



UNSW Medicine & Health

Phase 2 Clinical Skills Student Guide 2024

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Introduction

This guide is intended to assist you in developing your clinical and communication skills in Phase 2. It should be read in conjunction with the similar guide from Phase 1.

The guide also provides information about the Phase 2 Integrated Clinical Examination. As this examination will also assess your knowledge of the biomedical and social sciences underpinning clinical practice, this guide provides information to assist you in preparing for only the clinical component of this examination.

General Objectives for Clinical Skills in Phase 2

You enter Phase 2 having satisfactorily addressed the objectives of Clinical Skills in Phase 1 which are encapsulated in the Graduate Capabilities, especially *Patient Assessment and Management* and *Effective*.

You can apply principles of good communication in consultation with patients and identify important symptoms related to body systems. You can examine a body system or parts thereof, in isolation. The emphasis of the physical examination in Phase 1 was on the development of correct technique with no expectation that you could elicit or interpret physical abnormalities. You will need to continue to develop these skills in Phase 2 and should refer back to the Phase 1 Clinical Skills Guide.

The objectives of Clinical Skills in Phase 2 are similarly encapsulated in the Graduate Capabilities.

- You will be expected to further **develop your communication skills** in dealing with patients and families including skills in consultation, explanation and counselling and dealing with specific situations.
- You will be expected to be able to **conduct a physical examination of the child, adult and elderly person** to the standard described in this Guide. You will be expected to elicit and interpret physical abnormalities specifically in relation to the themes addressed in each course.
- You will **develop your skills in clinical reasoning** through an understanding of the differential value of specific clinical features (symptoms and signs) in the inclusion and exclusion of diagnostic possibilities.
- You will **begin to understand how pattern recognition influences clinical reasoning**. Recognising how certain signs and symptoms go together, with greater or lesser degrees of variability, greatly assists in drawing up your differential diagnoses. Whilst this guide will point you toward various conditions where this will be important, it will be up to you to learn the clinical features that correspond to them.
- You will also **develop skills in communicating your clinical assessment of patients in case presentations and case reports**.

The weekly themes in each course are the areas in which you will be expected to apply these skills. For each theme, there is a range of exemplary conditions. You will be expected to be able to ascertain the common and important exemplary conditions. This will usually be evident in the topics covered in campus and clinical activities.

A complementary approach to developing your clinical skills is by body systems. It is important to understand that this approach does not align with specific Phase 2 courses. The clinical skills relating to a body system are applicable to adults, children, pregnant women, aged patients, patients with cancer etc. The clinical approach in these different patient groups will vary - but the basic clinical skills are the same.

Specific objectives for each body system are included to provide additional guidance on what you are expected to address in Phase 2 regarding the history, physical examination and clinical reasoning. You must refer to the Phase 1 guide for details on how to perform components of the examination of the body systems. Additional details on some components are included in this guide.

You are expected to begin to develop your skills in the **systematic** examination of each body system. You may be expected to *perform a complete examination of a system* (e.g. cardiovascular) in an organised way. This will include starting at a remote, peripheral site (frequently the hands), and progressively working through the system. You should refer to Epstein or Talley & O'Connor for complete descriptions of systematic examinations.

It is *not* expected that you will develop skills in the elicitation and interpretation of all abnormal clinical findings related to a body system.

In each of the following sections relating to the physical examination, you will be expected to do one or other of the following:

- **Recognise** specified observable abnormalities.
- **Detect, elicit or demonstrate** specified abnormalities.
- **Describe** specified abnormalities i.e. how you would look for and find specified abnormalities.
- **Explain** specified abnormalities – you are expected to understand and explain the basis of physical abnormalities.
- **Interpret** specified abnormalities – relate an abnormality to a pathological condition or specific diagnosis.

Clinical Assessment of Patients

Assessing patients in the clinical environment is a critical part of your work in Phase 2. It is imperative that you also understand that there are expectations of how you go about this study, including expectations around professional behaviour and dress in hospitals and clinics. You must refer to Appendix 1-3 to review, become familiar with and demonstrate these behaviours and abide by these codes.

In Phase 2, you will be required to perform complete assessments on patients with clinical features relating to the weekly themes. It is important that you practice taking a full history and performing a *complete physical examination* (see section below on Physical Examination) on all patients. This will help you to continue to develop these skills, even on systems which are normal, and avoid missing important information. As your clinical skills improve, you will develop the ability to focus your history and examination on the patient's presenting problem. However, doing incomplete assessments too early in your training will result in missed findings and opportunities to extend your understanding of how clinical symptoms and signs co-exist, both in classical (textbook) ways and in 'real world' clinical practice.

In addition to the general points outlined below, you will need to consider additional aspects in the history or the physical examination when assessing women about reproductive health and children. See below some pointers with regard to more intimate examinations, but also consider that for some people, any examination or a specific examination may be very sensitive for them.

Approach to clinical communication

Take the opportunity to review your communications skills teaching from Phase 1. In Phase 2 the expectation is that you continue to apply the principles of good person/patient-centred communication in your consultations and engage respectfully with patients and seek to build rapport with them. As such it is important that you:

- Ask permission prior to patient contact and gain properly informed consent;
- Are sensitive to the patient's situation and culture/cultural norms;
- Gather information from all appropriate sources;
- Maintain strict confidentiality of information gathered;
- Understand the patient perspective and other aspects of the patient-centred approach to care
- Be aware of the need to transmit appropriate, effectively summarised information to the medical team and other HCWs.

A sensitive approach to physical examination

Who's this for?

You should assume that **anyone** may be self-conscious when exposing their torso to enable assessment of the cardiorespiratory system, spine and upper limbs; similarly, exposing the abdomen and pubic region for the purposes of gastro-renal or lower limb examination may create embarrassment. A modesty drape, in the form of a gown, folded sheet or towel, should always be provided and offered. Within the simulated clinical skills settings this may be less relevant due to the nature and training of the simulated patients, however this is of paramount importance

in the real clinical environment. When relevant, especially for internal examinations, you should request a chaperone of the same sex as the patient to be present, irrespective of your gender (though note that official guidance on this varies).

Commencing – Always ensure all available doors are shut and curtains fully drawn before conducting any examination. Be aware that consultation room doors may have windows and so you must block the line of sight with the screen provided.

Closing – Always offer to help the patient get dressed at the end of any examination. Ensure you leave them in an appropriate state (e.g. replace modesty drapes yourself once the examination is concluded, and ensure the patient is safe to dress themselves if that is their preference). After finishing your examination, make sure you help the patient back into their original position (or whichever position they request – as long as you are sure this is clinically appropriate).

Communication with patients around intimate examinations – The language you use when consenting and preparing a patient for an intimate examination is critical to their comfort and willingness to co-operate, which in turn facilitates an effective and thorough assessment. Certain words can be interpreted positively or negatively in this delicate situation, and unless you spend time reflecting and experimenting with the 'best' way to approach this issue, you may find in the heat of the moment that you broach the subject in a suboptimal way.

For example, using the words 'feel' and 'look' are not advisable, particularly in relation to a breast exam; 'are you happy for me to perform a breast exam?' (or similar) is more professional and goal-orientated. Use a polite but confident tone of voice when asking questions such as this; do not deliberately avoid eye contact with the patient, act shyly or gesture in a way which suggests you are uncomfortable with the situation, as this may instantly be detected and then reflected by the patient.

Similarly, asking a patient to show you their 'belly' may make them feel vulnerable and self-conscious about any excess weight they may be carrying. Consider what other words you might use such as 'tummy' or 'abdomen' (most patients know what this means). In the case of a per rectal/vaginal exam, asking if you may examine the patient's 'rectum' or 'vagina' is not commonplace; instead, more tactful words such as 'back passage' and 'internal' or 'vaginal' exam are preferred. It is not possible to provide an exhaustive list of such words and phrases in this guide, however the above examples provide a direction for further reading and reflection. Indeed, you are encouraged to start to make your own list of these words and phrases. It is important to think about these before seeing patients – try them out on friends and family and see how you/they feel asking/being asked.

Consent for Intimate Examinations:

It is important that students seek verbal consent from patients for any form of examination and make it completely clear to the patient that they are a medical student. For intimate examinations, informed consent is mandatory.

Intimate examinations include the following:

- Vaginal examination (also dealt with separately in the Obstetrics and Gynaecology guide)
- Rectal examination
- Examination of external genitalia
- Breast examination
- Any other examination that might embarrass patients through the removal of clothes, particularly those examinations that might expose external genitalia or breasts

As well as gaining explicit consent in advance, there should always be a chaperone in attendance for any such examinations. For examinations of the breasts, external genitalia, vagina and rectum, we recommend that students are supervised by a healthcare professional (usually a doctor) with experience of carrying out that examination. For other examinations that might embarrass patients through the removal of clothes, it is acceptable for another student to act as a chaperone provided that the patient agrees that this is acceptable to them.

Students are also expected to be aware of any cultural issues that may make more sensitive a physical examination that would normally be considered 'standard'. They should always ask their supervisor if they are unsure about what is appropriate.

For examinations of any anaesthetised patients, intimate examinations by medical students should be restricted to situations where there are genuine educational benefits, and the patient has, prior to the procedure, given written consent to the named student to conduct a specified examination whilst they are under anaesthetic. It is unacceptable for a student to conduct an intimate examination of an anaesthetised patient because they are instructed by a doctor involved in the patient's care if the patient has not already given explicit consent for the examination. If a patient does not have capacity to consent or if there is any doubt, then the examination should not go ahead.

Wherever possible, vulnerable adults should be included in any discussion that involves examination or procedures being performed by a student. Generally, the main carers should be involved in any discussion and if there is any concern or doubt it is mandatory that students should not examine the patient. All health professionals and students should work in the best interests of the patient.

Medical History

Clinicians vary in their approach to the medical history depending on the patient and the clinical situation. However, it is best that you have a systematic approach that you can rely on should you encounter difficulties in eliciting the patient's history. The following section outlines one approach to the medical history.

The format of the medical history is designed to provide a structure for both eliciting, recording and reporting the history. It is important to appreciate that in eliciting the history this structure should not impede the patient's description of their illness i.e. use open questions and active listening – and other communication skills learned and practiced in Phase 1 – and allow the patient to tell their story. The format of the medical history provides a means of recording and reporting the patient's narrative in an interpretative style.

1. Introduction.

- Always introduce yourself with your name and that you are a medical student and your year
- Ask them what they would like to be called
 - As part of the above points, it may be appropriate to seek to understand the patient's pronoun
- Ask their age, and possibly their occupation or previous work
- Ask if they have someone they would like to be with them

This assists in establishing a rapport with the patient showing your interest in him/her as a person and starts to give a picture of their social circumstances.

2. Brief description of the presenting illness / problem / complaint (PC)

- Invite the patient to describe their presenting complaint(s) and any concerns and how long they have been present.

3. Detailed history of the presenting illness / problem / complaint (HPC)

- Establish and characterise the principal symptoms. Recall helpful mnemonics like SOCRATES or OATES.
- Use the system review relevant to the presenting illness to fill in gaps in the history or elicit forgotten symptoms. Remember to include important negative or absent symptoms if relevant.
- Establish the chronology of the illness.
- Establish if the present illness has occurred previously or is related to a chronic illness.
- Ask about the patient's experience of illness/expectations/concerns especially in their social context and show you understand how these might affect the patient. Recall helpful mnemonics like ICE or FIFE.

4. Past health and inter-current illnesses (PMH)

- The history of the presenting illness may have referred to past illnesses, which may need clarification.
- Ask about specific common illnesses relevant to *patient's gender and age*.
- Specifically ask about previous hospitalisations and surgery.
- Ask about the patient's general health, including physical activity and nutrition (or defer the latter to PSH).
- Ask about inter-current illnesses (e.g. diabetes and hypertension) and try to determine their progress as these diseases may impact on the presenting illness
- Establish how well any current health issues are being managed – both medically and from the perspective of the patient.

5. Medication and allergy history

- Ask about present medications *including dose/frequency, route and duration*. Be aware that this may help you identify other chronic illnesses that might have been omitted from the enquiries in PMH above.
- Don't forget to ask about over the counter and traditional/complementary medications
- Carefully check for any allergies to medications and if so, how did the allergy present

6. Personal and social circumstances (Psychosocial History / PSH)

- Questions about the patient's background including home circumstances (who they live with), marital status, children, occupation and even country of birth, may also be asked during the history of their current illness (PMH) and can help to understand the context of the presenting problem.
- Ask open questions like:
 - How is this illness affecting you, your home circumstances or your work or study?
 - Is there anything going on at home or at work that is impacting this illness or helping you through it?
- Ask about the patient's ideas of what they think is the cause of this illness or what will help them get better as this will greatly influence your management plans
- If you have not got this information already in the history, ask directly about home and work or study environment, and then other aspects like sexual history or travel history etc. as appropriate
- Always ask about smoking, alcohol and recreational drug intake.
- Recall helpful mnemonics like OALDS: Occupation, Alcohol/smoking/drugs, Living situation, Diet and exercise, Stresses
- Consider how these issues might influence the management plan for the patient

7. Family history (FH)

- Questions about the family history should be placed in the context of the illness.
- Are there relevant features in the family history to indicate a familial illness or genetic predisposition?

8. System review.

The system review is a means of ensuring that you have not missed any important symptoms in the patient's presentation. It is very useful when first taking more detailed medical histories but is used less frequently by experienced clinicians.

Further information from the past history, personal and social history and family history may have indicated other problems, which may need to be further explored with the system review.

Physical Examination

In clinical practice, the physical examination of a patient is not restricted to isolated systems but performed as a whole. The nature of the patient's presenting illness will determine the focus of the physical examination but the complete assessment of a patient requires a general examination. This is a major change from the type of system examination about which you learned in Phase 1. *Moving to the complete assessment of a patient marks a considerable challenge as you enter Phase 2.* It merits considerable practice since you will feel quite unsure of how to proceed initially.

There is no single routine to performing the general examination. Some clinicians prefer to examine the system of interest (based on the history) first. Parts of the examination which will cause discomfort to the patient (e.g. abdominal examination in a patient with abdominal pain) may be left until last in order to avoid causing discomfort and interrupting the examination. Examination of the child needs to first focus on obtaining signs that require the child to be settled and quiet.

The following illustrates one routine in performing a general examination. At each step, you need to consider what signs may be present in relationship to all the systems.

Position and exposure

Begin the examination with the patient in a reclining position with (ideally) minimal clothing to allow easy exposure of different regions. In any patient, be wary of gender-based assumptions about exposure, and comfort or otherwise of the patient) when conducting the physical examination. Traditionally, the chest and abdomen can often be exposed in a male whereas for a female, it would be appropriate to not expose these regions until completely

necessary. As a general rule in modern practice, be mindful of only requesting the required exposure, gain consent and look for signs of discomfort in your patient and offer more privacy if this seems desirable for this particular patient. Also note that 'comfort' with physical examination may change at any point during the examination, especially if the conditions change e.g. other people are present in the location.

General Observation

- Although you may have made some relevant observations whilst taking a history, take the time to observe the patient and their surroundings more thoroughly before you begin the examination.
- As you examine each subsequent region, it is important that you inspect for observable abnormalities.

Hands

- Inspection of the hands can detect physical abnormalities related to different systems.

Vital Signs

- Palpate the radial pulse after inspecting the hands.
- Measure the respiratory rate.
- Measure BP, lying and standing or sitting if appropriate
- Temperature can be obtained either from the medical record or by taking your own reading

Head and neck

- Inspection of the head and neck (including eyes and mouth) can detect physical abnormalities related to different systems.
- Examine the jugular venous pressure.
- Palpate the carotid arteries.
- Palpate the trachea.
- Examine the cervical lymph nodes from in front of the patient. The cervical lymph nodes, including the supraclavicular nodes, may also be examined from behind the patient after you have examined the posterior chest.

Anterior Chest

- Inspection of the anterior chest - observing any abnormalities especially related to the respiratory and cardiovascular system.
- Examine the praecordium.

Posterior Chest

- Conduct examination of the posterior chest, as per the respiratory system.
- If the focus of the patient's illness suggests a possible respiratory cause, you must also examine the lateral and anterior chest.
- Examine the axillary lymph nodes. This may be left until late in the examination – if the patient is particularly sweaty, the examiner should wash his/her hands before examining other regions.

Abdomen

- Ask patient to lie flat and position them for abdominal examination (arms/hands resting by their sides; head on a pillow).
- Examine the abdomen.
- Examine the inguinal lymph nodes.

Legs

- While the patient is lying down, expose the legs.
- Examine the peripheral vascular system.

Musculoskeletal examination

- Examination of range of movement in neck and back
- Examine major lower limb joints (hips and knees)
- A screening examination of the musculoskeletal system may be appropriate if a MSK problem or systemic disease is suspected

Neurological examination

- Unless it is the focus of the presentation, the neurological examination is usually left until last. It can be tiring for the patient and it is preferable to perform it in an uninterrupted sequence.
- Examine mini-mental state examination (MMSE or MOCA or RUDAS) and basic cognitive functions.
- Examine cranial nerves.
- Examine upper and lower limbs
 - Motor: power, tone and reflexes
 - Sensory: light touch, pain, proprioception, vibration, temperature
 - Coordination and tremor
 - Stability of gait

Additional components

The following are also part of a comprehensive physical examination:

- Be sure to examine other important abnormalities e.g. with an orthopaedic patient, at least attempt to examine the affected joint or limb (e.g. fracture site), or important dermatological findings e.g. an ulcer etc. It is not unusual for students to forget these, sometimes very obvious, abnormal findings.
- Measure height and weight and calculate body mass index.
- Perform urinalysis.

Summary and differential diagnosis

- At the end of the case, it is important that you summarise the case in 2-3 sentences identifying the key features and concerns. The Phase 1 CS Guide provides some notes on summarising.
- A differential diagnosis and/or problem list should be generated based upon your history and examination. Don't just list the diagnoses recorded in the clinical notes. Try and list the most active or important problems or diagnoses first.
- After you gain further experience, you should also start to consider:
 - Preliminary investigations that may be required
 - Overarching management approach, e.g. broad categories of pharmacological or other interventions

Procedural and Specific Physical Examination Skills

At the completion of your medical degree, you will be required to be competent in a number of procedural skills. The Medicine program teaches these skills in an integrated way throughout all 3 phases of the course, using a combination of self-access packages and clinical instruction ('skills sessions').

To achieve competence in the following skills, a number of processes need to be understood:

1. The reason(s) why the procedure/examination might be performed.
2. The pathophysiology of the process.
3. The equipment required and the basis on which it works.
4. The technical aspects of actually performing the skill, including the explanation to the patient in order that they are able to cooperate to the best of their ability for the skill to be performed most efficiently and effectively.
5. Interpretation of the results obtained from performing the skill, and the explanation of these results to the patient (where appropriate).

Some skills are best learned on a mannequin or in a simulated environment (preferable to, or required prior to, learning on patients). For some skills, it is essential that students do not perform procedures on patients until the full learning package has been accessed.

These skills require repetitive learning and it is essential that procedural skills be practiced regularly once learned. Do not underestimate the amount of practice required, or the degree of 'de-skilling' that can occur if practice does not take place.

Additional learning resources on Moodle may be available for procedural skills.

The following skills should be learned in Phase 2:

Clinical Procedural Skills
Review of hand hygiene & infection control skills, & creation of aseptic & sterile fields (simulated)
Venous blood sampling using aseptic technique (mannequin) Venepuncture Video (through Moodle)
Insertion and removal of IV cannula (mannequin) Cannulation Demonstration Video (through Moodle)
Set up giving set and administer fluid IV (mannequin)
Intramuscular and subcutaneous injection and drawing up drugs (mannequin)
Orientation to the OT environment including use of Personal Protective Equipment
Operating Theatre Procedures (incl. sterile G&G) – could be deferred to Phase 3
Placement and removal of a plaster cast (backslab)
Performance and interpretation of a 12 lead ECG
Glucometer (BSL measurement)
Spirometry
Physical Examination Skills
Basic Life Support
Rectal examination
Vaginal exam & Pap smear
Height, weight and head circumference on a child
Paediatric otoscopy

These skills will be addressed during your Phase 2 courses either within the clinical sessions, in practical classes or as self-access online resource packages in Moodle. The opportunity to practice the skill in your own time is facilitated (for many skills) by having equipment available at your hospital. Please refer to the *Phase 2 Clinical Procedural and Physical Examination Skills Log* for further details and see below.

In the end-of-phase clinical examination, you may be asked to demonstrate your ability in performing any one or more of the above skills. It is essential that in this situation you recognise that you are performing the skill on a patient and not a “model”. This includes explaining to the patient what you are doing, what you require the patient to do and ensuring that they are comfortable during the procedure. You will be expected to demonstrate an understanding of each of the five phases of learning a skill (as above).

Phase 2 Clinical Procedural & Examination Skills Acquisition

Please refer to the Phase 2 Clinical Procedural and Physical Examination Skills Log.

The log documents all the skills listed above. By the end of Phase 2, each medical student is required to have addressed all these skills, and for most, this will require that the book is signed off by designated tutors. The tutor will sign this book only when satisfied that you can perform the skill or procedure and have completed the skill or procedure according to the instructions outlined. There is no limit to the number of times that the student and tutor may repeat the skill or procedure.

Some skills do not require to be signed off by a tutor but you are expected to address these skills which may be assessed in the Phase 2 Integrated Clinical Examination.

There is a Procedural Skills module in Moodle which contains information and resources for most of the listed procedural skills. This includes material which should be read before attending sessions where the skills will be taught.

Sessions will be arranged during the Phase 2 courses to demonstrate and instruct you in performing these skills. Your attendance at these sessions is compulsory and you will need to have the log book signed at these sessions, so remember to bring it along with you. Your competency in performing Basic Life Support will be assessed and your log book must be signed by the designated tutor.

Important notes:

1. Non-completion of the book according to the above conditions, or sign-off by non-designated persons, **may result in you being prevented from sitting the end of Phase 2 Integrated Clinical Examination.**
2. It is your responsibility to safeguard this log book during Phase 2. To minimize the distress and inconvenience caused by the inadvertent loss of your log book, it is recommended that you periodically scan your log book and save your files. This ensures you have a copy of your 'sign-offs' by designated tutors at your Clinical Campus.

Case Presentations and Case Reports

Recording and reporting on the information that you elicit from a patient through the history and physical examination is an important element of clinical communication. You will be asked to present cases verbally as part of clinical tutorials and you will also be required to write a case report in your individual assignments.

Case presentations and case reports vary in their detail, according to the complexity of the patient's illness and the purpose of the presentation or report.

Case presentations can range from a very brief summary of a patient's illness delivered as part of a ward round, through to more detailed case presentations for a tutorial, up to very detailed case report for a term assessment (case-based assignment). You will develop skills in determining the most crucial aspects of a patient's illness to present as a brief summary. Similarly, you will develop skills in presenting all the information in a more detailed presentation.

Case reports may be written in a structured format recording all the information as would be required in a patient's medical records at the time of admission or first consultation. A case report may also be written in a narrative style to summarise the pertinent features.

Other issues of importance regarding the assignments:

1. Use of literature to support assignments.
 - See your guidelines: Course guides state the required number of references – stick to the recommended number! Also, make them 'good' ones i.e. critically evaluate what literature used/sources.
 - Textbooks provide certain perspective, but you should consider what a good review article or relevant research paper might add to the quality of the assignment.
2. Writing the reflective component
 - Some students struggle to make this effective and it is important to avoid a 'what I did to complete this task' monologue.
 - You need to convey to your assessor what you learned through the process and what impact it will have in the future (on your approach to similar tasks as a student, or more broadly in your approach to medical practice, both as student and future doctor).

Communication Skills in Phase 2

You will be expected to apply the general communication skills that you acquired in Phase 1 throughout your clinical experiences in Phase 2. These skills will again be assessed in the Phase 2 Integrated Clinical Examination.

During Phase 2, you will also attend a number of sessions in which communication skills relating to particular circumstances will be addressed.

These include:

- Communicating with anxious or depressed patients (S&H).
- Communicating with Indigenous patients (S&H).
- Cross-cultural communication (S&H).
- Taking a social history (S&H)
- Taking a sexual history (BGD).
- Communicating with parents about obstetric problems (BGD).
- Motivational interviewing (AH1).
- Communicating with patients in late stage cancer (Oncology).
- Inter-disciplinary communication with non-medical professionals and students

The opportunity to practice these skills with patients in Phase 2 may be limited. Nevertheless, you should understand the principles of communication in these situations and try to apply these in role plays with peers or simulated patients. You may be asked to demonstrate your skills in these situations in the Integrated Clinical Examination.

In general, you should consider how you might explain a disease process or investigation results to a patient. On occasion, with support from your clinical supervisor, you could practise this. Be aware there is no expectation that you explain complex and/or significant diagnoses with patients unless you are well supervised and supported by experienced clinicians.

Clinical Workplace-based Assessments

Clinical Workplace Assessments (CWA) are observational assessments of a student's performance, as a student works in the clinical environment, in interactions with their patients.

Clinical Workplace Assessments, such as the miniCEX, are designed to support **Reflective Practice** and **Self-Directed Learning**. As formative assessments these tasks allow the student to monitor their progress, demonstrate and provide evidence of their learning and work towards achievement of Program Learning Outcomes through:

- seeking and receiving feedback
- reflecting effectively on this feedback, and
- actively planning and outlining actions required to address areas for further development of knowledge, skills or behaviour.

These assessments are entered into eMed using the CWAapp. Digitisation provides an easy and accessible way to create assessments which are a **formal record of student activity**. Digitisation also allows every entry to be scrutinised for authenticity, with in-built checks and flagging of suspect assessments. It is thus **vital for students to understand that 'creating' assessments that do not correspond to actual student activity and supervisor assessment (in short, fraudulent entries) is an extremely unwise and unprofessional activity and may result in highly adverse consequences for any student involved**. This is emphasised in the workflow in the app:

Mini-Clinical Evaluation Exercise (miniCEX)

The miniCEX is an example of a clinical workplace assessment, used to evaluate a student's clinical performance in real clinical settings. It provides an opportunity for students to be observed during their interactions with patients. The miniCEX aims to guide student learning and improve their clinical performance through structured feedback from an appropriate assessor. It can help the student recognise their strengths and to also identify strategies for them to improve their clinical practice in areas such as communication, history taking, physical examination and professional practice. The miniCEX also provides a learning opportunity where the assessor can share with students their own knowledge and experience. Students are encouraged to complete, submit and reflect on as many miniCEX assessments as possible – the more miniCEX assessment completed the more opportunities a student will have to reflect on and plan their learning, and therefore, to improve their clinical skills and practice.

However, it is a mandatory requirement for a minimum of six miniCEX assessments to be done in Phase 2 clinical coursework.

1:18
Search Confirm Authorisation Cancel

HAND THIS DEVICE TO THE ASSESSOR

I HEREBY STATE THAT I,

Associate Professor Silas Taylor
contactable on
Silas.Taylor@unsw.edu.au

WILL BE ASSESSING STUDENT

Student, Year3 (z1111113)

Students or unauthorised assessors should note that altering or making false statements when completing any assessment or log entry using this application constitutes academic misconduct which can result in significant penalties, including exclusion from the relevant UNSW program.

ACCEPT AND COMMENCE ASSESSMENT

- **The due date for the minimum **six** submissions is Friday, 20th September 2024. It is also recommended that students complete mini CEXs during each of your 6 courses and at least three miniCEX assessments prior to the start of the mid-year recess.**

All requirements stated are minimums – students can and should complete more miniCEX assessments where feedback/grades suggest that more practice and development of skills is required. miniCEX completions will be tracked by Faculty, but the primary responsibility for monitoring compliance with the miniCEX requirements lies with you. **Students are advised that failure to complete the required number (6) of mini-CEX assessments by the deadline will make you ineligible for the Phase 2 Integrated Clinical Examination (clinical component). Please be aware that students in previous years who have not completed the minimum number of mini-CEXs by the deadline have been disbarred from the Phase 2 Integrated Clinical Examination.**

What are the areas for assessment?

Students can complete Mini-CEX assessments on a range of patients with each encounter focussing on one or more specific parts of their clinical interactions with their patient. These can include:

- History taking,
- Physical examination skills,
- Synthesis of information,
- Explanation, and
- Professionalism.

How does a student organise a Mini-CEX?

The Mini-CEX is a self-directed formative assessment – it is up to the student to initiate and complete these assessments. Students need to arrange to do the Mini-CEX with an appropriate assessor. Students must meet with their assessor to first discuss and agree on the areas for assessment. Together, the student and their assessor then choose an appropriate patient consultation.

'Appropriate' assessors for miniCEX – Remember that your context is important as local instructions e.g. in specific placements etc may override the more general advice that follows. Unless clearly stated (as in the Clinical Transition Term when PRINT students are permitted to assess) an 'appropriate assessor' is a qualified health professional. Thus, you need to be assessed by someone who is very familiar with the task or activity you are asking to be assessed upon. So, for example, in BGD, a midwife might be an excellent assessor for many of the relevant tasks and indeed may be better placed to assess on some areas than, say, a registrar. Remember that miniCEX assessments are intended to assist you in *your* development of *your* skills, so a range of assessors (from any such 'appropriate assessor' group) can provide potentially diverse assessments on your skills and, more importantly, create the opportunity for you to receive high quality spoken (as well as written) feedback on your skills from their perspective. Your reflection on these potentially diverse assessments can then feed into your future development of said skill(s).

In terms of engaging appropriate assessors in an assessment of you, this is up to you. This is genuinely a life skill in itself that you need to develop – just asking people for help! Obviously try to pick your moment – if someone is clearly flat out, then it's not the time! But maybe asking "When is a good time to..." would be met both more warmly and may even earn you 'brownie points' for initiative and enthusiasm. Another option for enlisting willing assessors is to work with the Education Support staff in your Clinical Campus to help you identify 'friendly' staff who can assist you. You might be surprised to find that often the Education Support staff will have a list of people they can call upon!

Students must use the Clinical Workplace Assessments app (CWAapp) to submit their completed Mini-Clinical Evaluation Exercises (Mini-CEX) to eMed. You can download the CWAapp on your own phone – please see the information provided in the Clinical Skills Moodle module. Alternately, iPads at the clinical campuses with the CWAapp preloaded will be available for you to use with your assessor.

What happens during a Mini-CEX assessment? The role of the student versus the role of the assessor.

The Mini-CEX assessment takes approximately 30 minutes duration (approximately 15 minutes for the observation of the student/ patient consultation and 10-15 minutes for the assessor/ student feedback discussion).

Ideally the student introduces themselves to their patient and explains their role, the role of the assessor (to observe, evaluate and provide feedback to the student on their observed clinical practice), and obtains consent for the clinical interaction. Alternately, the Assessor can have this discussion with the patient with the student present.

The following video depicts an Emergency Medicine Trainee conducting a Physical Examination as part of a Mini-CEX assessment. This video <https://vimeo.com/90176861> provides an example of an Assessor appropriately introducing the Mini-CEX task, the student and assessor role, and obtaining consent from their patient, before proceeding with the assessment.

After setting up the interaction appropriately with the patient, students must then provide their assessor with an electronic copy of the Mini-CEX assessment form using the UNSW Clinical Workplace Assessment app (CWA App).

The assessor then observes the student consultation / interaction with their patient in the clinical setting. During the observation the assessor documents their observations and feedback comments into the MiniCEX assessment form. The assessor does not interrupt the student during the consultation, unless this is necessary to ensure patient safety. The student then summarises their findings to the assessor.

The following video depicts an Emergency Medicine Trainee taking a history from a patient presenting with epigastric abdominal pain as part of a Mini-CEX assessment. This video <https://vimeo.com/87741849> provides an example of the role, expectation, and appropriate behaviour of the student and assessor during the Mini-CEX assessment.

At the end of the consultation, the assessor may briefly clarify clinical findings with a focussed assessment of the patient. The assessor may also ask for feedback from the patient. Ideally the student then closes the clinical interaction, ensures their patient does not have any questions or concerns, and thanks their patient for their time. Alternately, the Assessor can have this discussion with the patient with the student present.

Immediately following the Mini-CEX consultation, the assessor gives the student their feedback. The assessor should provide constructive feedback on the student's performance and discuss possible improvement strategies.

For the Mini-CEX assessments in Phase 2 the assessor's feedback is targeted and directed at the gap between the student's current performance and the ideal clinical practice for a medical student student who will successfully pass the Phase ICE (clinical) examination.

The electronic Mini-CEX evaluation form is then automatically submitted by the Clinical Workplace Assessment app to eMed.

The following video depicts an Emergency Medicine Trainee receiving feedback from their Assessor as part of a Mini-CEX assessment. This video <https://vimeo.com/90176859> provides an example of this component of the Mini-CEX.

BEFORE THE MINI-CEX

Students need to arrange to do the Mini-CEX with an appropriate assessor.

Students must meet with their assessor to first discuss and agree on the areas for assessment.

Together, the student and their assessor then choose an appropriate patient consultation

DURING THE MINI-CEX

The Mini-CEX assessment takes approximately 30 minutes duration - approx 15 minutes for the observation of the student/ patient consultation and 10-15 minutes for the assessor/ student feedback discussion

The student introduces themselves to their patient and explains their role, the role of the assessor (to observe, evaluate and provide feedback to the student), and obtains consent for the clinical interaction

Students then provide their assessor with an electronic copy of the Mini-CEX assessment form using the UNSW Clinical Workplace Assessment app (CWA App)

The assessor then observes the student consultation / interaction with their patient in the clinical setting.

During the observation the assessor documents their observations and feedback comments into the MiniCEX assessment form. The assessor does not interrupt the student during the consultation, unless this is necessary to ensure patient safety.

The student then summarises their findings to the assessor.

At the end of the consultation, the assessor may briefly clarify clinical findings with a focussed assessment of the patient. The assessor may also ask for feedback from the patient.

The student then closes the clinical interaction, ensures their patient does not have any questions or concerns, and thanks their patient for their time

AFTER THE MINI-CEX

Immediately following the Mini-CEX consultation, the assessor gives the student their feedback

The assessor and student discuss their performance and possible improvement strategies

The electronic Mini-CEX evaluation form is then automatically submitted by the Clinical Workplace Assessment app to eMed and appears in your Phase 2 Portfolio

Clinical Skills Bedside Teaching in Phase 2

This teaching is intended to assist students in developing their clinical and communication skills at the bedside. Students should refer to the contents of this guide, the Phase 1 Clinical Skills guide and reference books such as, Epstein. et al. "Clinical Examination".

The following systems/body region examinations/assessments will be taught as bedside tutorials (one hour duration) by a hospital doctor (preferably a senior JMO, registrar or consultant surgeon or physician). Note that the tutor does not need to be a specialist in the discipline that is being taught. Some clinical campuses may offer these tutorials in the form of masterclasses. It would be appropriate for students to liaise with Clinical Campus administration staff in order to ensure that the appropriate tutorials take place in their Phase 2 terms. The relevant tutors should be requested to participate as far in advance as feasible. Part of the arrangement might be that prior to tutorials, students consent 2-3 appropriate patients to agree to be models for the teaching.

The outcome of bedside tutorials is intended to be, first and foremost, that the physical abnormalities the students are expected to be able to elicit in Phase 1 and 2 (as per the Phase 1 and 2 Clinical Skills Guides) should be demonstrated. As such, patients with clear abnormal physical signs should be found whenever possible.

Occasionally, it may not be possible to find patients with significant pathology (e.g. cranial nerve palsy). Consequently, a secondary outcome could be that these tutorials are used as opportunities for examination technique to be clarified and improved upon, where the need for patients with pathology is less important. In this instance, the tutor can focus on technique rather than the detection of abnormal physical signs, but this should be the exception, rather than the rule. For example, ask the student to examine the cranial nerves of a patient who is in hospital for heart disease.

Tutors should witness students performing the examination and provide verbal feedback thereon. Consequently, it is imperative that all students are familiar with the examination and have practiced it beforehand. In some instances, a tutor may have to demonstrate an examination, but again, this should be the exception, not the rule. Students should be aware that physical examination videos (both Phase 1 and Phase 2 level) made by UNSW staff (so pitched precisely to student phase requirements) are available in the Clinical Skills Moodle module: <https://moodle.telt.unsw.edu.au/course/view.php?id=7698>.

Below are the suggested Phase 2 terms during which the respective tutorials may be expected to take place.

Tutorial	Phase 2 term
Cardiovascular system	Adult Health 1
Respiratory system	Adult Health 1
Abdominal & GIT system	Adult Health 1
Genitourinary & Renal system	Adult Health 1
Neurological system – upper and lower limbs	Adult Health 2
Neurological system – cranial nerves	Adult Health 2
Musculoskeletal system – hands and wrists	Adult Health 2
Musculoskeletal system – hips	Adult Health 2
Neurological system - cerebral cortex and cognition	Aged Care & Rehab.
Neurological system – common spinal nerve root lesions	Aged Care & Rehab.
Neurological system - gait, cerebellum	Aged Care & Rehab.
Musculoskeletal system – neck & back	Aged Care & Rehab.
Inguino-scrotal region	Simulation and opportunistic e.g. Aged Care
Paediatric clinical skills	BGD
Paediatric assessment – variable focus	BGD
Clinical assessment of O&G	BGD

Tutorial	Phase 2 term
Haematological system	Oncology
Endocrine/thyroid	Oncology
Skin	Oncology

Feedback

Feedback should occur after each bedside encounter. It may come in a variety of forms, for example: feedback can be from just the tutor or from the whole group; it will usually be informal and verbal but some students may prefer more structured feedback e.g. using a mini-CEX form. Groups will also often debrief with their tutor after patient encounters back in the tutorial room.

Tutors should comment on generic communication skills, history taking and clinical examination skills, the student's ability to summarise the case, and clinical reasoning. Professional behaviour and empathy should also be observed and commented on. In some instances, principles of investigations and management may be discussed, but this should not be the focus of these sessions.

Patient encounters and the associated learning points, plus your reflections thereon, can all be documented in a Patient Log or by utilising the miniCEX appropriately. Such documentation is strongly encouraged: it is valuable for reinforcing learning, but also for reflection when it comes to writing up the P2 Portfolio essay.

Clinical Assessment by Body Systems

The following sections focus on the clinical assessment of adults. Further information on the clinical assessment of children and women is covered in later sections. The clinical conditions listed in each system reflect some of the common exemplary conditions that may be encountered in Adult Health 1 and 2, and/or Oncology and Aged Care and Rehabilitation terms.

This section must be read in conjunction with similar sections from the Phase 1 Clinical Skills Guide. Please recall that all skills addressed in Phase 1 are required and regarded as foundational in Phase 2. Phase 1 level skills can and will be assessed in the Phase 2 clinical examination.

Cardiovascular System

1. Elicit a history from patients with common symptoms of cardiovascular disease, including relevant aspects of personal, social and family history. This should include patients with palpitations, syncope, chest pain, dyspnoea, and peripheral oedema, e.g., ankle swelling.
2. Conduct a systematic examination of the cardiovascular system.
3. Elicit and describe physical signs related to the cardiovascular system.
 - Recognise peripheral signs of cardiovascular disease including clubbing, splinter haemorrhages, palmar erythema, tobacco staining.
 - Radial pulse Detect abnormalities of pulse rate and rhythm.
 - Measure blood pressure (lying and standing to detect a postural drop).
 - Jugular venous pressure:
 - Detect elevated jugular venous pressure.
 - Describe abnormalities of venous waveform.
 - Inspect the mouth to look for central cyanosis.
 - Carotid pulse:
 - Describe abnormalities of carotid pulse associated with aortic stenosis and aortic incompetence.
 - Detect carotid bruit.
 - Palpation of praecordium
 - Locate the apex beat; detect displacement of apex beat (cardiomegaly).
 - Describe abnormalities in character of apex beat associated with volume and pressure loads.
 - Detect thrills.
 - Describe abnormalities associated with cor pulmonale.
 - Auscultation of praecordium:
 - Describe abnormalities of 1st and 2nd heart sounds including abnormalities of splitting of 2nd heart sound.
 - Describe added heart sounds (3rd and 4th) and explain their cause.
 - Detect a cardiac murmur and determine its timing (i.e. systolic or diastolic). Describe features which determine the valvular origin of a cardiac murmur.
 - Peripheral vascular system:
 - Detect peripheral oedema.
 - Recognise cutaneous signs of vascular diseases including ischaemic changes and chronic venous insufficiency.
 - Detect abnormalities in peripheral pulses.
 - Detect peripheral ischemia using Buerger's test.
 - Recognise features of ischaemic and venous leg ulcers.
 - Recognise varicose veins and venous insufficiency.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Syncope.
 - Cardiac failure.
 - Ischemic heart disease.
 - Valvular heart disease
 - Peripheral vascular disease.

Respiratory System

1. Elicit a history from patients with common respiratory symptoms, including relevant aspects of personal, social and family history. This should include patients with chest pain, cough, dyspnoea and wheezing.
2. Conduct a systematic examination of the respiratory system.
3. Elicit and describe physical signs related to the respiratory system.
 - Recognise peripheral signs of respiratory disease including clubbing.
 - Respiratory rate:
 - Record the respiratory rate.
 - Describe abnormalities in respiration.
 - Recognise signs of respiratory distress including: cyanosis, use of accessory muscles, prolongation of the expiratory phase, wheeze, and stridor.
 - Describe signs of hyperinflation.
 - Demonstrate abnormalities in chest expansion.
 - Detect abnormalities of percussion note.
 - Auscultation of chest:
 - Detect bronchial breathing, crackles (crepitations), and wheezes (rhonchi).
 - Describe patterns of physical signs associated with consolidation, effusion and pneumothorax.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Pneumonia.
 - Asthma.
 - Chronic obstructive pulmonary disease.
 - Environmental lung disease.
 - Lung cancer.
 - Pulmonary fibrosis
 - Pleural effusion

Gastroenterology System/Abdomen

1. Elicit a history from patients with common symptoms of oral and gastro-intestinal disease, including relevant aspects of personal, social and family history. This should include patients with constipation, diarrhoea, weight loss, gastrointestinal tract/abdominal pain, vomiting, jaundice and abdominal swelling.
2. Conduct a systematic examination of the gastrointestinal system and abdomen.
3. Elicit and describe physical signs related to the gastrointestinal system/abdomen.
 - Recognise peripheral stigmata of chronic liver disease.
 - Recognise signs of oral infection or pathology
 - Detect hepatomegaly by palpation and/or percussion.
 - Detect splenomegaly. Describe features to distinguish splenomegaly from enlarged kidney.
 - Detect abdominal mass, including aortic aneurysm, incisional hernia and transplanted (or enlarged) kidney(s).
 - Demonstrate ascites by lateral dullness and shifting dullness.
 - Describe rectal examination and abnormalities detected by rectal examination.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Acute abdomen including appendicitis, cholecystitis, peritonitis and bowel obstruction.
 - Oral infections, including thrush.
 - Gastrointestinal infections.
 - Peptic ulcer disease and GORD
 - Inflammatory bowel disease.
 - Colorectal cancer.
 - Oesophageal, stomach and pancreatic cancer.
 - Acute liver disease including hepatitis.
 - Chronic liver disease including alcoholic liver disease.
 - Masses arising from the abdomen

Neurology

1. Elicit a history from patients with common symptoms of neurological disease, including relevant aspects of personal, social and family history. This should include patients with headache, loss of consciousness, disturbances of speech or vision, weakness, sensory disturbance, falls and problems with balance or coordination.
2. Conduct a systematic physical examination on a patient with clinical features suggestive of neurological disease.
3. Elicit and interpret physical signs related to the neurological system.
 - Recognise (through conversation rather than formal assessment) and explain speech abnormalities e.g. dysphasia (receptive (Wernicke's), expressive (Broca's), nominal) and dysarthria.
 - Elicit and interpret abnormalities of cranial nerves:
 - II
 - Elicit decreased visual acuity.
 - Elicit and interpret visual field defects.
 - Elicit and interpret abnormalities of pupillary reflexes.
 - III, IV & VI
 - Elicit and interpret abnormalities of eye movements.
 - Detect nystagmus.
 - V & VII
 - Elicit and interpret sensory abnormalities on face.
 - Elicit and interpret facial muscle weakness.
 - Explain abnormal corneal reflex.
 - VIII
 - Elicit decreased hearing.
 - Elicit and interpret abnormalities of air and bone conduction.

Examination of Cranial Nerves IX to XII

In addition to testing cranial nerves as in Phase 1, you should be able to detect abnormalities of cranial nerves IX to XII.

- Glossopharyngeal and Vagus (IX and X)
 - Describe the gag reflex – pressing a stick into the tonsillar fossa will cause the patient to gag. Should also ask the patient if the sensation is comparable on both sides.
 - Observe movements of the uvula and posterior pharyngeal wall when asking the patient to say “Ahhh” (use a torch to illuminate). Describe abnormalities of movement of the uvula in patients with Xth nerve palsy.
- Accessory (XI)
 1. Stand behind the patient.
 2. Ask patient to shrug shoulders to test power of trapezius.
 3. Feel the bulk of the muscle.
 4. Attempt to push the shoulders down.
 5. Place hand on lower jaw and ask patient to attempt to rotate the head against your resistance to test power of sternomastoid. Feel the bulk of the muscle on the opposite side.
- Hypoglossal (XII)
 1. Observe tongue resting in the mouth. Look for involuntary movements and wasting.
 2. Ask patient to protrude tongue straight out.
 3. Assess power by asking patient to push the tongue against the side of the cheek.
 4. Describe abnormalities associated with a XIIth nerve palsy.
- Elicit and explain abnormalities of upper and lower limbs:
 - Recognise and interpret common abnormalities of gait e.g. hemiplegic, cerebellar ataxia, Parkinsonian.
 - Recognise and describe common tremors e.g. Parkinsonian, postural, intention and describe other involuntary movements e.g. myoclonus, chorea.
 - Elicit and explain signs associated with Upper Motor Neuron versus Lower Motor Neuron lesions.
 - Elicit and explain patterns of motor weakness (power) in limbs e.g. hemiparesis/hemiplegia, paraparesis, nerve root lesions, peripheral neuropathy (e.g. is there differential involvement of flexors or extensors).
 - Elicit and explain patterns of sensory abnormalities in limbs e.g. hemianaesthesia, nerve root (dermatomal), peripheral neuropathy (e.g. is proprioception impaired, while other modes are preserved).
 - Recognise and describe abnormalities associated with cerebellar disorders including speech (dysarthria), coordination problems, limb signs and gait.
- Mini-mental state examination - interpret the MMSE or RUDAS test (there is no need to memorise these forms).

4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Falls.
 - Confusion and delirium.
 - Cerebrovascular accident.
 - Peripheral neuropathies.
 - Parkinson's disease.
 - Dementia.
 - Cerebellar disorders.

Musculoskeletal System

1. Elicit a history from patients with common symptoms of musculoskeletal disease, including relevant aspects of personal, social and family history. This should include patients with joint or muscle pain, joint or muscle stiffness, joint swelling, joints giving way or locking, or functional difficulties, e.g. with dressing or climbing stairs.
2. Elicit and interpret physical signs related to the musculoskeletal system.
 - Conduct a general, systematic physical examination on a patient with clinical features suggestive of musculoskeletal disease.
 - Perform specific examination of the hands and wrists, shoulders, spine, knees, hips and gait. Students should note that an approach to the examination of the hands and wrists, knees, and a musculoskeletal screening examination are described in the Phase 1 guide; the hip examination is detailed below.
 - N.B. Video resources explaining some of these examinations are available in the [Clinical Skills Moodle module](#).
 - It is important to note that some of the videos have been provided by clinical specialists and *may go beyond the minimum expected standard for Phase 2*.
 - Some specific abnormalities to recognise are:
 - Recognise the common clinical findings and appearance of rheumatoid hands.
 - Recognise and interpret characteristic deformities of the hands and demonstrate functional capacity.
 - Recognise characteristic abnormalities of spinal curvature. Elicit all movements of the spine and interpret abnormalities.
 - Examine the hip, elicit and interpret abnormalities of movement.
 - Elicit abnormalities on examination of knees including detection of joint effusion, abnormalities of movement and ligament abnormalities.
3. Describe patterns of presentation, and elicit and interpret clinical features on history and examination which are associated with the following conditions:
 - Osteoarthritis.
 - Rheumatoid arthritis.
 - Gout.
 - Ankylosing spondylitis.
 - Early assessment of multiple trauma.
 - Fractures (including neck of femur) and other musculoskeletal injuries.
 - Carpal tunnel syndrome.
 - Osteoporosis.
 - Metastatic bone disease.

Examination of hips

You should understand the normal anatomy of the hip joint.

Examine the patient lying supine in bed, initially. Patient should only be wearing underclothes, but use a sheet to protect privacy as necessary.

- Inspect
 - Look at the ankles for any obvious difference in leg length, best judged by observing the malleoli.
 - Look at the knees and the position of the patella on both sides. (A formal knee exam may also be necessary – see Phase 1 CS Guide)
 - Check the angle between thigh and bed.
 - Look around the hip for any scars, sinuses or swelling.

- Measure the legs, first checking that the anterior superior iliac spines (ASIS) are at the same level. Measure true leg length from the ASIS to medial malleolus, on each side. Then measure apparent leg length, from the umbilicus or xiphisternum to the medial malleoli.
- Palpate
 - Feel for any warmth or tenderness, especially over the greater trochanter and on the joint line, lateral to femoral artery pulse.
 - Perform Thomas' test to demonstrate a fixed flexion deformity at the hip. Place one hand under the lumbar lordosis. Flex one hip until the lordosis disappears. Now look at the other hip to see if it is flexed and the knee has come off the bed. If so, there is a fixed flexion deformity at that hip.
- Movements at the hip should be tested actively then passively, with the patient supine initially. When testing movements of the hip, it is important to ascertain that the pelvis remains stationary. Do so by keeping your free hand on the ASIS.
 - Flexion is tested by bringing the flexed knee up onto the abdomen.
 - Abduction is measured by taking the leg outward until the pelvis is felt to move (to approximately 45-50°).
 - Adduction is performed by crossing one leg in front of the other until the pelvis is felt to move (at 45°).
 - Rotation at the hip is tested by flexing the hip and knee to 90° and then moving the foot out (laterally) for internal rotation and the foot in (medially) for external rotation (both to 45°).
 - Get the patient to lie prone and test extension by asking them to lift the leg (until the pelvis starts to move) – possible to about 30°.

After completing the examination with the patient in bed, the patient should be asked to stand. Observe the joint in a standing position, including the posterior aspect.

- Perform the Trendelenburg test. Ask the patient to stand first on one foot and then the other. In the normal situation, as the foot is lifted the pelvis tilts up on the same side as the raised foot. If there is an abnormality of the hip joint (or a weakness of the associated muscles), then the pelvis sinks down (a positive Trendelenburg test).

Finally, ask patient to walk to assess gait. Check if the step lengths are equal on both sides.

Haematology

1. Elicit a history from patients with common symptoms of haematological disease, including relevant aspects of personal, social and family history. This should include symptoms of anaemia, easy bruising/bleeding tendency and lymph node enlargement.
2. Conduct a systematic physical examination on a patient with clinical features suggestive of haematological disease.
3. Elicit and interpret physical signs related to the haematological system.
 - Recognise pallor.
 - Recognise purpura and bruising.
 - Detect lymphadenopathy and examine relevant region (to look for cause in drainage area).
 - Detect splenomegaly. Describe features to distinguish splenomegaly from enlarged kidney.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Anaemia.
 - Thromboembolic disease.
 - Lymphoma.

Genitourinary/Renal

1. Elicit a history from patients with common symptoms of genitourinary and renal diseases, including relevant aspects of personal, social and family history. This should include haematuria, dysuria, nocturia, urinary retention, and renal angle pain.
2. Conduct a systematic physical examination on a patient with clinical features suggestive of renal disease.
3. Elicit and interpret physical signs related to the renal system.
 - Measure blood pressure.
 - Abnormalities of fluid balance including assessment of the JVP.
 - Describe common means to assess fluid status.
 - Detect peripheral oedema.
 - Describe features of enlarged kidney.
 - Describe renal artery bruit.
 - Detect grafted kidney.
 - Recognise AV fistula for haemodialysis.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Hypertension.
 - Acute and chronic renal failure.
 - Renal stones.
 - Urinary incontinence and retention.
 - Benign prostatic hyperplasia.
 - Prostate cancer

Endocrinology

1. Elicit a history from patients with common symptoms of endocrine diseases, including relevant aspects of personal, social and family history. This should include symptoms related to thyroid disorders, osteoporosis and diabetes.
2. Elicit and interpret physical signs related to the endocrine system.
 - Detect goitre and thyroid nodules.
3. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Diabetes.
 - Metabolic syndrome.
 - Thyroid disorders including hyperthyroidism, hypothyroidism and goitre.

Examination of the thyroid gland

The following description applies to examination of the thyroid gland per se and not examination of the patient for clinical features of hyper or hypothyroidism.

You should understand the normal anatomy of the gland itself and its relations in the anterior neck.

Preferably, sit the patient in a chair with the upper chest exposed.

1. Inspect
 - Look for scars and any skin changes.
 - Inspect the neck to observe any swelling at the level of the thyroid gland.
 - Ask the patient to swallow and see if the swelling moves (to differentiate between thyroid and non-thyroid swellings in the anterior neck).
 - If there is a mid-line swelling, ask the patient to protrude the tongue. A thyroglossal cyst will move upwards with movement of the tongue.
2. Palpate
 - Stand behind the patient to palpate the neck.
 - Palpate the neck at the level of the thyroid gland. Use both hands to palpate each side of the neck – be gentle!
 - Ask the patient to swallow (provide a glass or water) and feel the gland move with swallowing. Important that your hands are in place to palpate the gland as the patient swallows.

- If a swelling is detected, determine if it is diffuse (goitre) or localised (nodule). Determine the size and shape of the gland, the consistency and mobility of any mass (repeat on swallowing) and whether it is tender.
 - Check for cervical lymphadenopathy.
3. Percuss
- Determine if there is any retro-sternal extension of an enlarged thyroid by percussing over the upper third of the sternum.
4. Auscultate
- Listen over a goitre for a bruit.

See a video of this examination <https://batesvisualguide.com/MultimediaPlayer.aspx?multimediaid=6091248>

Skin and Subcutaneous Tissues

Note: In surgical teaching, "lumps and bumps" are one of the most important subjects. In part, this derives from their frequency but they provide an opportunity for students to demonstrate, through their skills in physical examination, the process of accurate data gathering, description and analysis. In some areas (e.g., breast, neck, inguino-scrotal region), specific pathology exists but, in all areas, there are common conditions, which must be considered.

1. Elicit a history from patients with symptoms associated with a skin or subcutaneous lesion including relevant aspects of personal, social and family history.
2. Conduct a systematic physical examination on a patient with a skin/subcutaneous lesion (includes examination of the lesion and other relevant systems e.g. regional lymph nodes, peripheral pulses).
3. Elicit and interpret physical signs related to the skin/subcutaneous tissues.
 - Describe features of common skin lesions including benign and malignant lesions.
 - Recognise characteristic clinical features of cellulitis and wound infection.
 - Recognise features of ischemic and venous leg ulcers.
 - Describe features of common subcutaneous swellings including sebaceous cysts, epidermoid cysts and lipomas.
4. Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Cellulitis and skin abscesses.
 - Leg ulcers.
 - Benign and malignant skin lesions.

A video resource illustrates a relevant examination:

<https://moodle.telt.unsw.edu.au/mod/book/view.php?id=1630909&chapterid=162605>

It is important to note that the video has been provided by clinical specialists and *may go beyond the minimum expected standard for Phase 2*, for example you are not expected to know how to use a dermatoscope in P2.

Inguino-Scrotal Region

1. Elicit and interpret physical signs related to the inguinoscrotal region. Students would be expected to **know how** to distinguish between causes of swelling in the inguino-scrotal region.
 - Inguinal and femoral hernia.
 - Saphena varix.
 - Scrotal swellings (hydrocoele, varicocoele, testicular or epididymal).

Clinical Assessment in Paediatrics

In the *Beginnings, Growth & Development term* you will have the opportunity to observe the clinical assessment of children and develop basic skills. The opportunities for you to practice these skills are limited but you will be required to address the objectives for clinical assessment as outlined in the BGD Term Guide.

Specific areas which should be addressed:

1. Systematic examination of the newborn.
 - Measure and plot the height, weight and head circumference on age appropriate charts.
 - Describe the approach to the examination of the newborn (i.e. a baby check with documentation in a 'Blue Book').
 - Describe and interpret primitive reflexes.
2. Assessment of child development
 - Measure and plot the height and weight / BMI on age appropriate charts.
 - Recognise stages of a child's development including:
 - motor skills,
 - social and emotional development, and
 - speech and language.
3. Assessment of an acutely ill child.
 - Elicit history of the illness to assess acute status and possible diagnoses.
 - Recognise signs of severe illness (alertness, respiratory rate, temperature, pulse rate, hydration status).
 - Describe the approach to the examination of the acutely ill child.
 - Interpret clinical features elicited on history or examination in a child with respiratory distress, fever, altered level of consciousness or a child who is having a seizure and a child with an acute abdomen.
 - Use and interpret appropriate standard paediatric observation charts and be able to explain importance of 'between the flag' data.
4. Assessment of an injured child.
 - Elicit history of the injury including an evaluation of the mechanism of injury.
 - Describe the approach to the examination of the injured child.
 - Interpret clinical features elicited on history or examination in a child with a musculoskeletal injury or infection.
5. Assessment of chronic illness in an adolescent.
 - Elicit history of chronic illness including an assessment of the impact of the illness with particular reference to adolescence.
 - Use the HEADSS Adolescent Psychosocial Assessment to take a history from an adolescent.
 - Perform a relevant systematic examination.
 - Interpret clinical features elicited on history or examination and describe patterns of presentation associated with the following:
 - Cystic fibrosis
 - Asthma
 - Anorexia
 - Inflammatory bowel disease
 - Cerebral palsy

In the Integrated Clinical Examination, you may be assessed against these objectives. To a large extent, you will be expected to **know how** to assess a child rather than being expected to demonstrate this. The opportunities for using children, especially sick children, in the examination are limited. However, there are other means for assessing your knowledge and skills, such as:

- Elicit history of a child's illness through a parent.
- Explain to the parent what you would do in the physical examination.
- Recognise abnormalities demonstrable on a video of an acutely ill child.
- Describe how you would approach the examination of a child shown in a video.
- Describe signs you would be looking for and how you would interpret these.

- Recognise development milestones in a child shown in a video.
- Describe to a parent how a procedure would be performed.
- Demonstrate using a model how to perform a procedure on a child.
- Interpret reported developmental milestones.
- Plot and interpret growth parameters and clinical observations.

Clinical Assessment in Obstetrics & Gynaecology

In the *Beginnings, Growth & Development* term you will have the opportunity to observe the clinical assessment of pregnant women and develop basic clinical skills including the pelvic examination. The opportunities for you to practice these skills are limited but you will be required to address the objectives for clinical assessment as outlined in the BGD Course Guide.

Specific areas which should be addressed:

1. Gynaecological history and examination.
 - Elicit history of sexual and reproductive health and problems.
 - Demonstrate vaginal examination (using mannequin) including collection of cervical smear specimen.
2. Assessment of pregnancy.
 - Elicit obstetric/antenatal history.
 - Determine fundal height (using mannequin).
3. Assessment of a woman in the post-partum period.
 - Elicit history of post-partum period.
 - Describe normal physical findings in post-partum period.
 - Describe and interpret relevant physical abnormalities.

In the Integrated Clinical Examination, you may be assessed against these objectives. The use of mannequins will allow assessment of your skills in performing elements of the physical examination/procedures. The opportunities for assessing pregnant or post-partum women in the examination are limited. However, the above objectives can be assessed in other ways e.g. using surrogate women, video clips and mannequins.

Relating knowledge of basic and social sciences to clinical practice

The Phase 2 Integrated Clinical Examination will include a written component aimed at assessing your knowledge of the basic and social sciences relevant to the course themes in Phase 2. The indicator statements for the capabilities of *Using Basic and Clinical Sciences* and *Social Determinants of Health and Disease* in Phase 2 encapsulate what will be expected.

In the Phase 2 Integrated Clinical Examination, the majority of the stations will involve a patient presenting with a clinical problem. In the viva section of the examination, you may be asked to apply your knowledge of the basic and social sciences to the clinical problem or the underlying disease.

You should develop an approach to relating what you are learning in the basic and social sciences to clinical practice.

Assessing the clinical problem

Assessing the problem from the history?

- How may patients with this problem present? How do patients with this problem usually describe their symptoms?
- How does it affect the patient's activities?
- How is the problem characterised? What are the variations?
- What other symptoms are commonly associated? Is there a recognisable pattern of symptoms?
- What other features (e.g. personal and social features, past and concurrent illnesses) are relevant?
- Is this symptom always abnormal? Under what circumstances could the symptom be considered normal?
- Which features help to differentiate the cause or determine the severity?

Assessing the problem from the physical examination?

- Which system(s) approach is/are most appropriate in assessing the problem?
- What other physical signs may be present? Is there a recognisable pattern of signs?
- Is this sign always abnormal? Under what circumstances could the sign be considered normal?
- Which physical signs support or exclude diagnostic possibilities?
- Which features help to differentiate the cause or determine the severity?

How does knowledge of the basic and clinical sciences help in understanding the clinical presentation?

- What is the anatomical/physiological abnormality underlying a particular symptom/sign or pattern of clinical findings?

Diagnosing the clinical problem

What is the provisional diagnosis or differential diagnoses?

- What conditions could present in this way?
- What is an **approximate order of likelihood** of these conditions? This may be based on the clinical features in this particular case and/or based on incidence of various conditions across similar presentations.

What investigations are appropriate?

- What changes are expected on routine investigations?
- What are the **most useful** diagnostic tests?

How do investigations support/exclude diagnostic possibilities?

How does knowledge of the basic and clinical sciences help in understanding the diagnostic investigations?

- What are the pathological changes associated with the problem?
- How does the pathology affect normal structure or function? How is this reflected in investigations?

Managing the problem

What are the broad principles of management?

- What are the options for treatment e.g. medical or surgical?
- Do particular clinical features affect the approach to the treatment?
- How does knowledge of the basic and clinical sciences help in understanding the approach to management? E.g. pharmacological mechanisms of drugs, understanding of surgical pathology.

What must be done early?

- What features necessitate urgent action?

Phase 2 Integrated Clinical Examination

In order to be eligible for the ICE, students must have demonstrated satisfactory completion of:

- All 6 Phase 2 courses, including assignments
- The clinical skills logbook ("white book") of procedural skills
- A minimum of 6 mini CEXs within the deadlines stated in this guide or otherwise communicated

Your level of achievement in the Phase 2 clinical courses will be assessed in an integrated clinical examination. Students are advised to be familiar with the Graduate Capabilities for the end of Phase 2 as well as the course guides for each course.

The end-of-phase Integrated Clinical Examination (ICE) is a barrier examination. Students must pass the Integrated Clinical Examination to progress to Phase 3 and to be eligible for the Year 4 Medicine Research Project. The Integrated Clinical Examination has two parts: a clinical component and a written component. Students must pass both to pass overall.

The clinical component examination will consist of six equal clinical stations which primarily (but not solely) relate to Patient Assessment and Management and Effective Communications graduate capabilities. You will be required to demonstrate competency in clinical and communication skills, and procedural skills. You will also need to demonstrate knowledge in the basic and social sciences. The format of the examination is similar to the Phase 1 Clinical Skills Examination.

The focus of the clinical examination will be on the clinical presentations, ethical, QMP and population health issues addressed in the weekly themes in the Phase 2 courses. Within the scope of these themes, the complexity and content of the stations will be deeper and broader than Phase 1.

- Each student will be assessed at six stations.
- Each station is 10 minutes.
- The examiners will include clinicians involved in teaching, clinical skills tutors and campus-based teachers.
- One examiner will be present at each station.
- You will be given an instruction document advising you what you are required to do at the station.
- All stations will include components of communication, procedural and clinical skills.
- Content and skills from practical classes, case-method tutorials, lectures, tutorials and other teaching activities based around the weekly themes from campus and clinical campus days will be examined, in varying amounts drawn from Phase 2 teaching. However, each station will not have every component.
- More complex communications skills such as motivational interviewing, taking a sexual history, talking with adolescents, depression and anxiety assessment, etc. may be examined.
- Investigations and broad management principles may be examined. Specific treatment will not be examined, although knowledge of the clinical pharmacology of relevant drugs may be examined.
- The examiner will assess your performance against five predetermined criteria. A station will have a primary focus on communication skills or physical examination. Examples of the assessment forms available below. Other types of stations may be included in a variety of formats – assessment forms are also available below.
- The stations will not be aligned to a specific Phase 2 Term i.e. there will not be an ACR station or S&H station etc. Each station may present a range of issues drawn from a variety of Terms.

Assessment of performance

Within the Medicine program, assessments are continuously reviewed to determine reliability, validity, examination performance and optimal student outcome. Whether a student passes or fails the Phase 2 ICE clinical component has always been determined by an algorithm based on the number of stations passed or failed and not a numerical mark. The Clinical Learning and Assessment Committee has been reviewing the performance of the P2 ICE examination for a number of years and this has led to the modifications detailed below. Grading sheets and criteria by which students are examined are shown on the following pages.

Borderline grade: Examiners may award a Borderline or B grade, which represents a borderline performance for a criterion. This indicates that the student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station; this student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion.

Using a statistical algorithm, information from all the raw examination grades will be used to reclassify all the B's (examiner awarded) to either F or P (the grade the student ultimately receives). The leading principle of the algorithm is that it considers all the examination grades across all criteria and across all students and estimates the difficulty of each criterion and the ability of each student which is relevant to the B grade achieved. Based on these estimations the algorithm reclassifies all the B grades to either P or F. Consequently, when results are published to students, only the 'resolved' grades (F, P and P+) will be seen.

Assessment algorithm: Note that, in conjunction with the Borderline method described above, the algorithm for determining overall pass/fail for the Clinical Skills Examination has been revised by the Clinical Learning and Assessment Committee in recent years. This revision has increased the rigour of the examination, in line with longstanding Faculty concerns that students with sub-optimal clinical skill performance have been able to 'just pass' this examination in the past. Whilst Faculty does not have an expected or desired number of overall fails, nor does Faculty seek to just 'fail more' students, the ultimate effect of this revision has increased the overall fail rate in recent years. Students are therefore strongly encouraged to ensure their performance in all relevant skills is at a Clear Pass level for this examination.

General expectations for the Phase 2 Integrated Clinical Examination – Clinical Component

- Where relevant, you should introduce yourself to every patient and seek permission to interview and / or examine him or her. It is important to tell the patient what you intend to do in the time available for the station (set the agenda). Do not assume that because it is an examination that you do not need to do this. On the contrary, this is explicitly assessed.
- Where relevant, you should seek to establish rapport and develop the relationship with the patient. Although the patient is there to assist with the examination, do not treat the patient as an exam "object". Begin with general questions and create rapport this will also help you work out what the problem may be.
- You are expected to demonstrate your ability to communicate effectively with a patient. For example, you should begin your history with open-ended questions even though you may be told what is the patient's presenting symptom. Allow the patient to describe the symptom in his or her own words. Give the patient time to respond to your questions. Do not prompt the patient with answers that you think fit a particular diagnosis.
- You must ask the patient about his/her personal/social circumstances and the impact of the illness or issue and his/her concerns (ICE). Do not focus solely on the disease.
- You should acknowledge the feelings and concerns expressed by a patient. You need to demonstrate that you have heard and understood these important issues (being person/patient centred). Do not ignore what a patient says and move onto another question about the symptoms.
- You should confirm your history with the patient by briefly summarising it (internal summary as per Ph1) for him or her.
- You should explain to the patient what you are going to do in the physical examination or a procedural skill and ensure your instructions to the patient, throughout the examination, are clear and understood (agenda setting and gaining consent).
- Where relevant, you are expected to demonstrate, or describe, good technique in the physical examination – you are expected to note obvious common abnormalities on examination and explain their meaning to the patient and/or examiner. You are not expected to detect rare or unusual clinical signs. Ensure you are clear what aspect of the physical examination you have been asked to perform.
- Procedural skills may be examined.
- You should report to the examiner a synthesis (summary) of your history and/or examination and report your findings. This should include the concerns that the patient raised, the significant features of the history and the important positive and negative clinical signs on examination. You should use appropriate clinical terms when describing symptoms and physical findings. It is expected that you will provide a differential diagnosis or problem list in some cases, demonstrating your clinical reasoning skills.

Phase 2 ICE Medical History station Assessment Form

Student Details:

Assessor:

Date:

Assess the student's ability to:	Mark - Circle one grade for each			
1. Listen attentively, engage patient and maintain respect - initiate session appropriately, allow patient to use his or her own words without premature interruption, use open and closed questions, reflect important feelings, pick up verbal and non-verbal cues, shows interest in eliciting the patient's perspective, display sensitivity to patient's needs, respect boundaries, gain patient's trust, thanks patient.	F Fail	B Borderline	P Pass	P+ Exceptional
2. Elicit a relevant clinical history - establish reason for presentation, course and nature of symptoms, demonstrate clinical reasoning in the approach to questioning, frames questions in ways that take into account patient's concerns and understanding of their situation, summarise back to patient to check understanding	F Fail	B Borderline	P Pass	P+ Exceptional
3. Gather a relevant psychosocial, past medical and family history - ask patient about family &, social support, cultural & lifestyle factors, employment issues; elicit relevant past medical and family history, as well as specific risk factor history where appropriate	F Fail	B Borderline	P Pass	P+ Exceptional
4. Summarise history to the examiner – smoothly present a brief summary of the history demonstrating the key or most relevant features, identify the patient's key concerns and reason for presenting	F Fail	B Borderline	P Pass	P+ Exceptional
5. Interpret patient history and presentation – suggest appropriate differential diagnoses, and, as appropriate, suggest suitable investigations or treatment options OR Discuss/explain diagnosis and/or management with patient – use appropriate language, respond appropriately with sensitivity to patient's questions,	F Fail	B Borderline	P Pass	P+ Exceptional

Additional comments

Feedback on station

Guidelines for Fail Grade

A fail grade in each of the following criteria would require that the student has failed in all or most of the elements.

Criterion 1: Listen attentively, engage patient and maintain respect

- Fails to introduce self and confirm agenda with patient.
- Fails to allow patient to describe illness – prematurely interrupts patient and uses closed questions only.
- Fails to recognise patient's feelings and ignores patient's concerns.
- Fails to respond to verbal and non-verbal cues or responds inappropriately.
- Fails to seek to establish rapport with patient – seems disinterested in patient as a person.
- Fails to acknowledge and thank patient at conclusion of station.

Criterion 2: Elicit a relevant clinical history

- Fails to clarify reason for presentation including the patient's underlying concerns.
- Fails to characterise the principal symptom. Fails to establish the course of the illness.
- Fails to establish the impact of the illness on the patient.
- Fails to demonstrate clinical reasoning in approach to questioning. History is disorganised and does not follow logical progression in response to patient's answers.

Criteria 3: Elicit a psychosocial history, relevant past and family history

- Fails to ask initial questions about these elements of the history. Note that the patient's history may not provide relevant or sufficient details to proceed with questioning but it is essential that the student addresses these elements.
- Fails to pursue aspects of history relevant to the presenting illness.

Criterion4: Summarise case findings

- Fails to summarise key elements in the history. Presentation lacks any structure.
- Fails to describe the patient's concerns/issues – focus is solely on the medical issues.

Criterion5: Interpret case findings OR discuss/explain to patient

- Fails to interpret history and is unable to offer any differential diagnoses.
- Fails to explain nature of diagnosis or approach to management.

B (Borderline): This grade represents a borderline performance for a criterion. The student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station. This student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion.

Phase 2 ICE Physical Examination station Assessment Form

Student Details:

Assessor:

Date:

Assess the student's ability to:	Mark - Circle one grade for each			
1. Engage patient and maintain respect - initiate session appropriately, explains nature of examination or procedure and asks for consent, explains steps in examination or procedure clearly, pick up verbal and non-verbal cues, display sensitivity to patient's needs, respect boundaries, gain patient's trust, thank patient and offer help with dressing etc.	F Fail	B Borderline	P Pass	P+ Exceptional
2. Perform technically competent physical examination or skill - correctly position patient, ensure patient comfort and privacy, avoid aggravating patient discomfort, adept with equipment, demonstrate a competent approach to examination	F Fail	B Borderline	P Pass	P+ Exceptional
3. Detect physical signs - correctly describe observations; detect/elicit reasonably evident physical signs; or describe expected physical signs which are not reasonably evident	F Fail	B Borderline	P Pass	P+ Exceptional
4. Summarise case findings - smoothly summarise examination findings and, if appropriate demonstrate provision or differential diagnoses, as well as investigations	F Fail	B Borderline	P Pass	P+ Exceptional
5. Interpret patient case – suggest appropriate differential diagnoses, and, as appropriate, suggest suitable investigations; be able to describe the significance of physical signs	F Fail	B Borderline	P Pass	P+ Exceptional

Additional comments

Feedback on station

Guidelines for Fail Grade

A fail grade in each of the following criteria would require that the student has failed in all or most of the elements.

Criterion 1: Listen attentively, engage patient and maintain respect:

- Fails to introduce self and confirm agenda with patient.
- Fails to allow patient to describe illness – prematurely interrupts patient and uses closed questions only.
- Fails to recognise patient's feelings and ignores patient's concerns.
- Fails to respond to verbal and non-verbal cues or responds inappropriately.
- Fails to seek to establish rapport with patient – seems disinterested in patient as a person.
- Fails to acknowledge and thank patient at conclusion of station. Fails to offer assistance in helping patient with repositioning or dressing.

Criterion 2: Perform technically competent examination or skill.

- Fails to explain to patient prior to performing examination or skill.
- Fails to provide clear instructions to patient.
- Fails to consider patient's comfort or ignores patient's discomfort. In patients in whom physical examination is likely to aggravate discomfort, fails to adjust approach to examination.
- Fails to demonstrate competency in all elements of the task.

Criteria 3: Detect physical signs

- Fails to elicit/detect/describe expected physical abnormality.

Criterion 4: Summarise findings.

- Fails to summarise key elements in the examination. Presentation lacks any structure.

Criterion 5: Interpret findings.

- Fails to interpret examination findings and is unable to offer any differential diagnoses.

B (Borderline): This grade represents a borderline performance for a criterion. The student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station. This student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion.

Phase 2 ICE Clinical Examination Station using Resource

Student Details:

Assessor:

Date:

Assess the student's ability to:	Mark - Circle one grade for each			
1. Approach to the patient in relation to the task/clinical resource presented: <i>Student discusses: Appropriate initiation of session; explanation of nature of task/clinical resource and asking for consent; explanation of steps in task/accessing clinical resource clearly; requirement to be sensitive to patient's and/or parent/guardian/carer needs, gaining parent/guardian/carer and/or patient's trust; appropriate follow up of task/clinical resource e.g. offering help with repositioning or dressing, explanation of next steps etc.</i>	F Fail	B Borderline	P Pass	P+ Exceptional
2. Key features of the task/clinical resource presented in the resource: <i>Student discusses competent approach to task/clinical resource: e.g. correct positioning of the patient / use of equipment/tool in question; ensuring patient comfort and privacy; avoiding aggravation of patient discomfort; eliciting desired outcome.</i>	F Fail	B Borderline	P Pass	P+ Exceptional
3. Describes observable and/or predictable findings from the task/clinical resource: <i>Correctly describes observations; describes predictable findings from the task/clinical resource.</i>	F Fail	B Borderline	P Pass	P+ Exceptional
4. Summarise case findings – <i>Smoothly and accurately summarises examination findings.</i>	F Fail	B Borderline	P Pass	P+ Exceptional
5. Interpret patient case – <i>Suggests appropriate differential diagnoses and/or suitable additional examinations/procedures/investigations; able to describe the significance of findings from the task/clinical resource.</i>	F Fail	B Borderline	P Pass	P+ Exceptional

Additional comments

Feedback on station

Guidelines for Fail Grade

A fail grade in each of the following criteria would require that the student has failed in all or most of the elements.

Criterion 1: Approach to the patient in relation to the task/clinical resource presented

- Fails to discuss introduction
- Fails to explain nature of task/clinical resource to patient and/or parent/guardian/carer.
- Fails to discuss establishing rapport with patient suggesting disinterest in patient as a person.
- Fails to discuss acknowledging/thanking/explaining next steps to patient at conclusion of task/clinical resource.
- Fails to discuss offering assistance in helping patient e.g. with dressing.

Criterion 2: Key features of the task/clinical resource presented in the resource

- Fails to discuss correct positioning of the patient and/or use of equipment/clinical resource.
- Fails to discuss providing clear instructions or education to patient.
- Fails to discuss actions to enhance patient's comfort or reduce patient's discomfort.
- Fails to discuss actions to enhance success of task/clinical resource or reduce patient's discomfort or mitigate risks in conducting task/clinical resource.
- Fails to discuss significant elements of the task.

Criteria 3: Describes observable and/or predictable findings from the task/clinical resource

- Fails to describe clearly observable findings from the task/clinical resource.
- Fails to describe reasonably evident findings from the task/clinical resource.
- Fails to describe expected or predictable findings from the task/clinical resource.

Criterion 4: Summarise case findings

- Fails to summarise key elements of the task/clinical resource.
- Presentation lacks any structure.

Criterion 5: Interpret patient case

- Fails to interpret task/clinical resource findings
- Does not exhibit understanding of significance of signs/outcomes/features detected, evident, expected or predicted.
- Unable to offer / discuss any differential diagnoses / issues / next steps.
- Offers / discusses very few differential diagnoses / issues / next steps.

B (Borderline): This grade represents a borderline performance for a criterion. The student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station. This student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion.

Phase 2 ICE Ethics Clinical Station Assessment Form

Student Details:

Assessor:

Date:

Assess the student's ability to:	Mark - Circle one grade for each			
1. Listen attentively, engage patient and maintain respect - initiate session appropriately, allow patient to use his / her own words without premature interruption, use open and closed questions, reflect important feelings, pick up verbal and non-verbal cues, show interest in eliciting the patient's perspective, display sensitivity to patient's needs, respect boundaries, gain patient's trust, thank patient	F Fail	B Borderline	P Pass	P+ Exceptional
2. Elicit a relevant narrative - establish reason for presentation, including concerns the patient is/appears to be reluctant to raise; gather relevant information from the medical history; frame questions taking into account patient's concerns and understanding of their situation; summarise back to patient to check understanding	F Fail	B Borderline	P Pass	P+ Exceptional
3. Explore the ethical issue - ask patient about the issue, exploring its impact, their concerns and/or expectations; seek to explore and understand ethical dilemma from patient's perspective; demonstrate respect for patient autonomy; maintain appropriate boundaries; check to see if patient understands relevant risks/harms, etc. of possible courses of action	F Fail	B Borderline	P Pass	P+ Exceptional
4. Summarise history to the examiner – smoothly present a brief summary of the narrative and issue demonstrating the key or most relevant features, especially the ethical dimensions; identify the patient's key concerns and reason for presenting	F Fail	B Borderline	P Pass	P+ Exceptional
5. Interpret patient history and presentation – suggest ethical theories and/or frameworks which help in understanding the issue presented, both from the patient perspective, but also from a 'practitioner' perspective; suggest possible courses of action relevant to one or both of these perspectives; exhibit awareness of the influence of student's personal values	F Fail	B Borderline	P Pass	P+ Exceptional

Additional comments

Feedback on station

Guidelines for Fail Grade

A fail grade in each of the following criteria would require that the student has failed in all or most of the elements.

Criterion 1: Listen attentively, engage patient and maintain respect

- Fails to introduce self and confirm agenda with patient.
- Fails to allow patient to describe current issue of concern – prematurely interrupts patient and/or uses closed questions only.
- Fails to recognise patient's feelings and/or ignores patient's concerns.
- Fails to respond to verbal and non-verbal cues or responds inappropriately.
- Fails to seek to establish rapport with patient
- Fails to acknowledge patient distress
- Seems disinterested in patient as a person
- Fails to acknowledge and thank patient at conclusion of station.

Criterion 2: Elicit a relevant narrative

- Fails to clarify reason for presentation including the patient's underlying concerns.
- Fails to gather relevant information from the medical history
- Fails to frame questions taking into account patient's concerns and understanding of their situation
- Fails to summarise back to patient to check understanding

Criteria 3: Explore the ethical issue

- Fails to explore the impact, concerns and/or expectations the patient has in regard to the issue at hand.
- Fails to seek to understand ethical dilemma from patient's perspective
- Fails to demonstrate respect for patient autonomy and/or maintain appropriate boundaries;
- Fails to check to see if patient understands relevant risks/harms, etc. of possible courses of action

Criterion 4: Summarise history to the examiner

- Fails to summarise key features of, and ethical issue, in the history.
- Presentation lacks any structure.
- Fails to describe the patient's concerns/issues – focus is solely on the medical issues.

Criterion 5: Interpret patient history and presentation

- Fails to interpret history and is unable to suggest ethical theories and/or frameworks which help in understanding the issue
- Unable to discuss patient or practitioner perspective, or courses of action relevant to one or both of these perspectives.

B (Borderline): This grade represents a borderline performance for a criterion. The student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station. This student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion.

UNSW Medicine Mini-Clinical Evaluation Exercise (mini-CEX) Form – Phase 2

This form is supplied for information only – no paper submissions should be made. For information on how to complete a miniCEX in the CWAapp – please see the Clinical Skills Moodle module:

<https://moodle.telt.unsw.edu.au/course/view.php?id=7698>

Student:	Student ID	
Date:	Term:	Attachment:

Clinical Case:
Patient Age: Patient Sex: M / F

Setting	Ambulatory/Outpatient <input type="checkbox"/>	Inpatient <input type="checkbox"/>	ED <input type="checkbox"/>	Other <input type="checkbox"/>
Complexity of case/topic	Low <input type="checkbox"/>	Average <input type="checkbox"/>	High <input type="checkbox"/>	
Assessment Focus	History <input type="checkbox"/>	Examination <input type="checkbox"/>	Explanation <input type="checkbox"/>	

Best Aspects
Suggestions for improvement
Agreed Actions

Please use the following scale to grade (PTO for guidelines to grade)					
	F Well below expectations	B Borderline performance	P Meets expectations	P+ Outstanding performance	N/A
1. History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Synthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Explanation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Rating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Assessor Name:	Assessor Position:	Assessor Signature:
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Guidelines for Grading Mini-CEX

	Well below expectations (F)	Borderline performance (B)	Meets expectations (P)	Outstanding performance (P+)
History	<ul style="list-style-type: none"> Fails to characterise the nature and course of the illness. Does not ask about impact of illness. History is disorganised. Fails to ask initial questions about psychosocial, past and family elements of the history. Fails to address patient's concerns. 	<ul style="list-style-type: none"> The student has failed to address an essential element OR the student has an understanding of the skill but has not demonstrated an overall satisfactory level of competency for this element of the station. This student is not a CLEAR FAIL, nor a CLEAR PASS on this criterion. 	<ul style="list-style-type: none"> Completes history in a systematic manner. Interprets findings as history taken and adapts questioning. Explores pertinent secondary issues. Links past, social and family history to presentation. Explores family and social supports including impairment in daily activities. 	<p>All of P grade plus:</p> <ul style="list-style-type: none"> Demonstrates skills in eliciting history of complex or chronic illness. Recognises and pursues subtle clues which are critical in diagnosis. Manages difficult patients effectively to obtain a reliable history.
Physical examination	<ul style="list-style-type: none"> Fails to demonstrate competency in most elements of the task. Fails to consider patient's comfort or ignores discomfort. Fails to elicit/detect/describe expected physical abnormality. 	<ul style="list-style-type: none"> As above 	<ul style="list-style-type: none"> Performs complete, systematic and logically sequenced examination. Correctly observes/elicits major findings. Demonstrates clear understanding of how physical signs are interrelated. 	<p>All of P grade plus:</p> <ul style="list-style-type: none"> Demonstrates advanced examination skills. Correctly detects/elicits all physical signs including subtle signs. Correctly interprets inconsistent physical signs.
Synthesis	<ul style="list-style-type: none"> Presentation lacks structure and fails to summarise key findings. Fails to interpret clinical information and is unable to offer any differential diagnoses. 	<ul style="list-style-type: none"> As above 	<ul style="list-style-type: none"> Presents interpretative summary in clear and concise manner. Recognises the key positive and negative features. Interprets clinical information with reasonable differential diagnosis. 	<p>All of P grade plus:</p> <ul style="list-style-type: none"> Accurately interprets discriminatory clinical features in resolving differential diagnosis. Correctly identifies atypical features based on probable diagnosis.
Explanation	<ul style="list-style-type: none"> Fails to explain nature of diagnosis or approach to management. Does not adapt approach if patient does not understand. 	<ul style="list-style-type: none"> As above 	<ul style="list-style-type: none"> Describes diagnosis and treatment correctly and relates to patient's situation. Invites patient to ask questions and answers them accurately and sensitively. Uses appropriate language. Checks patient's understanding. 	<p>All of P grade plus:</p> <ul style="list-style-type: none"> Explanation is detailed and accurate. Demonstrates skills in changing approach to explanation if patient does not understand.
Professionalism	<ul style="list-style-type: none"> Lacks discretion, respect or empathy. Launches into task without explanation or consent. Fails to explain instructions to patient or is impolite. 	<ul style="list-style-type: none"> As above 	<ul style="list-style-type: none"> Explains actions in appropriate language and checks patient understanding. Checks patient comfort throughout. Responds appropriately to observable or vocalised signs of discomfort or patient difficulty. 	<p>All of P grade plus:</p> <ul style="list-style-type: none"> Manages difficult situations effectively while maintaining professional manner.

Appendix 1: Excerpt from UNSW Medicine Professionalism in Medicine, Student Code of Conduct

Students attention is drawn to the following excerpts from the document issued to them at the start of Phase 1 and discussed and signed off in Foundations. Please be familiar with the full text, but these excerpts are particularly relevant to Clinical Skills and interacting with patients.

Professionalism: A set of values, behaviors, and relationships that underpins the trust that the public and society has in doctors.

Beginning your professional career in medicine

During your medical education, you will have privileged access to people and their families, and to their health information. The trust that people place in doctors and medical students carries considerable responsibility and expectation regarding your behaviour. It is important that you are aware of these responsibilities and expectations from the beginning of your medical training.

You also have a responsibility to your fellow students and your teachers to always act professionally, honestly and with integrity. Your behaviour outside the clinical environment, including your personal life, may have a lasting impact on your fitness to practice and professional standing. Your behaviour as a medical student should justify the trust that individuals and society place in the medical profession.

These principles operate in conjunction with current State and Federal Acts, Regulations and Codes of Practice that you will need to become familiar with during your training. These include the Good Medical Practice (Medical Board of Australia 2014) and the Health Information Privacy Act (2002).

In addition to the UNSW Student Code of Conduct and the Policies of UNSW Medicine you are registered with the Medical Board of Australia as a student and are governed by NSW Health policies with respect to clinical placements. You must be familiar with, and comply with these organisations' documents and policies.

When interacting with patients, staff, and the public in clinical settings, as a medical student you will:

1. Be aware and respectful that healthcare settings, including teaching hospitals, are workplaces whose principle function is to treat the sick or injured. Dress and act appropriately. Prioritise the running of healthcare for patients over your own learning or personal benefit.
2. At all times, treat patients, their families and all healthcare/hospital staff politely and considerately.
3. Respect the dignity and privacy of patients. Maintain confidentiality of patient information, whether spoken, written or electronic.
4. Understand that your own values and beliefs may differ from those of patients and healthcare staff. Manage these possible influences on your interactions and respect the autonomy of patients and their families.
5. Introduce yourself to patients, ensuring that they understand that you are a medical student. Clearly inform patients (or where applicable, family members and legal guardians) of your role and the purpose and nature of any proposed interaction with them.
6. Prior to undertaking any clinical activity, check that the patient understands your request and obtain their consent. Ensure that the patient understands that refusing or withdrawing consent will not impact in any way on their own healthcare.
7. If you are asked to carry out clinical duties, be aware of the limits of your knowledge and skills. Ensure that you have appropriate supervision and support when undertaking unfamiliar clinical activities.
8. Ensure that your written communications into patient's medical records, such as admissions or ward rounds, follow best practice. If you are documenting into an electronic medical record, ensure that the entry is finalised with sign-off by a clinician so that it can be viewed.
9. Your clinical teachers may be junior or senior doctors, nurses, or allied health professionals. Understand that most clinicians who teach medical students are not directly employed to do so. Respect their generosity with your timely attendance and engagement during any scheduled clinical teaching activities.

Consequences of unprofessional behaviour

Incidents of unprofessional behaviour (i.e. breaches of the student code of conduct) may result in serious consequences, ranging from:

- a reprimand;
- a permanent record in your portfolio;
- failure in an assessment or course;
- notification to the Medical Board of Australia (N.B. [Good medical practice: a code of conduct for doctors in Australia](#));
- Suspension or expulsion from the UNSW Medicine program (N.B. [Student misconduct policy and procedure](#))

Appendix 2: Dress code when working in clinical environments (includes working with SP's)

Students must note the following excerpt from NSW Health procedural document 'Uniforms Provision, Dress Code and appearance for Clinical and Corporate Services Staff'. This document states "COMPLIANCE WITH THIS DOCUMENT IS MANDATORY". UNSW Medicine also expects this from students.

Staff not required to wear a uniform:

Clothing must be neat and in good repair.

The following items are considered unacceptable:

- Singlet, low cut and revealing tops
- Clothing with writing, logos or advertisements
- Patches/ fringes on clothing
- Thongs/ crocs
- Leggings
- Midriff blouses
- Tracksuit pants, scruffy jeans, very short skirts

Shoes

- Closed footwear (i.e. not open toed or backless) with non-slip soles, of a solid colour (black, brown or navy blue) and with non-slip soles must be worn at all times
- Footwear should be leather/vinyl and impervious to hazards in the workplace
- A risk management approach is to be adopted when assessing suitability of footwear requirements within individual working environments

All Staff

Hair

- Hair below collar length should be tied back at all times.
- Head/ hair protection is mandatory in certain areas including: kitchens and operating theatres.
- Facial hair should be neat and trimmed.

Jewellery

- Clinical staff are advised that jewellery should be removed wherever possible prior to patient contact
- Fashion jewellery (long necklaces and earrings) are a WHS risk and are considered unacceptable.
 - Similarly; ID badges (specifically lanyards), ties and scarves that may present a WHS or infection risk if contact with patients occurs should be removed wherever possible or secured so as not to make contact with the patient or surrounds.
- Hand and wrist jewellery, including watches are to be removed as they present an infection risk. Simple/ plain wedding bands are the only acceptable piece of jewellery to be worn by clinical staff below the elbow.
- All jewellery, including wedding bands are to be removed prior to performing aseptic procedures to reduce the risk of infection and promote patient safety.

Hand Accessories

- All staff that have direct contact with patients are advised that artificial fingernails or fingernail extensions present an infection risk and are therefore considered unacceptable during work hours.
- Natural fingernails should be no longer than 0.5cm in length and be free of nail polish to reduce the risk of infection to patients.

Men's Attire

- Men's ties are only acceptable in non-clinical areas. Exceptions may be made where it is deemed appropriate, such as general consultation between a medical staff member and a patient. In these cases, ties should be secured so as not to make contact with the patient or surrounds.
- It is expected that shirt sleeves be rolled to above the elbow by all staff in clinical areas to aid hand hygiene and decrease the risk of infection to patients.

Religious/ Cultural Items

- Articles of clothing/ jewellery considered to have cultural/religious significance are acceptable if they comply with the acceptable standards set out above.

Appendix 3: Hand Hygiene, hand care & bare below the elbows; COVID PPE

UNSW Medicine and Health expects medical students comply with Clinical Excellence Commission policies:

<https://www.cec.health.nsw.gov.au/keep-patients-safe/infection-prevention-and-control/healthcare-associated-infections/policies,-guidelines-and-handbook>

Hand hygiene as per '5 moments of Hand Hygiene' is expected to be conducted by medical students. Posters of this policy can be found in the Clinical Skills Area in Wallace Wurth and is reproduced below. Students must also comply with the Hand Care and 'Bare below the elbows' requirements.

Students must familiarise themselves with PPE requirements, guidance, training and resources in response to COVID-19 in NSW Health: <https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19/personal-protective-equipment> and complete the online activity in Moodle: <https://moodle.telt.unsw.edu.au/mod/scorm/view.php?id=4285434>

Bare below the elbows

Medical students in clinical areas need to adhere to the following aspects of NSW Health Procedure document SESLHDP/343 4.9:

Hands/wrists and fingers

- **Fingernails**
 - Neat, no longer than the tip of the finger
 - No nail polish, acrylic/gel nails, nail extensions or nail art or other adornments
- **Fingers**
 - One significant plain ring is acceptable. Rings with large or multiple settings or detailed scrollwork must not be worn
 - If a plain ring is worn, the ring should be removed or "loosened" each time hand hygiene is performed. The area under the ring must be washed, rinsed and thoroughly dried if using soap and water, attention to these areas and drying of hands including areas under ring should be considered when using Alcohol Based Hand Rub
- **Hands and wrists**
 - No jewellery, rings with large or multiple settings or detailed scrollwork
 - If a wrist watch is necessary for clinical care, it must be removable and able to be cleaned
 - **All** hand and wrist jewellery must be removed for all invasive procedures, including preparation of aseptic or sterile field
 - Prior to commencing a surgical hand scrub, HCWs must remove: all hand and wrist jewellery, including the significant ring
 - If, for cultural reasons hand or wrist jewellery cannot be removed, a risk assessment will need to be attended by the service manager
 - Staff wearing support bandages, splints or casts that cover any part of the hand cannot perform the **5 Moments for Hand Hygiene** when providing patient care and therefore must be found alternative duties until the support bandage, splint or cast is removed

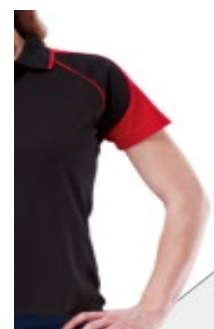


Arms

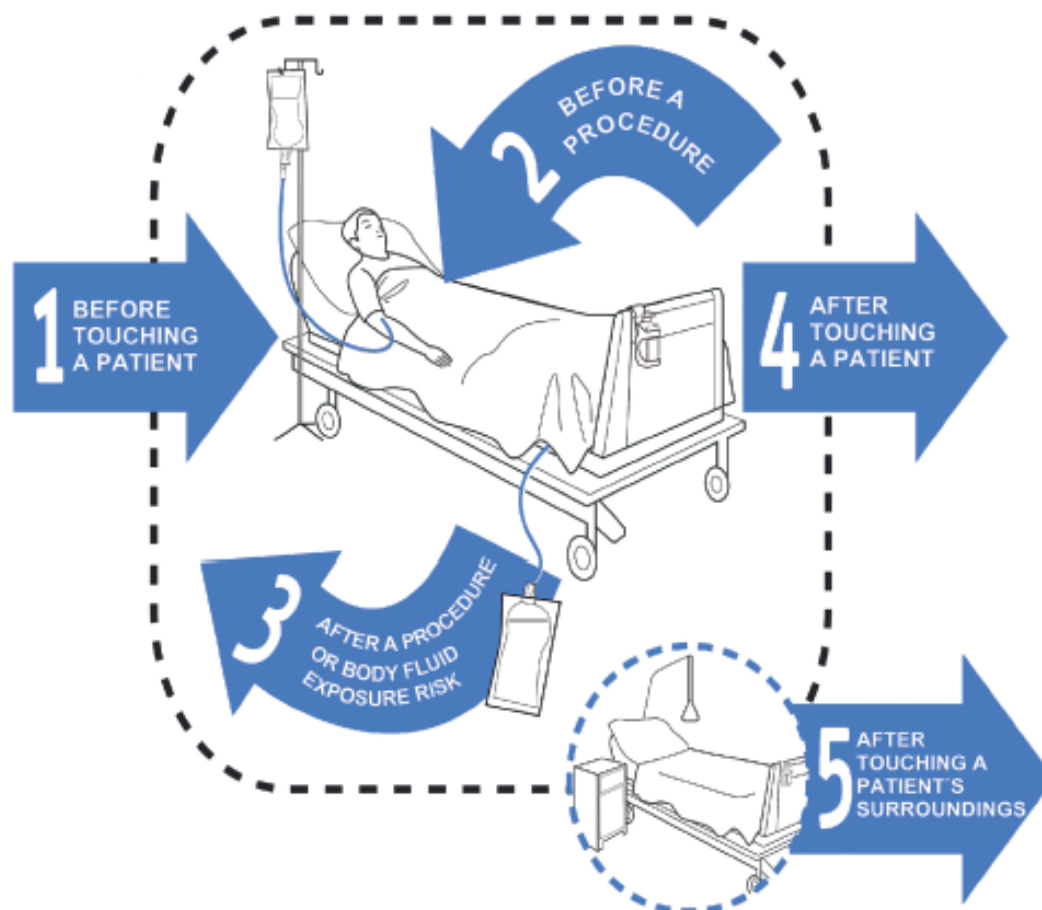
- Clothing that extends below the elbows must be removed or sleeves rolled up to the elbows during direct patient care.
- Patient gowns must not be worn over clothing/uniforms at any time

Head and neck

- Long neck scarves must not be worn
- Head scarves, if worn for cultural reasons, must be secured so as not to hang free at the front
- Ties should not be worn, consider 'no tie or bowtie' unless secured by a tie pin
- Lanyards must not be worn by persons involved in direct patient care
 - ID badges ideally should be attached to a 'zinger' (recoiling device) at the waist



5 Moments for HAND HYGIENE



1 BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
2 BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
3 AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
4 AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
5 AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.



Adapted from



<https://www.who.int/multi-media/details/5-moments-hand-hygiene--training-for-health-workers#>