Guidelines for Resident Education and Progression in COVID-19

1. Safety first.
   i. Any decision regarding education/training must first consider the safety of the residents, safety of patients, and safety of colleagues and coworkers.

2. Wherever/Whenever possible continue with your residency education program.
   i. Consider what ‘phase’ you might be in, in terms of whether your residents are being deployed to other services, or may be deployed to other services.
   ii. If you are in the ‘Peri-COVID’ phase, and your residents have not been redeployed and their education not greatly affected:
      a. Monitor completion of required assessments (for both CBME/CBD and traditional programs).
      b. Provide gentle ‘nudges’ to faculty and residents when required about missing assessments.
      c. Remind faculty to continue to assess and document EPAs.
      d. Monitor resident wellness: recognize that residents and faculty will be anxious and stressed. Check in often.
      e. Plan for any possible redeployment.
iii. What competencies/objectives/EPA’s could your residents accomplish while redeployed (if any).

iv. Consider how subsequent years will need to be adjusted to obtain any missed EPAs/Objectives/Required training experiences (RTEs).

v. If you are in the Deployment phase:
   a. Monitor wellness, safety. Provide re-assurance and support to trainees. Check in with them regularly/prn.
   b. Patient care trumps education.

vi. For the ‘Post-COVID’ phase
   i. Refocus on education:
      a. For each resident, detail what’s outstanding.
      b. Revamp schedule to address outstanding learning needs. Do this in partnership with your residents where possible.
      c. Be flexible; where you can, allow choice for the resident
      d. Connect with your specialty committee (RCPSC or CFPC):
         a. There is likely someone else with the same issues!

vii. Continue to meet as a CC and RPC throughout.

3. Perfection is the enemy of good.
   i. Your competency committee or RPC can use their judgement with regards to number of EPAs observations/assessments required, specifically for residents having difficulty achieving them. If your residents’ education is impacted by the COVID-19 pandemic, look for other opportunities for them to obtain needed competencies in other ways. Consider alternate forms of assessment (e.g. ITARS).

4. Graduates of your program must have demonstrated competence, both in terms of completing the required training experiences and the objectives of training/EPAs/Milestones.
   i. Programs must be able to demonstrate that their graduates have demonstrated competences required by the program. This includes completing the required training experiences, and attaining the competencies/milestones associated with the EPAs.
   ii. Where there is a deviation from the established program, Competency Committees or RPCs must record these decisions/recommendations, provide the rationale for the decision, and document these.

5. Flexibility will be required. What other ‘similar’ experiences and assessment processes can you implement.
   i. On-service:
      a. If they can be achieved, keep your previous plan.
      b. If they can’t be achieved consider a ‘new’ rotation, and new assessment (e.g. ‘covid-orthopedics’). This may mean adjusting schedule once Post-COVID.
      c. When needed, employ more global, less frequent assessments to capture performance which can be mapped back to EPAs later on (e.g. use of ITERs/ITARS, 360 evaluations, procedure logs). Encourage narrative, detailed comments to assist with this. Consider a focus on the intrinsic roles.
d. Consider both clinical and non-clinical topics for distance-based or on-line learning, such as discipline specific online courses, PGME Core Curriculum, selected academic half day topics, or program specific projects (such as developing a local clinical guideline or clinical update).

ii. **Off-service or redeployed:**
   a. Patient care comes first.
   b. This might mean adjusted expectations, as well as competencies and assessments.
   c. Communication is key between PDs/Programs.

iii. If ‘repatriated on-service’ *(e.g. can’t do ICU now, so resident is with home program)*
   a. Consider how schedule will need to alter for next year.
   b. Consider a personalized learning plan.

**Guidelines for Competency Committees (CC) and Residency Program Committees (RPC)**

1. **Continue to meet:**
   i. CC discuss resident progress, gaps in EPA attainment and learning plans to address gaps.
   ii. RPC discuss program issues – assessment, schedules, rotations:
      a. Review and approve any required program changes, and proposed new assessments – ensure rationale documented.
      b. Map new assessments to EPAs for CBME/CBD.
      c. Approve resident progression – document rationale for resident progression in absence of competency/EPA attainment.

2. **Consider options for meetings** – if changes in schedules impact participation. Timing may be out of sync with phase changes. How will decisions be made regarding promotion? Communicate with PGME office.