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Health Education England, NHS England and Skills for Health, 2020 Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care: Portfolio and Assessment Materials

**Adapted for use by Kent & Medway Training Hubs**

**Name:**

**Work Area:**

**Version: Final Version 1.0 30th June 2020**

**Version Control**

|  |  |  |  |
| --- | --- | --- | --- |
| Version  | Author | Date | Changes/comments |
| 1.0 | Health Education England, NHS England and Skills for Health and Royal College of General Practitioners  | January 2020 | Original document: <https://www.skillsforhealth.org.uk/services/item/724-advanced-clinical-practice-core-capabilities-for-nurses-working-within-general-practice-settings-in-england> |
| Draft 2.1 | Sara-jane Kray | 23/01/2020 | Compile all Documents from the Health Education England, NHS England and Skills for Health and Royal College of General Practitioners Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England 2020, into one usable document |
| Draft 2.2 | Sara-jane Kray | 11/02/2020 | Adjustments for copy write approvalTitle page, footer updated, Induction to include purpose from Skills for Health [website](https://www.skillsforhealth.org.uk/services/item/724-advanced-clinical-practice-core-capabilities-for-nurses-working-within-general-practice-settings-in-england) Hyperlinks to original document included and reference to systems to state ‘Please note these systems are a guide and not mandatory, Evidence is required for worked based assessments by a trained Clinical Supervisor’. |
| Draft 2.3 | Julia Taylor | 16/02/2020 | Copyright approval ‘I'm happy with your amendments. It is now clear that this is the national framework’. |
| Draft 2.4 | East Kent Training Hub | 23/06/2020 | Approved by EK TH Operations Board |
| Draft 2.5 | North & West Kent Training Hubs | 26/06/2020 | Approved by North &West Kent Training Hub |
| Final | Sara-jane Kray | 30/06/2020 | Locked areas with document |
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# Introduction:

Primary care and general practice are ever evolving to meet the increasing and more complex needs of local communities / populations. This will require new ways of working and the development of multi-professional general practice and primary care teams.

This framework provides a standard and greater clarity on the capabilities for nurses working at the advanced clinical practice level within general practice.

# Structure of the framework

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|  | The framework comprises 4 Domains.Within the Domains, 13 Capabilities describes the skills, knowledge and behaviours required for nurses working at the advanced clinical practice level.The Capabilities are underpinned by core indicative knowledge, key clinical presentations, investigations and referrals.A range of materials have also been developed that primary care nurses, clinical supervisors and others may find of use in evidencing achievement of the capabilities and in the development of a portfolio.This framework aligns with the requirements for clinical practice set out in the Multi-Professional Framework for Advanced Clinical Practice in England (HEE 2017). |

## Development of the framework

The framework was commissioned by NHS England GPN Ten Point Plan Team and Health Education England.

Project delivery was led by Skills for Health and guided by a project steering group which comprised key stakeholders including advanced clinical practitioners, NHS Trusts, Royal Colleges, professional bodies and patient representation.

## Acknowledgements:

The essence and purpose of the original Health Education England, NHS England and Skills for Health and Royal College of General Practitioners Core Capabilities [Primary Care framework](https://www.skillsforhealth.org.uk/services/item/724-advanced-clinical-practice-core-capabilities-for-nurses-working-within-general-practice-settings-in-england) remains the same and no words have been altered.

All documentation required is provided within this one document. However updated / additional documents in the future may be found [here](https://www.skillsforhealth.org.uk/services/item/826)

The Kent & Medway Training Hubs acknowledges HEE, NHSE and Skills for Health as the publishers of the 2020 Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care: Portfolio and Assessment Materials document. The Kent & Medway Training Hubs has with kind permission adjusted the document into a practical format for use by Advanced Clinical Practitioners (Primary Care nurses) and their Clinical Supervisors.

# SECTION ONE ACP (Primary Care Nurse) Capability Portfolio Evidence

Evidence is required for worked based assessments by a trained Clinical Supervisor

| **Evidence** |
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| **ACP (Primary Care Nurse) Capabilities** | **Section 1** | **Section 2** | **Section 3** | **Section 4** |
| **MSc Assignments**  | **Other training** | **Work based Assessments**  | **Reflections / Learning log** | **Feedback / Correspondence** |
| Domain A. Person-centred collaborative working:ACP (Primary Care Nurses) have highly developed interpersonal and communication skills to engage in effective, enabling and complex interactions with individuals, carers and colleagues in the clinical environments in which they practise. They have advanced skills in listening and information-processing, alongside empathetic skills to ascertain, understand and respond to individuals’ complex needs and concerns. They use sophisticated language and media (including remote consultation such as telephone, skype etc.), are sensitive to individual preferences and needs, and uphold and safeguard individuals’ interests. This level of practice will include ‘conversations with people to collaboratively manage highest complexity and significant risk’ i.e. Step 3 of the Person-Centred Approaches framework: Person-Centred Approaches (Health Education England & Skills for Health 2017). ACP (Primary Care Nurses) takes account of individuals’ preferences, priorities and needs, to guide the care and treatment they offer. They respect individuals’ expertise in their own life and condition and empower and support them to retain control and to make choices that fit with their goals. Avoiding mechanistic practice, they apply their knowledge and skills in a person-centred way. |
| 1 | Communication and consultation skills:a) Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation. b) Reflect on communication strategies and skilfully adapt those employed to ensure communication strategies foster an environment of person empowerment. c) Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people’s communication and language needs, preferences and abilities (including levels of spoken English and health literacy). d) Communicate effectively with individuals who require additional assistance to ensure an effective interface with a practitioner, including the use of accessible information. e) Evaluate and remedy situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing environments which may occur during home visits, care home visits or in emergency situations), and have strategies in place to overcome these barriers. f) Recognise when the person and their family/carer may have competing agendas and be able to facilitate shared agenda setting using a triadic consultation approach. g) Consult in a highly organised and structured way, with professional curiosity as required, whilst understanding the constraints of the time limited nature of general practice/primary care consultations and ensure communication is safe and effective. h) Elicit psychosocial history to provide some context for people’s problems. i) Enable effective communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation. j) Contextualise communication approaches to use in group situations. k) Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding, including use of verbal, written and digital information. l) Manage people effectively, respectfully and professionally (including where applicable, carers and families) especially at times of conflicting priorities and opinions. m) Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people’s care. n) Recognise that effective consultation skills are a subset of advanced communication skills highlighted in the capability for history taking and consultation skills.  |  |  |  |  |  |
| 2 | Practising Holistically Promoting Health:* ***public***

a) Critically appraise the impact that a range of social, economic, and environmental factors can have on health outcomes for people, and where applicable their family and carers.b) Effectively employ the Public Health England “All Our Health” framework in own and wider community of practicec) Analyse data and intelligence to critically appraise a ‘practice population’ to help identify needs of the people who are served, to add value and be mindful of the need to mitigate the impact of health inequalities on individuals and diverse communitiesd) Evaluate how a person’s preferences and experience, including their individual cultural and religious background, can offer insight into their priorities, wellbeing and managing their own care.e) Explore and act upon day to day interactions with people to encourage and facilitate changes in behaviour such as smoking cessation, reducing alcohol intake and increasing exercise that will have a positive impact on the health and wellbeing of people, communities and populations i.e. ‘Making Every Contact Count’5 and signpost additional resources.* ***person***

f) Recognise the impact of the presenting problem on the person and where applicable their carer/family.g) Recognise and respond appropriately to the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness and consider in the context of local social prescribing services.h) Engage people in shared decision making about their care by:➢ supporting them to express their own ideas, concerns and expectations and encouraging them in asking questions➢ explaining in non-technical language all available options (including doing nothing)➢ exploring with them the risks and benefits of each available option, discussing the implications, how it relates to them and promoting their understanding as much as possible➢ utilising motivational interviewing techniques➢ supporting them to decide on their preferred way forward➢ supporting them to explore the consequences of their actions and inactions on their health status and the fulfilment of their personal health goals.i) Develop and promote shared management/personalised care/support plans with people individualised to meet their needs in partnership, where appropriate, with other health and social care providers and with carers/family members and voluntary organisations where applicable. j) Evaluate how the vulnerabilities in some areas of a person’s life might be overcome by promoting resilience in other areas. k) Recognise and foster the importance of social networks and communities for people and where applicable their carers/families in managing long-term health conditions, such as linking with statutory and voluntary organisations and support groups. l) Work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities. m) Evaluate the implications of, and apply in practice, the relevant legislation for informed consent and shared decision making (e.g. mental capacity legislation, Fraser Guidelines). n) Advise on and refer people appropriately to psychological therapies and counselling services, in line with their needs and wishes, taking account of local service provision. o) Advise on sources of relevant local or national self-help guidance, information and support including coaching. p) Advocate for and contribute to person-centred approaches in the management and development of services.  |  |  |  |  |  |
| 3 | Working with colleagues and in teams:a) Ensure own work is within professional and personal scope of practice and access advice when appropriate. b) Advocate and utilise the expertise and contribution to peoples’ care of other allied health and social care professionals and work collaboratively within the multi-professional team to optimise assessment, diagnosis and integrated management and care for people. c) Have a deep and systematic knowledge and understanding of the wider primary, community care and secondary care, voluntary sector services and teams and refer independently using professional judgement. d) Work effectively within and across teams, managing the complexity of transition from one team to another or membership of multiple teams. e) Communicate effectively with colleagues using a variety of media (e.g. verbal, written and digital) to serve peoples’ best interests. f) Make direct referrals in a timely manner as indicated by peoples’ needs with regard for referral criteria i.e. 2-week wait cancer pathway, urgent or routine referrals. g) Initiate effective multi-disciplinary team activity as a lead member and understand the importance of effective team dynamics. This may include but is not limited to the following; service delivery processes, research such as audit/quality improvement, significant event review, shared learning and development. h) Advocate for and promote person-centred working. i) Take responsibility for one’s own well-being and promote the well-being of the team escalating any causes for concern appropriately.  |  |  |  |  |  |
| 4 | [Maintaining an ethical approach and fitness to practice](#_Toc5039310):a) Demonstrate the application of professional practice in one’s own day to day advanced clinical practice. b) Critically reflect on how own values, attitudes and beliefs might influence one’s professional behaviour. c) Identify and act appropriately when own or others’ behaviour undermines equality, diversity and human rights. d) Reflect on and address appropriately ethical/moral dilemmas encountered during one’s own work which may impact on care. Advocate equality, fairness and respect for people and colleagues in one’s day to day practice. e) Keep up to date with mandatory training and revalidation requirements, encompassing those requiring evidence for an advanced role. f) Recognise and ensure a balance between professional and personal life that meets work commitments, maintains one’s own health, promotes well-being and builds resilience. g) Demonstrate insight into any personal health issues and take effective steps to address any health issue or habit that is impacting on own performance as an ACP (Primary Care Nurse). h) React promptly and impartially when there are concerns about self or colleagues; take advice from appropriate people and, if necessary, engage in a referral procedure. i) Promote mechanisms such as complaints, significant events and performance management processes in order to improve peoples’ care. j) Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice.  |  |  |  |  |  |
| Domain B. Assessment, investigations and diagnosis:ACP (Primary Care Nurses) demonstrates safe, effective, autonomous and reflective practice, informed by available evidence and established best practice. They work at an advanced level within their agreed scope of practice. They work effectively as part of a multi-professional team, either as a leader or as a team member, contributing to multi-disciplinary team working to optimise the quality of service and clinical outcomes delivered to individuals. They will support and encourage shared decision-making e.g. working together with service users and carers to agree tests and investigations based upon clinical need and individuals’ informed preferences. ACP (Primary Care Nurses) undertakes clinical assessments and develops a clinical impression or diagnosis that will ensure most effective management and referral if needed. This includes identifying the need for and requesting appropriate investigations and tests. ACP (Primary Care Nurses) demonstrates skills in problem-solving, critical thinking and evaluating the impact and outcomes of their interventions. They analyse and synthesise information, particularly in relation to a wide range of contexts and presentations where information may be incomplete or contradictory. They work ethically, underpinned by their professionalism. They incorporate a critical approach to risk and uncertainty and work actively with others to resolve conflict. |
| 5 | Information gathering and interpretation:a) Structure consultations so that the person and/or their carer/family (where applicable) is encouraged to express their ideas, concerns, expectations and understanding.b) Use active listening skills and open questions to effectively engage and facilitate shared agenda setting.c) Explore and appraise peoples’ ideas, concerns and expectations about their symptoms and condition and whether these may act as a driver or form a barrier.d) Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental and psychological presentations.e) Be able to undertake general history-taking, and focused history-taking to elicit and assess ‘red flags’.f) Synthesise information, taking account of factors which may include the presenting complaint, existing complaints, past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses.g) Incorporate information on the nature of the person’s needs preferences and priorities from various other appropriate sources e.g. third parties, previous histories and investigations.h) Critically appraise complex, incomplete, ambiguous and conflicting information gathered from history-taking and/or examination, distilling and synthesising key factors from the appraisal, and identifying those elements that may need to be pursued further.i) Deliver diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of mediums including spoken word and diagrams for example to ensure the person has understanding about what has been communicated.j) Record all pertinent information gathered concisely and accurately for clinical management, and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance. |  |  |  |  |  |
| 6 | Clinical examination and procedural skills:a) Ensure the person understands the purpose of any physical examination (including intimate examinations), and/or mental health assessment, describe what will happen and the role of the chaperone where applicable.b) Obtain consent and arrange the place of examination to give the person privacy and to respect their dignity (and comfort as far as practicable). Ensure inspection and palpation is appropriate and clinically effective.c) Adapt practice to meet the needs of different groups and individuals, including adults, children and those with particular needs (such as cognitive impairment, sensory impairment or learning disability), working with chaperones, where appropriate.d) Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively.e) Perform a mental health assessment appropriate to the needs of the person, their presenting problem and manage any risk factors such as suicidal ideation promptly and appropriately.f) Use nationally recognised tools where appropriate to assess peoples’ condition.g) Recognise the need for a systematic approach to clinical examination, identify and interpret signs accurately.h) Record the information gathered through assessments concisely and accurately, for clinical management and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance.**Please see Section 2 for a list of Core Clinical Skills and an indicative list of Key Presentations in general practice/primary care.** |  |  |  |  |  |
| 7 | Making a diagnosis:a) Make a diagnosis in a structured way using a problem-solving method informed by an understanding of probability based on prevalence, incidence and natural history of illness to aid decision making. b) Target further investigations appropriately and efficiently following due process with an understanding of respective validity, reliability, specificity and sensitivity and the implications of these limitations. c) Understand the importance of and implications of findings and results and take appropriate action. This may be urgent referral/escalation as in life threatening situations, or further investigation, treatment or referral. d) Synthesise the expertise of multi-professional teams to aid in diagnosis where needed. e) Formulate a differential diagnosis based on subjective and where available objective data. f) Exercise clinical judgement and select the most likely diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate. g) Revise hypotheses in the light of additional information and think flexibly around problems, generating functional and safe solutions. h) Recognise when information/data may be incomplete and take mitigating actions to manage risk appropriately. i) Be confident in and take responsibility for own decisions whilst being able to recognise when a clinical situation is beyond own capability or competence and escalate appropriately. **For a range of likely diagnostic investigations please see Appendix 1** |  |  |  |  |  |
| Domain C. Condition management & treatment:ACP (Primary Care Nurses) prioritise opportunities for prevention to reduce the chances of problems arising in the first place; and when they do, support people to develop the knowledge, confidence and skills to self-manage their condition and the impact it has on their day to day life, and to facilitate and enable behaviour changes at any state in the life course. Whilst being mindful of how behavioural, social and environmental factors impact on health, ACP (Primary Care Nurses) focus on how they can have a positive impact on the health and wellbeing of individuals, communities and populations. They work in collaboration with health and social care colleagues and voluntary organisations, advise on interventions and formulate and enable the development and implementation of shared management/personalised care/support plans. These plans are developed in partnership, considering all the options and wishes of the individual. ACP (Primary Care Nurses) will support and encourage shared decision-making, i.e. working together with service users and carers to select investigations, treatments, management or support packages, based upon clinical evidence of all the options and peoples’ informed preferences. The shared management/personalised care/support plan needs to encourage self-management and consider health promotion and lifestyle interventions, drawing on a variety of resources and local social prescribing services, dependent on the availability of services and on the needs and wishes of the individual. |
| 8 | Clinical management:a) Vary the management options responsively according to the circumstances, priorities, needs, preferences, risks and benefits for those involved with an understanding of local service availability and relevant guidelines and resources. b) Consider a ‘wait and see’ approach where appropriate. c) Safely prioritise problems in situations using shared agenda setting where the person presents with multiple issues. d) Implement shared management/personalised care/support plans in collaboration with people, and where appropriate carers, families and other healthcare professionals. e) Arrange appropriate follow up that is safe and timely to monitor changes in the person’s condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate. f) Evaluate outcomes of care against existing standards and patient outcomes and manage/adjust plans appropriately in line with best available evidence. g) Identify when interventions have been successful and complete episodes of care with the person, offering appropriate follow-on advice to ensure people understand what to do if situations/circumstances change. h) Promote continuity of care as appropriate to the person. i) Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing the person’s autonomy. j) Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review. k) Support people who might be classed as frail and work with them utilising best practice. l) Recognise, support and proactively manage people who require palliative care and those in their last year of life, extending the support to carers and families as appropriate.  |  |  |  |  |  |
| 9 | Managing medical and clinical complexity:a) Understand the complexities of working with people who have multiple health conditions physical, mental and psychosocial. b) Simultaneously manage acute and chronic problems, including for people with multiple morbidities and those who are frail. c) Manage both practitioner and peoples’ uncertainty. d) Recognise the inevitable conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately. e) Communicate risk effectively to people and involve them appropriately in management strategies. f) Consistently encourage improvement and rehabilitation and, where appropriate, recovery. g) Manage situations where care is needed out of hours and understand how to enable the necessary arrangements. h) Support people appropriately and with regard for other care providers involved in their care.  |  |  |  |  |  |
| 10 | Independent prescribing and pharmacotherapy: a) Safely prescribe and/or administer therapeutic medications, relevant and appropriate to scope of practice, including an applied understanding of pharmacology which considers relevant physiological and/or pathophysiological changes and allergies. b) Promote person-centred shared decision making to support adherence leading to concordance. c) Critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision. d) Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g. medicines optimisation). e) Practice in line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources. f) Appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity, frailty, existing medical issues such as kidney or liver issues and cognitive impairment. g) Be able to confidently explain and discuss risk and benefit of medication with people using appropriate tools to assist as necessary. h) Advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options. i) Understand a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advising on the purchase of over-the-counter medicines). j) Facilitate and or prescribe non-medicinal therapies such as psychotherapy, lifestyle changes and social prescribing. k) Support people to only take medications they require and de-prescribe where appropriate. l) Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine.  |  |  |  |  |  |
| Domain D. Leadership and management, education and research:ACP (Primary Care Nurses) should have developed their skills and knowledge to the standard outlined in the Multi-Professional Framework for Advanced Clinical Practice Framework (2017)11. This sets out the capabilities which are common across this level of practice enabling standardisation. The four pillars that underpin this practice are: 1. Clinical Practice 2. Leadership and Management 3. Education 4. Research The knowledge, skills and behaviours specific to **Clinical Practice for ACP (Primary Care Nurse)** are articulated in Domains A, B and C of this framework. The capabilities for Leadership and Management, Education and Research (which apply to all models of advanced clinical practice across sectors, specialties and professions) are presented in the following Domain D. |
| 11 | Leadership, management and organisation: a) Be well organised with due consideration for people and colleagues, carrying out both clinical and non-clinical aspects of work in a timely manner, demonstrating effective time management within the constraints of the time limited nature of general practice/primary care. b) Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice. c) Proactively initiate and develop effective relationships, fostering clarity of roles within teams, to encourage productive working. d) Role model the values of being an ACP (Primary Care Nurse) and their place of work, demonstrating a person-centred approach to service delivery and development. e) Evaluate own practice and participate in multi-disciplinary service and team evaluation (including audit). f) Demonstrate the impact of advanced clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety). g) Actively engage in peer review to inform own and other’s practice, formulating and implementing strategies to act on learning and make improvements. h) Actively seek and be positively responsive to feedback and involvement from people, families, carers, communities and colleagues in the co-production of service improvements. i) Lead new practice and service redesign solutions with others in response to feedback, evaluation, data analysis and workforce and service need, working across boundaries and broadening sphere of influence. j) Critically and strategically apply advanced clinical expertise across professional and service boundaries to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice. k) Demonstrate leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others. l) Lead actively on developing practice in response to changing population health need, engaging in horizon scanning for future developments and to add value (e.g. impacts of genomics, new treatments and changing social challenges). m) Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect people, families, carers, communities and colleagues’ safety and well-being when necessary. n) Negotiate an individual’s scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety. o) Deal with compliments and complaints appropriately, following professional standards and applicable local policy. p) Actively participate in Significant Event Review and share the learning.  |  |  |  |  |  |
| 12 | Education and development: a) Critically assess and address own learning needs, negotiating a personal development plan that reflects the breadth of ongoing professional development across the four pillars of advanced clinical practice. b) Engage in self-directed learning, critically reflecting on practice to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care and services. c) Actively seek and be open to feedback on own practice by colleagues to promote ongoing development. d) Promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate advanced professional development. e) Advocate for and contribute to a culture of organisational learning to inspire future and existing staff. f) Facilitate collaboration of the wider team and support peer review processes to identify individual and team learning and support them to address these. g) Enable the wider team to build capacity and capability through work-based and interprofessional learning, and the application of learning to practice. h) Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities. i) Act as a role model, educator, supervisor, coach and mentor, seeking to instil and develop the confidence of others, actively facilitating the development of others. j) Actively seek to share best practice, knowledge and skills with other members of the team, for example through educational sessions and presentations at meetings.  |  |  |  |  |  |
| 13 | Research and evidence-based practice:a)Critically engage in research/quality improvement activity, adhering to good, ethical research practice guidance, so that evidence-based strategies are developed and applied to enhance quality, safety, productivity and value for money. b) Evaluate and audit own and others’ clinical practice, selecting and applying valid, reliable methods, then act on the findings by critically appraising and synthesising the outcome and using the results to underpin own practice and to inform that of others. c) Understand and utilise the evidence of best practice to inform own practice. d) Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding. e) Lead on Quality Improvement initiatives/projects – sharing outcomes and leading change. f) Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review. g) Disseminate best practice research findings and quality improvement projects through appropriate media and fora (e.g. presentations and peer review research publications). h) Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers.  |  |  |  |  |  |

# SECTION TWO Evidence across the systems:

Please note these systems are a guide and not mandatory

Evidence is required for worked based assessments by a trained Clinical Supervisor

| **Evidence across the systems** | **Section 1**  | **Section 2** | **Section 3** | **Section 4** |
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| **Core Clinical Skills** |

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| **Indicative** **presentations**  |

 | **Key clinical investigations / referrals (may include but not be limited to)** | **MSc Assignments**  | **Other training** | **Work based Assessments**  | **Reflections / Learning log** | **Feedback / Correspondence** |
| Cardiovascular:

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| Demonstrate knowledge of the cardiovascular system, analysing potential severity and the impact on related systems. Demonstrate knowledge of the influencing factors such as psycho-social & family history, risk factors, age, symptomatic and clinical signs.  |

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| • Identify the need for and initiate immediate treatment of person with obvious cardiovascular emergencies including cardiac arrest, cardiac chest pain. • Understand the implications of an existing cardiovascular condition. • Take a structured and appropriate history of a person presenting with a cardiovascular condition. • Perform appropriate cardiovascular assessment. • Provide well evidenced differential diagnosis and suggested management/personalised care and support plan. • Supply and/or administer appropriate therapies. Instruct & support service users in the use of medicines and devices.• Identify and rationalise need for additional tests such as ECG, X-ray, blood tests, echo etc.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the cardiovascular system and provide lifestyle and health promotion advice or referral, such as weight loss, exercise and smoking cessation etc.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | •Chest pain•Chest discomfort•Orthopnoea•Palpitations•Irregular pulse•Oedema•Blood pressure issues | • Temperature• Pulse rates, rhythm, volume and character• Blood pressure• Respiratory rate• Cardiovascular examination – including inspection, auscultation, percussion & palpation• Chest X-ray• Bloods – FBC, U&Es TFT, ESR, lipid profile, HbA1c, BNP• Electrocardiograph (ECG)• Echocardiogram (Echo)• 24-hour BP monitoring• 24-hour ECG Monitoring• Use of risk factor calculators• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Dermatology: Demonstrate knowledge of the dermatological system including the gross and surface anatomy of skin. Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. |
| • Take a structured and appropriate history of a person presenting with a skin problem.• Understand the implications of an existing skin condition.• Perform an appropriate skin and or wound examination.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Use of appropriate descriptors such as ABCDE• Identify the need for and initiate immediate treatment of a person with obvious skin emergencies.• Identify and initiate appropriate treatment for people presenting with minor wounds.• Follow national guidance and national navigation pathways to identify and rationalise need for additional tests such as biopsy, swab, doppler etc.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the skin and provide information, lifestyle and health promotion advice or referral.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | • Rash – localised• Rash – systemic• Itching• Infestation• Spots• Skin lesions, moles• Nail issues/changes• Changes in pigmentation• Skin ulcers• Skin wound – minor & complex• Post-operative wounds• Minor injury | • Temperature• Pulse rate• Inspection, palpation• Skin and/or nail scrapings/samples• Blood tests FBC, calcium, U&Es, LFT, ESR, CRP, TFT, haematinics,• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Ear, nose & throat:Demonstrate knowledge of the ear, nose and throat systems. Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. |
| • Take a structured and appropriate history of a person presenting with a person presenting with an ears, nose and/or throat condition.• Understand the implications of an existing ENT condition.• Perform an appropriate ENT examination/assessment. Including ear, nose/nasal, pharynx, mouth.• Identify the need for and initiate immediate treatment of a person with obvious ENT emergencies.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as swabs, blood tests etc.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the ENT system and provide information, lifestyle and health promotion advice or referral.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | • Dizziness• Vertigo• Otalgia• Otorrhoea• Sinus pain• Nasal pain, obstruction• Mouth pain• Neck swelling• Sore throat• Throat swellings• Tinnitus• Hearing loss• Snoring• Voice changes | • Temperature• Pulse rate• Respiratory rate• Assessment for lymphadenopathy• Blood tests – FBC, glandular fever screen. TFT• Otoscopy• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Emergency Presentations:Demonstrate knowledge of the range of emergency person presentations, understanding the complex interrelations of body systems and their inter-dependencies on life. Demonstrate knowledge of what appropriate actions to take in a range of emergency situations. |
| • Initial ABC assessment and action needed.• Take a structured and appropriate history of a person presenting.• Perform an appropriate examination/assessment.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Identify the need for and initiate immediate treatment needs of a person.• Make suitable and appropriate referrals. | • Respiratory distress• Cardiovascular adverse signs• Anaphylaxis• Angioedema• Collapse• Seizure• Sepsis• Non blanching rash• Overdose /poisoning• Suspected diabetic ketoacidosis• Meningism• Limp child |  • Emergency procedures for seeking assistance and calling ambulance• How to use the emergency equipment including basic life support, oxygen and defibrillator• Administration of adrenalin• Administration of benzylpenicillin or equivalent for those with penicillin allergy• Initiation of the sepsis 6 guidelines• Notification of clinically suspected notifiable infectious diseases |  |  |  |  |  |
| Eyes:Demonstrate knowledge of the opthalmic system and any impact on related systems. Demonstrate knowledge of how to recognise the influence of mechanism of injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. |
| • Take a structured and appropriate history of a person presenting with an eye problem.• Understand the implications of an existing eye condition.• Perform appropriate ocular, fundoscopy and visual examination / assessment.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Identify the need for and initiate immediate treatment of a person with obvious eye emergencies.• Identify and rationalise need for additional tests such as fluorescein staining, slit lamp or conjunctival swabs and referral for such if required.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the eye and provide information, lifestyle and health promotion advice or referral.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | • Red eye• Painful red eye• Painful eye – including eye & or lids• Visual disturbance – blurred vision, diplopia, flashing lights, floaters• Acute loss of vision• Eye discharge• Eye injury• Foreign Body• Swollen eye/lid | • Temperature• Pulse rate• Blood pressure• Eye examination including inspection and palpitation• Visual acuity• Fundoscopy• Pupils• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Family Planning & Sexual Health:Demonstrate knowledge of male and female reproductive systems and any impact on related systems. Demonstrate knowledge of how to recognise any injury, psycho-social, family & occupational history, age, symptomatic and clinical signs are relevant to the normal and abnormal anatomy and physiology in people. |
| • Understand the implications of an existing relevant condition.• Conduct and document a relevant health history, including a comprehensive obstetric, gynaecological & sexual health history as appropriate.• Work collaboratively with the multi-professional team and outside agencies in managing sexual health and care.• Collaboratively provide care and access to appropriate health care professionals as indicated by a person’s circumstances.• Carry out an assessment, using appropriate tests and make onward referrals as required.• Be able to write a comprehensive and appropriate referral letter.• Promote sexual health including immunisation and offer risk assessments and management of people who have sexual health concerns which may include contraception, and sexually transmitted infections.• Have a clear understanding of safeguarding issues including but not limited to female genital mutilation.• Advocate public screening and immunisations in line with local and national programmes. | • Genital rashes• Vaginal/penial discharge• Contraception including general advice, counselling on, problems with• Emergency contraception• Unprotected sexual intercourse• Sexual assault• Inability to conceive | • Family Planning Clinic referral• Genitourinary Medicine (GUM) /Sexual Health Clinic referral• Swabs• Blood tests – female- rubella status, mid-luteal progesterone (day 21 of 28d cycle), FSH & LH on day 1-5 of 28d cycle), TFT• Blood tests - male – testosterone, FSH & LH• Semen analysis• Fertility referral |  |  |  |  |  |
| Gastrointestinal & Hepatic:Gastrointestinal & Hepatic System Demonstrate knowledge of the gastrointestinal system. Demonstrate knowledge of the hepatic system, analysing severity and its impact on related systems. Understand how to recognise the influence of psychosocial & family history, age, risk factors, symptomatic and clinical signs, relevant to the normal and abnormal anatomy and physiology of the person. |
| • Take a structured and appropriate history of a person presenting with an abdominal or associated condition• Understand the implications of an existing GI/hepatic condition.• Perform appropriate abdominal examination/assessment including digital rectal examination.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Identify the need for and initiate immediate treatment of person with obvious GI & hepatic emergencies.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as urinalysis, stool and blood tests etc.• Identify the need for additional clinical and professional support such as referral, second opinion, notification of infectious diseases for public health management etc.• Be able to write a comprehensive and appropriate referral letter.• Identify and manage complications with medical devices, such as stomas.• Recognise the effect lifestyle that the environment, lifestyle and genetics can have the GI and hepatic systems and provide preventative advice regarding high risk behaviours, importance of screening and immunisations along with, information, lifestyle and health promotion advice or referral, such as substance misuse or weight loss etc.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. • Provide advice to prevent secondary transmission e.g. hygiene advice and refer to appropriate services where patient contact management required. | • Difficulty Swallowing• Poor appetite• Excessive thirst• Abdominal pain• Abdominal distension• Abdominal mass/swelling• Constipation• Diarrhoea• Faecal leaking / incontinence• Change in bowel habit – blood in stools, mucus in stools• Nausea & / Vomiting• Hematemesis• Weight loss• Indigestion• Jaundice• Rectal pain• Rectal bleeding• Abnormal blood results – deranged Liver function tests (LFTs), anaemia• High risk behaviours & concerns – intravenous (IV) drug use, sexual history, contact with suffers of• Stoma issues | • Temperature• Pulse rate• Blood pressure• Respiratory rate• Blood tests – FBC, LFT, U&Es ESR, CRP, coeliac screen, haematinics, amylase, hepatitis, HIV • Stool sample – culture and sensitivity, faecal calprotectin, helicobacter-pylori testing, FIT testing or FOB• Abdominal examination – including inspection, auscultation, percussion & palpation• Assessment for lymphadenopathy• Digital rectal examination• Abdominal Ultrasound• Direct referral for gastroscopy, endoscopy, routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Learning Disability:Have knowledge on how to access additional specialist advice and help support people and their relatives/carers. |
| • Demonstrate the ability to engage with people with a Learning Disability.• Demonstrate sensitivity to the impact of any change, such as hospital appointments, admission or any transition which people may find particularly distressing, as they are unfamiliar.• Support people to be fully informed and involved in their care decisions thereby empowering them to be autonomous.• Support people in accessing regular health checks and other universal services they are entitled to benefit from. (including immunisations).• Ensure that where people with a Learning Disability also have another condition that appropriate attention is made to their specific needs and their care is tailored to these. | • Any of the presentations included in this table | • Specialist Learning Disability Services• Advocacy Groups• Peer Networks |  |  |  |  |  |
| Male & Female Anatomical Health:Demonstrate knowledge of the anatomy and physiology of the male & female genitalia and related systems, including prostate and breasts. Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. Have knowledge and understanding of issues related to male & female anatomical health. Be aware of a variety of potential of issues that may present differently in males and females including but not limited to domestic abuse, female genital mutilation, sexual abuse, menopausal symptoms, erectile dysfunction & depression. |
| • Understand the implications of an existing relevant condition.• Take a structured and appropriate history including sexual health history when appropriate.• Assess disease risk factors specific to male or female anatomy.• Understand how to refer, in a timely manner, using national and local guidelines.• Be able to write a comprehensive and appropriate referral letter.• Have a clear understanding of adult safeguarding issues.• Be able to carry out male or female genital examination, prostate examination or breast examination when appropriate and with consent.• Request further investigations appropriately.• Advocate public screening and immunisations in line with local and national programmes. | • Testicular pain• Testicular lumps• Genital rashes/irritation• Urinary symptoms including nocturia, changes in urinary stream• Penile pain• Penile discharge• Erectile dysfunction• Groin swelling• Breast symptoms including pain, lump, nipple discharge, skin changes• Pelvic pain/mass• Inter-menstrual bleeding• Post-coital bleeding• Menstrual problems – including dysmenorrhoea, menorrhagia, oligomenorrhoea, primary & secondary amenorrhoea• Dyspareunia• Vaginal irritation• Vaginal discharge• Hirsutism• Menopausal symptoms – including hot flushes, night sweats, vaginal dryness | • Temperature• Pulse rate• Male genital examination including inspection and palpation of penis, testicular examination• Prostate examination• Female genital examination including inspection, palpation of vulvar area, vaginal examination, speculum examination & bimanual• High vaginal, endocervical and chlamydia swab• Abdominal examination• Assessment for lymphadenopathy• Ultrasound; pelvic transvaginal and testicular• Blood tests FBC, U&Es, HbA1c, lipids, testosterone, SHBG, free androgen index, FSH/LH +/- prolactin, CA125, PSA• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Medication review & medication issues:Medication Review & Medication Issues Understand the necessary monitoring requirements of medicines and how to act on the results. Understand how to document the details of a medication review on the clinical system. Have a sound understand how repeat prescribing works within the general practice/primary care and wider team – e.g. community pharmacy. |
| • Be able to review medication in terms of efficacy, need, side effects, safety, clinical cost and in line with prescribing guidelines. and AMR standards.• Assess for concordance and compliance issues considering the people individual circumstances and requirements.• Help people to understand what medication they have been prescribed (or not prescribed) and why.• Act appropriately on alerts issued by the MHRA.• Understand the traffic light system for local formulary and medications issued only under shared care agreements. | • Adverse side effects• Ineffective medication• Poor compliance• Overuse of medication• Misuse of medication• Issues with polypharmacy• Abnormal blood test monitoring results• Higher risk groups – requiring risk reduction medicines | • Blood monitoring – U&E, LFT, FBC, drug levels, CRP, TFT• Referral back to secondary care when required |  |  |  |  |  |
| Mental Health:Demonstrate knowledge of the range of different mental health needs and their impact on physical, behavioural, emotional and psychological wellbeing. Demonstrate knowledge of how to recognise any trigger & the importance of psycho-social, family & occupational history, age, symptomatic and clinical signs. Understand mental health and related services, and the policies and procedures for referring individuals to them. Demonstrate knowledge of the range of actions you can take when people may have mental health needs and/or related issues, and how to decide what action is appropriate. Understand the services which can be accessed by people in your locality who have specific mental health requirements including the eligibility criteria. Demonstrate knowledge of how to assess the required degree of urgency when referring people to services and how to assess risk. |
| • Understand the implications of a relevant existing mental health condition.• Take a structured and appropriate history.• Assess the impact of the person’s complaint on their daily life, including work life, home life, social life, dietary intake, sleep, illicit drug use, prescription drug misuse, thought of deliberate self-harm, suicidal ideation.• Develop, maintain & utilise links with other agencies in support of people with mental health issues.• Be aware of local guidelines & pathways for referral to other agencies to support this client group including psychiatry, counselling, support groups.• Be able to write a comprehensive and appropriate referral letter.• Understand the need for multi-agency working for adult safeguarding and know how to make a referral when there are concerns.• Understand how to make a referral to the crisis team.• Understand the procedures & protocols in place both within & outside of the practice in relation to adult safeguarding, care of vulnerable adults.• Understand the effect of long-term conditions and other diagnoses on mental and psychological health.• Recognise the effect that the environment, lifestyle and genetics can have on mental health and provide information, lifestyle and health promotion advice or referral.• Understand ways to promote recovery. | • Suicidal ideation, self-harm• Low mood• Anxiety• Stress• Panic• Post-natal mental health issues• Visual/auditory hallucinations• Paranoia• Anger• Bereavement• Eating disorders• Substance misuse | • Person Health Questionnaire (PHQ9)• Generalised Anxiety Disorder Questionnaire (GAD7)• Edinburgh Post Natal Depression Questionnaire• Referral to the crisis team• Urgent and routine referral to secondary care• Referral for counselling/psychotherapy• Referral to other agencies |  |  |  |  |  |
| Musculoskeletal System:Demonstrate knowledge of the musculoskeletal system and its impact on related systems. Demonstrate knowledge of how to recognise the influence of mechanism of any injury, psycho-social, family and occupational history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. Demonstrates knowledge of the gross and surface anatomy of the musculoskeletal system relevant to joint/area being assessed and presenting pathology. |
| • Take a structured and appropriate history of a person presenting with a musculoskeletal issue.• Understand the implications of an existing musculoskeletal condition.• Perform an appropriate musculoskeletal examination / assessment. Including examination of the spine, shoulder, elbow, wrist, hand & fingers: the pelvis, hip, knee, ankle, foot & toes.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Identify the need for and initiate immediate treatment of a with obvious musculoskeletal emergencies.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as X-ray, ultrasound, MRI, CT, blood tests etc.•Identify the need for additional clinical and professional support such as referral, second opinion etc. (could be but not limited to physiotherapy, occupational therapy, orthotics, orthopaedics).• Recognise the effect that the environment, lifestyle and genetics can have on the musculoskeletal system and provide information, lifestyle and health promotion advice or referral.• Be able to write a comprehensive and appropriate referral letter.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | • Pain• Swelling• Redness• Stiffness• Difficulty with movement – spasticity• Minor injury | • Temperature• Pulse rate• Examination of spine, including neck. Shoulders, elbows, wrists, hands & fingers. Hips, pelvis, knee, ankle, feet and toes.• Blood tests – FBC, calcium, ESR, CRP, vitamin D, rheumatoid factor, anti CCP, urate, autoimmune antibodies• X-ray• Ultrasound • Computerised Tomography (CT Scan)• Magnetic Resonance Imaging (MRI Scan)• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Neurological System:Demonstrate knowledge of the neurological system, and its impact on related systems. Demonstrate knowledge of how to recognise the influencers of mechanism of injury, psycho-social & family history, age, symptomatic and clinical signs relevant to the normal and abnormal anatomy and physiology in people. Demonstrate a sound understanding of the Mental Capacity Act (2005) and its application in practice including the relative testing procedures including: • The ethos underpinning the Act and the role of family and friends, and advanced directives. • The conditions under which capacity is decided. |
| • Take a structured and appropriate history of a person presenting with a neurological condition or head injury.• Understand the implications of an existing neurological condition.• Perform an appropriate neurological examination / assessment.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Identify the need for and initiate immediate treatment of a person with obvious neurological emergencies.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as CT head, MRI Scan, blood tests etc.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the neurological system and provide information, lifestyle and health promotion advice or referral. | • Altered level of consciousness• Fits, faints & funny turns• Dizziness• Altered power, tone, sensitivity• Paraesthesia• Altered level of consciousness• Weakness -localised, general• Altered gait• Facial palsy• Tremor• Speech Changes• Headache• Head Injury• Memory problems• Confusion | • Temperature• Pulse rate, rhythm, volume and character• Blood pressure• Neurological examination – including inspection, palpation, reflexes, power, tone, strength, pupils and nystagmus• Cranial nerve examination• Mini mental state examination (MMSE) • Computerised Tomography (CT Scan)• Magnetic Resonance Imaging (MRI Scan)• Routine, urgent and 2 week wait referral criteria including TIA clinic• Glasgow Coma Scale• Blood tests – ESR, U&E, drug levels e.g. anticonvulsants |  |  |  |  |  |
| Paediatrics:Understand factors that affect the child’s health, growth/development. E.g. genetic background, family history, demographics, prenatal factors, family & cultural influences. Be aware of local guidelines & pathways for referral to paediatrics, community paediatrics, health visitors and school health team. Understand the need for multi-agency working for child protection and know how to liaise with other health professionals/social services regarding children in need or with a child protection plan. Understand the procedures & protocols in place both within & outside of the practice in relation to child safeguarding. Have a clear understanding of how to make a referral to child safeguarding team and document appropriately. Understand the role of the midwife, health visitor and school health team and know when and how to make a referral. |
| • Understand the implications of an existing relevant condition.• Take a history, examine appropriately, make an assessment, refer for further investigation as necessary, refer to other services effectively, with consideration of the age of the child/young person.• Have a sound understanding of factors that affect the child’s/young person’s health, growth/development. E.g. genetic background, demographics, prenatal factors, family & cultural influences.• Promote the health of the child & support parents in making informed choices.• Be aware of local guidelines & pathways for referral to paediatrics, community paediatrics, health visitors and school health team.• Be able to write a comprehensive and appropriate referral letter.• Manage key conditions and red flag paediatric conditions.• Emphasise the importance of childhood immunisations and promote uptake in accordance with the national schedule. | • Vulnerable child• Rashes including inflammatory, infected, localised and systemic, napkin rashes• Pyrexia of unknown origin• Crying baby• Ear symptoms including otalgia, discharge• Eye symptoms including eye discharge, pink eye, red eye, visual symptoms• Cough /wheeze /stridor /respiratory distress/nasal symptoms• Sore throat• Vomiting, feeding problems, failure to thrive• Bowel symptoms including diarrhoea, constipation, worms• Urinary symptoms• Abdominal pain• Problem behaviour• Limp• Muscular-skeletal symptoms• Behavioural problems | • Temperature• Pulse rate, rhythm, volume and character• Blood pressure• Respiratory rate• Oxygen saturation• Capillary refill time• Appropriate systems review depending on presenting problem• Referral criteria for midwife, health visitor, school health team, paediatrician, community paediatrician, child safeguarding• Blood tests – only when absolutely necessary – appropriate to presentation |  |  |  |  |  |
| Pain – assessment and management:Pain physiology as it relates to clinical presentation of pain and the effects of pain on the person. Pain assessment tools and methods. Atypical presentation of pain. |
| • Understand the implications of an existing relevant condition.• Demonstrate the ability to assess both acute and chronic pain.• Recognise and acknowledge the effect of pain on the person’s activities of daily living and well-being.• Prescribe appropriately including the need for multimodal analgesic provision.• Initiate and review treatment options.• Recognise pain as potential cause of delirium and/or agitation.• Promote multi-disciplinary and palliative care teams in working with people in pain.• Carry out an assessment, using appropriate tests and make onward referrals as required.• Be able to write a comprehensive and appropriate referral letter. | • Acute pain• Chronic pain• Worsening of pain• Change in type of pain• Ineffective management of pain• Pain affecting sleep | • Pain Management Teams• Investigations appropriate to presentation |  |  |  |  |  |
| Palliative & end of life:Understand and practice within the key legal framework relating to end of life care such as, DNACPR, Advanced Directives, Lasting Power of Attorney, Allow Natural Death Orders and Treatment Escalation Plans. |
| • Take a structured and appropriate history of a person presenting in palliative care or in the last year to days of life.• Perform appropriate system and symptom assessment and examination.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan, to include the use of non-pharmacological interventions.• Identify the need for immediate treatment of oncology related palliative care emergencies such as metastatic spinal cord compression, superior vena cava obstruction and hypercalcaemia.• Identify and rationalise any need for additional support for the person and carer / family, socially, psychologically and medically.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter. | • Pain• Nausea / vomiting• Agitation• Low mood | • Referral criteria and processes for pain & symptomatic relief• Appropriate systems review depending on presenting problem• Referral for care – e.g. district nurses, palliative care, Macmillan |  |  |  |  |  |
| Renal & Genitourinary:Demonstrate knowledge of the renal system, analysing severity and its impact on related systems. Demonstrate knowledge of how the influencers of psych-social, family history, age, risk factors, symptomatic and clinical signs, are relevant to the normal and abnormal anatomy and physiology in people. Understand how the identifying relevant symptoms, clinical signs and the potential anatomical and physiological features are evident in: • People with Acute Kidney Injury. • People with Chronic Kidney Failure. |
| • Identify the need for and initiate immediate treatment of person with obvious renal emergencies.• Understand the implications of an existing GU/renal condition.• Take a structured and appropriate history of a person presenting with a renal or GU system problem.• Perform appropriate abdominal / genitourinary examination / assessment.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as urinalysis, ultrasound scan (KUB) and blood tests etc.• Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Identify and manage complications with medical devices, such as urinary catheters and urostomies.• Recognise the effect lifestyle that the environment, lifestyle and genetics can have the renal & GU systems and provide information, lifestyle and health promotion advice or referral, such as substance misuse or weight loss etc.• Recognise the impact of the presenting problem on the lifestyle and day to day living of the person. | • Loin pain• Groin pain• Haematuria• Urinary symptoms – dysuria, frequency, urgency, hesitancy, incontinence, retention• Abnormal blood results – deranged renal function including chronic kidney disease (CKD) and Acute Kidney Injury (AKI)• Family history of kidney problems / diseases• Catheter issues• Recurrent infection | • Temperature• Pulse rate• Blood pressure• Blood tests U&Es, PSA, ACR• Abdominal examination – including inspection, auscultation, percussion & palpation• Prostate examination• Urinalysis• Mid-stream urine culture• Ultrasound Kidneys, Ureters, Bladder (KUB)• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Respiratory:Respiratory System Demonstrate knowledge of the respiratory system, analysing severity, and its impact on related systems. Demonstrate knowledge of how to recognise the influence of psycho-social, occupational family history, age, symptomatic and clinical signs, relevant to the normal and abnormal anatomy and physiology in people. |
| • Identify the need for and initiate immediate treatment of a person with obvious respiratory emergencies including respiratory arrest, respiratory distress and anaphylaxis.• Understand the implications of an existing respiratory condition.• Take a structured and appropriate history of a person presenting with a respiratory condition.• Perform appropriate respiratory assessment including inspection, palpation, percussion and auscultation.• Provide well evidenced differential diagnosis and suggested management/personalised care and support plan.• Supply and/or administer appropriate therapies.• Identify and rationalise need for additional tests such as X-Ray, blood tests, respiratory function tests etc. • Identify the need for additional clinical and professional support such as referral, second opinion etc.• Be able to write a comprehensive and appropriate referral letter.• Recognise the effect that the environment, lifestyle and genetics can have on the respiratory system and provide lifestyle and health promotion advice or referral, such as smoking cessation etc.• Recognise the impact of the presenting problem | • Shortness of breath, breathing difficulties• Pain on breathing• Cough, including haemoptysis• Wheeze• Sleep apnoea• Pallor, cyanosis | • Temperature,• Pulse rate, rhythm, volume and character• Blood pressure• Respiratory rate• Oxygen saturation• Respiratory examination – including inspection, auscultation, percussion & palpation• Assessment for lymphadenopathy• Sputum sample• Chest X-ray• Blood tests –FBC, ESR• Peak flow rate• FeNO testing• Spirometry• Epworth Score• Routine, urgent and 2 week wait referral criteria |  |  |  |  |  |
| Additional key clinical presentation:Demonstrate knowledge and understanding of a range of additional clinical presentations, pertinent to the scope of practice of the individual practitioner. |
| • Take a structured and appropriate history.• Perform an appropriate examination / assessment.• Provide well evidenced differential diagnosis and suggested management / personalised care and support plan.• Identify the need for and initiate immediate treatment needs of a person.• Make suitable and appropriate referrals. | • Tired all the time• Generalised aches and pain• Lymphadenopathy• Sleep issues• Fever• Substance / alcohol misuse• Overdose / poisoning• Vulnerable adult• Family/carer concern• Genetic predisposition | • Temperature• Pulse• Blood tests – FBC, TFT, HbA1c, LFT, U&Es• Appropriate systems review as per other sections depending on presenting problem• Referral to substance/alcohol misuse treatment services• Support services for carer/families• How to access information from poisons centre• Referral criteria and processes for assessment and support of vulnerable adults• Referral criteria for genetic screening, counselling |  |  |  |  |  |
| Alternative modes of consultation (telephone, email, Skype, home visits, group, via interpreter etc.) Be aware of the challenges of consulting using an alternative mode of consultation. Be aware of the impact non-verbal communication has when using alternative modes of consultation. Be able to adapt the consultation appropriately with special consideration of confidentiality (e.g. ensuring you are speaking to the correct person, consent etc.). Be aware of the challenges of history taking remotely (e.g. without visual cues). |
| • Have the skills to interpret with the use of an interpreter – this may be for language which may require a face to face or telephone interpreter e.g. British sign language interpreter, use of hearing loop, or Makaton interpreter.• Provide information to the person & the interpreter about the purpose and the nature of the interaction.• Agree with the interpreter their role, any interventions they should make, and the level of detail required in the communication.• Explain to the interpreter any specific terms and concepts that the person may not understand.• Clarify with the interpreter any communications from the person that you are not able to understand.• Support the interpreter to work in ways that promote the person’s rights and choices, respect their experiences, expertise and abilities and promote inclusion.• Ensure the interpreter allows sufficient time for the person to communicate fully their thoughts, views, opinions and wishes.• Monitor the understanding of all involved and the effectiveness of the interpretation.• Modify interactions to improve communication and understanding.• Summarise communication at appropriate points to ensure that all involved agree what has been communicated and any actions to be taken. | • Any of the above presentations in the context of alternative modes of consultation context | • Interpreter services• Advocacy groups• Local Government/Social care• Third-Sector organisations |  |  |  |  |  |

## Scope of Practice Table

All ACP (Primary Care Nurses) need to evidence capability against the 13 capabilities detailed in the framework.

In addition to the 13 capabilities each ACP (Primary Care Nurse) or trainee needs to agree their scope of practice with their employer. The scope of practice will vary dependent on the role they are employed for. This tool is to assist that process and document the agreement.

**Section 2** above, details key clinical presentations that often present in general practice/primary care settings. If your role includes being able to assess and manage any of the presentations listed under a system, then that clinical system should be included in your scope of practice and evidence of managing all the presentations listed under that system should be included in your portfolio.

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical presentation**  | **In scope of role?**  | **Rationale (provide info’)**  | **Agreed between practitioner and employer? Who?** |
| Cardiovascular |  |  |  |
| Dermatology |  |  |  |
| Ears Nose and Throat |  |  |  |
| Emergency Presentations |  |  |  |
| Eyes |  |  |  |
| Family Planning & Sexual Health |  |  |  |
| Gastrointestinal & Hepatic |  |  |  |
| Learning Disability |  |  |  |
| Male & Female Anatomical Health |  |  |  |
| Medication Review |  |  |  |
| Mental Health |  |  |  |
| Musculoskeletal |  |  |  |
| Neurological |  |  |  |
| Paediatrics |  |  |  |
| Pain Assessment and management |  |  |  |
| Palliative & End of Life |  |  |  |
| Renal & Genitourinary |  |  |  |
| Respiratory |  |  |  |
| Additional Key Clinical Presentations |  |  |  |
| Other areas |  |  |  |

# SECTION THREE: Portfolio and Assessment Materials

A range of materials have also been developed that ACP (Primary Care Nurses), clinical supervisors and other stakeholders may find of use in evidencing the achievement of core capabilities and in the development of a portfolio. The portfolio tools offer the opportunity to collate a range of evidence triangulated by supervisors.

The COT and CBD assessment forms listed below have been mapped to the framework to help evidence each capability more easily.

These assessment materials are not mandated for use with the framework and individuals are at liberty to use their own local materials.

Many of these materials are derived from tools used by GP Speciality Trainees and have been adapted with kind permission from the Royal College of General Practitioners (RCGP).

The portfolio and assessment materials are as follows:

• Portfolio Guidance

• Personal Development Plan (PDP)

• Portfolio Reflection - Form

• Consultation Observation Tool (COT) - Guidance and Form

• Cased Based Discussion (CBD) - Guidance and Form

• Clinical Examination Procedures (CEPs) - Guidance and Form

• Consent for Recording for Training Purposes - Form

• Multi-Source Feedback (MSF) - Guidance and Form

• Person Satisfaction Questionnaire (PSQ) - Guidance and Form

• Debrief Record Sheet – Guidance and Form

• Tutorial Record & Evaluation - Guidance and Form

• Clinical Supervisors Report (CSR) - Form

## Portfolio Guidance

This guide is designed to help develop a portfolio of evidence to demonstrate capability as an ACP (Primary Care Nurse). National and regional work is underway to look at how portfolios will be reviewed in general practice/primary care. It is envisaged that there will be an electronic portfolio for all advanced level practitioners in the future to aid this process.

Portfolios should contain a range of evidence which is linked to the capabilities. Each piece of evidence should state why it demonstrates capability. It is often the case that one piece of evidence can demonstrate more than one capability.

For example - a learning log entry about a consultation seen may demonstrate data gathering/communication skills, clinical examination skills, and management/personalised care and support plan skills.

It is about quality of evidence rather than quantity.

Both existing and trainee ACP (Primary Care Nurses) will need to develop a portfolio. As ACP (Primary Care Nurses) they need evidence across the four pillars of advanced practice. Portfolios can also be used for appraisal and revalidation purposes.

Trainee ACP (Primary Care Nurses) may have portfolio requirements set by higher education institutes which can be included as evidence and link to the framework capabilities. This will help them to evidence their progress and identify learning needs.

**Each pillar of advanced practice should not be seen in isolation but more as four areas of practice than come together to allow a clinician to work at an advanced level.** For example, a quality improvement project could lead to a change in process requiring leadership skills to implement. Shared learning from this type of work, when presented at a local group/meeting could demonstrate some educational competencies.

**Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care:**

Portfolio and Assessment Materials

Portfolio Contents

It is advised that the portfolio should include the following;

• A record of achievement - modules successfully completed at university, and other training environments.

• Personal Development Plan (PDP) identifying SMART objectives.

• A record of workplace-based assessments to include;

* + consultation observation tool assessments (COT)
	+ case-based discussions (CBD)
	+ clinical examination procedures (CEPs).

• Learning Log – including reflection & identifying learning/impact on practice.

• Person satisfaction questionnaires (PSQ).

• Multi-Source feedback from colleagues (MSF).

• Any peoples’ compliments or complaints.

• Significant Event Analysis.

• Quality Improvement Projects/Audit:

* + This must demonstrate the audit cycle/show systematic change.
	+ It should include two data collections and any learning/changes should be shared with colleagues.
	+ It should leave a legacy in the workplace/i.e. a systematic change.

• Information relating to management and leadership.

• Information relating to education.

## PERSONAL DEVELOPMENT PLAN (PDP)

PDPs should have SMART objectives – which helps to make them achievable. Think about the following to help you;

**S** – specific things – be focused and not too general – why has this learning need arisen

**M** – measurable – so you know when you have achieved it

**A** – achievable – be realistic! You can’t learn everything in one go! How will you achieve it? What strategies can you use?

**R** – relevant – make it relevant to your role – how will achieving the goal make a difference to your practice?

**T** – time lined – so you can tick them off and add new objectives

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LEARNING/DEVELOPMENT NEED** | **DEVELOPMENT OBJECTIVE** | **ACHIEVEMENT DATE** | **STRATEGIES TO USE** | **OUTCOMES/EVIDENCE** |
| WHAT BROAD AREA DO YOU NEED TO ADDRESS? | WHAT SPECIFIC GOAL ARE YOU SETTING? | WHEN DO YOU HOPE TO ACHIEVE IT? | HOW WILL YOU ACHIEVE IT? | HOW WILL YOU KNOW YOU HAVE ACHIEVED IT? |
| ***An example;****To manage breast problems* | *To be capable in breast examination* | *3 months* | *Undertake 2 CEPS assessments with my clinical supervisor* | *When my CS has signed off 2 breast examination CEPs as capable* |
|  |  |  |  |  |
|  |  |  |  |  |

## ACP (Primary Care Nurse) - Portfolio Reflection.

|  |  |
| --- | --- |
| **Date seen** |  |

|  |
| --- |
| **What happened – brief description - Presenting problem** |
| **Differential diagnoses & your clinical reasoning** |
| **Reflection – what did you learn?** |
| **Impact on your practice – what will you do the same or differently next time & why?** |
| **Supervisor’s comments – competencies demonstrated, learning points?** |

ACP (Primary Care Nurse):

Supervisor:

## Consultation Observation Tool (COT) - Guidance.

Clinical Supervisors use the Consultation Observation Tool (COT) to support holistic judgements about the ACP level of practice in primary care. COT is one of the tools used to collect evidence for the ACP (Primary Care Nurse) Portfolio of evidence of capability, as a Workplace Based Assessment.

**Person consent**

The presenting person must give consent.

**Selecting consultations for COT**

Either record a number of consultations on video and select one for assessment and discussion or arrange for your clinical supervisor to observe a consultation. Complex consultations are likely to generate more evidence.

Consultations should be drawn from a range of people presentation that reflect the scope of the ACP (Primary Care Nurse) role. E.g. children, older adults, mental health, etc.

The ACP (Primary Care Nurse) can include consultations in different contexts – for example, a home visit.

An audio COT can also be evidenced e.g. to assess telephone consultation skills.

It’s inadvisable for a consultation to be more than 15 minutes in duration, as the effective use of time is one of the performance criteria.

When the ACP (Primary Care Nurse) is selecting a recorded consultation, it’s natural to choose one where they feel they’ve performed well. This isn’t a problem; the ability to discriminate between good and poor consultations indicates professional development.

But don’t spend a lot of time recording different consultations. COT isn’t a pass/fail exercise; it’s part of a wider picture of Advanced Clinical Practice.

**Collecting evidence from the consultation**

The ACP (Primary Care Nurse) will have time to review the consultation with their clinical supervisor, who will relate their observations to the ACP (Primary Care Nurse) capability framework as identified on the COT form. The Clinical Supervisor then makes an overall judgement and provides formal feedback, with recommendations for further development.

## Consultation Observation Tool: Marking/Notes Sheet – ACP (Primary Care Nurse)

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Clinical Supervisor Name:** |  |
| **Presenting Case:** |  |
| **Date:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GRADES**  | **I** – Insufficient evidence | **N** – Needs further development | **C** - Capable | **E** - Excellent |

| **Criterion** | **Grade** | **Evidence** |
| --- | --- | --- |
| **Discovers the reason for the person's attendance** |
| **Encourages the person’s contribution**Capabilities 1, 2, 4 |  |  |
| **Responds to cues**Capabilities 1, 2, 4, 5 |  |  |
| **Places presenting problem in appropriate psychosocial context**Capabilities 1, 2, 3, 4 |  |  |
| **Explores person's health understanding**Capabilities 1, 2, 4 |  |  |
| **Defines the clinical problem** |
| **Includes/excludes likely relevant significant condition**Capabilities 1, 2, 5 |  |  |
| **Appropriate physical or mental state examination**Capability 6 |  |  |
| **Makes appropriate working diagnosis**Capability 7 |  |  |
| **Explains the problem to the person** |
| **Explains the problem in appropriate language**Capabilities 1, 2, 8, 9, 10 |  |  |
| **Addresses the person's problem** |
| **Seeks to confirm the person's understanding**Capabilities 1, 2 |  |  |
| **Makes an appropriate shared management/personalised care/support plan**Capabilities 8, 9, 10 |  |  |
| **Person is given the opportunity to be involved in significant management decisions**Capabilities 2, 3, 4, 8, 9, 10 |  |  |
| **Makes effective use of the consultation** |
| **Makes effective use of resources**Capabilities 1, 2, 3, 4, 10, 11, 12 |  |  |
| **Condition and interval for follow up are specified**Capabilities 1, 2, 8, 9 |  |  |

|  |
| --- |
| **Feedback & recommendations for further development:** |
| **Agreed action plan:** |

COT guidance – can be undertaken during a shared surgery or by reviewing a video of a consultation (undertaken with person consent – form signed and scanned into notes).

An audio COT can also be evidenced e.g.; to assess telephone consultation skills.

## Cased Based Discussion (CBD) – Guidance

Case based discussions (CBD) are a great way to explore capability, clinical reasoning and critical thinking. The CBD is a structured interview designed to assess your professional judgement in clinical cases. CBD is one of the tools used to collect evidence for your Portfolio of evidence of capability, as a Workplace Based Assessment.

**They should be pre-planned and based on the clinical record. The CBD form has an area to write pre-planned questions by the clinical supervisor (CS). There is a useful CBD question maker for GPs on the RCGP Website:** <https://www.rcgp.org.uk/training-exams/training/mrcgp-workplace-based-assessment-wpba/cbd-for-mrcgp-workplace-based-assessment.aspx>

Good practice would be for the ACP (Primary Care Nurse) to send the clinical supervisor (CS) 3 or 4 cases – could do this by sending a task on system one for example. The CS can have a look at the cases/records and choose one to discuss.

Consultations should be drawn from a range of patient contacts that reflect the scope of the ACP role. E.g. children, older adults, mental health, etc.

The CS should ask the ACP (Primary Care Nurse) to ‘present’ the chosen case to them.

The CS can then ask questions and a discussion can follow.

**What’s covered in the discussion**

The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of competence; the discussion should not shift into a test of knowledge.

Your clinical supervisor will aim to cover as many relevant capabilities as possible in the time available. It’s unrealistic to expect all capabilities to be covered in a single CBD, but if there are too few you won’t have enough evidence of progress. It’s helpful to establish at the start of the discussion which competence areas your trainer or supervisor is expecting to look at.

The clinical supervisor records the evidence harvested for the CBD in the Portfolio, against the appropriate capabilities.

It is recommended that each discussion should take about 30 minutes, including the discussion itself, completing the rating form and providing feedback.

At the end the CS should provide some written feedback for the ACP (Primary Care Nurse):

**What went well and why?**

**Any working points?**

## Case Based Discussion ACP (Primary Care Nurse)

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Clinical Supervisor Name:** |  |
| **Presenting Case:** |  |
| **Date:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GRADES**  | **I** – Insufficient evidence | **N** – Needs further development | **C** - Capable | **E** - Excellent |

| **NO.** | **CAPABILITIES** | **QUESTIONS** | **EVIDENCE OBTAINED** | **GRADE** |
| --- | --- | --- | --- | --- |
| **Domain A. Person-centred collaborative working** |
| **1** | **Communication & consultation skills** |  |  |  |
| **2** | **Practising holistically to personalise care and promote public and person health** |  |  |  |
| **3** | **Working with colleagues and in teams** |  |  |  |
| **4** | **Maintaining an ethical approach & fitness to practice** |  |  |  |
| **Domain B. Assessment, investigations and diagnosis** |
| **5** | **Information gathering & interpretation** |  |  |  |
| **6** | **Clinical examination** |  |  |  |
| **7** | **Making a diagnosis** |  |  |  |
| **Domain C. Condition management & treatment** |
| **8** | **Clinical management** |  |  |  |
| **9** | **Managing medical & clinical complexity** |  |  |  |
| **10** | **Independent prescribing & pharmacotherapy** |  |  |  |
| **Domain D. Leadership and management, education and research** |
| **11** | **Leadership, management and organisation** |  |  |  |
| **12** | **Education and development** |  |  |  |
| **13** | **Research and evidence-based practice**  |  |  |  |

|  |
| --- |
| **FEEDBACK** |
| **ACTION PLAN** |

## Guidance when assessing Clinical Examination Procedures (CEPs) for ACP (Primary Care Nurse)

CEPs is a workplace-based assessment.

It provides a way of assessing what the trainee does in practice, day to day - how they apply their knowledge, skills, communication skills etc. Whilst CEPs exist to capture skills it is important to assess some common shared themes.

Suggested areas for consideration would be;

• Is there a clinical need for the examination?

• Has this been explained appropriately to the person?

• Has consent been granted?

• Has a chaperone been offered?

• Are there good hygiene practices?

• Is there an understanding of the relevant anatomy?

• Is the person treated with respect and provided with privacy?

• Does the ACP maintain an empathetic approach throughout?

• Does the ACP explain what is going on throughout the procedure?

• Are their findings accurate? – findings should be checked by the clinical supervisor

• Does the ACP provide an appropriate explanation of their findings to the person and the implications?

• Is there an appropriate management/personalised care and support plan made with the person?

Please note a grading of **Needs further development** is not a fail but a suggestion that more practice and exposure to similar clinical scenarios is required.

Please ensure that your clinical supervisor signs off your CEPs.

CEPs can be used to help gather evidence of capability and any skill/examination e.g. ear examination, cardiovascular examination, MSK, **BUT** must include the following if they are in your scope of practice i.e. if you see presenting problems where the following examinations would be required;

• Breast Examination

• Female Genital

• Male Genital

• Digital Rectal Examination

• Prostate Examination

Clinical Examination Procedure (CEP) Assessment– ACP (Primary Care Nurse**)**

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Clinical Supervisor:** |  |
| **Date:** |  |

|  |
| --- |
| **TYPE OF PROCEDURE**: Please provide a brief description below. |
|  |
| **DESCRIPTION OF CEP ASSESSED**; With reference to the items on the CEPs guidance sheet. |
|  |
| PLEASE MARK AS **CAPABLE** or **NEEDS FURTHER DEVELOPMENT** (circle) |
| WHAT WAS DONE WELL? |
|  |
| WORKING POINTS? |
|  |
| LEARNING NEEDS? |
|  |

## Consent Form for Recording for Training Purposes

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Date**  |  |
| **Name of person(s)****accompanying patient** |  | **Place of Recording** |  |

We are hoping to make video/digital recordings of some of the consultations between patients and ACP (Primary Care Nurses) whom you are seeing today. The recordings are used by trainee ACP (Primary Care Nurses) to review their consultations with their trainers. The recording is ONLY of you and the ACP (Primary Care Nurse) talking together. Intimate examinations will not be recorded and the camera/recorder will be switched off on request.

All recordings are carried out according to guidelines issued by the General Medical Council and will be stored securely in line with the General Data Protection Regulation (GDPR). They will be deleted within one year of the recording taking place.

You do not have to agree to your consultation with the ACP (Primary Care Nurse) being recorded. If you want the camera/recorder turned off, please tell Reception - this is not a problem, and will not affect your consultation in any way. But if you do not mind your consultation being recorded, please sign below. Thank you very much for your help.

**TO BE COMPLETED BY PATIENT**

I have read and understood the above information and give my permission for my

consultation to be recorded.

**Signature of patient BEFORE CONSULTATION:**

....................................................................................Date...........................................

**Signature of person accompanying patient to the consultation:**

....................................................................................Date...........................................

After seeing the ACP (Primary Care Nurse) I am still willing/I no longer wish my consultation to be used for the above purposes.

**Signature of patient AFTER CONSULTATION:**

....................................................................................Date...........................................

**Signature of person accompanying patient to the consultation:**

....................................................................................Date...........................................

##  Multi-Source Feedback (MSF) Guidance

Multi-source feedback is collected from colleagues. Good practice would be to send out a questionnaire to a range of both clinical and non-clinical colleagues.

This process requires at least 5 clinical and 5 nonclinical responses.

Ideally the responses should be looked at by the clinical supervisor and feedback given to the ACP (Primary Care Nurse).

## Multi-Source Feedback (MSF)

|  |  |
| --- | --- |
| ACP’s Name: |  |
| Location of MSF undertaken: |  |
| Date of MSF undertaken: |  |

**Part 1**

This part should be completed by **all** respondents

Please state your job title

|  |
| --- |
|  |

**Please provide your assessment of this ACP (Primary Care Nurse) overall professional behaviour (please circle)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Very poor** | **Poor** | **Fair** | **Good** | **Very Good** | **Excellent** | **Outstanding** |

Notes: You may wish to consider the following:

The ACP (Primary Care Nurse):

* Is caring of people
* Is respectful of people
* Shows no prejudice in the care of people
* Communicates effectively with people
* Respects other colleagues’ roles in the health care team
* Works constructively in the health care team
* Communicates effectively with colleagues’
* Speaks good English and at an appropriate level for people
* Does not shirk their responsibilities
* Demonstrates commitment to their work as a member of the team
* Takes responsibility for own learning

**Comments (Where possible please justify comments with examples).**

**Highlights in performance areas (areas to be commented)**

|  |
| --- |
|  |

**Possible suggested areas for development in performance**

|  |
| --- |
|  |

**Part 2**

**To be completed by Clinical Staff Only**

**Please provide your assessment of this ACPs overall clinical performance (please circle)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Very poor** | **Poor** | **Fair** | **Good** | **Very Good** | **Excellent** | **Outstanding** |

You may wish to consider the following about the ACP (Primary Care Nurse):

* Ability to identify peoples’ problems
* Take a diagnostic approach
* People management skills
* Independent learning habits
* Range of clinical and technical skills

**Comments (where possible please justify comments with examples)**

**Highlights in performance (areas to be commended):**

|  |
| --- |
|  |

**Possible suggested areas for development in performance:**

|  |
| --- |
|  |

## Person Satisfaction Questionnaire (PSQ) Guidance

A PSQ has been included for use as peoples’ feedback is very important.

Good practice would be to select a time to undertake the questionnaire with the support of the clinical supervisor and reception staff.

Ask reception to give out a questionnaire & pen to every person who attends to see the ACP (Primary Care Nurse) and ask the person to hand the questionnaire back to reception after their appointment.

This process should continue until a minimum of 40 completed responses have been received.

Ideally the responses should be looked at by the clinical supervisor and feedback given to the ACP (Primary Care Nurse).

## Person Satisfaction Questionnaire (PSQ) for an ACP (Primary Care Nurse)

Hello,

We would be grateful if you would complete this questionnaire about your visit to the ACP (Primary Care Nurse) today. The ACP (Primary Care Nurse) that you have seen is a fully qualified nurse who had masters level training to work at an advanced level in general practice/primary care.

Feedback from this survey will enable them to identify areas that may need improvement. Your opinions are therefore very valuable.

Please answer all the questions below. There are no right or wrong answers and your ACP (Primary Care Nurse) will not be able to identify your individual responses.

Thank you.

**Please rate the ACP (Primary Care Nurse) at:**

*Please circle your response*

Making you feel at ease, (being friendly and warm towards you, treating you with respect; not cold or abrupt).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Letting you tell "your" story… (giving you time to fully describe your illness in your own words; not interrupting or diverting you).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Really listening… (paying close attention to what you were saying; not looking at the notes or computer as you were talking).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Being interested in you as a whole person… (asking/knowing relevant details about your life, your situation; not treating you as "just a number").

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Fully understanding your concerns… (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Showing care and compassion… (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached").

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Being positive… (having a positive approach and a positive attitude; being honest but not negative about your problems).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Explaining things clearly… (fully answering your questions, explaining clearly, giving you adequate information; not being vague).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Helping you to take control… (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Making a plan of action with you… (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

Overall, how would you rate your consultation today?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Poor to Fair | Fair | Fair to Good | Good | Very Good | Excellent | Outstanding  |

**Many thanks for your assistance**

## CLINICAL SUPERVISORS REPORT

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Clinical Supervisor Name:** |  |
| **Date:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GRADES**  | **I** – Insufficient evidence | **N** – Needs further development | **C** - Capable | **E** - Excellent |

|  |
| --- |
| **RELATIONSHIP** |
| Explores person’s agenda (their Ideas, Concerns and Expectations). (Capabilities 1, 2) | Grade |
| Works in partnership to negotiate a plan (Capabilities 1, 2, 8, 10, 12) | Grade |
| Recognises the impact of the problem on the person’s life (Capability 2) | Grade |
| Works co-operatively with team members, using their skills appropriately (Capability 3) | Grade |
| **DIAGNOSTICS** |
| Takes a history and investigates systematically and appropriately (Capability 5) | Grade |
| Examines appropriately and correctly identifies any abnormal findings, (please comment on specific examinations observed) (Capability 6)  | Grade |
| Elicits important clinical signs & interprets information appropriately (Capability 5, 6) | Grade |
| Suggests an appropriate differential diagnosis (Capability 7) | Grade |
| Refers appropriately and co-ordinates care with other professionals (Capabilities 3, 8, 9) | Grade |
| **MANAGEMENT** |
| Keeps good medical records (Capability 11) | Grade |
| Uses resources cost effectively (Capabilities 11, 12) | Grade |
| Keeps up-to-date and shows commitment to addressing learning needs (Capability 12) | Grade |
| **PROFESSIONALISM** |
| Identifies and discusses ethical conflicts (Capability 4) | Grade |
| Shows respect for others (Capabilities 3, 4) | Grade |
| Is organised, efficient and takes appropriate responsibility (Capabilities 11) | Grade |
| Deals appropriately with stress (Capabilities 4, 11) | Grade |

If you have concerns or are unable to grade, please elaborate further.

Do you have any recommendations that might help the learner or the Educational Supervisor?

Are you aware if this trainee has been involved in any conduct, capability or Serious Untoward Incidents/Significant Event Investigation or named in any complaint?

\* Yes No

If yes, are you aware if this have been resolved satisfactorily with no unresolved concerns about this trainee’s fitness to practise or conduct? \*

## Debrief Guidance

The Debrief Record Sheet can be used to capture learning from debrief with your supervisor. It can be used to identify learning needs or cases to suggest for case-based discussion. It would then be good practice to write a reflective learning log regarding what you have learned and the impact on your practice.

## Tutorial Guidance

The Tutorial Record and Tutorial Evaluation form can be used to record the educational information from a tutorial/learning experience. It can be useful in identifying further learning needs. It would then be good practice to write a reflective learning log regarding what you have learned and the impact on your practice.

## Debrief Record Sheet

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Debrief Leader:** |  |
| **Date:** |  |

|  |
| --- |
| Issues discussed/arising from seeing patients in surgery/home visits: |
|  |
| Was documentation appropriate? |
|  |
| How did this make the trainee feel? |
|  |
| Any learning needs identified for the trainee? Any follow-up needed? |
|  |
| Time spent: |  |
| How useful/valuable was this debrief? |
|  |

## Tutorial Record

|  |  |
| --- | --- |
| **ACP (Primary Care Nurse) Name:** |  |
| **Tutorial Leader:** |  |
| **Date of tutorial:** |  |

|  |
| --- |
| Learning aims: |
|  |
| Items covered: |
|  |
| Any further areas for development |
|  |
| Time spent: |  |
| Signed by tutorial leader |  |
| Signed by ACP (Primary Care Nurse) |  |

## Tutorial Evaluation

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of tutorial:** |  | **With:** |  |
| **Tutorial aims:** |  |

|  |
| --- |
| Tutorial style; CBD, Presentation, Discussion, Brainstorming etc |
|  |
| Was the style appropriate/helpful? |
|  |
| What did you learn/achieve from the tutorial?  |
|  |
| What were the good aspects of the tutorial? |
|  |
| In what way could tutorial be improved? |
|  |
| Signed: |  |

# Appendix 1 Glossary

Blood tests and investigations

ACR - urine albumin to creatinine ratio

BNP – brain natriuretic peptide

CA125 - cancer antigen 125

CCP - cyclic citrullinated peptide antibody

CRP – C-reactive protein

ESR – erythrocyte sedimentation rate

FeNo - Fractional exhaled Nitric Oxide

FBC – full blood count

FIT - faecal immunochemical test

FOB – faecal occult blood

FSH – follicle stimulating hormone

Haematinics – usually includes ferritin, vitamin b12, folate

HbA1c - glycated haemoglobin

LFT – liver function tests

LH – luteinising hormone

Mid-luteal progesterone (day 21 of 28-day cycle)

PSA – prostate specific antigen

SHBG - sex hormone binding globulin

TFT = thyroid function test

U&Es – urea and electrolytes