Acute Internal Medicine (AIM) ARCP Decision Aid – AUGUST 2017

The ARCP decision aid documents the targets to be achieved for a satisfactory ARCP outcome at the end of each training level. This document replaces all previous versions from **August 2017**. Please see guidance notes below.

- The ePortfolio curriculum record should be used to present evidence in an organised way to enable the educational supervisor and the ARCP panel to determine whether satisfactory progress with training is being made to proceed to the next phase of training.

- Evidence should include supervised learning events (SLEs) and workplace based assessments (WPBAs), personal development plans (PDPs), reflective practice, quality improvement projects, e-learning and feedback on teaching delivered. It is suggested that the evidence for emergency and top presentations should include a supervised learning event (SLE)

- A summary of clinical activities and teaching attendance should be recorded using the form available in the assessment section of the ePortfolio. A template is available for recording a logbook of procedures and outpatient clinics but is not mandatory.

- Procedures should be assessed using DOPS. Please refer to comments section and footnotes for further guidance.

- Trainees should record a rating for the curriculum competencies covered and justification for their self-rating. Supervisors should sample approximately 10% of these competencies and record their supervisor ratings with explanatory comments for each one sampled (additional evidence and/or sampling may be required if there are concerns). Sampling will not apply to emergency presentations or procedures which must be signed off individually.

- The educational supervisor (ES) should record ratings at group competency level (eg other important presentations) as indicated in the ARCP decision aid. This will normally be done as part of the review of the ePortfolio in order to complete the ES report.

- An ES report covering the whole training year is required before the ARCP. The ES will receive feedback on a trainee's clinical performance from other clinicians via the multiple consultant report (MCR). The ES report should bring to the attention of the panel events that are causing concern e.g. patient safety issues, professional behaviour issues, poor performance in work-place based assessments, poor MSF report and issues reported by other clinicians. It is expected that serious events would trigger a deanery review even if an ARCP was not due.

- All trainees in AIM must develop a specialist skill. The complete list of specialist skills can be found on the JRCPTB AIM webpage

Acute Internal Medicine (AIM) ARCP Decision Aid – August 2017

Curriculum domain		ST3	AIM year 2	AIM year 3	CCT	Comments
Educational Supervisor (ES) report	Overall report	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	To cover training year since last ARCP
	Management and leadership	Demonstrate acquisition of leadership skills in supervising the work of Foundation and Core Medical trainees during the acute medical take	Demonstrate implementation of evidence based medicine whenever possible with the use of common guidelines. Demonstrate good practice in team working and contributing to multi-disciplinary teams.	Has senior level management skills for all medical presentations including complex cases. Reviews patients in ambulatory care and as newly presenting patient or in the inpatient setting. Supervises more junior doctors and communicates well with members of other professions and specialties within the acute medical unit. Provides input into organisational structures eg rota management, attendance at management meetings	Creation of management and investigation pathways; instigates safe patient treatment. Liaises effectively with other specialties. Implements local clinical governance policies. Involvement in management within directorates, as an observer or trainee representative. Direct involvement in the organisation and managerial structure of the acute medical unit	
Multiple Consultant Report (MCR)	Each MCR to be completed by one clinical supervisor	4-6	4-6	4-6	4-6	Feedback collated in year-end summary report and recorded in ES report
SCE				AIM SCE taken	AIM SCE passed	

Curriculum domain		ST3	AIM year 2	AIM year 3	CCT	Comments
ALS		Valid	Valid	Valid	Valid	Must be kept valid throughout training
AIM Audit or AIM Quality improvement projects		1	1	1	1	Quality improvement project assessment tool (QIPAT) or Audit Assessment (AA) to be completed
Supervised Leaning Events (SLEs) ACATs CbDs mini CEX	Minimum number of consultant SLEs per year	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	SLEs to be performed proportionately by a number of different assessors
Multi-source feedback (MSF) [1]	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical) for a valid MSF. Raters to be agreed with ES. Replies should be received within 3 months	1	1	1	1	MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF

[1] Health Education West Midlands use Team Assessment of Behaviour (TAB) as a multisource feedback tool

Curriculum domain		ST3	AIM year 2	AIM year 3	CCT	Comments
Common Competencies	Ten do not require linked evidence unless concerns are identified [2]	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level 3 or 4 achieved	Progress to be determined by sampling trainee's evidence and self-ratings. ES to record rating at group level and provide justification
Emergency Presentations	Cardio-respiratory arrest	Confirmation by educational supervisor that evidence recorded and AIM level achieved				ACATs, mini-CEXs and CbDs should be used to demonstrate engagement and learning. ES to confirm level completed by the end of stage 1 and record outcome in the ES report
	Shocked patient	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that evidence recorded and AIM level achieved		
	Unconscious patient	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that GIM level achieved	Confirmation by educational supervisor that evidence recorded and AIM level achieved		
	Anaphylaxis / severe adverse drug reaction	Confirmation by educational supervisor that AIM level achieved (after discussion of management if no clinical cases)				

[2] Refer to JRCPTB recommendations for specialty trainee assessment and review for further details

Curriculum domain		ST3	AIM year 2	AIM year 3	CCT	Comments
Top Presentations		Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level is satisfactory for AIM stage		Progress to be determined by sampling trainee's evidence and self-ratings. ES to record rating at group level with justification
Other Important Presentations		Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that satisfactory progress is being made	Confirmation by educational supervisor that level is satisfactory for completion of AIM	Progress to be determined by sampling trainee's evidence and self-ratings. ES should record rating at group level with justification
Clinical activity	Acute Take				1250 patients seen before CCT	Mini CEX / CbD to be used to give structured feedback. Patient survey and reflective practice recommended. Summary of clinical activity recorded on ePortfolio
	Ambulatory care				300 new patients before CCT	
Clinical experience	Acute Medical Unit				Completed before CCT	
	Cardiovascular Medicine				Completed before CCT	

Curriculum domain		ST3	AIM year 2	AIM year 3	CCT	Comments
	Respiratory Medicine				Completed before CCT	
	Geriatric Medicine				Completed before CCT	
	Intensive Care Medicine				Completed before CCT	
	Specialist Skill training				Completed before CCT	
Teaching	Overall teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance. 1 Teaching Observation before CCT	Summary of teaching attendance to be recorded on ePortfolio
	External AIM				100 hours before CCT	Includes regional teaching days

Procedure	ST3	AIM year 2	AIM year 3	CCT	Comments
DC cardioversion (R)	Clinically independent				DOPS to be carried out for each procedure. Formative DOPS should be undertaken before summative DOPS and can be undertaken as many times as needed. Summative DOPS sign off for routine procedures *(R)* to be undertaken on one occasion with one assessor Summative DOPS sign off for
Knee aspiration (R)	Clinically independent				
Abdominal paracentesis (PLT)	Clinically independent				
Central venous cannulation by internal jugular, subclavian or femoral approach (support for U/S guidance may be provided by another trained professional)(PLT)	Clinically independent				

Procedure	ST3	AIM year 2	AIM year 3	CCT	Comments
Intercostal drainage (1) pneumothorax insertion (PLT)[5]	Clinically independent				potentially life threatening procedures (*PLT*) to be undertaken on at least two occasions with two different assessors (one assessor per occasion) if clinical independence required[3] CMT procedural skills must be maintained[4]
Intercostal drainage (2) pleural effusion (support for U/S may be provided by another trained professional) (PLT) [5]				Clinically independent	
Arterial line (R)				Clinically independent	
Temporary cardiac pacing via transvenous route (PLT)				Skills lab training completed[6]	
Sengstaken-Blakemore Tube insertion (PLT)				Skills lab training completed[6]	

[5] Pleural procedures should be undertaken in line with British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by a pleural-trained ultrasound practitioner

[3] Clinically independent is defined as competent to perform the procedure unsupervised , be able to recognise complications and respond appropriately if they arise, calling for help from colleagues in other specialties when necessary. Support for ultrasound guidance is required from another trained professional where indicated. Two summative DOPS are required for life threatening procedures

[4] If a doctor has been signed off as competent in a procedure during CMT or ST3, then provided they continue to carry out that procedure it should not require further testing.

[6] Obtaining clinical independence in these procedures is desirable but not mandatory