Resident Educational Support and Assessment Framework 2017-2018
Educational Support

Providing comprehensive educational support optimizes the learning environment for residents and can identify early on residents who need additional supports. The elements of the Department of Family Medicine’s residency educational support strategy include:

**Resident orientation**

Each new Resident receives an orientation to the residency program and to the teaching. As part of this process, Residents complete a self-assessment questionnaire, which provides the basis for an initial education plan.

**Assignment of a Primary Preceptor**

At the start of the residency program, each Resident will be assigned a Primary Preceptor. The Primary Preceptor also plays the role of faculty advisor, and is responsible for professional coaching over the two years of his/her residency.

Professional coaching activities include:

- Orientation to the discipline of family medicine
- Reviewing program objectives and assisting Residents in setting personal learning objectives and education plans
- Helping Residents understand assessment feedback
- Assisting in defining career plans

This is achieved through regular planned meetings (every 6 months) over the course of the residency program.

Residents may request assignment of a faculty advisor who is not directly responsible for their assessment.

**Clinical supervision**

Preceptors within teaching sites will ensure the supervision of clinical activities of Residents.

In each teaching site:

- A Preceptor is assigned to supervise a resident each time the Resident does clinical work.
- Verbal feedback is provided on a daily basis and at least twice weekly, Preceptors will document feedback using Field Notes, Procedural Skills Field Notes, Direct Observation Forms or End-of-Shift Reports.
- To ensure reliability of assessments, and to ensure Residents are exposed to different practice approaches, multiple family medicine supervisors provide supervision to the same resident.

**Reflection in practice**

Residents are encouraged to reflect on their clinical activities and are expected to document their reflections on a twice-weekly basis using Resident Field Notes. These are for the Resident’s use only and are not used in assessment of the Resident.

**Education plan**

To support Residents in achieving short- and long-term learning goals, all Residents will have a documented education plan, which will be reviewed at least twice yearly.
Assessment

Residents are responsible to review rotation objectives and in-training assessment reports (ITARs) prior to the start of rotations. These are available in VENTIS.

The Resident assessment approach includes 2 components:

- Assessment of performance of individual rotations and other learning activities (such as QI projects, PEARLS exercises, etc.)
- A longitudinal assessment of the acquisition of competencies and meeting of specific milestones while progressing through the program

Residents are assessed not only on knowledge and skills, but also on attitudes and professional behaviors.

Assessment includes both formative and summative approaches.

To maximize validity, overall assessment is based on the collection of observations from multiple Preceptors in multiple settings or contexts, and provides a representative sample of the abilities of the Resident.

The assessment process on individual rotations

On rotations, all resident are assessed:

- **Daily**: all Residents receive verbal feedback on a daily basis. At least twice weekly, Preceptors will document feedback in the form of Faculty Field Notes, Procedural Skills Field Notes, Direct Observation Forms or End-of-Shift Reports.
- **Mid-rotation**: formative assessment occurs at the midway point of each rotation. For all rotations less than 6 weeks duration, a face-to-face discussion is acceptable unless there is a borderline or unsatisfactory performance. For rotations longer than 6 weeks, formative assessment must also be in written format.
- **End-rotation**: a summative assessment occurs at the end of each rotation.

During Family Medicine Block Time (FMBT), the Primary Preceptor is responsible for collecting information and completing the ITAR on behalf of the group of supervising Preceptors.

Longitudinal assessment & progression in the program

In a competency-based program, Residents must participate in the assessment of their own competence.

Reflection and self-assessment are critical skills for lifelong learning, which in turn is critical for continued success in practice. To assist in the development of the critical skills of reflection and self-assessment, progress review meetings are completed with the Primary Preceptor at 6-month intervals over the 2-year Family Medicine residency.

As part of the 6-month progress review, Residents will reflect on their achievements and identify areas for further development. The Primary Preceptor meeting with the Resident will monitor progress in achieving educational program requirements, assess the level of performance of Family Medicine Competencies and update the Resident’s education plan.

Following the meeting, the Site Education Directors will report on progress at the Department’s Resident Progress Sub-Committee meeting. The Resident Progress Sub-Committee is responsible for the oversight of Resident progress, and makes recommendations to Postgraduate
Medical Education on promotion, eligibility for the certification exam and confirmation of completion of training.

Consistent with Postgraduate Medical Education policy, the Resident Progress Sub-Committee reviews requests for accommodation, forward feeding and provides oversight of Resident remediation plans.

Accommodation for Postgraduate Medical Residents with Disabilities  

PGME Forward Feed Policy  

FPGME Resident Assessment, Promotion, Remediation, Probation, Suspension and Dismissal Policy  
Linkages to the DFM Competency Framework

Assessment tools have been designed to link to family medicine foundational and domain-specific competencies articulated in the Department of Family Medicine Competency Framework. ITAR items are articulated in terms of expected PGY1 or PGY2 milestones.

Assessment parameters

All tools (Field Notes, Direct Observation Forms, End-of-Shift Reports, ITARs, Periodic Review of Progress Forms) are designed to integrate the CFPC’s Six Dimensions of evaluation and CanMEDS-FM roles. For ease of use, the CFPC’s Six Dimensions and CanMEDS-FM have been integrated into a single set of assessment parameters:

**FM Expert**: Integrates all of the CanMEDS-FM roles, applying medical knowledge, clinical skills, and professional values in their provision of high quality and safe patient-centred care.

- **Patient-centered**: Focuses on the patient and his/her context and not on the disease alone.
  - Explores illness - Understands whole person/context – Builds common ground - Builds relationship - Is realistic
- **Selectivity**: Demonstrates a selective approach, adapting it to the patient and the context.
  - Appropriately focused – Appropriately thorough – Establishes priorities – Distinguishes between urgent and non-urgent
- **Clinical reasoning**: Gathers and interprets data in order to arrive at diagnosis and management.
  - Generates hypothesis/differential diagnosis – Gathers data (Hx & Px) – Makes decisions – Sets goals and objectives
- **Procedural skill**: Demonstrates appropriate technical skills and approaches to procedures.
  - Decision to act – Informed consent & preparation – Comfort & safety during procedure – Re-evaluation if problems - After care

**Communicator**: Utilizes effective verbal and non-verbal skills when interacting with patients.

- Listening skills – Verbal & written language skills – Non-verbal skills – Culture & age appropriateness – Attitudinal

**Collaborator**: Communicates and works effectively with colleagues and other professionals.

- Listening skills – Verbal & written language skills – Non-verbal skills – Teamwork - Handover

**Leader**: Takes responsibility for the delivery of excellent patient care.

- Resource allocation – Cost appropriateness – Leadership – Practice Management – Quality improvement

**Health Advocate**: Seeks to understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.

- Determinants of health – Community resources – Barriers to care

**Scholar**: Committed to continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.

- Identifies learning needs – Manages own learning - Integrates evidence – Teaches – Engages in scholarship

**Professional**: Committed to the well-being of individual patients and society through ethical practice, high personal standards of behaviour.

- Responsible/Reliable – Knows limits – Flexible – Evokes Confidence – Caring/Compassionate – Respect/Boundaries – Collegial – Ethical/Honest – Maintains good balance – Mindful approach
## Educational Program Requirement 2017-2018

### Rotations:

All Residents successfully complete all rotations, attaining associated competencies to the satisfaction of the Resident Progress Sub-Committee.

<table>
<thead>
<tr>
<th>Documentation</th>
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<tbody>
<tr>
<td>In-Training Assessment Reports (ITARs) of each block rotation submitted to the Department within one month of completion of the rotation, through the web-evaluation tool (VENTIS). ITARs on Family Medicine Block Time are completed every 2 periods.</td>
</tr>
<tr>
<td>In-Training Assessment Reports (ITARs) of each horizontal rotation submitted to the Department within one month of completion of the rotation.</td>
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### Resuscitation courses:

All Residents are to successfully complete:
- **Advanced Cardiovascular Life Support** (ACLS),
- **Advances in Labour and Risk Management** (ALARM) and **Neonatal Resuscitation Program** (NRP).

Residents in the Bilingual, Northern/Remote, and Rural Streams must successfully complete **Advanced Trauma Life Support** (ATLS) course.

Residents in the Northern/Remote Stream must successfully complete **Pediatric Advanced Life Support** (PALS) and the **Procedural Sedation** courses.

- Proof of completion of required resuscitation courses.

### Core College of Medicine PGME courses:

All residents shall attend the following core PGME courses:
- Resident & Learning Environment
- Teacher Development Program 1 (online)
- Teacher Development Program 2 (online)
- Conflict Management (online)
- Professional Boundaries
- Practice Management *

* For Family Medicine Residents, Practice Management course requirements are covered in the practice management academic day sessions.

### Core Family Medicine PGME courses:

All Residents shall attend the following core FM PGME course:
- Indigenous Cultures Awareness Workshop

### Academic days:

All Residents shall demonstrate 75% attendance at Family Medicine Academic Days.

- Sign in sheets at Academic days.

### Scholarly activity:

All Residents will attend the PGY1 workshop on Evidence-Based Medicine.

All Residents will complete PEARLS exercises in both PGY-1 and PGY2 years.

**PGY1- Patient based questions:**
- Therapy - Diagnostic test - Prognosis/Harm

**PGY2- Practice based questions:**
- Overview article - Clinical practice guideline

- EBM pre-test and written article analysis.
- PEARLS submissions.
All Residents shall complete a group Quality Improvement Project in PGY-1.

All Residents shall complete an individual Quality Improvement Project in PGY-2 and present to Resident Research Day.

All Residents shall present a minimum of once per year at a journal club.

All Residents shall present at least twice a year at guideline review.

**Procedural skills:**

All Residents must demonstrate competence in performing “High Priority Procedures.” All Residents are required to document at least 10 different “Low Priority Procedures”

**Practice SOOs & SAMPs:**

All Residents shall complete a minimum of 6 Simulated Office Orals in PGY1, and 3 in PGY2 years.

All Residents will complete a practice SAMP exam in PGY2.

**Observation & feedback in the clinical setting:**

During Family Medicine rotations, Residents shall be observed regularly in the clinical setting.

**Periodic Progress Review:**

Attainment of competence will be reviewed regularly during the residency (every 6 months).

Ultimate decisions about Resident acquisition of competence and decisions for promotion are made by the Resident Progress Sub-Committee.

**In testing phase at select sites in 2017-2018 Entrustable Professional Activities:**

All Residents shall demonstrate progress to achieving Entrustable Professional Activities (EPAs)

** EPAs will not be used as a formal requirement for completion of the program in test sites**

Project submission.

Project submission and presentation.

Journal Club feedback.

Guideline review feedback.

Procedural Skills Field Notes or other documentation of procedural skills competence (i.e., ITARs).

Completed score sheets for each Practice SOO.

Documentation of attendance.

Daily documentation with field notes is recommended. A minimum of 2 faculty-generated and 2 resident-generated field notes based on direct observation of resident performance with a patient is required in each week of block time.

A minimum of 2 complete patient interviews will be directly observed per year. Ideally, these will be recorded for review with the Resident.

Residents are responsible for building a portfolio, which demonstrates they are acquiring the expected competencies, and receiving ongoing feedback.

Adequate field notes (and other formative and summative assessments) are required to document attainment of competence in all the Clinical domains and across CanMEDS-FM roles.

Documentation is completed on Periodic Review of Resident Progress forms every 6 months.

EPA tracking tool completed by the Primary Preceptor in select sites.

The maximum length of training may not exceed 4 years. This includes leaves of absence.