# Acute Care Assessment Tool (ACAT)

Royal College of Paediatrics and Child Health
Leading the way in Children's Health

(Please answer all questions with block capital letters using blue or black ink. Mark boxes with an ☒)

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| **Trainee's Forename:** | | | | | | | | | | | | | | | | | | | | |
| **Trainee's Surname:** | | | | | | | | | | | | | | | | | | | | |
| **Trainee's GMC:** | | | | | | | | **Date of Assessment** (dd/mm/yyyy): / / 20__ | | | | | | | | | | | | |

**Please feedback on how the trainee has performed for each area**

| | Feedback Comments |
|---|---|
| Clinical Assessment | |
| Medical record keeping | |
| Investigations and referrals | |
| Safe prescribing | |
| Management of acutely unwell patient | |
| Time Management | |
| Team Management | |
| Decision making | |

**What went well? Trainer to complete (include feedback from others including nurses).**

**Suggested areas for development:** Trainer to complete after discussion

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**Please describe what you have learned from this case. How will it change your practice in the future?**

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|---|
| Trainee to complete after discussion |

**On the basis of this assessment do you have significant concerns which should be discussed with the educational supervisor?** ☐

**Assessor's position:**

Consultant ☐ SpR ☐ SASG☐ Nurse ☐ ST1 ☐ ST2☐ ST3☐ ST4☐ ST5☐ ST6☐ ST7☐ ST8☐
Other (specify):

**Other (Please specify):**

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Assessors Surname:** | | | | | | | | | | | | | | | | | | | | | |
| **Assessors Registration No.** | | | | | | | | **Assessors Signature:** | | | | | | | | | | | | | |

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