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CBD
Workplace-Based Observations and Assessments: Strategies for Success

CBD Development Day

April 12, 2019

The best health for all. The best care for all.

Nothing to Disclose

Objectives

- Discuss CBD workplace-based assessment expectancies and perceived challenges to implementation
- Describe strategies to effectively observe and document constructive feedback on resident trainee performance
- Describe the concept of entrustment as it relates to resident observation and evidence based rating scales
- Identify features of and demonstrate ability to write high quality narratives describing resident performance in the clinical environment
- Describe how multiple WBA's will inform entrustment and the work of the competency committee

Assessment

- Different but familiar
- More frequent observations that are documented
- Increased focus on rich narrative comments
- “Assessment *for* learning”
  - Coaching
- Standard is competent for safe independent practice

What do we want our frontline clinical teachers to *do*?

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RX-OCD

Coaching in the Moment: A Process

1) RAPPORT
2) EXPECTATIONS
3) OBSERVE
4) CONVERSATION
5) DOCUMENT

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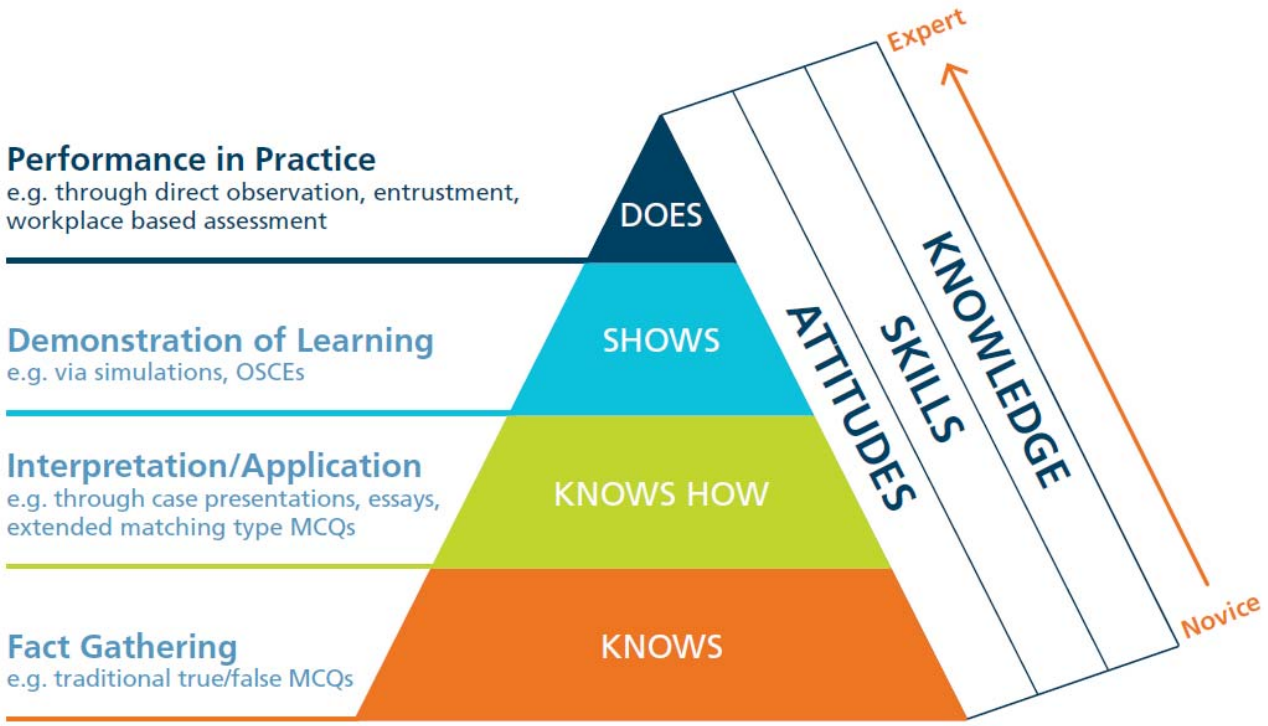
RX-OCD

Part One – Observation Issues

Major Challenge



"Miller's Pyramid of Clinical Competence," by R. Mehay and R. Burns, 2009. In R. Mehay (Ed.), The Essential Handbook for GP Training and Education (chapter 29: Assessment and Competence, p414). Also available at: http://www.essentialgptrainingbook.com/chapter-29.php. Reproduced with kind permission of Dr. Ramesh Mehay.

Observation Strategies

- Orient the trainee to being observed
- Two approaches
  - Watch it all
  - Watch bits and pieces
    - Some aspect of history
    - Repeat physical exam
    - Provide the plan
- Introduce concept to patient
  - “I’m a fly on the wall”
- Define what you need to watch
- Make a schedule to observe

Observation challenges

- What are the challenges to completing observations and WBA's in our residency training environment? What are your concerns?

What about indirect observation?

- Inferences you make from clinical work
  - Case presentations
  - Chart review
  - Information you find out when you see patient
- Discuss your observations with trainee
  - May include having them demonstrate technique, walk you through their reasoning, etc.
- Comments from patients and colleagues

Part Two – Rating Scale Anchors

Traditional rating scale anchors

1 – Consistently below expectations

2 – Sometimes below expectations

3 – Meets expectations

4 – Sometimes above expectations

5 – Consistently above expectations

Unsatisfactory	Requires Attention	Meets Objectives	Area of Strength	Expert	N/A
1	2	3	4	5	N/A
○	○	○	○	○	○

What works?

What doesn't work?

Rating scale anchors

- 1 – “I had to do”
- 2 – “I had to talk them through”
- 3 – “I had to direct them from time to time”
- 4 – “I needed to be available just in case”
- 5 – “I did not need to be there”

- What do you think?

Tools using these anchors

- O-SCORE – Ottawa Surgical Competency Operating Room Evaluation
  - Tool to assess the performance of a trainee on one surgical procedure

- OCAT – Ottawa Clinic Assessment Tool
  - Tool to assess the performance of a trainee during one clinic

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The Ottawa Surgical Competency Operating Room Evaluation (O-SCORE)

Trainee #:	Level: 1 2 3 4 5	Staff:
Procedure:		Date:

Relative complexity of this procedure to average of same procedure Low Medium High

The purpose of this scale is to evaluate the trainee's ability to perform this procedure safely and independently. With that in mind please use the scale below to evaluate each item, irrespective of the resident's level of training in regards to *this* case.

Scale

1—"I had to do"—*i.e., Requires complete hands on guidance, did not do, or was not given the opportunity to do*
2—"I had to talk them through"—*i.e., Able to perform tasks but requires constant direction*
3—"I had to prompt them from time to time"—*i.e., Demonstrates some independence, but requires intermittent direction*
4—"I needed to be in the room just in case"—*i.e., Independence but unaware of risks and still requires supervision for safe practice*
5—"I did not need to be there"—*i.e., Complete independence, understands risks and performs safely, practice ready*

1. Preprocedure plan Gathers/assesses required information to reach diagnosis and determine correct procedure required	**1**	**2**	**3**	**4**	**5**
2. Case preparation Patient correctly prepared and positioned, understands approach and required instruments, prepared to deal with probable complications	**1**	**2**	**3**	**4**	**5**
3. Knowledge of specific procedural steps Understands steps of procedure, potential risks, and means to avoid/overcome them	**1**	**2**	**3**	**4**	**5**
4. Technical performance Efficiently performs steps, avoiding pitfalls and respecting soft tissues	**1**	**2**	**3**	**4**	**5**
5. Visuospatial skills 3D spatial orientation and able to position instruments/hardware where intended	**1**	**2**	**3**	**4**	**5**
6. Postprocedure plan Appropriate complete post procedure plan	**1**	**2**	**3**	**4**	**5**
7. Efficiency and flow Obvious planned course of procedure with economy of movement and flow	**1**	**2**	**3**	**4**	**5**
8. Communication Professional and effective communication/utilization of staff	**1**	**2**	**3**	**4**	**5**
9. Resident is able to safely perform *this* procedure *independently* (circle)		**Y**		**N**	
10. Give at least 1 *specific* aspect of procedure done well					
11. Give at least 1 *specific* suggestion for improvement					

Entrustment

Do they work?

- Highly reliable & excellent evidence for validity
  - A large improvement on most other assessment tools
- Do not need rater training beyond reading the instructions
- Residents accept “low marks”
- Staff uses whole scale
- Residents note increased daily feedback when these tools used

Why do these scales seem to work?

Potential Reasons

- Mirror how we think
  - Construct alignment
  - Less translation
- Rely on rater's clinical expertise
  - Less reliance on rater training (which has proven unsuccessful)
- Used in low stakes, repetitive assessment
- Fit into milestone progression
  - Improved resident acceptance
  - Less reliance on knowing what a typical resident at a particular level looks like
- Formative assessment

How to Use these Tools

- Do not be afraid to assign the rating that describes the performance
  - i.e. Do NOT worry about level of training
- Focus on today's performance
  - i.e. Do NOT worry about what this means for the future
- Do not be so worried about how the resident will react to being told that they are not a "5"
  - i.e. Most know that they are not ready to be entirely on their own
- Prepare residents for the different approach

EPA: SF Providing patient education and informed consent in preparation for surgical care

Assessment

Completed by assessor

- Indicate the rating that best applies
- **NOTE: If unable to assess, indicate NO RATING**

Ensures pt and family are informed about risks and benefits of each tx option in context of best evidence and guidelines, addressing fears and concerns

Obtains informed consent for commonly performed procedures and therapies, under supervision

Communicates with cultural awareness and sensitivity

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Documents information about patients and their medical conditions in a manner that enhances intra- and interprofessional care

Manages conflicts of interest related to surgical care

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Indicate the OVERALL entrustment in this EPA at this time

Entrustment of this professional activity implies that the resident demonstrated an autonomous performance of the activity/task in a safe and effective manner at this time

Providing patient education and informed consent in preparation for surgical care

Feedback & Comments

Describe 2-3 strengths and actions or areas for improvement

2 - 3 Strengths

2 - 3 Actions or areas for improvement

Other comments

Save as Draft

Submit

How to Use these Tools

- What about situations where I do not see an entire EPA?
  - Common
  - Partial assessment is better than no assessment
    - Useful to know that they can do part of the EPA
  - Options
    - Complete part of an EPA rating form
    - Do only a narrative observation

Using Different Scales

Example scenario A

PGY2 trainee working in a clinic is functioning beyond what one would expect with respect to their physical exam skills for some but not all of the patients seen in this clinic. Some of the exam skills do not need any intervention from you but on others you need to provide some guidance.

How would you rate their physical exam skills on their daily observation form using each of the following scales?

Using Different Scales

Rating scale A

1. rarely meets expectations
2. inconsistently meets expectations
3. meets expectations
4. sometimes exceeds expectations
5. consistently exceeds expectations

Rating scale B

1. requires complete guidance; “I had to do”
2. able to perform but requires repeated direction; “I had to talk them through”
3. some independence but intermittent prompting required; “I had to direct them from time to time”
4. independent for most things but requires assistance for nuances; “I had to be there just in case”
5. complete independence; “I did not need to be there”

Using Different Scales

Scale A – 4 (sometimes exceeds expectations)

Scale B – 3 (some independence but intermittent prompting required)

Using Different Scales

Example scenario B

PGY4 trainee needs to perform a laparoscopic simple ovarian cystectomy. The resident is aware of sterile technique and how the steps of the procedure. However, they required direction on port placement and orientation to some of the laparoscopic equipment. You would have expected that a resident at their level would know and be able to complete this procedure quite independently.

How would you rate their technical performance on this procedure using each scale?

Using Different Scales

Rating scale A

1. rarely meets expectations
2. inconsistently meets expectations
3. meets expectations
4. sometimes exceeds expectations
5. consistently exceeds expectations

Rating scale B

1. requires complete guidance; “I had to do”
2. able to perform but requires repeated direction; “I had to talk them through”
3. some independence but intermittent prompting required; “I had to direct them from time to time”
4. independent for most things but requires assistance for nuances; “I had to be there just in case”
5. complete independence; “I did not need to be there”

Using Different Scales

Scale A – 2 (inconsistently meets expectations)

Scale B – 2 (able to perform but requires repeated direction)

Part Three – Narrative Observation

Qualitative Assessment

- Misconception
  - Subjective = Unreliable
  - Objective = Reliable

- “Faculty need to recognize that numeric ratings are nothing more than a process to synthesize and then represent a composite judgment about a trainee.”

  Holmboe et al., Academic Medicine, 2011

Qualitative Assessment

- More recently:
  - More emphasis on qualitative assessments
  - Some suggesting that narrative descriptions replace numerical ratings
  - Research demonstrates that a large portion of the usefulness of these methods is in the narrative (qualitative) part

- Think about this clinically
  - “My pain is 6 out of 10 doc”
  - “My pain is constant, burning and interfering with my ability to wear my prosthesis”

- What is more useful?

Words and not Numbers

- Rich narrative observations of performance
  - Enhance the formative function
    - Provides the information required for guided reflection
  - Required for defensible decisions in summative assessments
  - Can be compiled
    - “reliability” obtained with adequate sampling

What do you think of this comment?

- She’s great – very confident, thorough, at expected level of training or beyond. Clinically very good, no gaps.

How could you improve it?

High Quality Comments

- Justify the ratings
- Have specific examples
- Provide recommendations for improving performance
- Written in a supportive/respectful manner
- Detailed enough for an independent reviewer to understand the issues

How to write descriptive comments

- Transform your verbal feedback into written comments
- Focus on behaviors – not attitudes
- Be specific
- When possible discuss the outcome
- Note their response to the feedback
- Write it down

Behaviours – Not Attitudes

- Example
  - “Lazy” resident

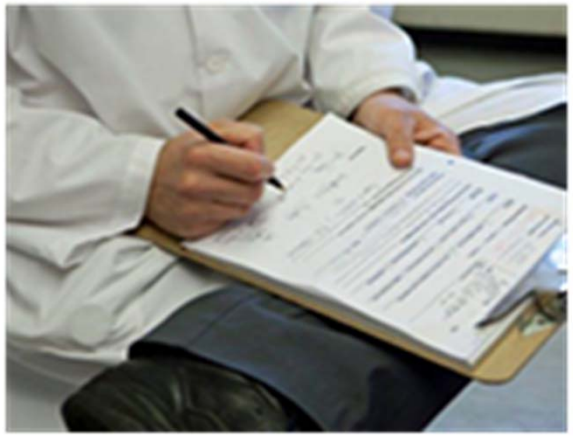
Behaviours – Not Attitudes

- Attitude
  - Lazy

- Behaviours & (Outcomes)
  - Consistently late (staff work late to accommodate)
  - Does not follow up on tests (missed critical issue)
  - Does not answer pages (called staff/other resident)
  - Does not do assigned readings (staff wastes time in teaching session)

Narrative Observation Form

- Describe one aspect of performance that was done well.
  - Was this done at the level of “competent for independent practice”?
    - Yes
    - Not yet
- Describe one aspect of performance that could improve.
  - What are your suggestions for how the resident could address the above area of performance to improve?



Okay comments

- Responds well to feedback
- Communication skills need work
- Read more
- Great case presentations

Better comments

- Responds positively to feedback. Ex) Noted that you missed a breech presentation for a patient in early labour. Reviewed signs and features on clinical exam that will increase suspicion for breech. On observation at a later point during the shift you had altered your physical exam/assessment appropriately.

- Tendency to use too much medical jargon when explaining issues to patients. Ex) In the patient with an abnormal finding on ultrasound you said, “It could be malrotation or situs inversus, or possibly a diaphragmatic hernia…”

- Focus anatomy reading on the pelvis…. need to be able to describe the blood supply and innervation as it relates to other pelvic organs.

- Case presentations in triage are succinct and include all relevant info Ex) Patient with headache and blurred vision… you were able to focus on the issues relevant to the question asked by the referring doctor in presenting the case

Practice

- Think of a resident or student that you recently worked with
- What verbal feedback did you give them?
- Turn that feedback into a comment
- Share the comment with a person at your table
  - Do they understand the comment?
  - Does it seem like a useful comment? Why or why not?
- Discuss with whole group

Summary

- Need to watch and provide verbal feedback
- Entrustment based anchors demonstrate promise with increased evidence for validity compared to tools with more traditional rating scale anchors
- Verbal feedback is the basis of good written assessment
- Good written assessment includes specific, behaviour-based comments that include examples
- Good written assessment is the key step to dealing with poor performance
- Good written assessment can guide further training

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Images

- **Slide # 8** “Miller’s Pyramid of Clinical Competence,” by R. Mehay and R. Burns, 2009. In R. Mehay (Ed.), The Essential Handbook for GP Training and Education (chapter 29: Assessment and Competence, p414). Also available at: http://www.essentialgptrainingbook.com/chapter-29.php.
- **Slide # 14** Title: O-SCORE – Ottawa Surgical Competency Operating Room Evaluation; Author: Gofton W, Dudek N, Wood T, Balaa F, Hamstra S. The Ottawa Surgical Competency Operating Room Evaluation (O-SCORE): a tool to assess surgical competence. *Academic Medicine.* 2012; 87: 1401-1407; Source: *Academic Medicine.* 2012; 87: page 1407 ; License: Used with permission under Licence Agreement (insert #)
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