**COMPETENCE COMMITTEE ASSESSMENT PROCESS GUIDELINES**

**Principles:**

The roles, responsibilities, and activities of a Competence Committee are guided by the following principles:

* The Competence Committee (CC) is a sub-committee of the Residency Program Committee (RPC).
* The CC allows for an informed group decision-making process where patterns of performance can be collated to reveal a broad picture of a resident’s progression toward competence.
* The CC has authority to make decisions on individual EPA achievement and resident assessments and progress. The CC presents status change determinations as recommendations to the RPC, which would then be approved by the RPC. Alternatively, the CC may provide a report for information to the RPC, without the requirement for approval. The RPC will report on resident progression to Postgraduate Medical Education as required ([see “Appendix A”](#Resident_Status_Recommendations)).
* Committee work is guided by the national specialty competency framework, including specialty-specific milestones and EPAs by stage, as established by the specialty committee as well as the relevant university and Royal College assessment policies.
* The CC is expected to exercise judgment in making EPA decisions and status recommendations: i.e., they will use specialty defined EPAs and the expected number of observations as a guideline, but they are not bound to a specific number, context or type of assessments. The key is that the Committee must feel it has adequate information on the EPAs and other resident assessments to make holistic judgments on the progress of the resident.
* ***In addition to utilizing milestones and EPAs, CC discussions will be based on all of the assessment tools and relevant evidence from the program as contained in the resident’s file. See*** [***chart***](#Composition) ***below for examples of assessment tools.***
* There are written criteria outlining program-based assessments, required training activities, and expectations beyond EPA completion.
* All Committee discussions are strictly confidential and only shared on a professional need-to-know basis.
* Committee decisions must be based on the evidence available in the resident’s file at the time of the committee meeting. Individual committee member’s experience can only be introduced with appropriate documentation within the resident’s file. Committee members must make every attempt to avoid the introduction of hearsay into the deliberations. Discussions are informed only by the evidence available in the resident’s file.
* The functioning of the CC, including its decision-making processes, is a focus of internal reviews and accreditation surveys.
* Individual trainees, or their Academic Advisors[[1]](#footnote-1) (for programs that implement this approach), may be invited to discuss their progress with the members of the CC.
* Committee work must be timely to ensure fairness and appropriate sequencing of training experiences.
* Competence Committees operate with a growth mindset. This means that Committee work is done in a spirit of supporting each trainee to achieve their own individual progression of competence.
* Competence Committees have a responsibility to make decisions in the spirit of protecting patients from harm, including weighing a trainees' progress in terms of what they can safely be entrusted to perform with indirect supervision. Some Committee discussions must be shared to provide focused support and guidance for residents.
* Competence Committees, on an exceptional basis, have the option to identify trainees who are eligible for an accelerated learning pathway provided that all requirements are met.
* Program expectations for promotion and readiness for certifying examinations (RCPSC or CFPC) are shared, and there is a written, communicated criteria to determine readiness for exam.
* CC decisions/recommendations and their associated rationales must be documented within the CC minutes and the resident’s file.

| **PRE-COMPETENCE COMMITTEE MEETING CONSIDERATIONS** |
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| **Agenda Development** | Trainees are selected for the agenda of a planned CC meeting by the Chair of the Committee, the Program Director, or their delegate. This must occur in advance of the Committee meeting to provide reviewers ([*see below*](#Composition)) adequate time to prepare for the meeting. |
| **Composition** | Competence Committee Chair; Program Director; Program Administrator; recommended non-division/department or allied health care member(s). Members are all aware of CBD principles and CC processes / functioning. |
| **Frequency** | Every trainee in the program must be discussed a minimum of twice per year. However, greater frequency of monitoring is desirable. |
| **Quorum** | There should be at least 50% attendance from the members of the CC to achieve quorum, with an absolute minimum of 3 clinical supervisors for smaller Committees. The program director (or ‘delegate’ in large programs) should be present for all discussions.Attendance must be incorporated into the minutes. |
| **Selection** | Trainees may be selected for CC review based on any one of the following criteria:1. Regularly timed review;
2. A concern has been flagged on one or more completed assessments;
3. Completion of stage requirements and eligible for promotion or completion of training;
4. Requirement to determine readiness for the Royal College exam;
5. Where there appears to be a significant delay in the trainee's progress or academic performance; or
6. Where there appears to be a significant acceleration in the trainee's progress.
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| **Primary Reviewer** | Each trainee scheduled for review at a CC meeting is assigned to a designated primary reviewer – ***generally, this is not the Program Director***. The primary reviewer is responsible for completing a detailed review ([*see below*](#Detailed_Report)) of the progress of the assigned trainee(s) based on evidence from completed assessments or reflections included within the resident’s file. The primary reviewer considers the trainee's recent progress, identifies patterns of performance, including numerical data and comments, from the assessments (please see below). At the meeting, the primary reviewer provides a succinct synthesis and impression of the trainee's progress to the other CC members. After discussion, the primary reviewer proposes a formal motion on that trainee's status going forward ([see “Appendix A”](#Resident_Status_Recommendations)). |
| **Secondary Reviewers** | All committee members are responsible for reviewing all trainees on the agenda as secondary reviewers. All secondary reviewers must be prepared to discuss all trainees' progress |
| **Types of Assessments** | In order to get a holistic view of the trainee’s performance*,* ***programs must not rely solely on EPA-based assessment***. Examples of other types of assessments include, but are not limited to:[ ]  In-Training Assessment/Evaluation Reports (ITARs/ITERs)[ ]  Multi-source Feedback (MSF)[ ]  Mini Clinical Evaluation Exercise (Mini-CEX)[ ]  Objective Structured Clinical Exam (OSCE)[ ]  Written/Oral Exams[ ]  Log Books[ ]  Peer Assessment[ ]  Journal Club Presentations[ ]  Ground Round Presentations[ ]  Clinical Teaching Assessments[ ]  Written Dictation[ ]  Participation in Scholarly Projects[ ]  Participation in Group Learning Projects and Seminars[ ]  Awards[ ]  Leadership Roles[ ]  Field Notes[ ]  Summary of Daily Clinical Performance Assessments[ ]  Self-reflection Requirements |

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| **COMPETENCE COMMITTEE PROCESS AND PROCEDURES – DURING MEETING** |
|[ ]  The Chair welcomes members and orients all present to the agenda and the decisions to be made. |
|[ ]  The Chair reminds members regarding the confidentiality of the proceedings and asks if there are any conflicts of interest to declare. |
|[ ]  Each trainee is considered in turn, with the primary reviewer presenting their synthesis, displaying relevant reports from the resident’s file, and sharing important quotes from any observational comments about the trainee. The primary reviewer concludes by proposing a status for the trainee going forward in the program. |
|[ ]  If seconded by another Committee member, all members are invited to discuss the motion. |
|[ ]  The Chair will call a vote on the proposed recommendation of the primary reviewer. |
|[ ]  If the recommendation of the primary reviewer is not seconded, or the motion does not achieve a majority of votes, the Chair will then request another motion regarding the trainee. |
|[ ]  This will continue until a majority of CC members support a status motion. The rationale for the recommendation must be documented in the CC minutes and resident file. |
|[ ]  Status recommendations can only be deferred if additional information is required. However, this deferred recommendation must be revisited within 4 weeks. |
|[ ]  A status recommendation is recorded in the CC minutes and resident’s file and is communicated to the RPC. |
|[ ]  The CC or delegate will communicate the status decision to the trainee and the decision will be recorded in the CC archives. This should include written communication in addition to verbal communication. |
|[ ]  The committee and primary reviewers all have access to EPA and other assessment data all of which are reviewed. |
|[ ]  Competence Committees should flag EPAs or Milestones which are inconsistently met at a defined stage for a cohort of residents to the Program Director. |
|[ ]  When reviewing a trainee’s assessment data, the CC will consider expired EPAs as complete. |

| **POST-COMPETENCE COMMITTEE MEETINGS** |
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| As soon as possible after the committee decision and communication to the RPC, the Program Director, Academic Advisor or other appropriate delegate will discuss the decision of the Competence Committee with the trainee. Changes to the trainee's learning plan, assessments, or rotation schedule will be developed with the resident and implemented as soon as feasible. |
| **Each program may take a slightly different approach to CC follow-up.****These questions may help inform you as you create your process:** | * How will you notify your residents? What time frame can you commit to for this resident notification?
* The CC must provide a report to the RPC.
 |
| * A formal written communication of the CC decision to the resident is required.
* In addition, the CC may consider if a personal communication or face-to-face meeting is advisable with the resident.
 |
| * Is it clear to relevant stakeholders how and when they can access key information from the CC?
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| **Appeal Process** | [Schulich School of Medicine & Dentistry](https://www.schulich.uwo.ca/medicine/postgraduate/future_learners/docs/Policies%20for%20Website/2021%20PGME%20Resident%20Assessment%20and%20Appeals%20Policy.pdf)[PGME Appeal Process](https://www.schulich.uwo.ca/medicine/postgraduate/future_learners/docs/Policies%20for%20Website/2021%20PGME%20Resident%20Assessment%20and%20Appeals%20Policy.pdf) |

**COMPETENCE COMMITTEE PRIMARY REVIEWER PROCESS AND PROCEDURES – ONE PAGE SUMMARY:**

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| **TRAINEE NAME:** | Click or tap here to enter text. | **DATE:** | Click or tap to enter a date. |
| **TRAINING YEAR:** | Choose an item. | **TRAINING STAGE:** | Choose an item. |
| **PRIMARY REVIEWER NAME:** | Click or tap here to enter text. |
| **NUMBER OF REVIEWS FOR TRAINEE THIS YEAR:****(INCLUDING THIS REVIEW)** | [ ]  First[ ]  Second[ ]  Third[ ]  Other: Click or tap here to enter text. |
| **REASON FOR SELECTION:** | [ ]  Regularly timed review[ ]  A concern has been flagged on one or more completed assessments[ ]  Completion of stage requirements and eligible for promotion or completion of training[ ]  Requirement to determine readiness for the Royal College exam[ ]  Appears to be a significant delay in the trainee's progress or academic performance[ ]  Appears to be a significant acceleration in the trainee's progress |
| **TYPES OF ASSESSMENTS USED IN REVIEW:** | [ ]  In-Training Assessment/Evaluation Reports (ITARs/ITERs)[ ]  Multi-source Feedback (MSF)[ ]  Mini Clinical Evaluation Exercise (Mini-CEX)[ ]  Objective Structured Clinical Exam (OSCE)[ ]  Written/Oral Exams[ ]  Log Books[ ]  Peer Assessment[ ]  Journal Club Presentations[ ]  Ground Round Presentations[ ]  Clinical Teaching Assessments[ ]  Written Dictation[ ]  Participation in Scholarly Projects[ ]  Participation in Group Learning Projects and Seminars[ ]  Awards[ ]  Leadership Roles[ ]  Field Notes[ ]  Summary of Daily Clinical Performance Assessments[ ]  Self-reflection Requirements[ ]  Other: Click or tap here to enter text. |
| **RECOMMENDED STATUS AND RATIONALE:** | Click or tap here to enter text. |

**APPENDIX A: RESIDENT STATUS RECOMMENDATIONS**

The following section is recommended and kept in general terms, as CCs determine their decision-making process. Below provides an example of resident status recommendations. We recommend that each program provide further details about components of decisions towards certain statuses as they see fit (e.g., adding expectations about ITERs or standardized test results, etc.)

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| **STATUS RECOMMENDATION** | **CRITERIA** |
| **Progress is Accelerated** | * EPA achievement well before expected date, *and*
* Learning trajectory significantly above expected, *and*
* Satisfactory performance on other assessments as determined by program
 |
| **Progressing as Expected** | * EPA achievement as expected, *and*
* Learning trajectory as expected, *and*
* Satisfactory performance on other assessments as determined by program
 |
| **Not Progressing as Expected** | * EPA achievement is below expected, *or*
* Learning trajectory is below expected, *or*
* Unsatisfactory performance on other assessments as determined by program
 |
| **Failure to Progress** | * EPA achievement is substantially below expected, *or*
* Learning trajectory is flat or substantially below what is expected, *or*
* Repeated and continued unsatisfactory performance on other assessments as determined by program
 |
| **Inactive** | * The resident is on leave (illness, parental, etc.)
 |
| * **Additional statuses to consider include the following when the resident is *“Progressing as Expected”* or *“Progress is Accelerated”*:**
* **Exam Eligible**
* **Certification Eligible**
 |

| **Possible Actions for Resident Statuses****\*** **denotes that the PGME must be notified** |
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| **For residents who are:****“*Progress is Accelerated*”** | **The resident can remain in the current stage*** Action plan will be determined by the Program Director in collaboration with the RPC and should be informed by the Competence Committee Assessment
 |
| **The resident can be considered for promotion to the next stage earlier than expected*** The training may be modified but must consider patient safety and contractual obligations.
 |
| **\* The resident can be deemed eligible for RCPSC exam earlier than expected** |
| **\* The resident can be deemed eligible for RCPSC certification earlier than expected** |
| **For residents who are:****“*Progressing as Expected*”** | **The resident remains in the current stage** |
| **The resident can be considered for promotion to the next stage** |
| **\* The resident can be deemed eligible for RCPSC exam** |
| **\* The resident can be deemed eligible for RCPSC certification earlier than expected** |
| **For residents who are:****“*Not Progressing as Expected*”** | **Action plans will be determined by the Program Director in collaboration with the RPC and should be informed by the Competence Committee Assessment.** |
| **For residents who are:****“*Failure to Progress”*** | **Action plans will be determined by the Program Director in collaboration with the RPC and should be informed by the Competence Committee Assessment.** |

1. An Academic Advisor is a faculty member specifically appointed to individual resident(s) to review the residents’ academic progress during residency. Academic Advisors are an optional role within Competence by Design. They are not required. In some programs, the Academic Advisor is also the Primary Reviewer and a member of the CC. [↑](#footnote-ref-1)