Introduction
The Case-based Discussion (CbD) is a RANZCP-approved Workplace-based Assessment (WBA) tool. The purpose of this tool is to promote learning for trainees by providing structured feedback on performance within an authentic workplace context.

What is a CbD?
A CbD is a discussion based on case notes and other relevant written correspondence for a current case in the workplace. It assesses a trainee’s clinical reasoning and decision making and their ability to document the integration of medical knowledge within case management. The most important part of a CbD is the feedback given to the trainee.

CbDs, like all WBAs, should contribute to the evidence base that informs a supervisor’s judgement as to whether a trainee can be entrusted with a particular Entrustable Professional Activity (EPA) and/or for the mid-rotation In-Training Assessment (ITA) Form and end-of-rotation ITA Report.

Choosing an encounter
The trainee should select at least four cases for possible discussion in the CbD, of which the supervisor will select one case to discuss.

The trainee should have had the opportunity to manage a number of patients prior to arranging a CbD.

Supervision
The supervisor must be familiar with the CbD assessment process.
• Supervisors must be clinically competent in the area of psychiatry being assessed.

A CbD can be conducted during regular supervision time in an appropriate office or working space that lends itself to privacy.

Assessment criteria
The aim of the CbD is to enable supervisors to provide structured feedback across the following areas:
• clinical record keeping
• clinical assessment
• risk assessment and management
• assessment and treatment of medical comorbidities
• treatment planning
• referral
• follow-up and transfer of care
• professionalism
• clinical reasoning.

Prior to conducting each CbD, the trainee and supervisor should determine together which of the assessment criteria to focus on during the formative assessment.
How to undertake a CbD

The trainee is responsible for planning when a CbD will occur in consultation with the supervisor.

1. The trainee makes arrangements with a supervisor to carry out the CbD and organises all administration required (including providing the supervisor with the CbD form).

2. The trainee and supervisor determine the assessment criteria to be considered during the CbD.

3. The trainee selects four cases in which they have had direct clinical responsibility for the patient’s care and brings the case notes for all four patients to the supervisor for possible discussion.
   - The four cases should incorporate some but not necessarily all of the following: assessment; mental state; physical examination and cognitive testing; synthesis of information and/or formulation and management plans.

4. The supervisor will choose one of the four cases for the trainee to discuss in detail.

5. The trainee discusses the selected case with the supervisor.
   - When required the supervisor prompts the trainee on further discussion points (see guidance for discussion below).
   - This discussion should typically take 15–20 minutes.

6. The feedback session occurs immediately after the discussion within the 1-hour weekly supervision time.
   - The feedback should be constructive and address: areas that were especially good, suggestions for improvement, agreed actions and goals.
   - The total time required for the CbD and feedback session will usually be 30–40 minutes.

7. The supervisor rates the trainee’s performance for the relevant assessment criteria using the 3-point scale on the CbD form.
   - The cumulative weight of the feedback comments and ratings helps determine a defensible judgement of a trainee’s competence at their stage of training.
   - Please note that not all assessment criteria on the form are required to be rated during each CbD. Not applicable criteria are rated with the N/A option.

<table>
<thead>
<tr>
<th>Trainee stage</th>
<th>Below standard for end of stage</th>
<th>Meets standard for end of stage</th>
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<tr>
<td>Stage 1 Basic</td>
<td>Below standard for basic trainee.</td>
<td>At basic level as described in Developmental Descriptors.</td>
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<td>Stage 3 Advanced</td>
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<td>Meets the standard of an advanced trainee as described in Developmental Descriptors.</td>
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Please note: standards are at the level expected on completion of the relevant stage of training. CbDs conducted at the beginning of a stage may typically include ratings of below ‘Meets standard for the end of stage’. This approach highlights areas for improvement and allows trainees to view their progress along a continuum.
8. The trainee and supervisor discuss and agree upon the next steps to progress learning. Both the supervisor and trainee sign the CbD form.

9. The trainee is required to maintain a portfolio of their Fellowship Program forms, including their WBA forms. Trainees are required to provide this portfolio to their next supervisor for review at the start of each new rotation.

Feedback

The feedback given after a CbD is important. Constructive and useful feedback should be given to the trainee on:

- areas that were especially good
- areas that need improvement
- potential ideas to gain further experience and skill in the areas requiring development.

Feedback that focuses on the strengths and weaknesses of the trainee’s performance will, through self-reflection, inform their learning and skill development.

Guidance for discussion

This guide is intended to provide direction for the supervisor in eliciting further information from a trainee to support the CbD. It may also guide the trainee to understand important focal points for the discussion regarding their case.

The assessment must commence from the trainee’s entry in the case notes. There is no other set structure for the discussion but the following prompts may be used as a guide. Discussion is not limited to these questions and others may be used to prompt a focused discussion about the case at the supervisor’s discretion.

- **General**
  - ‘Please tell me about this meeting/visit/appointment.’
  - ‘Please tell me about your approach to the patient’s presenting problem.’
  - ‘What were the key points about this meeting/visit/appointment?’

- **Assessment/diagnosis**
  - ‘What specific features led you to this impression/conclusion or diagnosis?’
  - ‘What other conditions have you considered/ruled out?’

- **Investigation/referrals**
  - ‘What specifically led you to choose these investigations?’
  - ‘Were there any other investigations or referrals that you considered?’
  - ‘I see that you have written down a number of different investigations – how did you think the results would help you work out what was going on and what you needed to do?’

- **Management**
  - ‘What specific features led you to the management/therapy that you chose?’
  - ‘Were there any other treatments that you thought about or ruled out?’
  - ‘I see that you have decided to treat the patient with ... – talk me through how you decided to prescribe that regimen and what alternatives you considered?’
  - ‘What was going through your mind when you wrote that management plan? Just talk me through your thought process.’
  - ‘You have referred to treatment guidelines to help with ... – tell me a bit about how you used the treatment guidelines to help plan management and whether there were any aspects that didn’t fit in this case?’
• Follow-up/care plan
  - ‘What decisions were made about follow-up (to this entry)’?
  - ‘What were the factors that influenced this decision’?
  - ‘You have written down that you were going to ask Dr … for their advice – what specifically did you want to discuss with them, why was it important in this case, how did their advice help and what did you learn from it’?

• Monitoring chronic illness
  - ‘In your care of X, have you discussed the monitoring of their progress’?
  - ‘Do you think that there are some monitoring strategies that would be appropriate’?
  - ‘Have you discussed any health promotion strategies, e.g. alcohol use, diet, etc.’?

• Individual patient factors concerning context of care
  - ‘Was there anything particular/special about this patient that influenced your management decisions’? (E.g. demography, psychosocial issues, past history, current medications and treatment?)
  - ‘On reflection, is there anything about this patient that you wish you knew more about’?

• Care setting
  - ‘Is there anything about the setting in which you saw the patient (e.g. home, ward, accident and emergency department) that influenced your management’?
  - ‘In considering this case, what changes would improve your ability to deliver care to this patient’?

Revision Record

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<th>Description</th>
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<td>v2.0</td>
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10/2017 NEXT REVIEW