

Living Curriculum

**Fellowship in the College of Emergency Medicine
(FCEM)**



College of

EMERGENCY MEDICINE

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1. Introduction

The establishment of the College of Emergency Medicine of South Africa (CEM) in 2003 marked an important step in the standardisation of training and assessment for specialist Emergency Physicians. While the Masters of Medicine (MMed) in Emergency Medicine is offered at six universities in South Africa, the CEM plays a crucial role in providing a national standardised curriculum for training and assessment. (1)

However, the current curriculum for the Fellowship of the College of Emergency Medicine in South Africa (FCEM) is not outcomes nor competency based; and does not reflect the current focus on work based learning and assessment. Although each university program has its own curriculum tailored to local resources, the existence of a national exit examination highlights the need for clear guidance on training outcomes, specialist competencies, and assessment. The CEM Curriculum is essential in guiding and supporting registrar training as well as defining the role of a specialist Emergency Physician in the South African context.

Africa's first Emergency Medicine training programme started at the University of Cape Town in 2004, and borrows largely from international programmes and texts. However, South Africa's unique context of poverty, inequality, inequitable access to health care, and a high prevalence of emergencies related to trauma and infectious disease require a high standard of training in order to produce Emergency Physicians who can not only provide emergency care, but be change agents within society. (2)

The Colleges of Medicine of South Africa together with the South African Committee of Medical Deans are currently driving for formal incorporation of work-based assessment (WBA) in all post-graduate registrar programmes by 2024. WBAs move away from single exit level exams and instead assess trainee's clinical knowledge and skills as well as professional behaviour in clinical environments. In light of the absence of work-based assessment (WBA) in the current FCEM curriculum, and, recognizing the necessity for a significant overhaul of this curriculum, the Living Curriculum Workgroup was established in 2022. The workgroup comprises representatives from all six universities that provide the MMED Emergency Medicine programme. The workgroup, under the auspices of the Council of the College of Emergency Medicine, are mandated to develop an updated values-based curriculum that is reflective of the training of EM specialists in South Africa, is responsive to current teaching, learning and assessment practices and is a living document that is continuously improved and refined as new feedback is generated from the EM community.

In 2022, the group conducted a needs assessment and engaged with stakeholders in the provinces where Emergency Medicine specialisation is available. In January 2023, the members convened in person at the CMSA offices for a workshop, during which they shared stakeholder feedback, identified values and key themes, participated in focus group discussions to design a competency framework for Emergency Medicine, created an initial strategy for workplace-based assessment, and formulated plans for the next steps.

Throughout 2023, the workgroup has been involved in re-engagement with stakeholders, in particular Emergency Medicine faculty and trainees, to discuss the ideas and present prototypes of potential action points to implement work-based assessment.

This document constitutes the second iterative draft of the Living Curriculum, which is expected to undergo significant development through repeated feedback cycles and integration into the Emergency Medicine programs. Key modifications in this iteration encompass:

- A proposed phased strategy for incorporating WBA into the Emergency Medicine curriculum.
- A streamlined approach to the initial introduction of WBA, incorporating EPAs for registrars within mid- and end-of-block assessments instead of as distinct, standalone evaluations.
- Simplification of the WBA tools, with the initial rollout featuring a single tool incorporating EPAs: Replacing the previous array of assessment methods such as case-based assessments, shift reports, DOPS, etc; while still availing these tools for use on an ad-hoc basis by the supervisors and registrars.
- An initial feasibility and impact study as part of the initial introduction to evaluate its effects on time, cognitive demands, patient care, patient safety, educational value, and the psychological well-being of both staff and faculty.

2. Purpose

The purpose of the workgroup is an ongoing, living, values-based curriculum which will reflect the values of the training and assessment of Emergency Medicine specialists in South Africa today. This current iteration of the curriculum aims to integrate these values into outcomes and provide an outline for the assessment process of Emergency Physicians in South Africa, as well as provide an initial outline for the incorporation of work-based assessment into the Emergency Medicine programmes in South Africa.

3. Rationale

Access to Emergency Care is a basic human right, and the Constitution of South Africa clarifies that no one may be denied emergency care. (3,4)

The College of Emergency Medicine aims to produce Emergency Medicine specialists who can alleviate the provincial and national shortage of specialist emergency medicine physicians, and capacitate emergency systems in order to provide high quality care. These specialists are envisioned to be leaders and teachers, who will go on to grow the field of Emergency Medicine nationally, and ultimately have high quality emergency care accessible to all South Africans.

4. Competency Frameworks

Competency frameworks are used to qualify and elucidate those knowledge, skills, attitudes and other attributes necessary for health professions in practice. (5) The Canadian CANMEDs Competency Framework is utilised worldwide, including by the Health Professions Council of South Africa. (6,7)

Based on stakeholder input and a needs analysis, the workgroup group analysed the themes and values to identify a draft list of core roles and competencies.

The competency framework was graphically depicted in the form of a Baobab, an African, pre-historic tree that symbolizes life, community, wisdom, and resilience.

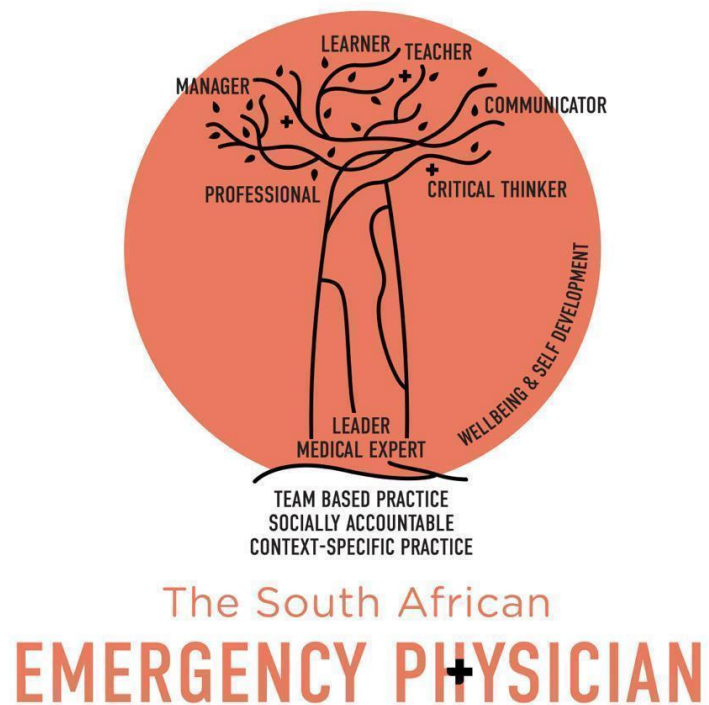


Figure 1: The South African Emergency Physician Competency Framework. Graphic credit: Anneli Lombaard

The South African Emergency Physician: A **Medical Expert**, rooted in community as evidenced by **team-based practice**, **social accountability**, and **context-specific practice**, demonstrating

leadership as a **critical thinker, communicator, teacher and learner, professional, and manager**, held together by the practice of **wellbeing**.

Medical Expert

As Medical Experts, Emergency Physicians (EPs) should demonstrate a mastery of the knowledge, skills and attitudes relevant to Emergency Medicine as outlined by the College of Emergency Medicine of South Africa. Emergency Physicians should be competent in providing evidence-based, patient-centered care in assessing and managing undifferentiated patients of all groups presenting with illness and injury. Emergency Physicians should demonstrate the competency for a lifetime of self-directed learning, and demonstrate the capacity in gathering information, critical appraisal, critical thinking, and diagnostic reasoning, in order to apply best practice appropriate to the patient in a range of contexts. In our strive for medical expertise, Emergency Physicians should be competent in planning and conducting high quality research.

Leader

As leaders, Emergency Physician specialists ensure that patients receive excellent, evidence-based clinical care, role players in emergency medicine are developed and nurtured, and that our systems are continuously innovating and improving.

Critical Thinker

Critical thinking in the field of medical sciences is a kind of cognitive activity for understanding and evaluating phenomena. It is based on reasoning and analysing purposeful, self-regulatory judgment that uses cognitive tools such as interpretation, analysis, evaluation, inference, and explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations on which judgment is based.

Communicator

As communicators, EPs are skilled at conveying and receiving information in a professional manner to facilitate relationships that enhance patient wellbeing and healthcare systems.

Professional

As professionals, EPs are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health.

Teacher and learner

An EP is an educator who utilises opportunities to teach and motivate relevant, meaningful learning experiences. These experiences integrate knowledge, skills and attitudes into practical applications. An educator is also a continuous learner who utilises evidence-based medicine in their teaching principles.

Socially accountable

A socially accountable physician is one who has a deep and profound understanding of their community responsibilities, from having been trained in the community with a view towards eliminating health inequities on various collaborative platforms.

Team-based practice

The EP is skilled at optimising and co-ordinating holistic medical care for patients using a multimodal, multi-disciplinary approach which advocates for the patient and system.

Context-specific practice

Emergency Physicians should be adaptable in order to provide a high level of patient care in a range of different environments and clinical settings. Emergency Physicians will therefore need to demonstrate the competencies of innovation and adaptability in resource limited settings, the ability to adapt and modify practice according to context, an inclusive and non-discriminatory approach to patient centered care, and sensitivity to patient differences in multi-racial and diverse populations.

Manager

As managers, Emergency Physicians demonstrate the ability to manage clinical Emergency units, human resources, administrative duties, pre- and in-hospital committees, and a wide range of quality improvement and clinical governance initiatives.

Wellbeing and self-development

An Emergency Physician's ability to pursue a sustainable work life is in part shaped by their ability to achieve a sense of wellbeing. It may be thought of as including 'the cultivation of healthy relationships at personal and professional levels based on appreciation, kindness, gratitude and compassion' and as being 'at the heart of competencies required for good medical practice'.

5. Assessment framework

The assessment framework for the Fellowship in the College of Emergency Medicine of South Africa reflects the values of all stakeholders as encompassed in the competencies and learning outcomes. The programmatic assessment includes formative, continuous summative, and exit summative aspects, encompassing multiple data points from a wide range of observers, to allow for the defensible elimination of bias. While there may always be subjectivity in performance assessment, this is mitigated by multiple data points, a structured process and collective decision making so as to make defensible performance judgements. The College of Emergency Medicine encourages assessment practices that are aligned, integrated, flexible and contextual. The programmatic assessment is described summarised in Figure 2:

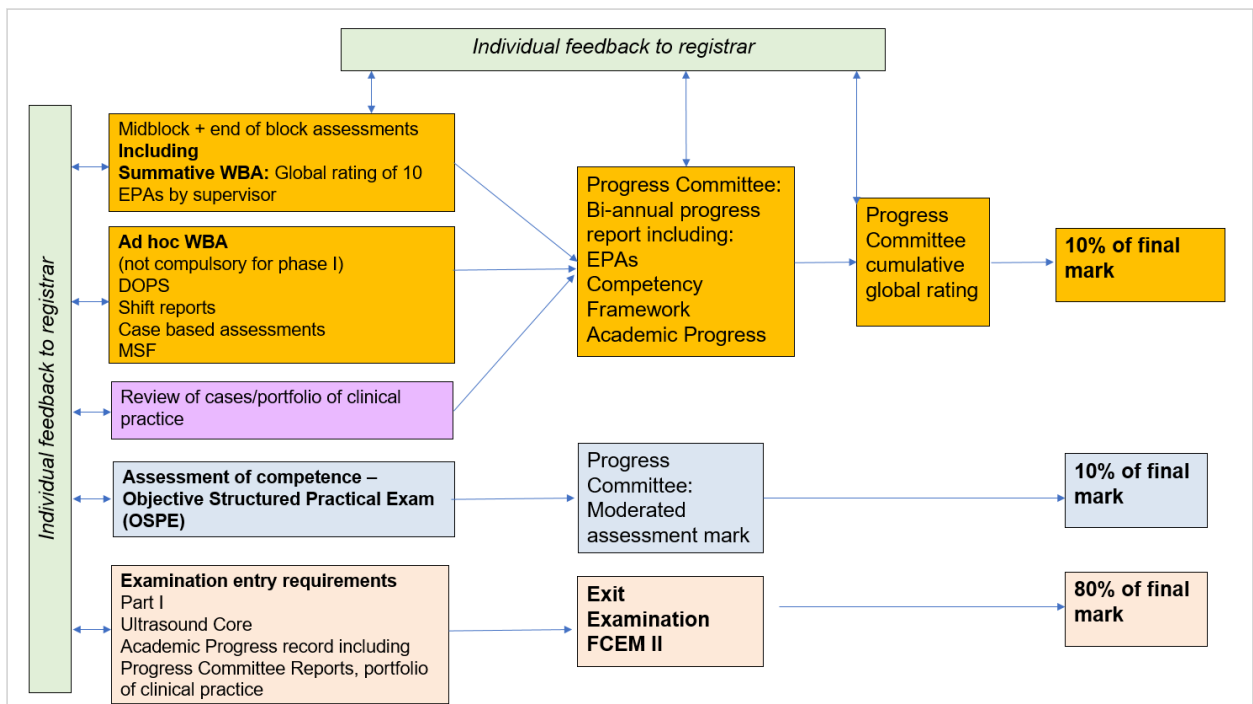


Figure 2: Programmatic Assessment for the Fellowship of the College of Emergency Medicine of South Africa

Overall final exit success:

Progress Committee cumulative global ratings and the results of a moderated assessment observable annual performance examination mark will **each** count 10% toward the final mark. The exit examination (FCEM II) will be unchanged and will count 80% of the final mark.

Entry into the FCEM II will include the following requirements:

- Passing of the FCEM Part I examination
- Successful completion of an emergency point-of-care ultrasound examination or equivalent
- Portfolio of evidence and academic record signed by HOD
- Research dissertation completed to satisfaction of HOD

Annual Objective Structured Practical Examination (OSPE)

The use of directly observed procedures (DOPS) is not always practical, as supervisors may not always be present when critical procedures are performed by registrars. While the logbook

continues to suffice for the logging of critical procedures and skills, the workgroup decided that certain “observable competencies” should be assessed in a simulated environment.

Annually, all Universities will hold an annual observable performance examination (OPE) in the form of objective structured clinical examinations (OSPEs). The purpose of this annual observable performance examination is to create an observable set of skills that can be benchmarked nationally.

The annual examination will consist of 8 - 10 Objective Structured Practical Examination (OSPE) stations, inclusive of skills that are necessary competencies for South African emergency medicine specialists. This examination will be standardised across all Universities, with external examiners at all universities to ensure validity. OSPE questions and pass marks will be pre-determined by the examiners and the assessment oversight committee of the CEM. Ideally, depending on examiner and skills lab availability, the assessment will take place across all universities asynchronously but within a short time frame, usually around August. While in the future bi-annual or more frequent assessments may be instituted, we suggest starting with a yearly annual performance examination due to staffing and capacity restraints. **All registrars within training are expected to participate in the examination**, and the assessment data (ratings and feedback) for the OSPEs will be forwarded to the University Progress Committee. The OSPE Portfolio mark will be a progress committee decision, being a moderated mark by the Progress Committee based on the information available from 3 top completed OSPE assessments. This mark will count 10% of the registrar’s final mark in their portfolio and FCEM Part II final assessment.

Work based assessment

Work-based assessment involves various tools that assess the competency of postgraduate trainees’ skills, attributes and application of knowledge objectively within their workplace, using multiple data points. These are holistic assessments that objectively measure the progress of a trainee on their road to competency and entrustability.

For the Emergency Medicine field, it is important to have tools that measure the accuracy of diagnostic reasoning that a registrar requires, as well as that the registrar possesses adequate skill sets and that they can also manage the floor of an emergency unit, where interruptions are common. A major concern for the assessors who will be using these tools, is the time resource that it would require to assess registrars. For this reason, tools were designed to be electronic, easily accessible and can easily assess the registrar at the bedside in real time.

With stakeholder feedback, multiple concerns were raised about the potential impact on time and cognitive load within busy Emergency Departments. Therefore, for the first phase of the WBA rollout, an assessment will be made on each of the 10 EPAs (see below) by the trainee’s supervisor, during both the mid- and end-of-block assessments. These will also provide opportunities for the supervisor to provide feedback to the trainee.

Portfolio of Learning

The portfolio of learning, including the portfolio of evidence and academic progress record are being revised and will take electronic format.

The following broad headings will be included in the Portfolio of Evidence:

- Emergency Medicine-related Academic Development
- Learning Objectives for proposed Individual Rotations
- Record of work completed

The following broad headings will be included in the academic progress record:

- Academic Development
- Work based assessments (DOP; CBA; Shift Reports; Oral discussions; CEx)
- Mid-block assessments
- End of block assessments
- Personnel Management Development System (PMDS) assessments (DOH requirement)
- Portfolio (Global rating)
- Reflections
- Annual OSPE results and composite OSPE final mark
- Progress Committee Reports (Bi-annual)

Declaration on Completion of Training

Declaration by Progress Committee on level of entrustment for Entrustable Professional Activities (EPAs)

Declaration on adequate completion of the portfolio of learning

The University Progress Committee (see below) will review all of the data collected through WBAs in order to decide the level of entrustment for the Entrustable Professional Activities (EPAs.)

Midblock and end-of block assessments

Mid and end-of-block assessments utilising an electronic tool will be compulsory for every registrar in every rotation.

Midblock assessment	6 weekly discussion with EM faculty/supervisor	Every ED rotation		Mid and end of block assessment tool
End of block assessment	End of 3 months discussion with EM faculty/supervisor	Every ED rotation		Mid and end of block assessment tool

Entrustable Professional Activities

EPAs are defined as “a unit of professional practice that can be fully entrusted to a trainee, once he or she has demonstrated the necessary competence to execute this activity unsupervised,” (8) and defines the profession, contributes to health care practice, has a clearly defined beginning and end, and is a discrete group of tasks. (8)

Based on the stakeholder engagements and working group consensus, the working committee suggested an initial 20 set of EPAs that define the Emergency Medicine specialist:

Entrustable Professional Activities		Crit thinker	Communicator	Professional	Med expert	Leader	Teach/Learn	Wellbeing	Social	Context	Team	Manager
1	Resuscitation of pulseless patients	x	X	X	X	X	X	X			X	
2	Managing critically ill patients	X	X	X	X	X	X				X	X

3	Assessing and managing urgent and non-urgent patients	X	X	X	X	X	X		X	X	X	X
4	Managing the unit floor on a shift	x	x	x	x	x	x			x	x	x
5	Managing acute mental health care patients	X	X	X	X		X		X	X	X	
6	Leading handover rounds	X	X	X	X	X	X		X	X	X	X
7	Disposition of critically ill patients for transport	X	X	X	X	X				X	X	
8	Transition of care of patients	X	X	X	X		X		X	X		X
9	Teaches a small group of juniors and provides feedback	X	X	X	X	X	X	X				
10	Giving telephonic or digital advice/telemedicine	X	X	X	X	X	X			X		
11	Creating and implementing an integrated management plan for a palliative care patient	X	X	X	X	X	X	X	X	X	X	X
12	Recognizing and managing the vulnerable patient	X	X	X	X				X	X	X	X
13	Managing a patient-related complaint	X	X	X	X	X	X	X	X	X	X	X
14	Managing conflict	X	X	X		X					X	X
15	Patient safety incident management	X	X	X	X	X					X	X
16	Assessing and managing the poisoned patient	X	X	X	X				X	X	X	

17	Managing a hospital major incident	X	X	X		X				X	X	X
18	Developing and producing an ED staffing roster	X	X	X		X					X	X
19	Managing flow and access block	X	X	X		X				X	X	X

The first 10 EPAs have been developed by the team, and drafts of the EPAs are available as **Appendix A**. The first 10 EPAs will be implemented initially, and may be broadly considered as junior and senior EPAs. We acknowledge that there will be some overlap in the timing of the development of these EPAs

Junior EPAs:

- Resuscitation of pulseless patients
- Managing critically ill patients
- Assessing and managing urgent and non-urgent patients
- Managing acute mental health care patients
- Disposition of critically ill patients for transport

Senior EPAs:

- Managing the unit floor on a shift
- Leading handover rounds
- Transition of care of patients
- Teaches a small group of juniors and provides feedback
- Giving telephonic or digital advice/telemedicine

We anticipate 20 - 30 EPAs are required to describe the full range of work-based competencies for a South African EM registrar. Potential further EPAs are included in the EPA table above.

There are many entrustability scales developed. This is a generic example, but each EPA will have its own 5 point scale.

1	Entrusted to observe
2	Entrusted to perform under direct supervision
3	Entrusted to perform under distant supervision
4	Entrusted to perform unsupervised
5	Entrusted to supervise

Supplementary WBA

A number of additional WBA tools have been developed – currently utilising the REDCAP application, ideally available on the registrar’s device (smartphone or tablet). This data can then be included in the registrar’s Portfolio of Evidence and communicated to the Progress Committee as supplementary material to assist in progress decisions. These tools are as follows:

WBA	Description	REDCAP tool
Directly Observed Procedure	Observation by other/supervisor of a skill with real-time feedback	WBA tool
Case based discussion	Observed or reflective case based discussion	WBA tool
Shift Report	Self-filled by registrar regarding reflection on a shift	WBA tool
Teaching and learning tool	Feedback given by a person who received teaching from registrar – may include peers, interns, medical students, supervisors, etc	Teaching and learning tool
Stimulated case reflection	Registrar reflection on a patient case with relevance to 1 of the 10 EPAs	Stimulated case reflection tool

Multi-source feedback (MSF)	Documents inter-professional feedback including nursing staff, juniors and peers – collected by supervisor.	MSF tool
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University Progress Committee

Each University will nominate representatives for the University Progress Committee. Terms of reference and progress report templates will be released by the CEM. The University Progress Committee will review the portfolio of evidence, mid- and end-of rotation assessments, and Work-Based Assessments for each registrar, twice yearly. This process will have oversight by and support from the CEM Assessment Committee (a subgroup of the CEM council), as well as yearly moderation by an appointed external faculty member. Each University will have clear plans for feedback to individual registrars on progress committee judgements, as well as documented processes for development in the case of a not yet competent candidate. A schematic representation of the relationship between the WBA tools, portfolio, and the Progress Committee is depicted in Figure 3.

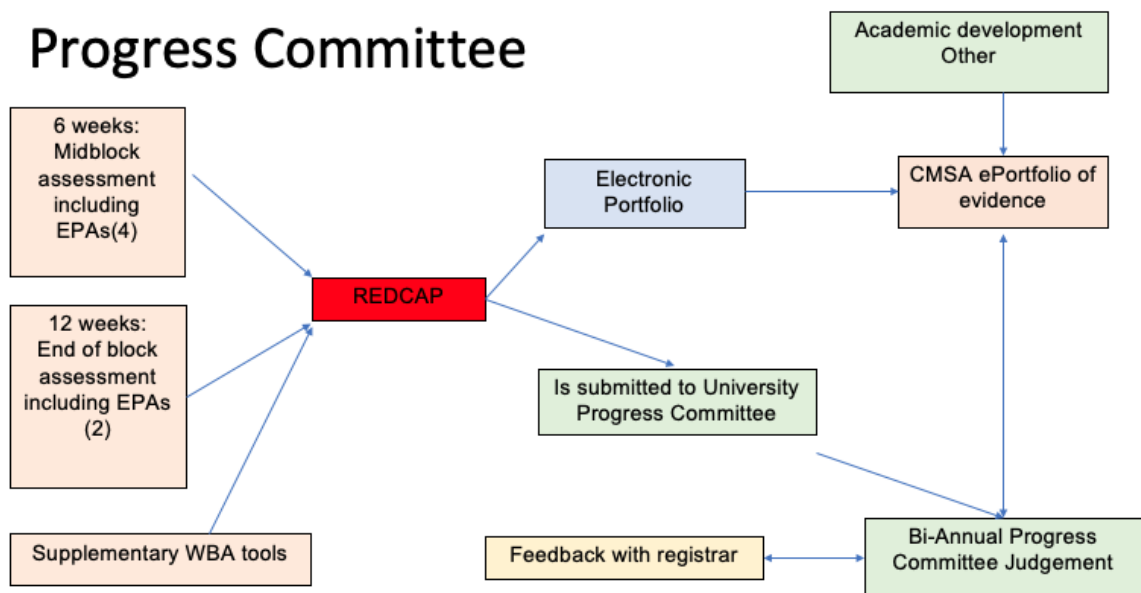


Figure 3: Schematic representation of electronic interaction between registrar, faculty and progress committee

The Progress Committee will generate a bi-annual (6 monthly) Progress Report for each registrar, including the following domains:

- 1) Academic Progress
 - a. FCEM examinations
 - b. Portfolios
 - c. Scheduled teaching attendance
- 2) University MMED/Research progress
 - a. University specific milestones
- 3) Entrustable Professional Activities
- 4) Wellbeing and personal development
- 5) Moderated Annual Observable Performance Examination mark – prior to admission to FCEM II
- 6) Global Work Based Assessment mark – prior to admission to FCEM II.

The Progress Committee gives feedback to the registrar, HOD and University regarding Progress on a bi-annual basis. The Progress Committee bi-annual reports are a prerequisite to entry to the Final examination. The Progress Committee will meet with the registrar individually to provide feedback, establish level of development, determine risk of failure to progress, and develop progress plans.

For EPAs, the committee will utilise all information above to agree upon the level of entrustment. These can graphically represented in the form of a dashboard, which will be generated for each registrar at every 6 bi-annual evaluation. An example of this is shown in the chart below. To be allowed entry into the FCEM II examination, the registrar will need to be found entrusted to perform all 10 EPAs unsupervised (Level 4.)

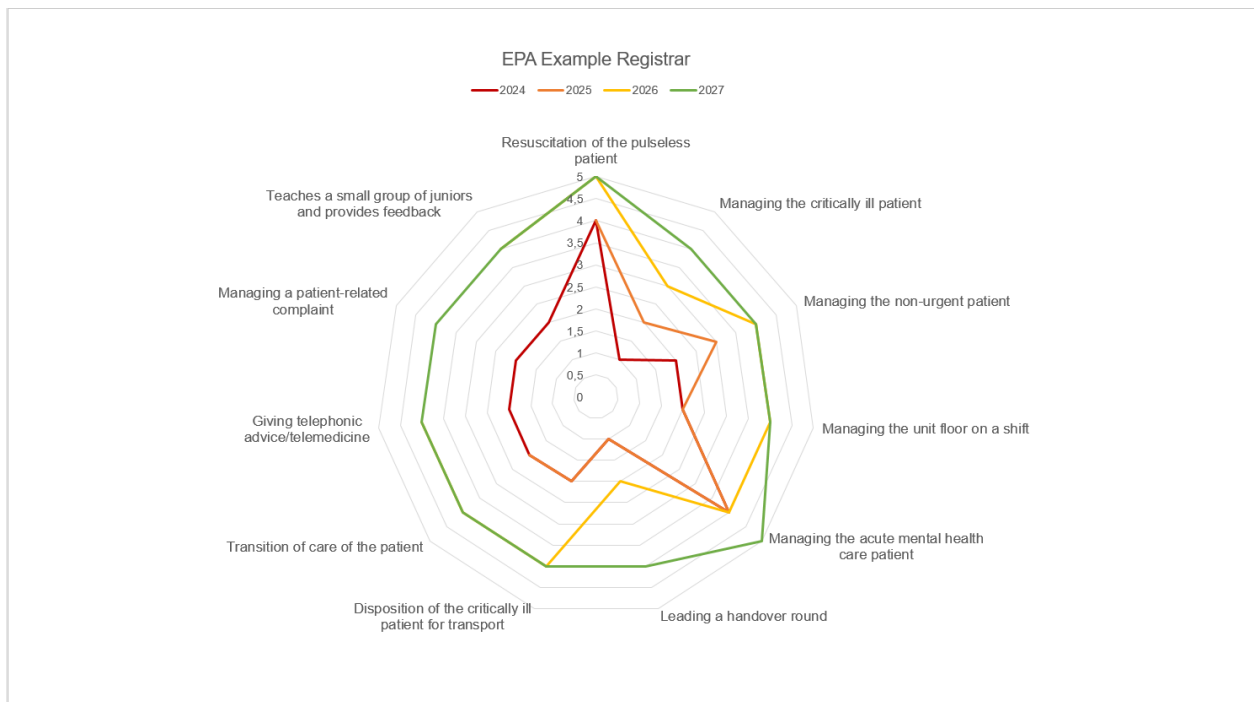


Chart 1: Example of a Progress Committee yearly dashboard for a hypothetical registrar. In 2024, they are entrusted a level 4 to resuscitate a pulseless patient, and by 2027 are entrusted to supervise others in doing so. In 2025 and 2026, the progress committee are unable to make judgements on the registrar's ability to manage a patient related complaint, but in 2027 note them to be entrustable at level 4. This registrar would now be entrustable at all EPAs at least level 4, and competent to sit the FCEM II.

Exit level examination

There is no change planned for the current exit level examination, FCEM II. The written and oral examinations will continue to take place in the same format as per the CMSA website.

Implementation and faculty development

Adequate resources and in-depth training for faculty development is imperative to ensure the standardisation of work-based assessment throughout the country. The CMSA and College of Emergency Medicine will support programmes to develop competencies in WBA facilitation for faculty and registrars as well as national standard setting.

Timelines for implementation

The suggested timelines for the implementation of Work Based Assessment and the development of the updated curriculum are explained graphically in Figure 4:

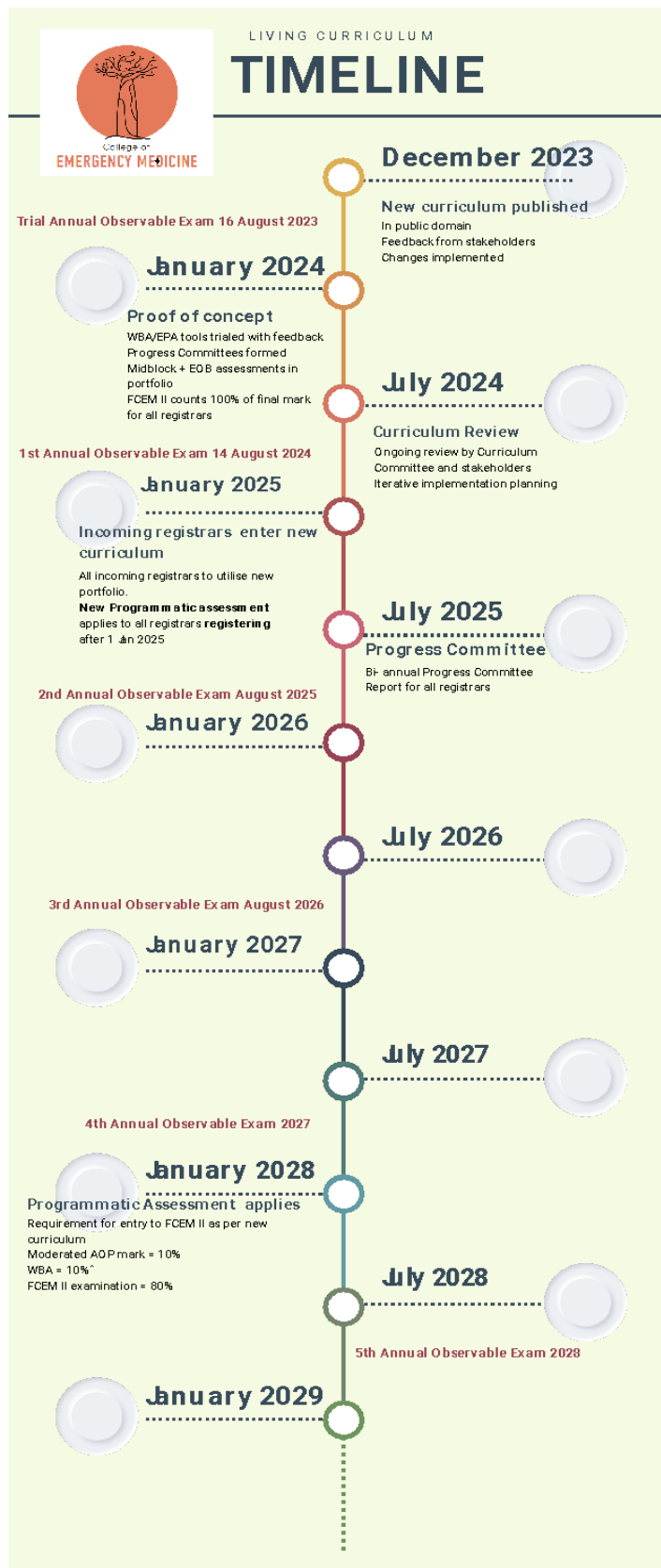


Figure 4: Suggested timeline for implementation of the Work-Based Assessment (WBA)

All registrars will be assessed using the WBA tools from January 2024, however, registrars currently in the programme will not have the WBA count towards their final mark. The current entry requirements to the FCEM II examination will remain.

All registrars registering for the FCEM/MMED Emergency Medicine programme after 1 January 2025 will be subject to the update programmatic assessment and updated entry criteria into the FCEM II examination.

	WBA	Annual Performance Examination	FCEM II exit examination	Total
Registrars starting prior to 1 January 2025	-	-	100%	100%
Registrars starting after 1 January 2025	10%	10%	80%	100%

Resources and further reading

Simple explanation for entrustability scales: <https://www.royalcollege.ca/mssites/entrustability/index.html#/>

Olle Ten Cate & David R. Taylor (2021) The recommended description of an entrustable professional activity: AMEE Guide No. 140, *Medical Teacher*, 43:10, 1106-1114, DOI:10.1080/0142159X.2020.1838465

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EPA: Managing the unit floor on a shift

1. EPA Title	Managing the unit floor on a shift
2. Specifications and Limitations	This activity contains the following activities: 1. Maintaining situational awareness regarding the status of patients currently in the Emergency Department and coming into the Emergency Department 2. Having a birds-eye view of staffing, patient numbers, and potential challenges 3. Coordination of care activities within the unit 4. Managing overcrowding in the emergency department by addressing current factors contributing to access block, in, through, and output factors, identifying patients who can be seen quickly (reverse triage) and streamlining patients for discharge 5. Teamwork with the multi-disciplinary team to identify barriers 6. Supervising of junior staff while working in the Emergency Department Limitations: 1. This EPA does not include other management functions (see EPAs for managing a patient-related complaint, managing an adverse event, compiling a staffing roster, etc)

3. Potential risks in case of failure	1. Patient care – increased morbidity and mortality due to access block 2. Trust amongst members of the team 3. Breakdown in intra and inter-departmental relationships 4. Stress and Emotional distress to registrar and team if floor not managed calmly and well
4. Most Relevant Competency Domains	1. Critical thinker 2. Communicator 3. Professional 4. Med expert 5. Leader 6. Context specific practice 7. Team based practice 8. Manager
5. Required Knowledge, Skills, Attitudes and Experience	<u>Knowledge:</u> 1. Understanding of when to call for help 2. Identification of the sick patient requiring urgent attention 3. Thorough understanding of in, through, and output factors affecting a shift Skills: 1. Manage multiple demands on time and attention. Manage interruptions 2. Leadership 3. Communication to junior staff members including feedback Attitudes: 1. Ensure wellbeing for self and team by ensuring staff take breaks 2. Courteous to members of multi-disciplinary team

6. Assessment information sources to assess progress and support summative entrustment decision	1. WBA: Shift report 2. Reflection a. Annually x four 3. Shift reports 4. Multi-source feedback 5. Summative entrustment decision-making made by Education (Competency) Committee
6. Entrustability scale	1: Entrusted to participate in shifts as a junior registrar, not as a team leader 2: Entrusted to manage the floor and lead during a shift, under supervision 3: Entrusted to manage the floor independently with a consultant on telephonic call 4: Entrusted to manage the unit floor on a shift, unsupervised 5: Entrusted to supervise and teach junior registrars floor and shift management
7. Entrustment for which level of supervision is to be reached at which stage of training?	Entrustment level 4 by end of registrar training

EPA: Resuscitation of the pulseless patient

1.	Title	Resuscitation of the pulseless patient
2.	Specifications and limitations	<u>Includes:</u> - The identification and resuscitation of a pulseless patient who presents in cardiac arrest to the Emergency Department - The identification and resuscitation of a pulseless patient who deteriorates whilst already present in the Emergency Department - This is from the time that the patient is identified as pulseless, until either post-ROSC care is initiated; or the patient demises - Adult and pediatric patients can be included in this EPA <u>Does not include:</u> - Care of the critically ill patient (EPA 2)
3.	Risks in case of failure	<u>Patient morbidity and mortality due to:</u> - Failure to initiate the resuscitation timeously may result in patient mortality or morbidity - Failed resuscitation may result in patient mortality - Suboptimal resuscitation may result in permanent patient morbidity or disability <u>Failed inter-professional teamwork due to:</u> - Unprofessional behaviors - Poor communication
4.	Most relevant domains of competence	1. Critical thinker 2. Communicator 3. Professional 4. Medical Expert 5. Leader 6. Team based practice

5.	Required experience, knowledge, skills, attitude, and behaviour	<u>Experience</u> - Recognise a patient in cardiac arrest - Perform a brief initial assessment focused on gathering pertinent data pertaining to the patient's presentation - Communicate the severity of the patient's condition clearly to a senior clinician and seek supervision in a timely manner <u>Knowledge</u> - Knowledge of the relevant ACLS algorithms - Knowledge of the reversible causes of cardiac arrest and how to rapidly identify and reverse them - Knowledge of the latest ACLS guidelines and updates, and how this is applied at a specialist level - Show the ability to interpret ECG conditions requiring immediate intervention, including but not limited to ischemia and dysrhythmias - Indications for prolonged CPR - Indications for terminating a resuscitation <u>Skills</u> Demonstrate airway and respiratory management in the pulseless patient; which includes but are not limited to: - Basic airway maneuvers - BVM use - Advanced airway management; including endotracheal intubation and the use of supraglottic devices - Performing a thoracostomy; and the placement of a thoracostomy tube if indicated Demonstrate the hemodynamic management of the pulseless patient; which includes but are not limited to: - Initiation of appropriate patient monitoring; including invasive hemodynamic monitoring - Performing CPR - Use of a mechanical CPR device - Demonstrate the ability to integrate ultrasonography into the ACLS algorithm - Obtaining venous access; this includes intra-osseous access and central venous access - Administration of medications as guided by the ACLS algorithm; and the administration of antidotes if clinically indicated
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		- Administration of thrombolysis during cardiac arrest if clinically indicated Demonstrate the initiation of post-ROSC care, including but not limited to: - Recognize the return of spontaneous circulation; which includes the use of, and the interpretation of ETCO₂, arterial lines, and ultrasound - The set-up and initial use of invasive mechanical ventilation - Initiate appropriate inotropic support; this include the use of an infusion pump - Initiate appropriate temperature management Demonstrate administrative skills, including but not limited to: - Documenting clinical encounters in an accurate, complete, timely and accessible manner, and in compliance with legal and privacy requirements - Complete a D28 form <u>Attitude</u> - Assemble a resuscitation team from within the Emergency Department - Allocate clear resuscitation roles to the members of the resuscitation team - Communicate with the team shared mental models - Demonstrate closed loop communication - Summarize the patient's condition and initial treatment priorities to the resuscitation team - Communicate with the patient's family where applicable; this includes breaking bad news - Debrief with the members of the team on completion of the resuscitation <u>Behavior</u> - Demonstrate professional behaviour at all times - Encourage team work to ensure an optimal patient outcome
6.	Assessment information sources to assess progress and ground a summative entrustment decision	<u>Case based discussions</u> - Resuscitation of the pulseless patient is discussed using a real case, either retrospectively or prospectively - 5 cases need to be assessed

		<u>Directly observed</u> - Resuscitation of the pulseless patient is directly observed by a faculty member - Simulation can be used to observe this EPA <u>360/Global assessment</u> - Peer assessment by a fellow registrar, or a medical officer with at least 3 years of emergency medicine experience, that was part of the resuscitation team
7.	Entrustability scale	1. Entrusted to observe and assist a team leader during the resuscitation of a pulseless patient 2. Entrusted to lead the resuscitation of a pulseless patient under direct supervision of a senior registrar or consultant 3. Entrusted to lead the resuscitation of a pulseless patient with the telephonic guidance of a consultant 4. Entrusted to lead the resuscitation of a pulseless patient unsupervised 5. Entrusted to supervise medical officers and junior registrars during the resuscitation of a pulseless patient
8.	Entrustment for which level of supervision is to be reached at which stage of training?	By the time of application to write the FCEM final exit exam, all trainees should have mastered this EPA at: Level 4 (Unsupervised practice)

1. Title	Assessing and managing patients with urgent and non-urgent emergency department presentations
2. Specifications and limitations	The focus of this EPA is the assessment and emergency department management of urgent and non-urgent patient presentations. Examples of these types of presentations include, but are not limited to: ● Cough or wheeze ● Musculoskeletal injuries or pain ● Eye complaints ● ENT complaints ● Headache ● Fever ● Vomiting ● Rash ● Syncope ● Weakness ● Acute gynecological presentations This does not include patient categories which are covered in other EPAs including: ● Pulseless patients (EPA1) ● Critically ill patients (EPA2) ● Palliative patients (EPA4) ● Mental health care users (EPA5) ● Vulnerable patients

3. Risks in case of failure	1. Patient morbidity and mortality due to missed or delayed diagnosis and management 2. Over or under investigation of the patient (laboratory or radiology investigations) 3. Inappropriate use of hospital resources (point-of-care tests, allied services) 4. Inappropriate disposition plan 5. Omission of consideration of the psychosocial needs of the patient
4. Most relevant domains of competence*	1. Critical thinker 2. Medical expert 3. Communicator 4. Professional 5. Context-specific practice 6. Team based practice 7. Leader 8. Teacher / learner 9. Social accountability 10. Manager
5. Required experience, knowledge, skills, attitude, and behaviour	1. Experience a. Should be in an EC or specialized unit with an EP that can perform relevant assessments and give feedback 2. Knowledge b. Apply clinical judgement to differentiate a critically ill patient from an urgent or non-urgent patient c. Recognize problems that may need the involvement of more experienced colleagues and seek their assistance immediately d. Apply knowledge of clinical and biomedical sciences to assess the patient and formulate a problem-list or differential diagnosis e. Selection and interpretation of bedside and formal investigations f. Insight regarding various pharmacological and non-pharmacological therapeutic options and execution of a plan for the management of a patient's condition g. Develop a comprehensive, context-specific disposition plan

	3. Skills a. Communicates using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect, and compassion b. Documents a well-defined patient-specific assessment and management plan. c. Performs appropriate bedside investigations d. Communicates professionally with medical and non-medical personnel. e. Forms a collaboration with a multidisciplinary team. 4. Attitudes a. Demonstrates professional and compassionate care. b. Applies transparent and empathetic communication. c. Considerate of patient specific values and needs. d. Recognize and respond to ethical concerns related to the care of the patient 5. Behaviour a. Displays appropriate and respectful behaviour during patient assessment and interaction b. Actively advocates for the patient when necessary c. Interacts professionally with and respects all individuals in work environment. d. Consider appropriate resource utilization when choosing care options e. Manage multiple patients simultaneously in a safe and efficient manner, including the appropriate delegation of tasks to other health care team members
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6. Assessment information sources to assess progress and ground a summative entrustment decision	<u>Case based discussions:</u> at least 3 - Candidate presents the case to the assessor <u>Directly observed:</u> at least 2 - Directly observed patient interaction from patient interview to disposition
7. Entrustment for which level of supervision is to be reached at which stage of training?	By end of 1st year: entrusted to perform under distant supervision By end of 2nd year: entrusted to perform unsupervised By end of 3rd year: entrusted to supervise
8. Time period to expiration	None stipulated, should remain competent throughout the career as an emergency physician practising in the emergency centre.

EPA TITLE	Managing the acute mental health care patient
SPECIFICATION AND LIMITATIONS	This entrustable professional activity includes: 1. Assessment of the approach to verbal de-escalation of an agitated mental health patient. 2. Performing physical and pharmacological restraint of an agitated mental health patient. 3. Demonstration of a clinical approach to the diagnosis of: ● Mood disorders ● Psychotic disorders ● Anxiety disorders ● Eating disorders (Including history, physical and mental state exam) 4. Discussion of appropriate special investigations for acute mental health patients. 5. Applying suicide risk assessment tools appropriately. 6. Demonstration of the use of MHCA forms. 7. Mitigating the risk of abscondment of boarding psychiatric patients in the EC. 8. Mitigating the risk of psychiatric patient's self-inflicted harm or, harm to staff, patients and escorts in the EC. 9. Counselling a family member on the implications of patients certified under the MHCA.

	A summative entrustment decision for this EPA does not apply for: 1. Patients with life threatening injuries or requiring intensive medical therapy.
	• Risk of harm to the patient themselves, staff and escorts/family members. • Legal implications for improper documentation on MHCA forms. • Patient adverse events in the form of drug administration errors and injury during physical restraints. • Risk to the public as a consequence of abscondment. • Suicide from poor risk assessment. • Delayed psychiatric management in misdiagnosed conditions.
	X Critical Thinker X Leader X Manager X Communicator 0 Teaching and Learning X Social Accountability X Professional 0 Wellbeing X Team Based Practice X Medical Expert X Context Specific Practise

REQUIRED KNOWLEDGE, SKILLS, ATTITUDES AND EXPERIENCE	• Collaborating with security personnel in the EC to apply restraints physically and keep patients with mental illnesses under close supervision
	• Direct observation (DOPS) of verbal de-escalation technique. • Direct observation (DOPS) of leadership in coordinated 5-point restraint • Case -Based discussion (CBD) of relevant pharmacology and direct observation of chemical restraint of an agitated patient. • Mini Clinical Exam (MiniCEX) of clinical approach to the diagnosis and management of emergency psychiatric conditions. • Case note review of completed MHCA forms to ensure that documentation is present and that it contains the required information. • Direct observation (DOPS) of a discussion of family counselling • Discussion of EC safety plan for psychiatric patients
	Junior registrar must demonstrate competency across all K, S, for this EPA Senior registrar must demonstrate all K, S, A above including leadership and unit management skills.

INFORMATION SOURCES TO ASSESS PROGRESS AND SUPPORT SUMMATIVE ENTRUSTMENT	None stipulated, should remain competent throughout the career as an emergency physician practising in the emergency centre.
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WHEN IS ENTRUSTMENT SUPERVISION LEVEL EXPECTED? EXPIRY DATE	
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EPA Title	Leading a handover round
Specifications and limitations	This activity includes the following elements: • The provision of information of a patient from one healthcare worker to another as part of the patient assessment and disposition process • The reception of information of a patient from another healthcare worker, along with the transfer of direct responsibility of the patients care within the emergency department • Oversight of the professional manner in which communication and transition occurs • Includes oral transfer of information as well as written transfer of information • The information that is transferred includes at least patient demographics, a concise medical history, current problems and issues, pending lab/radiographic and other diagnostic results information, anticipatory guidance/upcoming possibilities, and a justified to-do list. • Critical overview of the clinical and historical information and its interpretation in the context of the patients presentation. This EPA does not include: • Information provision amongst healthcare providers where the primary responsibility for patient care is not handed over • Referrals to other disciplines/facilities
Risks in case of failure	• Morbidity and mortality to patient in the instance of ○ poor or incorrect communication and/or ○ incorrect management of the patient • Medicolegal implications ○ for incorrect information transmitted or documented

	○ Ethical repercussions in the instance of breach of confidentiality/autonomy
Relevant domains of competence	● Critical thinker ● Communicator ● Professional ● Medical expert ● Teacher/Learner ● Social responsibility ● Context specific care ● Manager
Required experience, knowledge, skills, attitude and behaviour	<i>Knowledge:</i> ● Candidate needs to fully understand all details of the condition of the patient, including diseases present and their potential future complications, anticipate future developments, and prioritise competing tasks. ● Candidate requires knowledge of all common illness scripts of the discipline and setting is required, if the trainee is to be entrusted with the responsibility to conduct handovers in this discipline and setting. <i>Skills:</i> ● Communicate effectively with clinicians, with family or with other caregivers ● Communicate situation awareness, illness severity, action and contingency plans between and to other healthcare providers. ● Use of a standardised verbal and written template to improve reliability of the information transfer and prevent errors of omission. ● Ensure that the healthcare professional accepting responsibility for the patient also has specific communication skills, including clarifying and synthesising information. ● Ensure that the received mental model matches the sender's mental model, and provide feedback to the individual

	instigating the handover on any errors that occurred, including inaccurate information transmission. <i>Attitudes:</i> • The trainee must show willingness to take sufficient time for information transfer, to understand the perspectives of the healthcare teams, especially if not from the same profession, and to serve the patients' interest above institutional and specialty interests. • Should be courteous and professional to other healthcare workers and patient • Shows insight into emergency department healthcare teams limitations or capabilities <i>Teaching approaches:</i> • Use of a systematically structured oral handover, for example, using a mnemonic such as SBAR (Situation, Background, Assessment, Recommendation) or similar • Candidate must make use of the written or electronic medical record as a dynamic tool.
Assessment information sources to assess progress and ground a summative entrustment decision	• Structured observation during handovers, preferably with a validated handover observation and feedback tool (minimum TBC) • Shift reports (minimum TBC) • Multi-source feedback reports
Entrustability scale	1. Entrusted to observe handovers 2. Entrusted to lead handover rounds under direct supervision 3. Entrusted to perform handover rounds under distant supervision 4. Entrusted to lead handover rounds unsupervised 5. Entrusted to supervise handover rounds

Entrustment for which level of supervision is to be reached at which stage of training?	Candidate is expected to reach proficiency (unsupervised) within first year of training, with supervision at a distance to be resented throughout the training period.
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1. Title	Preparation of critically ill patients for transport
2. Specifications and limitations	Includes: - From the time the decision is made to transport, until the patient leaves the room -Preparation for intra-hospital transfer of the critically ill patient (i.e. from ED to CT scan or ICU) - Preparation for the inter-hospital transfer of the critically ill patient (via air or road transfer) - Handover to retrieval crew Does not include: -Transfer of a chronically ill patient to a step-down facility -Primary (on-scene) transfers - Transfer once patient has left the department - Handover at receiving facility - Resuscitation of the critically ill patient not related to stabilisation for transfer (see EPA 2)

3. Risks in case of failure	Patient morbidity and mortality due to: - Dislodgement of critical lines and tubes - Inadequate monitoring and missed deterioration - Inadequate equipment prepared for transfer, including “running out” of oxygen, drugs, battery life on IVACs, etc Failed inter-professional teamwork due to: - Inadequate handovers - Unprofessional behaviour
4. Most relevant domains of competence	7. Critical thinker 8. Communicator 9. Professional 10. Medical Expert 11. Leader 12. Context specific practice 13. Team based practice
5. Required experience, knowledge, skills, attitude, and behaviour	<u>Experience</u> - <u>EPA 2: Managing the Critically Ill Patient</u> is a pre-requisite for this EPA

Knowledge

- Discuss of the advantages and disadvantages of road and air transport
- Understand the levels of care and scopes of practice of Emergency Medical Care practioners in South Africa
- Critically discuss the risks and contra-indications to patient transfer
- Apply a systemic process of ensuring patient is stable for transfer, including:

PPE

Primary survey (Airway & Disability including cervical spine immobilisation as needed)

Packaging including exposure and pressure point checks

Documentation

Equipment

Emergency drugs

	- Utilise a checklist to ensure that all necessary safe guarding is applied for the safe transfer of the critically ill patient <u>Skills</u> - Perform medical and diagnostic procedures relevant to transport including but not limited to: - Adequate (at least 2!) Peripheral or central venous or IO access sites - Perform inter-costal drains, intubation, catheters, splinting - Interpret radiography and laboratory diagnostics i.e. pre-transport blood gases <u>Attitudes</u> - Work together with members of the multi-disciplinary team including nursing, EMS and porters - Communicate with the team shared mental models and closed loop communication - Organise and prioritise responsibilities to prevent unnecessary delays - Demonstrate professional verbal and written handover to the retrieval team
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	- Communicate with the patient, patient's family, and receiving facility where applicable <u>Behaviour</u> - Demonstrate professional behaviour at all times
6. Assessment information sources to assess progress and ground a summative entrustment decision	<u>Case based discussions – at least 2</u> Preparation of the critically ill patient for road or air inter-facility transfer is discussed using a real case, either retrospectively or prospectively <u>Directly observed – at least 2</u> The preparation of a critically ill patient for transfer is directly observed by a faculty member <u>360/Global assessment – at least 2</u> - Member of Nursing team - Member of EMS

6. Entrustability scale	1: Entrusted to observe and assist a team leader to prepare critically ill patients for transport 2: Entrusted to prepare critically ill patients for transport under direct supervision by a senior registrar or consultant 3. Entrusted to prepare critically ill patients for transport with consultant on telephonic call 4. Entrusted to prepare critically ill patients for transport unsupervised. 5. Entrusted to supervise junior registrars and Medical Officers to prepare critically ill patients for transport.
7. Entrustment for which level of supervision is to be reached at which stage of training?	By the time of application to write the FCEM final exit exam, all trainees should have mastered this EPA at: level 4 (Unsupervised practice)
8. Time period to expiration if not practiced	Not applicable

1. EPA Title	Teaches a small group of juniors and provides feedback
2. Specifications and Limitations	This activity contains the following activities: 1. Teaching of a procedure to a group of juniors (undergrad students and/or junior staff, e.g., interns, medical officers and/or nurses) 2. Teaching of a knowledge-based topic to a group of juniors (undergrad students and/or junior staff, e.g., interns, medical officers and/or nurses) 3. Engage in opportunistic bed-side teaching whenever the potential arises, as appropriate. 4. Apply a structured approach to deliver constructive feedback to junior medical staff about emergency medicine practice. Limitations: 1. This EPA does not include teaching in a classroom (didactic lectures) 2. This EPA does not include simulation-based training. 3. This EPA does not include the design and delivery of presentations.
3. Potential risks in case of failure	1. Patient safety (if time away from patient care outweighs the benefits of a teaching intervention) 2. Trust amongst members of the team 3. Emotional distress to registrar 4. Inaccurate skills, knowledge conveyed to junior staff during teaching transaction. 5. Insensitive/harsh/untactful feedback to juniors that may cause distress to junior staff.

4. Most Relevant Competency Domains	1. Critical thinker 2. Communicator 3. Professional 4. Med expert 5. Leader 6. Teach/Learn 7. Wellbeing
5. Required Knowledge, Skills, Attitudes and Experience	<u>Knowledge:</u> 1. Understand the components of a structured approach to deliver constructive feedback to junior medical staff about emergency medicine practice. 2. Understand basic principles of adult learning 3. Understand basic strategies of teaching in emergency department, e.g., one-minute preceptor 4. Basic understanding of equipment used when teaching procedural skills 5. Understand how to seize and capitalise on a teachable moment in a busy emergency centre <u>Skills:</u> 1. Balance the operational needs of a busy emergency centre with the opportunity to teach - to maintain patient safety. 2. Develop structured learning outcomes and critically apply teaching and learning techniques while teaching undergraduate and peer postgraduate students. 3. Confidently engage in knowledge translation of new evidence in team based practice 4. Lead small and large group didactic teaching sessions 5. Integrate basic principles of adult learning to proficiently deliver a teaching session to a small

	audience 6. Recognise opportunistic situations (teaching moments) to facilitate bed-side teaching whenever the potential arises, as appropriate. 7. Lead and teach on a multi-disciplinary ward rounds (bedside teaching) 8. Apply the one-minute preceptor teaching method effectively. 9. Structured approach to teach a procedural skill Attitudes: 1. Promoting a safe learning environment for the learner 2. Courteous and professional to patient and students/junior staff 3. Responsive to the needs and demands of the students/junior staff and the patients 4. Respect dignity and privacy of patients involved in bedside teaching 5. Effective role modelling by the registrar
6. Assessment information sources to assess progress and support summative entrustment decision	1. WBA: Direct observation a. To collect two observations from two different observers in the first year (one procedure and one knowledge based topic) b. To collect two observations from two different observers in the second year (one procedure and one knowledge based topic) 2. Simulated cases (annual observable performance examination) a. Annually x four 3. Shift reports 4. Multi-source feedback (from junior staff and students)

	a. Opportunistic bedside teaching b. Feedback from students and junior staff 5. Summative entrustment decision-making made by Education (Competency) Committee
7. Entrustability scale	1: Entrusted to observe and assist a team leader teach a small group of juniors and provide feedback 2: Entrusted to teach a small group of juniors and provide feedback under direct supervision by a senior registrar or consultant 3. Entrusted to teach a small group of juniors and provide feedback with consultant on telephonic call (not really applicable) 4. Entrusted to teach a small group of juniors and provide feedback unsupervised. 5. Entrusted to supervise junior registrars and medical officers to teach a small group of juniors and provide feedback.
8. Entrustment for which level of supervision is to be reached at which stage of training?	1. By the time of application to write the FCEM final exit exam, the trainee should have mastered this EPA at level 4.

8. Time period to expiration if not practiced	
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1. EPA Title	The transition of care of the acutely ill patient
0. Specifications and Limitations	This activity may contain the following elements: • The provision of care for an acutely ill patient from one healthcare worker to another as part of the disposition process • The reception of care of an acutely ill patient from another healthcare worker for the continuation of care within the emergency department • The professional manner in which communication and transition occurs • Sufficient and clear documentation of the above processes • Adequate and clear case summary presentations <u>Limitations:</u> This EPA does not include: • Preparation of the patient for transport • Where the healthcare worker was not the main treating physician
Potential risks in case of failure	• Morbidity and mortality to the patient in the instance of poor or incorrect management of the patient • Medicolegal implications for incorrect information transmitted or documented • Ethical repercussions in the instance of breach of confidentiality/autonomy
Most Relevant Competency Domains	1. Critical thinker 2. Communicator 3. Professional 4. Medical expert 5. Teacher/Learner 6. Social responsibility 7. Context-specific care 8. Manager

Required Knowledge, Skills, Attitudes and Experience	<i>Knowledge:</i> ● Full complement of medical knowledge to recognise, manage and communicate life threatening emergencies during the transition of care of the acutely ill patient ● Anticipation of potential complications of patient condition that may arise during the transition of care ● Shows familiarity with hospital specific patient transition protocols <i>Skills:</i> ● Effectively communicates patient condition and severity in a professional and succinct manner to healthcare worker ● Continuously updates patient notes ● Demonstrates care that is professional and time effective <i>Attitudes:</i> ● Courteous and professional to other healthcare workers and patient ● Willingness to receive feedback ● Shows insight into referring institute/disciplines limitations or capabilities
Assessment information sources to assess progress and support summative entrustment decision	● Structured Direct Observation of patient transitions ● Shift reports ● Multi-source feedback reports ● Simulated cases

Entrustment for which level of supervision is to be reached at which stage of training?	1 Entrusted to observe 2 Entrusted to perform under direct supervision 3 Entrusted to perform under distant supervision 4 Entrusted to perform unsupervised 5 Entrusted to supervise The candidate is expected to reach stage 4 within the first year of training.
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