

Accreditation in Stress Echocardiography

This pack is for the use of all candidates undergoing the accreditation process and becomes effective as of January 2019.

This document supersedes all previous versions.

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Welcome message from the Accreditation Chair

Dear Candidate,

Welcome to the British Society of Echocardiography. The Stress Echo Accreditation process has been set up to assist all those in training in Stress echo and is designed to accommodate the requirements of multiple disciplines including Cardiologists, Physiologists and Healthcare Scientists. It is important that you read all the information carefully before commencing your specific speciality logbook.

The written section of the Stress Echo Assessment will be held each year in various venues around the UK and Republic of Ireland. The Practical assessment will also be held in a variety of locations. Full details and registration forms will be published on the website www.bsecho.org.

We would like every BSE member to undertake the relevant Accreditation process, which has, as its ultimate aim, the achievement and maintenance of high standards of clinical echocardiography for the benefit of our patients.

A list of Accredited members is maintained on the BSE website. The process has to be regulated, and the standard of proficiency required for each specific Accreditation has to be set at a high enough level to command the respect of our professional colleagues. Subject to these constraints, we want to make it possible for as many members as possible to obtain Accreditation, and not to put any unnecessary barriers in their way.

Please let us know if we can assist you in this process in any specific way, or if you have constructive feedback to offer the accreditation committee, then please get in touch.

Good luck with your accreditation process.

Best wishes,



Dr Claire L Colebourn
Chair, BSE Accreditation Committee

Introduction and Aims

- Accreditation is run as a service for members of the British Society of Echocardiography and is not a compulsory or regulatory certificate of competence or excellence.
- Accredited members are expected to be able to perform and report stress echocardiographic studies unsupervised.
- Accreditation is a minimum requirement and cannot be regarded as a guarantee of competence.
- The Accreditation process comprises a written exam, (theory and case reporting sections) and a practical assessment comprising acquisition of defined stress echo views in an exam setting, review of the required log-book and a review of selected Viva echo cases performed to a high standard.
- Echo skills can only be maintained by continued education and practical involvement in echocardiography. The importance of this is underlined by limiting Accreditation to 5 years after which reaccreditation must be sought.

Summary of process requirements

- You must be a [member](#) of the British Society of Echocardiography.
- You must hold current BSE or EACVI Adult Transthoracic Accreditation
- You should address all queries regarding accreditation to:

BSE Accreditation Department, address details are available on www.bsecho.org.
Tel: 020 7345 5185 (lines open 10am-4pm Mon-Fri) , Email: accreditation@bsecho.org.
- You should register for the [written](#) and [practical](#) assessments by visiting the [accreditation](#) section of www.bsecho.org. This will advise the dates and location of the next examinations.
- You must pass the written assessment before attending the practical assessment.
- The practical assessment cases should be collected over a period of no more than 24 months from the written examination with the practical assessment being taken no later than two months after the end of the collection period. Therefore cases can be collected prior to the written exam, but the total time for cases to be collected remains 24 months.

You must submit:

- Five full digital Viva cases accompanied by reports signed by yourself
- A logbook containing 200 reports of a specific case mix (maximum 140 cases with no significant pathology, at least 40 cases demonstrating ischaemia and at least 20 cases demonstrating the assessment of structural heart disease (e.g. cardiomyopathy or mitral regurgitation)
- The full mentor sheet - [Appendix 6](#)
- Stress Echo Accreditation Summary Sheet- [Appendix 8](#)
- Mentor statement signed- [Appendix 9](#)
- Final checklist – [Appendix 14](#)

- Extensions to the 24-month deadline may be granted only following periods of parental or extended sick leave or in exceptional circumstances. Extension requests forms must be submitted **before the case COLLECTION deadline**. Extension request forms can be obtained by visiting [FAQ section](#) of accreditation of www.bsecho.org. Requests received after the case deadline may not be reviewed. We strongly advise that requests are supported by documents such as doctors letter or letter from employer confirming the reasons for an extension.
- **Extensions are not guaranteed**. A non-refundable charge of £100 will be made for each extension request regardless of the outcome.
- A fee of £250 is charged for the complete Accreditation process. This fee is payable, in advance upon registration for the written section of the examination and will also cover the Practical assessment.
- Candidates who are unsuccessful in the written section of the examination will be charged a reduced fee of £125 to re-sit this section. This reduced fee only applies to candidates who re-sit the examination within two sittings of the unsuccessful attempt. A re-attempt at the Practical assessment is also subject to a fee of £125.
- Candidates are entitled to one re-attempt at the practical assessment, after which the entire process has to be repeated.
- The full training syllabus is available in [Appendix 2](#).
- Appeals - Please see the [Appeal document](#) available on FAQs section of www.bsecho.org.

Details of [written assessment](#) and [practical assessments](#)

Written section

- The written assessment is held up to two occasions each year. The examinations are held at various Pearson VUE centres (online) in the UK, Republic of Ireland, South Africa and Hong Kong.
- Please follow instruction on [written examination dates](#) section of www.bsecho.org or see [Appendix 5](#) for further information on registrations for the written exams.
- The written assessment is conducted under formal examination conditions. It is comprised of two parts: The Theory section and the Reporting section. The suggested reading list is available in [Appendix 1](#).
- Both parts of the examination will be computer marked - guidelines in [Appendix 5](#). In the written assessment it is necessary to pass both the multiple choice and imaging questions at the same exam sitting. The approximate pass mark for the Theory Section is 70% and for the Reporting Section 60%. These may vary slightly at the discretion of the Chief Examiner following moderation.
- There is no bar to re-sitting the written assessment any number of times.
- Accreditation will only be awarded once a candidate has successfully completed the practical assessment. Satisfactory performance at the written assessment alone does not allow 'partial accreditation.'

Theory Section (MCQs)

- This consists of **20** questions which must be answered within 60 minutes. The questions test knowledge of echocardiographic findings related to stress echo including questions based on guidelines, indications and complications.
- Each question comprises a stem followed by 5 questions. Candidates are required to say whether each question is 'true' or 'false'. Some example questions are provided in [Appendix 3](#).
- The subject matter reflects the spectrum of clinical practice. Thus ischaemic disease is more frequently represented than valve disease since it forms the majority of Stress echo procedures.
- This part of the examination will be marked +1 for correct answers, 0 for incorrect or unanswered questions (no negative marking).
- There are no 'trick' questions.
- There are no fixed number of correct answers, i.e. for each question it is possible for every answer to be false or every answer to be true or any combination of true or false.
- The maximum possible mark is 100.

Reporting (video cases)

- This will consist of 15 stem questions that represent 15 cases. Each question will have 5 possible answers and candidates will be asked to select the best answer. These reflect the range of clinical material seen in routine stress echocardiographic practice.
- Normal or near-normal studies may be presented.
- For each case, a number of still and moving images will be available to view. The clips and stills will contain sufficient information to answer the questions.
- An example question is provided in [Appendix 4](#). Each case is worth 1 mark giving a total of 15.

Practical assessment

- All candidates will be required to attend a practical assessment within 26 months of beginning to collect their cases (i.e. within two months of their case collection deadline). The written examination must have been passed at anytime during the collection period, before attending. The Practical assessment will be held up to five times per year.
- Dates and locations will be announced on the [Practical Registrations](#) section of www.bsecho.org. Candidates will need to select an available date and register online (full instructions provided on the [website](#)). Registrations will open at least three months before the assessment date. Upon a confirmed placement, candidates will be given an assessment time.

The assessment will consist of three sections:

- On attendance at the exam, your logbook portal reference will be activated for the examiners who will review your logbook whilst you attend Station 2. Feedback for Station 1 will be given after you have completed Stations 2 & 3.

- **Logbooks and cases must be fully anonymised – please read the BSE Policy on the Non-Anonymisation of Patient data in [Appendix 15](#) breach of this policy will result in an automatic fail.**
- Logbook submission: the logbook should be submitted in a ring binder folder (**do not use plastic pockets**) with the different categories separated by dividers or ideally via the [online logbook portal](#). **As of January 2020, we will not accept non-portal logbooks.**
- **Station 2** will consist of a Practical assessment. The Practical assessment is designed to demonstrate the candidate's ability to carry out an Exercise Stress Echo study on a normal volunteer. The candidate will be required to give notice of the preferred stressor (either treadmill or a supine bicycle) so that the correct apparatus can be made available. Only the BSE recommended protocols for both apparatus will be used. (ie. WHO 25 protocol for the bicycle and BRUCE protocol for the treadmill. For further details please refer to the June 2016 issue of Echo, http://bsecho.azurewebsites.net/media/185477/echo_no94_web.pdf)
- An assistant will be present to help with the treadmill/bicycle controls on the instructions of the candidate, but the candidate will be expected to acquire the images. The Assessor(s) present in the room will help adjust the echo machine controls as directed by the candidate if the system is unfamiliar. The candidate will be asked to acquire a number of views on a normal volunteer. The study may be stopped before completion of the protocol at the assessor's discretion. There may be discussions around image acquisition (e.g. optimisation) during the assessment.
- If unsuccessful at station 2, the candidate can still proceed to the following station for the purpose of summative examination. The chief examiner will discuss this with the candidate.
- **Station 3** will be a Viva assessing the video cases. All aspects of stress echo may be discussed during this station while assessing the cases.
- Following Station 3, the candidate will receive their logbook feedback. Accreditation is achieved if all three stations are passed. However, from March 2019, candidates unsuccessful at Stations 1, 2 or 3, need only re-sit stations at which they were unsuccessful at their next attempt.
- **Please note that only two attempts to pass the practical are allowed per successful sitting of the written exam.**

Logbook

- The Logbook should comprise details of **200 stress echo** cases personally **performed and reported** by the candidate during the specified period of 24 months. It is not acceptable to include cases performed or reported by someone else.
- The format for the Logbook is a set of copies of actual clinical reports enclosed in a folder or binder, or submitted via the [BSE online logbook portal](#). Please note, as of January 2020, all logbooks must be submitted via the portal. The reports should ensure:

- All patient data has been removed including the full date of birth, name or address. See [Appendix 10](#)
 - All cases have been collected in accordance with local requirements for data protection, i.e. your trust policy.
 - Inclusion of cavity and Doppler measurements, objective observations and a comment - [Appendix 7](#).
 - The signature and full name of the candidate is included.
 - At least **180** cases should be reported primarily by the candidate alone although it is acceptable to include up to 20 reports that are overseen by a supervisor or experienced operator.
 - In some hospitals, Trust Policy dictates that only medical staff sign reports. In such cases, the reports may be included in the logbook but should be countersigned by both the candidate and the supervisor to confirm that the trainee has produced the report.
- The studies should reflect a normal stress echo case-load of a general adult department with the following constraints;
 - Up to 140 cases may be normal
 - At least 40 cases should demonstrate ischaemia/viability
 - At least 20 cases should demonstrate the assessment of structural heart disease (e.g. valve disease and HCM)
 - At least 50 studies need to show the use of transpulmonary contrast
 - Cases should be a mixture of exercise and pharmacological stress. Depending on the case mix in your base department, you may have a predominance of experience in one type of stressor. At least 25 studies need to demonstrate that you can use another type. So for example, if you have trained in a department that predominantly uses Dobutamine Stress echo (DSE), you can submit 175 DSEs and 25 Exercise stress echoes (ESE). However, please note the Practical Assessment will be with exercise so if you are not confident with either the treadmill or bicycle protocols you will be at a disadvantage. We would advise you to discuss this with your mentor to fill the training gap.
 - It may be necessary for the candidate to attend another department to gain experience in certain conditions.
 - The different categories of echoes should be separated by dividers. This is done under separate tabs within the portal.
 - A tally of the primary diagnosis assigned to each case must be entered on the appropriate enclosed summary sheet - [Appendix 8](#).

Video Case Submission

- Five Full studies with reports must be brought to the Practical Assessment. The cases **must** be anonymised. The cases must be submitted as digital loops and stills within a PowerPoint presentation. Do not label the views or include text.
- This is the section that is often done least well and is where many candidates fail. It is worth spending extra time doing this to make sure the submission is as good as it can be. Remember that it is assumed you will submit your best cases, so we will expect the

studies to be complete and of a high standard. Also, remember we are assessing your echo skills, not the pathology you are sending in. A commentary about the case background needs to be presented followed by a full echo evaluation using the BSE minimum dataset for TTE. The examiner needs to be satisfied that the candidate ruled out significant resting outflow obstruction or valve disease before proceeding to the stress echo. The following image acquisition are required for the video cases. These and your reports will be scrutinised.

- **All** cases must have patient data removed. Some machinery cannot do this post-examination so please ensure due care is taken to put 'case 1' instead of patient's name or patient's personal details.
 - Case 1: A normal Dobutamine stress study using trans-pulmonary contrast. The Parasternal or apical long axis, parasternal short axis, Apical 4-chamber and apical 2-chamber views have to be acquired. 4 stages (baseline, low dose, intermediate dose and peak dose) have to be displayed in a quad-screen and synchronised format.
 - Case 2: A normal exercise stress study on the treadmill or bicycle with/without contrast. At least 4 views have to be acquired as above but can be baseline and post-peak if using a treadmill or as per case 1 if using a bike.
 - Case 3: A reversible ischaemic response with Dobutamine or exercise using the appropriate displays as above.
 - Case 4: A Dobutamine study either showing non-viable or viable myocardium using at least the low and intermediate doses of Dobutamine using the same views and displays as above. Peak dose imaging is not required but can be done if reversible ischaemia is also being demonstrated in the case.
 - Case 5: A stress study to evaluate structural heart disease. This could be a viability study for aortic stenosis with left ventricular impairment. Another example would be a study to assess LVOT gradient on exercise.

In order to ensure that your cases play properly and remain anonymised at the assessment, it is recommended that you bring your own laptop to the centre having checked that the cases play on this.

Outcomes and process for re-attempts

If you are successful at all three stations, you will be deemed to have passed the accreditation process and will receive your certificate prior to leaving the assessment.

- If you are unsuccessful at any station, you will be deemed to have been unsuccessful at this sitting of the practical assessment. You will be provided with constructive feedback to facilitate a re-attempt, and offered the opportunity to continue on to the next station.
- Any parts of the exam passed at that sitting **do not** need to be re-attempted at the next attempt.
- This only applies to two attempts at the practical within a reasonable time-frame.
 - Please note feedback on unsuccessful stations is for guidance only and does not necessarily represent the opinion of the deciding assessor at your next attempt. To re-attempt, you will need to attend another practical assessment and begin at the

station at which you were unsuccessful and complete all outstanding stations successfully. The timescale allowed for re-attempts will depend on which stations were not passed and the number of Viva cases required to be resubmitted. This will be discussed with you in the assessment.

A second attempt at the practical assessment is subject to a fee of £125. Candidates are entitled to one re-attempt at the practical assessment, after which the entire process must be undertaken again.

Appendix 1: Suggested Reading List

The syllabus is set by the Accreditation Committee of the British Society of Echocardiography and is presented as a guide to candidates.

The reading list is provided by the Accreditation Committee of the British Society of Echocardiography.

- ASE guidelines on performance, interpretation and application of stress echo; Pellikka et al. Journal of the American Society, September 2007.
- Contrast echocardiography: evidence-based recommendations by European Association of Echocardiography; Roxy Senior et al. European Heart Journal Cardiovascular Imaging; Volume 10: p194 – 212.
- Stress echocardiography expert consensus statement- EAE guidelines; Sicari et al; Circulation. 2010;121: p1756-1767.
- EACVI toolbox on contrast echo- Lead authors Roxy Senior and Benoy Shah.
<https://www.escardio.org/Guidelines-&Education/Practice-tools/EACVI-toolboxes/Contrast-Echo/Contrast-Echocardiography-Box>
- Chest pain of recent onset: Assessment and diagnosis of recent onset chest pain or discomfort of suspected cardiac origin. NICE guidelines 95. March 2010. www.nice.org.uk
- ESC guidelines on the management of stable coronary artery disease: the Task Force on the management of stable coronary artery disease of the European Society of Cardiology. Task Force Members. Eur Heart J 2013;34(38):2949-3003
- Guidelines on the management of valvular heart disease (version 2012): the Joint Task Force on the Management of Valvular Heart Disease of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). Eur Heart J 2012;33:2451-96
- 2014 ESC/ESA Guidelines on non-cardiac surgery: cardiovascular assessment and management: The Joint Task Force on non-cardiac surgery: cardiovascular assessment and management of the European Society of Cardiology (ESC) and the European Society of Anaesthesiology (ESA). Eur Heart J. 2014 Sep 14;35(35):2383-431
- Bierig S, Ehler D, Knoll M, Waggoner A. American Society of Echocardiography minimum standards for the cardiac sonographer: a position paper. J AmSoc Echocardiogr 2006;19:471-4
- Incidence, Pathophysiology, and Treatment of Complications During Dobutamine-Atropine Stress Echocardiography, Marcel L. Geleijnse et al.; Circulation. 2010;121:1756-1767
- Bracco revised warnings for Sonovue, October 2014
www.mhra.gov.uk/home/groups/comms-ic/.../con475311.pdf
- Picano, Eugene. Stress Echocardiography, Sixth edition, Springer 2015

Appendix 2: Training syllabus for BSE Stress echo accreditation

Topics that may be included in the multiple choice examination

1. Underlying Principles

- a. Ischaemic cascade
- b. The difference between wall motion imaging and perfusion imaging
- c. The relationship between coronary arteries and LV segments
- d. Working knowledge of chest pain guidance form NICE (ref 1) and ESC guideline on stable coronary disease (ref 2)
- e. Role of stress echo in the assessment of structural heart disease (ref 3)

2. Indications

- a. Diagnosis of ischaemia
- b. Functional significance of known CAD
- c. Risk stratification post-myocardial infarction
- d. Post revascularisation (thrombolysis, PTCA, CABG) prognosis
- e. Pre-op evaluation prior to non-cardiac surgery ESC/ESA guidelines (ref 4)
- f. Assessment of transplant CAD
- g. Myocardial Viability
 - i. Myocardial stunning
 - ii. Hibernating myocardium
 - iii. Myocardial scar or non-viable myocardium
- h. Assessment of contractile reserve in DCM
- i. Stress Echo for Haemodynamics
 - i. Valvular stenosis
 - ii. Valvular regurgitation
 - iii. Prosthetic valves
 - iv. Pulmonary hypertension
 - v. Hypertrophic cardiomyopathy

3. Relative or true contraindications

- i. Unstable angina
- ii. Acute MI within 48hrs
- iii. Haemodynamic instability, eg hypotension, severe hypoxia
- iv. Hypertension- BP>200/110 at baseline
- v. Serious, uncontrolled arrhythmias
- vi. Mobile LV thrombus
- vii. Symptomatic severe aortic stenosis
- viii. Decompensated heart failure
- ix. Acute myo/pericarditis
- x. AV block and asthma (Adenosine)

4. Technical Aspects

- a. Types of tests (pros and cons)
 - i. Treadmill
 - ii. Bicycle
 - iii. Pharmacological- Dobutamine/Dipyridamole/Adenosine
 - iv. Adjunctive use of Atropine
 - v. Role of pacing
 - vi. Role of handgrip
- b. Consent
 - i. Verbal vs written
 - ii. Patient information
- c. Staffing requirements
 - i. Role of the physician, nurse, physiologist
 - ii. Training in TTE and stress echo
 - iii. Training in ALS/ILS
 - iv. Competency maintenance 100/operator/year (ref 5)
- d. Protocols
 - i. Protocols for exercise- both treadmill and bicycle Protocols for Dobutamine/Dipyridamole/Adenosine
 - ii. Basic knowledge of the stressor pharmacokinetics
 - iii. Protocols for viability
 - iv. Use of beta-blockade
 - v. Use of Atropine/hand grip
- e. End-points
 - i. Completion of protocol
 - ii. Target heart rate/workload
 - iii. Hypotension (BP <90)
 - iv. Hypertension (BP ≥ 220/120 mmHg)
 - v. Sustained arrhythmia
 - vi. Significant ischaemia including cavity dilation
 - vii. ST elevation on ECG if monitored
 - viii. Significant symptoms
- f. Side effects and complications
 - i. Vasovagal reactions
 - ii. The occurrence of major complications (ref 6)
- g. Set-up/equipment/drugs
 - i. Digital echocardiography machine with offline analysis package specific for SE
 - ii. Automated blood pressure machine with manual back up if needed.
 - iii. Continuous ECG monitoring
 - iv. Fully equipped resuscitation trolley with defibrillator
 - v. Oxygen supply and suction.
 - vi. Availability of transpulmonary contrast when echo window is suboptimal
 - vii. Drugs to manage severe allergic reactions and anaphylactic shock. To include – IV adrenaline 1:1000, IV chlorpheniramine, IV hydrocortisone,

- salbutamol nebuliser – in dose and preparation to meet current Resuscitation UK guidelines
- viii. Cannulation equipment
- ix. Exercise treadmill and/or semi-supine bike with protocol options
- x. Dobutamine infusion and administration pump.
- xi. IV Atropine - up to 1.2mg.
- xii. IV beta-blockers, e.g. metoprolol
- xiii. Aminophylline
- h. Image acquisition
 - i. Baseline minimum dataset
 - ii. Commence with apical views- Ap4c, Ap2c +/- Ap 3C
 - iii. PLAX and SAX
 - iv. Peak/post-peak imaging for exercise (suggested timing of post-peak images within 60 secs)
 - v. 85% target vs 100% target HR
 - vi. Role of recovery imaging
 - vii. Imaging during symptoms

5. Interpretation

- a. Quad screen display
- b. Assessment of wall thickness vs WMAs
- c. Patterns for ischaemia, hibernation, stunning and non-viability/scar
- d. Wall motion score index
- e. Nomenclature of 17 segment model
- f. Inter-observer variability and reproducibility
- g. Causes of false positive tests
 - i. Non-ischaemic cardiomyopathy- mismatch without CAD
 - ii. Septal motion abnormalities (LBBB, post-CABG)- overcome by assessing wall thickness
 - iii. Basal inferior wall artefact
 - iv. Hypertensive response- usually preserved wall thickness
 - v. Poor image quality
 - vi. Interpreter bias
- h. Causes of false negative tests
 - i. Single vessel disease
 - ii. “Mild” coronary stenosis
 - iii. Left circumflex artery disease
 - iv. Inadequate stress
 - v. Rapid recovery
 - vi. Poor image quality
 - vii. Severe LVH
- i. Accuracy
 - i. Sensitivity and specificity

1. Overall and in different coronary territories
2. In single vs multivessel disease
3. In the context of LVH and LBBB
4. In viability assessment
- ii. Comparisons with
 1. exercise ECG
 2. other functional imaging modalities
- iii. Comparisons between
 1. Treadmill vs bicycle
 2. Exercise vs pharmacologic
 3. Comparison of various pharmacologic agents
 4. Contrast vs no contrast
 5. Perfusion vs WMA assessment
- j. Prognostic value of a negative vs positive test

6. Contrast Echocardiography & Tissue Harmonic Imaging

- a. Bubble characteristics
 - i. composition
 - ii. size
 - iii. Stability
 - iv. Administration (bolus vs continuous)
 - v. Safety
 - vi. Available agents in the UK
- b. Instrumentation for Contrast Agents
 - i. Mechanical Index
 - ii. Fundamental vs Harmonic imaging
 - iii. High (power Doppler) vs low power (Pulse inversion, power modulation) imaging
 - iv. Contrast destruction/refill analysis (qualitative and quantitative)
 - v. Signal to noise ratio improvement techniques (background subtraction, filtering)
 - vi. Capture mode
- c. Capture mode
 - i. Continuous
 - ii. Triggered (intermittent; gated)
 - iii. Destruction/fill imaging
 - iv. Sequential pulse imaging
- d. Clinical Applications
 - i. Endocardial border enhancement
 - ii. Global and regional wall motion evaluation
 - iii. Doppler signal enhancement
 - iv. Myocardial perfusion
- e. Contraindications and warnings for contrast (guidance is for Sonovue, which is the main agent used in the UK- please see revised Bracco guidelines from October 2014, ref 7)

- i. Contra-indicated in known hypersensitivity
- ii. Contraindicated in large right-left shunts
- iii. Contraindicated in severe pulmonary hypertension $>90\text{mmHg}$
- iv. Caution advised within 7 days of any cardiac decompensation
- v. “Not suitable” in ventilated patients
- vi. “Not suitable” in patients with unstable neurological disease
- vii. “Should not be administered” in pregnancy and lactation

7. Basic knowledge of new technologies applied to stress echo

- i. Real-time 3D echo
- ii. TDI and derivatives
- iii. Coronary flow reserve

The level of knowledge expected is that of a competent echocardiographer performing stress echo studies and sustaining knowledge through the BSE and other educational resources, including issues relevant to clinical scanning and practice raised in the BSE Newsletter

Appendix 3: Proficiency Examination: Example Theory Questions

Answer 'True' (T) or 'False' (F) to each of the following. Each correct answer gains one mark, while each incorrect answer. A question left blank does not gain any marks.

| | | |
|-----------|---|---|
| Q1 | The following are all acceptable indications for stress echocardiography | |
| a) | Assessment of the functional significance of a 60% lesion on CT angiography | T |
| b) | Determination of viability following inferior myocardial infarction with known right coronary occlusion | T |
| c) | Diagnosis of crescendo angina in a 67 year old male with a typical history and pre-test probability of 93% | F |
| d) | Determination of prognosis following anterior myocardial infarction | T |
| e) | Risk stratification prior to abdominal aortic aneurysm repair in a patient unable to exercise due to claudication | T |

Appendix 4: Proficiency Examination: Example Reporting Questions

Clips and stills will be shown lasting 1-3 mins and below is an example of a question with all relevant information provided.

SELECT THE SINGLE BEST ANSWER There is no negative marking. One mark added for a correct answer, no mark deducted for an incorrect answer.

Case 1

The case shown in the accompanying images demonstrates

- a. Ischaemia in the right coronary artery (RCA) territory
- b. An infarction in the left anterior descending territory
- c. An infarction in the RCA territory
- d. Ischaemia in the circumflex territory
- e. Ischaemia in all three territories

Single best answer is (a).

Appendix 5: Pearson VUE guidance notes

BSE written exams are delivered in partnership with Pearson VUE. Candidates will be able to sit the exam at local centres throughout the UK, Republic of Ireland and in South Africa. Each candidate will have their own monitor and will be able to replay videos during the examination. Full instructions will be provided on the day of the exam.

Pre-Registration

- Candidate must register their interest to sit the [written exam](#) by completing an online pre-registration form via accreditation section of www.bsecho.org. BSE will transfer your data and requirements to Pearson VUE who will contact all pre-registered candidates with further information on confirming placements for the exam.
- Pearson VUE will manage all registration and payments after the stage of pre-registration.
- Candidates with special requirements or conditions should notify the BSE during the pre-registration stage.

On the day of the exam

- Instructions will be given on the day of the exam via a video tutorial at the test centre. Candidates will complete the exam on a computer at the test centre.
- A basic calculator is already built into the online exam. An erasable sheet will be given to candidates by the examining centre.
- Candidates are required to bring photo ID that reflects on the registration as booked.
- Candidates are not required to bring any stationery to the exam.
- The test centre will not facilitate any last-minute requests of special accommodations.

Part 1 Theory Section

A. Time

The theory section will last 60 minutes.

B. Format

The theory section will consist of multiple choice questions with True/False answers.

Part 2 Digital Reporting Section

A. Time

The reporting section will last up to 90 minutes

B. Format

The section will consist of 15 cases, each with 1 single best answer questions relating to it

There will be NO negative marking for this paper – each correct answer will receive a score of 1. Incorrect or unanswered questions/stems will receive a score of 0.

Please watch the demo available via Pearson VUE; <http://www.pearsonvue.com/demo/>

D. Additional Information

Candidates are advised to check the security procedures in the “What to expect section” of the Pearson VUE/BSE guide page; <https://home.pearsonvue.com/test-taker/security.aspx>

Appendix 6: Curriculum-Based Competency Assessment Tool.

This will also be available in digital form via the online logbook portal.

MENTOR TO COMPLETE DURING CANDIDATE'S TRAINING PERIOD

How to use this document:

You should keep it with you throughout your training period

At each hospital, you must have a mentor who should be a senior and experienced echocardiographer. Someone holding BSE Accreditation is encouraged but not mandatory.

Your mentor should initial and date each entry once he or she is satisfied that you are competent to perform and report it unsupervised. This competency checklist should be submitted with your logbook.

Knowledge of standard transthoracic echocardiography will be assumed by virtue of the entrance criteria (i.e. BSE or EACVI accreditation in TTE). The theory component will be self-taught. Your department may have suitable text-books

Knowledge base (please also see full curriculum)

Ischaemic cascade and the differences between wall motion and perfusion imaging.

Differences between viability and ischaemia assessment

Coronary arteries and LV territories

Indications for different types of stress echo including exercise and pharmacological stress

Assessment of structural heart disease by stress echo, eg MR, HOCM, AS

Physics of transpulmonary contrast

Contra-indications and cautions for stressors and contrast

Side effects and complications

End-points for test completion

Treatment of complications including contrast reactions

Treatment of arrhythmias, eg beta blocker but also as per ILS/ALS guidelines

Knowledge of relevant guidelines, eg for chest pain or valvular heart disease testing

Knowledge of strengths and limitations of stress echo

Working knowledge of other functional imaging modalities as compared with stress echo

Practical Competencies

Interacts appropriately with patients and stress echo team

Able to obtain informed consent

Able to tease out relevant contra-indications from patient history

Recognises cautions and contra-indications from baseline study, eg thrombus, critical AS

Understands basic instrumentation

Cares for machine appropriately

Can obtain standard views at baseline and reproduce views during stress

Can carry out stress protocols according to guidelines (at least dobutamine and bike/treadmill)
Able to use Atropine and handgrip at the appropriate time
Can optimise gain settings, sector width, depth, focus, Doppler settings or colour gain as appropriate
Can handle contrast and optimise machinery for contrast settings
Can recognise and correct for artefacts, eg lateral lung shadow, apical foreshortening, LVOT vs MR
Can use all appropriate tools for valve/LVOT/PA pressure assessments
Able to recognise signs and treat contrast allergy, vasovagal response, arrhythmias, prolonged ischaemia

Interpretation competencies

Able to recognise different responses – normal, ischaemic, biphasic etc
Able to report ischaemic burden in 16 or 17 segment models of LV
Able to recognise LV dilatation
Able to recognise artefacts, eg basal inferior wall
Able to assess contractile reserve in aortic stenosis
Able to assess the severity of valve disease, eg pseudo-severe AS

Initials and date

Mentor

Name _____

Signature _____

Appendix 7: Suggested format for a report

A comprehensive report should include-

1. The indication for the study
2. Details of stress technique used including the haemodynamic parameters during the test
3. Use of contrast
4. Symptoms occurring during the test, eg whether the patient had their typical symptoms during stress
5. Assessment of the 12 lead ECG findings if used.
6. Image quality: good/moderate/poor
7. LV size and function at rest and peak
8. Wall motion assessment/scoring at each stage – example pictured below. Most modern echo systems have a template for reporting based on a 16 segment model. The 17 segment model which includes the LV apex is less common due to the fact that in the true apical imaging plane the apex is stationary and therefore wall motion is less applicable.
9. Interpretation and diagnosis including a conclusion regarding the risk stratification.

Appendix 8: Stress Echo Accreditation: Summary Sheet

Complete this sheet and place it at the front of your Logbook

Name:..... Membership No.....

BSE/EACVI Accreditation valid until.....

Date of Passing Stress Echo Written Examination.....

Case collection period

Only one diagnosis can be assigned to each study.

Summarise the primary diagnosis assigned to each case in your Logbook. (Note the target guidelines for case mix)

| Primary Diagnosis | Number of cases |
|---|------------------------|
| Normal response (max 140) | |
| Ischaemic response (min 40 cases) | |
| Assessment of structural heart disease (min 20 cases) | |
| Total Cases by primary diagnosis (200) | |
| Use of exercise (Min 25 cases) | |
| Use of dobutamine (min 25 cases) | |
| Use of transpulmonary contrast (Min 50 cases) | |

Appendix 9: Mentor statement to accompany the Practical Assessment

Candidate's name _____

| | Initial |
|---|---------|
| I certify that the candidate has undergone a programme of training in stress echocardiography | |
| I certify I have observed the candidate scanning and I am satisfied that he/she is competent at completing a full stress echo study. | |
| I certify that the candidate has reached a standard of training to be able to independently perform and report a stress echocardiographic study. He/she has reached all of the mandated competencies. I have signed off the candidate's competency sheet. | |
| I certify that the candidate above has performed and reported the cases included in the accompanying Log Book within a 24-month period. | |
| I certify that all cases are fully anonymised (no patient's personal details such as names, full date of births or addresses) as per Appendix 13 | |
| I certify that all cases are signed with name printed of the candidate | |
| I certify that these cases are being handed in as per Trust Policy Guidelines | |

Mentor's name: _____

Signature: _____ Date: _____

I am satisfied that the candidate above has performed and reported the cases included in the accompanying Log Book within a 24-month period and five cases are also enclosed.

Medical/Technical Head of Echocardiography's name: _____

Signature: _____ Date: _____

Notes: The Head of Echocardiography is usually the lead clinician or consultant cardiologist with overall responsibility for echocardiography. This may be a representative from a local Cardiology department who has personally observed the candidate scanning and is satisfied that they have the ability to perform and report echoes independently.

Appendix 10: BSE Policy on the Non-Anonymisation of Patient Data

Introduction

The duty of confidentiality arises out of the common law of confidentiality, professional obligations and also staff employment contracts. Breach of confidence may lead to disciplinary measures, bring into question professional reputation and possibly result in legal proceedings.

Guidance is provided to NHS staff in the 'NHS Code of Practice on Confidentiality' (November 2003).
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069254.pdf

Patient information that can identify individual patients is confidential and must not be used or disclosed. In contrast, anonymised information is not confidential and may be used.

Key identifiable information includes:

Patient's name, address, full postcode, date of birth; NHS number and identifiable local codes; Anything else that may be used to identify a patient directly or indirectly. For example, rare diseases, drug treatment or statistical analyses which have very small numbers within a small population may allow individuals to be identified.

Anonymisation requires the removal of such information from all reports and images.

For accreditation purposes, BSE Administrators and BSE Assessors must not be able to identify the patient from the detail or combination of details given.

Speakers presenting on behalf of the BSE at meetings and speakers on courses/meetings awarded BSE re- accreditation points must ensure that all presentation material is anonymised.

Guidance to candidates submitting Logbooks and Cases for Accreditation

The NHS Code of Practice on confidentiality means that evidence submitted for the practical part of the Accreditation process must have all patient identification removed.

In order for evidence to be considered to have been anonymised, BSE Administrators and BSE Assessors must not be able to see any of the identifiers listed above. As age is relevant to the assessment either the age or year of birth must be provided however a full date of birth must not be shown.

Reports

Please note that correction fluid may still allow data to be visible if you look at the back of the page, as does placing a sticker over the patient data. Marker pen often fades so that data may

be correctly disguised at the point of anonymisation but not when brought to a Practical Assessment session

We therefore advise:

Submitting via the logbook portal with all patient details except age and gender removed

Or: cutting out the patient data

Or: Deleting data electronically before printing

Or: Using corrective fluid or marker pen, then photocopying the sheet

Cases

In order for cases to be classed as anonymous BSE Administrators and BSE Markers must not be able to gain personal information about the patient that is not directly relevant to the echocardiogram. This means that name, address, NHS/Hospital number and full date of birth must not be visible on the report that is enclosed with the images nor on the images themselves. If the age is not given separately the year of birth must be left visible on the report.

Please see the notes above about correctly removing patient ID from the paper report that is enclosed with the cases.

We appreciate that the removal of patient ID from cases may be difficult depending on the machine being used, we, therefore, advise that the cases are specifically collected for the BSE, and the data inputs are made relevant to your cases.

E.g. Patient Name could be 'BSE Case 1' or 'Aortic Stenosis', Patient Number could be your membership number followed by case number, '1111-1'

Explanatory notes for the inclusion of patient identifiable data in any medium are NOT acceptable.

Breach of NHS Code of Practice on Confidentiality

Major breach:

One or more examples of detailed patient demographics (e.g. name and address) OR

One or more examples of patient data sufficient to allow a patient to be traced in any way

Minor breach:

Examples of patient identifiable information found within the logbook. These might include, for example, first name or date of birth but insufficient information to identify the patient.

In the event of a major breach:

The candidate will automatically fail, and the candidate will be informed of the fail and notified of the reason for it. The Chair of the Accreditation Committee will be notified of all major breaches and will make the decision as to whether the Head of Information Governance at the candidate's place of employment should be informed.

In the event of a minor breach:

The candidate will be informed of the breach and notified of the reason for it. This will be taken into account in the marking scheme.

The final decision remains at the discretion of the Chair of the Accreditation Committee.

Appendix 11- Examples of Practical Assessment Marksheets for Station 1

| | Candidate Initials | Assessor Initials | Comments |
|---|--------------------|-------------------|----------|
| Logbook submitted in one ring binder/file or via logbook portal | | | |
| All cases collected within 24 month period unless Proof of Extension granted (attach email) | | | |
| 200 Stress Echo reports performed and reported by the candidate. All reports with full name and signature | | | |
| All cases fully anonymised | | | |
| Correct case mix | | | |
| Curriculum-based assessment tool (Appendix 6) | | | |
| Summary Sheet present (Appendix 9) | | | |
| Mentor statement present | | | |
| Final checklist present | | | |

| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
| Indication given for stress echo | | | | | | |
| Rhythm during test | | | | | | |
| Comment on resting LV global and segmental function | | | | | | |
| Type of stressor clear on the report | | | | | | |
| For exercise: Duration/workload on the treadmill/bike and reason for stopping exercise | | | | | | |
| For DSE: Peak dobutamine and Atropine dose (if used) | | | | | | |
| The comment about LV global and segmental function at peak stress | | | | | | |
| For structural- clear description of the relevant pathology | | | | | | |
| Conclusion | | | | | | |
| Pass or fail | | | | | | |

Appendix 12- Examples of Marksheets Station 2

| | |
|--|---|
| Acquisition should be of best quality Assessors will encourage candidates to move on once images obtained | You will have to declare beforehand whether you want to stress on a bike or treadmill so the correct set-up can be arranged for you. A volunteer will role play as a patient having an exercise stress echo for ischaemia testing. Please interact with him/her as you would a patient attending your stress list. |
| 1 | Check identity before starting |
| 2 | Assess safety to proceed – e.g. ask about allergies, check for unstable symptoms, check for severe aortic valve stenosis, serious arrhythmia or hypertension |
| 3 | Explain the test and consent the volunteer (verbal) |
| 4 | Identify if contrast is required- you should be able to discuss your decision-making processes. |
| 5 | Acquire Baseline images after adequate optimisation |
| 6 | Instruct your assistant (maybe the examiner or a designated physiologist from the host dept) regarding the protocol you want to use |
| 7 | Instruct the volunteer how you want them to proceed |
| 8 | Acquire low/intermediate/peak images (if bike) or post-peak images (if treadmill). The examiner will normally stop you when they have observed for long enough |

Mark scheme for Station 2: demonstration of performing a stress echo

| Performance Competency | Criteria | F | BF | BP | P | Weighting | Guidance | Max Score |
|--|---|---|----|----|---|-----------|---|-----------|
| Checks patient identity | Checks patient identity using 3 unique identifiers | 0 | 1 | 2 | 3 | 3 | Checks the correct patient identity. Award P if 3 unique identifiers are checked, BP if 2 unique identifiers are checked, BF if 1 unique identifier is checked and F if no checks are made. | |
| Baseline Requirements | Pays attention to detail and is able to record baseline parameters including assessment of AV at rest | 0 | 1 | 2 | 3 | 5 | Ensures resting BP is normal and No evidence of AS with acquisition of good quality 2D image and CW Doppler of the AV. Award P if high quality optimised image. BP if clinically satisfactory image with limited optimisation. BF if unable to accurately acquire image although is able to identify remedial measures. F if unable to reproduce image which reflects the PLAX in the specific model. | |
| Contrast Requirement and Associated risks of using contrast | Pays attention to detail and is able to recognise/acquire a good image | 0 | 1 | 2 | 3 | 5 | Operator must identify if the patient would require contrast administration. Award P if clear communication of this is demonstrated. BP is able to identify if contrast required or not although limited knowledge of potential issues with contrast and why the decision has been made. BF if able to identify if contrast is required and demonstrates many shortcomings in knowledge of why contrast could/should be used F if unable to identify why contrast could be used and is not able to outline the potential risks of contrast. | |
| Driving a stress protocol | Is able to inform patient and demonstrate knowledge of stress protocols | 0 | 1 | 2 | 3 | 5 | Award P if appears competent and knowledgeable about stress protocols, BP if lacking some knowledge but appears competent, BF if lacking a lot of knowledge but still safe to perform a stress study, F if deemed unsafe. | |
| Acquisition of baseline Apical Images | Pays attention to detail and is able to recognise/acquire a good image | 0 | 1 | 2 | 3 | 3 | Acquisition of good quality 2D Apical Images in required timeframe. Award P if high quality optimised image. BP if clinically satisfactory image with limited optimisation. BF if unable to accurately acquire image although is able to identify remedial measures. F if unable to reproduce image which reflects the Assessors image acquisition in the model. | |

Appendix 13- Examples of Mark sheets- Station 3

Video Case 1: Normal Dobutamine Stress Echo using transpulmonary contrast

| Competency | | Satisfactory | Unsatisfactory | Comments |
|------------|---|--------------|----------------|----------|
| 1 | ECG | | | |
| 2 | Pre-stress safety checks, eg severe aortic stenosis | | | |
| 3 | Contrast optimisation | | | |
| 4 | Baseline- All views present | | | |
| 5 | Low- all views present | | | |
| 6 | Intermediate- all views present | | | |
| 7 | Peak- all views present | | | |
| 8 | Recovery (optional) views | | | |
| 9 | Synchronised Quad-screen display | | | |
| 10 | Report - accurate | | | |

| Adult Stress Echo Accreditation | | | |
|---|------|--|------|
| Practice must be satisfactory in all areas to pass | | | |
| Evidence of satisfactory practice | Tick | Evidence of unsatisfactory practice | Tick |
| ECG: present throughout with good synchronisation | | ECG: Unstable or absent | |
| Optimisation: demonstrates good endocardial border definition with MI, gain, TGC controls | | Optimisation: Frequent, repetitive optimisation errors which detract from the case conclusion | |
| Complete study: Images are complete enough to allow assessment of ischaemia | | Incomplete study: Images are missing which are relevant to the assessment | |
| Report is complete and accurate | | Report is incomplete or inaccurate | |
| <ol style="list-style-type: none"> Comprehensive and accurate description of all LV segments Correct interpretation of findings in the clinical context | | <ol style="list-style-type: none"> Partial and inaccurate description of parts of the heart Incorrect categorisation of chosen pathology Incorrect interpretation of findings in the clinical context | |

Video Case 2: Normal Exercise Stress Study

| Competency | | Satisfactory | Unsatisfactory | Comments |
|------------|---|--------------|----------------|----------|
| 1 | ECG | | | |
| 2 | Pre-stress safety checks, eg severe AS | | | |
| 3 | Contrast optimisation (optional) | | | |
| 4 | Baseline- All views present | | | |
| 5 | Low- all views present (optional) | | | |
| 6 | Intermediate (optional) all views present | | | |
| 7 | Peak/post-peak- all views present | | | |
| 8 | Recovery (optional) views | | | |
| 9 | Synchronised multi-screen display | | | |
| 10 | Report - accurate | | | |

| Adult Stress Echo Accreditation | | | |
|---|------|---|------|
| Practice must be satisfactory in all areas to pass | | | |
| Evidence of satisfactory practice | Tick | Evidence of unsatisfactory practice | Tick |
| ECG: present throughout with good synchronisation | | ECG: Unstable or absent | |
| Optimisation: demonstrates good endocardial border definition with MI, gain, TGC controls | | Optimisation: Frequent, repetitive optimisation errors which detract from the case conclusion | |
| Complete study: Images are complete enough to allow assessment of ischaemia | | Incomplete study: Images are missing which are relevant to the assessment | |
| Report is complete and accurate | | Report is incomplete or inaccurate | |
| 3. Comprehensive and accurate description of all LV segments 4. Correct interpretation of findings in the clinical context | | 4. Partial and inaccurate description of parts of the heart 5. Incorrect categorisation of chosen pathology 6. Incorrect interpretation of findings in the clinical context | |

Video Case 3: Ischaemic stress study

| Competency | | Satisfactory | Unsatisfactory | Comments |
|------------|---|--------------|----------------|----------|
| 1 | ECG | | | |
| 2 | Pre-stress safety checks, eg severe AS | | | |
| 3 | Contrast optimisation (optional) | | | |
| 4 | Baseline- All views present | | | |
| 5 | Low- all views present (optional) | | | |
| 6 | Intermediate (optional) all views present | | | |
| 7 | Peak/post-peak- all views present | | | |
| 8 | Recovery (optional) views | | | |
| 9 | Synchronised multi-screen display | | | |
| 10 | Report - accurate | | | |

| Adult Stress Echo Accreditation | | | |
|--|------|---|------|
| Practice must be satisfactory in all areas to pass | | | |
| Evidence of satisfactory practice | Tick | Evidence of unsatisfactory practice | Tick |
| ECG: present throughout with good synchronisation | | ECG: Unstable or absent | |
| Optimisation: demonstrates good endocardial border definition with MI, gain, TGC controls | | Optimisation: Frequent, repetitive optimisation errors which detract from the case conclusion | |
| Complete study: Images are complete enough to allow assessment of ischaemia | | Incomplete study: Images are missing which are relevant to the assessment | |
| Report is complete and accurate 5. Comprehensive and accurate description of all LV segments 6. Correct segmental analysis 7. Correct correlation to coronary circulation | | Report is incomplete or inaccurate 7. Partial and inaccurate description of LV segments 8. Incorrect segmental analysis 9. Incorrect correlation to coronary circulation | |

Video Case 4: Viability study

| Competency | | Satisfactory | Unsatisfactory | Comments |
|------------|--|--------------|----------------|----------|
| 1 | ECG | | | |
| 2 | Pre-stress safety checks eg severe AS | | | |
| 3 | Contrast optimisation (optional) | | | |
| 4 | Baseline- All views present | | | |
| 5 | Low- all views present | | | |
| 6 | Intermediate- all views present | | | |
| 7 | Peak (if hybrid study) - all views present | | | |
| 8 | Recovery (optional) views | | | |
| 9 | Synchronised multi-screen display | | | |
| 10 | Report - accurate | | | |

| Adult Stress Echo Accreditation Practice must be satisfactory in all areas to pass | | | |
|---|------|--|------|
| Evidence of satisfactory practice | Tick | Evidence of unsatisfactory practice | Tick |
| ECG: present throughout with good synchronisation | | ECG: Unstable or absent | |
| Optimisation: demonstrates good endocardial border definition with MI, gain, TGC controls | | Optimisation: Frequent, repetitive optimisation errors which detract from the case conclusion | |
| Complete study: Images are complete enough to allow assessment of viability | | Incomplete study: Images are missing which are relevant to the assessment | |
| Report is complete and accurate 8. Comprehensive and accurate description of all LV segments 9. Correct segmental analysis 10. Correct correlation to coronary circulation | | Report is incomplete or inaccurate 10. Partial and inaccurate description of LV segments 11. Incorrect segmental analysis 12. Incorrect correlation to coronary circulation | |

Video Case 5: Structural stud

| Competency | | Satisfactory | Unsatisfactory | Comments |
|------------|---|--------------|----------------|----------|
| 1 | ECG | | | |
| 2 | Pre-stress study to show all TTE images relevant to pathology | | | |
| 3 | Image optimisation | | | |
| 4 | Baseline- All views present | | | |
| 5 | Low- all views present (if relevant to pathology) | | | |
| 6 | Intermediate- all views present (if relevant to pathology) | | | |
| 7 | Peak - all views present (if relevant to pathology) | | | |
| 8 | Recovery views (if relevant to pathology) | | | |
| 9 | Synchronised multi-screen display | | | |
| 10 | Report - accurate | | | |

| Adult Stress Echo Accreditation | | | |
|--|------|---|------|
| Practice must be satisfactory in all areas to pass | | | |
| Evidence of satisfactory practice | Tick | Evidence of unsatisfactory practice | Tick |
| ECG: present throughout with good synchronisation | | ECG: Unstable or absent | |
| Optimisation: demonstrates otpimisation of relevant pathology | | Optimisation: Frequent, repetitive optimisation errors which detract from the case conclusion | |
| Complete study: Images are complete enough to allow assessment of pathology | | Incomplete study: Images are missing which are relevant to the assessment | |

Appendix 14: Final Checklist for candidates.

Please complete and bring to your Practical Assessment. Some of these documents are included in the online logbook.

| App | | | Comments |
|---|-----|----|----------|
| | YES | NO | |
| Logbook submitted in one ring binder /file with dividers: must be via portal from January 2020. | | | |
| All cases collected within a 24-month period. | | | |
| 200 reports performed and reported by the candidate All reports with full name and signature or e-signature. | | | |
| All cases fully anonymised | | | |
| Correct case mix. | | | |
| Curriculum based assessment (Appendix 6) tool signed | | | |
| Summary sheet present (Appendix 8). | | | |
| Mentor statement Present (Appendix 9) and signed. | | | |