conduct, honesty and integrity • Recognises their own limitations and seeks help when required in an appropriate way <u>Sub points</u> • Maintains patient privacy and confidentiality	**Professionalism** • Displays lapses in professional conduct, such as acting disrespectfully or providing inaccurate or incomplete information • Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team-member

	• Displays respect and sensitivity towards patients • Maximises patient autonomy and supports patients' decision making • Takes responsibility and is accountable for patient care **Aboriginal and Torres Strait Islander health** • Demonstrates effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care. **Teamwork** • Works effectively as a member or leader of the interprofessional team, and positively influences team dynamics	concerns, or delay in responding to or asking for help for patients in need of urgent care. • Lacks insight into learning needs and does not seek or act on feedback • Inadequately maintains confidentiality, for example: ○ Gathering and displaying confidential information on patients **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care. **Teamwork** • Works in a way that disrupts effective functioning of the inter-professional team
Domain 3: Advocate	**Whole of person care** • Recognises and takes precautions where the patient may be vulnerable • Incorporates psychosocial considerations and stage in illness journey into assessment, acknowledging these factors can influence a patient's experience of illness and healthcare behaviours **Population health** • Incorporate disease prevention, health promotion and health surveillance into interactions with individual patients **Cultural safety** • Is respectful of patients' cultures and beliefs • Appropriately accesses interpretive or culturally-focused services • Identifies and considers culturally safe and appropriate means of obtaining patient histories and/or physical examination. **Aboriginal and Torres Strait Islander health**	**Whole of person care** • Disregards social history and the patient's goals of care/treatment in their assessment and management **Population health** • Does not consider population-based risk factors • Does not take opportunities to discuss healthcare behaviours **Cultural safety** • Does not take account of relevant cultural or religious beliefs and practices, for example diet, burial practices or processes for decision-making. • Demonstrates an inadequate awareness of, or difficulty accepting and understanding, the cultures of others **Aboriginal and Torres Strait Islander health**

	• Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues).	• Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples.
Domain 1: Scientist & scholar	**Knowledge** • Makes use of local service protocols, guidelines, to inform clinical decision making • Draws on medical literature to assist in clinical assessments, when required • Demonstrates the ability to manage uncertainty in clinical decision making **Quality assurance** • Performs hand hygiene and takes infection control precautions at appropriate moments • Advocates for and actively participates in quality improvement activities including incident reporting **Aboriginal and Torres Strait Islander health** • Demonstrates a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity.	**Knowledge** • Demonstrates poorly formed approaches to identifying local service resources to support clinical decision making • Cannot implement strategies to respond to clinical ambiguity and uncertainty such as ensuring patients and team members are clear about what to do if things change. **Quality assurance** • Demonstrates an undisciplined approach to hand hygiene and infection control **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity.

EPA 2

Theme: Recognition and care of the acutely unwell patient

Title: Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (This EPA recognises that PGY1/2 doctors often called after hours to assess patients whose situation has acutely changed)

Focus and context: This EPA applies in any clinical context but the critical aspects that differentiate it from EPA 1 are for the PGY1/PGY2 doctor to:

1. Recognise the acutely unwell and or deteriorating patient (including acute deterioration in mental health)
2. Act immediately, demonstrating a timely approach to management
3. Escalate appropriately

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments, in and after hours, and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to:

1. recognise clinical deterioration or acutely unwell patients
2. respond by initiating immediate management, including basic life support if required
3. seek appropriate assistance, including following the local process for escalation of care
4. communicate critical information in a concise, accurate and timely manner to facilitate decision making
5. lead the resuscitation initially, and involve other necessary services, such as intensive care or retrieval services

Behaviours:

Outcome	**Requires minimal supervision** *(I trust the prevocational doctor to complete the task, I need to be contactable/ in the building and able to provide general overview of work)* Examples of behaviours of a prevocational doctor who can perform this activity with minimal supervision.	**Requires direct supervision** *(I need to be there to observe the interactions and review the work)* Examples of behaviours of a prevocational doctor who requires direct supervision to perform this activity.
Domain 2: Practitioner	**Patient assessment** • Identifies deteriorating or acutely unwell patients **Patient management** • Initiates a timely structured approach management, actively anticipates additional requirements and seeks appropriate assistance • Identifies, where possible, patients' wishes and preferences about care, including CPR and other life-sustaining treatments (e.g. intubation and ventilation) • Demonstrates and applies knowledge of associated anatomy, physiology, indications, and potential risks and complications of resuscitation, if appropriate to the case	**Patient assessment** • Does not identify deteriorating or acutely unwell patients • Has difficulty gathering, filtering, and prioritising the critical data **Patient management** • Does not initiate timely basic management correctly • Does not seek appropriate assistance including inappropriate delay in escalating • Applies skills inconsistently, resulting in an inability to reliably complete procedures, such as inconsistent use of universal precautions and aseptic technique

	Sub points • Where appropriate, has discussions with patients about their rights to refuse medical therapy, including life-sustaining treatment • Involves patients or substitute decision maker, where appropriate, in discussions regarding treatment and end-of-life care **Communication** • Recognises the need for timely escalation of care and escalates to appropriate staff or service, following escalation in care policies and procedures • Communicates accurately and effectively with the healthcare team. • As appropriate, explains the situation to patients and/or carers in a sensitive and supportive manner, avoiding unnecessary jargon and confirming their understanding • Performs succinct, accurate, and complete handover of care of patients, including ongoing care requirements. **Aboriginal and Torres Strait Islander health** • Demonstrates cultural competence in working alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of an acutely unwell patient.	**Communication** • Inadequately escalates to senior colleagues • Communicates in an unclear manner with other team members regarding management • Explains the situation to patients and/or carers in an unclear or insensitive manner • Handover is inaccurate and/ or incomplete and/or missing critical information, including ongoing care requirements. **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and include; current Indigenous health evidence, exposure to the determinants of health and Indigenous health models within their practice, in the context of an acutely unwell patient.
Domain 4: Professional & leader	**Professionalism** • Recognises their own limitations and seeks help when required in an appropriate way • Demonstrates professional conduct Sub-points: • Maintains patient privacy and confidentiality • Displays respect and sensitivity towards patients • Maximises patient autonomy and supports patients' decision making • Demonstrates graded assertiveness. **Aboriginal and Torres Strait Islander health** • Demonstrates effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework	**Professionalism** • Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team-member concerns, or delay in responding to or asking for help for patients in need of urgent care. • ~~Demonstrates a defensive or argumentative attitude.~~ • Displays lapses in professional conduct, such as acting disrespectfully or providing inaccurate or incomplete information. **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate effective interpersonal skills, empathic communication, and

	inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of an acutely unwell patient. **Teamwork** • Works effectively as a member of a team and utilises other team members, based on knowledge of their roles and skills, as required **Self-education** • Seeks guidance and feedback from health care team to reflect on the encounter and improve future patient care • Participates in debrief sessions	respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of an acutely unwell patient. **Teamwork** • Avoids playing a leading role in the management of patients • Demonstrates inadequate team work **Self-education** • Lacks insight into learning needs • Does not seek or act on feedback on areas for improvement.

Domain 3: Advocate	**Cultural safety**
	• When appropriate:
	  ○ accesses interpretive or culturally-focused services.
	  ○ considers relevant cultural or religious beliefs and practices.
	
	Aboriginal and Torres Strait Islander health
	• Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), in the context of an acutely unwell patient.
		Cultural safety
		• Does not take account of relevant cultural or religious beliefs and practices.
		
		Aboriginal and Torres Strait Islander health
		• Requires further opportunities to demonstrate effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of an acutely unwell patient.

Domain 1: Scientist & scholar	**Knowledge** • Observes local service protocols and guidelines on acutely unwell patients **Quality Assurance** • Complies with escalation protocols maintains up-to-date certification in advanced life support appropriate to level of training. • Performs hand hygiene and takes infection control precautions at appropriate moments • Raises appropriate issues for review at quality assurance processes e.g. morbidity and mortality meetings **Aboriginal and Torres Strait Islander health** • Demonstrates a clear understanding	**Knowledge** • Demonstrates poorly formed approaches to identifying local service resources to support clinical decision making relating to acutely unwell patients **Quality Assurance** • Demonstrates an undisciplined approach to hand hygiene and infection control **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain

	of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity in the context of an acutely unwell patient.	health inequity in the context of an acutely unwell patient.

EPA 3

Theme: Prescribing

Title: Appropriately prescribe therapies (drugs, fluids, blood products oxygen) tailored to patients' needs and conditions

Focus and context: This EPA applies in any clinical context but the critical aspects are to:

1. Prescribe autonomously when appropriate, taking account of registration, health service policies, and individual confidence and experience with that drug or product
2. Prescribe as directed by a senior team member, taking responsibility for completion of the order to ensure it is both accurate and appropriate in the context of the patient

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, as appropriate and where possible:

1. obtain and interpret medication histories
2. respond to requests from team members to prescribe medications
3. consider whether a prescription is appropriate
4. choose appropriate medications
5. where appropriate, clarify with the senior medical officers, pharmacists, nursing staff, family members or clinical resources the drug, including name, dose, frequency and duration
6. actively consider drug/ drug interactions and/or allergies and if identified check whether to proceed
7. provide instruction on medication administration effects and side effects, using appropriate resources
8. elicit any patient concerns about the benefits and risks, as appropriate seek advice and support to address those concerns
9. write or enter accurate and clear prescriptions or medication charts
10. monitor medications for adverse reactions, efficacy, safety, and concordance
11. review medications and interactions, and cease where indicated, in consultation with the senior team members, including a pharmacist

Behaviours:

Outcome	**Requires minimal supervision** *(I trust the prevocational doctor to complete the task, I need to be contactable/ in the building and able to provide general overview of work)* Examples of behaviours of a prevocational doctor who can perform this activity with minimal supervision.	**Requires direct supervision** *(I need to be there to observe the interactions and review the work)* Examples of behaviours of a prevocational doctor who requires direct supervision to perform this activity.
Domain 2: Practitioner	**Prescribing** • Appropriately, safely, and accurately prescribes therapies (drugs, fluids, blood products, oxygen), and demonstrates an understanding of the rationale, side effects, risks– benefits, contraindications, dosage, routes of administration, and drug interactions • Initiates, modifies or ceases therapies (drugs, fluids, blood products, oxygen) safely, adheres to all relevant	**Prescribing** • Makes frequent and/ or critical prescribing errors • Initiates, modifies or ceases therapies (drugs, fluids, blood products, oxygen) beyond scope of practice (registration), health service protocols or their experience Sub-points: • Does not consider potential side-effects and practical prescription points, such as medication

	protocols and monitors patient reactions, reporting when relevant
	
	Aboriginal and Torres Strait Islander health
	• Demonstrates cultural competence in working alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of and prescribing.
	
	Patient management
	• As appropriate, monitors and adjusts medications
	• Identifies and manages potential and actual adverse events
	
	Communication
	• Ensures the patient understands the rationale and requirements of the treatment
	• Writes clearly legible prescriptions or charts using generic names as required
	• Understands the principles and is able to safely electronic prescribe and document medications
	• Informs treating team of changes to prescriptions
		compatibility and monitoring in response to therapies
		• Prescribes when it is not appropriate
		• Does not take into account the following factors for all therapies:
		  ○ contraindications
		  ○ cost to patients, families, and the community
		  ○ routes of administration
		  ○ funding and regulatory considerations
		  ○ generic versus brand medicines
		  ○ interactions
		  ○ risk–benefit analysis
		• Demonstrates an inadequate understanding of the rationale behind the choice of therapy
		• Unable to source suitable dosing guidelines or implement dose modifications based on organ function, patient age, or size
		• Demonstrates an inadequate understanding of fluid requirements, the compatibility of medications with intravenous fluids or the need for medication monitoring
		
		Aboriginal and Torres Strait Islander health
		• Requires further opportunities to demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and include; current Indigenous health evidence, exposure to the determinants of health and Indigenous health models within their practice, in the context of prescribing.
		
		Patient management
		• Does not follow up monitoring instructions or relevant test results.
		• Does not identify or manage adverse events
		
		Communication
		• Fails to explain the rationale for the treatment and other relevant information for example adherence issues, follow up and monitoring for side-effects, and the practical aspects of administration
		• Produces incomplete or inaccurate prescriptions or medication charts

		• Writes illegible prescriptions or drug orders or enters data into electronic systems incorrectly • Inadequately consults with the multidisciplinary team (including clinical supervisor ~~consultant~~ and/ or allied health professionals)
Domain 4: Professional & leader	**Professionalism** • Demonstrates professional conduct, honesty and integrity • Recognises their own limitations and seeks help when required in an appropriate way • Demonstrates an understanding of the regulatory and legal requirements and limitations regarding prescribing <u>Sub-points:</u> • Demonstrates an understanding of the ethical implications of pharmaceutical industry marketing and funded research • Maintains patient privacy and confidentiality • Maximises patient autonomy and supports patients' decision making **Aboriginal and Torres Strait Islander health** • Demonstrates effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of prescribing. **Clinical responsibility** • Reports adverse events related to medications **Teamwork** • Works collaboratively with the multidisciplinary team, including pharmacists and nursing staff • Participates in medication safety meetings and morbidity and mortality meetings	**Professionalism** • Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team-member concerns, or delay in responding to or asking for help **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of prescribing.
Domain 3: Advocate	**Cultural safety** • Appreciates patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological	**Cultural safety** • Does not consider patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological

	and non-pharmacological management approaches
	
	Aboriginal and Torres Strait Islander health
	• Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), in the context prescribing.
	
	Population health
	• Considers population level constraints on prescribing, including:
	  ○ economic costs to community
	  ○ antimicrobial resistance
		and non-pharmacological management approaches
		
		Aboriginal and Torres Strait Islander health
		• Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples in the context of prescribing.
		
		Population health
		• Does not consider population level constraints on prescribing, including:
		  ○ economic costs to community
		  ○ antimicrobial resistance

Domain 1: Scientist & scholar	**Knowledge** • Demonstrates knowledge of clinical pharmacology, including side effects and drug interactions, of the drugs they are prescribing • Makes use of local service protocols, guidelines, to ensure decision making is evidence-based and applies guidelines to individual patients appropriately **Quality Assurance** • Applies the principles of safe prescribing, particularly for drugs with a risk of significant side-effects, using evidence based prescribing resources, as appropriate • Prescribes in accordance with institutional policies, including policies on antibiotic stewardship • safely uses electronic prescribing systems as appropriate <u>Sub points:</u> • Applies information regarding side-effects and monitoring requirements of medications • Identifies medication errors and institutes appropriate measures uses electronic prescribing systems safely **Aboriginal and Torres Strait Islander health** • Demonstrates a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this current evidence around systemic bias as a determinant of health and how these biases maintain health inequity marginalisation in the context of prescribing.	**Quality Assurance** • Does not apply the principles of prescribing and/ or consider the use of evidence based prescribing resources • Does not prescribes in accordance with institutional policies • Displays inadequate knowledge of the monitoring requirements or potential side-effects of the medications they are prescribing **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity in the context of prescribing.

EPA 4

Theme: Team communication – documentation, handover and referrals

Title: Communicate about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral

Context and focus: This EPA applies to any clinical context but the critical aspects are to:

1. Communicate timely, accurate and concise information to facilitate transfer of care across various health sector boundaries including:
   - at referral from ambulatory and community care
   - at admission
   - between clinical services and multidisciplinary teams
   - at changes of shift
   - at discharge to ambulatory and community care
2. Produce timely, accurate and concise documentation of episodes of clinical care

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to:

1. Communicates effectively to
   - Facilitate high quality care at any transition point
   - ensure continuity of care
   - share patient information with other health care providers and multidisciplinary teams in conjunction with referral or the transfer of responsibility for patient care
   - use local agreed modes of information transfer, including oral, electronic and written format to communicate (at least):
     - patient demographics
     - concise medical history and relevant physical examination findings
     - current problems and issues
     - details of pertinent and pending investigation results
     - medical and multidisciplinary care plans
     - planned outcomes and indications for follow up
2. Documents effectively to:
   - enable other health professionals to understand the issues and continue care
   - produce written summaries of care, including admission and progress notes, team referrals, discharge summaries, and transfer documentation
   - produce accurate records appropriate for secondary purposes
   - complete accurate medical certificates, death certificates and cremation certificates
   - enable the appropriate use of clinical handover tools

Behaviours:

Outcome	**Requires minimal supervision** *(I trust the prevocational doctor to complete the task, I need to be contactable/ in the building and able to provide general overview of work)* Examples of behaviours of a prevocational doctor who can perform this activity with minimal supervision.	**Requires direct supervision** *(I need to be there to observe the interactions and review the work)* Examples of behaviours of a prevocational doctor who requires direct supervision to perform this activity.
Domain 2: Practitioner	**Information management**	**Information management** • Produces incomplete and/or inaccurate records that:

	• Produces medical record entries that are timely, accurate, concise and understandable • Document and prioritise the most important issues for the patient **Patient management** • Displays understanding of the details of patients' condition, illness severity, comorbidities and potential emerging issues summarising planned management including indications for follow up. <u>Sub -points:</u> • Uses a structured approach to thinking about patients' issues and prioritising these **Communication** • Creates verbal or written summaries of information that are timely, accurate, appropriate, relevant and understandable for patients and/ other health professionals <u>Sub-points:</u> • Accurately identifies key problems or issues • Ensures a suitable environment and adequate time for handover • Communicates clearly with patients, team members and other caregivers • Confirms information has been received and understood, and seeks questions and feedback	• Omit clinically significant history, examination findings, investigation results or management plans; and/or • Do not include identification details, entry date and time, signature, printed name, designation or contact details • Records or updates to documentation are not produced in a timeframe appropriate to the clinical situation • Develops minimal notes with pertinent, major issues missed. • Creates unstructured medical record • Makes illegible notes, uses jargon and/or inappropriate acronyms **Patient management** • Medical record lacks an overall impression or plan <u>Sub-point</u> • Doesn't form an appropriate structure for the clinical context e.g. use a traditional presenting problem history or systems-based structure **Communication** • Creates verbal or written summaries of information that are not timely, appropriate, relevant or understandable for patients and/or other health professionals and/ or carers • Uses language that may be offensive or distressing to patients or other health professionals • Does not mitigate the risks associated with changing care teams or environments • Inadequately summarises the active medical problems • Has an unstructured approach in transferring oral or written information • Includes unnecessary or irrelevant information • Omits significant problems • Inadequately clarifies treatment changes and clinical reasoning • Omits ongoing management plans, discharge medications, pending tests at discharge, or patient counselling

	Aboriginal and Torres Strait Islander health • Demonstrates cultural competence in working alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of team communication.	• Communicates in an inappropriate environment, such as handover in public places **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and include; current Indigenous health evidence, exposure to the determinants of health and Indigenous health models within their practice, in the context of team communication.
Domain 4: Professional & leader	**Professionalism** • Demonstrates professional conduct, honesty and integrity • Appropriately prioritises the creation of medical record entries • Informs patients that handover of care will take place and to which team, service, or clinician as appropriate • Maintains respect for patients, families, carers, and other health professionals, including respecting privacy and confidentiality <u>Sub-points:</u> • Complies with the legal requirements of preparing and managing documentation • Provides honest and accurate medical certification where required • Maintains confidentiality of documentation and stores clinical notes appropriately • Uses appropriately secure methods of clinical communication. • Maximises patient autonomy and supports patients' decision making • Takes responsibility for their actions/ is accountable **Aboriginal and Torres Strait Islander health** • Demonstrates effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and	**Professionalism** • Assigns a low priority to the creation of medical record entries when ordering daily tasks, such as deferring it to the end of the day or clinic leading to delays that may affect patient care or the quality of the record • Inappropriately delays preparing transfer documentation and/or undertaking transfer communications • Inadequately maintains confidentiality, for example: ○ Gathering and displaying confidential information on patients, such as information displayed on a list that the patient's relatives could access, or sharing information that is not relevant to patient care • Displays lapses in professional conduct, such as providing inaccurate or incomplete information **Teamwork** • Does not engage with nursing staff and/or other relevant allied health practitioners • Omits or disregards key information from other team members in handover **Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate effective interpersonal

	emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of team communication.	skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander Peoples patient care in the context of team communication.
Domain 3: Advocate	**Whole person care** • Considers social/economic context for example: • Factors transport issues and costs to patients into arrangements for transferring patients to other settings • Appropriately prioritises social history and cultural factors **Cultural safety** • Includes relevant information regarding patients' cultural or ethnic background in the handover and whether an interpreter is required **Aboriginal and Torres Strait Islander health** • Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples (patients and colleagues), including an understanding of what services are available and discussing with the patient/family/community to find out their preferences around accessing these services.	**Whole person care** • Disregards social history or cultural factors and their management in transfer of care documentation. **Cultural safety** • Demonstrates insensitivity or lack of awareness of relevant cultural issues such as not specifying when an interpreter is required • Uses language that may be offensive or distressing to patients or other health professionals **Aboriginal and Torres Strait Islander health** • Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander Peoples, including an understanding of what services are available and discussing with the patient/family/community to find out their preferences around accessing these services.
Domain 1: Scientist & scholar	**Quality Assurance** • Maintains records sufficiently to enable optimal patient care and secondary use of the document such as adequate coding, incident review, research or medico-legal proceedings • Ensures all outstanding results or procedures will be followed up by receiving units and clinicians <u>Sub-points:</u> • Provides and receives feedback to and from team members regarding handovers and any errors that occurred, including inaccurate information transmission	**Quality Assurance** • Does not maintain records adequately • Produces records lacking key information regarding episodes of care • Uses ambiguous or inappropriate acronyms • Performs incomplete handover • Omissions and errors in transfer of care communications • Transfer of care communications are not undertaken in a timely manner

	• Communicates accurately and in a timely fashion to ensure an effective transition between settings, and continuity and quality of care **Aboriginal and Torres Strait Islander health** • Demonstrates a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity in the context of team communication.	**Aboriginal and Torres Strait Islander health** • Requires further opportunities to demonstrate a clear understanding of Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence around systemic bias as a determinant of health and how these biases maintain health inequity in the context of team communication.

C. Record of Learning

Update since last consultation:

Proposal to include a record of learning in the revised two-year framework.	The March - April 2021 consultation sought feedback on a proposal that record of learning be incorporated in the revised framework and captured in the e-portfolio. Stakeholder feedback was supportive of the record of learning and suggested areas to be included. Agreed this will be included in the revised framework and additional detail added below. The specifics will need to be developed alongside the e-portfolio.

The revised framework will include a Record of Learning which will be captured in an e-portfolio. The record of learning will include the following components:

1. **Access to training and assessment material:**
    - Outline of and access to training requirements (outcome statements and EPAs).
2. **Record of training and assessment:**
    - Record of longitudinal achievement/progress against outcome statements and EPAs.
    - Record of assessments.
    - Record of additional education training (export/ import) e.g. Basic Life Support or hand hygiene.
    - Record of Medical Board of Australia CPD activities (PGY2).
    - Record of procedures - for prevocational doctor to add procedures (not prescribed list).
    - Space for prevocational doctors' goals and reflections

Note: this section will continue to be developed as the detailed requirements for the e-portfolio are developed. See the e-portfolio specifications at **ATTACHMENT D** for further details.

3. Prevocational assessment

Note: This document is based on the previous *Intern training – Assessing and certifying completion document*.

Introduction

This document details requirements for assessing prevocational doctors (PGY1 and PGY2) participating in accredited training programs, and for certifying completion of each year. It should be read in conjunction with:

- For PGY1 - *Registration standard – Australian and New Zealand graduates*
- *Training Environment – National standards and guidelines for prevocational (PGY1 & PGY2) training programs*

A. Assessment approach

Note: text will be updated once national standards numbering and content confirmed.

The basis for this assessment approach is contained in *Training Environment – National standards and guidelines for prevocational (PGY1 & PGY2) training programs.* Assessment must be based on prevocational doctors achieving outcomes stated in prevocational outcome statements (reference to standard) and it must be understood by supervisors and prevocational doctors (reference to standard).

Therefore, assessing prevocational doctors has three distinct imperatives:

- First, the process must be clear and transparent for all involved.
- Second, the assessment process must be based on outcomes consistent with the national standards. To achieve this, prevocational doctors must be assessed against the *Prevocational outcome statements*.
- Third, assessment for PGY1 doctors must capture the essential information that prevocational training providers must provide to the Medical Board of Australia for determining whether they have met the registration standard. For PGY2, assessment must capture information to facilitate issuing a certificate of completion. See page 4 for more information.

Summary of proposed process and changes since the last consultation

Stakeholder feedback was broadly positive and suggestions for change were minor. Most feedback had be raised in previous discussions and were not new areas for discussion. The following table summarises the proposed revised assessment processes for PGY1 and PGY2. These concepts were consulted on in 2020. The tables include:

Green text highlights a change that has been made in response to April 2021 consultation feedback. A high-level summary of stakeholder feedback in response to the last consultation.

Assessment component	Description of proposed process	Summary of feedback and further changes
Beginning of term discussion	Mandatory beginning of term discussion between the prevocational doctor and term supervisor to outline the learning outcomes, term description and assessment requirements. A template will be provided.	Broadly supportive. The review is proposing to mandate this discussion.
Mid-term assessment	• Purpose: Provide feedback on performance and identify learning needs early. • Number: 1 each term • Format: Term supervisor completes (suggested prevocational doctor does self-assessment too). Discussion between supervisor and prevocational doctor. • Assessor/s: Supervisor to conduct or registrars to contribute to/conduct mid-term assessments, with a process for formal sign off by the supervisor.	Stakeholders supported involvement of registrars in mid-term assessments with appropriate training. Determined not to set level of training as this is context specific, judgement by supervisor.
Entrustable professional activity assessments	• Purpose: To increase opportunities for feedback based on observed clinical practice and provide data for end of year global judgements. Assessment of an EPA is about what is observed in that context, at that time, with that particular patient. The goal of prevocational training is to reach the required level of entrustability by the end of the year, therefore it is not necessary that entrustability is reached for every EPA during the year. • Number: ○ A minimum of 10 EPAs are to be assessed in total across the year and a minimum of 2 in each term. ○ EPA 1 assessed in each term, and EPAs 2-4 assessed two to three times each throughout the year. ○ Opportunities to increase the EPAs for individuals with development needs. • Format: Proposing the format of assessment is an Activity Based Discussion, which would entail a combination of direct observation and case-based discussion. The following would be requirements for the assessment of an EPA: ○ that it is based on a real patient for whom the prevocational doctor is involved in the care of ○ that the patient is known to the assessing supervisor ○ that the supervisor should have observed some significant part of the clinical interaction (or if not	Support for introduction of EPA assessments. There were mixed views about the proposed number of EPA assessments (ten per year) - ranging from too few to too many. The review plans to continue with the proposed ten assessments, evaluate when the Framework is implemented and adjust as required. Language describing the format of the EPA assessment has been adjusted to clarify the intention to incorporate this assessment in routine daily work. The review is proposing that other team members might conduct the EPA assessment - e.g. the ward pharmacist for the prescribing EPA.

	possible e.g. EPA2 that feedback is sought from someone who did) ○ the discussion might include some expansion on the parameters of the EPA observed, e.g. "what would you do if the patient was older?" or "…was from a non-English speaking background?" or "…lived at home alone with no immediate carer support available?" • Assessor/s: Supervisors and/or registrars should be able to assess some EPAs with some training. Other members of the healthcare team such a nurse or ward pharmacist might also conduct or contribute to an EPA in a term, where deemed suitable by the supervisor. A minimum of one EPA per rotation should be assessed by a specialist or equivalent. • PGY1/PGY2: The same EPAs will be assessed for PGY1 and PGY2 doctors but at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work. This will be an important focus of supervisor training.	
End of term assessment	• Purpose: Provide feedback on performance and evidence to support global decision at the end of the year. • Number: 1 each term • Format: Term supervisor completes (suggested prevocational doctor does self-assessment too). Discussion between supervisor and prevocational doctor. Supervisor should consider the prevocational doctor's self-assessment, data from EPA assessments, the observations of others and evidence against outcome statements from the learning plan in the discussion. At end of term supervisor gives global rating of progress towards completion of PGY1/PGY2. • Assessor: Term supervisor. Note: Proposing a clinical supervisor (e.g. registrar) may fill in the information of the term assessment and have some initial discussions and the term supervisor would counter sign. This would allow for internal flexibility of processes. • Assessment of Aboriginal and Torres Strait Islander outcomes: It is intended that the e-portfolio will provide a mechanism for tracking achievement of all outcomes throughout the year. Where an outcome is not able to be directly observed it is expected that additional evidence (such as attendance at an approved course) will be uploaded to demonstrate achievement of the outcomes. It is proposed that a guide be developed to support the different ways in which this outcome could be assessed this will include: 1. Direct observation: A rubric/ matrix will be provided for term supervisors to make this assessment.	Change to reflect the e-portfolio will enable data from other sources, such as EPA assessments, to be incorporated into the term assessment forms.

	2. Evidence: Completion of an approved list of course(s).	
Certifying completion	See section below.	

Assessment forms

Note: text will be updated once the term assessment and EPA forms are confirmed, will include information on rating scales.

Assessor training

Note: Review is proposing strengthening assessor/supervisor training requirements.

Under national standard (update reference), prevocational training providers must have processes for ensuring those assessing prevocational doctors have the relevant capabilities and understanding of the processes involved.

Prevocational training providers should therefore incorporate specific training in using assessment forms in their supervisor support and development programs, in addition to general training in assessment and feedback skills. Training may also include supervisor 'frames of reference' and calibration of ratings to improve reliability and validity of the assessment processes.

Feedback and performance review

The Prevocational training - National standards for programs address feedback and performance review. Prevocational training providers must:

- provide regular feedback to prevocational doctors on their performance
- document assessment performance
- ensure feedback from supervisors is received each term
- encourage prevocational doctors to take responsibility for their own performance and to seek feedback
- have clear procedures to immediately address patient safety concerns
- identify prevocational doctors who are not performing to the expected level and organise early appropriate remediation.

To meet these standards, term supervisors should assess prevocational doctors at the end of each term. For terms longer than five weeks, term supervisors should also assess prevocational at the term's mid-point. Prevocational doctors should also complete self-assessments of their performance, and discuss these with the term supervisor at the mid-term (if relevant) and end-of-term assessment meetings. Feedback should be provided to prevocational doctors at these meetings.

B. Improving performance

Note: The Review is proposing changes to the current remediation processes. The intention is to strengthen and clarify the processes, including emphasising the focus on early identification, feedback and support. Performance can be impacted by a range of factors including individual skills, wellbeing and the work environment. All of these factors must be assessed and addressed to optimise performance. Longitudinal program and performance issues will be managed by the prevocational doctor, director of training and term supervisor(s).

- A learning need or performance issue could be identified in a range of ways including:
  - Term assessment processes
  - Observed practice (e.g. re-occurring through EPAs or team feedback)
- Early discussions are important to ensure appropriate support and feedback is provided.

Phase 1 — **Informal discussion**

- An timely and informal discussion should follow between the prevocational doctor, term supervisor and registrar, with support from the Director of Clinical Training (or equivalent) as required.
- Focus of Phase 1 is providing clarity around concerns and giving options or suggestions for improvement.
- May include a written summary of outcomes, recommendations and actions. Might include an action plan.
- Phase 1 may include a timeframe for review.

Phase 2 — **Formal discussion and action plan**

- If further support or action is required the Director of Clinical Training (or equivalent) should discuss the circumstances with the term supervisor and the prevocational doctor, and implement a tailored plan (might include managed supervision). The registrar might be part of this discussion and plan.
- Improving Performance Action Plan (IPAP) should document the specific actions and timelines jointly agreed to support and improve the prevocational doctor's performance, and enable progress to be tracked.

Phase 3 — **Managed supervised practice**

- A period of managed supervision is required where there is continuing concern about a prevocational doctor's performance. Normally, the DCT would make this decision, initiate the managed supervision plan, and communicate the requirements directly to term supervisors and the Director of Medical Services. The assessment panel will be convened to support the process.
- Additional managed supervision is indicated when prevocational doctor performance:
  - does not meet the requirements of one of the terms, and/or
  - does not satisfy the requirements of a previous remediation plan, and/or
  - raises sufficiently complex issues during the scheduled term supervisor assessment to require more detailed consideration and action.
- This period will include undertaking a period of very close supervision and/or additional work.
- Additional assessment methods may be used to facilitate and support learning such as mini-cex, multi source feedback or additional EPA assessments.

There may be circumstances where the prevocational training provider considers it not appropriate to offer the prevocational doctor additional remediation within that employment period, or that remediation is unlikely to be successful. For PGY1 the training provider should report this to the Medical Board of Australia, using the same process of certifying completion of internship described below.

All decisions regarding additional remediation or non-completion of a term must be clearly documented and communicated directly to the Director of Medical Services. This will ensure that the employer is informed about these aspects of prevocational doctor performance.

Notifiable conduct

The requirement under national standard (will update standard reference) to immediately address concerns about patient safety will require action beyond remediation, including possible withdrawal of a prevocational doctor from the clinical context. Prevocational training providers and employers must also be aware of sections 141 and 142 of the *National Law*. This requires registered health practitioners and employers to make notifications about registered medical practitioners who have engaged in 'notifiable conduct' as defined in section 140 of the *National Law*. Notifiable conduct by prevocational doctors must be reported to the Medical Board of Australia immediately.

Assessment review and quality

Note: Once confirmed the text will be updated to reflect the assessment panel's role in both routine progression decisions and in more complex decisions.

C. Certifying completion of PGY1 and PGY2 training

The requirements for certifying completion of PGY1 and PGY2 will be different. Satisfactory completion of PGY1 will remain the point at which a decision to grant general registration is made. A summary of the proposed processes for each is provided below. Green text highlights changes made in response to April 2021 consultation feedback.

Overview of process

Assessment component	Description of proposed process	Summary of feedback and further changes
Certifying completion	• Purpose: Global judgement by an assessment panel at the end of each year, taking account of EPA assessments and all end of term assessment forms. As is currently the case, a longitudinal approach to assessment will be employed and satisfactory performance will be judged on attainment of the required standard by the end of the year rather than a requirement to pass a specified number of EPA or end of term assessments. • PGY1 - Satisfactory completion of PGY1 will continue to be a requirement for general registration. • PGY2 - A certificate of completion will be issued at the end of PGY2. The AMC is proposing that this certificate should be a pre-requisite for entry into (or continuation of) vocational training. Note flexibility to enter vocational training in PGY2 will remain. • Panel composition Proposed prevocational training providers have some flexibility in determining panel composition. The panel composition should ensure procedural fairness and consist of individuals with a sound understanding of prevocational training requirements. Members might include the following roles: DCT, DMS/CHO delegate, MEO, an individual with HR expertise, experienced supervisor/s and/or a consumer. There must be a minimum of three panellists. Note: The role of an individual with HR expertise would be to assist the process and provide relevance expertise such as leave options in wellbeing and remediation discussions. Their role does not include performance management in this context. Prevocational doctors should not be panellists. • Process/ number of meetings The Panel will meet at least once in a year to discuss progression decisions. However, can also be convened as required to support the Improving Performance pathway, and particularly in the case of Phase 3. See Improving Performance section for details.	General support for a panel for decision-making. There was agreement that the process needs to be streamlined to avoid additional burden. There was strong feedback that it will be important to avoid duplication of assessment and certification for those PGY2 doctors who have commenced vocational training program.

Evidence for decision-making

The following provides a summary of the proposed evidence to be provided to the assessment panel at the end of the year to support decision making on completion of PGY1 or PGY2, this data will be collected by and reported through an e-portfolio. This has not been previously consulted on but builds on current requirements for PGY1.

Note there are some specific requirements for certifying completion of PGY1 that relate to Medical Board of Australia's process for granting general registration these will be revised in line with changes to mandatory term requirements.

It is proposed that to streamline the process the assessment panel might consider the evidence in varying level of detail depending on the outcomes of assessment. For example:

Prevocational doctor group	Level of detail of evidence required	Assessment panel action
1. Routine	High level summary of components	For noting only (all components satisfactory)
2. Routine with some areas for discussion/ noting	Summary of components, further detail where required e.g. if criteria not met initially but successfully resolved.	For discussion/ noting
3. Complex	Presentation of components for discussion, further detail around components including assessments provided	For discussion

Requirement	Details
Program length	Evidence demonstrating time requirement (facilitated through e-portfolio).
Term requirements	The revised Training environment – Requirements and guidelines for programs and terms will define new parameters that will be put in place instead of the current mandatory term requirements. Evidence of terms meeting these requirements will be required (facilitated through e-portfolio).
Completion of the outcomes (part of Record of Learning)	As part of the Record of Learning, proposed that there is a mechanism for demonstrating that each outcome statement is marked as complete at the end of each year which would form part of the assessment panel discussions. Currently an intended function of the term assessment forms. This might form part of the PGY1/ PGY2 doctor's learning plan for the year. Evidence of achieving outcomes could be achieved through: • Mid/ end of term assessments (noting that term assessments have currently been raised to the level of Domains) • Completion of entrustable professional activities. Outcome statements mapped to the EPAs. • PGY1/PGY2 doctors uploading evidence against outcome statement (for example – attendance at a workshop). This will be facilitated through the e-portfolio.
Term assessments (mid and end)	Level of detail required will depend on whether routine, routine with areas for discussion, or complex case. E.g. Routine – Summary of ratings against domains and global ratings, Complex – assessment forms.

Assessment of EPAs	Number Evidence that a minimum of 10 EPAs have been assessed (facilitated through e-portfolio). Outcomes Level of detail required will depend on whether routine, routine with areas for discussion, or complex case. E.g. Routine – 10 EPAs have been assessed, summary of level of entrustability against each of the EPAs, Complex – EPA forms. Note: The goal of prevocational training is to reach the required level of entrustability by the end of the year, therefore it is not necessary that entrustability is reached for every EPA during the year.
CPD requirements	Evidence that Board CPD requirements for PGY2 have been met.

Certifying completion – PGY1 for general registration

Prevocational training providers are required to certify completion of internship. On the basis of the information provided, the Medical Board of Australia makes the decision on granting general registration to the intern. The form for use in certifying internship completion, *Certificate of completion of an accredited internship,* is available on the Medical Board of Australia's website.

The Medical Board of Australia requires only the completion of the *Certificate of completion of an accredited internship* form. Term assessment reports and supporting documentation, including outcomes of remediation, should be stored by the training provider in the case that additional information is sought by the Board.

The Medical Board of Australia's requirements for certification, as per the *Registration standard – Australian and New Zealand graduates,* are summarised below [to be revised].

The Medical Board of Australia has further clarified these requirements as:

> Term supervisors are expected to indicate whether interns have satisfactorily 'passed' each term, but the Medical Board will consider the totality of advice in deciding whether to grant general registration. An intern who has performed marginally or unsatisfactorily in a specified term but who has demonstrated 'significant' progress with evidence of remediation may be deemed to have met the standard expected for general registration by the end of the year.

Notes on terminology

Prevocational doctors can complete supervised terms and training in various health care settings, including hospitals, general practices and community-based medical services. In this document, the key roles in the intern assessment process are those commonly used in hospitals:

- *Director of Medical Services*, for the senior medical administrator who leads the medical workforce at a facility
- *Director of Clinical Training*, for the individual with responsibility for implementing the intern training program
- *Term Supervisor*, for the senior clinician responsible for intern orientation and assessment during a particular term.

These roles, albeit with different titles, will apply in non-hospital settings and the requirements in this document apply accordingly.

These national standards use the terms specified in the glossary at the end of the document.

D. Prevocational training -Term assessment form (Revised)

Update since last consultation:

Stakeholder feedback	Response
Broad support to record additional evidence to demonstrate progress against an outcome where it has not been observed.	The review will continue with proposed approaches to global term ratings and capacity for additional evidence to support assessment of achievement of outcome statements that have not been observed in clinical practice.
Stakeholders support the proposed change in wording from 'borderline' to 'conditional'.	The wording in the Global Rating scale at the end of the assessment form was changed from 'borderline' to 'conditional pass' to reflect the principle that assessment is a longitudinal process across the year.
Support for a mandated national form to increase consistency and standardisation as well as portability across the country.	The review will proceed with mandating the form and make no further changes based on the feedback received.
Concern that a level of detail will be lost when making ratings against the domain and that the removal of "clinical anchors" may make using the form more difficult for supervisors.	As stated, the review will progress with global ratings and will consider mechanisms for tracking individual outcomes across the year in the development of the e-portfolio.

Green text highlights changes made in response to April 2021 consultation feedback.

Prevocational training

Term Assessment Form

Note: This form will be translated into an online version prior to implementation. Most of the details in the form will be prepopulated in the e-portfolio, or inputted by the prevocational doctor.

Prevocational doctor details	
Name:	
AHPRA registration no.:	
Assessment type	
☐ Mid-term	☐ End-of-term
☐ Prevocational doctor self-assessment (optional)	

Term details	
From (dd/mm/yyyy):	
To (dd/mm/yyyy):	
Term name:	
PGY:	Term: ____ of ____
Organisation and Department / Unit where term undertaken:	

Sources of information used to complete this form			
Consultation with/ feedback from:	☐ Nursing staff	☐ Registrars	☐ Allied health professionals
	☐ Other specialists	☐ Other (please specify)	
☐ EPAs (as data points and as a point of discussion)			
☐ PGY1/ PGY2 record of learning (progress against outcome statements)			

Assessments of EPAs completed during the term to date (and number of each)	**Outcomes of EPA assessments completed**
☐ EPA 1 Clinical Assessment	
☐ EPA 2 Acutely unwell patients	
☐ EPA 3 Prescribing	
☐ EPA 4 Communicating about patient care	

About this form

The purpose of this form is to provide feedback to the prevocational doctor on their performance to support their learning and support decisions about satisfactory completion of PGY1, as the point of general registration, and PGY2.

The form is to be completed by the term supervisor and by the prevocational doctor (for self-assessment) at the mid-point in any term longer than five weeks and at the end of the term. The registrar may conduct or contribute to the mid-term and end-of-term assessments with final sign off completed by the term supervisor.

This form **has not been designed** for recruitment purposes and should not be used for such purposes.

Instructions for prevocational doctors

Complete this form before assessment meetings and discuss it with your supervisor at those meetings. Consider your strengths, areas where you could benefit from additional experience, and the possible ways in which you could gain this experience. Your self-assessment is not for submission.

Instructions for supervisors

Complete and discuss the form with the prevocational doctor. Consider the prevocational doctor's self-assessment and the observations of others in the discussion. The supervisor should: [will be finalised once form design confirmed]

- Identify the observed outcome statements that the assessment of the Domain has been based on by ticking the appropriate boxes.
- Assign a rating for PGY1 or PGY2 doctor performance against each Domain, taking into consideration the expected performance at the individual's level of training.
- A Domain rating of 3 indicates that all **observed** outcome statements within the Domain would be rated a 3 individually.
- Domain ratings of 1 or 2, will require further information about which specific outcomes were inconsistently met.
- A not observed rating will require further information about which outcomes and whether supplementary evidence was provided, e.g. attendance at a course.
- Liaise with the Medical Education Unit (MEU) or Director of Clinical Training (DCT), and complete an Improving Performance Action Plan (IPAP) when a prevocational doctor requires remediation or additional support in order to meet the required standard (e.g. when the prevocational doctor is assigned ratings of 1 or 2 for one or more items, or at the supervisor's discretion).
- At the end-of-term assessment, assign a global rating of progress towards completion of PGY1 or PGY2. Review any existing improving performance plan to determine if it is complete, or if ongoing actions are required.

Relevant documents

[To be updated once framework finalised.]

Domain 1: Science and scholarship – The prevocational doctor as scientist and scholar	
The assessment of Domain 1 is based on the following outcomes: [tick all that apply]	
☐	1.1 **Knowledge:** Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.
☐	1.2 **Evidence-informed practice:** Access, critically appraise and apply evidence from the medical and scientific literature to clinical and professional practice.
☐	1.3 **Quality assurance:** Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management and incident reporting and reflective practice.
☐	1.4 **Advancing Aboriginal and Torres Strait Islander Health:** Demonstrate a knowledge of evidence informed medicine that supports and advances Aboriginal and Torres Strait Islander health.
Due to variable experiences provided during different terms, components of this Domain might be difficult to observe in practice. Where an outcome has not been observed, evidence will be required to support feedback given on this Domain. Evidence may include but is not limited to, attending a relevant educational course or conference, participating in quality assurance or quality improvement activities e.g. contributing to morbidity and mortality reviews. This will be recorded in the e-portfolio as part of the learning plan.	
[If any of the above outcomes were NOT observed a matrix table will ask to identify: a) which outcome and b) whether additional evidence was provided in the learning plan against that outcome (e.g. attendance at a course)]	

Domain 1 rating overall:				
1 ☐ Rarely met	2 ☐ Inconsistently met	3 ☐ Consistently met	4 ☐ Often exceeded	5 ☐ Consistently exceeded
[If a rating of 1 or 2 is selected, this will trigger a matrix table to specify which outcome/s were inconsistently or rarely met.]				
Feedback on Domain 1				
[Free text for Supervisor to provide global feedback about the Domain. Please identify which outcome statements this feedback relates to.]				

Domain 2: Clinical practice – The prevocational doctor as practitioner	
The assessment of this Domain is based on the following outcomes: [tick all that apply]	
☐	2.1 **Patient safety:** Place the needs and safety of patients at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective clinical handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting.
☐	2.2 **Communication:** Communicate sensitively and effectively with patients, their family/carers, and health professionals applying the principles of shared–decision making and informed consent.
☐	2.3 **Communication - Aboriginal and Torres Strait Islander patients:** Demonstrate effective interpersonal skills, empathic communication, and respect while affording dignity to the patient, within an ethical framework, inclusive of Indigenous knowledges of well-being and health models to support Aboriginal and Torres Strait Islander patient care.
☐	2.4 **Patient assessment:** Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and summary of the patients' health issues.
☐	2.5 **Investigations:** Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of cost-effectiveness.
☐	2.6 **Procedures:** Safely perform a range of common procedural skills required for work as a PGY1 or PGY2 doctor.
☐	2.7 **Patient management:** Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and the healthcare team.
☐	2.8 **Prescribing:** Prescribe therapies and other products including drugs, fluid, electrolytes, and blood products safely, effectively and economically.
☐	2.9 **Emergency care:** Recognise, assess, communicate and escalate as required, and provide immediate management to deteriorating and critically unwell patients.
☐	2.10 **Utilising and adapting to dynamic systems:** Appropriately utilises and adapts to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making.
[If any of the above outcomes were NOT observed a matrix table will ask to identify: a) which outcome and b) whether additional evidence was provided in the learning plan against that outcome (e.g. attendance at a course)]	

Domain 2 rating overall:				
1 ☐ Rarely met	2 ☐ Inconsistently met	3 ☐ Consistently met	4 ☐ Often exceeded	5 ☐ Consistently exceeded
[If a rating of 1 or 2 is selected, this will trigger a drop-down menu to specify which outcome/s were inconsistently or rarely met.]				

Feedback on Domain 2
[Free text for Supervisor to provide global feedback about the Domain. Please identify which outcome statements this feedback relates to.]

Domain 3 – Health and society – The prevocational doctor as a health advocate

The assessment of this Domain is based on the following outcomes: [tick all that apply]	
☐	3.1 **Population health:** Incorporate disease prevention, appropriate and relevant health promotion and health surveillance into interactions with individual patients. Including screening for common diseases, chronic conditions, and discuss healthcare behaviours with patients.
☐	3.2 **Whole of person care:** Apply whole of person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs. Acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.
☐	3.3 **Cultural safety:** Demonstrate culturally safe practice with ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.
☐	3.4 **Understanding biases:** Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander Peoples. This includes understanding current evidence around systemic bias as a determinant of health and how these biases maintain health inequity.
☐	3.5 **Understanding impacts of colonisation and racism:** Demonstrate knowledge of the ongoing impact of colonisation and racism on the health and wellbeing of Aboriginal and Torres Strait Islander Peoples.
☐	3.6 **Integrated healthcare:** Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare system. Where relevant, this should include communicating with caregivers and other health professionals.

Due to variable experiences provided during different terms, and its potential difficulty to assess, evidence will be required to support feedback given on this Domain. In filling out this assessment, you are taking account of evidence provided and reflecting on that and the context in which you are making the assessment. Evidence may include but is not limited to, attending a relevant educational course. This will be recorded in the e-portfolio as part of the learning plan.

[If any of the above outcomes were NOT observed a matrix table will ask to identify: a) which outcome and b) whether additional evidence was provided in the learning plan against that outcome (e.g. attendance at a course)]

Domain 3 rating overall:

1 ☐ Rarely met	2 ☐ Inconsistently met	3 ☐ Consistently met	4 ☐ Often exceeded	5 ☐ Consistently exceeded

[If a rating of 1 or 2 is selected, this will trigger a drop-down menu to specify which outcome/s were inconsistently or rarely met.]

Feedback on Domain 3

[Free text for Supervisor to provide global feedback about the Domain. Please identify which outcome statements this feedback relates to.]

Domain 4 – Professionalism and leadership – The prevocational doctor as a professional and leader

The assessment of this Domain is based on the following outcomes: [tick all that apply]	
☐	4.1 **Professionalism:** Demonstrate ethical behaviours and professional values including integrity; compassion; self-awareness, empathy; patient confidentiality and respect for all.
☐	4.2 **Self-management:** Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.
☐	4.3 **Self-education:** Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching and supervision and feedback.
☐	4.4 **Clinical responsibility:** Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.
☐	4.5 **Teamwork:** Respect the roles and expertise of healthcare professionals, learn and work collaboratively as a member of an inter-professional team.
☐	4.6 **Safe workplace culture:** Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.
☐	4.7 **Culturally safe practice for Aboriginal and Torres Strait Islander patients:** Critically evaluate cultural and clinical competencies to improve culturally safe practice and create culturally safe environments for Indigenous communities. Incorporate into the learning plan strategies to address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care.
☐	4.8 **Time management:** Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.
[If any of the above outcomes were NOT observed a matrix table will ask to identify: a) which outcome and b) whether additional evidence was provided in the learning plan against that outcome (e.g. attendance at a course)]	

Domain 4 rating overall:				
1 ☐ Rarely met	2 ☐ Inconsistently met	3 ☐ Consistently met	4 ☐ Often exceeded	5 ☐ Consistently exceeded
[If a rating of 1 or 2 is selected, this will trigger a drop-down menu to specify which outcome/s were inconsistently or rarely met.]				

Feedback on Domain 4

[Free text for Supervisor to provide global feedback about the Domain. Please identify which outcome statements this feedback relates to.]

Global rating (required only for the end-of-term assessment)

Assign a global rating of progress towards completion of PGY1 or PGY2. In assigning this rating, consider the prevocational doctor's ability to practise safely, work with increasing levels of responsibility, apply existing knowledge and skills, and learn new knowledge and skills during the term.

Global rating	
☐ Satisfactory	The prevocational doctor has met or exceeded performance expectations for the level of training during the term.
☐ Conditional pass	Further information, assessment and/or remediation will be required before deciding that the prevocational doctor has met performance expectations for the level of training during the term.
☐ Unsatisfactory	The prevocational doctor has not met performance expectations for the level of training during the term.

Please provide feedback on the following:

Strengths
Areas for improvement

Additional support

Please contact the Medical Education Unit (MEU) or Director of Clinical Training (DCT), when a prevocational doctor requires additional support to meet the required standard; refer to the instructions on page 1.

MEU Contact details	[Details will prepopulate based on data stored in the e-portfolio]
DCT Contact details	[Details will prepopulate based on data stored in the e-portfolio]

[It is intended that the e-portfolio will flag unsatisfactory or conditional ratings with DCTs.]

Supervisor

Name (print clearly)

Signature

Position

Date

Day Month Year

Director of Clinical Training

Name (print clearly)

Signature

Date

Day Month Year

Director of Clinical Training feedback

Prevocational doctor

I (insert name) _____

confirm that I have discussed the above report with my Term supervisor or delegate and know that if I disagree with any points I may respond in writing to the Director of Clinical Training within 14 days.

Signature

Date

Day Month Year

Return of form

Please forward to (contact person, department):

Relevant documents

Relevant documents are available on the AMC website http://www.amc.org.au/index.php/ar/psa

E. Prevocational training - Entrustable Professional Activity (EPA) form (New)

Update since last consultation: Stakeholders broadly supported the form, including its structure, clarity and how it reflects the work of prevocational doctors. Feedback provided will be considered in developing training resources to support EPA assessments. Minor changes to wording have been made based on stakeholder feedback. Green text highlights changes made in response to April 2021 consultation feedback.

Note: This form will be translated into an online version prior to implementation. Most of the details in the form will be prepopulated in the e-portfolio, or inputted by the prevocational doctor.

This form is a tool used to assess an EPA of a prevocational doctor. The importance of breadth of experience and a range of task complexities across EPAs assessed throughout PGY1 and PGY2 is emphasised.

Prevocational doctor name:	

Term name:					
Term start date:				Term end date:	
PGY:		Term:	____ of ____	Week of term:	
Date of assessment:					

Supervisor name:	
Assessor name:	
Assessor:	[Drop down menu] ☐ Specialist or equivalent (term supervisor) ☐ Specialist or equivalent (other) ☐ Registrar ☐ Nurse/ nurse practitioner ☐ Pharmacist ☐ Other
Consultation with/ input from:	☐ Specialist or equivalent (term supervisor) ☐ Specialist or equivalent (other) ☐ Registrar ☐ Nurse/ nurse practitioner ☐ Allied health ☐ Pharmacist ☐ Patient ☐ PGY1/2 peer ☐ Other

EPA 1 – Clinical Assessment

Title: Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan including appropriate investigations.

Focus and context: This EPA applies in admission, reviewing patient on request of particular concern, ward call tasks, ward round, lower acuity ED presentations, general practice consultations or outpatient clinical attendance.

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, where appropriate or possible complete some or all of the following list. The prevocational doctor is to tick the task descriptions that are relevant to this assessment:

☐	1.	if clinical assessment requested by a team member, clarify the concern(s) with them
☐	2.	identify pertinent information in the patient record
☐	3.	obtain consent from the patient
☐	4.	obtain history
☐	5.	examine patient
☐	6.	consider and integrate information from patient record, clinical assessments, and relevant ward protocols/ guidelines/ literature
☐	7.	develop provisional and differential diagnoses and/or problem lists
☐	8.	produce a management plan, confirm with senior colleague as appropriate, and communicate with relevant team members and the patient

☐	9.	implement management plan, initiate or perform appropriate investigations and procedures, document assessment and next steps, including indications for follow up

See Section 2B for descriptions of behaviours that demonstrate entrustability to the supervisor.

Prevocational doctor to complete this section

Case details

Brief description of issues of case:
[Short narrative text written by prevocational doctor - e.g. age, gender, diagnosis etc.]

Self-assessment

Self-reflection on performance of the task:
[Electronic props to add to e-portfolio: how do you feel you went?, what went well and why?, what could you have done better and how?]

Based on this case, what will you do to develop your learning further?

Outcome statements

[Will prepopulate what outcome statements this assessment will map to, based on what aspects of the task description have been ticked in the above section]

Assessor to complete this section

Case details:	Patient type: ☐ Child ☐ Adult	Brief description: [Short narrative text - e.g. age, gender, diagnosis etc.]

Complexity of the case(s) for the level of training:	☐ Low ☐ Medium ☐ High

Note: Case complexity is a combination of the complexity of the medical presentation and relevant social factors. Case complexity also has to do with the experience of the PGY1 or PGY2 doctor. Therefore, a case which is assessed as high complexity early in PGY1 may be assessed as low complexity in late PGY2. It is expected that as prevocational doctors progress through their program, the cases the EPAs are assessed on increase in complexity. It is also expected there will be some cases assessed that are complex for the level of training.

Assessor's declaration	
☐	The patient(s) is known to me and I have directly observed some part of the clinical interaction or have spoken to a team member that has

Entrustability scale	
Supervisors are asked to make a judgement on the degree of entrustment for this task; the level of supervision required appropriate to the level of level of training (acknowledging that supervision requirements for PGY1 or PGY2 are different)	
☐	Requires direct supervision (I need to be there to observe the interactions and review the work)
☐	Requires proximal supervision (I need to be easily contacted, and able to provide immediate or detailed review of work)
☐	Requires minimal supervision (I trust the prevocational doctor to complete the task/ I need to be contactable/ in the building and able to provide general overview of work)

Feedback

What went well?

What could be done to improve?

Agreed learning goals arising from the experience

Assessor sign off:	

Prevocational training

Entrustable Professional Activity (EPA) form

This form is a tool used to assess an EPA of a prevocational doctor. The importance of breadth of experience and a range of task complexities across EPAs assessed throughout PGY1 and PGY2 is emphasised.

Prevocational doctor name:	

Term name:					
Term start date:				Term end date:	
PGY:		Term:	____ of ____	Week of term:	
Date of assessment:					

Supervisor name:	
Assessor name:	
Assessor:	[Drop down menu] ☐ Specialist or equivalent (term supervisor) ☐ Nurse/ nurse practitioner ☐ Specialist or equivalent (other) ☐ Pharmacist ☐ Registrar ☐ Other
Consultation with/ input from:	☐ Specialist or equivalent (term supervisor) ☐ Pharmacist ☐ Specialist or equivalent (other) ☐ Patient ☐ Registrar ☐ PGY1/2 peer ☐ Nurse/ nurse practitioner ☐ Other ☐ Allied health

EPA 2 – Recognition and care of the acutely unwell patient

Title: Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (This EPA recognises that PGY1/2 doctors often called after hours to assess patients whose situation has acutely changed)

Focus and context: This EPA applies in any clinical context but the critical aspects that differentiate it from EPA 1 are for the PGY1/PGY2 doctor to:

1. Recognise the acutely unwell and or deteriorating patient (including acute deterioration in mental health).
2. Act immediately, demonstrating a timely approach to management
3. Escalate appropriately

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments, in and after hours, and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, where appropriate or possible complete some or all of the following list. The prevocational doctor is to tick the task descriptions that are relevant to this assessment:

☐	1.	recognise clinical deterioration or acutely unwell patients
☐	2.	respond by initiating immediate management, including basic life support if required
☐	3.	seek appropriate assistance, including following the local process for escalation of care
☐	4.	communicate critical information in a concise, accurate and timely manner to facilitate decision making
☐	5.	lead the resuscitation initially, and involve other necessary services, such as intensive care or retrieval services

See Section 2B for descriptions of behaviours that demonstrate entrustability to the supervisor.

Prevocational doctor to complete this section

Case details

Brief description of issues of case:
[Short narrative text written by prevocational doctor - e.g. age, gender, diagnosis etc.]

Self-assessment

Self-reflection on performance of the task:
[Electronic props to add to e-portfolio: how do you feel you went?, what went well and why?, what could you have done better and how?]

Based on this case, what will you do to develop your learning further?

Outcome statements

[Will prepopulate what outcome statements this assessment will map to, based on what aspects of the task description have been ticked in the above section]

Assessor to complete this section

Case details:	Patient type: ☐ Child ☐ Adult	Brief description: [Short narrative text - e.g. age, gender, diagnosis etc.]

Assessment of complexity of the case(s) for the level of training:	☐ Low ☐ Medium ☐ High

Note: Case complexity is a combination of the complexity of the medical presentation and relevant social factors. Case complexity also has to do with the experience of the PGY1 or PGY2 doctor. Therefore, a case which is assessed as high complexity early in PGY1 may be assessed as low complexity in late PGY2. It is expected that as prevocational doctors progress through their program, the cases the EPAs are assessed on increase in complexity. It is also expected there will be some cases assessed that are complex for the level of training.

Assessor's declaration	
☐	The patient(s) is known to me and I have directly observed or confirmed some part of the clinical interaction or have spoken to a team member that has

Entrustability scale	
Supervisors are asked to make a judgement on the degree of entrustment; the level of supervision required appropriate to the level of level of training (acknowledging that supervision requirements for PGY1 or PGY2 are different)	
☐	Requires direct supervision (I need to be there to observe the interactions and review the work)
☐	Requires proximal supervision (I need to be easily contacted, and able to provide immediate or detailed review of work)
☐	Requires minimal supervision (I trust the prevocational doctor to complete the task/ I need to be contactable/ in the building and able to provide general overview of work)

Feedback

What went well?

What could be done to improve?

Agreed Learning goals arising from the experience

Assessor sign off:	

Prevocational training

Entrustable Professional Activity (EPA) form

This form is a tool used to assess an EPA of a prevocational doctor. The importance of breadth of experience and a range of task complexities across EPAs assessed throughout PGY1 and PGY2 is emphasised.

Prevocational doctor name:	

Term name:					
Term start date:				Term end date:	
PGY:		Term:	____ of ____	Week of term:	
Date of assessment:					

Supervisor name:	
Assessor name:	
Assessor:	[Drop down menu] ☐ Specialist or equivalent (term supervisor) ☐ Specialist or equivalent (other) ☐ Registrar ☐ Nurse/ nurse practitioner ☐ Pharmacist ☐ Other
Consultation with/ input from:	☐ Specialist or equivalent (term supervisor) ☐ Specialist or equivalent (other) ☐ Registrar ☐ Nurse/ nurse practitioner ☐ Allied health ☐ Pharmacist ☐ Patient ☐ PGY1/2 peer ☐ Other

EPA 3 – Prescribing

Title: Appropriately prescribe therapies (drugs, fluids, blood products oxygen) tailored to patients' needs and conditions

Focus and context: This EPA applies in any clinical context but the critical aspects are to:

1. Prescribe autonomously when appropriate, taking account of registration, health service policies, and individual confidence and experience with that drug or product
2. Prescribe as directed by a senior team member, taking responsibility for completion of the order to ensure it is both accurate and appropriate in the context of the patient

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, where appropriate or possible complete some or all of the following list. The prevocational doctor is to tick the task descriptions that are relevant to this assessment:

☐	1.	obtain and interpret medication histories
☐	2.	respond to requests from team members to prescribe medications
☐	3.	consider whether a prescription is appropriate
☐	4.	choose appropriate medications
☐	5.	where appropriate, clarify with the senior medical officers, pharmacists, nursing staff, family members or clinical resources the drug, including name, dose, frequency and duration
☐	6.	actively consider drug/ drug interactions and/or allergies and if identified check whether to proceed
☐	7.	provide instruction on medication administration effects and side effects, using appropriate resources
☐	8.	elicit any patient concerns about the benefits and risks, as appropriate seek advice and support to address those concerns
☐	9.	write or enter accurate and clear prescriptions or medication charts
☐	10.	monitor medications for adverse reactions, efficacy, safety, and concordance
☐	11.	review medications and interactions, and cease where indicated, in consultation with the senior team members, including a pharmacist

See Section 2B for descriptions of behaviours that demonstrate entrustability to the supervisor.

Prevocational doctor to complete this section

Case details

Brief description of issues of case:
[Short narrative text written by prevocational doctor - e.g. age, gender, diagnosis etc.]

Self-assessment

Self-reflection on performance of the task:
[Electronic props to add to e-portfolio: how do you feel you went?, what went well and why?, what could you have done better and how?]

Based on this case, what will you do to develop your learning further?

Outcome statements

[Will prepopulate what outcome statements this assessment will map to, based on what aspects of the task description have been ticked in the above section]

Assessor to complete this section

Case details:	Patient type: ☐ Child ☐ Adult	Brief description: [Short narrative text - e.g. age, gender, diagnosis etc.]

Assessment of complexity of the case(s) for the level of training:	☐ Low ☐ Medium ☐ High

Note: Case complexity is a combination of the complexity of the medical presentation and relevant social factors. Case complexity also has to do with the experience of the PGY1 or PGY2 doctor. Therefore, a case which is assessed as high complexity early in PGY1 may be assessed as low complexity in late PGY2. It is expected that as prevocational doctors progress through their program, the cases the EPAs are assessed on increase in complexity. It is also expected there will be some cases assessed that are complex for the level of training.

Assessor's declaration	
☐	The patient(s) is known to me and I have directly observed or confirmed some part of the clinical interaction or have spoken to a team member that has

Entrustability scale	
Supervisors are asked to make a judgement on the degree of entrustment; the level of supervision required appropriate to the level of level of training (acknowledging that supervision requirements for PGY1 or PGY2 are different)	
☐	Requires direct supervision (I need to be there to observe the interactions and review the work)
☐	Requires proximal supervision (I need to be easily contacted, and able to provide immediate or detailed review of work)
☐	Requires minimal supervision (I trust the prevocational doctor to complete the task/ I need to be contactable/ in the building and able to provide general overview of work)

Feedback

What went well?

What could be done to improve?

Agreed Learning goals arising from the experience

Assessor sign off:	

Prevocational training
Entrustable Professional Activity (EPA) form

This form is a tool used to assess an EPA of a prevocational doctor. The importance of breadth of experience and a range of task complexities across EPAs assessed throughout PGY1 and PGY2 is emphasised.

Prevocational doctor name:	

Term name:					
Term start date:				Term end date:	
PGY:		Term:	____ of ____	Week of term:	
Date of assessment:					

Supervisor name:	
Assessor name:	
Assessor:	[Drop down menu] ☐ Specialist or equivalent (term supervisor) ☐ Nurse/ nurse practitioner ☐ Specialist or equivalent (other) ☐ Pharmacist - ☐ Registrar - ☐ Other
Consultation with/ input from:	☐ Specialist or equivalent (term supervisor) ☐ Pharmacist ☐ Specialist or equivalent (other) ☐ Patient ☐ Registrar ☐ PGY1/2 peer ☐ Nurse/ nurse practitioner ☐ Other ☐ Allied health

EPA 4 – Team Communication – documentation, handover and referrals

Title: Communicate about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral.

Focus and context: This EPA applies to any clinical context but the critical aspects are to:

1. Communicate timely, accurate and concise information to facilitate transfer of care across various health sector boundaries including:
   - at referral from ambulatory and community care
   - at admission
   - between clinical services and multidisciplinary teams
   - at changes of shift
   - at discharge to ambulatory and community care
2. Produce timely, accurate and concise documentation of episodes of clinical care

Perform this activity in multiple settings, including inpatient and ambulatory (or community) care settings or in emergency departments and in the care of different populations for example children, adults and elderly.

Description: This activity requires the ability to, where appropriate or possible complete some or all of the following list. The prevocational doctor is to tick the task descriptions that are relevant to this assessment:

☐ 1. Communicate:
- facilitate high quality care at any transition point
- ensure continuity of care
- share patient information with other health care providers and multidisciplinary teams in conjunction with referral or the transfer of responsibility for patient care
- use local agreed modes of information transfer, including oral, electronic and written format to communicate (at least):
  - patient demographics
  - concise medical history and relevant physical examination findings
  - current problems and issues
  - details of pertinent and pending investigation results
  - medical and multidisciplinary care plans
  - planned outcomes and indications for follow up

☐ 2. Document:

- enable other health professionals to understand the issues and continue care
- produce written summaries of care, including admission and progress notes, team referrals, discharge summaries, and transfer documentation
- produce accurate records appropriate for secondary purposes
- complete accurate medical certificates, death certificates and cremation certificates
- enable the appropriate use of clinical handover tools

See Section 2B for descriptions of behaviours that demonstrate entrustability to the supervisor.

Prevocational doctor to complete this section

Case details

Brief description of issues of case:
[Short narrative text written by prevocational doctor - e.g. age, gender, diagnosis etc.]

Self-assessment

Self-reflection on performance of the task:
[Electronic props to add to e-portfolio: how do you feel you went?, what went well and why?, what could you have done better and how?]

Based on this case, what will you do to develop your learning further?

Outcome statements

[Will prepopulate what outcome statements this assessment will map to, based on what aspects of the task description have been ticked in the above section]

Assessor to complete this section

Case details:	Patient type: ☐ Child ☐ Adult	Brief description: [Short narrative text - e.g. age, gender, diagnosis etc.]

Assessment of complexity of the case(s) for the level of training:	☐ Low ☐ Medium ☐ High

Note: Case complexity is a combination of the complexity of the medical presentation and relevant social factors. Case complexity also has to do with the experience of the PGY1 or PGY2 doctor. Therefore, a case which is assessed as high complexity early in PGY1 may be assessed as low complexity in late PGY2. It is expected that as prevocational doctors progress through their program, the cases the EPAs are assessed on increase in complexity. It is also expected there will be some cases assessed that are complex for the level of training.

Assessor's declaration	
☐	The patient(s) is known to me and I have directly observed or confirmed some part of the clinical interaction or have spoken to a team member that has

Entrustability scale	
Supervisors are asked to make a judgement on the degree of entrustment; the level of supervision required appropriate to the level of level of training (acknowledging that supervision requirements for PGY1 or PGY2 are different)	
☐	Requires direct supervision (I need to be there to observe the interactions and review the work)
☐	Requires proximal supervision (I need to be easily contacted, and able to provide immediate or detailed review of work)
☐	Requires minimal supervision (I trust the prevocational doctor to complete the task/ I need to be contactable/ in the building and able to provide general overview of work)

Feedback

What went well?

What could be done to improve?

Agreed Learning goals arising from the experience

Assessor sign off:	

Reference documents [to be updated]

Glossary [to be updated]