



Accreditation in Adult Critical Care Echocardiography (ACCE) Information Pack

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

30 April 2026

This document supersedes all previous versions.

This document is a guide to completing BSE ACCE accreditation

Submission and assessment criteria are included



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Welcome message from the Chair of Accreditation

Dear Candidate,

Welcome to the British Society of Echocardiography (BSE). The process underlying accreditation is set up to assist the echocardiographer in training with the ultimate aim of achieving and maintaining a high standard of clinical echocardiography for the benefit of our patients.

The Adult Critical Care Accreditation (ACCE) process represents a joint venture between the BSE and the Intensive Care Society (ICS) and is primarily offered as a service to the members of both these specialist societies. It is designed to accommodate the requirements of those working within the Critical Care environment.

The accreditation process is regulated to ensure high proficiency and professional standards. We aim to enable as many members as possible to achieve accreditation. A list of accredited members is maintained on the BSE website.

Please remember that we are here to support you throughout this process. If you need any assistance or have constructive feedback to offer the accreditation committee, please don't hesitate to let us know. We are committed to your success.

Good luck with your accreditation process.

Best wishes,

Michâel Purdon

Chair, BSE Accreditation Committee



Introduction & aims

- Accreditation is a service for BSE members and is not a compulsory or regulatory certificate of competence or excellence.
- Accredited members are expected to be able to perform and report echocardiographic studies unsupervised.
- The Accreditation process consists of a written theory examination and a practical assessment. This pack provides further instructions for both.
- Accreditation is a minimum requirement and cannot be regarded as a guarantee of competence.
- Echocardiography skills can only be maintained by continued education and practical involvement in echocardiography. This is underlined by limiting accreditation to five years, after which re-accreditation must be sought. Further details surrounding re-accreditation are available in the re-accreditation section on the BSE website.
- Accredited members are expected to uphold the BSE code of conduct standards. Where concerns about an accredited member's echocardiography practice arise, they should be dealt with locally in the first instance and escalated to the Accreditation Chair only if improvement in echocardiography practice has not been demonstrated.
- [Return-to-practice pathways](#) for reaccreditation are available for previously accredited members.
- [International candidates](#) working outside the United Kingdom must pass the logbook section of the practical examination before booking a place on a practical assessment day. This will help the Society manage capacity, and candidates manage their travel arrangements (including visas, where necessary) for overseas candidates.

Summary of process requirements

1. The candidate must be a member of the BSE.
2. Candidates must have a designated mentor to assist them through the accreditation process.
3. The accreditation process has two compulsory elements: a written theory examination and a practical assessment. **You must pass both elements to become an accredited member.**
4. The written theory exam comprises A multiple-choice question (MCQ) theory section and a "best answer" image reporting section.
5. The practical assessment consists of a logbook, a practical scanning assessment, and a viva assessment of five patient case studies.
6. The candidate must pass the written assessment before registering to attend the practical assessment.
7. The logbook should be collected within 36 months of the written examination.



Any queries regarding the accreditation process should be addressed to the BSE Accreditation Department; contact details and registrations are available at www.bsecho.org.

Tel: 0208 065 5794 (lines open from 09:00-17:00 Mon-Fri). Email: accreditation@bsecho.org.

Exam fees

A fee of £375 is charged for the complete accreditation process. This fee is payable upon registration for the written section of the examination and covers the practical assessment. There is a non-refundable booking fee of £50 upon registering for a secured placement at the practical assessment.

Candidates who are unsuccessful in the written section of the examination will be charged a reduced fee of £187.50 to re-sit this section. This reduced fee only applies to the second attempt if taken within 12 months of an unsuccessful first attempt.

Candidates are entitled to one re-attempt at the practical assessment. A re-attempt at the practical assessment is subject to an additional fee of £187.50.

Fee increases may occur annually.

Extensions

Extensions to the 36-month deadline may be granted. Extension request forms must be submitted **before the submission deadline**. Requests received after the case deadline may not be granted.

Less-than-full-time extensions are available for up to 24 months for candidates working less than full-time as stipulated by their contracted hours. Further information can be found on the BSE website's [extension request](#) page.

Appeals

Candidates can appeal the decision on a practical assessment result. **There is no appeals process for the written section of the examination.** Further information on applying for an appeal can be found on the [practical assessment](#) page of the BSE website.

Mentor

A mentor is an experienced echocardiographer who can successfully guide a candidate through the BSE accreditation process. If the echocardiographer is BSE accredited, this is an advantage but not essential.

The mentor should understand the accreditation process, including the training syllabus (see Appendix 1) and all relevant assessment criteria.

The mentor must assess the candidate's ability to perform an echocardiogram proficiently. Once a proficient level of ability is achieved, the mentor must complete the curriculum-based competency tool and the mentor statements. These can be accessed and completed via the online logbook portal. The curriculum-based competency tool can also be found in Appendix 2.



The accreditation process cannot be completed without the support of a mentor. Ongoing supervision is essential to the accreditation process. **Candidates should only pursue accreditation when they have a designated mentor.** Candidates may have more than one mentor if working between Hospitals.

Written Theory Examination

Appendix 1 contains the whole training syllabus for this accreditation process, and Appendix 3 includes a recommended reading list.

The written theory examination is held up to twice a year (subject to demand). It is held at various Pearson VUE centres across the UK, the Republic of Ireland, and some overseas locations. Registration dates are announced on the written assessment section of the BSE website. See Appendix 4 for registration guidance.

The written examination has two parts: an MCQ theory section and an Image reporting section. To pass the written examination overall, it is necessary to pass both parts at the same exam sitting.

If the first attempt is unsuccessful, candidates may be eligible to retake the exam at a reduced rate.

Reduced rate: This applies only to a second attempt taken within 12 months of the first attempt. If the second attempt is unsuccessful, the next attempt will be charged at the full fee.

There is no bar to re-sitting the written examination any number of times.

The pass mark for the MCQ section is 70%, and for the image reporting section, 60%. Following moderation, the Accreditation Chair may decide to vary these slightly.

Accreditation is awarded once a candidate has successfully completed the practical assessment. Satisfactory performance at the written assessment alone does not allow 'partial accreditation.'

Multiple-choice section

- Consists of 25 questions that must be answered within 60 minutes.
- Questions are designed to test the knowledge of echocardiographic findings, basic cardiology and the physics of ultrasound.
- Each question comprises a brief statement followed by five questions. Candidates are required to answer 'true' or 'false' to each question. Example questions are provided in Appendix 5.
- This part of the examination will be marked +1 for correct answers and 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, every answer can be false or, every answer to be true or any combination of true or false.
- **The maximum possible mark is 125.**



Image reporting section

- Consists of 50 questions centred around 10 patient case studies that must be answered within 90 minutes.
- The candidate will be presented with 10 patient case studies. Each case study will consist of relevant patient details and various echocardiographic images.
- For each case study, the candidate must answer five questions. Each question will have four possible answers; the candidate must select the best single answer. An example case study and questions are provided in Appendix 6.
- **The maximum possible mark is 50.**

Practical Assessment

The practical assessment is held up to four times per year (subject to candidate demand). Dates, locations and online registration instructions are announced on the practical assessment section of the BSE website.

The **practical assessment has three parts**: a 250-case logbook, a practical scanning assessment, and a viva assessment of five patient case studies.

All candidates must attend an assessment within 38 months of starting the accreditation process (i.e., within two months of their case collection deadline). A two-month grace period gives the candidate time to review, prepare, and submit the logbook and five viva cases.

- Registration for the practical assessment should **ONLY** be sought after collecting the logbook and patient case studies.
- It is the candidate's responsibility to complete online registration forms and update personal information correctly.
- If you have any concerns about the information provided, you should contact the [accreditation team](#) for guidance and support.

Logbook submission

The logbook should demonstrate the candidate's ability to meet the competencies, as shown in Appendix 2. The specific case mix of the logbook is shown below.

It should consist of **250 reports** personally **performed and reported** by the candidate during the specified 36-month period.

If the candidates hold **BSE or EACVI TOE Accreditation**, the logbook is reduced to 150 reports. The logbook numbers are not reduced for candidates holding EAVCI TTE accreditation.

The logbook format is a copy of the actual clinical report. The reports must be uploaded and submitted via the BSE online logbook portal. Please contact accreditation@bsecho.org for access.

Non-portal logbooks will not be accepted.

Please see Appendix 7 for full details of what is expected in reports and how the logbook is marked.



Duplicate reports are not acceptable.

If you have problems finding enough specific cases, discuss this with your mentor, who may consider arranging for you to attend a nearby centre.

The logbook should reflect the candidate's best clinical practice. As such, targeted scans should not be included unless they show significant and rare pathology.

Competencies and mentor statements are to be completed via the BSE online logbook portal.

Fully subscribed BSE members can request access to the portal before taking the written examination by emailing accreditation@bsecho.org.

The logbook should reflect the normal case-load of a general adult department with the following constraints:

- At least 25 cases should be for assessment of the shock state.
- At least 25 cases should be for valve disease assessment.
- At least 10 cases should be for right heart assessment.
- At least 5 cases should be for pericardial disease/effusion assessment.
- At least 15 cases should be for volume status and volume responsiveness.
- At least 3 cases should be for abnormalities of the aorta.
- At least 2 cases should be for confirmed endocarditis, mass or thrombus.
- 1. At least 10 cases should be for refractory hypoxaemia / difficult to wean.
- 2. At least 3 cases should be for complications of acute myocardial infarction.
- A maximum of 50 cases should be for ICU re-assessment studies.
- A maximum of 50 cases should be for no significant abnormality.

Other information regarding the logbook:

- **All patient-identifiable data needs to be removed.** This may require the manual removal of identifiable data. See Appendix 9.
- **At least the final 150 cases** should be reported primarily by the candidate, although another operator may check them.
- **Logbook reports should reflect the latest [BSE guidance](#).** Where local policy deviates from this, a supporting letter (and current standing operating procedure) from the department echo lead stating local policy should be included. This should be submitted under the "Supporting information" section on the BSE logbook portal.
- **The candidate's name must appear on the report as the performing and reporting echocardiographer/sonographer.** Where local policy deviates from this, a supporting letter and current standard operating procedure from the department's Echo lead stating local policy should be included. This should be submitted under the "**supporting information**" section on the BSE logbook portal.
- The department's echo lead completes the logbook's final sign-off / validation.



Scanning Assessment

This part of the assessment is designed to assess a candidate's practical scanning ability and ability to perform basic image optimisation.

A candidate must acquire up to 10 different echocardiographic imaging views within 20 minutes. A real-life model or simulator may be used.

- All imaging views used in this assessment are taken from the minimum BSE transthoracic echocardiography dataset.
- A pass mark/trigger score of 66% is used. Once obtained, the candidate will be deemed successful at this part of the assessment process.
- The candidate is not expected to be familiar with the equipment. The Assessor will alter the equipment setting as directed by the candidate.
- For full details of the practical scanning marking criteria, please see Appendix 10.

Viva case submission

Consists of a viva assessment of five separate patient case studies. See below for the required case mix.

The candidate will be expected to discuss their patient cases with the Assessor. All five cases may be reviewed.

For full details of the viva case marking criteria, please see Appendix 11.

The case studies should be assessed using the most up-to-date BSE guidance. Candidates are expected to know this guidance, and local deviations in practice **will not** be accepted.

The cases must represent a complete, high-quality study. They should be accompanied by a printed report that is complete and comprehensive and reflects the patient case study presented.

The candidate must ensure that at least one complete cardiac cycle is recorded. The cases must play automatically / continuously within a PowerPoint presentation (or equivalent). Cases that do not play appropriately may be classified as an unsuccessful attempt.

Candidates must bring and present their patient case studies on their own laptop. It is the candidate's responsibility to ensure these are anonymised and can be viewed in a manner that allows an assessment of the cases being presented.

Up to three studies may be performed outside the critical care setting, and two should be performed in the critical care setting.

The patient case studies should include:

1. A study showing no significant abnormality.
2. Fluid responsiveness and volume status assessment in a critically unwell patient.
3. Cardiogenic shock of any cause in a critically unwell patient.

Patient case studies four and five should include any of the below pathologies:

- a. At least moderate valvular dysfunction.
- b. Significant pericardial effusion.
- c. Intra-cardiac mass.



- d. Significant structural abnormality such as severe left ventricular hypertrophy or hypertrophic obstructive cardiomyopathy.

****Patient case studies may be used in subsequent BSE written exams, educational and training sessions.****

Practical assessment - outcomes and process for re-attempts (resubmissions)

A candidate will have two attempts at passing the practical assessment part of the accreditation process. A second attempt (referred to as resubmission) at the practical assessment is subject to a fee of £187.50.

- **If a candidate is successful** in all three parts of the practical assessment, the candidate will be awarded BSE accreditation and will join the [accredited member list](#).
- **If a candidate is unsuccessful** in any of the three parts of the practical assessment, the candidate will be deemed unsuccessful at this first attempt. The candidate will be given constructive feedback to facilitate a re-attempt. The candidate may be requested to resubmit logbook reports/patient case studies. **These must be new reports / patient case studies.** A candidate is not permitted to resubmit previously assessed work under any circumstances.
- If a candidate fails the second attempt (resubmission), the accreditation process must start over, with the candidate undertaking the written examination again.

In the event of an unsuccessful attempt, the candidate is required to:

Attend another practical assessment and re-attempt **ONLY** the parts of the practical assessment that the candidate was unsuccessful at in the first attempt. The pass marks from the remaining practical assessment elements will be upheld.

The timescale allowed for re-attempts (resubmissions) will depend on which elements were unsuccessful and the candidates' current and future work commitments. This will be discussed with the candidate during the first attempt. Typical timeframes may include 3-9 months and can be up to 12 months following the first attempt.

Our feedback consistently demonstrates that non-face-to-face feedback does not adequately equip a candidate to pass at the next sitting. Therefore, all re-attempts at the practical assessment require the candidate's attendance in person to facilitate adequate and helpful face-to-face feedback*

****We may authorise virtual or remote submissions, subject to committee approval. If remote submission is approved, the reassessment will occur on or near a practical assessment day or during the logbook marking cycle before a practical assessment (only if submitted by the logbook marking deadline as announced online).***

Appendix 1: Training Syllabus



The following sections form the minimum suggested training syllabus for this accreditation process.

Candidates should use this as a guide to prepare for this accreditation process's written and practical assessments.

1. The role of TTE in the critically ill patient

- Awareness of the potential for TTE to guide first-line management of the critically ill
- Awareness of important pathology that can be missed by TTE
- Awareness of specific indications for TOE examination
- Appropriate action and *in*action in relation to clinical findings
- Awareness of indications for immediate expert assistance
- Knowledge of common indications in acute/critical care
- Knowledge of the relationship between TTE, TOE and other methods of assessing cardiac status (e.g. MRI)
- Knowledge of the potential hazardous biological effects of ultrasound eg. heating/resonance

1.1 Service design and provision

- Awareness of mechanisms for safe devolution of critical care echocardiography
- Awareness of how to design a service to suit local need
- Awareness of the importance of linking cardiology and critical care services
- Appreciation of service costs: outlay and ongoing
- Awareness of issues surrounding staff training
- Knowledge of the importance of quality control within devolved echo services
- Awareness of equipment maintenance including infection control

1.2 Professional relationships

- Awareness of providing patient explanations relevant to the clinical setting
- Awareness of maintaining professional interdepartmental relationships with colleagues

1.3 Reporting and Documentation

- Knowledge of standard report structure
- Awareness of accurate documentation of cardiorespiratory support at the time of the study
- Awareness of the distinction and importance of both a technical and clinical report
- Awareness of the Data Protection Act with respect to echocardiography reporting
- Awareness of the need for appropriate storage systems for echocardiograms
- Awareness of digital acquisition and storage systems, scan converters and digital memories



2. Imaging Physics & Instrumentation

2.1 Concepts and Terminology

- Knowledge of compression wave definitions: frequency, wavelength, propagation velocity and their units of measurement
- Knowledge of the differences between audible and ultrasound frequencies

2.2 Propagation of ultrasound through tissues

- Knowledge of the speed of sound in different body tissues
- Knowledge of the frequency range used for diagnostic imaging
- Knowledge of the distinction between specular reflection and backscatter
- Knowledge of the principles of attenuation and scattering

2.3 Ultrasound Transducers

- Knowledge of the piezo-electric effect
- Knowledge of the structure of the 2D ultrasound beam including far (Fraunhofer) and near (Fresnel) zones and the importance of side lobes
- Knowledge of beam steering methods: mechanical vs electronic
- Knowledge of focusing methods including dynamic receive focusing
- Knowledge of appropriate focus position and use of dual focus

2.4 Imaging physics

- Knowledge of appropriate imaging frequencies in adults
- Knowledge of the effect of harmonics on imaging quality
- Knowledge of B mode and M Mode imaging methods
- Knowledge of the relationship between pulse repetition frequency, frame rate, lines per frame, field of view, and imaging depth.
- Awareness of 'parallel processing' and influence on frame rate and image quality
- Knowledge of the grey scale and dynamic range
- Knowledge of optimisation of resolution: axial, lateral and temporal
- Knowledge of reverberation artefacts
- Knowledge of factors limiting detection of small targets

2.5 Echo Instrumentation

- Knowledge of machine controls: overall gain, time gain compensation, reject, and logarithmic compression
- Knowledge of signal processing, dynamic range, pre-processing and post processing
- Knowledge of correct imaging optimisation including transducer frequency, scan angle, spatial and temporal smoothing

2.6 Optimising Images

- Awareness of the importance of optimal patient positioning



- Appreciation of the importance of the use of echo gel and the relevant infection risk
- Knowledge of all standard views
- Awareness of the potential and pitfalls for the use of non-standard views

3. Doppler physics & fluid dynamics

3.1 Basic Fluid Dynamics

- Knowledge of fluid flow: significance of peak and mean velocities
- Knowledge of determination of volumetric flow using the continuity equation
- Knowledge of laminar and turbulent flow: Reynolds' equation (qualitative)
- Knowledge of the transition from laminar to turbulent flow: inlet jet Bernoulli equation

3.2 Principles of Doppler

- Knowledge of the generation of the Doppler effect by red blood cells and ultrasound waves
- Knowledge of the Doppler equation and factors influencing the magnitude of Doppler shift
- Knowledge of the concept of spectral analysis: fast Fourier transform (qualitative)
- Knowledge of the spectral Doppler display: mean, modal and peak velocities
- Awareness of the limitation of CW Doppler caused by lack of depth discrimination
- Knowledge of the audible range of Doppler shift frequencies
- Knowledge of the effect of beam angle errors on Doppler velocities
- Knowledge of the concept of aliasing including cause and clinical manifestation
- Knowledge of the Nyquist limit
- Knowledge of the influence of transducer frequency/sample depth/beam angle on aliasing
- Awareness of high pulse repetition frequency PW Doppler and range ambiguity
- Awareness of the advantages and disadvantages of CW, PW and HPRF modes
- Knowledge of the concept of colour flow imaging as multi-sampled PW
- Knowledge of the effect of aliasing when using colour Doppler
- Appreciation of the effect of packet size/colour mode/sector size on frame rate and aliasing
- Awareness of the principles of pulse wave tissue Doppler

4. Doppler instrumentation

4.1 Spectral Doppler Instrumentation

- Awareness of the appropriate use of the 'stand-alone' Doppler probe
- Knowledge of the spectral display: positive/negative velocities, scale and baseline controls
- Awareness of the effect of high and low pass filter and intensity threshold ('reject') settings



- Knowledge of setting pulsed Doppler sample volume: influence of gate length and distance
- Awareness of representation of signal strength by image intensity
- Awareness of how aliasing manifests on the spectral display

4.2 Colour Flow Instrumentation

- Knowledge of the colour display: 'BART' convention
- Knowledge of the use of colour maps to show velocity scales
- Knowledge of the relationship between velocity and power (signal amplitude) displays
- Awareness of the principles of Tissue Doppler Imaging

5. Deformation Analysis

5.1 Principles of myocardial deformation

- Awareness of the concepts of myocardial displacement, velocity, strain and strain rate

6. Cardiac Anatomy and Physiology

6.1 Anatomy of the thorax

- Knowledge of thoracic anatomy including vascular structures

6.2 Gross anatomy of the heart

- Knowledge of basic relevant cardiac embryology
- Knowledge of the nomenclature of the cardiac chambers and valves
- Knowledge of the relationships between the cardiac chambers, valves and blood vessels
- Knowledge of the pericardial reflections

6.3 Cardiac anatomy and physiology as demonstrated by echocardiography

- Knowledge of echocardiographic anatomy: chambers/valves/great vessels/pericardium
- Knowledge of normal variants in standard echocardiographic planes
- Knowledge of the phases of atrial function: reservoir/conduit/contractile phases
- Knowledge of the effect of AF on the appearance of cardiac function
- Knowledge of cardiac remodelling in response to chronically elevated preload /afterload
- Knowledge of the effects of vasoactive drugs and positive pressure ventilation on cardiac physiology

6.4. Coronary anatomy and relationship to LV function

- Knowledge of the anatomy of the major coronary arteries
- Knowledge of the derived regional blood supply to the cardiac walls
- Knowledge of the nomenclature for describing myocardial segments: 16 and 17 segment models
- Knowledge the definitions of segmental



- systolic myocardial function: o normal
- o hypokinesia
- o Akinesia
- o dyskinesia

6.5 The Cardiac Cycle

- Knowledge of the temporal relationships of the ECG/chamber pressures/valve movements
- Knowledge of typical values for intracardiac pressures
- Knowledge of the relationship of valve movements to heart sounds
- Knowledge of valve opening and closure signals on Doppler recordings
- Knowledge of the timing of aortic valve closure as a marker of end-ejection in M-mode
- Knowledge of the effect of spontaneous unsupported ventilation on the cardiac cycle

7. Cardiac functional parameters

7.1 General measurements and calculations

- Knowledge of on-screen measurement of length/slope/area/volume/time interval
- Knowledge of measurement significance in 2-D/M-mode/spectral Doppler displays
- Awareness of the effect of off-axis images on area and volume measurements
- Knowledge of geometric assumptions in estimation of chamber volumes with M mode/2D
- Awareness of the limitation of single plane measurements of atrial size
- Knowledge of standard M-mode measurements including LV wall thickness

7.2 Methods for determining systolic function and cardiac work

- Awareness of the importance of overall visual assessment of LV function
- Appreciation of technique limitations/selection for assessing LV function
- Application of the following measures of LV function/ejection fraction where appropriate:
 - o LV fractional shortening
 - o LV volume measurements: biplane area/area-length/Simpson's methods
 - o Doppler velocity time integral calculation of stroke distance/stroke volume/cardiac output
 - o M-mode assessment of annular function: TAPSE/MAPSE
- Awareness of the influence of volume status/vasoactive medication on the above

7.3. Methods for determining diastolic function

- Appreciation of the importance of diastolic function
- Knowledge of the four progressive stages of diastolic dysfunction
- Knowledge of the characteristic transmitral and tissue Doppler patterns, and pulmonary venous flow patterns associated with each stage
- Knowledge of accurate assessment of E/A velocity and ratio and deceleration



time

- Awareness of pseudonormal transmitral filling
- Awareness of the effect of significant mitral regurgitation on transmitral flow patterns
- Appreciation of the potential effects of ventilation/vasoactive medication/sepsis on diastolic function
- Appreciation of the complexities of interpretation of diastology during critical illness

7.4 Methods for determining fluid status/responsiveness

- Knowledge of the normal patterns of IVC movement on inspiration in
 - unsupported spontaneous respiration
 - patient triggered positive pressure ventilation
 - mandatory positive pressure ventilation
- Knowledge of percentage IVC collapse with respiratory cycle indicating fluid responsiveness
- Knowledge of the use of inter-atrial septal motion as an indicator of filling status
- Knowledge of trans-mitral/aortic velocity variation as an indicator of fluid responsiveness
- Knowledge of the clinical definition of fluid responsiveness
- Awareness of the use of serial targeted studies to assess the effects of vasoactive medication/fluid challenges

8. Contrast Studies

- Awareness of the significance of spontaneous echo contrast
- Knowledge of indications for a bubble contrast study:
 - diagnosis of intracardiac shunts and PFO
 - diagnosis of left sided SVC
 - assessment of unexplained hypoxaemia
- Knowledge of the technique for performing a hand-agitated contrast study:
 - optimal injection site injection
 - timing
 - use of valsalva to accentuate right to left shunts
- Knowledge of the effects of positive pressure ventilation on intra-cardiac shunts
- Awareness of the interaction between ultrasound and encapsulated contrast agents
- Awareness of the main indications for LV and RV opacification

9. Mitral valve

9.1 Normal Mitral Valve

- Knowledge of the 2D, M-mode and Doppler characteristics of the normal mitral valve

9.2 Mitral stenosis

- Recognition of valvular appearance in rheumatic mitral stenosis



- Recognition of valvular and subvalvular calcification in degenerative valve disease
- Measurement of orifice area by planimetry
- Measurement of mean/end-diastolic gradient using CW Doppler
- Measurement of 'pressure half-time': technique and limitations

9.3 Mitral regurgitation

- Recognition of functional regurgitation related to LV chamber size or wall ischaemia
- Recognition of bowing of the leaflets, mitral valve prolapse, flail leaflet, Barlow leaflets
- Recognition of calcified annulus and retracted calcified leaflets
- Recognition of the features of a rheumatic valve
- Recognition of features of infective endocarditis
- Assessment of severity
 - Colour jet size in relation to LA
 - Assessment of regurgitant fraction
 - CW Doppler: shape and density of contour of Doppler signal
 - Vena contracta width
 - PISA and effective regurgitant orifice area
 - Pulmonary vein flow patterns
 - Indirect effects on LV and LA
 - Awareness of the influence of volume status/ inotropes/ventilation on severity
- Awareness of the echocardiographic indications for TOE assessment of the mitral valve

10. Aortic Valve

10.1 Normal Aortic Valve

- Knowledge of the 2D, M-mode and Doppler characteristics of the normal aortic valve

10.2 Aortic stenosis

- Recognition of valvular appearance in senile degenerative aortic stenosis
- Recognition of the features of a bicuspid aortic valve
- Recognition of the appearance in rheumatic aortic valve disease
- Recognition of subvalvular and supra-annular obstruction
- Planimetry of the valve area
- Assessment of peak and mean gradients using CWD
- Awareness of cross-checking peak gradient using right parasternal/suprasternal windows
- Measurement of valve area using the continuity equation

10.3 Aortic regurgitation

- Recognition of functional regurgitation related to ectasia of the aortic root
- Recognition of AR related to bicuspid valve



- Recognition of flail leaflet
- Recognition of the features of a rheumatic valve
- Recognition of features of infective endocarditis including aortic root abscesses
- Appreciation of the relevance of TOE where root abscess is suspected
- Assessment of severity
 - Colour jet size in relation to the LV and LVOT
 - CW Doppler: shape and density of contour of Doppler signal
 - PHT of the CWD signal
 - Vena contracta width
 - Diastolic flow reversal in the descending aorta
 - Indirect effects on LV size
 - Measurement of the EROA
 - Awareness of the influence of volume status/ inotropes/ventilation on severity

11. Tricuspid Valve Disease

11.1 Normal Tricuspid valve

- Knowledge of the 2D, M-Mode and Doppler characteristics of the normal tricuspid valve

11.2 Tricuspid stenosis

- Recognition of valve appearance and increased transvalvular peak gradient

11.3 Tricuspid regurgitation

- Recognition of functional regurgitation related to dilatation of the RV
- Recognition of artefact TR in association with trans-tricuspid wires
- Recognition of TR related to endocarditis
- Recognition of the features of a rheumatic/carcinoid valve
- Assessment of severity
 - Colour jet size in relation to RA size
 - CW Doppler: shape and density of contour of Doppler signal
 - Vena contracta width
 - Diastolic flow reversal in the hepatic veins
 - Awareness of the influence of volume status/ inotropes/ventilation on severity

12. Pulmonary Valve Disease

12.1 Normal Pulmonary valve

- Knowledge of the 2D, M-Mode and Doppler characteristics of the normal tricuspid valve

12.2 Pulmonary stenosis

- Recognition of valve appearance and increased transvalvular peak gradient

12.3 Pulmonary regurgitation

- Recognition of common functional jet vs pathological jets



- Assessment of severity
 - Colour jet size in relation to the PA size
 - CW Doppler: shape and density of contour of Doppler signal
 - Awareness of the influence of preload/inotropes/ventilation on severity

13. Infective endocarditis

- Knowledge of risk factors for infective endocarditis
- Knowledge of pathological patterns: right vs left sided vegetations
- Recognition of typical echocardiographic appearance of vegetations
- Recognition of anterior aortic root abscess
- Recognition and awareness of 'kissing' lesions
- Recognition of acute valvular dysfunction or wall perforation
- Recognition of vegetations on intracardiac foreign objects e.g. pacing wires
- Knowledge of the indications for TOE in suspected endocarditis

14. Prosthetic Valves

14.1 Normally functioning prosthetic valves

- Knowledge of the appearance of a well-seated normally functioning prosthetic valve
 - Tilting Disc
 - Bi-leaflet
 - Ball & cage
 - Bioprostheses: stented and stentless
- Appreciation of echo artefacts resulting from prosthetic valves
- Knowledge of where to source normal range values for transvalvular gradients
- Knowledge of normal pattern of washing jets according to different valve type

14.2 Prosthetic valve stenosis

- Knowledge of assessment using 2D, m-mode and CWD assessment
- Knowledge of the use of the continuity equation in prosthetic valve assessment

14.3 Prosthetic valve regurgitation

- Knowledge of the appearance of abnormal para-valvular leaks using colour Doppler
- Knowledge severity assessment using CWD

15. Cardiomyopathies

15.1 Dilated cardiomyopathy

- Recognition of the key echocardiographic features of DCM
- Knowledge of the causes of DCM
- Recognition of intra-cardiac thrombus

15.2 Hypertrophic cardiomyopathy

- Knowledge of diagnostic wall thickness ratio in HCM
- Recognition of systolic anterior motion of the mitral valve using 2D and M-mode



imaging

- Assessment of mid-cavity flow acceleration for detection of obstruction
- Awareness of the effect of inotropes on mid-cavity gradients
- Awareness of the differential diagnosis and features of an athletic heart

15.3 Restrictive cardiomyopathy

- Awareness of potential diagnosis of restrictive cardiomyopathy
- With preserved or moderate to severe diastolic dysfunction

15.4 LV Non-compaction

- Recognition of the main features of LV non-compaction
- Knowledge of the clinical manifestations of non-compaction

15.5 Takotsubo cardiomyopathy

- Recognition of the classical appearance of a Takotsubo's cardiomyopathy
- Knowledge of the clinical causes of Takotsubo's cardiomyopathy

16. Myocardial ischaemia

16.1 Acute myocardial ischaemia

- Recognition of acute regional wall motion abnormalities
- Knowledge of the coronary anatomy relevant to those wall motion abnormalities
- Recognition of acute valve dysfunction due to acute ischaemia

16.2 Early post-infarction complications

- Recognition of post-infarction complications
 - LV dysfunction
 - Papillary muscle rupture and flail mitral valve leaflet
 - Acute VSD
 - Free wall perforation and tamponade
 - True and pseudo-aneurysm formation
 - Dressler's syndrome

17. Intracardiac Masses

- Recognition of intracardiac thrombus in typical locations and the relevant causes
- Recognition of a typical atrial myxoma

18. Pericardial Disease

18.1 Echocardiographic features of pericardial fluid

- Recognition of a pericardial effusion as distinct to a pleural effusion
- Measurement and categorisation of volume of pericardial fluid

18.2 Features of tamponade

- Recognition of the progressive signs of cardiac tamponade
 - Collapse of the RA
 - Diastolic and then systolic collapse of the RV free-wall



- Exaggerated interdependence of tricuspid/mitral/aortic Doppler velocities
- Splinting of the IVC
- Awareness that cardiorespiratory support may distort the classical echocardiographic features of tamponade
- Awareness that cardiovascular compromise may occur in the critically ill without classical features of tamponade

18.3 Features of pericardial constriction

- Recognition of an abnormal thickened and bright pericardium
- Awareness of how to distinguish pericardial constriction from restrictive cardiomyopathy

19. Assessment for pulmonary hypertension

- Knowledge of aetiologies:
 - Acute:
 - Tricuspid valve destruction/dysfunction due to all motion abnormalities
 - Pulmonary embolism
 - Physiological pulmonary
 - Vasoconstriction
 - Chronic
 - Primary
 - Secondary to chronic lung disease/pulmonary emboli
 - Left heart lesions
- Knowledge of RV size and functional assessment by
 - visual assessment
 - fractional area change
 - TAPSE
- Appreciation of the effect on septal motion of volume and pressure overload including
 - 'D' deformity
 - paradoxical septal motion

20. Diseases of the aorta

- Knowledge of normal aortic sizes
 - Ascending
 - Arch
 - Descending limb
- Awareness of the features of Marfans syndrome
- Recognition of a dissection flap and associated findings

21. Grown-up congenital heart disease

- Recognition of atrial septal defects
- Recognition of ventricular septal defects



- Recognition of aortic coarctation
- Knowledge of the shunt calculation

22. The post-cardiac arrest patient

- Awareness of the technical considerations inherent in peri-arrest echocardiography
- Knowledge of the relationship between peri-arrest echo and the ALS algorithm
- Knowledge of the process and role of focused peri-arrest echocardiography in excluding:
 - Cardiac tamponade
 - Gross left ventricular overload and failure
 - Gross hypovolaemia
 - Massive pulmonary embolus
 - Gross RV impairment
- Limitations of the technique

23. Assessment of the hypotension/shock/acute breathlessness

- Awareness of the order in which life-threatening pathology should be sought and remedied
- A full study should be undertaken following exclusion and remedy of abnormalities in the following hierarchy:
 - Pericardial fluid
 - Aortic dissection
 - Severe hypovolaemia
 - Evidence of massive pulmonary embolism
 - LV dysfunction: causes and sequelae
 - RV dysfunction: causes and sequelae
 - Acute valvular pathology

24. LV assessment in sepsis

- Knowledge of the potential effects of sepsis on ventricular function
- Awareness that functional status during sepsis is poorly reflective of baseline function
- Knowledge of how echocardiography findings should influence:
 - volume resuscitation and maintenance
 - inotrope/vasopressor selection and dosing
 - decisions regarding further cardiovascular support
- Awareness of the need for re-assessment following changes in therapy
- Awareness of the need for re-assessment following resolution sepsis

25. Assessment in blunt and penetrating cardiac trauma

- A full study should be undertaken following exclusion and



remedy of abnormalities in the following hierarchy

- Pericardial fluid
- Aortic dissection
- LV dysfunction: causes and sequelae
- RV dysfunction: causes and sequelae
- Acute valvular pathology
- Recognition of the need for urgent TOE in the presence of:
 - a wide mediastinum on CXR and normal TTE findings
 - any other clinical findings that do not correlate with TTE findings

26. Assessment in failure to wean from mechanical ventilation

- Recognition of the need for a full standard echocardiographic assessment with particular focus on:
 - search for unexpected vegetations
 - consideration of the presence of intracardiac shunts
 - consideration of unexpected pulmonary emboli
 - assessment of observed fluid balance compared with cumulative volume status

27. Assessment post cardio-pulmonary by-pass/surgical and obstetric intervention

- Awareness of the transient effects of cardio-pulmonary by-pass on ventricular function
- Awareness of the need for frequent re-assessment in this setting
- Awareness of unusual causes of LV dysfunction following surgical intervention including:
 - regional tamponade: the need for TOE to visualise posterior collections
 - thromboembolism
 - fat embolism
 - amniotic fluid embolism
 - peri-anaesthetic myocardial ischaemia
 - fluid overload
 - intrathoracic pressure effects on cardiac chambers
 - intrathoracic pressure causing graft occlusion

28. Findings/clinical settings in the critically ill which should trigger expert help

- Echo windows insufficient to answer the clinical question
- Greater than moderate valvular dysfunction
- Any concern regarding prosthetic valve function
- Post myocardial infarction complications
- Suspected takotsubo cardiomyopathy
- Suspected hypertrophic cardiomyopathy
- Moderate to severe diastolic dysfunction: to exclude restrictive cardiomyopathy
- Suspected or impending cardiac tamponade
- Abnormal appearance of the pericardium: to exclude constrictive pericarditis
- Intracardiac mass
- Suspected congenital heart disease
- Unusual intracardiac devices such as TAVI, Mitraclips or LVAD



Appendix 2: Curriculum-based Competency Tool

The following competency assessment tool should be used to ensure all knowledge and practical experience is covered during the candidates' training period.

The candidate's mentor must now complete the competency tool via the BSE online logbook portal.

Principles of using TTE in the critically ill	Date	Signed
Demonstrates theoretical knowledge of the role of TTE in the critically ill patient		
Makes appropriate, timely use of abbreviated or specific echo protocols according to the clinical context for example: Cardiac arrest Shock Trauma Sepsis Acute breathlessness		
Demonstrates good clinical practice with respect to repeating or completing abbreviated studies in a timely fashion		
Can accurately and systematically report echo findings describing all parts of the heart and including and interpreting the context of the patient's illness and organ support		
Is familiar with and strives to achieve the BSE minimum dataset for each study		
Is aware of Caldicott principles of patient confidentiality and uses them in day to day practice		
Relays clinical findings to the critical care team in an appropriate and timely manner		
Demonstrates consistent and appropriate referral of echo findings requiring expert help		
Imaging physics and instrumentation		
Demonstrates theoretical knowledge of ultrasound physics to allow full and accurate use of imaging equipment		
Knows how to and routinely optimizes all images in accordance with this		
Principles of Doppler physics and fluid dynamics		
Demonstrates understanding of the appropriate use of PWD including colour flow and TDi, CWD		
Describes the Nyquist limit and how this affects clinical practice		
Doppler instrumentation		
Demonstrates accurate use of colour Doppler with attention to: Box size and position, gain setting, scale and baseline		
Demonstrates accurate and appropriate use of PWD and TDi with attention to clear spectral optimization		
Demonstrates accurate and appropriate use of CWD with attention to clear spectral optimization		
Anatomy and physiology		
Demonstrates knowledge and use of standard nomenclature for describing the 17 left ventricular segments		
Demonstrates accurate description of the motion of each individual region		



Measurements and calculation		
Measures 2D distances from point to point accurately		
Measures M-mode distances from leading edge to leading edge accurately		
Demonstrates accurate qualitative assessment of ventricular performance		
Accurately measures ejection fraction using fractional shortening or volume measurements		
Accurately measures stroke volume and cardiac output		
Demonstrates accurate assessment and interpretation of the components of diastolic function within the clinical context		
Demonstrates accurate measurement and interpretation of assessments of fluid status and responsiveness in the ventilated and non-ventilated patient		
Valve pathologies		
Demonstrates full and accurate assessment of the stenotic valve within the clinical context		
Demonstrates full and accurate assessment of the regurgitant valve within the clinical context		
Recognises features of infective endocarditis and can accurately assess the functional consequences		
Can recognise and assess normal and pathological function in the common types of prosthetic valves		
Cardiomyopathies		
Recognises and assesses cardiomyopathy including interpretation and reassessment according to the clinical context		
Myocardial infarction		
Distinguishes acute from chronic cardiac ischaemia		
Recognises and assesses the severity of acute ischaemia		
Recognises and assesses the consequences of sub-acute and chronic ischaemia		
Pericardial disease		
Can recognise and accurately assess the haemodynamic effects of abnormal pericardial fluid		
Recognises and refers possible cases of constrictive pericarditis		
Pulmonary hypertension		
Demonstrates recognition of acute versus chronic pulmonary hypertension		
Accurate assesses pulmonary hypertension using all qualitative and quantitative features		
Aortic disease		
Can recognise acute dissection of the aortic root and knows when to refer for TOE		
Congenital Heart Disease		
Can recognise the features of common presentations of grown-up congenital heart disease		



Appendix 3: Reading list

The reading list is provided by the Accreditation Committee of the British Society of Echocardiography and represents only a handful of texts that are available for candidates to learn from

- Echo made Easy Sam Kaddoura Churchill Livingstone 2001 ISBN 0443061882
- Echocardiography: Guidelines for reporting – a practical handbook Helen Rimington and John Chambers Taylor & Francis 1998 ISBN 1850700117
- Cardiac Ultrasound Leonard M Shapiro & Antoinette Kenny Manson Publishing 1999 ISBN 1874545081
- Feigenbaum's Echocardiography H. Feigenbaum Lippicott, Williams & Wilkins 2004 ISBN 0781731984 Textbook of Clinical Echocardiography Catherine Otto W. B. Saunders 2004 ISBN 0721607896
- Echocardiography: The Normal Examination and Echocardiographic Measurements. Second Edition Bonita Anderson MGA Graphics, Australia 2007 ISBN-13 9780646468631 ISBN-10 0646468634
- Hemodynamic Monitoring Using Echocardiography in the Critically Ill. DeBacker, Cholley, Slama, Vieillard- Baron, Vignon. Springer 2011. ISBN-13 9783540879541 ISBN-10 3540879544
- Newton J, Sabharwal N, Myerson S et al. Oxford Specialist Handbooks in Cardiology: Valvular Heart Disease. Oxford University Press, Oxford, 2011.
- Consensus of circulatory shock and haemodynamic monitoring. Task force of the European Society of Intensive Care Medicine. Maurizio Cecconi, Daniel De Backer et al. Intensive Care Med DOI 10.1007/s00134-014-3525-z
- The introduction of intensive care-led echocardiography into a tertiary care unit. SR Alam, A Docherty, I Mackle, MA Gillies. JICS 14(1) January 2013.
- The accuracy of diagnostic and haemodynamic data obtained by transthoracic echocardiography in critically ill adults: a systematic review. CL Colebourn, V Barber, JB Salmon, JD Young. JICS 9(2) July 2008.
- Measuring and monitoring quality in satellite echo services within critical care: an exploration of best practice. T Thomas, C Colebourn Echo Res Pract June 2015 2:57-64; published April 15, 2015, doi:10.1530/ERP-14-0098
- Echocardiographically derived parameters of fluid responsiveness. J Gerstle, S Shahul, F Mahmood. International Anaesthesiology Clinics 2010;48(1);37-44.
- Echocardiographic measurement of fluid responsiveness. C Charron, V Caille, F Jardin, A Vieillard-Baron. Curr Opin Crit Care 2006 12;249-254.
- Shape and movement of the interatrial septum predicts change in pulmonary capillary wedge pressure. CF Royse, PF Soeding, DW Blake. Ann Thoracic Cardiovasc Surg. 2001;7(2);79-83.



- Can transthoracic echocardiography be used to predict fluid responsiveness in the critically ill patient? A systematic review. J Mandeville, C Colebourn. Crit Care Res Pract. 2012;2012:513480.
- Predicting fluid responsiveness in the critically ill adult. J Mandeville, C Colebourn. British Journal of Intensive Care 05/2013;23(1):20.
- Assessing left ventricular systolic function in shock: evaluation of echocardiographic parameters in intensive care. Bergenzaun et al. Critical care 2011, 15 R:200.
- Evaluation of left ventricular systolic function revisited in septic shock. Critical Care, 2103 17(4) 164. Septic cardiomyopathy. Vieillard Baron, Annals of Intensive Care Medicine 2011 1:6.
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- Moschietto S, Doyen D, Grech L, Dellamonica J, Hyvernat H, Bernardin G: Transthoracic Echocardiography with Doppler Tissue Imaging predicts weaning failure from mechanical ventilation: evolution of the left ventricle relaxation rate during a spontaneous breathing trial is the key factor in weaning outcome. Critical care (London, England) 2012, 16(3):R81.
- Aurigemma GP, Gaasch WH: Clinical practice. Diastolic heart failure. The New England journal of medicine 2004, 351(11):1097-1105.
- Vignon P, Allot V, Lesage J, Martaille JF, Aldigier JC, Francois B, Gastinne H: Diagnosis of left ventricular diastolic dysfunction in the setting of acute changes in loading conditions. Critical care (London, England) 2007, 11(2):R43.
- Jacques DC, Pinsky MR, Severyn D, Gorcsan J, 3rd: Influence of alterations in loading on mitral annular velocity by tissue Doppler echocardiography and its associated ability to predict filling pressures. Chest 2004, 126(6):1910-1918.
- Echocardiographic assessment of the right ventricle and associated hemodynamics. Karas MG, Kizer JR. Progress in Cardiovascular Diseases (2012);55:144–160.
- Imaging the failing right ventricle. Mitoff PR, Beauchesne L, Dick AJ, Chow BJ, Beanlands RS, Haddad H, Mielniczuk LM.. Curr Opin Cardiol (2012);27:148 – 153 .
- Right ventricular responses to massive and submassive pulmonary embolism. C Castillo, VF Tapson.
- Cardiol Clin.2012 30:233-241.
- Fibrinolysis for patients with Intermediate-Risk Pulmonary Embolism. G Meyer, E Vicaut, T Danays. NEJM. 2014;370:1402-11.
- Modern protective ventilation strategies: impact upon the right heart. CGT Morris, SA Burn, SB Richards
- JICS 2014 15(1):28-33.



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- Wunderlich, N, Beigel, R, Siegel, R. Management of Mitral Stenosis using 2D and 3D Echo-Doppler imaging. *JACC: Cardiovascular imaging* 2013; 6(11):1191-1205
- Carabello B. The current therapy for mitral regurgitation. *J Am Coll Cardiol* 2008; 52:319–26.
- Bhattacharyya S, Khattar R, Chahal N, Senior R. Dynamic mitral regurgitation: review of evidence base, assessment and implications for clinical management. *Cardiol Rev.* 2015 May-Jun; 23(3):142-7.
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- Transthoracic echocardiography in obstetric anaesthesia and obstetric critical illness. AT Dennis. *Int J Obstet An* 2011 Apr;20(2):160-8.
- Transthoracic Echocardiography with Doppler Tissue Imaging predicts weaning failure from mechanical ventilation: evolution of the left ventricle relaxation rate during a spontaneous breathing trial is the key factor in weaning outcome. Moschietto S, Doyen D, Grech L, Dellamonica J, Hyvernat H, Bernardin G. *Crit Care.* 2012;16(3):R81. doi: 10.1186/cc11339.

Protocols and the most up-to-date BSE guidelines are available under the [Education](#) tab of www.bsecho.org.

Please note that only fully subscribed BSE members are granted full access to all education and exam content.



Appendix 4: Written Examination Registration Guidance

BSE written exams are administered in collaboration with Pearson VUE testing services. Candidates can take the exam at local testing centres across the UK, the Republic of Ireland, and certain overseas locations.

➤ **Pre-registration (through the BSE website)**

1. Candidates must have an active BSE membership (fully paid and up to date).
2. Candidates must register their interest in taking the written exam by completing an **online pre-registration** form via the accreditation section of www.bsecho.org, during the pre-registration window specified online. **Candidates' registered names should match their photo identification. Pearson VUE follows a strict admission policy.**
3. BSE will transfer your data and requirements to Pearson VUE, who will contact all pre-registered candidates with further information on confirming exam placements.

Delivery methods: Candidates can take the exam in two ways: in a **Test Centre (recommended)** or online proctored exam (OnVUE), which allows them to sit the exam from home (subject to system requirements).

Note: Candidates taking the exam from home accept full responsibility for technical issues like device updates, pop-up blocking, connection errors, and bandwidth. System checks before the exam may not catch all faults, which can still occur during the exam. Understand these risks.

➤ **Special accommodations**

Pearson VUE can provide [special accommodations](#) (reasonable adjustments) to candidates with official requirements, such as extra time, a reader, or medication during the examination.

All requests must be in writing and supported by documents from a healthcare professional/provider detailing the requirements and reason for the request. The BSE will approve requests at its discretion and **must be submitted within the pre-registration window**. To submit such requests, forward them to accreditation@bsecho.org.

➤ **Registration (through Pearson VUE)**

Pearson VUE will manage all registration and payments after the pre-registration stage. Some automated emails may end up in spam or junk mail. Pearson VUE may notify candidates of any changes to bookings; candidates must ensure that their contact information is accurate.

Cancellations made less than 7 days in advance do not qualify for a refund. All cancellations must be processed through Pearson VUE.

➤ **On the day of the exam**

Instructions will be given on the day of the exam via a video tutorial at the test centre. The instructions can also be accessed through Pearson VUE's online resources before the exam. Candidates will complete the exam on a computer at the test centre.



The exam already includes a basic calculator and a whiteboard application. The examining test centre will give candidates an erasable sheet.

If the candidate chooses to take the exam from home using online proctoring (OnVUE), a basic calculator and whiteboard are built into the exam as an online application for the candidate to use at their convenience. Therefore, **no form of stationery is permitted when taking the exam.**

Candidates are required to bring a government photo ID and another form of identification. Please ensure that the registration details match your photo ID exactly; otherwise, you will be refused entry. If denied entry, candidates should contact BSE immediately.

The test centre will not facilitate any last-minute requests for special accommodations.

➤ **Results**

Results are released 5-6 weeks after sitting the exam, and scores will be uploaded to BSE profiles. **Both sections must be passed for a complete pass.**

Pass: Candidates can request portal login details to upload logbook reports. The deadline appears under 'Practical submission deadline' after written exam scores in the 'Participation' tab of the BSE profile. This information is also emailed to the candidate (subject to account status).

Fail: candidates can register interest to sit in the next sitting of the exam.

- The reduced fee applies only to first-time, unsuccessful candidates who sit the exam physically. The second attempt must occur within 12 months. **Results cannot be appealed or remarked since tests are computer-based.**

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

➤ **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-takers/Resources.aspx>.

Pearson VUE has a strict admissions policy. Candidates' registered names should be exactly as they appear on their government-issued photographic ID.



Appendix 5: Written Exam multiple-choice questions examples

Answer 'True' (T) or 'False' (F) to each of the following.

There is no negative marking—one mark is added for a correct answer, and no mark is deducted for an incorrect answer.

Q1	In an ultrasound imaging system:	
a)	Sector width, sector depth and frame rate can all be controlled independently.	F
b)	Frame rate falls as sector width increases	T
c)	Using a lower-frequency transducer improves the frame rate	F
d)	Frame rate increases as sector depth increases	F
e)	Using Colour Flow Doppler reduces the frame rate	T

Q2	On a spectral Doppler display:	
a)	The velocity at which aliasing occurs increases at higher ultrasound frequencies	F
b)	The velocity at which aliasing occurs increases at greater depths	F
c)	The velocity at which aliasing occurs increases at greater sector angles	F
d)	At 2MHz the aliasing velocity at 10cm is approximately 1.5m/s	T
e)	The aliasing velocity can be increased by increasing the pulse rate (high PRF)	T

Q3	An Atrial Septal Defect (ASD) may be associated with:	
a)	Paradoxical interventricular septal motion	T
b)	No obvious defect of the atrial septum on imaging	T
c)	Right ventricular dilatation	T
d)	Left ventricular dilatation	F
e)	Flow of blood from left atrium to right atrium	T

Q4	Regarding assessing aortic stenosis:	
a)	Aortic valve maximum velocity of 5.2m/s is consistent with severe AS	F
b)	A mean gradient of 30mmHg and a valve ratio of 0.20 is consistent with severe AS	F
c)	In severe AS there is rapid acceleration and early peaking of the Doppler waveform	F
d)	A rate of change of >0.9m/s/year is associated with poor patient prognosis	F
e)	An aortic valve velocity ratio of 0.34 and a maximum velocity of 3.8m/s is consistent with moderate AS	T



Appendix 6: Written Exam image reporting questions examples

Several moving clips and stills will be included in each question. Although these can be viewed and replayed as many times as the candidate wishes, the candidate should be mindful of the time spent on each question.

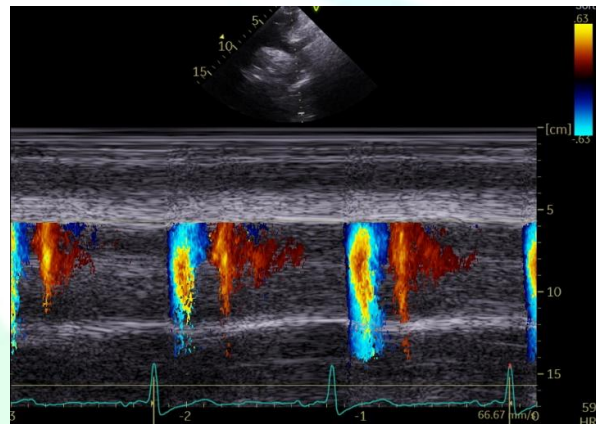
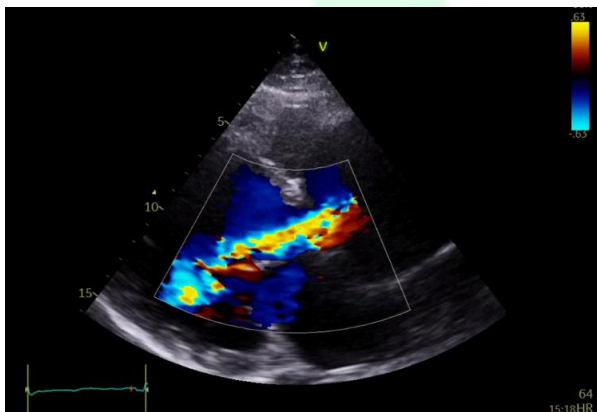
The **SINGLE BEST ANSWER** should be selected.

There is **no negative marking**—one mark is added for a correct answer, and no mark is deducted for an incorrect answer.

Case 1

Request: male, 42-year-old, admitted with chest pain radiating into back, SOBOE.

Data: LVIDD: 7.4cm, SoV dimension: 7.0cm, STJ: 6.9cm, proximal ascending aorta: 7.4cm, TAPSE: 1.4cm. proximal RVOT dimension: 4.2cm. Descending aorta end diastolic velocity: 0.30m/s. TR Vmax: 3.2m/s, right atrial area: 26cmsq, pulmonary valve acceleration time: 100ms, AR Pressure half time: 149msec.



1.1	Regarding the severity of the aortic regurgitation	Answer
a	There is moderate central aortic regurgitation	
b	There is moderate eccentric aortic regurgitation	
c	There is severe central aortic regurgitation	T
d	There is severe eccentric aortic regurgitation	

1.2	Regarding the echo probability of pulmonary hypertension	Answer
a	There is no echo probability of pulmonary hypertension	
b	There is low echo probability of pulmonary hypertension	
c	There is intermediate echo probability of pulmonary hypertension	
d	There is high echo probability of pulmonary hypertension	T



Appendix 7: Logbook guidance and marking criteria

In order to meet all competencies of this accreditation process the logbook should represent good/excellent examples of a candidate's daily workload. Ideally, it should reflect the most up to date BSE guidance (see page 6 if your department has different locally agreed working practices).

Whilst we encourage the use of good / excellent work to be included in the logbook, it is acknowledged that not every report in the logbook will meet this standard. Therefore, when considering whether to include a report, please refer to the following as an absolute minimum.

*****If a report does not meet the below, it should not be included as a logbook report*****

Demographic and other Identifying Information:

- Referral information Indications for echo
- Inotropic support
- Ventilatory support
- Rate and rhythm
- Date of study
- Patient's age

A report should have a section for objective 2D dimensions and Doppler measurements. There should be a section for describing observations and a short conclusion.

Measurements section:

- LV dimensions, wall thickness dimensions.
- LA volume (monoplane)
- RA area
- RV dimension where able to measure accurately
- AV VTI, AV Vmax and mean gradient, LVOT VTI, LVOT Vmax and mean gradient
- E/A ratio, DT, TDI's (minimum of one)
- Aortic root, proximal ascending aorta dimensions if seen
- RV dimensions where appropriate
- TAPSE

Description of all parts of the heart:

- This should include a description of observations and should include:
- A comment on structure and function of all valves
- A comment on size and function of the LV
- A comment on size and function of the RV
- A comment on size of the atria
- A comment on the absence / presence of pericardial effusion



- A comment on assessment of the IVC
- A comment on the assessment of the atrial and ventricular septum
- If a particular part of the heart cannot be fully assessed this along with the reason must be standard

Conclusions:

This should summarize the whole study and be easily understood by a non-echocardiographer.

It should identify key abnormalities, their cause and any secondary effect. Key normal information should also be included. Differences from repeated studies and technical difficulties should be mentioned.

Logbook marking criteria

When marking a candidate's logbook, the Assessor will review a selection of reports in the candidate's logbook.

The following marking criteria are used when assessing each logbook report

Does the report meet the following criteria?	Yes / No (if no, state reasons why)
Fully Anonymised	
Indication for echo present	
Appropriate measurements present	
Appropriate Doppler calculations present	
Do measurements / Doppler calculations match descriptions?	
All parts of heart described	
Descriptions complete	
Appropriate to request	
Conclusion present	

Logbook outcomes include:

Satisfactory log-book for BSE accreditation OR Unsatisfactory at present and a resubmission is required.

If a logbook is unsatisfactory, the candidate will be asked for one of the following resubmissions.



- **10-20 further specified reports:** To address persistent inaccuracies in certain measurements or observations (e.g. lack of diastolic function assessment).
- **25-75 further specified reports:** To address repeated inaccuracies, lack of correct conclusion or lack of sequential systematic comments on all parts of the heart. (e.g. lack of RWMA description + lack of quantitative valve pathology measurements).
- **250 reports:** To address significant errors, inaccurate or lack of systematic comments. The presence of Patient ID on any report will require a complete resubmission of the logbook.

To ensure consistency in logbook marking, all logbooks are discussed with the national logbook leads and the chief assessor prior to requesting a resubmission.

Appendix 8: Guidance for the removal of patient identifiable data

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

Guidance is provided to Healthcare Professionals 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 any part of the submission required for this accreditation process. In contrast, anonymised information is not confidential and may be used.

Key identifiable information includes:

- a. Patient's name**
- b. Address**
- c. Full post code**
- d. Date of birth**
- e. NHS number and local identifiable codes**

Key identifiable information may also include information that can be used to identify a patient directly or indirectly. For example, rare diseases, drug treatment, or statistical analyses involving very small numbers within a small population may allow individuals to be identified.

Guidance to candidates submitting Logbooks and Cases for Accreditation

The NHS Code of Practice on confidentiality means that evidence submitted for this accreditation process must have removed **ALL** patient identifiable information beyond gender and age/year of birth.



Reports – Please use the BSE online portal and electronically delete all patient information except age and gender.

We advocate against using other electronic anonymisation methods as sometimes data is still present. If in doubt, manually remove patient identification information before use.

Video cases—We appreciate that removing patient IDs may be difficult. Therefore, it is advised that the video cases are specifically collected and the data inputs made relevant to your cases (E.g., the Patient Name could be 'BSE Case 1', and the Patient Number could be your membership number followed by the case number, '1111-1').

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



Appendix 9: Practical scanning mark scheme

The marking criteria used for the practical scanning assessment can be seen below.

2 minutes:	<ul style="list-style-type: none"> Familiarisation of echo machine / equipment. Assessor will be on hand if assistance is required.
20 minutes:	<ul style="list-style-type: none"> Candidate to have 2 minutes to obtain and acquire each image. The Assessor will instruct the candidate on the images to acquire. The Assessor can alter echo machine / equipment setting to optimise images at the direction of the candidate.

The pass mark is set at 66%. Once this mark is achieved, the candidate will be deemed successful at this station.

Each image the candidate acquires is scored as per the marking scheme below.

F = Fail = 0 points:	unable to demonstrate appropriate skill set
BF = Borderline Fail = 1 point:	unable to demonstrate appropriate skill set, is able to describe reasons how improvement could be achieved
BP = Borderline Pass = 2 points: quality	able to acquire/demonstrate skill set although fails to optimize image acquisition quality
P = Pass = 3 points: optimization of images	able to fully demonstrate high quality image acquisition with appropriate optimization of images

All images used in the practical scanning assessment are taken from the BSE minimum dataset. An example of the imaging list used in this assessment can be see

Image List One

2 minutes per acquisition Encourage candidates to move on if necessary	Image (Score Weighting)
1	2D Parasternal Long Axis (5)
2	2D Parasternal Short Axis Left Ventricle (5)
3	2D modified Short Axis demonstrating Main Pulmonary Artery (3)
4	PW Doppler RVOT (1)
5	2D Apical 4 Chamber (5)
6	PW Doppler Mitral Valve (1)
7	2D Apical 2 Chamber (5)
8	2D A4C modified to show RV, with Colour Doppler, demonstrating TR if present (3)
9	2D Subcostal 4 Chamber (3)
10	Blind CW Doppler Descending Aorta (3)
	Modification of Patient Position to Optimise Image Quality (5)
	Image Optimisation (3)



Appendix 10: Patient case studies viva marking criteria

The next few pages show the individual marking criteria for each of the patient video case studies. All criteria must be met to a satisfactory standard in order for the patient case study to be passed. A minimum of two patient case studies will be assessed. The British Society of Echocardiography reserves the right to assess all five patient case studies.

Adult Critical Care Echo Accreditation. Case 1 – No significant pathology.			
Practice must be satisfactory in all areas to pass			
Evidence of satisfactory practice	Tick	Evidence of unsatisfactory practice	Tick
ECG Largely present throughout without 2D image interference		ECG Unstable or frequently absent, making timings inaccurate	
Optimization Infrequent, non-repetitive optimization errors which do not detract from the case conclusion		Optimization Frequent, repetitive optimization errors which detract from the case conclusion	
Complete study Images are complete enough to allow full assessment of the selected pathology, including Doppler study and measurements		Incomplete study Images are missing which are relevant to the accurate assessment of the selected pathology, including inadequate Doppler study or relevant measurements quoted in report but not demonstrated.	
2D measurements Accurate throughout with minor errors that do not change the categorisation of the chosen pathology		2D measurements Frequent inaccuracies or isolated inaccuracies that change the categorisation of the chosen pathology	
Colour Doppler Accurate box size, gain, scale and baseline settings demonstrating anatomy clearly		Colour Doppler Frequent inaccuracies of box size, gain, scale and baseline settings which prevent clear demonstration of the anatomy	
Spectral Doppler Accurate use with good cursor alignment and optimised waveforms		Spectral Doppler Inaccurate use with poor cursor alignment or waveform optimization altering pathology assessment	
Pathology assessment No images missing which are key to pathology assessment No measurements significantly inaccurate that are key to pathology assessment		Pathology assessment Poor quality or missing images missing which are key to pathology assessment Measurements key to pathology assessment significantly inaccurate and change the categorisation of the pathology	
Report is complete and accurate Comprehensive/accurate description of all parts of the heart Correct categorisation of chosen pathology (NB non-significant abnormalities may be included in this case) Correct interpretation of findings in the clinical context		Report is incomplete or inaccurate Partial/inaccurate description of parts of the heart Incorrect categorisation of chosen pathology Incorrect interpretation of findings in the clinical context	



Adult Critical Care Echo Accreditation. Case 2 – Fluid responsiveness case: this case must be performed on a critically ill patient. Practice must be satisfactory in all areas to pass			
Evidence of satisfactory practice	Tick	Evidence of unsatisfactory practice	Tick
ECG Largely present throughout without 2D image interference		ECG Unstable or frequently absent making timings inaccurate	
Optimization Infrequent, non-repetitive optimisation errors which do not detract from the case conclusion		Optimization Frequent, repetitive optimisation errors which detract from the case conclusion	
Complete study Images are complete enough to allow full assessment of the selected pathology, including Doppler study and measurements		Incomplete study Images are missing which are relevant to the accurate assessment of the selected pathology, including inadequate Doppler study or relevant measurements quoted in report but not demonstrated	
2D measurements Accurate throughout with minor errors that do not change the categorisation of the chosen pathology		2D measurements Frequent inaccuracies or isolated inaccuracies that change the categorisation of the chosen pathology	
Colour Doppler Accurate box size, gain, scale and baseline settings demonstrating anatomy clearly		Colour Doppler Frequent inaccuracies of box size, gain, scale and baseline settings which prevent clear demonstration of the anatomy	
Spectral Doppler Accurate use with good cursor alignment and optimised waveforms		Spectral Doppler Inaccurate use with poor cursor alignment or waveform optimization altering pathology assessment	
Pathology assessment Ventilated: 1. Inferior vena cava (IVC) diameter and reactivity is correctly measured and interpreted 2. Stroke volume variation or aortic Vmax variation with respiration is correctly measured and interpreted 3. Velocity time integral (Vti) response to passive leg raise or fluid bolus is correctly measured and interpreted Non-ventilated: 1. IVC diameter and reactivity is correctly measured and interpreted 2. Vti response to passive leg raise or fluid bolus is correctly measured and interpreted		Pathology assessment Evidence of fluid responsiveness is incomplete such that assessment cannot be made There are significant errors in the measurement of fluid responsiveness	
Report is complete and accurate Comprehensive and accurate description of all parts of the heart Correct categorisation of evidence of all parts of the heart Correct contextualisation		Report is incomplete or inaccurate Partial and inaccurate description of parts of the heart Incorrect categorisation of chosen pathology Incorrect interpretation of findings in the clinical context	



Adult Critical Care Echo Accreditation. Case 3 – Cardiogenic shock case: this case must be performed on a critically ill patient. Practice must be satisfactory in all areas to pass			
Evidence of satisfactory practice	Tick	Evidence of unsatisfactory practice	Tick
ECG Largely present throughout without 2D image interference		ECG Unstable or frequently absent making timings inaccurate	
Optimization Infrequent, non-repetitive optimisation errors which do not detract from the case conclusion		Optimization Frequent, repetitive optimisation errors which detract from the case conclusion	
Complete study Images are complete enough to allow full assessment of the selected pathology, including Doppler study and measurements		Incomplete study Images are missing which are relevant to the accurate assessment of the selected pathology, including inadequate Doppler study or relevant measurements quoted in report but not demonstrated	
2D measurements Accurate throughout with minor errors that do not change the categorisation of the chosen pathology		2D measurements Frequent inaccuracies or isolated inaccuracies that change the categorisation of the chosen pathology	
Colour Doppler Accurate box size, gain, scale and baseline settings demonstrating anatomy clearly		Colour Doppler Frequent inaccuracies of box size, gain, scale and baseline settings which prevent clear demonstration of the anatomy	
Spectral Doppler Accurate use with good cursor alignment and optimised waveforms		Spectral Doppler Inaccurate use with poor cursor alignment or waveform optimisation altering pathology assessment	
Pathology assessment EF is correctly measured using Simpsons measurement AND Correlated with visual impression and other methods CO is correctly and accurately measured using LVOT diameter and LVOT Vti Or Simpsons method		Pathology assessment Simpsons is measured inaccurately and changes the categorisation of the reported EF CO is incorrectly or inaccurately measured (> 10% error)	
Report is complete and accurate 1. Comprehensive accurate description of all parts of the heart 2. Correct categorisation of EF and CO 3. Correct interpretation of EF and CO in the clinical context		Report is incomplete or inaccurate 1. Inaccurate or incomplete description of the heart 2. Incorrect categorisation of EF and CO 3. Incorrect interpretation of EF and CO in the clinical context	



Adult Critical Care Echo Accreditation. Case 4 – Non-FR/CO case: these cases may or may not be performed in a critical care setting. Practice must be satisfactory in all areas to pass			
Evidence of satisfactory practice	Tick	Evidence of unsatisfactory practice	Tick
ECG Largely present throughout without 2D image interference		ECG Unstable or frequently absent making timings inaccurate	
Optimization Infrequent, non-repetitive optimisation errors which do not detract from the case conclusion		Optimization Frequent, repetitive optimisation errors which detract from the case conclusion	
Complete study Images are complete enough to allow full assessment of the selected pathology, including Doppler study and measurements		Incomplete study Images are missing which are relevant to the accurate assessment of the selected pathology, including inadequate Doppler study or relevant measurements quoted in report but not demonstrated	
2D measurements Accurate throughout with minor errors that do not change the categorisation of the chosen pathology		2D measurements Frequent inaccuracies or isolated inaccuracies that change the categorisation of the chosen pathology	
Colour Doppler Accurate box size, gain, scale and baseline settings demonstrating anatomy clearly		Colour Doppler Frequent inaccuracies of box size, gain, scale and baseline settings which prevent clear demonstration of the anatomy	
Spectral Doppler Accurate use with good cursor alignment and optimised waveforms		Spectral Doppler Inaccurate use with poor cursor alignment or waveform optimisation altering pathology assessment	
Pathology assessment No images missing which are key to pathology assessment No measurements significantly inaccurate that are key to pathology assessment		Pathology assessment Images missing which are key to pathology assessment Measurements key to pathology assessment significantly inaccurate and change the categorisation of the pathology	
Report is complete and accurate 1. Comprehensive and accurate description of all parts of the heart 2. Correct categorisation of chosen pathology 3. Correct interpretation of findings in the clinical context		Report is incomplete or inaccurate 1. Partial and inaccurate description of parts of the heart 2. Incorrect categorisation of chosen pathology 3. Incorrect interpretation of findings in the clinical context	



Adult Critical Care Echo Accreditation. Cases 4 & 5 – Other pathology. Practice must be satisfactory in all areas to pass			
Evidence of satisfactory practice	Tick	Evidence of unsatisfactory practice	Tick
ECG Largely present throughout without 2D image interference		ECG Unstable or frequently absent making timings inaccurate	
Optimization Infrequent, non-repetitive optimisation errors which do not detract from the case conclusion		Optimization Frequent, repetitive optimisation errors which detract from the case conclusion	
Complete study Images are complete enough to allow full assessment of the selected pathology, including Doppler study and measurements		Incomplete study Images are missing which are relevant to the accurate assessment of the selected pathology, including inadequate Doppler study or relevant measurements quoted in report but not demonstrated.	
2D measurements Accurate throughout with minor errors that do not change the categorisation of the chosen pathology		2D measurements Frequent inaccuracies or isolated inaccuracies that change the categorisation of the chosen pathology	
Colour Doppler Accurate box size, gain, scale and baseline settings demonstrating anatomy clearly		Colour Doppler Frequent inaccuracies of box size, gain, scale and baseline settings, which prevent clear demonstration of the anatomy	
Spectral Doppler Accurate use with good cursor alignment and optimised waveforms		Spectral Doppler Inaccurate use with poor cursor alignment or waveform optimisation altering pathology assessment	
Pathology assessment No images missing which are key to pathology assessment No measurements significantly inaccurate that are key to pathology assessment		Pathology assessment Images missing which are key to pathology assessment Measurements key to pathology assessment significantly inaccurate and change the categorisation of the pathology	
Report is complete and accurate Comprehensive and accurate description of all parts of the heart Correct categorisation of chosen pathology Correct interpretation of findings in the clinical context		Report is incomplete or inaccurate Partial and inaccurate description of parts of the heart Incorrect categorisation of chosen pathology Incorrect interpretation of findings in the clinical context	



Appendix 11: Mentor Statement & Declaration

The candidate must email a completed copy to accreditation@bsecho.org at the point of registration for a practical assessment.

I confirm that I have provided overall supervision and guidance for the following candidate, during the period in which they have performed and reported logbook studies and viva cases.

I have reviewed the logbook and viva cases prior to the submission, and I am fully satisfied that the candidate has met the BSE submission criteria.

I believe the candidate is ready to attend the practical assessment to present their work.

Following the assessment, should the BSE wish to contact me for any information, I will be able to answer any questions the BSE may have regarding the candidate's performance.

Full name of mentor	
Mentor job title	
Mentor place of work	
Mentor email address	
Mentor phone number	
Name of candidate	
BSE ID of the candidate	
Candidate's place of work	

By signing this document, I declare that the information provided in this document is true and correct to the best of my knowledge.

Mentor signature:

Date:



Appendix 12: Appeal guideline and application

Appeal application process for all BSE accreditation specialities

The following information is provided by the British Society of Echocardiography (BSE) to assist a candidate who wishes to appeal the decision of their practical assessment for any of the BSE accreditation specialities. There is no appeals process for the written examination.

Please read the following information to ascertain if there are grounds for an appeal. The information below will also provide an overview of the appeal process from start to finish.

1. Reasons for appeal

An appeal for the following reasons is welcomed by the BSE Accreditation Committee:

- A decision to refuse to accredit a person
- A decision to request a resubmission of cases (logbook or/and video-case)
- A decision to impose a condition of accreditation
- A decision to revoke accreditation on retrospective review of submitted works for quality assurance purposes
- Any other decision that is not listed above, for which the candidate feels is relevant

2. The Appeals Panel and role

The appeals panel will consist of two senior assessors who have not been involved with the original assessment and who are not from the same centre as the candidate submitting the appeal.

The appeals panel role is to:

- Look at the information used by the assessor/person who made the initial decision
- Clear up any misunderstanding
- Correct any errors
- Make a final verdict on whether the initial decision should be upheld, varied or changed
- Provided a detailed response to the candidate informing them of the decision along with feedback as to why this decision has been reached.



3. The appeals process

Candidates submitting an appeal must complete and return the following to the accreditation operational team within **2 months** of the initial practical assessment.

- Complete appeal form (see below)
- Any relevant documentation (Assessor's mark sheets/comments)
- **Appeal fee £100** to be paid by BACS (see bank details below)-
Bank Natwest- Account number:73699519, Sort code- 53-70-15, include **A**-followed
by your **BSE ID** number as the payment reference.

Please note that if the appeal outcome changes from the original decision, the fee will be reimbursed.

Please send this form via email to accreditation@bsecho.org. If you have any supporting documents or case presentations, please request an upload link from the accreditation team.

4. Appeal outcome

The appeal panel appointed will review the appeal application. This will usually be at the next practical assessment day to ensure a fair hearing (please be mindful that assessors are volunteers of the BSE who have other work and life commitments and should not be expected to work above what is reasonable).

The panel will provide written feedback on the appeal outcome and any relevant feedback. This will be provided to the candidate who submitted the appeal within 28 days of the appeal being heard.

The review panel's decision is final. There is no appeal against the decision of the appeals panel.



APPEAL FORM

Applicant Details:

Title: Dr Mr Ms Mrs Miss Other (please specify): Click or tap here to enter text.

Membership number: Click or tap here to enter text.

Hospital/Company: Click or tap here to enter text.

Candidate postal address: Click or tap here to enter text.

Telephone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Question 1: What decision are you appealing?

- A decision to refuse to accredit a person (go to Question 3).
- A decision to request a resubmission of cases (go to Question 3).
- A decision to request a resubmission of reports (go to Question 3).
- A decision to impose a condition of accreditation (go to Question 3).
- A decision to revoke accreditation on retrospective review of submitted works for quality assurance purposes (go to Question 3).
- Other (go to Question 2).

Question 2: Please list the details of the condition or conditions, or any other decision, that you are appealing (after filling in the information, go to question 3).

Click or tap here to enter text.



Question 3: When did you receive notice of this decision? (After filling in the information, go to Question 4).

Click or tap here to enter text.

Question 4: What are your reasons for appealing the decision?

You may wish to attach additional documents to this form. Please ensure you detail which exact cases and which sections of marking you are querying. Please provide copies of the original cases and reports submitted if appropriate

Click or tap here to enter text.

By signing below, you confirm that you have read the guidelines and are aware of the timeframe required to provide a complete outcome for this appeal application.

Appeal fee £100 payment date: Click or tap to enter a date.

Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.

End of form



Appendix 13: Terms and Conditions Written Exam

By registering for the written exam, the candidate agrees to the terms and conditions listed below.

1. **To pursue the written (theory) examination for BSE level II accreditation, a candidate must:**
 - a. Have an active (paid) BSE membership.
 - b. The membership account must be populated with the candidate's full name as it appears on their government photo identification.
 - c. The membership account must include a complete postal address, contact telephone number and a current email address.
 - d. The candidate is responsible for updating their BSE profile before registering interest to take the written exam.
 - e. The candidate must read the relevant accreditation pack before registering for the exam.
2. **Pre-registration is a compulsory step** to register interest in taking the exam; this must be completed after becoming a paid BSE member and completing the online pre-registration form. Through pre-registration, the candidate grants the BSE permission to share personal data with Pearson VUE testing services.
 - a. Pre-registration must be completed within the advertised registration period.
 - b. Requests after registration closing dates will not be accepted.
 - c. Payment is not expected at the point of pre-registration.
3. **Special accommodations:** additional time, nursing or relief breaks, could be permitted if the candidate:
 - a. Provides documentation from a governing body to confirm the details and reasoning for the special accommodations.
 - b. The documentation must be submitted within the pre-registration window to allow time for BSE to approve and for Pearson VUE to accommodate the request.
 - c. The candidate must immediately contact the Accreditation department if a diagnosis has been made post-pre-registration.
 - d. All queries will be directed to accreditation@bsecho.org, quoting the five-digit BSE ID number.
4. **Registration through Pearson VUE:** upon successfully transferring data to Pearson VUE, the candidate will receive automated messages to create a Pearson VUE account and then book the exam.
 - a. Candidates must read the booking instructions and book the exam within the registration booking window.



- b. Late registrations will not be accepted.
- 5. **Fee payment:** the appropriate fee must be paid in full when booking the exam. The reduced rate only applies to candidates who have taken the second attempt after an unsuccessful first attempt (physical).
- 6. **Cancellations:** cancellations made less than 7 working days before the exam will not be eligible for a refund. Cancellations must be made more than 7 working days before the exam through Pearson VUE.

Appendix 14: Terms and Conditions- Practical assessment

Assessment eligibility:

The BSE Practical Assessment is available to Level II candidates who have successfully passed the written exam with a current membership.

Level 1 candidates with a current membership and a completed logbook are eligible to take the practical assessment.

A mandatory booking fee must be paid when registering for a practical assessment. This fee is non-refundable and cannot be transferred under any circumstances. Places for assessments are allocated on a first-come, first-served basis and depend on the successful submission of the logbook. Once a venue reaches its capacity, candidates' names will be added to the waiting list. Registration will close once the maximum capacity for the practical assessment is reached.

When registering for the waiting list, the candidate acknowledges that a logbook submission deadline is advertised on the registration page and that the candidate intends to submit their logbook by that deadline, even while on the waiting list.

BSE reserves the right to reject registrations that are not eligible for the assessment.

**Booking fee noted online and in the relevant accreditation pack. Fees are subject to annual increases.*

Cancellations:

Cancellations with less than one week's notice (7 calendar days or less) will be classed as a no-show and automatically fail.



Appeals may be considered by the Accreditation Committee in cases of extenuating circumstances.

All cancellations must be made in writing to accreditation@bsecho.org stating name, membership number, date and time of confirmed assessment and reason for cancellation.

Personal Property:

BSE accepts no liability for the loss of belongings at the assessment venue.

Candidates are allowed to bring a bottle of water, any device, and printed reports needed for their assessment. These items can be stored in a simple carrier for easy movement between stations.

Cloakroom facilities differ between venues; we advise candidates to pack their belongings appropriately. Candidates must keep their photographic identification with them at all times.

All items are left in designated areas at the owner's risk. Please do not bring any other valuables.

Logbook and Digital Cases

Logbook reports and digital cases must fulfil the requirements and timelines detailed in the relevant Accreditation pack. The logbook must be submitted by the date advertised on the event's practical registration page.

By registering for the practical assessment, you, as the candidate, have accepted the following:

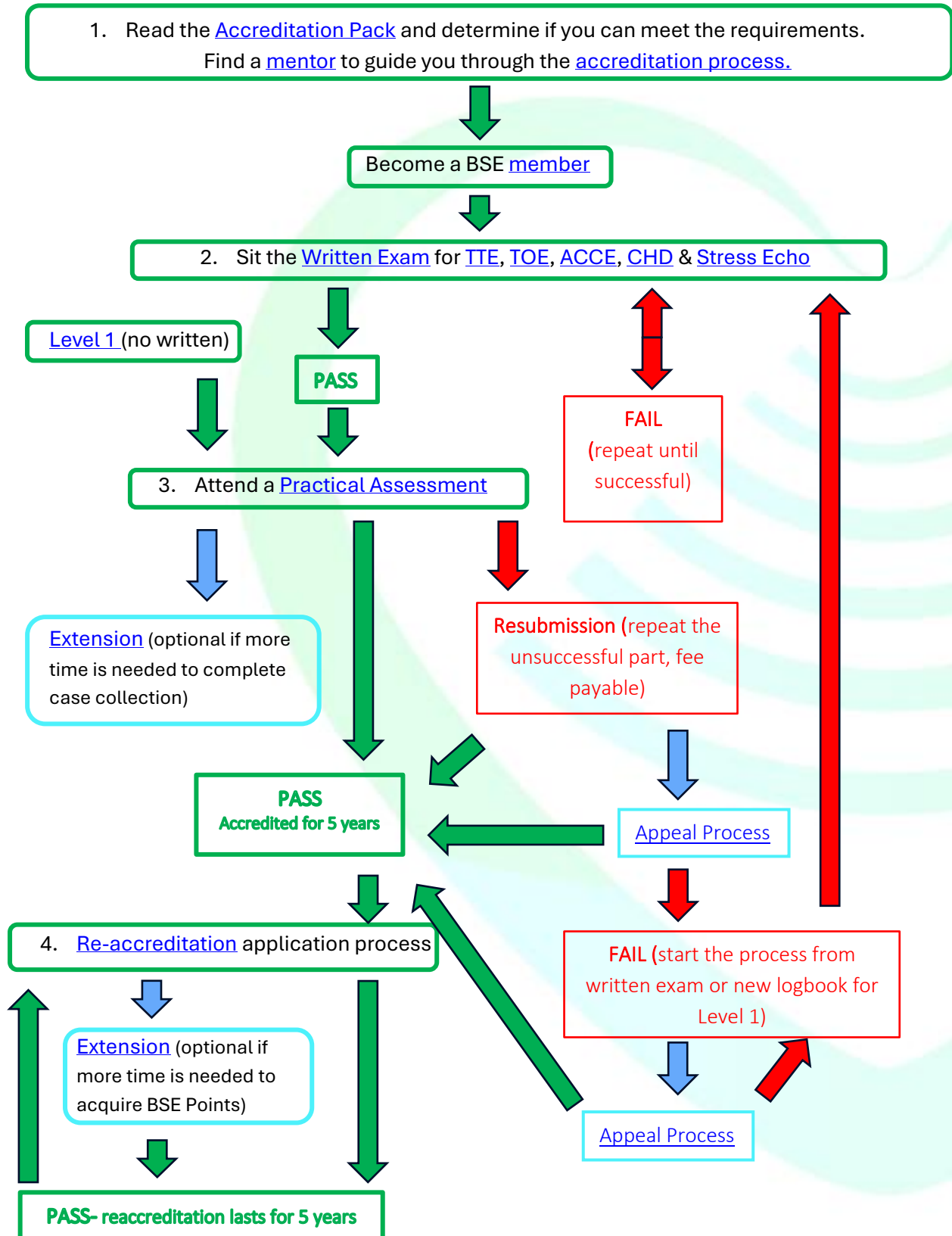
1. You have read the accreditation pack and understand the requirements for achieving BSE accreditation.
2. You have paid the relevant fees and your membership is current.
3. You have passed the written exam, and your work is ready for submission on the date you registered.
4. Your logbook must be submitted by the deadline advertised on the registration page, unless an extension has been authorised by the BSE.
5. Failure to submit the logbook by the agreed deadline will result in the loss of your placement.
6. You understand that the exam and booking fees paid are non-transferable and non-refundable.

Accommodation and Travel:

All participants are responsible for their travel and accommodation if required.



Accreditation Process Overview





Useful Links & Contacts

Click the following titles to link to areas of www.bsecho.org

- [Accreditation process](#)
- [Education resources \(protocols & guidelines\)](#)
- [Extension requests](#)
- [Logbook portal](#)
- [Pearson VUE Testing](#)
- [Practical assessments](#)
- [Re-accreditation](#)
- [Regional representatives map](#)
- [Written examination dates](#)

Join the Accreditation Clinics on the first Thursday of each month at 1 pm to ask questions about accreditation. These clinics are hosted by the Accreditation team, with support from a committee member involved in the assessment process.

Sign up for a 🖱️ [Accreditation clinics](#)

Contacts

- **All accreditation** queries (including exam registrations) and requests to access the portal should be made to accreditation@bsecho.org
- Membership questions should be sent to membership@bsecho.org
- Events, education and e-learning questions should be sent to events@bsecho.org
- Concerns or complaints should be directed to admin@bsecho.org
- Phone number for all areas: 0208 065 5794 (Mon-Fri 9 am-5 pm, excluding UK public holidays)