



<p>Departmental Operating Standard Department of Family Medicine Residency Program Assessment</p>
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**DEPARTMENT OF FAMILY MEDICINE
 CORE AND ENHANCED SKILLS PROGRAM RESIDENCY ASSESSMENT OPERATING STANDARD**

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<p>Approval Authority Family Medicine Postgraduate Executive Committee (PGEC)</p>	
<p>Implementation Authority Postgraduate Director – Family Medicine</p>	
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- Purpose**
1. 1.1. The purpose of this Operating Standard is to outline the process governing the assessment of Family Medicine Residents’ performance and progress in the Core Family Medicine and Enhanced Skills Residency Training Programs in the Cumming School of Medicine at the University of Calgary.
 - 1.2. This Operating Standard has been developed in compliance with the accreditation standards of the College of Family Physicians of Canada (CFPC).
- Scope**
2. 2.1. This Operating Standard applies to all Family Medicine Residents in the Core Family Medicine and Enhanced Skills Residency Training Programs in the Cumming School of Medicine, at the University of Calgary as well as any pre-transfer Residents.
 - 2.2. This Operating Standard does not apply to Residents from other programs completing electives in Family Medicine in which case the Resident’s own program assessment policies and processes apply.
 - 2.3. In this document, the word “must” is used to denote something that is required, and the word “should” is used to denote something which is highly recommended.

Definitions

3. In this Operating Standard;

- 3.1. “Academic year” means the entire calendar year from the initial date of commencement of residency training (usually July 1) and thereafter, annually based on the promotion date to the next training (PGY) level.
- 3.2. “AHS” means Alberta Health Services.
- 3.3. “Associate Dean” means Associate Dean of Postgraduate Medical Education in the Cumming School of Medicine at the University. The Associate Dean is the senior faculty member responsible for the overall conduct and supervision of postgraduate medical education within the School.
- 3.4. “Assessment” means performance feedback that is both Formative and Summative and is a systematic mechanism for the collection and interpretation of performance feedback data given to or provided about a Resident to inform progress and overall performance. While “Assessment” is preferred to avoid ambiguity around evaluation of program elements and preceptors, “Evaluation” has been used interchangeably with “Assessment” in the past.
- 3.5. “Assessment for Learning” or Formative Assessment means assessment that is continuous, constructive and ‘low stakes’. Its overall purpose is to guide and improve the learner’s performance.
- 3.6. “Assessment for Progression” (or Summative Assessment) means assessment that integrates multiple sources of information and feedback, and is used to make decisions around advancement, including completion and promotion, by comparing a Resident’s performance to the Assessment Objectives.
- 3.7. “Block” means a required element of training, which is a continuous clinical experience, of a prescribed length and duration. While the term “Rotation” is sometimes used synonymously, a “Rotation” may be comprised of multiple “Blocks” of training
- 3.8. “Assessment Objectives¹” means the essential skills and observable competencies that are expected from residents at the end of their training, as defined by the College of Family Physicians of Canada, and incorporate skill dimensions, priority topics, phases of the encounter, and key features, as applicable to programs.
- 3.9. “Calgary Program” means the part of the Core Calgary FM Residency Programs which is based in the city of Calgary, and is comprised of 3 Divisions: North-West, North-East and South.
- 3.10. “Calgary Resident” means a Resident in the Calgary Program.
- 3.11. “Competence Committee” means the committee in Enhanced Skills Programs that synthesizes the assessment data for each trainee and makes recommendations related to promotion (or progress).
- 3.12. “CanMEDS-FM” means the framework describing roles and/or competencies implicit to the overall core knowledge skills and

¹ “Assessment Objectives” were previously defined as “Evaluation Objectives” but the language has changed to reflect a consistent definition of Assessment, being in relation to learners, whereas Evaluation applies to Programs and preceptors.

abilities of family physicians, as adopted by the College of Family Physicians of Canada.

- 3.13. "Category 1 Program" means an Enhanced Skills Program that leads to a Certificate of Added Competence by the College of Family Physicians of Canada.
- 3.14. "Category 2 Program" means an Enhanced Skills Program that does not lead to a Certificate of Added Competence by the College of Family Physicians of Canada.
- 3.15. "Core Program" means the program accredited by the College of Family Physicians of Canada to train residents to be competent to enter and adapt to the independent practice of comprehensive family medicine anywhere in Canada.
- 3.16. "CFPC" means the College of Family Physicians of Canada.
- 3.17. "Clinical Coach" means the individual who provides day-to-day teaching, supervision, and guidance around the competencies required of a family physician, and stimulates clinical reasoning and problem-solving, both with individual learners and groups of learners in the clinical setting.
- 3.18. "Competency Based Medical Education (CBME)" means a medical education framework or approach to program design that focuses on outcomes (acquisition of skills, knowledge, competencies, or Program elements), which may not be constrained by defined periods of time, such as Blocks or Rotations, for their acquisition.
- 3.19. "Competency Coach" means a Family Medicine preceptor who facilitates the regular review of learner progress throughout training. They help orient the Resident to the discipline of Family Medicine; help the Resident set personal learning objectives and oversee their drafting at the time of each progress review; guide the Resident in identifying appropriate educational resources to help achieve these objectives; help the Resident reflect on feedback; and help the Resident with career planning. The Competency Coach also facilitates the learner taking ownership of personal lifelong learning and career development by providing guidance and advice and using assessment tools, such as learning plans and portfolios. The Competency Coach also examines available assessment data to make decisions around Resident progress. In Enhanced Skills Programs, individual Program Directors may act as the Competency Coaches, and are responsible for regular progress reviews with their respective residents.
- 3.20. "Continuity Preceptor" means the physician in the Rural Program identified as the Family Medicine Resident's main Preceptor in their FM Continuity Clinic experience during PGY1. The "Continuity Preceptor" may act as a Resident's "Competency Coach".
- 3.21. "Coordinator" means the program administrative staff member with responsibility for a relevant section of the Program.
- 3.22. "CPSA" means the College of Physicians and Surgeons of Alberta.
- 3.23. "Director" means the relevant Program leader responsible for coordinating and supporting the Program in any of the Calgary Program (Division Director), Rural Program (Site Director), or individual Enhanced Skills Programs. Directors report to the

Postgraduate Director, or in the case of individual Enhanced Skills Directors, to the Overall Enhanced Skills Director. Directors may act as a “Competency coach”

- 3.24. “Dismissal” means the dismissal of a Resident from a Program in keeping with the grounds laid out in the Family Medicine Remediation, Probation, and Dismissal Policy.
- 3.25. “Educational Experience” means an experience in a particular environment or set of environments selected/designed to support the Resident’s achievement of competencies. This may or may not occur in a “Block” or “Rotation”, and may be a clinical (e.g. “Rotation” or longitudinal clinical experience) or non-clinical “Program Element” such as a mandatory course or project.
- 3.26. “Enhanced Skills Program” means an additional formal and focused training period in a specialized area of family medicine after completion of a Core family medicine residency program.
- 3.27. “Elective” means a learning experience chosen by the Resident based on their identified learning needs.
- 3.28. “Entrustable Professional Activity (EPA)” means a unit of professional practice that can be fully entrusted to a resident, as soon as they have demonstrated the necessary competence to execute this activity unsupervised.
- 3.29. “Faculty Adviser” means an individual who undertakes a role similar to the “Competency Coach” but who does not have a primary responsibility of assessment of the Resident. Residents may in certain circumstances be provided with a distinct Faculty Adviser where necessary or appropriate.
- 3.30. “Failed Rotation” shall have the meaning set out in Section 10.
- 3.31. “Field Note” means a categorized, narrative record of feedback provided by a supervising Preceptor or other health care professional based on direct observation of Resident performance/behavior or case discussion.
- 3.32. “FM Block” means a 4-week period in the Calgary Program where the Resident is predominantly in their home FM clinic. During these blocks the Resident spends time in scheduled PLUS experiences based on specific domains of care.
- 3.33. “FM Community” means a Calgary Program 4-week block when the Resident is based in their home FM clinic 2 days a week and in another FM clinic for the other 2.5 days per week.
- 3.34. “Focused Learning Plan” means a structured learning plan drawn up by the Resident and their Competency Coach (with input from the relevant Director if needed) or by the Resident and their Director to describe an area of Performance Deficiency requiring focused attention to bring the Resident up to the expected level of proficiency, but not yet requiring a formal period of Remediation. The plan includes a description of how the deficiency will be addressed and does not require any extension to training, nor does it impede promotion to the next PGY level. Where there is insufficient improvement on a Focused Learning Plan, the Resident may be referred to the Resident Progress Subcommittee.

- 3.35. "Home Clinic" means the clinic where the Calgary Family Medicine Resident is based for continuity Family Medicine clinic experiences over the duration of training.
- 3.36. "Immersion Rotation" means a 2-8 week, mandatory rotation in an off-service experience, and which uses specific assessment tools as described in Appendix A
- 3.37. "Incomplete Rotation" shall have the meaning set out in Section 7.
- 3.38. "iSAP" means informed Self-Assessment of Progress. This is a reflective tool completed by Residents ahead of each progress review meeting with their Competency Coach.
- 3.39. "ITER" means In-Training Evaluation Report. This can include a Remediation ITER and Probation ITER.
- 3.40. "Key Feature" means the operational level, problem-specific description of competence in a given situation that is dealt with by Family Physicians (organized by CFPC Priority Topics). This is the component that is used for the assessment of competence in specific situations during daily clinical supervision.
- 3.41. "Milestone" refers to an observable marker of a learner's ability along a developmental continuum towards competency. Milestones are used for planning, teaching, and monitoring resident progress. In the Family Medicine Residency Program, these may include benchmark supervision levels or levels of entrustment for individual EPAs identified over the period of training. The Programs also use specific requirements for Promotion to the next PGY level (in Enhanced Skills to graduated levels of responsibilities), and completion of training.
- 3.42. "MRITER" means Mid-Rotation In-Training Evaluation Report.
- 3.43. "ORITER" means Overall Rotation In-Training Evaluation Report, usually completed at the end of an immersion rotation. They are aligned with the set learning objectives for the rotation as well as the CFPC 6 skill dimensions and Program EPAs, as appropriate.
- 3.44. "Performance Deficiency" means inadequate performance in one or more of knowledge, skills, or attitudes, including professional behaviors, any one, or combination of which may lead to a Failed Rotation or a "refer to RPS" decision at the time of a Progress Review.
- 3.45. "Personal Learning Plan" means a description of a Learning/Change Plan constructed by the Resident ahead of each Progress Review as part of the regular cycle of assessment and periodic review in the Program. The Learning Plan describes the changes a Resident wishes to make, what the Resident will do, when the plan will begin, timelines, resources, barriers and a description of how success attainment in listed changes will be assessed/measured.
- 3.46. "PGME" means Postgraduate Medical Education.
- 3.47. "PGY" means postgraduate year and is used interchangeably with residency (R) year.
- 3.48. PLUS Experience means a collection of themed clinical learning experiences within a specific domain of care.
- 3.49. "Preceptor" means a physician directly responsible for a period or segment of the Resident's professional training, teaching and/or instruction.

- 3.50. "Priority Topics", along with core procedures, are a list of problems or situations that a Family Physician must be competent to deal with upon entry into unsupervised practice.
- 3.51. "Probation" is a formal program of individualized educational support, assessment and monitoring with the requirement that the resident must demonstrate sufficient improvement in order to continue in the Residency Program, and has the meaning set out in the Family Medicine Remediation, Probation, and Dismissal Policy.
- 3.52. "Probation Supervisor" means the identified Preceptor responsible for taking the lead during a period of Probation. This includes seeking input from others in completing assessment tools e.g. Probation mid and final ITERs.
- 3.53. "Program" means the Family Medicine Residency Training Program at the Cumming School of Medicine, at the University of Calgary.
- 3.54. "Program Element" means any component of the Program which is part of training. This includes clinical and non-clinical experiences, such as courses, academics, projects, and requirements as determined by the Program.
- 3.55. "Postgraduate Director" means the person responsible for the overall conduct of the Residency Training Program. The Postgraduate Director may delegate responsibilities attributed to them in this Operating Standard to another individual, as they deem appropriate.
- 3.56. "Progress Report" means the written report generated at the completion of the "Progress Review". It serves as both a formative (Assessment for Learning) and summative (Assessment for Progress) construct, and describes if a Core or Enhanced Skills Program resident is "on track" or not, in relation to the expected progress towards acquisition of competencies at each specified time point. The Report also includes a learning plan which has been agreed upon between the Resident and their Competency Coach. It must be signed by the Resident, their Competency Coach, and the Resident's Director. In Enhanced Skills, it must be signed by the resident and Program Director who may act as the Competency Coach.
- 3.57. "Progress Review"(or Periodic Review) means, in the Core FM Program, the scheduled meeting between the Resident and their Competency Coach which occurs generally every 4-5 months over the period of training. During this meeting, the Competency Coach and Resident review the assessment data collected over the previous 4-5 months, the Resident's informed self-assessment, and the Resident's draft learning Plan. The Competency Coach provides feedback on the Resident's progress in relation to the Assessment Objectives, Skill Dimensions, and EPAs, and assesses the Resident's performance against the expected level of competency (level of supervision) for the time point at which the review occurs, as appropriate to the program. The Competency Coach decides whether the Resident is performing at the expected level (on track, or not). A "Progress Report" and updated learning plan are completed at the end of each review.

- 3.58. "Remediation" means a formal program of individualized educational support, assessment and monitoring to assist in correcting identified Performance Deficiencies, as defined in the Family Medicine Remediation, Probation, and Dismissal Policy.
- 3.59. "Remediation Supervisor" means the identified Preceptor responsible for taking the lead during a period of remediation. This includes seeking input from others in completing assessment tools e.g. remediation ITER.
- 3.60. "Residency Program Committee" (RPC) means the committee or delegated subcommittee that assists the Postgraduate Director in the planning, organization, and supervision of the Residency Training Program.
- 3.61. "Resident" means a physician enrolled in the Calgary or Rural Family Medicine Residency Program at the Cumming School of Medicine, University of Calgary or a Resident on a pre-transfer rotation.
- 3.62. "Rotation" means a required element of training, which usually is a continuous clinical experience, of a prescribed length and duration. A completed rotation is defined by the Attendance and Absence Policy. The term "Block" may also be used interchangeably for any single continuous clinical experience.
- 3.63. "Rotation Assessment" means the written feedback which may be provided at the end of a rotation and may be comprised of information compiled from one or more assessment tools as determined by the Program (see Appendix A).
- 3.64. "Rotation Lead Preceptor" means the named preceptor who is responsible for overseeing the learning experience of the Resident and for completing any interim and/or final assessments of the Resident.
- 3.65. "Resident Progress Sub-committee" (RPS) means the committee responsible for reviewing Residents in difficulty, determining the need for and review of remediation, probation and dismissal. In the Core Program, RPS also makes decisions about promotion and completion.
- 3.66. "Rural FM" means a mandatory rural Family Medicine rotation which is between 4 and 24 weeks in duration.
- 3.67. "Rural Program" means the part of the Core Calgary FM Residency Programs which is based outside of Calgary in distributed sites in Southern Alberta (e.g. Medicine Hat and Lethbridge).
- 3.68. "Rural Resident" means a Resident in the Rural Program.
- 3.69. "School" means Cumming School of Medicine at The University of Calgary.
- 3.70. "Selective" means a structured Rotation in which Residents choose to participate. A Selective may occur during an Elective block, or longitudinally. By committing to participate in a Selective, Residents cannot withdraw later. This reflects the intensity of schedule planning by the Rotation or experience. which is a requirement of schedule planning by the receiving experience. Examples may include CCU and ICU.

- 3.71. “Skill Dimension” is one of the six essential generic skills that allow a Family Physician to deal competently with problems in the domain of Family Medicine, as defined by the CFPC Assessment Objectives. They include: patient-centered care, communication, clinical reasoning, selectivity, professionalism, and procedural skills.
- 3.72. “University” means University of Calgary.

Guiding Principles

4.

- 4.1. Fairness: Assessment must be fair, equitable, timely, and unbiased.
- Core FM Program**: Assessment is based on EPAs, Skill Dimensions, Assessment Objectives and additional identified program-specific competencies and completion requirements and takes into account the PGY level of the Resident. The PGY level denotes progressively increasing responsibilities and decreasing level of direct supervision of the Resident.
- Enhanced Skills Programs**: Assessment in all ES Programs is based on Assessment Objectives and program-specific completion requirements. In addition, Category 1 Programs assess EPAs.
- 4.1.1. Where possible the timing of the provision of assessments must be adhered to when made explicit in this Operating Standard and when not explicit is generally expected to occur within twenty-eight (28) days of the completion of a required Program Element.
- 4.1.2. Feedback should be specific and include both strengths and deficiencies with advice and assistance for improvement, even for Residents who are doing well.
- 4.1.3. A Preceptor should not discuss the performance of a Resident with another Preceptor until between them they have independently supervised and observed (and documented an assessment) of the Resident’s performance. This can be achieved through the use of various assessment tools (e.g. Field Notes).
- 4.2. Transparency: expectations are clearly articulated between the Resident and Program, at the Program outset and as policies are revised. This includes the clear identification of the processes and steps that are undertaken when it is determined that a Resident is not progressing as expected.
- 4.2.1. Performance expectations and methods of assessment for each Program component must be communicated to the Resident in advance of or at the beginning of each Program component or educational experience.
- 4.2.2. Discussion of Performance Deficiencies in any area may be given during rotation feedback, in required Assessments, or they may be addressed separately with the Resident. The Resident **must** be informed of Performance Deficiencies in a timely manner so that the Resident has an adequate opportunity to remedy Performance Deficiencies before the end of the Rotation or Educational Experience.

- 4.3. Open Communication: there must be open, ongoing and timely communication between Program Directors or delegates, Preceptors and Residents.
- 4.3.1. Together with Rotation Assessments, frank, accurate, and timely Assessments must be provided to Residents during Rotations and Educational Experiences. These include verbal, informal, formative feedback, and written Assessments which may constitute Assessments for both Learning and Progress.
 - 4.3.2. There must be ongoing dialogue with the Resident about their performance and progress through feedback given as part of each Rotation or Educational Experience.
 - 4.3.3. Preceptors must provide documentation of informal feedback in the case of significant Performance Deficiencies and/or a repeated pattern of minor deficiencies (using Field Notes, MRITERS, or others, including emails to the Resident and records of meetings etc.). Recommendations for improvement and correction of minor Performance Deficiencies are part of this process.
 - 4.3.4. Feedback should be specific and include both strengths and deficiencies with advice and assistance for improvement, even for Residents who are doing well.
 - 4.3.5. Feedback should be in-person whenever possible, though video- and teleconferencing is acceptable.
 - 4.3.6. Every Resident must receive feedback and advice on how to meet objectives and EPAs from their Director, or delegate (i.e. Competency Coach), at least every four (4) months.
 - 4.3.7. All feedback should be documented and kept in the Resident's file.
 - 4.3.8. Preceptors must inform the relevant Director when a Resident demonstrates significant Performance Deficiencies
 - 4.3.9. Notwithstanding the requirement for timely feedback, the Program may use information from any assessments that are provided late to inform decisions around Remediation, Probation and Dismissal.
- 4.4. Mutual Accountability: progress through training is a joint responsibility of both the Resident and the Program; as such, Residents are not passive recipients of the assessment process, but should be active participants in their own acquisition of competence.
- 4.4.1. Residents are active partners in their learning and are responsible for reviewing written feedback, reflecting on, and documenting verbal feedback (e.g. using Field Notes) and acting on all feedback. Residents are responsible for requesting that feedback be provided to them beyond formal Assessment requirements.
 - 4.4.2. Preceptors have a responsibility to provide verbal and written feedback to Residents.
 - 4.4.3. Results of Assessments must be provided to Residents in a timely manner.

- 4.4.4. Residents have a responsibility to both review and act on Assessments in a timely manner.
- 4.4.5. Residents experiencing difficulties must be advised of the support available to them through the Professional Association of Resident Physicians of Alberta and that they may request accommodations based upon restricted grounds as per Human Rights legislation through the PGME's Resident Accommodation Committee..
- 4.4.6. Assessment of a Resident's on-going progress is the joint responsibility of the Resident, their Competency Coach, and the Program. Where applicable, this includes progress in relation to identified EPAs and Assessment Objectives.

**Policy
Statement**

5. Process of Assessment

- 5.1. Residents must receive timely, regular and meaningful feedback on their performance, both on a day-to-day basis and also in relation to expected development of competencies and competency over time.
 - 5.1.1. In the Core FM Program, Competency Coaches should meet with their Residents at least every 4-5 months, as specified by the Program, for Progress (Periodic) Reviews to provide feedback on how the Resident is progressing in relation to the identified EPAs and Skill Dimensions for the Program and to provide advice on how the Resident might continue to develop towards expected competencies.
 - 5.1.2. In Enhanced Skills Programs, Individual Enhanced Skills Program Directors who act as Competency Coaches for their Program's Residents meet with these Residents regularly, as specified by their Program, for Progress (Periodic) Reviews to provide feedback on how the Resident is progressing in relation to the identified EPAs and Assessment Objectives for Category 1 Programs and individualized learning objectives for Category 2 Programs, and to provide advice on how the Resident might continue to develop towards expected competencies.
 - 5.1.3. The Programs have a set of EPAs as a description of the expected goals of training (see Appendices A through D).
 - 5.1.4. The Assessment program is based on the collection, collation and regular review of multiple assessment data that allows the Resident's Clinical Coaches to gradually reduce the supervision level of the Resident in relation to a subset of identified EPAs to the point of readiness for unsupervised practice. Assessment is based on expected levels of supervision for this set of EPAs at various time points over the period of training. The Competency Coach and the Resident's Director also assess and review the Resident's progress towards readiness for independent practice in relation to the remaining EPAs by the end of the training period.
 - 5.1.5. The Assessment Program for the Core FM Program also employs the six Skill Dimensions as defined by the CFPC to monitor and provide feedback around resident progress throughout training.

- 5.2. The Residency Programs use various assessment tools (see Appendices A through D) and explicit criteria to assess Residents readiness, by the end of training, for unsupervised, clinical practice. For this to occur, the Resident must demonstrate an acceptable level (4 or 5) of entrustability on all EPAs, and competency in the six Skill Dimensions as appropriate, with no performance concerns. Evidence for this is gained through Assessment of competence based on the CFPC Assessment Objectives (and in Category 2 Enhanced Skills Programs the Resident's individualized learning objectives) as well as the other mandatory completion requirements of the Program.
- 5.2.1. Frank, accurate, and timely assessments must be provided to Residents during all clinical experiences. These include face-to-face and written assessments as well as feedback given frequently throughout clinical experiences by Preceptors as in section 5.1.1.
- 5.2.2. Results of Assessments must be provided to Residents in a timely manner. The Resident has a responsibility to review and act on assessments in a timely manner.
- 5.2.3. Discussion of Performance Deficiencies in any area may be given in required Assessments or they may be addressed separately with the Resident during or at the end of any clinical experience, when reviewing a mid-rotation ITER, or during a Progress Review.
- 5.2.4. The Resident must always be informed of Performance Deficiencies in a timely manner so that the Resident has an adequate opportunity to remedy Performance Deficiencies before any subsequent Assessment for Progress (Summative Assessment) is completed (e.g. completion of an overall rotation ITER or Progress Report).
- 5.2.5. If a Resident completing an educational experience that uses a Rotation Assessment (e.g. ITER) is informed of a Performance Deficiency in a timely manner, but the time or experiences remaining do not allow the Resident to demonstrate satisfactory improvement prior to completion of the experience, the Rotation Lead Preceptor may be justified in determining that the Resident was unsuccessful on the Rotation ("fail").
- 5.2.5.1. For example, where a Performance Deficiency is identified during the final week of a Rotation, and the remaining experiences do not permit the Resident to demonstrate satisfactory improvement of the identified deficiency, the Rotation Lead Preceptor may, depending on the significance of the deficiency, deem the overall performance to be unsatisfactory ("fail").
- 5.2.6. If a Resident completing an educational experience that does NOT use a Rotation Assessment (e.g. ITER) is informed of a Performance Deficiency in a timely manner, but the time or experiences remaining do not allow the Resident to demonstrate satisfactory improvement prior to completion of the experience, the Competency Coach may be justified in determining that there are Performance Deficiencies Identified and refer the Resident to RPS, or institute a Focused Learning Plan.

5.2.7. Where a Resident has been identified as not having demonstrated the requirements for program completion as described in Appendices B and D (e.g. EPAs, Skill Dimensions, required program elements), and the Educational Experiences remaining in their training are deemed by their relevant Director or Competency Coach to be insufficient to allow their acquisition, the Program may:

5.2.7.1. adjust remaining experiences to increase the likelihood of addressing these deficiencies (e.g. changing a Resident's rural rotation to a site that performs deliveries)

5.2.7.2. direct the Resident to adjust any remaining elective time to undertake experiences that will address these deficiencies

5.2.7.3. refer the Resident to RPS for the consideration of an extension of training to ensure their acquisition prior to program completion.

5.2.8. When there is insufficient Assessment data available to make a decision on an Assessment for Progress (Summative Assessment) including ITERs or Progress Reviews, the Program may determine an experience is "incomplete". The Program may require the Resident to:

5.2.8.1. repeat the Educational Experience with an extension of training

5.2.8.2. use elective time to acquire the necessary assessment data to enable decision making.

5.2.8.3. modify remaining rotations to increase the likelihood of addressing these deficiencies, or

5.2.8.4. make other arrangements to ensure the Resident meets program requirements.

This applies to those examples described under 13. Special Situations.

5.3. The primary tools for final Assessment of a Resident are defined in Appendices A and C

5.3.1. ORITERs are used to record final, summative, rotation Assessments for Progress.

5.3.2. Progress Reports are used throughout the period of training to make Summative decisions about whether the Resident is on track ("progressing as expected") towards readiness for unsupervised practice (Appendix C).

5.3.3. Any Resident receiving written feedback in any ORITER or Progress Report highlighting significant Performance Deficiencies, including but not limited to Pass With Concerns or Fail, must arrange to meet with their relevant Director within 28 days of receiving this feedback.

5.4. The completion of a program-specific Progress Review (e.g. Appendix C) is a shared responsibility.

5.4.1. The Director and their associated Coordinator are responsible for collating and preparing the relevant elements of the Progress Review ahead of time.

- 5.4.2. The Resident is responsible for completing and submitting the relevant portions of the Progress Review, such as a satisfactorily completed iSAP, a draft updated Learning Plan, and copies of any Field Notes or other assessment tools not in the possession of the Program (e.g. captured outside of electronic methods) for the period under review to their Competency Coach.
- 5.4.3. These submissions must be provided ahead of any scheduled Progress Review such that the Competency Coach has adequate time to prepare for the meeting.
- 5.4.4. The Competency Coach's responsibility is to:
 - 5.4.4.1. review the resident assessment data for the period of review, ISAP, resident proposed learning plan, and the resident-completed portion of the progress review in its entirety
 - 5.4.4.2. complete and submit the Progress Report
 - 5.4.4.3. make a judgement of resident progress
 - 5.4.4.4. provide coaching to the Resident to attain expected competencies and assist the Resident in updating learning plan
 - 5.4.4.5. communicate to the Program about resident deficiencies if the resident is "not on track".
- 5.4.5. The Competency Coach or Competence Committee, Director, and Resident must sign-off all completed Progress Reports.
- 5.4.6. Rotation Lead Preceptor must complete and submit all ORITERs.
- 5.4.7. The Resident's signing-off (signature) on a Progress Report does not mean that the Resident necessarily agrees with its content but acknowledges that they have seen and read its details.
- 5.4.8. It is a Resident's responsibility to review all Assessment data including Progress Reports in a timely manner and arrange any required follow up.
- 5.4.9. A Resident failing to review and/or sign-off on a MRITER, ORITER or Progress Report, whether through oversight or refusal, does not constitute procedural unfairness in the event of an appeal.
- 5.4.10. The individual Enhanced Skills Program's Competence Committee or equivalent Resident Progress Subcommittee's responsibility is to ratify the ES PD's recommendation of the Resident's progress based on the review of each Resident's progress over the training period, and contribute to making promotion and completion of training decisions to the ES PD.
- 5.5. Where a Resident has received an Assessment that indicates that Performance Deficiencies have been identified (including on an ITER, Progress Review, or other non-summative Assessment tools including Field Notes) Residents may be referred to the Resident Progress Subcommittee (RPS) for review, in accordance with its Terms of Reference.
- 5.6. Where Performance Deficiencies not otherwise captured in the relevant Assessment tools are identified and shared with the Program, a written record should be created and shared with the Resident.

- 5.7. Uncorrected Performance Deficiencies on any type of assessment may contribute to failing a relevant Rotation or a decision by a Continuity Preceptor, Competency Coach or Competence Committee, or relevant Director to “refer to RPS” and/or may independently contribute subsequently to a Remediation, Probation, and Dismissal decision.
- 5.8. Any serious patient safety issue or concern may be defined as a Performance Deficiency and must be documented in writing in the Resident file. This may lead to:
 - 5.8.1.a Failed Rotation; or
 - 5.8.2.a decision to “refer to RPS” made by the Competency Coach, or relevant Director

6. Types of Assessment - Informal Assessment and Feedback

- 6.1. There must be ongoing dialogue with the Resident about their performance and progress through informal feedback that is given as part of the day-to-day course of all clinical experiences.
 - 6.1.1. The frequency of this activity will vary but will be such that the Resident is given regular meaningful feedback that ensures learning occurs, and where Performance Deficiencies are identified, the Resident is informed of these in a timely manner so that the Resident has an adequate opportunity to remedy these performance deficiencies before any subsequent Assessment for Progression is completed (e.g. completion of an overall rotation ITER or a Progress Report).
 - 6.1.2. The provision of feedback to a Resident about any identified Performance Deficiencies and any agreed plan made about how these Performance Deficiencies will be corrected must be documented by the Preceptor (see 6.2.1).
 - 6.1.3. Recommendations for improvement and correction of minor Performance Deficiencies are part of this process, and may include completion of a Field Note when the relevant case is selected for this purpose by the Preceptor and Resident. Documentation must occur for minor Performance Deficiencies when they form a repeated pattern as described in 6.2.1.
- 6.2. Competency and Clinical Coaches must inform the relevant Director when a Resident demonstrates Performance Deficiencies.
 - 6.2.1. Competency Coaches, Clinical Coaches, Rotation Supervisors/Preceptors, and Continuity Preceptors must provide documentation of informal feedback in the case of significant Performance Deficiencies and/or a repeated pattern of minor Performance Deficiencies. (For Clinical Coaches and Continuity Preceptors, this documentation will usually be in the form of completed Field Notes that document the feedback provided to the Resident by the Primary and/or other Preceptors about identified Performance Deficiencies).

7. Types of Assessment – Mid Rotation

- 7.1. Documented mid-Rotation feedback will be provided in the form of a MRITER on those Rotations and at the intervals prescribed as indicated in Appendix A.
- 7.2. Documented mid-Rotation feedback and Assessment must be provided to any Resident who demonstrates persistent Performance Deficiencies in the current Rotation.
- 7.3. While feedback is ideally provided mid-Rotation, when Performance Deficiencies arise later in a Rotation, a Rotation may be deemed unsuccessful (failed) without having documented mid-Rotation feedback.
- 7.4. When Performance Deficiencies arise after a MRITER has been completed or late in the cycle of a Progress Review, a Resident may be placed on a Focused Learning Plan or referred to RPS by their Competency Coach or relevant Director at the subsequent Progress Review without having documented mid-term feedback about these Performance Deficiencies.
- 7.5. While on a Clinical Rotation, Residents are expected to address identified Performance Deficiencies to achieve a “Pass”.
- 7.6. When Performance Deficiencies are identified at any point between Progress Reviews, Residents are expected to address these Performance Deficiencies ahead of the next Progress Review.
- 7.7. When a Resident is on a Focused Learning Plan (FLP), the Resident’s Competency Coach or Competence Committee, or relevant Director must also meet mid-way through the period of the FLP and provide documented feedback on how the Resident is progressing in relation to the objectives of the FLP.
 - 7.7.1. This may be achieved through recording the feedback provided in an email to the Resident and copied to their relevant Director.

8. Types of Assessment – Rotation Assessment

- 8.1. Rotation Assessments (i.e. ORITERS) are Assessments for Progress (Summative Assessments) that are completed at the end of those clinical rotations prescribed in Appendix A & D-iii).
 - 8.1.1. On some Rotations where ORITERS are used, specific internal assessment tools may be used to enable the reliable completion of the ORITER at the end of the rotation (e.g. shift encounter cards).
 - 8.1.2. For the purpose of Assessment in elective experiences, an ORITER is only required for electives of 2 weeks or more in duration in the same experience. This equates to 8 shifts, or 8 days. Electives of shorter duration or with fewer shifts/days completed do not require an ITER.
 - 8.1.3. With prior approval, alternate assessment tools may be substituted for an ORITER on electives at the discretion of the relevant Director.
- 8.2. Any Rotation Assessment must be completed for each Resident within TWENTY EIGHT (28) days after completion of the Rotation.

- 8.3. The individual completing the Rotation Assessment may or may not have worked directly with the Resident.
- 8.4. In determining the final status of a Rotation Assessment, the individual completing the assessment may allow for differential weighting of contributing elements depending on factors such as the length and type of clinical interactions with the Resident, type of activity during the rotation, and other factors.
 - 8.4.1. For this reason, a Resident can fail a rotation due to a single or small number of negative assessments, even when others are positive.
- 8.5. If Performance Deficiencies were identified during the Rotation and/or if the Resident fails the Rotation, a discussion with the person completing the Rotation Assessment is recommended for all Residents on completion of the Rotation.
- 8.6. Residents must be advised of a Failed Rotation within TWENTY- EIGHT (28) days of completion of the Rotation Assessment. This should be done in-person or by virtual means by the Rotation Preceptor or relevant Director, or a delegate, but notification may also occur directly through usual Rotation Assessment formats (e.g. through online Assessment tools).
- 8.7. When a Resident fails a Rotation, the Assessment must be discussed in-person or by virtual means with the Resident by the relevant Director, or delegate, within TWENTY-EIGHT (28) days after the Resident receives notice of the failure.
- 8.8. In the event that the Resident takes a leave, such as sick or special leave, before there has been a required meeting, the meeting will be deferred until the Resident returns to the Program and will be completed as soon as possible on return of the Resident, and no later than TWENTY-EIGHT (28) days following the Resident's return.
- 8.9. A Rotation may be deemed "incomplete" if less than the required Rotation length and/or fewer than the number of rotation elements are completed, as defined in the Attendance and Leave Policy.
- 8.10. Where the reliability of the Assessment of a Resident is deemed to be in question, the Postgraduate Director or the individual Enhanced Skills Program Directors may determine whether a rotation is considered incomplete (see also 10.2 below).
- 8.11. Residents completing pre-transfer Rotations will be assessed against a set of agreed EPAs for entering Residency in Canada as defined by the AFMC, and also on their demonstration of the CFPC skill dimensions.
 - 8.11.1. Pre-transfer Residents will be expected to be at the "entrustable" level for all EPAs to be considered for transfer.
 - 8.11.2. At the end of any pre-transfer Rotation(s), the Rotation Lead Preceptor will complete a pre-transfer ORITER which will be used, along with other Assessment data, by the Postgraduate Director in determining whether the Resident is suitable for transfer into the Program.

9. Other Assessment Tools and In-Training Progress Monitoring

9.1. In addition to Rotation Assessments, the Program utilizes a number of other competency-based Assessment tools and processes in a program of Assessment designed to monitor each Resident's performance and progress, initially towards promotion and then to readiness for independent unsupervised practice (see Appendices A through D). These Assessment tools and processes are also used when necessary to inform decisions with respect to Remediation, Probation and Dismissal.

9.1.1. Residents are informed about the Assessment tools and processes used during their orientation on entry to the Program.

9.2. During periods of Remediation and/or Probation, specific assessment tools and methods will be described in the Remediation or Probation plan and these may supersede the assessment requirements in this Operating Standard.

9.3. In addition to Rotation Assessments, the Core FM Program utilizes a series of 6 Progress (Periodic) Reviews completed by the Resident's Competency Coach approximately every 4 months during the period of training. At each Progress Review, all assessment data from the preceding 4 months is reviewed along with the Resident's own self-reflection (iSAP) on their progress to date, and the Resident's drafted Learning Plan. For ES Programs there are program-specific progress reviews.

9.3.1. Completed Progress Reports must be submitted to the Program within FOURTEEN (14) days of completion of the period under review, unless an extension to this expectation has been approved by the relevant Director.

9.3.2. Following each Progress Review, the Competency Coach will decide if the Resident is;

- a) on track ("progressing as expected"); or
- b) has some minor deficiencies where a Focused Learning Plan is necessary; or
- c) where, in the presence of concerns regarding major Performance Deficiencies, referral to RPS is required with a view to formal Remediation.

9.4. All assessment data and information regarding decisions made based on assessments will be included in the Resident's file.

10. Failed Rotation or Equivalent Decision Made by RPS

10.1. A Resident fails a rotation when, pursuant to 10.2, it is determined that the Resident did not meet the overall rotation objectives, and/or where significant Performance Deficiencies are identified. This is deemed to be the case when:

- 10.1.1. indicated on the Rotation Assessment ORITER by a rotation designation of "Fail - significant concerns identified"; or
- 10.1.2. following referral for review RPS makes the decision that a period of formal Remediation or Probation is necessary; or
- 10.1.3. any serious patient safety issue/concern is identified.

- 10.2. Final determination of whether a rotation is “failed” is made by the Postgraduate Director or the individual ES Program Directors. A Resident must be advised of a failed rotation as described previously under Section 8.
- 10.3. RPS will determine what action is required for a failed rotation, and if Remediation or Probation is required. This may require an extension to training or may involve a period of Remediation arranged longitudinally within the Resident’s regular schedule.
 - 10.3.1. Upon completion of any Remediation following a failed rotation, the Resident is always required to repeat the failed rotation.
 - 10.3.1.1. This may include repeating rotations or experiences that led to a Progress Review resulting in a referral to RPS where Remediation was recommended.
 - 10.3.2. In repeating the previously failed Rotation, the Resident will usually be assessed using that Rotation’s usual assessment tools as described in Appendices A and C.
 - 10.3.3. RPS may require additional or modified assessment tools during a repeat Rotation.

11 Determination of Overall Progress/Promotion to Next Stage of Training, Remediation, Probation and Dismissal

- 11.1 The Resident Progress Sub-Committee (RPS) makes decisions on behalf of the RPC and the Family Medicine Postgraduate Executive Committee (PGEC) related to the progress of Residents enrolled in the Core and Enhanced Skills Programs. Decisions are based on the demonstration of achievement of competence as defined nationally by the College of Family Physicians of Canada in the Accreditation Standards for Family Medicine Residency training, and/or learning objectives as defined by individual Enhanced Skills Programs).
- 11.2 The roles, responsibilities and activities of the RPS are governed by the following principles:
 - 11.2.1 Committee work will be guided by the CFPC Accreditation Standards, particularly those that apply to Assessment and the description and determination of competence in Family Medicine.
 - 11.2.2 The RPS has a dual purpose;
 - 11.2.2.1 to determine if Residents have met the appropriate standard for promotion and completion of training; and
 - 11.2.2.2 to review Residents referred to the Committee due to Performance Deficiency for consideration of and planning around appropriate Remediation, Probation or Dismissal.
 - 11.2.3 The RPS is expected to exercise judgment in making decisions based on available Assessment data but are not bound to a specific number of assessments.

- 11.2.4 The RPS must feel it has adequate Assessment information to make holistic judgments on the progress of the Resident or around any necessary Remediation, Probation or Dismissal.
- 11.2.5 In the absence of adequate Assessment information, consideration will be given to the reasons for this deficiency, in keeping with Section 13 of this Operating Standard.
- 11.2.6 RPS decisions will be based on data generated by a group of Assessment tools and any other relevant evidence as appropriate and as described in the terms of reference for RPS.
- 11.3 The RPS reports to PGEC and is responsible for:
 - 11.3.1 Synthesizing the results from multiple Assessments and observations to make decisions related to:
 - 11.3.1.1 The promotion of Residents from one PGY level to the next;
 - 11.3.1.2 Residents with identified Performance Deficiencies and the need for Remediation or Probation;
 - 11.3.1.3 Determining completion of training and readiness to enter independent practice;
 - 11.3.1.4 The outcome of any planned period of remediation or probation; and
 - 11.3.1.5 Deciding if a Resident should be Dismissed from the Program.

Instructions

12 Disclosure of Performance

- 12.1 It is essential that everyone associated with a Residency Training Program maintain professionalism and appropriate confidentiality regarding any difficulties that Residents are experiencing. This requires the application of discretion, professionalism, compassion, and the use of objective criteria for assessing Residents.
- 12.2 Tailoring the Resident’s experience appropriately, addressing individual Resident’s needs, ensuring patient safety, and meeting other goals of postgraduate medical education requires carefully considered disclosure of a Resident’s Performance Deficiencies to those working directly with and assessing the Resident.
 - 12.2.1 Therefore, with due cause, Directors may exercise their discretion in informing Preceptors and/or other appropriate educational leaders of a Resident’s difficulties and individualized goals. The intent of this is to be able to provide the Resident support in identified areas of Performance Deficiency and to ensure patient safety.
 - 12.2.2 For Residents commencing remediation or probation, the relevant elements of the remediation/probation plan (usually the identified Performance Deficiencies that require to be addressed, remediation/probation objectives and information about how these will be assessed) will be shared with the remediation/probation Lead Preceptor and other Preceptors identified as having a significant input to the remediation/probation period.

- 12.2.3 Such disclosure does not and should not imply harmful interference or bias in the assessment of the Resident, but rather, adherence to sound educational principles and the goal of enhancing the Resident’s opportunities to succeed.
- 12.2.4 Regulatory requirements and placement agreements must be adhered to and this may mandate the sharing of information regarding Performance Deficiencies with the CPSA and/or AHS.

Special Situations

13 Special Situations

- 13.1 This Operating Standard is modified from the PGME Assessment Operating Standard to reflect the specific approach to competency-based, programmatic assessment within the Family Medicine Residency Programs.
- 13.2 Any responsibility of the Postgraduate Director or Program Director found in this Operating Standard may be delegated to an appropriate faculty member.
- 13.3 Though terms “in person” and “face-to-face” may appear in this document, the use of virtual presence technologies such as telephones and videoconference are reasonable substitutes to overcome barriers to convenience or safety, such as distance, time, and other risks.
- 13.4 In the event of missing experiences or Assessment data, outside the control of the Resident or Program, the Program will make reasonable efforts to examine alternate forms of Assessment to make decisions about the Resident around competency, promotion, and completion. In some circumstances, an extension of training may be required.
- 13.5 Where the missing Assessment data was the result of the Resident’s mistake, neglect, or misadventure, and there is insufficient assessment data to make a decision, the Resident may be required to repeat an experience, and an extension of training may be required.

Responsibilities

14 Approval Authority: Family Medicine Postgraduate Executive Committee (PGEC)

- 14.1 Ensure appropriate rigor and due diligence in the development or revision of this Operating Standard.

15 Implementation Authority

- 15.1 Ensures that Program leaders, Faculty, Residents and PG FM associated staff are aware of and understand this Operating Standard and related procedures.
- 15.2 Monitors compliance with this Operating Standard.
- 15.3 Regularly reviews this Operating Standard and related procedures to ensure consistency in practice. Operating Standard reviews/revisions recommended to occur within a 5-year cycle.
- 15.4 Sponsors the revision of this Operating Standard and related procedures when necessary.

15.5 Ensures Program-specific processes and policies related to the assessment of Residents are in appropriate compliance with this Operating Standard.

16 Resident Access

16.1 All Residents must be given a copy of, or access to, this Operating Standard as well as any Program-specific policies relating to assessment when they enter the Program and when placed on a Remediation/Probation program.

Appendices

17 Appendices

- A. Assessment Tools Chart
 - i. Calgary
 - ii. Rural
- B. EPA Assessment and Sign Off
 - i. Calgary
 - ii. Rural
 - iii. Enhanced Skills
- C. Progress Review Report
 - i. Core Program
 - ii. Enhanced Skills Programs
- D. Program Completion Checklist
 - i. Calgary
 - ii. Rural
 - iii. Enhanced Skills

Related Policies

18 Related Polices

- 18.1 PGME Appeals Policy
<https://cumming.ucalgary.ca/sites/default/files/teams/6/policies/resident-appeal-policy-pgme-July2021-v2.pdf>
- 18.2 Family Medicine Residency Programs Resident Remediation, Probation & Dismissal Policy_2024-03-14
[FM Remediation Probation Dismissal Operating Standard - PGME Approved 2024-03-14.pdf \(ucalgary.ca\)](#)

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