Case Title: Acute Chest Pain

Age: 58 years, Sex: Male, Past Medical History: Hypertension, hyperlipidemia, type 2 diabetes mellitus; Medications: Metformin, Lisinopril, Atorvastatin

№	Skill Assessment Criteria	Action Algorithm
1	Measurement of vital signs	Measure blood pressure, heart rate, respiratory rate, and oxygen saturation. Record values accurately. Monitor for hypotension, tachycardia, or hypoxia.
2	Assessment of chest pain	Ask patient about the onset, duration, character, and location of chest pain. Evaluate aggravating and relieving factors. Document using OPQRST (Onset, Provocation, Quality, Radiation, Severity, Time).
3	Physical examination	Perform inspection, palpation, and auscultation. Look for signs of heart failure (e.g., edema, jugular venous distension), abnormal heart sounds, and lung congestion.
4	ECG acquisition and interpretation	Place ECG electrodes according to standard 12-lead placement. Record ECG and identify ST-segment changes, T-wave inversions, or pathological Q waves.
5	Laboratory evaluation	Ensure blood samples are taken for cardiac biomarkers (e.g., troponin, CK-MB). Record timing of sample collection.
6	Risk stratification	Assess risk using tools like GRACE or TIMI score. Consider patient history, ECG changes, biomarkers, and hemodynamic status. Document findings.
7	Administration of acute therapy	Administer oxygen if needed, antiplatelets (aspirin), nitrates, and analgesics according to guidelines. Monitor patient response and adverse effects.
8	Continuous monitoring and reassessment	Continuously monitor vital signs, symptoms, and ECG changes. Adjust therapy based on patient condition. Record all interventions and observations.

Duration– 10min.

EVALUATION SHEET (CHECKLIST)
Specialty: Cardiology

Date «__» _____ 20__ y. Accredited Person Number _____

Assessed Practical Skill: History taking. Assessment of chest pain

№	Skill / Task	Steps / Action	Done (✓)	points
1	Measure vital signs	Measure BP, HR, RR, SpO_2 accurately. Note hypotension, tachycardia, or hypoxia.		1
2	History taking / Assess chest pain	Ask about onset, duration, character, location, radiation, severity, triggers, relief. Document using OPQRST.		3
3	Perform physical exam	Inspect, palpate, auscultate for edema, jugular venous distension, abnormal heart sounds, lung crackles.		1
4	ECG acquisition	Place 12-lead electrodes correctly. Record ECG. Identify ST changes, T-wave inversions, pathological Q waves.		1
5	Laboratory assessment	Collect blood for cardiac biomarkers (troponin, CK-MB). Record collection time.		1
6	Risk stratification	Use GRACE or TIMI score. Consider history, ECG, biomarkers, hemodynamics. Document findings.		1
7	Initiate acute therapy	Administer oxygen if needed, aspirin, nitrates, analgesics per guidelines. Monitor for effect and side effects.		1
8	Continuous monitoring	Monitor vitals, symptoms, ECG changes. Adjust therapy as required. Record all observations.		1

Examiner's full name: Signature: Database entry status: Entered / Not entered

6 points – "3"; 7-8 points – "4" ; more than 8 points– "5"

The Examinee's Workplace

The examinee's workplace simulates a clinical environment of healthcare facilities and includes the necessary equipment and consumables.

Materials, Equipment, and Station Setup:

1. Blood pressure monitors
2. Stethoscope
3. ECG machine
4. Height measuring device (stadiometer)
5. Weighing scale
6. Examination couch
7. Video cameras in each station

Medications:

1. Nitroglycerin (tablets, spray)
2. Aspirin / Clopidogrel
3. Heparin
4. Beta-blockers (e.g., Metoprolol)
5. ACE inhibitors
6. Diuretics (e.g., Furosemide)
7. Antiarrhythmic drugs (Amiodarone, Lidocaine)
8. Medications for management of hypertensive crisis

Case Title: Chronic Heart Failure
Age: 65 years, Sex: Female

Past Medical History: Hypertension, ischemic heart disease, chronic kidney disease
Medications: Furosemide, Lisinopril, Metoprolol, Spironolactone

№	Skill Assessment Criteria	Action Algorithm
1	Measurement of vital signs	Measure BP, HR, RR, SpO_2, and weight. Monitor for hypotension, tachycardia, or signs of fluid overload (e.g., sudden weight gain). Record accurately.
2	Symptom assessment	Ask about dyspnea (at rest or exertion), orthopnea, paroxysmal nocturnal dyspnea, fatigue, edema, and exercise tolerance. Document symptom severity and timing.
3	Physical examination	Inspect, palpate, and auscultate for signs of CHF: peripheral edema, jugular venous distension, pulmonary crackles, displaced apex beat, S3 gallop. Check for hepatomegaly and ascites if indicated.
4	Laboratory evaluation	Ensure blood tests are taken: BNP/NT-proBNP, renal function, electrolytes. Record timing and results.
5	ECG and imaging	Obtain ECG and check for arrhythmias, LV hypertrophy, previous MI. Consider echocardiography to assess ejection fraction and valvular abnormalities.
6	Risk stratification	Assess NYHA functional class. Evaluate comorbidities, vital signs, lab results, and imaging to guide prognosis and therapy. Document findings.
7	Medication review and adjustment	Review current medications (diuretics, ACE inhibitors, beta-blockers, aldosterone antagonists). Adjust therapy based on symptoms, labs, and BP. Monitor for adverse effects.
8	Patient education	Advise on fluid and salt restriction, daily weight monitoring, recognition of worsening symptoms, and adherence to medications.
9	Continuous monitoring	Monitor vital signs, weight, symptoms, and lab parameters. Adjust therapy based on clinical changes. Record interventions and observations.

Duration– 10min.

EVALUATION SHEET (CHECKLIST)
Specialty: Cardiology

Date «__» _____ 20__ y. Accredited Person Number _____

Assessed Practical Skill: Examination of a patient with chronic heart failure

№	Skill / Task	Steps / Action	Done (✓)	Points
1	Measure vital signs	Measure BP, HR, RR, SpO_2 accurately. Note hypotension, tachycardia, or hypoxia.		1
2	History taking / Assess chest pain	Ask about onset, duration, character, location, radiation, severity, triggers, relief. Document using OPQRST.		1
3	Perform physical exam	Inspect, palpate, auscultate for edema, jugular venous distension, abnormal heart sounds, lung crackles.		2
4	ECG acquisition	Place 12-lead electrodes correctly. Record ECG. Identify ST changes, T-wave inversions, pathological Q waves.		1
5	Laboratory assessment	Collect blood for cardiac biomarkers (troponin, CK-MB). Record collection time.		1
6	Risk stratification	Use GRACE or TIMI score. Consider history, ECG, biomarkers, hemodynamics. Document findings.		1
7	Initiate acute therapy	Administer oxygen if needed, aspirin, nitrates, analgesics per guidelines. Monitor for effect and side effects.		1
8	Continuous monitoring	Monitor vitals, symptoms, ECG changes. Adjust therapy as required. Record all observations.		1
9	Recognize normal vs abnormal	Know normal HR (60–100 bpm), BP (~120/80 mmHg), ECG pattern. Identify deviations suggesting ACS.		1

Examiner's full name: _____

Signature: _____

Database entry status: Entered / Not entered

6 points – "3"; 7-8 points – "4" ; more than 8 points– "5"

The Examinee's Workplace

The examinee's workplace simulates a clinical environment of healthcare facilities and includes the necessary equipment and consumables.

Materials, Equipment, and Station Setup:

8. Blood pressure monitors
9. Stethoscope
10. ECG machine
11. Height measuring device (stadiometer)
12. Weighing scale
13. Examination couch
14. Video cameras in each station

Medications:

9. Nitroglycerin (tablets, spray)
10. Aspirin / Clopidogrel
11. Heparin
12. Beta-blockers (e.g., Metoprolol)
13. ACE inhibitors
14. Diuretics (e.g., Furosemide)
15. Antiarrhythmic drugs (Amiodarone, Lidocaine)
16. Medications for management of hypertensive crisis

Case Title: Sinus Bradycardia
Age: 60 years, Sex: Male
Past Medical History: Hypertension, Coronary Artery Disease
Medications: Metoprolol, Lisinopril

№	Skill Assessment Criteria	Action Algorithm
1	Measurement of vital signs	Measure BP, HR, RR, SpO_2. Note bradycardia (HR < 60 bpm), hypotension, or signs of poor perfusion (cold extremities, dizziness). Record accurately.
2	Symptom assessment	Ask about dizziness, syncope, weakness, fatigue, chest pain, or shortness of breath. Document onset, duration, and severity.
3	Physical examination	Inspect, palpate, and auscultate. Assess pulse rate and regularity, capillary refill, mental status, and signs of hemodynamic instability.
4	Laboratory evaluation	Check electrolytes (K^+, Mg^{2+}), thyroid function (TSH), glucose, and if indicated, cardiac biomarkers. Record timing and results.
5	ECG evaluation	Obtain a 12-lead ECG. Identify sinus bradycardia, PR interval, QRS duration, and any conduction abnormalities (e.g., AV block). Compare with previous ECG if available.
6	Identification of underlying causes	Evaluate for medication effects (beta-blockers, CCBs, digoxin), hypothyroidism, ischemia, electrolyte imbalances, or vagal stimulation. Document suspected cause.
7	Management and intervention	Determine if patient is stable or unstable. For symptomatic bradycardia, prepare for guideline-based treatment (e.g., atropine). If unstable, anticipate need for temporary pacing. Monitor response.
8	Patient education	Advise on medication adherence, avoiding self-adjusting doses, recognizing worsening symptoms (dizziness, syncope), and when to seek urgent care.
9	Continuous monitoring	Monitor vital signs, symptoms, and ECG rhythm regularly. Reassess after interventions. Document all findings and actions.

Duration– 10min.

EVALUATION SHEET (CHECKLIST)
Specialty: Cardiology

Date «__» _____ 20__ y. Accredited Person Number _____

Assessed Practical Skill: Performing ECG examination

№	Skill / Task	Steps / Action	Done (✓)	Points
1	Prepare equipment & patient	Check ECG machine, explain procedure, ensure patient comfort and privacy.		0.5
2	Skin preparation	Clean skin, dry electrode sites, remove hair if needed for proper contact.		0.5
3	Correct electrode placement	Place limb leads (RA, LA, RL, LL) and chest leads V1–V6 in standard positions.		2
4	Record ECG	Ask patient to stay still and breathe normally. Record tracing without artifacts.		0.5
5	Determine heart rate	Calculate HR; identify bradycardia, tachycardia, or irregular rhythm.		1
6	Assess rhythm	Check P waves, P-QRS relationship, determine if sinus rhythm.		1
7	Evaluate intervals	Measure PR, QRS, and QT intervals. Note prolongation or shortening.		
8	Check QRS axis	Determine axis (normal, left deviation, right deviation).		1
9	Analyze waveforms	Inspect P wave, QRS complex, ST segment, T wave for abnormalities (ischemia, block, hypertrophy).		1
10	Documentation	Record findings: rate, rhythm, intervals, axis, abnormalities, clinical impression.		0.5

6 points – “3”; 7-8 points – “4” ; more than 8 points– “5”

The Examinee's Workplace

The examinee's workplace simulates a clinical environment of healthcare facilities and includes the necessary equipment and consumables.

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15. Blood pressure monitors
16. Stethoscope
17. ECG machine
18. Height measuring device (stadiometer)
19. Weighing scale
20. Examination couch
21. Video cameras in each station

Medications:

17. Nitroglycerin (tablets, spray)
18. Aspirin / Clopidogrel
19. Heparin
20. Beta-blockers (e.g., Metoprolol)
21. ACE inhibitors
22. Diuretics (e.g., Furosemide)
23. Antiarrhythmic drugs (Amiodarone, Lidocaine)
24. Medications for management of hypertensive crisis