# IMPORTANT INFORMATION

# TRAINEE AND SUPERVISOR INSTRUCTIONS

# This Learning Development Plan (LDP) is to be used when significant concerns about a Trainee’s performance and progress are identified in the Six-monthly Summative Assessment Report. The LDP is developed through consultation between the Trainee and the Training Supervisor. Regular review of the Plan with the Trainee will allow the Training Supervisor to assess their progress.

IMPORTANT

* If the Trainee’s performance is referred for review to the CMFM Committee for consideration, it is ESSENTIAL that a LDP is developed and submitted with the relevant six-monthly Summative Assessment Report. The LDP must then be implemented in the next training period.
* The LDP must be signed and dated by both the Trainee and the Training Supervisor and copies should be retained by both parties.

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| TRAINEE DETAILS |

Full Name: …………………………………………………………………… Year Training commenced: ............................................

Current Year Level: ........................................................ Semester: 1 / 2

Total training time already credited in program (FTE weeks): .........................................................................................

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| TRAINING DETAILS |

Training Supervisor: ..................................................................................................................

Training Unit: ........................................................................... NZ/AU State: ......................................................

Six-month period: From: ........................................................ To: .....................................................................

Full/Part Time: F/T □ P/T □ FTE 0.5 – 1.0

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| SUMMARY OF DOMAIN/S WHERE DEVELOPMENT IS NEEDED (*PLEASE TICK APPROPRIATE BOXES*) |

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| --- | --- | --- |
| □ Clinical expertise | □ Academic abilities | □ Professional qualities |

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| LEARNING DEVELOPMENT PLAN AGREEMENT |

I have agreed to this Learning Development Plan after appropriate consultation with the Training Supervisor

Trainee signature: ................................................... Date: ..............................................

Training Supervisor’s signature: .............................. Date: ..............................................

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| CLINICAL EXPERTISE | |  |  | | |
| Competency | | Tick | Specific expertise/skills/areas for development | | |
| Demonstrates responsibility, reliability and initiative in undertaking clinical and other duties and follow up | |  |  | | |
| Manages clinical load effectively in consultation with other members of the multidisciplinary team | |  |  | | |
| Demonstrates appropriate maternal fetal medicine procedural and surgical skills | |  |  | | |
| Demonstrates appropriate maternal fetal medicine non procedural skills | |  |  | | |
| Demonstrates appropriate ultrasound skills | |  |  | | |
| Demonstrates appropriate documentation and organisational skills | |  |  | | |
|  | |  |  | | |
| ACADEMIC ABILITIES | |  |  | | |
| Competency | | Tick | Specific expertise/skills/areas for development | | |
| Demonstrates appropriate knowledge of the literature in obstetrics and gynaecology, and maternal and fetal medicine | |  |  | | |
| Demonstrates appropriate skills in all aspects of clinical research | |  |  | | |
| Demonstrates teaching at both undergraduate and postgraduate level | |  |  | | |
| Demonstrates attendance and participation at continuing education meetings | |  |  | | |
|  | |  |  | | |
| PROFESSIONAL QUALITIES | |  |  | | |
| Competency | | Tick | Specific expertise/skills/areas for development | | |
| Communicates effectively with patients and their families | |  |  | | |
| Communicates effectively with colleagues | |  |  | | |
| Works as a member of a team | |  |  | | |
| Demonstrates appropriate understanding and judgement of ethical issues | |  |  | | |
| Accepts constructive feedback | |  |  | | |
| Reviews and updates professional practice | |  |  | | |
| Leadership and management responsibilities | |  |  | | |
| Professionalism | |  |  | | |
| Health Advocacy | |  |  | | |
|  | |  |  | | |
| TRACKING YOUR ACTION/DEVELOPMENT PLAN | | | | | |
| Areas identified requiring further development | Outline how this will be addressed | | | Proposed date or timeline for review | Actual date achieved (signature required) |
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\*Ensure areas identified and actions planned are “SMART”: Specific, Measurable, Achievable, Relevant, Time framed