ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

Adolescent Medicine

Structured Assessments of Clinical Evaluation Report (STACER)

PROCEDURE FOR THE CONDUCT OF THE CLINICAL EXAMINATION

The purposes of this STACER are to evaluate the resident's ability: to acquire a medical history from a patient and parent/guardian (as appropriate); to perform an appropriate physical exam; to interpret the acquired information, to develop a management plan and to provide feedback to the patient and parent/guardian (as appropriate.) This STACER can also be used purely as a formative and feedback tool with the resident at any time during training.

The assessment can be performed at any stage of training where the resident is acting as a consultant. This STACER is to be done during clinical care with a new patient referred to the adolescent service. The patient could be an inpatient or an outpatient, but the patient must be previously unknown to the resident. The evaluating physician will select an appropriate patient, obtain the patient's consent (and parents/guardian as appropriate) and ensure appropriate time and facilities are made available. The evaluating physician will be responsible for observing the resident as they perform the history and physical.

Other specific requirements for the STACER are as follows:

1. The procedure and rating scale for this STACER must be shown to the resident at least three days before the evaluation.
2. Ideally, the evaluator would not be the Program Director.
3. The resident is provided with the referral information for the patient and it is the responsibility of the resident to begin the encounter as they see fit – i.e. deciding whether to start with the adolescent alone or with adolescent and parent(s). (Please note that through this document the word "parent" can be considered to include "guardians", as appropriate.)
4. Overall the STACER has a total duration of 90 minutes although the parts of the STACER may be used independently.
5. **PART 1 History and Physical: DURATION 60 MINUTES**
    a. The patient (and parents, if applicable) will be brought to the examination room by the resident with the evaluator observing. The evaluator should not ask questions or interrupt the resident and patient during the encounter unless there is a compelling reason to intervene (e.g., patient safety).
    b. If the interview is started together with the parents, the resident has the liberty to request time alone with the patient (i.e. request the parents to step out). Conversely, the resident may invite the parents into the interview if they were not initially present.
6. **PART 2 Case Presentation : DURATION 15 MINUTES** (5 minutes preparation time, 10 minutes presentation)
    a. At the end of the interview and examination, the resident will exit the interview room. The resident can reflect and organize their thoughts prior to the commencement of the second portion of the STACER. During this time the evaluator can spend a few minutes with the patient to clarify important points on history or physical, if needed. DURATION 5 MINUTES

b. The resident presents the history and physical examination findings to the evaluator, a synthesis of the obtained data, their diagnostic formulation and management plan, including investigations, referrals and follow-up arrangements. The evaluator may ask probing questions to clarify the resident's diagnostic and therapeutic reasoning.

7. **PART 3 Patient Feedback: DURATION 15 MINUTES**

   a. The third part of the STACER consists of the resident providing feedback to the patient and parents (as appropriate). If the circumstance arises that it is not suitable for the resident to provide the feedback directly to the patient, the evaluator can ask the resident to describe how the feedback would be given to the patient. The feedback should include diagnosis and management plan. The resident is expected to be able to answer questions and provide clarification as needed. The evaluator should not ask questions or interrupt the resident during the feedback unless there is a compelling reason to intervene (e.g., patient safety).

8. FEEDBACK FROM PATIENT: The evaluator may elicit feedback from the patient or family about their level of comfort during the resident's performance in the history and physical (e.g. rapport building, attention to privacy). If the situation arises that the evaluator thinks that the feedback provided by the resident is below standard the evaluator may clarify the feedback with the patient and family.

9. The evaluator observes and rates the resident's performance according to the evaluation grid.

10. At the end of the assessment, the evaluator will give feedback to the resident on their performance. If improvement in any area is recommended, supporting comments should be included

11. The resident must review and sign the assessment form.

12. A copy of the evaluation form will be sent to the Program Director who will retain the copy for the trainee's file. STACERS completed in the final year of training should contribute to the completion of the FITER.

Item	Expectations	*Does not meet Expectations	Meets Expectations	N/A	Comments
Negotiates the process of the adolescent encounter	Introduces him/ herself to both the adolescent and the parent(s)** as appropriate and explains the format of the interview. Explains purpose of the encounter and the structure of the interview, i.e., determines whether to meet with adolescent alone or with adolescent and parent(s) together.	☐	☐	☐	
Addresses confidentiality	Appropriately explains confidentiality and its limits to adolescent and parent(s), if appropriate.	☐	☐	☐	
Rapport	Interacts at all times in a professional, respectful and supportive manner and maintains boundaries with both adolescent and parent(s), if applicable.	☐	☐	☐	
Interviewing technique	Asks open and closed–ended questions appropriately. Redirects patient as needed to remain focused. Asks non-judgmental, developmentally appropriate, and gender-neutral questions. Uses appropriate interview techniques.	☐	☐	☐	
Use of parent(s) / guardians(s)/	Using the parent(s) and other informants as historians effectively and appropriately.	☐	☐	☐	
History of presenting complaint(s)	History is appropriately complete, relevant and accurate. Follows leads well but does not get diverted from primary presenting complaint.	☐	☐	☐	
Past Medical History	Reviews relevant past medical, surgical and gynecologic history.	☐	☐	☐	
Family History	Obtains family history – medical, surgical and psychiatric appropriate from the adolescent and parent(s), as appropriate.	☐	☐	☐	
Medication, Allergies and Immunizations History	Reviews present medications including non-prescription drugs, complementary and alternative medicines including dosages, effectiveness, adherence, allergies.	☐	☐	☐	
Review of Systems	Performs a review of systems as relevant for the presenting complaint, including menstrual history.	☐	☐	☐	
Psychosocial Assessment	Performs a thorough psychosocial assessment including strengths, protective factors and risks (i.e., HEADS / SHADESS type interview)	☐	☐	☐	
	Home	☐	☐	☐	
	Education	☐	☐	☐	
	Activities and employment	☐	☐	☐	
	Drugs	☐	☐	☐	

Item	Expectations	*Does not meet Expectations	Meets Expectations	N/A	Comments
	Diet, nutrition, eating behaviours	☐	☐	☐	
	Sexuality	☐	☐	☐	
	Suicide/ Mood	☐	☐	☐	
	Safety	☐	☐	☐	
	Strengths and Protective Factors	☐	☐	☐	
Collateral Information	Elicits or indicates need to obtain information from appropriate sources (school, social workers, psychologists etc)	☐	☐	☐	
Physical examination	Resident washes hands. Performs complete, organized physical examination relevant to the presenting complaint(s) as indicated. Uses appropriate physical exam techniques. Obtains and plots weight and height on growth curve. Obtains vital signs. SMR, genital exam, PAP, STI testing as indicated. Mental status exam as indicated. Attention paid to adolescent's comfort and need for privacy. Explains procedures and provides feedback to patient where appropriate.	☐	☐	☐	
Case Presentation	Presentation is succinct and organized. Issues and findings are presented with appropriate emphasis or priority.	☐	☐	☐	
Diagnosis / Formulation	Presents appropriate and complete problem list including all relevant biopsychosocial issues. Presents appropriate differential diagnoses for presenting problems.	☐	☐	☐	
Investigations	Identifies appropriate and cost-effective, investigations. Is able to justify investigations recommended.	☐	☐	☐	
Treatment/ Management Plan	Proposes comprehensive and realistic management plan for the adolescent. Suggests referrals as appropriate.	☐	☐	☐	
Feedback	Provides feedback to the adolescent and parent(s), as appropriate, regarding diagnosis, recommended treatment and next steps (other referrals, investigations, follow-up.) Allows the adolescent opportunity to ask questions. Allows the parent to ask questions as appropriate.	☐	☐	☐	
Organization	Conducts an organized and complete interview and physical examination in the allotted time.	☐	☐	☐	

***Requires comments**
****Please note that the word "parent(s)" is being used to indicate parent(s)/guardian(s).**

Overall Assessment of Candidate	Below Expectations	Meets Expectations

Summary of resident's strengths and suggestions for development:

Comments on the process:

Date: _____

Evaluator's Name: _____ Evaluator's Signature: _____

Resident's Name: _____ Resident's Signature: _____