Competence assessment of competence 1-3

How do we perform the assessment process in practice?

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Competence assessment in clinical stays

Formative assess-ment	Formative assess-ment	Extra formative assess-ment	**Summative assessment**
At the beginning of the stay	Midway	In the last half	At the end
Fellow student	Doctor	Associate professor/PCEO*	Associate professor/PCEO*

**PCEO: Pregraduate Clinical Education Officer (In Danish: Uddannelsesansvarlig prægraduat lektor (UPL))*

Competence 1

Admission of patient for hospitalization or outpatient treatment

Clinical situation

- Admission with medical record writing

  or

- First contact in an outpatient clinic including medical record writing

Step 1

- The student records the anamnesis and conducts relevant objective examination
- On your own/not direct observation

Step 2

- The student presents the patient case and demonstrates the relevant objective findings for the person making the assessment (student /doctor/PCEO)*
- Opportunity for dialogue between student and feedback provider in form of reflection, questions and elaboration of anamnesis, and objective findings

**PCEO: Pregraduate Clinical Education Officer*
(In Danish: Uddannelsesansvarlig prægraduat lektor (UPL))

Step 3

- The student is assessed based on the clinical situation and the subsequent relevant medical record-keeping

- The student receives feedback and assessment based on both competence card and assessment criteria and subsequently receives a signature in the competence book

Competence 2

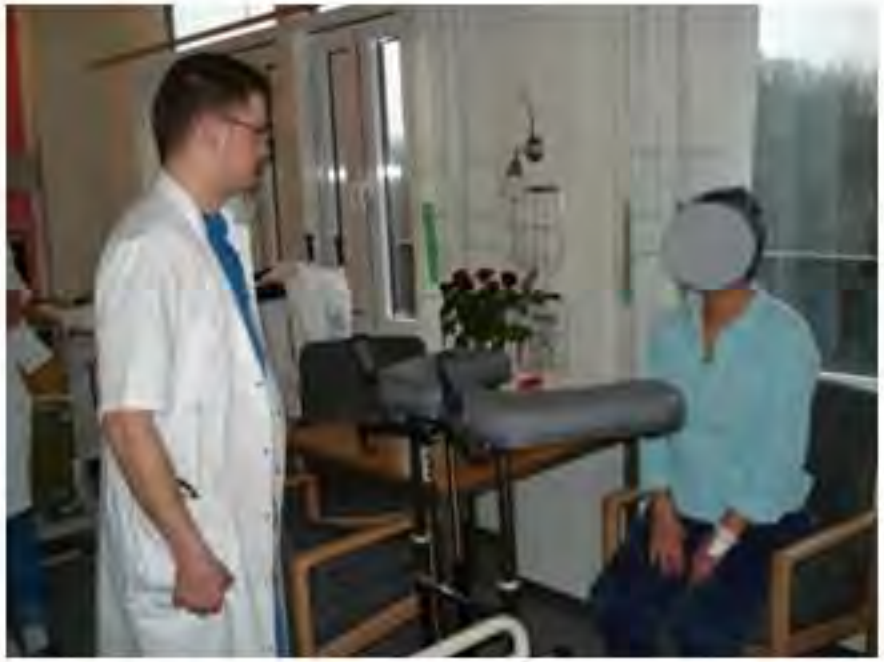
Check the fulfillment of a medical plan for patient during hospitalization or in outpatient procedure

Clinical situation

- Ward round in ward

  or

- check-up in outpatient clinics



Step 1

- The student records the anamnesis and makes relevant objective examination

- The student is observed by the person making the assessment (student/doctor/PCEO)

Step 2

- The direct observation allows dialogue between student and observer in form of reflection, questions, and elaboration of anamnesis, and objective findings

Step 3

- The student is assessed based on the clinical situation and the subsequent relevant medical record-keeping

- The student receives feedback and assessment based on both competence card and assessment criteria and subsequently receives a signature in the competence book

Competence 3

Take care of discharge or completion of an outpatient course

Clinical situation

- Create discharge summary in connection with discharge of patient after hospitalization

  or

- Completion of outpatient course

Step 1

- The student updates FMK * and creates a discharge summary at the end on hospitalization or outpatient course

- The discharge summary solely serves as assessment (basis for assessment) for competence 3

*Not in all semesters

Step 2

- The student presents a discharge summary (+ potential FMK) for the person making the assessment (student/doctor/PCEO)

- Opportunity for dialogue between student and feedback provider in form of reflection, questions, and elaboration of anamnesis and objective findings

Step 3

- The student's medical record-keeping in the discharge summary is assessed
- The student receives feedback and assessment based on both competence card and assessment criteria and subsequently receives a signature in the competence book

Enjoy your work with the competence cards!