Learning Log for MRCGP Workplace Based Assessment

Maintaining your log is just as important as completing your formal assessments.

The learning log is your personal learning record. Entries you 'share' can be read and commented on by your clinical or educational supervisor. These log entries will contribute to the evidence available to your supervisors and ARCP panels when they come to take a view on your competence progression.

You should link entries in your Learning Log to curriculum headings, indicating which parts of the curriculum you think you were addressing. When linking a log entry to curriculum headings, take care to look at the learning objectives in the relevant curriculum statement. A log entry will often be relevant to more than one curriculum heading, but try not to choose inappropriate headings.

Your clinical or educational supervisor can only validate log entries against the professional competences if they are of sufficient quality to make a judgement about your level of progress with that competency. **Familiarise yourself with the word pictures used to describe the criteria for assessing the 12 professional competency areas and ensure your log entries provide evidence for assessing your progression in those areas.**

Log entries should be reflective, demonstrating personal insight into how you are performing and learning from your everyday experiences. According to the RCGP a good, reflective log entry will show:

- Some evidence of critical thinking and analysis, describing your own thought processes
- Some self-awareness, demonstrating openness and honesty about performance along with some consideration of your own feelings
- Some evidence of learning, appropriately describing what needs to be learned, why and how
- Appropriate linkage to the curriculum
- Demonstration of behaviour that allows linkage to one or more competence areas

Learning logs are not about quantity, but relate much more to the quality of the entries. BUT, if there is insufficient quantity within the learning log then it is unlikely that an adequate quality will have been demonstrated and the areas of the curriculum are unlikely to have been covered.

Above all, reflective writing is not just a description of what you did. It is not a detailed description of what actually took place; it should be a brief synopsis only. The reader does not need to know all the exact details but the relevant ones that put the experience in context. It is important to make evident any emotional context to the entry and reflect why this might be plus your past experiences of similar situations and the views of others (be this colleagues or the medical evidence base)

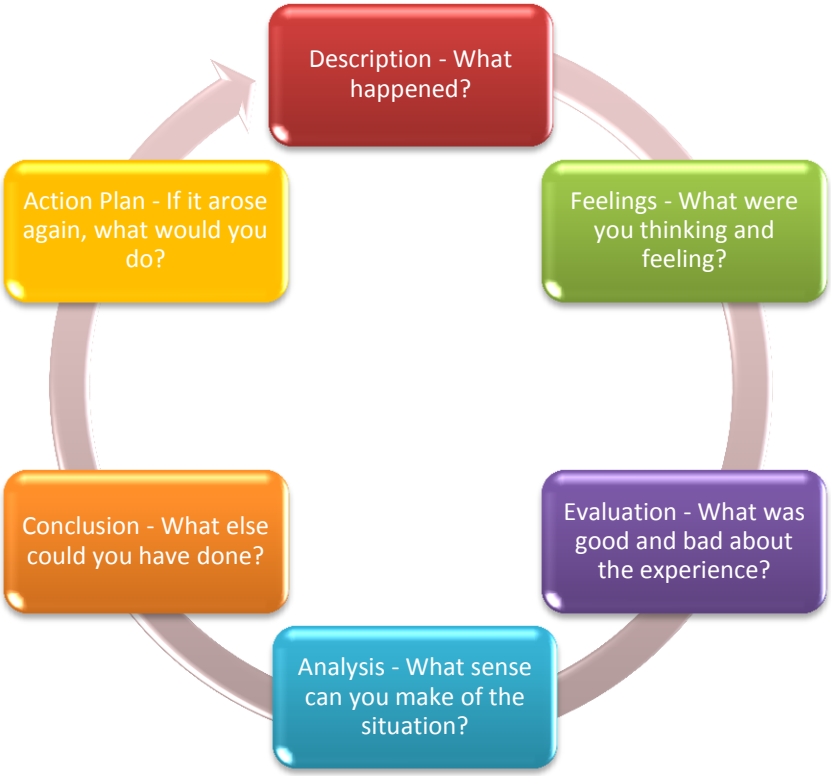
A narrative of events is the starting point for reflective writing, not the end point. You need to think from a personal point of view – think about what you have learned that will apply in future situations. What would you do differently next time and what insights have you gained about your own practice? Consider what actions/steps you will take as a result of the reflective process.

The template for documenting the learning event in your learning log section of the ePortfolio is there to help you develop your reflective skills. **You should consider how to complete all of the boxes in the template** not just record “what happened” and “what happened next!”

Do's and Don'ts for ePortfolio (adapted from Preston training scheme website)

Do's	**Don'ts**
Record & share your entries with your supervisor on a **regular** basis as and **when they happen**. This will result in more meaningful reflection and learning and will also be appreciated by your supervisor.	**Do not save up your entries** - they will have lost some of their value to you and your supervisor will not be able to read them all if put on in large amounts, or just weeks before your 6 monthly review.
Use your ePortfolio regularly to become familiar with it. Documenting 2-3 good quality pieces per week is far better than 10 poor quality entries.	**Do not avoid entering things that went less well than you would have liked.** Learning is life-long, when things don't go very well that is sometimes how we learn best. It will be seen as a strength if you are reflecting on the event if you are taking action to improve things.
Participate in & enter on your ePortfolio a variety of learning events to add breadth and depth to your learning	Avoid leaving the assessments until the last few months of your 6 month post - you will struggle to complete them.
Spend 30 minutes thinking about what you have learnt that day/week, what and how you will use what you have learnt - how can you best record this on the ePortfolio?	Do not set yourself unrealistic learning actions, you will not achieve them and your supervisor and ARCP panel will have to ask why.
Link all entries to the appropriate curriculum **statement headings.** Review your curriculum statement coverage & minimum required evidence regularly to identify your gaps	Only attach the curriculum statement headings to an entry on your ePortfolio justifiable to the educational activity. You check their meanings before adding each statement (explanations are available on the RCGP website and examples are given on the back pages of 'The Condensed Curriculum Guide' book). If inappropriate your supervisor will remove the headings.
Anonymise all staff & patient identifiable information.	
Do **respond to feedback** from you supervisor - when entries have been read by your supervisor you may receive comments back on them.	

Gibbs' cycle of Reflection



"It is not sufficient simply to have an experience in order to learn. Without reflecting upon this experience it may quickly be forgotten, or its learning potential lost. It is from the feelings and thoughts emerging from this reflection that generalisations or concepts can be generated. And it is generalisations that allow new situations to be tackled effectively."

Gibbs (1988)

Appendix 1: RCGP workplace based assessment working group guidance re criteria for "acceptable" standards of reflection

Hallmarks of good practice in information recording in the ePortfolio *(courtesy of the RCGP WPBA Standards Group)*

The following table provides a framework for assessing reflection in the ePortfolio: **REFLECTION** **(WPBA Standards Group)**		
Not Acceptable	**Acceptable**	**Excellent (in addition to acceptable)**
Information Provided: Entirely descriptive e.g. lists of learning events/ certificates of attendance with no evidence of reflection. **Critical Analysis:** No evidence of analysis (i.e. an attempt to make sense of thoughts, perceptions and emotions). **Self-Awareness:** No self-awareness. **Evidence of Learning:** No evidence of learning (i.e. clarification of what needs to be learned and why).	Limited use of other sources of information to put the event into context. Some evidence of critical thinking and analysis, describing own thought processes. Some self-awareness, demonstrating openness and honesty about performance and some consideration of feelings generated. Some evidence of learning, appropriately describing what needs to be learned, why and how.	Uses a range of sources to clarify thoughts and feelings Demonstrates well developed analysis and critical thinking e.g. using the evidence to justify or change behaviour Shows insight, seeing performance in relation to what might be expected of General Practitioners Consideration of the thoughts and feelings of others as well as him/herself Good evidence of learning, with critical assessment, prioritisation and planning of learning

Appendix 2: Example of a good reflective log entry (from RCGP)

- professional competences 4 - making a diagnosis
- professional competences 5 - clinical management
- curriculum statement headings 8 - care of children and young people
- curriculum statement headings 15 - cardiovascular problems

Date	**25/11/13**
What happened?	A two week old baby was brought to the surgery with a history of a few days of coryzal symptoms and poor feeding. The parents thought that the baby had a viral infection. I examined the baby and thought that she had some crepitations on the left lung. She was also tachypnoeic and tachycardic. I was concerned about this baby as she was not feeding well and the parents mentioned that she had been more sleepy than usual. I discussed the case with the paeds registrar on call, who said it sounded like bronchiolitis and suggested conservative management. However I stressed that I felt this baby needed to be assessed as she was not well and eventually the paeds registrar agreed to see the child.
What if anything happened subsequently?	While in the children's emergency department, the baby had a cardiorespiratory arrest, was resuscitated and transferred to a hospital in London. She had coarctation of the aorta and left basal consolidation of the left lung. She was subsequently operated on and is now progressing well in intensive care.
What did you learn?	To be aware that accurate assessment of a baby is vital as they can be seriously unwell and only display non-specific symptoms. I am very glad that I insisted on sending the baby to hospital despite the objections of the paediatric registrar. It felt very awkward at the time, but it has taught me to trust my judgement and I will find it easier to be more assertive next time.
What will you do differently in the future?	On reflection, the baby arrested while she was in the CED. The parents took her there by car. I could have arranged a blue light ambulance to take her to hospital. However, although I thought she was unwell, I did not expect such a serious underlying problem and she was certainly not looking like a baby that was about to arrest.
What further learning needs did you identify?	Need to refresh my memory re: congenital heart disease and its presentation in neonates.
How and when will you address these?	GP notebook and paediatric textbook, in the next couple of weeks.
Record created	15/12/13 21:24:32
Comments	[16/12/13 18:50:36] (Educational Supervisor) You did extremely well here, recognising the baby was not well and sticking by your own clinical judgement when a more specialist doctor was suggesting an alternative. This can be a difficult thing to do and in this case saved this baby's life. Well done.

Appendix 3 – examples of reflective learning log entries written by local GP trainees

Example 1

Date	**16.01.15 – Mens Health**
What happened?	A 49 year old gentleman I had seen previously made an appointment with me to discuss some difficulties he was having with his relationship. I also know his wife so was aware of confidentiality issues. He had found recently that he was having a lot of pain around the tip of his penis when having sex. He thought there may be an ulcer at the end of his penis which was discharging fluid. His wife was going through the menopause and was suffering from vaginal dryness but he didn't want to say anything to her because he didn't want to upset her.
What if anything happened subsequently?	On examination he had a small tear in his frenulum, there were no signs of infection or cellulitis and no ulcers present. His abdomen was soft and none tender and testicular examination was NAD. I told him the reason for his soreness being a small tear which may have resulted from having sex without lubrication. I advised him to abstain for a couple of weeks to allow the small tear to heal and offered further STI screening. The patient was relieved with the diagnosis and declined any further screening. I advised that maybe he should discuss this with his wife to see if she is having any problems and maybe to try lubrication. He said he would wait and see.
What did you learn?	This consultation was very awkward at the beginning as I felt the patient was embarrassed to talk about his problem. I had seen him for a chest infection previously and we had built a good rapport in this consultation. I tried to reassure him from the beginning that he could talk to me about anything and that everything discussed in the consultation will be completely confidential. I also offered him an appointment with a male doctor if he would prefer. By the time we had discussed the problem I could see the patient felt more relaxed and when I advised examination again I offered to get one of my male colleagues and of course a chaperone. This case highlights the importance of good communication and picking up on patient cues, for example when I feel that the consultation is uncomfortable to try and reassure the patient. This also highlights the importance of always being aware of confidentiality especially if you are seeing several members of the same family.
What will you do differently in the future?	I haven't seen alot of mens health during the past 6 months hence feel that I do need to reflect on any cases seen to update my knowledge.
What further learning needs did you identify?	To look at ED and the changed guidelines for Viagra prescription to keep my knowledge up to date.

How and when will you address these?	To look at the NICE guidelines.

Example 2

Date	**12.01.15 – UTI in child**
What happened?	Whilst oncall for my GP practice, a worried mum called up requesting an urgent appointment for her 5 year old daughter. She had been seen by the OOH doctors the evening before due to high temperatures and abdominal pain. They had done a urine dip which was positive for leucocytes and blood and had prescribed trimethoprim for a UTI but advised mum not to give her any antibiotics until she had obtained a full urine sample for MSU. Unfortunately the patient did not pass any urine over the next 20 hours hence mum did not give the antibiotics. When the little girl came in I saw immediately that she looked unwell, she was lethargic, pale and looked dry. Mum stated that she had only had half a cup of water in the past 20 hours and was refusing to eat. She had not passed any urine since the OOH doctors had seen her. She had a small amount of diarrhoea and had vomited once through the night. Mum had found it difficult to control her high temps with paracetamol and ibuprofen.
What if anything happened subsequently?	On examination her chest was clear, she was not coryzal, her ENT were normal. Her abdomen was tender suprapubically with no guarding. Her temp was 39.9, PR was 100. I explained to mum that she was clearly unwell and that we would need to send her into hospital. It was likely that she had a UTI but that I was worried that she wasn't drinking and she may need to be admitted for IV fluids. Mum agreed that she needed to go to hospital. I called the paeds reg who accepted the patient and mum took her straight to paeds A&E.
What did you learn?	This case highlights 2 main learning points for me. The first in recognising an acutely unwell child and the second in being careful how you say things to parents. The OOH doctors had told mum to not give antibiotics until she had obtained a urine sample which sound sensible as we would want to know the responsible bacteria to aim antibiotic therapy appropriately. However the OOH did not tell mum what to do if her daughter was not to pass urine for a prolonged period of time. This highlights the importance of safety netting but also being specific with your advice. For example to inform mum that if she is to have a reduced urine output to see a doctor urgently and to give antibiotics in the next 2 hours if she has not yet passed urine then to monitor urine output and see a doctor if she does not pass urine in the next 4 hours.
What will you do differently in the	I will always try to explain diagnoses and management carefully to patients and ensure I am very specific with my safety netting. This

future?	case has highlighted this as this child became acutely unwell with a UTI because her mum was told not to give antibiotics until she had obtained a urine sample but was not given a time scale on when it was appropriate to worry if she had not passed urine.
What further learning needs did you identify?	To make sure I am specific with my safety netting especially when working OOH.
How and when will you address these?	Reflect on specific cases during my remaining OOH shifts.

Example 3

Date	**14.04.15 - DKA**
What happened?	I was asked to see an unwell patient who had been vomiting since a few hours. This was a 27yr old male with type 1 diabetes mellitus who has been vomiting and having abdominal pain since a few hours before presentation. o/e-he appeared unwell and was tender over the epigastrium. His urine showed ketones, blood gas showed that he was acidotic and his blood reports were still awaited. After appropriately assessing the patient and writing him up correctly for the treatment of his condition, I informed the nurse responsible for his care of the management plan. After some time, I reviewed the patient again as he was clearly at high risk of deterioration and as his parameters were not heading in the right direction, appropriate steps were taken to remedy the situation – I prescribed some extra IV fluids for the patient as per protocol and requested the nursing staff to initiate treatment without any delay. In order to facilitate the speedy administration of treatment, I was asked to countersign the fluids which were about to be administered. I did this in all good faith as I realized it would help given the urgency of the situation. Little did I know at the time that the incorrect fluid had been presented to me and started; although this was picked up in a timely way after which the treatment was stopped with the correct fluids then being given as prescribed. As the treatment had been delayed, I had involved my senior and the medical team for further input and management which resulted in the patient being sent to the medical ward for further observation. The following day I made sure I found out how the gentleman had fared overnight; I was pleased to learn that he made a good recovery and that by the afternoon had been discharged.
What if anything happened subsequently?	There were a couple of issues that was raised during discussion with my seniors and my supervisor- 1. Inspite of working in a busy environment it is essential to take

	time to ensure that the correct treatment is commenced in an appropriate way. This implies to patients who are unwell and require that extra attention and repeated reviews. I Felt that it was my responsibility to ensure that the nurse had commenced the treatment, in addition to making sure that i had prescribed/signed for the right treatment. 2. I need to double-check any prescription/medication I sign for as I am ultimately legally responsible for what is administered, even when it comes to countersigning something. Even in a situation such as this when timing is crucial, looking at what is on the charts and making sure that it tallies with what is put up is necessary
What was done well?	Firstly I had gauged the severity of the situation already at my baseline assessment, hence my review shortly afterwards which highlighted the fact that treatment had not been commenced. Secondly i approached my senior and medical team for further support and input in managing this patient. I realised my mistake of countersigning for a wrong bag of fluids and rectified it in a timely manner and accepted my responsibility and apologised for the same. On the next day, i rechecked on the progress of this patient and had a sense of relief as he had improved exceptionally and been discharged home.
What was not done well?	1. I felt that i should have involved my senior/medical team sooner for further support. 2. In spite of being rushed in a busy environment, i should have counterchecked the bag of fluids i was signing for.. 3. Lastly i felt that probably i should have highlighted to situation (regarding how unwell the patent was..) to the nurse in charge of the patient -this might have led them to focus more on this particular patient.
What could be done differently in the future?	1. During my discussion with my supervisor, he mentioned that sometimes as junior doctors we might not be taken seriously by some of the staff, therefore in future if i consider any urgent treatment/if patient is acutely unwell-he has advised that i approach my senior sooner and probably shift the patient to resus (as this will signify the acuteness of the situation and speed up treatment). 2. To take my time and not be pressurised or rushed into signing anything (even ECG' s which happens quite so often in A&E) . 3. Involve my seniors sooner when i realise that i might need help.

Example 4

Date	**18.02.15 -** Plantar Fasciits in an anxious patient
What happened?	I saw what I thought was a very straight forward case however for some reason I spent 30 minutes with this patient. I think I did not take full control of this consultation as she was very chatty and I found it hard adding structure to this. She had plantar fasciitis and wanted to talk about treatment. She was trying physio exercises, had NHS insoles fitted and was trying to lose weight but despite all of that she still was symptomatic.
What if anything happened subsequently?	We discussed option of steroid injection (I felt appropriate as it seemed she had tried first line treatment) - she was keen. Therefore I advised she booked to see ESP phsyio. I also printed out a leaflet including more exercises. This case was then discussed with my supervisor as a random case analysis
What did you learn?	The patient managed to get a cancellation with ESP that same day - it seems she spent over 30 minutes with her. In the end she continued with exercises and was advised about stretching exercises. Steroid injections were not done as patient said she didn't want them. I learnt from this session that this patient is really quite anxious, I also learnt about Achilles stretch exercises to improve plantar fasciitis.
What will you do differently in future?	In hindsight I think I referred to quickly to the esp. - this was probably not an efficient use of their time. If I had known the patient more or knew more about advice RE Achilles tendon exercises then maybe I would have prevented a referral. Try to be more structured/doctor led and give patient more obvious cues to speed up consultation
What further leaning needs did you identify?	I wonder if my referral rate is higher as I am less experienced and therefore worry more. I am pleased I learnt more about pathophysiology of plantar fasciitis and Achilles exercises, I hope to learn more exercises for other common MSK complaints
How and when will you address these?	spend a session with physio and ESP