

**DEPARTMENT OF FAMILY MEDICINE
2 YEAR PROGRAM RESIDENCY ASSESSMENT POLICY**

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<p>Approval Authority Family Medicine Postgraduate Executive Committee (PGEC)</p>	
<p>Implementation Authority Residency Program Directors</p>	
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- Purpose** 1. 1.1. The purpose of this policy is to outline the process governing the assessment of Family Medicine Residents’ performance and progress in the 2 year Family Medicine Residency Training Program in the Cumming School of Medicine at the University of Calgary.
- 1.2. This policy has been developed in compliance with the accreditation standards of the College of Family Physicians of Canada (CFPC).
- Scope** 2. 2.1. This policy applies to all Family Medicine Residents in the 2 year Family Medicine Residency Training Program in the Cumming School of Medicine, at the University of Calgary as well as any pre-transfer Residents.
- 2.2. This policy does not apply to Residents from other disciplines 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 policy;**
- 3.1. “Academic Advisor” is a Family Medicine Preceptor or Program Leader identified by the Program for each Resident who assumes the

role of a Competency Coach. (CFPC FTA definition; https://www.cfpc.ca/uploadedFiles/Education/PDFs/FTA_GUIDE_TM_ENG_Apr15_REV.pdf). A Resident's Clinical Preceptor can act as both clinical coach and competency-coach, as directed by the Program.

- 3.2. "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
- 3.3. "AHS" means Alberta Health Services.
- 3.4. "ACE" means Ambulatory Clinical Experience.
- 3.5. "AEM" means Adult Emergency Medicine
- 3.6. "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.
- 3.7. "Assessment" refers to 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. "Evaluation" may be used interchangeably with "Assessment".
- 3.8. "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.
- 3.9. "Assessment for Progression" (or Summative Assessment) means assessment that integrates multiple sources of information and provides intermittent decision-making by comparing performance to the expectations of progression including promotion and completion.
- 3.10. "Block" means a 4-week period of training.
- 3.11. "Calgary Program" is the part of the 2 year Calgary FM Residency Program which is based in the city of Calgary. Comprises 3 Divisions: North-West, North-East and South.
- 3.12. "CanMEDS-FM (Family Medicine)" refers to the framework describing roles and/or competencies implicit to the overall core knowledge skills and abilities of family physicians.
- 3.13. "Clinical Coach" provides day-to-day teaching and supervision; models 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. A Resident's primary preceptor or Rural FM Continuity Preceptor usually assumes this role which can be combined with the role of Competency Coach.
- 3.14. "COE" means Care of the Elderly.
- 3.15. "Competency Based Medical Education (CBME)" means a medical curriculum approach that focuses on outcomes (skills, competencies or program elements), which may not be constrained by defined periods of time, such as blocks or rotations, for their acquisition.
- 3.16. "Competency Coach" A Family Medicine preceptor who facilitates the planning and career development of the learner. The competency coach may also be termed "Academic Advisor". Using tools such as

learning plans and portfolios, and providing guidance and advice, the teacher facilitates the learner taking ownership of personal lifelong learning and career development. An intentional focus on professional identity is also part of this task.

- 3.17. “Continuity Preceptor” is the physician identified as the Family Medicine Resident’s main Preceptor in their FM Continuity Clinic experience during PGY1 in the Rural Program
- 3.18. “CPSA” means the College of Physicians and Surgeons of Alberta.
- 3.19. “Direct Observation of Procedure (DOP) Form” is a specific field note to record performance and feedback provided related to the observation of a procedure completed by a Resident.
- 3.20. “Division Director” is the Program leader responsible for coordinating and supporting the delivery of the Calgary Program in the home clinics in each of 3 Divisions in Calgary (NW, NE and S). The Division Director reports to the Calgary Residency Program Director.
- 3.21. “Elective” means a non-mandatory learning experience chosen by the Resident based on their identified learning needs.
- 3.22. Entrustable Professional Activity (EPA) – is 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.
- 3.23. “Evaluation objectives” are those described by the College of Family Physicians of Canada (CFPC) and incorporate skill dimensions, priority topics, phases of the encounter and key-features.
- 3.24. “Faculty Adviser” this is the same as the “Academic Adviser/Competency Coach” role and is a named preceptor who; helps orient the Resident to the discipline of Family Medicine; helps the Resident set personal learning objectives; oversees the drafting of learning plans at the time of each progress review; helps guide the Resident on identifying appropriate educational resources to help the Resident achieve the objectives described in the Learning Plan; helps the Resident reflect on feedback and with career planning.
- 3.25. “Failed Rotation” shall have the meaning set out in Section 9.
- 3.26. “Field note” is 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.
- 3.27. “FM Block” is a 4-week period in the Calgary Program PGY1 or PGY2 where the Resident is in their home FM clinic 2 days a week. During these blocks the Resident spends time in scheduled ACEs for the other 2.5 days per week based on specific Domains of Care; Care of the Adult, Care of the Child and Adolescent, Behavioral Medicine & Mental Health, Adult Emergency Medicine and Pediatric Emergency Medicine. PGY2 when the Resident is based in a rural FM clinic outside the Regional centers.
- 3.28. “FM Urban” is 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.
- 3.29. “Focused Learning Plan” is a structured learning plan drawn up by the Resident and their Academic Advisor (with input from Division

Director or Rural Program Site Director if needed) or by the Resident and Division Director or by the Resident and the Rural Program Site Director to describe an area of performance deficiency requiring focused attention to bring the Resident up to the expected level of proficiency but not requiring a formal period of remediation. The plan includes a description of how the deficiency will be addressed and how it will be assessed and does not require any extension to training or result in any delay to promotion from PGY1 to PGY2.

- 3.30. "Home Clinic" is the clinic where the Calgary Family Medicine Resident is based for continuity Family Medicine clinic experiences over the duration of training.
- 3.31. "Immersion rotation" is a 2-8 week, mandatory rotation in an off-service experience – internal medicine, pediatrics, hospitalist medicine, obstetrics/low risk maternity care/gynecology, care of the elderly, psychiatry, orthopedics/sports medicine, general surgery, emergency medicine & anesthesia, critical care, pediatric emergency and palliative care.
- 3.32. "Incomplete rotation" shall have the meaning set out in Section 7.
- 3.33. "IPFN" means Intra-Partum Field Note, completed by a supervising preceptor to record feedback provided at the end of a clinical intra-partum experience.
- 3.34. "iSAP" means informed Self-Assessment of Progress. This is a reflective tool completed by Residents ahead of each progress review meeting with their primary preceptor.
- 3.35. "ITER" means In-Training Evaluation Report. This can include a remediation ITER and probation ITER.
- 3.36. "Key Feature" - is 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 most useful for the assessment of competence in specific situations during daily clinical supervision.
- 3.37. "Learning Plan" This is 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 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.
- 3.38. "Mid-term review" Calgary program - is the informal 15-20 minute meeting between Primary Preceptor and Resident approximately mid-way between progress reviews. A short mid-term review report is completed at the end of the meeting using "One45"
- 3.39. "Milestone" refers to an observable marker of a learner's ability along a developmental continuum in a Royal College Residency Program. Milestones are used for planning and teaching. Typically multiple milestones constitute an EPA. In the Family Medicine Residency Program, this term is generally not used. Instead specific requirements are in place for the milestones that occur between PGY1 and PGY2 when promotion occurs and the second milestone which is completion of training. For certain EPAs, expected (reducing)

levels of supervision are also identified at various time-points over a 2 year period of training. These are sometimes referred to as benchmark supervision levels.

- 3.40. "MRITER" means Mid-Rotation In-Training Evaluation Report.
- 3.41. "MSF" means Multi-Source Feedback.
- 3.42. "ORITER" means Overall Rotation In-Training Evaluation Report, usually completed at the end of an immersion, rural FM, FM Urban, Adult Emergency Medicine or Pediatric Emergency Medicine rotation. They are aligned with the set learning objectives for the rotation as well as the CFPC 6 skill dimensions.
- 3.43. "One45" is the web-based data collection electronic platform used for the completion and submission of ITERs and mid-term review reports.
- 3.44. "OSCE" means Objective Structured Clinical Examination
- 3.45. "PEM" means Pediatric Emergency Medicine
- 3.46. "PCSF" means Patient Centred Skills Form, completed at the end of a patient centred care lab following review of a video consultation of a patient by the Resident.
- 3.47. "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 rotation failure or a "refer to RPS" decision at the time of a Progress Review.
- 3.48. "PGME" means Postgraduate Medical Education.
- 3.49. "PGY" means postgraduate year and is used interchangeably with residency (R) year.
- 3.50. "Preceptor" means a physician directly responsible for a period or segment of the Resident's professional training, teaching and/or instruction.
- 3.51. "Primary Preceptor" is the physician identified as the Calgary Program Family Medicine Resident's main Preceptor in their home clinic over their 2 years of training and who is responsible for monitoring the performance of the Resident over this time.
- 3.52. "Priority Topics" along with core procedures and themes, provide a list of problems or situations that a Family Physician must be competent to deal with upon entry into unsupervised practice.
- 3.53. "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 – (refer to PGME document on Guidelines for Remediation and Probation <https://wcm.ucalgary.ca/pgme/files/pgme/guidance-notes-learning-support-remediation-probation-31aug17.pdf>).
- 3.54. "Probation supervisor" is 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.
- 3.55. "Program" means the Calgary and/or Rural Family Medicine Residency Training Program at the Cumming School of Medicine, at the University of Calgary.

- 3.56. “Program Director” means the person responsible for the overall conduct of the Calgary or Rural Family Medicine Residency Training Program.
- 3.57. “Progress report” means the written report which describes if a 2 year FM Program resident is “on track” or not, in relation to the expected acquisition of competencies at each specified time point and which is completed approximately every 4 months (6 over complete period of training) by the Resident’s Academic Advisor during the period of training. The report also includes a learning plan which has been agreed upon between the Resident and their Academic Advisor.
- 3.58. “Progress review”(or Periodic Review) in the 2 year FM Program is the scheduled meeting between the Resident and their Academic Advisor which occurs generally every 4-5 months over the period of training. During this meeting, the Academic Advisor reviews with the Resident the Resident’s draft learning Plan, the assessment data collected over the previous 4-5 months and provides feedback on how the Academic Advisor feels the Resident is progressing (on track, or not) in relation to the identified set of EPAs and expected level of competency (level of supervision) for the time point at which the review occurs. A progress report and updated learning plan are completed at the end of each review, which must be signed by the Resident, their Academic Advisor and the Resident’s Division Director/Site Director.
- 3.59. “PSQ” means Patient Satisfaction Questionnaire
- 3.60. “Remediation” is a formal program of individualized educational support, assessment and monitoring to assist in correcting identified performance deficiencies – refer to document on Guidelines for Remediation and Probation
<https://wcm.ucalgary.ca/pgme/files/pgme/guidance-notes-learning-support-remediation-probation-31aug17.pdf>.
- 3.61. “Remediation Supervisor” is 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.
- 3.62. “Residency Program Committee (RPC) is the committee or delegated subcommittee that assists the Program Director in the planning, organization, and supervision of the Residency Training Program.
- 3.63. “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.
- 3.64. “Rotation” is defined by each Residency Training Program as a required element of training and in the Family Medicine Residency Program may be of anything between 2 and 24 weeks in duration. A completed rotation is defined by the attendance and absence policy
- 3.65. “Rotation Assessment” is 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.

- 3.66. "Rotation Lead Preceptor" is 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.
- 3.67. Resident Progress Sub-committee (RPS) is the Committee identified within the 2 year FM Residency program and in the Enhanced Skills Program as being responsible for reviewing all Residents in difficulty referred to this Committee and for making decisions about promotion, completion, remediation, probation and dismissal on behalf of most of the FM RPCs (where delegated to do so)
- 3.68. "Rural FM" means a mandatory rural Family Medicine rotation (can be between 4 and 24 weeks in duration)
- 3.69. "Rural Program" is the part of the Program based in Medicine Hat and Lethbridge.
- 3.70. "School" means Cumming School of Medicine at The University of Calgary
- 3.71. "Selective" is either a 4 week rotation in the intensive care unit (ICU) or in Coronary Care unit (CCU) offered to Residents who may wish either or both of these experiences.
- 3.72. "Site Director" is the Program leader responsible for coordinating and supporting the delivery of the Program in each of the 2 main regional sites. (Medicine Hat and Lethbridge).
- 3.73. "Skill dimension" is one of; patient-centered care, communication, clinical reasoning, selectivity, professionalism or procedural skills, as described by the CFPC evaluation objectives. One of six essential generic skills that allow a Family Physician to deal competently with problems in the domain of Family Medicine.
- 3.74. "University" means University of Calgary.

Guiding Principles

- 4. 4.1. Fairness: assessment must be fair, equitable, timely and unbiased.
 - 4.1.1. Assessment in both parts of the FM Residency Program is based on EPAs, CFPC Evaluation Objectives (Skill dimensions, Priority topics and Key Features) 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
 - 4.1.2. Timing of the provision of assessments must be adhered to when made explicit in this policy and when not explicit is generally expected to occur within twenty eight (28) days of the completion of a required program element.
 - 4.1.3. Feedback should be specific and include both strengths and deficiencies with advice and assistance for improvement, even for Residents who are doing well.
 - 4.1.4. 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 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 face-to-face and written Assessments.
 - 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 (this can be by the use of field notes, MRITERs, mid-term reviews or other 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 face-to-face whenever possible.
 - 4.3.6. Every Resident must receive in-person feedback and advice on how to meet objectives and EPAs from the Program Director, or delegate (e.g. Academic Advisor), at least every six (6) months and this should be documented and kept in the Resident's file.
 - 4.3.7. All feedback should be documented and kept in the Resident's file.
 - 4.3.8. Preceptors must inform the Program 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 oral feedback and acting on all feedback. Residents are responsible for requesting that feedback be provided to them beyond formal Assessment requirements.
 - 4.4.2. Results of Assessments must be provided to Residents in a timely manner.
 - 4.4.3. Residents have a responsibility to both review and act on Assessments in a timely manner.
 - 4.4.4. 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 any workplace accommodations (including medical) based upon restricted grounds as per Human Rights legislation through the University of Calgary and/or Alberta Health Services.
 - 4.4.5. Assessment of a Resident's on-going progress in relation to the identified EPAs for the Program are the joint responsibility of the Resident, their Academic Advisor and the Program.

**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. Academic Advisors 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 for the Program and to provide advice on how the Resident might continue to develop expected competencies in these.
 - 5.1.2. The program has a set of EPAs as a description of the expected goals of training (see appendix [A](#) & [B](#)). 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 sub-set 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 Academic Advisor and the Resident's Division or Site 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.
- 5.2. The Residency Program uses various assessment tools (see appendices [C](#) & [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 of the EPAs. Evidence for this is gained through assessment of competence based on the CFPC Evaluation Objectives as well as the other mandatory completion requirements of the Program.
- 5.2.1. 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.
 - 5.2.2. 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, during a mid-term review, when reviewing a mid-rotation ITER or during a progress review. 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 summative assessment is completed (e.g. completion of an overall rotation ITER or a progress report).
 - 5.2.3. Together with progress reviews, mid-term reviews and mid-rotation feedback, 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.
- 5.3. The primary tool for final assessment of a Resident in any immersion, rural FM, AEM, PEM, elective of 2 weeks and more duration, selective or Calgary-based FM-Urban rotation is the relevant Overall Rotation In-Training Evaluation Report (ORITER) for that rotation and throughout the remainder of the Program, it is the Progress Report.
- 5.3.1. ORITERS are used to record final, summative, rotation assessments in all immersion, electives of 2 weeks duration or more, selectives, rural FM, FM- Urban, AEM and PEM rotations (see appendices [B](#) & [C](#)).
 - 5.3.2. Progress Reports are used throughout the period of training to make summative decisions about whether or not the Resident is on track (“progressing as expected”) towards readiness for unsupervised practice by or before the regularly scheduled period of training.
 - 5.3.3. Any Resident receiving written feedback in any ORITER or Progress Report highlighting significant performance deficiencies must arrange to meet with their Division Director/Site Director within 28 days of receiving this feedback.
- 5.4. The Division/Site Director and Division/Site Coordinator are, responsible for collating MRITERS, ORITERS and previous mid-term (Calgary Program only) and progress reviews for any upcoming progress review. The Resident is responsible for submitting the partially completed Progress Report, a satisfactorily completed iSAP, a draft updated Learning Plan and copies of all field notes and DOPs forms for the period under review to their Academic Advisor ahead of

- any scheduled progress review such that the Academic Advisor has adequate time to prepare for the meeting.
- 5.4.1. It is the Resident's responsibility to review all assessments in a timely manner.
 - 5.4.2. The Academic Advisor, Division Director/Site Director and Resident must sign all completed Progress Reports and the Resident and rotation Lead preceptor must sign all ORITERS.
 - 5.4.3. The Resident's signature on a progress report does not mean that the Resident necessarily agrees with its content but acknowledges that they have seen and read the details of the assessment.
 - 5.4.4. It is a Resident's responsibility to review all MRITERS, ORITERS and Progress Reports in a timely manner and arrange any required follow up.
 - 5.4.5. A Resident failing to review and/or sign a MRITER, ORITER or Progress Report does not constitute procedural unfairness in the event of an appeal.
- 5.5. The Resident will not be present at any RPS meeting during which their assessment and progress are being discussed.
- 5.5.1. The RPS sitting Resident representative will usually be present during discussion of any Resident's assessment that has resulted in referral to RPS.
 - 5.5.2. A Resident must be notified in writing at least 10 days ahead of the RPS meeting date that he/she will be reviewed by RPS and must be notified also in writing that he/she can submit, at least 7 days ahead of the meeting, any supporting documentation for this review.
- 5.6. At the discretion of the RPS, a less than satisfactory assessment of a Resident on any assessment tool or other provided feedback may be defined as a performance deficiency. There should be a written record of identified deficiencies if feedback is provided verbally to the Program Director, Division Director, Site Director, Academic Advisor or Primary Preceptor.
- 5.6.1. Uncorrected performance deficiencies on any type of assessment may contribute to failing a relevant rotation or a decision by a Primary Preceptor, Continuity Preceptor, Academic Advisor, Division Director, or Site Director to "refer to RPS" and/or may independently contribute subsequently to a Remediation, Probation, and dismissal decision.
 - 5.6.2. Any serious patient safety issue/concern may be defined as a performance deficiency and lead to failing a rotation or a decision to "refer to RPS" made by the Primary Preceptor, Continuity Preceptor, Academic Advisor, Program Director, Division Director or Site Director and must be documented in writing in the Resident file.

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 that, 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 summative assessment 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 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.
- 6.2. Primary Preceptors, Continuity Preceptors or Rural FM Preceptors must inform the Division/ Site Director when a Resident demonstrates performance deficiencies.
 - 6.2.1. Primary Preceptors, Rural FM Preceptors or Continuity Preceptors must provide documentation of informal feedback in the case of significant performance deficiencies and/or a repeated pattern of minor deficiencies. (For Primary, Continuity and Rural FM 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. In the Calgary Program, documented mid-rotation feedback will be provided in the form of a MRITER on the rural FM rotation and immersion rotations where the use of a MRITER has been agreed. (See appendix [C](#)).
- 7.2. In the Rural Program, a MRITER must be completed mid-way through each 8-week PGY1 rural FM rotation and after 2 blocks and 4 blocks in the PGY2 24-week rural FM rotation. Mid rotation feedback and the completion of a MRITER must also occur during the 8 week Ob rotation. (See appendix [D](#)).
- 7.3. Mid-rotation remediation or probation ITERs must also be completed every 4 weeks during any period of remediation or probation.
- 7.4. As part of the regular assessment program, Residents in the Calgary Program must also meet with their Academic Advisor for a mid-term review approximately mid-way between each Progress Review. At this meeting, feedback is provided to the Resident on their performance and a mid-term report is completed.

- 7.5. 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. In the same way, when performance deficiencies arise after a mid-term/mid-rotation review, a Resident may be placed on a focused learning plan or referred to RPS by their Academic Advisor/Site Director at the subsequent Progress Review without having documented mid-term feedback about these deficiencies.
- 7.6. Residents are expected to address identified deficiencies in order to pass a clinical rotation. When deficiencies are identified at a mid-term review or at any point between Progress Reviews, Residents are expected to address these deficiencies in order to be assessed as 'on track' at the next Progress Review.
- 7.7. When a Resident is on a Focused Learning Plan (FLP), the Resident's Academic Advisor 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. (This may be achieved through recording this on a mid-term review report in the Calgary Program or in an email to the Resident, copied to the Site Director, in the Rural Program.)
- 7.8. Documented mid- rotation feedback and assessment must be provided to any Resident who:
- a) Demonstrates persistent performance deficiencies in the current rotation or;
 - b) Is on a Remediation Program or;
 - c) Is on Probation, except when superseded by Section 7.9.1
- 7.8.1. Probation contracts with explicit feedback requirements will comprise the required feedback standard for the probationary period.

8. Types of Assessment – Rotation Assessment

- 8.1. The Program has an agreed set of EPAs that define the expected higher-level competencies for Residents to graduate from the Program (see appendix A). The Resident must demonstrate readiness for unsupervised, independent practice in relation to all of the EPAs. The curriculum is designed to provide each Resident with the opportunities they need to achieve competency in all of the EPAs and the assessment program is designed to provide evidence, through assessment, that this is the case with reference to CanMEDS-FM and the CFPC Evaluation Objectives (Skill Dimensions, Priority Topics and Key Features).
- 8.1.1. The curriculum includes a series of mandatory and elective rotations, which provide opportunities for Residents to acquire and develop required competencies around each EPA.

- 8.2. Rotation Assessments are collated, summative (pass/fail) assessments that are completed at the end of specified clinical rotations; i.e. all immersion rotations, rural FM, Calgary FM-Urban, AEM, PEM, electives of 2 weeks or longer, selectives and COE. (see also appendices [C](#) & [D](#))
 - 8.2.1. ORITERs are used for all Rotation Assessments listed in 8.2.
 - 8.2.2. 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 on PEM and AEM).
 - 8.2.3. For the purpose of assessment in elective experiences, an ITER is only required for electives of 2 weeks or more in duration in the same experience. This equates to a minimum of 8 shifts or 8 days.
- 8.3. Any Rotation Assessment must be completed for each Resident within TWENTY EIGHT (28) days after completion of the rotation.
- 8.4. The individual completing the Rotation Assessment may or may not have worked with the Resident personally.
- 8.5. 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 at the discretion of the RPS.
 - 8.5.1. For this reason, a Resident can fail a rotation due to a single or small number of negative assessments, even when others are positive.
- 8.6. If performance deficiencies were identified during the rotation and/or if the Resident fails the rotation, an in-person discussion with the person completing the Rotation Assessment is recommended for all Residents on completion of a rotation, and is *required* within TWENTY EIGHT (28) days of completion of the Rotation.
- 8.7. An In-person discussion with the Program Director or Division Director/Site Director must occur within TWENTY EIGHT (days) of completion of a Rotation when a Resident fails the rotation (see section 9).
- 8.8. In the event that a leave, such as sick or special leave, is taken by a Resident 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 75% of the rotation length and/or rotation elements are completed).
 - 8.9.1. Where the reliability of the assessment of a resident is deemed to be in question, the Program Director may determine at any time

whether a rotation is considered complete or not. (See also 10.2 below).

8.10. Residents completing pre-transfer rotations will be assessed against a set of agreed EPAs for entering Residency in Canada and also on their demonstration of the [CFPC skill dimensions](#). Residents will be expected to be at the “entrustable” level for all of the EPAs to be considered for transfer. 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 Program Director in determining whether or not 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 [C](#) & [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. (See appendices [C](#) & [D](#))

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 policy.

9.3. In addition to rotation assessments, the Program utilizes a series of 6 Progress (Periodic) Reviews completed by the Resident’s Academic Advisor approximately every 4 months during the period of training. At each Progress Review, all assessment data (MRITERS, ORITERS, mid-term review, field notes, DOPs forms etc.) 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.

9.3.1. Progress Reports must be completed and submitted within FOURTEEN (14) days of completion of the period under review unless an extension to this expectation has been approved by the Division/Program/Site Director.

9.3.2. Following each Progress Review, the Academic Advisor 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. This is indicated on the Rotation Assessment ORITER by a rotation designation of "Fail -significant concerns identified".

10.1.1. A Resident is also deemed to have failed a period of training when, following referral for review; RPS makes the decision that a period of formal remediation or probation is necessary.

10.1.2. Any serious patient safety issue/concern may also be defined as a performance deficiency and lead to a failed rotation or a decision by RPS that formal remediation is necessary.

10.2. Final determination of whether a rotation is "failed" is made by the Program Director. A Resident must be advised of a failed rotation within TWENTY-EIGHT (28) days of completion of the Rotation. It is preferable that this is done in-person by the rotation Lead Preceptor but may also be completed through usual Rotation Assessment formats (e.g. online through One45).

10.3. When a Resident fails a rotation, the assessment must be discussed in-person with the Resident by the Program Director or Division Director/Site Director within TWENTY EIGHT (28) days after the Resident receives notice of the failure.

10.4. The RPS will determine what action is required for a failed rotation or when a decision that 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. Upon completion of any remediation following a failed rotation, the Resident is always required to repeat the failed rotation, at some point. (Residents are not permitted to use electives for remediation, probation or repeating a rotation).

10.4.1 When RPS determines that a Resident requires remediation or probation, the Resident must be informed of this within 14 days of the decision by RPS.

10.4.2 When RPS determines that a Resident requires remediation or probation, this must be discussed in person with the Resident by the Program Director or Division Director/Site Director within TWENTY-EIGHT (28) days after the Resident receives notification of this decision.

10.4.3 In the event that Remediation or Probation is recommended, notification is provided to the Associate Dean.

10.5. When the Resident fails one rotation and passes all others within a PGY-level, the RPS may promote the Resident to the next PGY-level, at the Committee's discretion, on a case-by-case basis. The Resident must still repeat the failed rotation and is not permitted to use elective or scheduled rotations to do so. (i.e. there is always an extension to training).

10.5.1. If an extension of training is required; this will result in a change in the promotion and/or graduation date.

10.6. When the Resident fails two or more rotations (including any decision by RPS that remediation is required) within a 12-month period, the Resident must be formally reviewed by the RPS with consideration given to placing the Resident on Probation.

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

11.1 The Residency Progress Sub-Committee (RPS) makes decisions on behalf of the relevant RPCs and the Family Medicine Postgraduate Executive Committee (PGEC) related to the progress of Residents enrolled in the Calgary or Rural FM Residency 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.

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 committee has a dual purpose;

- a) to determine if Residents have met the appropriate standard for promotion and completion of training and
- b) 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 Committee is expected to exercise judgment in making decisions based on available assessment data but are not bound to a specific number of assessments. The key is that the committee 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.

11.2.4 Committee 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 Residency Progress Sub-Committee reports to the Family Medicine Postgraduate Executive Committee (PGEC) and is responsible for:

- 11.3.1 Synthesizing the results from multiple assessments and observations to make decisions related to:
 - a) The promotion of Residents from PGY1 to PGY2
 - b) Residents with identified performance deficiencies and the need for remediation or probation
 - c) Determining completion of training and readiness to enter independent practice
 - d) The outcome of any planned period of remediation or probation
 - e) 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, Program 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 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 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 policy is modified from the PGME Assessment policy to reflect the specific approach to competency-based, programmatic assessment within the Family Medicine Residency Program.

13.2 Any responsibility of the Program Director found in this policy may be delegated to an appropriate faculty member.

- 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 policy.
- 15 Implementation Authority**
- 15.1 Ensures that Program leaders, Faculty, Residents and PG FM associated staff are aware of and understand this policy and related procedures.
- 15.2 Monitors compliance with this policy.
- 15.3 Regularly reviews this policy and related procedures to ensure consistency in practice. Policy reviews/revisions recommended to occur within a 5-year cycle.
- 15.4 Sponsors the revision of this policy 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 policy.
- 16 Resident Access**
- 16.1 All Residents must be given a copy of, or access to, this policy 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. Calgary EPA Assessment and Sign Off
<http://calgaryfamilymedicine.ca/residency/dox/container/Assessment-Calgary-EPA-Assessment&SignOff-17-08-18.pdf>
- B. Rural EPA Assessment & Sign Off
<http://calgaryfamilymedicine.ca/residency/dox/container/Assessment-Rural-EPA-Assessment&Signoff-17-08-16.pdf>
- C. Calgary Assessment Tools Chart
<http://calgaryfamilymedicine.ca/residency/dox/container/Assessment-Calgary-Assessment-Tools-Chart-17-09-06.pdf>
- D. Rural Assessment Tools Chart
<http://calgaryfamilymedicine.ca/residency/dox/container/Assessment-Rural-Assessment-Tools-Chart-2017-08-17.pdf>
- E. [FM Program EPA Domain of Care Matrix](#)
- Related Policies**
- 18 Related Polices**
- 18.1 Family Medicine Residency Programs Appeals Policy
<http://calgaryfamilymedicine.ca/residency/dox/container/FM%20Residency%20Programs%20Appeals%20Policy%202018-09-06.pdf>
- 18.2 Family Medicine Residency Programs Resident Remediation, Probation & Dismissal Policy

<http://calgaryfamilymedicine.ca/residency/dox/container/Family%20Medicine%20Remediation%20Probation%20Dismissal%20Policy%20018-09-06.pdf>

18.3 Relevant PGME policies (duplicated here where relevant and modified where appropriate)

18.3.1 PGME Resident Assessment Policy;
<https://cumming.ucalgary.ca/pgme/files/pgme/pgme-resident-assessment-policy-final-jul2018.pdf>

18.3.2 PGME Resident Remediation, Probation & Dismissal Policy;
https://cumming.ucalgary.ca/pgme/files/pgme/pgme-resident-remediation_probation_dismissal-policy-final-jul2018.pdf

18.3.3 PGME Resident Appeals Policy;
<https://cumming.ucalgary.ca/pgme/files/pgme/pgme-resident-appeal-policy-final-jul2018.pdf>

History

19 *Approved: September 21, 2017*
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Appendix E – EPA Domain of Care Matrix

FM Residency Program											
EPA	Domains of Care										
	Care of the Adult	Care of the Child	Care of the Elderly	EBM Research QI Patient Safety	Ethics	Maternity & Newborn Care	Mental Health and Behavioural Medicine	MSK	Palliative Care & End of Life Care	Procedures	Vulnerable & Underserved populations
1. Assess, manage, and follow-up patients with common presenting complaints and undifferentiated symptoms.	Y	Y	Y				Y	Y			
2. Recognize and appropriately refer for emergent conditions.	Y	Y	Y			Y	Y	Y	Y		
3. Complete an adult periodic health assessment, using evidence-based screening and risk reduction recommendations.	Y		Y								
4. Complete a well-child check-up, using evidence-based screening and risk reduction recommendations.		Y									
5. Manage and follow-up patients with common chronic conditions.	Y		Y				Y	Y			
6. Care for pregnant patients throughout pregnancy.						Y					
7. Manage postpartum mothers and their newborns in the first few weeks of life.						Y					

EPA	Care of the Adult	Care of the Child	Care of the Elderly	EBM Research QI Patient Safety	Ethics	Maternity & Newborn Care	Mental Health and Behavioural Medicine	MSK	Palliative Care & End of Life Care	Procedures	Vulnerable & Underserved populations
8. Manage the elderly patient with multiple co-morbidities.			Y								
9. Identify, diagnose, and manage common mental health symptoms and disorders.			Y				Y				
10. Care for underserved populations.											Y
11. Demonstrate general key features for procedural skills.	Y							Y		Y	
12. Care for the palliative patient and their family.									Y		
13. Perform low-risk, spontaneous, term, vertex vaginal delivery.						Y					
14. Recognize when an obstetric patient requires referral for higher level care.						Y					
15. Determine when an adult patient requires admission and inpatient hospital care.	Y		Y						Y		

EPA	Care of the Adult	Care of the Child	Care of the Elderly	EBM Research QI Patient Safety	Ethics	Maternity & Newborn Care	Mental Health and Behavioural Medicine	MSK	Palliative Care & End of Life Care	Procedures	Vulnerable & Underserved populations
16. Assess and appropriately manage the adult patient in hospital.	Y		Y								
17. Recognize and provide appropriate management of the unstable adult patient in the hospital setting.	Y		Y								
18. Determine when an unstable patient requires referral for higher level care.	Y		Y								
19. Plan and coordinate discharge of adult patients from hospital.	Y		Y								
20. Determine when a child or adolescent requires admission and inpatient hospital care.		Y									
21. Assess and appropriately manage the child or adolescent patient in hospital.		Y									
22. Recognize and provide appropriate management of the unstable pediatric patient in the hospital setting.		Y									
23. Determine when an unstable child or adolescent patient requires transfer to a higher level of care.		Y									

EPA	Care of the Adult	Care of the Child	Care of the Elderly	EBM Research QI Patient Safety	Ethics	Maternity & Newborn Care	Mental Health and Behavioural Medicine	MSK	Palliative Care & End of Life Care	Procedures	Vulnerable & Underserved populations
24. Plan and coordinate discharge of the child or adolescent from hospital.		Y									
25. Recognize and provide appropriate management of common pediatric emergencies.		Y									
26. Recognize and provide appropriate management of common adult emergencies.	Y		Y						Y		