

RCGP WPBA Guidance

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Clinical case review

Example 1:

Title: Tele-text Telephone Consultation

Date: xx yy zz

Setting: General Practice

Brief description:

During a duty day I noticed VH, an elderly gentleman was on the list requesting a call back. The telephone number had a code in front of it. I was aware VH was very hard of hearing. The telephone number took me through a text telephone service. I witnessed the use of the text telephone system and conveyed my questions via an operator. VH in turn answered the questions. VH was concerned he may have had a recurrence of his piles and was keen for something to help. We had a brief conversation on the telephone. I became acutely aware that I needed to ask short and simple questions that could be conveyed via a text. Having never seen VH with a similar problem, nor could I see a recent documentation of treatment for haemorrhoids and that it was harder to communicate over the telephone I arranged to see him to further assess face to face.

Clinical Experience Groups (max 2):

- People with vulnerabilities (for example veterans, addictions, mental capacity difficulties, safeguarding issues, and those with communication difficulties) - People with long-term conditions and disability

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Communicating and consulting

Justification [*describe how your actions and approach link to the capability*]: It was interesting to experience the text telephone system.^[SEP] I have now had experience of using a different communication modality. I was able to adapt the language that I used to take into consideration his individual needs. I was able to manage the consultation effectively with the patient through using the text telephone interpreter, which required me to be organized and structured.

Supervisor:

You adapted the language you used to take into consideration the communication difficulties. Your questioning style was adapted to allow for the tele-text service, using an 'interpreter'. Additional consideration to what you asked and explained to the patient was needed due to the way the information was conveyed to the patient.

Reflection and learning needs

Reflection: what will I maintain, improve or stop? [*Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence*]

When asking questions via an operator it is important to be precise with the questions to. It made me consider the importance of each question I asked to discriminate what the underlying problem was. I felt it was clinically appropriate to ask VH to come to the surgery for

a further assessment. For some patients it is appropriate to take a full history over the telephone however for others, it is more appropriate and easier to take full history face to face such as this patient. I will continue to build up my experience of using the text telephone system as well as improving communication with patients using different modalities. Overall I felt this telephone consultation and the process of the consultation was successful.

Learning needs identified from this event

I would like to gain experience of using a translation telephone line (something we don't use regularly in my current practice). I would also like to develop further strategies to communicate effectively with patients who have a loss of hearing – should they present alone, or with a signer.

Supervisor comment:

I'm really glad that you have used this service and found ways to adapt to make it useful for you and the patient. Your capability link here look very appropriate and I've confirmed this. In this situation the offer to use a text telephone service came from the patient who had given this number to the practice. Have you considered how you as a team might encourage use of this service? The newer texting service which allows patients to respond with text/pictures may also be of benefit to patients who have communication difficulties (you could reflect on the Organisation, Management and Leadership capability!)

Example 2:

Title: Reflection on on-call shift

Date: xx yy zz

Setting: Other: out of hours psychiatry hospital setting

Brief description:

I worked a busy weekend on call covering general psychiatry over several hospital sites.

Clinical Experience Groups (max 2):

- Mental health (including addition, alcohol and substance misuse)
- Urgent and unscheduled care

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Team-working

Justification (describe how your actions and approach link to the capability): I find that during on calls you have to use a very particular type of team working skills, as you have to create a mini, instant team for the on calls without knowing who is going to be in the team in advance. The same doctors do nights and days for the weekend, so you hand over to them at the start and end of the shifts, and this continuity is really helpful for patient care. Since the pandemic, there has been a meeting every night at 21.30 via skype, which includes the SHOs, registrar, consultant and matron or nurse in charge. It is really helpful to have the nursing staff represented at the meeting. In one meeting, I discussed a patient who had just become unwell and the meeting meant that the consultant was able to share an experience of Covid19 presenting in a manner like my patient, and the nursing staff being present meant they could immediately go and put the plan we came up with into place, as well as me phoning the nurse directly after the meeting. It facilitated improved patient care.

Supervisor:

The pattern of work during COVID has evolved. You highlight a really positive step of having a remote handover with the whole team present, to deliver efficient, safe patient care. I wonder if this will remain moving forwards.

Capability: Clinical examination and procedural skills

Justification *[describe how your actions and approach link to the capability]:* I was attended one of the psychiatric hospitals to review a male patient with abdominal pain. In order to assess him I examined him. At the moment, in a psychiatric hospital, this involves reviewing them in a locked treatment room with a nurse present. I also wear PPE with gloves, a mask and apron. I tried to be sensitive to the fact that I knew he was in a lot of pain and very anxious, and that examining his abdomen was likely to be very uncomfortable, but very important as it meant I could elicit signs such as guarding, which added to my concerns about him needing to go to hospital to rule out serious pathology.

Supervisor:

You recognised that the patient was anxious and carried out the examination without causing any harm. Wearing PPE causes additional anxiety for patients, given they can't always hear what we are saying, and we lose some of our communication by wearing a mask covering a lot of our face.

Capability: Organisation, management and leadership

Justification *[describe how your actions and approach link to the capability]:* During this busy weekend, I attended Ravenswood Hospital, which is geographically remote and therefore I needed to manage my time well to ensure I did tasks at hospitals which were on my way to Ravenswood. When I arrived, there was a major incident occurring and therefore I could not immediately do the seclusion reviews which I had attended to do. Once I established that there was nothing I could do to help, I asked if there was somewhere I could work, so that whilst I was waiting I could continue to work remotely on my laptop. This allowed me to ensure that the delay did not effect patients which still needed my attention, for example medications prescribing remotely, as I could access their records online and prescribe remotely.

Supervisor:

COVID has enabled much more remote working, with IT being provided, and system in place to enable this, which has benefits to providing safe and timely reviews and care whilst on call. You utilised your time efficiently and prioritised tasks to help manage your time during your on-call shift.

Reflection and learning needs

Reflection: What will I maintain, improve or stop? *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

I will continue to improve my time management skills during busy working periods. I feel that every job I have done have been busy in different ways and have required me to juggle tasks and prioritise tasks differently. I am now imminently going to be moving to GP and am excited to see how my skills transfer and what new ones I need to learn. The experience of covering multiple different sites has been unique with this job and is extremely challenging at times,

when you cannot be everywhere at once. There will also be a different type of team in GP, which I am looking forward to, especially after having quite minimal contact with a team for much of this rotation.

Learning needs identified from this event

I am aware that I need to continue to improve my skills in seeing patients in remote of nonclinical environments, for example on home visits. There are parallels with seeing patients with medical problems OOH in a psychiatric hospital with doing home visits, as psychiatric hospitals are not set up for medical emergencies, and is it very limited in terms of what medical problems can be dealt with.

Supervisor comment:

COVID has led to us working more closely as a team, working from the same list at times, rather than having our own clinics. We have introduced video consultations which has helped some remote consultations, in addition to using a text service to submit pictures. It is now possible to have an additional clinician/relative join a video call; this will help during the 'shadowing' induction period.

Supporting Documentation (CPD Evidence)

Example 1

Title: CPR update

Date: xx yy zz

Briefly describe your key learning from this event *[this could include helping you to maintain existing knowledge and skills]*

- Annual CPR update within the practice. Adults 30:2 breaths at a rate of 120 compressions a minute pressing approx. 6cm down. Use of automated defibrillator and bag and mask for giving breaths. Practice administering shocks
- Paediatric – child and baby 15:2
- Anaphylaxis – using auto filled pens with adrenaline
- Choking child and adult recap

Reflection: what will I maintain, improve or stop? *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

It is important to practice regularly so that when I need to use the skills I feel confident to do so until further support arrives. I have already experienced the need to use the skills outside the GP practice when someone arrested outside the practice- it feels quite different performing CPR outside the hospital environment. I am aware as I near the end of my GP training that I must ensure when I move to a new practice once qualified that I find out where the emergency bag/equipment is before starting my clinical work. Should I need to doublecheck any protocols – I am aware all emergency protocols are easily accessible in the BNF as a resource.

What learning needs have you identified?

I am aware as I near the end of my GP training that I must ensure when I move to a new practice once qualified that I find out where the emergency bag/equipment is before starting my clinical work.

Clinical Experience Groups (max 2):

- Urgent and unscheduled care

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Performance, learning and teaching

Justification: *[describe how your actions and approach link to the capability]* It is a requirement to complete annual BLS training when qualified. Having recently worked in the acute hospital setting, I have used my resuscitation skills so this was a refresher. I will ensure I remain in date with the mandatory training requirements and seek opportunities to attend appropriate courses.

Supervisor:

You allude to the session being a refresher and that it can feel quite different in real life – especially when outside the hospital setting. I have wanted to set up a few emergency situations in the surgery – as a role play – possibly without too many staff having awareness

of this, so we can practice our theoretical knowledge in a more real life setting. Maybe we could set this up as a mini QIP?

Supervisor comments:

I'm aware that the bits that I find easy to forget are checking for safety (as you don't practice this with the mannequins) and the paediatric rescue breaths

You have suggested links to working with colleagues and in teams. Whilst I'd agree that this is necessary for effective life support when I look at your entry I can't see evidence that you have reflected on your practice against the word descriptors for this capability. Similarly, this is the case too I'd suggest in relation to clinical management, you have not written about the learning in such a way that a connection has been clearly made I'm afraid so I've not linked to these.

(Linking to capabilities is much less commonly appropriate when looking at CPD events rather than at clinical practice as it is hard to demonstrate what you do in a CPD setting.)

Example 2:

Title: Certificate in the Management of Drug Misuse Part 1 RCGP **Date:**
xx yy zz

Briefly describe your key learning from this event *[this could include helping you to maintain existing knowledge and skills]*

This course took place online during the pandemic, and was very well run online. It was really useful to hear from others who work or would like to work within substance misuse all over the country. It helped me see the wealth of experience I've gained already doing this post.

Reflection: what will I maintain, improve or stop? *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

I will continue to learn from this placement in substance misuse and ask questions. The course made me more confident in the skills in prescribing methadone and buprenorphine which I've developed already and gave me additional knowledge, for example, I learned that methadone can be up titrated slightly more rapidly than I thought, and that this can actually be desirable - both for the patient's withdrawal symptoms and in terms of getting on top of drug seeking behaviour and drug taking rapidly. Taking about clinical experiences with other attendees on the course made me realise that I am confident prescribing in patients with very chaotic lives and medical histories, and that this type of patient is actually the norm we see here.

What learning needs have you identified?

I need to continue to learn about specific times when prescribing is more complex - for example, I have had a few patients recently where the drug taking is actually the secondary issue compared to their alcohol dependence (here methadone prescribing has to be kept to minimal doses) or in pregnancy.

Clinical Experience Groups (max 2):

-Mental health (including addition, alcohol and substance misuse)

- People with vulnerabilities (for example veterans, addictions, mental capacity difficulties, safeguarding issues, and those with communication difficulties)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Clinical Management

Justification *[describe how your actions and approach link to the capability]*: This course expanded my clinical management skills. I am confident prescribing methadone and buprenorphine within the legal parameters, and in initiating, uptitrating and reducing doses. I am learning more about more complex prescribing situations, such as in pregnancy and in alcohol dependence.

Supervisor:

You have gained increased knowledge and confidence in the management of patients on methadone, in particular safe prescribing, particularly amongst specific patient groups, which you can now put into clinical practice.

Capability: Organisation, Management and Leadership

Justification *[describe how your actions and approach link to the capability]*: This course originally should have been a face to face day of teaching in London, however it was moved to online learning because of the pandemic. It ran very smoothly, and I made sure I could access the live teaching via zoom before the start time. There are different considerations to make with teaching moving to online, such as working equipment, speakers and being familiar with the technology. It was a useful experience as it likely that more teaching and courses will be delivered in this manner in the future, which I would welcome.

Supervisor:

You have used your time-management skills to complete this certificate, whilst insuring patients and colleagues are not affected during this time out. You have reflected on the adaptations made with remote education/teaching. Within the GP setting, we are using Microsoft teams often for meetings we would previously have attended face to face. I'm aware the GP Half Day release course is currently running a remote teaching programme too, and will be for some time due to COVID. Moving forwards, I think some meetings will remain remote log ons, as this reduces travelling time.

Capability: Performance, learning and teaching

Justification *[describe how your actions and approach link to the capability]*: Attending this course, which ran online because of the COVID19 pandemic, contributed to my professional development and consolidated learning and experienced gained during this placement in substance misuse. I also recognise that there is more experience I need to gain in the field and will continue to attend supervision and ask questions of my consultant during this placement.

Supervisor:

You have accomplished additional learning during your rotation. You have addressed a learning need, and have been able to implement your learning during the remainder of your rotation

Supervisor comment:

You have clearly gained quite a lot of knowledge and experience from this rotation, which is further enhanced by your additional learning. Have you thought if you would want to consider developing a specialist interest, for example exploring options to become a GPwSI?

Learning Event Analysis/Significant Event

Title: Late diagnosis of pancreatic cancer

Date: xx yy zz

Setting: GP Surgery

What happened, including your role?

An 80-year-old woman with known IBS following full investigation in 2009 presented to the surgery in February with feeling of nausea and gas following bowel movements. She had previously been investigated in 1990s with similar results. She was under the colorectal team and had a planned dilatation of anal stenosis; she had postponed her procedure as she didn't feel up to it following a recent fall. The patient saw a colleague a couple of weeks before I met her for the first time due to her abdominal pain; they ordered bloods and an abdominal USS, which she had had, and was reported as being normal. At the time she reported that she was passing flatus, burping and didn't get any relief from buscopan. She described being off food but not having any weight loss. She admitted to being under stress recently, she thought nortriptyline was working. Examination revealed some epigastric tenderness but no guarding/rebound tenderness, and normal bowel sounds. I suggested that she trialed omeprazole, continued paracetamol, considered amitriptyline which had worked before, and to contact the colorectal surgeons. I safety netted advising to return depending on response to medication and symptoms. The patient had a subsequent fall, and was seen by the falls service, who assessed her, and didn't find anything untoward on abdominal examination. A subsequent CT scan (arranged by the Gastroenterology team) showed a pancreatic cancer with liver mets the same day, despite a normal reported USS within the last month, and normal bloods 5 weeks before the scan. Unfortunately, the patient deteriorated quickly and passed away in the local hospice 2 weeks after initial cancer diagnosis. The family reported the hospice were very caring, and that the patient had a peaceful death.

Why did it happen?

There was a quick deterioration in patients' condition. The patient had normal blood tests and ultrasound scan the day I saw her in clinic. The patient had been seen by a geriatrician, and the emergency department team and a colleague in the surgery when she had a fall in the interim between my review of her abdomen and the diagnosis. No abnormality was detected on USS; I wonder if the USS was reviewed again if it may show early signs of abdominal pathology.

What was done well? [describe your personal involvement]

I felt I made an appropriate assessment of the patient the one time I saw her. I took a thorough history, checking for red flags. I examined her, and made an appropriate management plan given the information that I had at the time. I also safety netted appropriately. I had also encouraged involvement of secondary care colleagues who were already involved in the patients care, to provide an additional level of assessment. My colleagues promptly referred to oncology/the palliative care team, as well as involving the

community nursing team. Good communication with the patient's husband and family took place throughout the diagnosis and subsequent management, including proactive home visits being arranged.

What could be done differently? *[describe your personal involvement]*

I feel given the information I had at the time when I reviewed the patient that I would not have changed my management plan and advice. I am unsure if the pancreatic cancer was very aggressive and that it was undetectable at the time of the ultrasound scan.

Who was involved in the discussion of the event?

The registered GP and one of my colleagues were closely involved in the care of the patient after the diagnosis. The registered GP wrote to inform both the ultrasonographer and the geriatrician the outcome of the CT scan to enable them to reflect on their assessments.

What have you and the team learnt?

This case highlights that pancreatic cancer can often present late. It often has non-specific symptoms. At times an USS can be unreliable, and falsely reassuring. I will consider pancreatic pathology within my differential when seeing a patient with abdominal pain.

What changes have you or the organisation made? *[As a consequence of this learning event]*

We have discussed the patient's care within the surgery and reviewed the notes to see if we could have done anything different to improve the quality and safety of care of patient's in my practice, which we concluded we couldn't.

Does this learning event meet the threshold for reporting as a Significant Event for revalidation purposes on the Form R in England, Wales & Northern Ireland (and on the SOAR declaration in Scotland)?: No

If yes, additional boxes appear:

1. Have you discussed this event with your ES/CS?
2. How was the SUI identified?
3. How did identification and progress of this SUI make you feel?

Clinical Experience Groups (max 2):

- People with long-term conditions including cancer, multi-morbidity and disability -
Older adults including frailty and/or people at end of life

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Data gathering and interpretation

Justification *[describe how your actions and approach link to the capability]:* I systematically gathered information, targeting my examination. I utilised the investigations and imaging that was available to me at the time, taking a stepwise approach, however this in the end was misleading, as the blood test and ultrasound were normal however the patient ended up having the diagnosis of pancreatic cancer with liver metastasis.

Supervisor: You tried to take a stepwise approach to this patients' care. The blood test and USS were falsely reassuring, as was the additional reviews away from the surgery.

Capability: Decision-making and diagnosis

Justification *[describe how your actions and approach link to the capability]*: I had reviewed previous letters/secondary care reviews and built on my examination findings to suggest that the patient might benefit from trying a PPI, however with a CT scan eventually, a diagnosis of pancreatic cancer as made, which sadly is often a late diagnosis as it presents with nonspecific symptoms initially. Unfortunately, blood tests can sometimes be falsely reassuring.

Supervisor: The pancreatic cancer presented in quite an undifferentiated way, which unfortunately it often does. You correctly highlight tests can sometimes be falsely reassuring – a limitation of pattern recognition. Both yourself and the practice reflected on this case and the patients' journey.

Capability: Clinical management

Justification *[describe how your actions and approach link to the capability]*: I had attempted to take an incremental approach to the management and tried to remain patient centred throughout. I safety netted when seeing the patient, and she had clearly followed colleague's safety netting advice as she had re-presented. We discussed this patients' care within the practice as a significant event, given the normal investigations that were reported just a short time before the cancer diagnosis.

Supervisor: You took a step-wise approach to this case. The patient had been referred to secondary care already and was actively under their follow up. We have discussed this case and reflected on it both formally and informally.

Supervisor comment:

This was really difficult for all concerned. It is stressful being involved in the care of people when you might feel you did thing badly... you might like to reflect in the ePortfolio about the emotional challenges of this case, (F to P elements here). Though we have talked about it and you assure me that you feel fine.

Reflection on Feedback

Title A verbal compliment **Date:**

xx yy zz

Brief description

A patient, X, booked to see me about her allergic rhinitis. Previously she had told me about her negative experiences of our local hospital. X had recently been referred by a colleague via a 2-week wait proforma for a breast lump she had detected. X managed to go to the appointment however she was fairly sure she was going to be told bad news at her follow up appointment and was unsure whether she could go back to the hospital. She knew she was unable to have surgery at the local hospital following the experiences she had witnessed through the care of her late mother, sister and brother in law. X approached me to ask what she should do. She had private health insurance that would cover her to have her operation privately. I respected her views and explained there was no specific reason why she needed to be treated in the local hospital. I agreed to speak to the team at the hospital to ascertain what the results were and find out how best to change the route of care to private care. I was unable to be told over the telephone what X was going to be told at her clinic appointment however I clarified with the secretary the process to transfer between NHS and private care and conveyed this information to the patient.

I phoned X following her appointment to find out what was happening. X was diagnosed with breast cancer. She was pleased with how she was able to transfer her care to a private team. She was pleased she had managed to go into the local hospital. X described feeling 'numb' and was fairly stunned with the diagnosis of breast cancer. I offered for me to make an appointment for X to be reviewed in the surgery to talk face to face about the diagnosis. I explained that there would be lots of hospital appointments but wanted to make sure that she felt she could come to the surgery and talk at any stage. X was grateful for the telephone call and we made an appointment. We talked further at the follow up appointment. I encouraged X to return to discuss any concerns whenever she wished.

How does this feedback make you feel?

X was very grateful for the support that I had given her. She was touched that I had bothered telephoning to check how she had got on at the hospital appointment (we had received a fax highlighting the breast cancer diagnosis). For some patients it is helpful to know that we are aware of the diagnosis however they feel they don't need our support at present as they have other appointments at the hospital. For others it is important to maintain the contact with the GP practice. One telephone call and a possible appointment can go a long way in patient satisfaction.

What are your key learning points?

I felt this was a good example of patient care. The positive response I have received has reiterated the importance of the call to check a patient is OK.

Reflection: what will I maintain, improve or stop? *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

Should I meet a similar situation of a new diagnosis I will place importance on contacting the patient. Depending on how well I know the patient I will either telephone the patient, or write

to them to highlight that we are aware of the diagnosis and to invite them to come to the surgery as they feel is appropriate.

I will continue to develop communications and links with patients following diagnosis of cancer. I will continue to reflect on my consultations and learn from colleague's experiences in the context of breaking bad news/checking understanding following breaking bad news and providing appropriate support.

What support have you had or require?

Within my practice all partners try to contact patients once they have received notification of a cancer diagnosis. Should I not be able to make telephone contact with a patient, I will explore the options for sending a carefully worded letter to the patient to let them know they can contact the surgery as required.

Have you taken your plans to your PDP? No

How will you re-assess/monitor improvements?

I will reflect on formal patient feedback via my PSQ which I will undertake in the next 2 months.

Clinical Experience Groups (max 2):

- People with long-term conditions including cancer, multi-morbidity and disability - Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Holistic practice, health promotion, and safeguarding

Justification *[describe how your actions and approach link to the capability]:* I understood the patients problem, with patients reported concerns about the local hospital, following the death of her late mother. I worked with the patient to find a agreeable and practical solution to her concerns and aimed to support her through a difficult time of her breast cancer diagnosis.

Supervisor: You clearly put the patient at ease during your consultations. You remained nonjudgemental when the patient told you about her previous experiences of the hospital. We of course cant comment on previous care provided by colleagues as we don't have all the facts.

Capability: Communicating and consulting

Justification *[describe how your actions and approach link to the capability]:* I was able to explore and respond to this patients' preferences and agenda and work with her to negotiate a mutually acceptable plan, creating a positive, supportive relationship with the patient.

Supervisor: We have previously talked about how taking the time to contact a patient is often greatly appreciated. When seeing the patient face to face you were able to use both verbal and non-verbal communication including active listening to elicit the patients concerns, build rapport and help her feel comfortable during the consultations.

Supervisor comments:

It's great when you get positive feedback like this; well done. You have described what you did to achieve this and clearly demonstrate communication skills and holistic care here. Do try and keep the brief description brief – using this box to contextualise the entry, and channel your energy into the reflective boxes.

If you had wanted to take this further there are some interesting Community Orientation elements here (effective MDTs in a private setting, why not use another local hospital through choose and book) follow up implications of being out of NHS system) and some ethical and Fitness to practice ones too as you juggle the patient's needs and beliefs and your own ones... possibly for another time though!

Leadership, management and professionalism

Title: Chairing a Meeting

Date: xx yy zz

State your role in relation to the activity:

I chaired the palliative care Gold Standards Framework (GSF) Meeting

People present at meeting: Secretary (taking minutes), community nurse representative, palliative care nurse attached to practice, assistant practice manager, all doctors present on day of meeting (GP partners and Foundation doctor in GP)

How did you approach this activity? [*what planning you undertook for the activity*] Prior to the meeting the assistant practice manager had put together an agenda, we have a process in the practice to update a spreadsheet before the meeting with all patients on the GSF – outlining when they were last seen, any current problems and whether we have proactively involved the relevant health care professionals and had advanced planning discussions. This forms the list of patients that are discussed. From this information – which is shared with the external visitors, the chair can then look at patient notes to complement the discussion taking place. I made sure I familiarised myself with the list prior to the meeting.

How did you demonstrate your ability to work with others? [*For example, how did you demonstrate your ability to work with colleagues, patients, learners and/or users (individually or in teams)?*]

I have looked after a couple of the patients on the list but I did not know all the patients well. During the meeting, whilst acting as the chair, it was important to allow all health care professionals to share their involvement with the patients (including the GP partners), to ensure everyone was aware of the patient's current situation and allow a management plan to be constructed as appropriate. I was conscious of the need to keep to time – as we had a predefined time for the meeting, and needed to ensure all patients had adequate discussion. If we went off topic, I was able to guide the team back to the aim of the meeting. I was able to communicate with all the team members in the room, rather than getting bogged down looking at the computer too much. All team members knew what they needed to do for each patient following the meeting.

How effective were you within this role? [*Reflect on your achievements and feedback received*] I think I was effective in this role. I accomplished the task of chairing the meeting, keeping within the time frame we had without any major problems. My trainer fed back afterwards that she was impressed with how I managed to keep to time, allowing all the different health care providers to share their information. As a GP trainee, it was helpful to be given the opportunity to chair the meeting in a safe environment – something I was slightly anxious about doing before, as historically this has been undertaken by the senior partner.

Reflection: what will I maintain, improve or stop? [*Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence*]

This experience has given me confidence in my ability to chair a meeting and take on more leadership roles, even as a trainee. It was important that I was prepared for the meeting – ensuring I had all the information to hand, whilst working with the secretary/assistant practice

manager to ensure all team members had been invited and knew when and where to meet in addition to having the correct paperwork to hand. I believe in proactive care for patients who have a terminal diagnosis. This meeting reinforced the importance of good clinical care and good communication.

I will continue to take opportunities to chair meetings within the practice to develop these important leadership skills, which I will need once qualified. This meeting has given me confidence in my abilities; I will have more courage in my conviction when I am given the opportunity to chair a meeting. I will try to stop worrying about the meeting in anticipation of it taking place!

What have you learnt about yourself? *[Consider what motivates you, your core beliefs and areas to develop]*

I need to have faith in my abilities a little more when chairing a meeting, gaining confidence in my skills as a chair. I have also learnt that I have a keen interest in palliative care – striving for proactive care, tailored to patients' needs and wishes. This is an area I would like to specialise in (within a practice) once I qualify.

Clinical Experience Groups (max 2):

- People with long-term conditions including cancer, multi-morbidity and disability

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Organisation, management and leadership

Capability: Team-working

Supervisor comments:

Clearly a very effective meeting, I wish I could have been there. Did you have any or the senior members of the team trying to take over and run things... or dominating the meeting (hopefully not!)? Did you have plans on how to manage these behaviours?

QIA Reflective Log

Title: Visual acuity charts in the surgery **Date:**
xx yy zz

Brief description of QIA *[Be explicit about your role and the extent of your contribution]* I conducted a small quality improvement project in the surgery looking at how the GPs use their visual acuity chart. I undertook the QIA with my supervisor overseeing me. I proposed the idea to the GP partners at their clinical meeting and shared my findings with the team.

What were you trying to accomplish? *[This could include a statement of the problem, a brief summary of relevant literature or guidelines, relevant context, and the priority areas for improvement]*

As a trainee I often move between consulting rooms. I recently saw a patient who had described an acute deterioration in vision. I realised the room I was in didn't have an easy set up for recording visual acuity. On making my referral to hospital I was asked what the visual acuity was for the patient. I wasn't able to give an accurate reading. I wanted to ensure all

rooms had an appropriate and accurate visual acuity chart in the clinical consulting rooms. I was keen to put the theory of the PDSA cycle that I have read about into practice – plan- do – study – act.

How will we know that a change is an improvement? *[What information/data did you gather – baseline and subsequent data?]*

I collected data before I made any changes to aim to demonstrate an improvement. I asked each clinician how they measured visual acuity in their consulting room. I measured the distance from the point they measured from and the chart. I subsequently asked the clinicians once I had measured the accurate distance from the visual acuity chart and put a mark on the floor to signify the distance (having got support and agreement from the partners that they were happy with this suggestion). No clinicians measured visual acuity correctly at the correct distance initially, following my intervention all clinicians correctly measured visual acuity.

How have you engaged with others? *[For example, the team, patients and other stakeholders?]*

All the clinical team were on board to have an accurate way to measure visual acuity to aid assessment and referrals. On raising the problem at the clinical meeting, the clinical team were keen to make a change. This in turn allows better patient care with an accurate clinical assessment. Marking the floors did not require input from anyone else and minimally disrupts how the room looks, and does not affect the cleaning of the rooms.

What changes have taken place? *[What changes have taken place as a result of your work? How will these be maintained? If improvement was not achieved, explain why]*

A marker is in place marking out an appropriate distance to measure visual acuity in each clinical room. The marker is fairly permanent. Should it wear off, it is easy to re-apply.

Reflection: what will I maintain, improve or stop? *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

This QIA demonstrated it is easy to make improvements within the practice. I have also shared some of the QI methodology with colleagues in the practice. I will continue to undertake QIA in the GP setting. I am keen to develop my understanding of other QI tools and approaches. I would like to integrate a different approach with the next QIA I undertake. I will stop worrying that QIA means a big project, and embrace the methodology to make more improvements within not only my training practice, but also in the practices I work in once qualifying.

Clinical Experience Groups (max 2):

- Clinical problems not linked to a specific clinical experience group

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Team-working

Capability: Performance, learning and teaching

Capability: Organisation, management and leadership

Supervisor comment:

This was simple, but a small step in the right direction for the practice. Did you also check that there was enough light on the chart when testing the acuity?

Prescribing trainee assessment reflection

Title: Prescribing assessment reflection

Date: xx yy zz

I confirm that I have completed a review of 50 of my prescriptions in line with the RCGP WPBA prescribing assessment guidelines and have attached my anonymised spread sheet of results to this log: Yes

Reflect with reference to the GP Prescribing Proficiencies:

All prescribing GPs are expected to demonstrate the following, across people of all ages which includes extremes of age, for example babies, children and older people with frailty (*based on the GMC GPCs 2017*):

1. Assesses the risks and benefits including those posed by other medications and medical conditions, reducing polypharmacy where possible.
2. Identifies when prescribing unlicensed medicines and informs patients appropriately.
3. Adheres to national or local guidelines (including recommendations for over the counter prescribing (OTC) and evidence-based medicine.
4. Uses antimicrobials appropriately.
5. Counsels patients appropriately including giving instructions for taking medicines safety in line with up to date literature.
6. Reviews and monitors effects including blood testing at appropriate intervals.

What do you plan to maintain with regard to your prescribing? [Reflect on what you are doing well]

I hope to maintain a high quality of safe, appropriate and accurate prescribing going forwards. I feel that I am a safe prescriber and that this is reflected in my assessment. In future, I will continue prescribing in an evidence-based manner using guidelines and best practice. I feel this is demonstrated by appropriate antibiotic and other prescribing (e.g. for acne) in my assessment attached. I did prescribe some medication in my assessment which diverged from guidelines or local policy but it was clear from my documentation (and noted in my Excel document) that this was a conscious decision informed by clinical and individual need - something I am keen to continue ongoing forwards.

What do you plan to improve with regard to your prescribing? [Consider how to improve your suboptimal prescribing]

There are a few key areas in the assessment that were highlighted for improvement. The main area is being mindful when using EMIS pre-populated dosage instructions and editing these where appropriate. I used these in multiple instances but, for instance, often didn't qualify the 'Twice Daily' Naproxen as 'When Required.' Although not a frank error, this isn't best practice and isn't a clear and appropriate instruction. More generally, ensuring clarity with regards to how to take a medication and for how long could be improved going forward.

As an aside, my antibiotic prescribing which was audited was generally good. Despite this, there were some instances where I could have employed delayed prescribing or altered the length of course of antibiotic so it was in line with national guidelines. This is something that I will be more mindful of in the future.

With regards to using unlicensed medications, only one such medication was highlighted (Nifedipine for Oesophagael Spasm). Although I remember discussing it being off license with the patient, I didn't document this appropriately. This is something I must improve on in the future.

What do you plan to stop with regard to your prescribing? *[Comment on any significant errors]*

From the assessment there wasn't any specific things that I needed to stop outright but, as discussed above, I need to not use the EMIS generated dosage instructions and instead tailor these where appropriate.

Which of the GP prescribing skills listed above have you not covered (if any) in this assessment? How will you address these?

Due to the assessment being conducted at the start of the COVID pandemic, there were fewer chronic disease management medications included as part of the assessment. This is due to the nature of the work being carried out during this time in GP. This meant that very few if any of the medications in the assessment required follow up blood tests or similar. This is something, however, that has formed a large part of my practice before COVID and will after COVID and which I will be more aware of as a result of this exercise.

After saving and submitting this log please go and create a PDP entry using your reflections above.

Clinical Experience Groups:

- Clinical problems not linked to a specific clinical experience group

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Clinical management

Justification *[describe how your actions and approach link to the capability]:* The audit demonstrated my ability to prescribe safely as well as my awareness of local and national prescribing guidelines. In addition, it demonstrated where I actively chose to deviate from these guidelines and why. I feel I was also able to demonstrate elements of empowering patients to manage their own medical problems - giving them leeway to titrate dosages for instance - where appropriate.

Supervisor

I agree this review demonstrates that you are a safe prescriber. You are very aware of guidelines and know where to look them up if needed. You have the ability to choose to make decisions outside of these, and can justify when you choose to do so.

Capability: Performance, learning and teaching

Justification *[describe how your actions and approach link to the capability]:* This assessment demonstrates good critical appraisal of my practice and a willingness to grow and improve. Engaging in this process demonstrates good clinical governance and an active approach to seeking feedback. I found it a useful exercise with tangible learning points to take away.

Supervisor

You continue to have a great approach to learning and development and are willing to receive feedback which is important for all of us.

Capability: Fitness to practice

Justification *[describe how your actions and approach link to the capability]:* This assessment was an exercise in scrutinising my individual prescribing behaviour with a view to improving my prescribing. I feel I have demonstrated a good critical approach and a willingness to improve and change as a result of measures resulting from the assessment.

Supervisor

You have a very thorough approach, and if anything, are more critical of yourself than you need to be. You have high standards which is good and are open to comment and any suggestion of improvement (not that there were many!)

Supervisor comment:

This was an interesting exercise for both of us. It didn't bring up any worrying trends and its affirming to see that you are a safe effective prescriber.

CEPS reflection

Title: Fundoscopy examination

Date: xx yy zz

CEPS performed: *[Please be specific, for example prostate examination not just rectal examination or cranial nerve examination not just neurological examination]* : Fundoscopy

Reason for CEPS: *[State reason for examination or procedural skill performed. Describe physical signs elicited (to include if this was the expected finding):*

I reviewed a 30 year old woman who presented with headache and was found to have new significantly elevated blood pressure (200/125). I needed to perform fundoscopy to look for signs of retinal haemorrhage or papilloedema (accelerated hypertension). I thought I could see papilloedema so I referred the patient into hospital for further review.

Communication and cultural factors: *[reflect on any communication and cultural factors]:* I made sure I clearly explained to the patient what the examination entailed. It was important to assess whether there were any changes in the back of the eye as this might influence the management strategy I took and whether the patient required a hospital admission.

Reflect on any ethical factors: *[to include consent]:*

As a male doctor, I am aware this is actually quite an intimate examination, as I am required to come very close to the face of a patient in a darkened room. This patient presented alone. I did consider whether I should get a chaperone for this examination.

Self assessment of performance: *[to include overall ability and confidence in this type of examination or procedure]:*

I find fundoscopy sometimes quite difficult depending on how dilated the pupils are, and how dark I can get my room. I am aware I can dilate the pupils when assessing, however consideration needs to be given as to how the patient arrived at the surgery (I don't want to prevent them from driving home if they would otherwise be able to!)

Learning needs identified: *[How and when will these learning needs be addressed?]*

Fundoscopy is not as routinely conducted as examining chests, therefore I must ensure that I take each opportunity to practice the skill to help ensure a reliable assessment is made.

Clinical Experience Groups:

- Clinical problems not linked to a specific clinical experience group

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Clinical Examination and Procedural skills

Justification *[describe how your actions and approach link to the capability]:*

Supervisor comment:

You correctly identify that actually fundoscopy could be considered an intimate examination. Appropriate informed consent, and clear documentation of your examination and findings is important. If there was a language barrier, have you thought how you would gain appropriate consent and explain what and how you plan to undertake the examination?

Placement Planning Meeting entry

Title: Clinical supervisor meeting Palliative Care

Date xx yy zz

What were the main areas discussed?

- My goals for the rotation
- My background and previous experience of palliative care
- Educational opportunities including protected study time
- Pastoral care needs

What learning opportunities were highlighted?

- Regular teaching
- Opportunity to give teaching
- Regular small group teaching discussions with clinical supervisor
- MDTs
- Ward rounds
- Opportunity to go into the community

What objectives did you agree on?

- Develop understanding of how the hospice fits into the wider community of services available to patients
- Develop knowledge and confidence in prescribing palliative drugs
- Develop communication skills further in discussing end of life to patients and families through observing other clinicians and 'useful phrases'
- Go on community visits as possible

How do you plan to achieve these objectives?

- Attend teaching and ward rounds
- Ask questions
- Complete CBDs and mini CEXes

Clinical Experience Groups: (max 2)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:

Justification *[describe how your actions and approach link to the capability]:*

Supervisor comment:

Sounds like it was a helpful meeting focusing your learning over the next 6 months. We have regular gold standard framework meetings, where we discuss our palliative patients. We have a link palliative care nurse. Maybe you could organise to come with our link nurse to the practice to see how this works from both sides?

Academic Activity

Title: Foundation Investigation Group (FIG) **Date:**

xx yy zz

How did you approach this task?

I volunteered in 2017 to run the Foundation Investigation Group (FIG) at the local hospital, which was set up by a Geriatrician with the aim of collating and disseminating learning points of Foundation doctor's quality improvement and serious incident (SIRI) investigations. I organise meetings for interested heads of department, clinicians and junior doctors approximately quarterly, and chair these meetings.

As the main task of the group is to try to spread learning points, we have tried to develop systems such as a How To Guide for juniors doing QI/SIRI projects which includes creating a poster. This can then be used in the live learning screens which are being used in the hospital - they were initially used in ITU to good effect.

How did you gather, appraise and interpret available information?

I chair meetings, which I set up and consider the agenda of beforehand. We get given new QI/SIRI projects and have developed an area of the local intranet to 'advertise' these projects to people who may want to complete one. These meetings are a useful way to develop my leadership skills and work on important patient safety issues. Often these QI/SIRI projects are done in isolation and the learning points which are gleaned from them not shared widely enough. The Foundation Investigation Group was developed as a way of overcoming this problem.

What problems did you encounter and how did you solve them?

The meetings are an opportunity to practise my leadership and organisational skills, as I help organise each meeting and chair them. I also answer emails in between meetings and have been invited to sit on other patient safety panels. Chairing meetings involves organisation to decide on an agenda beforehand and good communication skills to listen to ideas and make sure everyone is heard. It's a good opportunity to utilise a different type of communication skill to that which I use daily on wards; here I'm communicating with doctors of all levels and ages and may other members of the wider multi-disciplinary team including pharmacists, nursing leads and non-clinicians.

Describe any other strengths highlighted by this work?

This group helps share learning points, with the aim to help prevent similar potential patient safety concerns in the future. By a junior doctor chairing the meeting, it might be perceived as less 'threatening' than attending the meeting presented by a senior colleague. I hope I have shown others they can take part in similar and make a difference.

What developmental needs are highlighted by this work?

It is important to ensure that the group continues as doctors move through the hospital with different speciality placements. Having reviewed the projects, it might be helpful to re-review them some time after, to check the changes have been properly embedded into the wards

Clinical Experience Groups: (max 2)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Organisation, management and leadership

Justification *[describe how your actions and approach link to the capability]:* I helped run a group with aimed to support change in my local hospital, by disseminating learning points of QI projects and SIRI investigations. In order to run the meetings effectively, it relied on good time management skills.

Supervisor: This is a fantastic opportunity to actively facilitate change in the local organisation. It is good practice to share the learning points from SIRI/QIPs. You were able to integrate IT into this work, developing part of the intranet for sharing this information having discussed it.

Capability: Communicating and consulting

Justification *[describe how your actions and approach link to the capability]:* : I communicated with colleagues from a multidisciplinary team and with doctors both more junior and senior than myself. I used my communication skills to communicate with colleagues rather than with patients.

Supervisor: Although not communicating with patients, you needed to communicate with the whole team involved in an organised and structured and timely way, bringing together everyone's thoughts.

Capability: Performance, learning and teaching

Justification *[describe how your actions and approach link to the capability]:* I have helped to coordinate disseminating information about quality improvement activities that have taken place in the local hospital, which itself is a quality improvement activity! I chaired the meeting, and sought feedback from my senior colleagues on this experience.

Supervisor: You have actively facilitated the development of a multi disciplinary team by chairing this meeting. You were inclusive of the wider team. You continue to go above what we would expect in terms of teaching and learning during your training.

Supervisor comment:

What a fantastic learning experience, not only have you gained experience of chairing a meeting, but you have also worked with a multi disciplinary team, and also seen how the reporting systems work in hospital. In the GP setting, we hold regular significant event meetings, reviewing cases. We revisit the outcomes at a later date to check the changes have been imbedded into our working practice. When in GP, you will have other opportunities to chair meetings and get involved in other projects.