UOC Summary of Evaluation Results Digest 2017

This report is a summary of process and outcomes from the 2017 module convenors formally reporting to the University of Otago - Christchurch Curriculum Sub-Committee (UOC-CSC) on their module evaluation activities. It is divided into the following sections:

1. The process that the UOC-CSC has taken,
2. A summary report on the module digests submitted,
3. Key points from the final UOC-CSC meeting on the process and outcomes,
4. The module digests (appendix), and
5. Module reporting plan 2013-2020

1. UOC-CSC Process

   Scheduled to report in 2017:

<table>
<thead>
<tr>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Surgery/Emergency Medicine/Gastroenterology/Oncology (SEGO)</td>
<td>&gt; Hauora Māori *</td>
<td>&gt; Surgery</td>
</tr>
<tr>
<td>&gt; Cardiology/Vascular Surgery/Plastic Surgery/Dermatology (CVPD)</td>
<td></td>
<td>&gt; Critical Care</td>
</tr>
<tr>
<td>&gt; Hauora Māori *</td>
<td></td>
<td>(Anaesthesia, Intensive Care, EM)</td>
</tr>
</tbody>
</table>

* Module requested in July 2017 that the combined digest be submitted in 2018 due to RSL. UOC-CSC granted that request.

Process to receive reports:
- Nov 2016 – Education Advisor email to module convenors indicating they are expected to submit a module digest report to the UOC-CSC in Aug 2017.
- Feb, Apr 2017 – UOC-CSC agenda item included this year’s process and modules to be reporting.
- May, July 2017 – reminder emails by the Undergraduate Administrator to reporting module convenor and corresponding administrator and HoD.

Reports submitted:
All five modules submitted a digest by the due date.

2. Summary Report on the Module Digests

This section of the report will highlight common themes or aspects identified in the 4 module digests submitted. Section 5 contains the module digests in their entirety.

Method(s) used to gather, and who were asked for, feedback

- **Students (15)**
  - Formal [9] – HEDC survey (5), SurveyMonkey (1), focus groups (2), Student Staff Committee (1)
  - Informal [6] – emails (2), verbal (2), student rep meetings (1), signpost sessions (1)

- **Teaching staff (8)**
Formal means were used in 69% of all methods.

*Overall feedback and observations*

The following bullet lists highlight themes in the submitted digests. Due to the low number of modules required to submit a digest this year, only the first two points were mentioned twice, the rest once.

**Aspects/areas that were identified as good:**
- Being part of a team
- Real life experience of busy clinical workplaces
- Relevant lectures
- Relevant assignments
- Student learning resources
- Moodle – interactive quizzes
- Student choice in their learning opportunities
- Simulated clinical scenarios
- Tutorials
- Overall organisation
- Bedside teaching
- Clinical sessions in theatre
- Assessment that matches objectives
- Feedback on case histories

**Aspects/areas that were identified as needing improvement:**
- More feedback on assignments (case histories)
- More consistency between assessors
- Too many students compromising clinical learning opportunities
- More clarity around core learning
- Difficulty arranging some learning opportunities
- Short notice cancelation of sessions
- Cancellation during school holidays
- Lack of dermatology teaching slots
- Lack of slot for nurse led vascular assessment
- Lack of patients
- Busy junior staff
From the above lists we can extract what is valued:

- Relevant learning opportunities/assessment a major theme
- Feedback on assessment
- More learning opportunities, including rescheduling of cancellations
- Remainder of the points were isolated to single modules

**Staff development/support request(s), individual or group and action arising:**

<table>
<thead>
<tr>
<th>Request</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff are very appreciative of the support of the existing E-Learning Co-Ordinator, but would also like the additional support of a computer programmer or equivalent who is able to develop Moodle to match the individual needs of the different assessments and assessors within the module. <strong>Y4 SEGO</strong></td>
<td>E-Learning co-ordinator to be asked to take to eLICTT</td>
</tr>
<tr>
<td>Geoff Clare – HEDC starter, new staff orientation <strong>Y4 CVPD/CR</strong></td>
<td>Contact by EA</td>
</tr>
<tr>
<td>Due to a staff member leaving at the end of February 2017, there is currently a Convenor but no Co-Convenor for the course. A Convenor needs to be appointed as soon as practicable, so that a back-up staff member is available. <strong>Y6 Surgery</strong></td>
<td>EA Communication to HoD</td>
</tr>
<tr>
<td>Although a few of us individually have had a session with Scott Hallman, all our academic staff would appreciate an introductory course on Med Moodle from him. <strong>Y6 Critical Care</strong></td>
<td>EA to forward to E-Learning co-ordinator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending an evidence based training programme to facilitate student learning with respect to unwanted behaviour directed towards them or patients. <strong>Y4 Public Health</strong></td>
<td>Chair UOC CSC to communicate to PD module convenor, Professional Practice Domain group, and Director of PG Nursing</td>
</tr>
<tr>
<td>Training in writing EMCQs. <strong>Y4 Public Health</strong></td>
<td>UOC EU (in process)</td>
</tr>
<tr>
<td>Support to continue attending and accepting national and international invitations to conferences and opportunities to work with like colleagues. <strong>Y4 Hauora Maori</strong></td>
<td>HoD</td>
</tr>
</tbody>
</table>

**What’s working for you that others could learn from:**

- Student rep meetings: the administrator meets four students (two from each group) once a fortnight during the run, to troubleshoot and give/receive feedback. Students appreciate this, as it nips problems in the bud and allows the course to adapt more quickly to the changing hospital environment. (This was introduced in time for the final run in 2015) **Y4 SEGO**
- Provisional assessments: An email to senior registrars at the start of week 3 of the run, to ask for feedback of any problems so far and a more structured feedback request sent to the senior registrars in week 6 of the run. Both allow the convenors to talk to students should there be a need for any remedial actions, and the second feedback at 6 weeks helps inform the surgeon of the views of his or her team regarding the students on the team. **Y4 SEGO**
- Workbook to facilitate preparation, interaction and reflection for each clinical session. **Y4 CVPD/CR**
- Individualized feedback to clinical reasoning case histories. **Y4 CVPD/CR**
• Frequent signpost sessions to address not anticipated problems or learning needs. **Y4 CVPD/CR**

• Students have the option of choosing a placement in Timaru for the Surgery module. We only allocate them to Timaru if they are really keen to go. Feedback from these students is consistently very positive. The extra option decreases pressure on Christchurch Hospital to accommodate increasing numbers of students. Students in Timaru and Nelson attend some of their tutorials via Video-Conference, and others are available to them on Moodle. **Y6 Surgery**

• The Critical Care Rotation provides an example of positive interactions between three Disciplines (Anaesthesia, Intensive Care, and Emergency Medicine). We have all learnt to interact collegially to get the job done. Students in Timaru and Nelson attend some of their tutorials via Video-Conference, and others are available to them on Moodle. **Y6 Critical Care**

• For c.2 years we’ve used Moodle to present reading material for TIs and to conduct part of the TIs’ assessments. This has worked well and has improved time-efficiency for the convenor. **Y6 General Practice**

Prof Tim Wilkinson, Chair UOC – CSC
August 2017
4. 2017 Module Digests

<table>
<thead>
<tr>
<th>Module Name</th>
<th>Surgery, Emergency Medicine, Gastroenterology, Oncology (SEGO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module Year</td>
<td>4</td>
</tr>
<tr>
<td>Module Convenor</td>
<td>Professor Michael Ardagh</td>
</tr>
<tr>
<td>Three Year Data Collection Period</td>
<td>September 2014 to August 2017</td>
</tr>
</tbody>
</table>

Method(s) used to gather, and who were asked for, feedback

Student feedback
- SurveyMonkey (whole module survey for groups GH, EF, AB 2016)
- Focus group (for group CD 2016)
- HEDC questionnaires (whole module survey for groups EF, CD, AB 2017)
- Student reps’meetings (once a fortnight for all groups, initiated late 2015)
- Emails

Staff feedback
- Convenors’ meetings (held 5 times per year)
- Business meetings (held 5-6 times per year)
- Emails

Overall feedback and observations

Strengths
- Being part of the surgical team.
- A ‘real life’ introduction to the busyness and complexity of a surgeon’s schedule, with emphasis on gaining practical experience backed by relevant lectures and assignments.
- The new General Surgery Manual, written by A/Prof Tim Eglinton in 2015, has been labelled a ‘fantastic resource’ by the students and is also useful to TIs on their Surgery module.
- Interactive Oncology quizzes on Moodle (created in 2015).

Suggestions for improvement:
- Surgical case history marking: students would like to see more feedback and in particular, more consistency between marks/markers.
- Crowded ward round experience: too many students per team means that students can be left out of the ward round on some teams; on other teams, students take it in turns; on yet other teams, students are always included in the ward round but often can’t fit round the bed with the rest of the team, so stand outside the curtains and listen.

Area(s) identified for, and strategy to address, improvement

Identified for improvement
- Surgical case history marking: inconsistency between markers

Strategy that will be adopted to address
- A detailed marking template was designed for the surgeons marking the cases, to encourage feedback and demonstrate specific areas of strengths and weaknesses in the submitted work. There remains some variation in the threshold for awarding a PD. The idea of standardising a PD, based on the number of subcomponent PDs, is currently being debated. However, overall, consistency of marking and quality of feedback has improved since the last digest. However, there is room for further improvement.
- Since the last digest a number of exemplar case histories have been posted on Moodle to aid the students’ understanding of what their markers value.
- A fundamental problem is that some surgeons are more engaged with 4th Year teaching than others. Those who are truly engaged with the 4th Years will spend some time marking the case histories and providing helpful feedback. Those who aren’t will spend less time on marking. The best way to obtain consistent marking would be for one or two surgeons to mark them all. The problem with this is it would disenfranchise some surgeons even further and it would remove a valuable tool by which they have an opportunity to assess the students on their team. Furthermore,
the team surgeons know the patient who is the subject of the case history, and have an opportunity to provide specific feedback that an unfamiliar surgeon would not.

- This issue is on the agenda to discuss at the next General Surgery Business Meeting to gauge the Department’s view, and if the majority opinion is that individual surgeons should continue to mark then we will continue with that.

**Identified for improvement**

- Crowded ward round experience

**Strategy that will be adopted to address**

- The increased numbers of students coming to Christchurch was not associated with increased team capacity to accommodate them. This was compounded by the loss of surgical clinical experience at Ashburton Hospital. Attempts to ‘decompress’ Christchurch surgical teams by rotating students to Timaru were unable to be progressed, despite a willingness of both the Department of Surgery and the South Canterbury DHB to make it happen.

- Although these factors were outside the Department of Surgery’s control, a number of things have been done to help improve this: Since the last digest, the ‘super-team’ structure has changed back to pairs of surgeons with a more traditional team under them. Consequently, the numbers of people on ward rounds are less. There is greater clarification of the requirement of students to partake in ward rounds given at the SEGO introduction. Although there is still some variation among teams regarding their expectation of the students, the evolution of thought is that many, fast-paced, service ward rounds offer little educational value. However, post-acute rounds in particular, are valuable, especially if the student was present during the acute activities the day before.

### How has your module responded to previous digest report comments?

**Area identified for improvement in 2014 digest**

- Students in 2014 requested more feedback on their marked case histories. The response is outlined in the previous section. This remains an issue, but is much better than it was. The SEGO run explicitly values immersion in the surgical team. The surgical teams are busy service providers, and they remain committed to undergraduate medical education. However, inevitably, both the commitment and the capacity will vary.

**Area identified for improvement in 2014 digest**

- The response is outlined in the previous section. Perhaps it is wrong to imagine that CDHB clinical services would maintain the same level of clinical supervision and clinical exposure for students when there are more of them. Furthermore, perhaps it is unrealistic to expect that the transition from an educational institution, built around students, to a service institution, built around patients, would continue to deliver to the students as comprehensive and standardised an educational package as previously experienced. The surgical ward rounds are the surgical ward rounds and if we value immersion in the activities of the surgical team then, for better or worse, that includes the surgical ward rounds as they currently exist. While the SEGO convenors will do what they can to make them more educationally useful, students will always need to make best use of the clinical opportunities available to them.

### Describe how your stated learning objectives, teaching strategies, and assessments (if any) are aligned with each other, and with the MBChB Teaching and Learning Masterplan 2015.

The SEGO learning objectives include gaining knowledge in General Surgery, Emergency Medicine, Gastroenterology, and Oncology. Details of the objectives, the opportunities to learn, and the assessments, can be found on Moodle. The objectives are pursued during the module by student attendance at clinics, theatres, ward rounds, acutes, bedside skills sessions, emergency department shifts, lectures, etc. Abdominal examination and Emergency Medicine core skills are taught at the Simulation Centre at a session held at the end of the first week of the run.

The SEGO module is well aligned with the Masterplan. For example, as listed on page 2 of the Masterplan, our course:

- Is always in evolution, and we constantly see scope for ongoing improvement.
- Aims to educate better doctors through high quality education.
- Promotes learning in context, which improves subsequent retention and application.
- Promotes being part of a team, which enhances students’ learning and professional development.

As listed on page 3 of the Masterplan, our course:
- Optimises supervised clinical experiences.
- Has a flexible curriculum that is able to be delivered in a variety of locations.
- Increases opportunities for learning in context.
- Increases opportunities to observe the journey of the patient over time.
- Optimises opportunities for independent learning.

As requested, we completed exercises to link our module with Core Presentations and Core Professional Activities in both 2015 and 2016.

**Staff development request(s), individual or group**
Staff are very appreciative of the support of the existing E-Learning Co-Ordinator, but would also like the additional support of a computer programmer or equivalent who is able to develop Moodle to match the individual needs of the different assessments and assessors within the module.

**What’s working for you that others could learn from?**
Student rep meetings: the administrator meets four students (two from each group) once a fortnight during the run, to troubleshoot and give/receive feedback. Students appreciate this, as it nips problems in the bud and allows the course to adapt more quickly to the changing hospital environment. (This was introduced in time for the final run in 2015.)

Provisional assessments: An email to senior registrars at the start of week 3 of the run, to ask for feedback of any problems so far and a more structured feedback request sent to the senior registrars in week 6 of the run. Both allow the convenors to talk to students should there be a need for any remedial actions, and the second feedback at 6 weeks helps inform the surgeon of the views of his or her team regarding the students on the team.

---

<table>
<thead>
<tr>
<th>Module Name</th>
<th>CardioRespiratory / CVPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module Year</td>
<td>4th year</td>
</tr>
<tr>
<td>Module Convenor</td>
<td>Jeremy Simcock / Lutz Beckert / Geoff Clare</td>
</tr>
<tr>
<td>Three Year Data Collection Period</td>
<td>2014, 2015, 2016</td>
</tr>
</tbody>
</table>

**Method(s) used to gather, and who were asked for, feedback**

**Student feedback**
- HEDC course evaluation
- Staff student committee
- Signpost sessions

**Staff feedback**
- Staff feedback at pre-OSCE meeting
- Staff feedback at post-OSCE meeting

**Other**
- MedMoodle activity report

**Overall feedback and observations**

**Positive**
- Overall organisation – best administrator
- Bed side teaching
- Clinical sessions in theatre
- Assessment, as it matches objectives
- Individualized feedback to Case Histories

**Areas for Improvement**
- Short term cancellation of sessions
- Cancellation during school holidays
- Lack of dermatology teaching slots
- Lack of slot for nurse led vascular assessment
- Lack of patients or busy junior staff

**Area(s) identified for, and strategy to address, improvement**
- Dermatology – more eLearning objects
- Dermatology – four new dermatologists employed
- Logbook has developed into a workbook with specific tasks for each clinical session
- All course content and assessment are on MedMoodle
- Succession planning (for CR component)

**How has your module responded to previous digest report comments?**
- Weekly signpost sessions, which allow a rapid response to student concerns
- Behaviour issues (telephone / texting) during examinations addressed
- Succession planning
- Additional teaching is available via junior staff (Teaching Forum)
- We are working to change the ‘project presentation’ to match the ‘EBP Clinical Question Project’ (Lianne Parkin) to link better to skills learned in 2nd and 3rd year.

**Describe how your stated learning objectives, teaching strategies, and assessments (if any) are aligned with each other, and with the MBChB Teaching and Learning Masterplan 2015.**
- Spiral of learning; e.g. remind students that they have already learned respiratory or cardiological examination technique in 2nd / 3rd year. The 4th year is time to revise and implement clinically.
- Good alignment between objectives and assessment. Itemized in the workbook
- Immerse student in clinical learning environments (Curriculum Masterplan 4.2, 4.3)
- Role model inter-professional collaborations (plastic, respiratory physiology, ECHO, vascular, wound care nurses) (interprofessional education, Curriculum Masterplan 11.1)
- See doctors as teachers and researches

**Staff development request(s), individual or group**
- Geoff Clare – HEDC starter, new staff orientation
- Jeremy Simcock – Master in Surgical Education (due for completion 2018)

**What’s working for you that others could learn from?**
- Workbook to facilitate preparation, interaction and reflection for each clinical session
- Individualized feedback to clinical reasoning case histories
- Frequent signpost sessions to address not anticipated problems or learning needs.

**Module Name** | Surgery
---|---
**Module Year** | 6
**Module Convenor** | Professor Justin Roake
**Three Year Data Collection Period** | September 2014 to August 2017

**Method(s) used to gather, and who were asked for, feedback**

**Student feedback**
- Focus groups (for groups 1-3 in 2015 and 2016)
- Individual teacher evaluation surveys
- Verbal feedback (at tutorials and while waiting for Viva)
- Emails

**Staff feedback**
- Convenors’ meetings (held as necessary)
- Business meetings (held 5-6 times per year)
- Emails
Overall feedback and observations

Strengths
- Being part of the surgical team.
- A ‘real life’ introduction to the busyness and complexity of a surgeon’s schedule, with emphasis on gaining practical experience backed by relevant lectures and assignments.
- Student choice: students prioritise their team preferences and are allocated to teams accordingly.

Suggestions for improvement:
- There are no aspects significant to the success of the module that have been suggested for improvement but have not been addressed. Using feedback from focus groups, most student suggestions have been addressed, e.g. trying to hold tutorials during lunch hours.

Area(s) identified for, and strategy to address, improvement

Identified for improvement
- The following student suggestion (not significant to the success of the module) has not yet been addressed: Some students suggested adding to Moodle a list of core ward-based skills for the module, which would also serve as a guide to students’ integration into PGY1.

How has your module responded to previous digest report comments?

Area identified for improvement in 2014 digest
- There were no areas identified for improvement in the 2014 digest. All feedback is and considered and acted on where appropriate.

Describe how your stated learning objectives, teaching strategies, and assessments (if any) are aligned with each other, and with the MBChB Teaching and Learning Masterplan 2015.

The Surgery module learning objectives include being able to demonstrate the clinical skills, knowledge, and attitudes necessary to perform as a competent surgical House Surgeon.

This module builds on the learning gained in the 4th Year SEGO and 5th Year OAS modules. The objectives are pursued during the module by student attendance at clinics, theatres, ward rounds, acutes, bedside skills sessions, tutorials, etc.

The Surgery module is well aligned with the Masterplan. For example, as listed on page 2 of the Masterplan, our course:
- Aims to educate better doctors through high quality education.
- Promotes learning in context, which improves subsequent retention and application.
- Promotes being part of a team, which enhances students’ learning and professional development.

As listed on page 3 of the Masterplan, our course:
- Optimises supervised clinical experiences.
- Has a flexible curriculum that is able to be delivered in a variety of locations.
- Increases opportunities for learning in context.
- Increases opportunities to observe the journey of the patient over time.
- Optimises opportunities for independent learning.

As requested, we completed exercises to link our module with Core Presentations and Core Professional Activities in both 2015 and 2016.

Staff development request(s), individual or group

Due to a staff member leaving at the end of February 2017, there is currently a Convenor but no Co-Convenor for the course. A Co-Convenor needs to be appointed as soon as practicable, so that a back-up staff member is available.

What’s working for you that others could learn from?

Students have the option of choosing a placement in Timaru for the Surgery module. We only allocate them to Timaru if they are really keen to go. Feedback from these students is consistently very positive. The extra option decreases pressure on Christchurch Hospital to accommodate increasing numbers of students.
Students in Timaru and Nelson attend some of their tutorials via Video-Conferece, and others are available to them on Moodle.

<table>
<thead>
<tr>
<th>Module Name</th>
<th>Critical Care (Anaesthesia, New Zealand Resuscitation Level 7 Course, Intensive Care, and Emergency Medicine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module Year</td>
<td>6</td>
</tr>
<tr>
<td>Module Convenor</td>
<td>Seton Henderson</td>
</tr>
<tr>
<td>Three Year Data Collection Period</td>
<td>January 2014- January 2017</td>
</tr>
</tbody>
</table>

**Method(s) used to gather, and who were asked for, feedback**

- **Student assessment**
  - New Zealand Resuscitation Council Level 7 Course results

- **Feedback from PGY 1 Doctors**
  - Trainee Interns in 2016

- **Student feedback**
  - HEDC questionnaire - 2014 – 2016
  - Direct student feedback

**Overall feedback and observations**

**HEDC questionnaire – Student Feedback**

- 2014 – 74% response rate – median 1.3
- 2015 - 79% response rate – median 1.6
- 2016 – 69% response rate – median 1.9

**HEDC questionnaire – Student Feedback Comments**

Here the students frequently ask for more time to be allocated to the Critical Care Rotation (PGY1 feedback). Sixty per cent of the PGY 1s surveyed felt that the run was too short or much too short (PGY1 feedback). Not only does the block help with their applied pharmacology, but provides them with skills for acute crises care and for clinical decision making.

**Direct Student Feedback – CPR Training**

We continue to receive much positive feedback from the trainee interns undertaking the level 7 training of the New Zealand Resuscitation Council. They enjoy acquiring the airway and resuscitation skills, and interacting as a clinical team in the simulated clinical scenarios. In 2015 the Department of Anaesthesia acquired a Resus Anne Simulator. It provides the key simulation functionalities including a high-quality airway, spontaneous breathing, ECG, live defibrillation, IV, blood pressure, voice, lung sounds and heart sounds for basic simulation training. For cardiopulmonary resuscitation, two additional airway manikins have been purchased to increase group teaching and practice opportunities. Each year the Department of Anaesthesia tries to ensure updating of equipment for cardiopulmonary resuscitation. We have recently purchased a Megacode kid to help with our paediatric simulation scenarios.

**Area(s) identified for, and strategy to address, improvement**

Anaesthesia, Intensive Care, and Emergency Medicine (three major specialities) are all crammed into four-week Critical Care attachment during the Trainee Intern year. In addition, each Trainee Intern group has to be trained and pass the New Zealand Resuscitation Council’s (NZRC’s) Certificate of Resuscitation (Level 7). This is a mandatory requirement by the Medical Council of New Zealand, and takes 250 hours of Anaesthetists’ time.

The Anaesthetic trainee logbook has this year been revised and updated. It welcomes the Trainee Interns to the Department. It outlines the Course and its Aims, and orientates students to the various teaching locations. It provides the learning objectives of the course, the skills needed to be acquired, and defines the assessment process. The New Zealand Resuscitation Council Level 7 course is summarised. It provides problem-based cases, and space for their clinical learning experiences to be recoded.
In Anaesthesia, trainee intern students are able to directly participate in the preoperative assessment of anaesthetic and pain patients in the Outpatient Departments of Christchurch and Burwood Hospitals. Students are able to directly participate in the pre-induction, induction, maintenance and recovery of patients undergoing anaesthesia and in various interventional pain procedures in the operating rooms of Christchurch and Burwood Hospitals. They also observe patients undergoing anaesthesia or conscious sedation for interventional radiology and imaging in the radiology suites at Christchurch Hospital. The students can participate on the Acute Pain Service ward rounds at Christchurch and Burwood Hospitals, and in the activities of the Pain Management Centre. The practical experience gained with one-on-one interaction with Anaesthetists in the theatre should not be underestimated.

In Emergency Medicine, attempts have been made to improve the clinical experience – particularly to improve continuity of the TIs relationship with clinical supervisors. Unfortunately, the complexity of the ED rosters, and the crowded nature of the run for TIs, has made this difficult. A flexible ‘roster yourself’ process for TIs is the best outcome under current circumstances. Even so, clinical shifts are disrupted as TIs have commitments elsewhere.

The Emergency Medicine component emphasises clinical decision making in both undifferentiated and unwell patients. These skills are essential for junior doctors, yet students have very little exposure to genuinely undifferentiated patients during their ward based modules, and they get only a handful of shifts in the Emergency Department. Recently, a specific focus has been placed on cognitive processes, bias and error. An introduction session is given at the start of the run, TIs are asked to record in their log books, potential cognitive biases they note in their interactions with patients and, at the end of run OSCE, a scenario is discussed with an emphasis on the potential cognitive biases apparent in the scenario. As one student noted, the Emergency Department is rich with examples of potential biases.

The intensive Care component emphasises recognition of the critically ill or deteriorating patient, and the skills (technical, cognitive and communicative) needed for the initial management of such patients. Over the past 3 years the department has streamlined the didactic teaching component of the course, to improve on-the-floor exposure to sick patients. The unpredictable nature of ICU occupancy and Outreach workload, combined with the limited time each student spends in the department, at times severely limits the amount of quality clinical experience each student gets. The frequent absences of students to attend non-ICU tutorials during their rotation impede the opportunities for the TIs to feel like part of the team.

We need the minimum of an extra week in the Critical Care Rotation (PGY1 feedback). With more teaching time we could be offering so much more, such as crisis management teaching, and pain management teaching (e.g. a half-day Essential Pain Management course) and more, protected, clinical exposure. The Trainee Interns would become more part of the team both in Anaesthesia, Intensive Care, and Emergency Medicine (similar to what happens in other disciplines). The NZRC course could be run in a less disruptive way as well. Preferably as a block (PGY1 feedback).

The recent review of SOAR noted the crowded nature of the Critical Care run and suggested the NZRC course be taken out of the run and be taught at a different time (PGY1 feedback). This would free up some time, reduce the amount of assessment in the run and might allow better protection of blocks of clinical time in the three disciplines.

- The Critical Care Module conveners group met recently to consider options for improving the clinical experience on the run, and are surveying recent graduates for an indication of their junior doctor perspective of what would improve the value of the run to them (PGY1 feedback).

How has your module responded to previous digest report comments?

This is the first time that the Critical Care Rotation has submitted a Digest. The Critical Care Rotation has never been considered a major rotation in the Trainee Intern Year, despite the excellent practical skills it gives to students for PGY 1. The majority of PGY 1s surveyed felt that the Critical Care Rotation should become a Pass/Fail subject for terms in Year 6 (PGY1 feedback).

Describe how your stated learning objectives, teaching strategies, and assessments (if any) are aligned with each other, and with the MBChB Teaching and Learning Masterplan 2015.
The year 2012 saw the start of the new Curriculum in Year 6. The Critical Care Rotation felt that the overarching goals in the Trainee Intern year should be to prepare students for Post Graduate Year (PGY) 1 and 2, and set the foundations for a career in medicine including awareness for further training (68% of the PGY1s surveyed said that the Critical Care run was extremely valuable or very valuable preparation for PGY1). We aspired to help them work as an apprentice within a healthcare team. We concentrated on skills that needed to be developed in clinical assessment and prioritisation, and in teamwork.

The Critical Care Rotation played a major role in developing the Faculty Curriculum Committee document entitled ’The Trainee Intern Year from 2012’. The document includes the overarching and core objectives, the elective period, and long-term placement of Trainee Interns in peripheral hospitals.

Regional Placements
The Department of Anaesthesia continues to be involved with Trainee Interns doing their training in Nelson this year, during which time they rotate through the Critical Care slot. This is co-ordinated with Professor Don Wilson, the Undergraduate Dean in Nelson. The students are being assessed regionally, and fitted into accredited CPR training courses in Nelson. We receive video recordings of the assessments for review; this enables consistency of standards to be applied. For example in 2012 - eight Trainee Interns; in 2013 – ten Trainee Interns; in 2014 - seven trainee interns; in 2015 - six trainee interns; and in 2016 - ten trainee interns.

Assessment
Because of the annual increase in medical student numbers, it was decided in 2015 to change the rest of the Anaesthetic and Intensive Care and Emergency Medicine assessment process to evaluate two different students at the same time. A ten minute written paper is undertaken in Anaesthesia, in Intensive Care and in Emergency Medicine. The Anaesthetic and Emergency Medicine logbooks logbook, in which their clinical experience is recoded, is evaluated as well. Finally, they undergo an OSCE in Anaesthesia, one in Intensive Care, and one in Emergency Medicine. The addition of OSCE stations has improved the standardization and equity of the assessment process. Lecturer feedback on their run is taken into account before an electronic Professional Attitudes and Summary of Achievement Form (or PASAF) is filled in.

Chronic Pain Management
Chronic pain has now been included in the Year 6 Anaesthesia module for the past two years, with as many Trainee Interns as possible rotating to the Pain Management Centre at Burwood hospital to be in the Procedure Clinic or in theatre with Professor Shipton.

Pain Medicine – Learning Objectives and Expected Outcomes
1. Have a basic understanding of the whole person approach to pain assessment (awareness of pathophysiological pathways; complexities underlying pain experiences)
2. Recognise patients at risk for long-term distress and disability (impact and management of psychological factors in pain).
3. Recognise the need to educate patients about multidisciplinary pain management.
4. Learn to distinguish between neuropathic and nociceptive pain.
5. Grasp the identification and management of low back pain in the primary care setting.
6. Learn basic skills to initiate and monitor risk in opioid therapy, and understand the influences that drive high opioid use within vulnerable patients.
7. Develop an understanding of analgesic medications and mechanisms present in chronic pain to drive rational prescribing.
8. Understand causes of chronic muscular-skeletal pain.
9. Learn about current evidence and best practice in the management of post-surgical acute pain in the community.
10. Grasp the context in which to use pain-related procedures.
11. Appreciate the differences between adult pain and acute and chronic pain in children.

Med Moodle
The Department of Anaesthesia (and Intensive Care) continues to update its Med Moodle site on a regular basis. It has increased the amount of content on the site while at the same time refining it to demonstrate the strengths of the Department. It is now much clearer what the Department has to offer potential students.
Last week the three disciplines met with Scott Hallman to enable our written papers to be marked online, our logbooks to be filled in online, and our OSCEs to be marked on IPads. This will occur from the beginning of 2018.

**Staff development request(s), individual or group**

Although a few of us individually have had a session with Scott Hallman, all our academic staff would appreciate an introductory course on Med Moodle from him.

**What’s working for you that others could learn from?**

The Critical Care Rotation provides an example of positive interactions between three Disciplines (Anaesthesia, Intensive Care, and Emergency Medicine). We have all learnt to interact collegially to get the job done. Students in Timaru and Nelson attend some of their tutorials via Video-Conference, and others are available to them on Moodle.

---

**Module Name**  
GP (TI)

**Module Year**  
2017

**Module Convenor**  
Ben Hudson

**Three Year Data Collection Period**

---

**Method(s) used to gather, and who were asked for, feedback**

Student feedback  
- HEDC questionnaires.

---

**Overall feedback and observations**

Respondents consistently identified their time in practice as being valuable and they rated the teaching from their host GPs highly. Feedback on the tutorials provided at the beginning of the run was positive but these sessions were not as highly rated as the time in practice. Difficulties in arranging attachments were mentioned frequently in free text feedback.

---

**Area(s) identified for, and strategy to address, improvement**

Pre-reading for the tutorials was suggested in the feedback and this is now provided on Moodle. We are exploring new ways of arranging placements which we hope will reduce the pressure for TIs.

---

**How has your module responded to previous digest report comments?**

We now contact students earlier about arranging placements and make clear the support we can offer them in doing this.

---

**Describe how your stated learning objectives, teaching strategies, and assessments (if any) are aligned with each other, and with the MBChB Teaching and Learning Masterplan 2015.**

The GP module provides ample opportunity for TIs to focus on the Masterplan’s three key purposes for the TI year: patient care, teamwork, and professionalism and ongoing learning. These areas are specifically assessed by the TIs’ host GPs at the end of their attachments, and the assessment criteria are provided for TIs at the beginning of their placement.

---

**Staff development request(s), individual or group**

We are planning a teaching session for host GPs to optimise their workplace teaching.

---

**What’s working for you that others could learn from?**

For c.2 years we’ve used Moodle to present reading material for TIs and to conduct part of the TIs’ assessments. This has worked well and has improved time-efficiency for the convenor.
# 5. Module reporting plan 2013-2020

## UOC Module Digest Submission Timeline (2013 -2020)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care of the Elderly/Rehabilitation/Psychogeriatric</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEGO</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVPD/CR</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health (Including Addiction Medicine from 2014)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Orientation &amp; Hauora Māori</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology (Anatomic, Haem, Biochem, Micro, Radiology)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics and Law</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative and End of Life Care</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5th Year - 2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Medicine</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal Medicine (DOAS from 2015)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Medicine (incl Neurology from 2015)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s Health and Developmental Medicine</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology (Anatomic, Haem, Biochem, Micro, Radiology)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction Medicine</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics and Law</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative and End of Life Care</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6th Year - 2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care (Anaesthesia, Intensive Care, EM)</td>
<td>✓?</td>
<td>✓?</td>
<td>✓?</td>
<td>✓?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>✓?</td>
<td>✓?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition to Practice</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Module did not submit digest according to schedule*  
*Module requesting one year deferral due to RSL*

---

**Notes**

- **General evaluation guidelines:**
  - Approxi three modules will be expected to submit a module report in any given year
  - All evaluations should consider any questions/aspect that UOC-CSC has stated to be important
  - The EA is available to support you in this process. Please contact Anthony as required.

- **Common areas of evaluation:**
  - The environment supported and encouraged my learning
  - Please comment on what/who helped or hindered your learning