Western Psychiatry Program Handbook

Contents

1. Overview of CBD 3
2. Elentra 3
3. How to Complete an EPA 4
4. CBD & EPA Requirement Basics 5
4.1 Psychiatry CBD Ground Rules 5
4.2 EPA Requirements FAQs: 6
5. Competence Committee Review Deadlines for Document Submission 7
6. Program Director Reviews and Learning Plans 8
7. When to complete EPAs 8
7.1 Specific Information about getting EPAs, by Stage of Training 11
8. EPA Benchmarks 12
9. PGY1 14
9.1 Suggested PGY1 EPA Completion Schedule 15
10. PGY2 16
10.1 Suggested PGY2 EPA Completion Schedule 18
10.2 PGY 2 Supervision Guidelines 19
11. PGY3 Curriculum Guide & Requirements 24
11.1 Suggested PGY3 EPA Completion Schedule 26
11.2 Longitudinal Case Requirement 26
12. PGY4 Curriculum Guide & Requirements 27
12.1 Suggested PGY4 EPA Completion Schedule 29
12. 2 Longitudinal Case Requirement 30
13. **PGY5 Curriculum Guide & Requirements** 31
14. **Western Psychiatry Competence Committee Documents** 33
PRINCIPLES 33
PROCESS AND PROCEDURES 35
15. **Guidelines for Applying for Senior Electives** 43

16. **Elective Time Away Policy Senior Residents** 45
17. **Rotation Templates** 46
18. **Policies** 46
19. **Scholarly Curriculum for Psychiatry** 47

<u>The information contained within this document should be considered the most up-to-date source on resident requirements for the psychiatry residency program.</u>

The handbook will be updated at least annually (by end of academic year in June) based on updates to RCPSC documents, updates to Schulich policies, and changes to the curriculum (based on results, feedback, and the recommendations of the Evaluations and Curriculum committees). This document and links to other documents will be updated as necessary to reflect any major changes to the program.

1. Overview of CBD

Competence by Design (CBD) is a competency-based training model developed by the RCPSC for all residency programs across the country. Psychiatry residency programs started formally using the CBD model starting with the cohort who entered PGY1 in July 2020.

Those who are in a CBD program are likely to be familiar with the basics of how CBD works from other sources. If you are unfamiliar with EPAs, milestones, competencies or psychotherapy requirements of the residency program, **please follow these links to the relevant documents**:

- Overview of Competence by Design (CBD), pdf
- RCPSC Psychiatry Competencies 2020
- Table of EPAs
- RCPSC Psychiatry EPAs 2020
- Elentra users guide: https://www.schulich.uwo.ca/cbme/docs/PGME_Elentra_User_Guide.pdf
- Schulich Assessment and Appeals Policy
- All other Schulich policy documents
- 2. Resident Psychotherapy Training Handbook 2024-25 Sep edits.pdf

Residents and supervisors should be familiar with these documents and the information contained in them. They may be referred to for answers to many training and CBD-related questions.

2. Elentra

Elentra is the platform and e-portfolio for EPA assessments (https://elentra.schulich.uwo.ca/).

EPA forms are filled in on Elentra, using a computer or a mobile device.

There are different options for residents to send out EPA assessments to a supervisor and supervisors can also initiate an EPA on their own.

Supervisors can create a PIN on Elentra. This allows residents to fill out initial portions of the EPA before passing the same device to supervisors where they login to complete their portion and sign off on the form.

Tip: An icon can be created for the desktop of your mobile device, making it easy to access assessments.

Full, detailed instructions can be found in the Elentra users guide:
https://www.schulich.uwo.ca/cbme/docs/PGME_Elentra_User_Guide.pdf

3. How to Complete an EPA

1. Resident and/or consultant identify a clinical encounter that is suitable for observation of one of the EPAs **before** a clinical contact takes place.

   In some settings, such as the emergency department, this would be done in the moment, before seeing a new patient. In other clinical settings it could be planned the day before or at the start of the clinical day.

2. The resident or supervisor communicates to the other that they would like to do an EPA assessment for the selected clinical encounter.
3. The EPA assessment can be triggered in two ways; either:
   a. The resident logs into Elentra and sends an EPA request to the supervisor (see the Elentra guide and CBD Ground Rules for more information), or
   b. The supervisor logs into Elentra and selects the resident and the EPA, filling out any parts of the EPA that can be completed prior to the EPA observation and saving the partially completed form.

   (Note: this can also be done after the clinical assessment takes place but it is often helpful to have the EPA and milestones available for reference before the clinical encounter)

4. The resident performs the clinical task, usually with the supervisor present (unless it is one of the few EPAs where indirect observation is possible, which are typically in the later stages of training)
5. The supervisor gives the resident feedback about the performance of the clinical task, ideally referencing the EPA form while filling it out with the same feedback.
6. The supervisor signs off on the EPA form.

4. CBD & EPA Requirement Basics

4.1 Psychiatry CBD Ground Rules

Entrustable Professional Activities (EPAs)

- Ideally, an EPA should be completed **at every possible opportunity**.
    - Recognizing that observation is not always possible when opportunities exist, observations should be done on a regular basis, **even if the resident is not confident that they are yet entrustable, so that they can get direct feedback** on their performance.

- The completion of an EPA is **a shared expectation of residents and consultants**.
    - Residents are expected to send an EPA form to their supervisor at the time an opportunity to complete a particular EPA is identified, **or**
    - If an observed clinical consult is planned, the EPA form should be sent before the clinic starts, so it is ready at the time of assessment.
    - **An EPA request cannot be sent if it was not discussed with the consultant at the time of direct observation and must be sent by the end of the day that the clinical encounter took place.**
    - **It is the resident's responsibility to ensure that they complete enough EPA assessments to fulfill the RCPSC requirements (attaining entrustability for a sufficient number of EPAs as well as fulfilling the required contextual variables). If a resident is having significant difficulty in attaining the EPA requirements or finding appropriate EPA opportunities, they should first discuss this with their rotation supervisor(s). If the problem persists after discussing it with rotation supervisors, the resident should reach out to the Program Directors and CBD Lead (Dr. Thomson) for further assistance in finding appropriate opportunities.**

- **An EPA should be completed by the consultant within one week (7 days) of the time it was sent**.
    - While timely completion of EPA assessment forms on Elentra is expected of consultants, it is recommended that residents follow-up with the consultant on any EPA assessments that have not been completed within 5 days of the observed clinical task. If there are repeated challenges in getting EPA forms completed, please bring this to the attention of the CBD Lead (Dr. Thomson) or a Program Director.

- Which EPAs may be filled by PGY5 residents is outlined on the EPA forms as designated by the RCPSC Psychiatry specialty committee

- Residents should complete as much of the patient demographic and clinical information as possible on the EPA form before sending it to the supervisor. This clinical information is required to satisfy contextual variable requirements so it is very important that it be added accurately. **Residents should not be completing the rating scores or narrative feedback, as this is to be completed by the supervisor.**

- In some cases, the consultant may ask the resident to complete a separate self-assessment. In these circumstances **the consultant must still complete the milestone ratings and narrative feedback.**

- **A rating of 4 or 5 on the entrustability scale is considered entrustable for psychiatry EPAs**

4.2 EPA Requirements FAQs:

1. **What types of requirements are there for EPAs?**

Answer: There are two different requirements for EPA numbers that are set by the Royal College (RCPSC) and need to be followed by all psychiatry residency programs. The requirements are:

a. Number of entrustable EPAs. These are decided upon by the RCPSC and can be found in the following document: RCPSC Psychiatry EPAs 2020
b. Contextual variables: These are decided upon by the RCPSC and can be found in the following document: RCPSC Psychiatry EPAs 2020

2. **What happens if a resident is missing RCPSC EPA requirements at the time of a Competence Committee review?**

Answer: If residents are missing EPA requirements than the Competence Committee needs to decide if these missing requirements would be considered critical to demonstrate sufficient competence to progress into the next CBD stage. As the RCPSC sets EPA requirements these requirements are taken seriously. Significant deficiencies in them could result in findings of Not Progressing as Expected, Failure to Progress or a resident not progressing into the next CBD stage at the normal timepoint.

Ground Rules regarding Schulich Psychiatry Competence Committee (CC)

- Attempts are made to rotate file reviews at each review round, in order to have “a fresh set of eyes” on each resident file. However, for residents on an Independent Learning Plan (ILP), remediation, or probation, the file reviewer will generally be the Program Director overseeing the learning plan. Residents have an opportunity to discuss the CC results with a program director during the Program Director Review. These meetings with a Program Director will happen following every Competence Committee review for residents that are found to be “not progressing as expected” or “failure to progress”.

- The entire file is reviewed for the time period since the last CC meeting, including the longitudinal assessment requirements, which are regularly updated and listed in this guide.

- The PGE office sends a reminder to residents to submit materials approximately 2 weeks before the last day of the current review period. Residents must submit the required items by the deadline (which is the last day of Block 3, 6, 9 or 13 depending on the review period). If items are unable to be submitted on-time, residents are asked to contact the program directly (pgepsychiatry@lhsc.on.ca).

- Residents are notified of their progression status through the One45 CC Resident Review form. If changes to the progression status are made by the RPC during the ratification process, affected residents will be notified on an individual basis.

- Appeals occur in accordance with the Schulich PGME Assessment and Appeals Policy

- The following may be appealed, in accordance with the policy:

    - a Summative Assessment of "Failing to Progress" from a Competence Committee
    - a decision that the Resident's remediation program was unsuccessful
    - a refusal to promote the Resident to the next level or stage of training
    - a refusal by an RPC to complete a FITAR or CITAR certifying that the Resident has acquired the competencies of the specialty/subspecialty, or to affirm Resident's readiness for independent practice
    - dismissal following an unsuccessful probation program
    - a decision by the Associate Dean PGME to dismiss a Resident because he or she has not made satisfactory progress, or has engaged in unprofessional conduct, and/or has jeopardized patient care or safety.

5. Competence Committee Review Deadlines for Document Submission

The Competence Committee meets four times per year to review resident files. The deadline for residents to submit documentation to be reviewed by the committee is at the final calendar day of the last block under review. The PGE Psychiatry office will notify residents of the exact deadline by e-mail prior to the committee meeting.

Meeting	Deadline for Documentation	Blocks to be Reviewed	Typical Dates of CC Meeting(s)
CC #1	Last day of block 3	1-3	Early October
CC #2	Last day of block 6	4-6	Mid-January
CC #3	Last day of block 9	7-9	Late March
CC #4	Last day of block 13	10-13	Early July (next academic year)

2024-2025 Academic Year

CC Review (blocks being reviewed)	Deadline for Document Submission
1st (blocks 1 - 3)	September 23, 2024
2nd (blocks 4 - 6)	December 16, 2024

3rd (blocks 7 - 9)	March 10, 2025
4th (blocks 10 - 13)	June 30, 2025

After the Competence Committee Meeting the RPC will ratify progression and promotion statuses.

6. Program Director Reviews and Learning Plans

At least twice per year residents will be booked for a review with a program director following the Competence Committee review. The frequency of these review meetings may vary throughout different PGY years. Residents will be contacted by PGE staff to arrange the meeting. Residents that received a finding of Not Progressing as Expected or Failure to Progress by the Competence Committee and residents that are on a remediation plan or probation will be scheduled for a Program Director Review following each Competence Committee review. The half-hour meeting with a program director is an opportunity to discuss the resident's success at meeting the training expectations of the program, review their progression status, and develop strategies to improve performance or to meet new goals.

As part of the Program Director Review, the resident will complete a **learning plan** with the following headings:

- **Short-term goals:** (*Including areas for skill development, types of patients to gain exposure to or professional goals, using specific EPAs or competencies as relevant).*
- **Long-term/career goals:** *(Including interests for future practice and electives of interest)*
- **Resources needed:** *(Including specific coaching, mentorship or experiences)*

7. When to complete EPAs

1. **Residents must be familiar with the EPAs for the speciality and the contextual variables (different settings, age groups and patient types) that are required to attain** entrustable EPA observations. The RCPSC Psychiatry EPAs 2020 document outlines these requirements by stage. The contextual variables for the Foundations of Discipline and Core of Discipline stages are listed in this document.

2. Residents **must attain a minimum number of entrustable observations** (observations of achievement) on each EPA, in a variety of **settings and situations**, known as **contextual variables**, **by the end of a stage of training**. If a resident does not attain the minimum number of entrustable observations, they **may have to do extra training** to ensure that they are attaining an adequate level of competency. A global entrustability rating on an EPA of "I had to provide minimal guidance" or "4/5" is sufficient for entrustability on all psychiatry EPAs. (This is subject to ongoing reassessment and revision).

Examples of contextual variables:

Minimum entrustable observations/observations of achievement and contextual variables for **EPA Foundations #2** (Psychiatry EPAs 2020). Most contextual variables for F2 are based on observation in a **specific setting or demographic** with at least 3 different case types.

Collect 6 observations of achievement
- At least 1 emergency setting
- At least 2 inpatient settings
- At least 2 outpatient settings
- At most 2 child and adolescent patients
- At most 2 older adult patients
- At least 3 different case types [i.e. diagnoses]

Minimum entrustable observations/observations of achievement and contextual Variables for **EPA Foundations #3** (from the RCPSC **Psychiatry EPAs 2020** document). Most of these are related to **specific diagnoses and demographics**:

Collect 6 observations of achievement
- At least 1 mood disorder
- At least 1 psychotic disorder
- At least 1 personality disorder
- At least 1 substance use disorder
- At least 1 of anxiety or trauma or OCD
- No more than 2 child or adolescent patients
- No more than 2 older adult patients
- At least 3 different observers

3. EPAs by Stages of training

Transition to Discipline – Orientation month – 2 TTD EPAs (D1 and D2)

Foundations of Discipline – PGY1 and PGY2 – 5 Foundations EPAs (F1-F5)

Core of Discipline – PGY3 and PGY4 – 10 Core EPAs (C1-C10)

Transition to Practice – PGY5 – 3 TTP EPAs (P1-P3)

Psychiatry - CBD
EPAs by stages (final)

Stage 1 – Transition to Discipline	Stage 2 – Foundations of Discipline	Stage 3 – Core of Discipline	Stage 4-Transition to Practice
Approx. 1-3 months	Approx. 20-23 months	Approx. 23-26 months (2 years)	Approx. 10-14 months (1 year)
TTD 1. Obtaining a psychiatric history to inform the preliminary diagnostic impression for patients presenting with mental disorders TTD 2. Communicating clinical encounters in oral and written/electronic form	F 1. Assessing, diagnosing and participating in the management of patients with medical presentations relevant to psychiatry F 2. Performing psychiatric assessments referencing a biopsychosocial approach, and developing basic differential diagnoses for patients with mental disorders F 3. Developing and implementing management plans for patients with psychiatric presentations of low to medium complexity F 4. Performing risk assessments that inform the development of an acute safety plan for patients posing risk for harm to self or others F 5. Performing critical appraisal and presenting psychiatric literature	C 1. Developing comprehensive treatment/management plans for adult patients C 2. Performing psychiatric assessments and providing differential diagnoses and management plans for children and youth C 3. Performing psychiatric assessments, and providing differential diagnoses and management plans for older adults C 4. Developing comprehensive biopsychosocial formulations for patients across the lifespan C 5. Identifying, assessing, and managing emergent situations in psychiatric care across the lifespan C 6. Integrating the principles and skills of psychotherapy into patient care	TTP 1. Managing the clinical and administrative aspects of a psychiatric practice TTP 2. Supervising junior trainees TTP 3. Developing and implementing personalized training experiences geared to career plans or future practice C 7. Integrating the principles and skills of neurostimulation into patient care C 8. Integrating the principles and skills of psychopharmacology into patient care C 9. Applying relevant legislation and legal principles to patient care and clinical practice C 10. Providing teaching for students, residents, the public and other health care professionals

EPAs should be completed in the stage that the resident is currently in, with some exceptions. Where a **foundations EPA is clearly describing an earlier version of a core EPA, the resident should get the foundations EPA first** and only work on the core EPA if they have attained entrustability on the foundations EPAs (with attainment of all of the contextual variables). This includes C&A or geriatric patients, who should be seen as F2 or F3 in the PGY1 and PGY2 years unless these Foundations EPAs have been completed.

Examples:

EPA (earlier version)	EPA (later version)
F4 – Performing a risk assessment that informs the development of an acute safety plan for patients posing risk of harm to self or others	C5 – Identifying, assessing, and managing emergent situations in psychiatric care across the lifespan.
F2 – Performing a psychiatric assessment referencing and BPS approach, and developing a basic differential diagnosis for all psychiatric patients	C1 - Performing psychiatric assessments, providing differential diagnosis and developing a comprehensive treatment/management plan for all presentations in adult patients of medium to high complexity

F3 – Developing and implementing management plans for patients with psychiatric presentations of low to medium complexity	C2 - Performing psychiatric assessments, providing differential diagnoses and management for presentations in children and youth C3 - Performing psychiatric assessments, providing differential diagnoses and management for older adults

4. **In some cases, it may be appropriate for a foundations resident to work towards a core EPA, *if there is no equivalent and the EPA is on a task that is worked on throughout residency*.** Examples of this would be attempting C6 (psychotherapy), C7 (neurostimulation), C9 (application of relevant legislation and legal principles) and C10 (teaching) EPAs in PGY2.

5. Senior residents in their PGY4 year can complete the Transition to Practice EPA #2 (P2 – “Supervising junior trainees”). **However, P1 and P3 should not be completed prior to the resident starting their PGY5 year.**

    a. P1 should be completed during the Independent Practice (“Junior Attending”) rotation as the objectives of this rotation are meant to satisfy the EPA requirement.
    b. Residents will be allocated time during their PGY5 academic days to develop, work on and reflect upon their learning plans for the TTP3 EPA.

6. Most EPAs require direct (in-person) observation. In some cases, indirect observation may take place for *some observations but not all*, through reviewing a report or case discussion. These are spelled out explicitly in the RCPSC Psychiatry EPAs 2020 document**. The <u>only</u> EPAs that allow for some indirect observations are: F3, C1, C2, C3, C4, C7 (part A), C8 and P3. C6 part A (the psychotherapy EPA) can be done by having the supervisor directly observe the psychotherapy session or by review of audio, video or written transcript.**

7.1 Specific Information about getting EPAs, by Stage of Training

The pages below have specific information about how to get EPAs in each year of training.

Completion of the expected EPAs, including contextual variables, is a crucial element for completing training requirements and advancing to the next year of training. **Failure to obtain the EPAs expected in a year of training, could result in being held back to complete the required EPAs.**

There is also guidance about where to get specific contextual variables on the other pages.

The **PGY2 outpatient supervision guidelines** outline what residents can expect from their outpatient supervisors on rotation in both core and selectives.

The **complexity table**, created by the RCPSC Psychiatry specialty committee (included later in this document), defines low, medium and high complexity patients to clarify what types of cases can be

counted for different EPAs. These levels of complexity are asked for in the assessment plan of the EPA assessment and help define the required conditions for an EPA.

Residents must know the EPAs and contextual variables well. The RCPSC Psychiatry EPAs 2020 document contains information about all of the EPAs, with their key features, assessment plans and the necessary **contextual variables** that have to be met (e.g. settings, case types, demographics). The total number of EPA observations needed to meet training requirements is also outlined in this document.

8. EPA Benchmarks

Benchmarks for EPA completion have replaced the previous requirement of having a minimum number of EPA observations done per block or rotation. This change was made to provide residents with more autonomy in determining when they do their EPA evaluations within their CBD stages. Residents are still encouraged to complete EPAs regularly to develop mastery of their skill sets and to get ongoing coaching from clinical supervisors. The RCPSC has established the number of entrustable findings required for each individual EPA, as well as the contextual variables that residents must attain. To adequately evaluate the resident's training progression, the Competence Committee needs to have markers or established norms that the resident's progression can be compared to. As such, benchmarks have been established to allow this. The expectation would be that a resident's attainment of EPA requirements is in keeping with these benchmarks and that if deficiencies exist compared to the benchmarks, that they are relatively minor. It is also important that residents prioritize getting the EPAs and contextual variables that will be difficult to attain outside of particular residency rotations. For example, C2 involves performing psychiatric assessments, providing differential diagnoses and developing management plans for children and youth. Residents should have completed all requirements for this EPA (entrustable findings and contextual variables) by the end of their PGY3 child and adolescent rotations. Residents will not routinely see child and adolescent patients in their PGY4 rotations, so any incomplete C2 EPA requirements may be difficult to attain once the C&A rotation has ended. Likewise, there are contextual variables for C8 that are specific to child and adolescents and should be done during the PGY3 C&A rotations. There are comparable requirements for C3 and C8 EPAs involving geriatric populations that should be completed before the end of the PGY3 geriatrics rotation.

50% Benchmark: Resident is expected to have attained half of the required entrustable findings by this point in their residency training. Multiple contextual variables should also have been attained.

75% Benchmark: Resident is expected to have attained 75% of the required entrustable findings by this point in their residency training. Multiple contextual variables should also have been attained.

100% Benchmark: Resident is expected to have attained all of the required entrustable findings **and** all of the contextual variables by this point in their residency training.

EPA	50% Benchmark	75% Benchmark	100% benchmark
Transition to Discipline			
D1	N/A	N/A	PGY1 CC Review #1
D2	N/A	N/A	PGY1 CC Review #1
Foundations of Discipline			
F1	PGY1 CC Review #3	N/A*	**PGY1** CC Review #4
F2	PGY2 CC Review #2	PGY 2 CC Review #3	PGY2 CC Review #4
F3	PGY2 CC Review #2	PGY 2 CC Review #3	PGY2 CC Review #4
F4	PGY2 CC Review #2	PGY 2 CC Review #3	PGY2 CC Review #4
F5	PGY2 CC Review #3	N/A	PGY2 CC Review #4
Core of Discipline			
C1	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C2	PGY3 CC review following the completion of 3 blocks of PGY3 Child & Adolescent	PGY3 CC Review following the completion of all PGY3 Child &Adolescent rotations	PGY4 CC review #4
C3	PGY3 CC review following the completion of 3 blocks of PGY3 Geriatrics rotations	PGY3 CC Review following the completion of all PGY3 Geriatrics rotations	PGY4 CC review #4
C4**	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C5	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C6	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C7	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C8**	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C9	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4
C10	PGY4 CC Review #2	PGY4 CC Review #3	PGY4 CC review #4

* There isn't a defined benchmark for this as it will be dependent on when residents complete their off-service rotations

** "Child" contextual variable should be attained by the end of PGY3 C&A rotations.

** "Older adults" contextual variable should be attained by the end of PGY3 geriatrics rotations

EPA	50% Benchmark	75% Benchmark	100% benchmark
Transition to Practice			
P1 (Parts A & B)	N/A		PGY5 CC Review #3
P2	PGY5 CC Review #2		PGY5 CC Review #3
P3 (Parts A, B & C)*	PGY5 CC Review #2		PGY5 CC Review #3

*2 observations of achievement are expected for P3 within the Western Psychiatry Residency Program

9. PGY1

It is very challenging to complete F1 EPAs after PGY1 as residents will no longer be doing off-service rotations starting in PGY2. As such, it is crucial to complete all of your F1 contextual variables in your PGY1 year.

Contextual Variables for F1

-At least 8 observations of achievement
-At least 2 medical emergencies
-At least 1 substance intoxication
-At least 1 overdose and/or withdrawal
-At least 1 neuropsychiatric presentation
-At least 1 endocrine or metabolic disorder

EPA	Basis of EPA	# of Entrustable Required	Contextual Variables	# of Contextual Variable Required
D1	Psychiatric history	2	At least 1 done by a psychiatrist	2
D2	Clinical documentation	2	At least 1 done by a psychiatrist	2

Here are the **ideal rotations to get your contextual variables**:

EPA	Contextual Variable	Optimal rotations
D1 and D2		Orientation (ability to do a history and a clinical note)
Foundations 1 (F1)	Medical Emergency	Emergency medicine, neurology, medical selective, family medicine, addictions medicine
	Substance intoxication	Emergency medicine, medical selective, family medicine, addictions medicine
	Overdose/withdrawal	Emergency medicine, addictions, family medicine
	Neuropsychiatric	Neurology, emergency medicine
	Endocrine/metabolic	Emergency medicine, medical selective, family medicine
Foundations 2 (F2)	Emergency	CEPS/on-call
Foundations 4 (F4)	Various	CEPS, various psychiatry rotations
Foundations 5 (F5)		History of Psychiatry teaching session during an academic half-day near the end of PGY1

The number of required observations of achievement (entrustable observations) over residency is documented in the RCPSC Psychiatry EPAs 2020 document.

PGY1 Curriculum Guide & Requirements	
EPA Requirements	
Transition to Discipline Stage	All of the entrustable EPA findings and contextual variables should be attained by the 1st CC review of PGY1 (September of PGY1 year for most residents). Once residents have completed all of the required EPAs for the Transition to Discipline stage, they should start getting EPAs from the Foundations of Discipline stage (this will often happen before the resident is promoted into the Foundations of Discipline stage by the Competence Committee).
Foundations of Discipline Stage	Residents are expected to get all of their **F1** Entrustable findings and contextual variables by the end of their PGY1 year. Residents should start obtaining Foundations EPAs once they have completed their Transition to Discipline EPAs.
Longitudinal Training	
Psychotherapy Log (C6 part B EPA)	**Not required in PGY1** as residents generally do not begin formal psychotherapy training until their PGY2 year.
Scholarly Project (Research)	**Not required in PGY1**. Residents may opt to start a research program or look for research opportunities by speaking to the Scholarly Project Lead.
Interview Skills	There are no STACER requirements for PGY1.
On Call Requirements	
On Call Assessment	Minimum of 1 Junior On Call Assessment (either C&A or adult) per on-service rotation For London residents, must have 4 Adult and 2 C&A Junior On Call assessments by end of PGY1 year. For Windsor residents, must have 6 Adult Junior On Call assessments by end of PGY1 year (C&A on call doesn't apply for Windsor) On call assessments must be sent to a consultant within one week of the call shift.
Teaching Requirements	
Academic half-days	Attend teaching sessions (minimum 80% of academic Thursdays sessions must be attended on non-excused days).

9.1 Suggested PGY1 EPA Completion Schedule

Rotation	Recommended EPA Observations
Orientation	2x D1 & 2x D2 (completion of these EPAs will be required before CC Review #1 of PGY1)
General Adult Psychiatry	2x F2, 2x F3, 1x F4
CEPS/Emergency Psychiatry	2x F2 (emerg contextual variable), 1x F3, 2x F4
Child & Adolescent Psychiatry (London only)	2 F2, 2x F3, 1x F4
Addiction Medicine	2x 11 observations (intoxication & overdose/withdrawal contextual variables), 2x F2, 1x F3, 1x F4
Neurology (2 blocks)	3x F1 over the 2 blocks (with at least one having neuropsychiatric contextual variable)

Emergency Medicine	3x F1 (resident should attempt to complete the "Medical emergency" contextual variables as this may be their best opportunity)
Family Medicine	3x F1 (this may be a good opportunity for multiple different contextual variables)
Medicine Service (Endocrinology, CTU or Hospitalist)	3x F1 (this may be a good opportunity for multiple different contextual variables)
Selective rotations	Psychiatry-based rotations: 1x F2, 1x F3, 1x F4 Off-service selective: 3x F1

10. PGY2

There are many contextual variables for F2 and F3, so it is important to do them as many times as possible.

F5 will be done for most presentations in PGY2. The most common opportunities for this will be journal club, complex case rounds and department-wide morbidity and mortality rounds. It may be possible to do an F5 for the Scholarly Project Update Group, but residents will need to discuss this with the Scholarly Project Lead beforehand to ensure that EPA requirements will be met.

PGY2 – **You must complete all Foundations EPAs to progress to Core (PGY3).**

Here are the rotations **where you must get your contextual variables**:

EPA	Contextual Variable	Only rotations available
Foundations 2 (F2)	2 Inpatient	Inpatient rotation
	2 Outpatient	Outpatient rotation
Foundations 3 (F3)	Various	Most settings, but be aware of opportunities
Foundations 4 (F4)	Various	Most likely to be obtained during inpatient rotation or CEPS rotation
Foundations 5 (F5)	2 observations of achievement	Be certain to get at presentations in PGY2, including ethics, CPD or Journal Club
Core 6 (C6)	Part A – CBT	Must be completed throughout CBT training
Core 6 (C6)	Part A – Psychodynamic	Must be completed during psychodynamic
Core 6 (C6)	Part A – Supportive	Must be completed alongside Supportive ITARs
Core 6 (C6)	Part A – Family/Group	Should be completed by the end of PGY3
Core 6 (C6)	Part B – logbook	Must be started in PGY2 with therapies including supportive hours Note: the "Psychotherapy Log Sheet" is a summary of hours for each CC meeting and is considered equivalent to the C6B EPA, but residents also will maintain the more comprehensive log as indicated in the psychotherapy handbook, which may be reviewed with the program director or during meetings with the Psychotherapy Lead
Core 7 (C7)	Part B – ECT	Must have one EPA *observation*

PGY2 Curriculum Guide & Requirements	
EPA Requirements	
Foundations of Discipline Stage	Residents are expected to get all of their Foundations of Discipline entrustable findings and contextual variables by the end of their PGY2 year. Once a resident has all of the requirements for a Foundations of Discipline EPA, they can start completing related EPAs from the Core of Discipline Stage (e.g. doing C1 EPAs instead of F4 EPAs once all F4 requirements have been attained). See **8. EPA Benchmarks** above for further details.
Longitudinal Training	
Psychotherapy Log (C6 part B EPA)	Resident should be actively maintaining a psychotherapy log as indicated in the psychotherapy handbook for each modality. This log is considered equivalent to EPA C6 part B and a psychotherapy hours summary ("Psychotherapy Log Sheet") must be submitted by the CC Review document submission deadline prior to **every** CC meeting throughout residency. This requirement **starts in September of the PGY2 year** (the first CC meeting of the PGY2 year) and continues until the resident has completed all psychotherapy requirements for the residency program.
Psychodynamic Therapy (LONDON)	Start case by end of PGY2 academic year. First ITAR & C6 – part A will be due by the CC document submission deadline for the 1st CC review in PGY3 (this is September of PGY3 for most residents). C6 part A – 1 observed EPA required every 3 months while psychodynamic training is ongoing 2. Resident Psychotherapy Training Handbook 2024-25 Sep edits.pdf
Psychodynamic Therapy (WINDSOR)	Windsor residents generally do not begin psychodynamic therapy until PGY3.
CBT (LONDON) 1st due in March	CBT ITAR 1 due at third CC review of PGY2 year (this is usually around March of the PGY2 year) C6 part A – 1 observed EPA required every 3 months while CBT training is ongoing
Supportive Psychotherapy	C6 part A and ITAR – **two** cases (with one EPA observation per and ITAR per case) are required by end of PGY2 academic year (deadline for CC#4). Each supportive case must have a minimum of 5-8 hours and a minimum of 5 sessions before completion of the ITAR.
Scholarly Project (Research)	Residents are expected to have chosen a scholarly project by January of their PGY2 year. Scholarly Activity Report Form– resident completes this form on One45. The first must be submitted by the CC document submission deadline prior to the 4th CC Review (June 30th of PGY2 year for most residents). Scholarly Project (Research) ITAR 1 – faculty completes this form on One45 but resident must send it to the faculty member by the document submission deadline for the 4th CC review (June 30th of PGY2 year for most residents).

	See: **19. Scholarly Curriculum for Psychiatry** below for information on scholarly project requirements during the residency program.
Interview Skills	PGY2 Inpatient STACER must be completed by the end of PGY2 inpatient rotations. Generally completed with one of the inpatient supervisors. PGY2 Outpatient STACER must be completed by the end of PGY2 outpatient rotations. Generally completed with one of the outpatient supervisors.
ECT Experience	C7 part B – one observation recommended
On Call Requirements	
On Call Assessment	At least 2 Adult and 1 C&A Junior On Call assessments must be sent to a consultant for each q3 month CCC review for London residents. Windsor residents must send 3 adult On Call assessments for each q3 month CC review period. On call assessments must be sent to a consultant within one week of the call shift. For London residents, 16 Adult & 8 C&A Junior On Call assessments required by the end of PGY2 (this includes assessments from PGY1 & PGY2). For Windsor residents, 24 Adult Junior On Call assessments (spanning PGY1 and PGY2) are required by end of PGY2 year.
Teaching Requirements	
Academic days	Attend teaching sessions (minimum 80% of academic Thursdays sessions must be attended on non-excused days).
Teaching EPAs	An F5 EPA should be completed with any teaching activities that are observed by a supervisor. For Department of Psychiatry CPD teaching please contact the CPD Lead, Dr. Verinder Dua before the presentation date to make arrangements for this.

10.1 Suggested PGY2 EPA Completion Schedule

Rotation	Recommended EPA Observations
Inpatient Psychiatry	Per 4-week block: 2x F2, 2x F3, 1x F4 During the 6-blocks of inpatient: At least 1x F5 C6 – Part A EPAs should be getting completed regularly
Outpatient Psychiatry	Per 4-week block: 2x F2, 2x F3, 1x F4 During the 6-blocks of outpatient: At least 1x F5 C6 – Part A EPAs should be getting completed regularly

Rotation Templates found within Teams:

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/CBME/Rotation%20Templates?csf=1&web=1&e=M14y64

10.2 PGY 2 Supervision Guidelines

PGY2 Outpatient Supervision Guidelines

6 Month PGY2 Outpatient Rotation

For 6 months in PGY2 outpatient rotation, the supervisor works with resident 2d/week. *Please familiarize yourself with the assessment requirements (see page 3).* For the supervisor:

1. At least one new consult should be booked for the resident per week and there should be at least 3 supervised new assessments booked per block (4 weeks). In order to be an outpatient supervisor, you will need to be accepting new referrals from Coordinated Intake regularly and be responsible for ongoing care, if required, beyond the time of the resident rotation.
2. As many follow-ups as possible should be seen by the resident and supervisor together for the first 2 weeks. This should involve occasions where the supervisor leads the interview and resident observes. When the resident does the interview, an F2 observation should be done.
3. The 6-month supervisor must offer the resident an experience constituted by managing an ongoing case load where the resident is the primary clinician and following longitudinally. While some cases may be “inherited” at the beginning of the rotation, many of the patients should be initially assessed by the resident and then followed by them for each subsequent visit.
4. All new consults seen (un-observed) by residents should be discussed with the supervisor as soon as possible. The patient should then be seen by the resident and supervisor together to clarify any unresolved details and review management plan with the patient (when the resident takes the lead doing this, a F3 observation should be done). Early in the rotation, the supervisor would take lead, with increased responsibility to the resident over time.
5. PGY2 outpatient supervisors are expected to commit to a minimum of 2 hours/week (preferably more) of face-to-face direct observation or supervision.
6. Supervisors must routinely review documentation by residents and provide feedback.
7. The cap (i.e., maximum) for resident work is 1 consult and 1 follow-up or 4 follow-ups per *half* day. This is a cap and not a minimum expectation.
8. One Supportive Psychotherapy patient must be provided and supervised by the 6-Block PGY-2 outpatient supervisor. In addition, the 6-Block supervisor will be expected to ensure the resident has an opportunity for the outpatient STACER.

3 Month PGY2 Outpatient Rotation

The requirements for the 3 Month supervisors remain the same as for the 6 Month supervisors, with two notable exceptions:

1. The 3-month supervisor would have a rotation where consultations with limited follow-up and/or one-time follow-up appointments with unfamiliar patients make up a higher proportion of the clinical population.
2. If it is the resident’s 4th month of outpatient (i.e., when resident begins work with their 2nd 3-month supervisor), the need to see patients together at the outset of the block (as outlined in points 3 and 4 above) is lessened.

3. 3-month supervisors are encouraged, but not required, to provide a patient for supportive psychotherapy.

Selective 3 Month PGY2 Outpatient Rotation

To increase exposure to different patient populations, enhance learner-centred curriculum and possibly increase opportunities for observed practice, one of the two 3-block supervisors for the outpatient rotation will be from a specialized clinic (patient population range: 16-65 years old). Expectations and patients seen would have to be adjusted to a PGY2 level (ITARs, patient complexity guideline in program handbook, and Foundation of Discipline EPAs will assist in gauging expectations).

Selective Options:

- PIMH adult ambulatory – Dr. Renwick, Dr. Ganjavi & Dr. Shanmugalingam
- Forensics – Dr. Prakash & Dr. Quinn
- Bipolar Disorders & Perinatal Psychiatry – Dr. Sharma
- ACT – Dr. Dua
- FEMAP – Dr. Armstrong
- PEPP – Drs. Subramanian, Dhaliwal
- Operational Stress Injury Clinic – Dr. Thomson & Dr. Watling

Selective Supervision Guidelines

For 3 months in PGY2 selective rotation, the supervisor works with resident 2d/week. *Please familiarize yourself with the assessment requirements (see page 3).* For the supervisor:

1. At least one new consult should be booked for the resident per week, when this is possible. If new consults are not available, the resident should be given as many opportunities as possible to do detailed follow-up interviews which allow for an F2 observation.
2. There should be at least 6 supervised patient assessments of some form booked per block (4 weeks).
3. In the first 2 weeks, as many follow-ups as possible should be seen together by the resident and supervisor. This should include occasions where the supervisor is observed by the resident.
4. All new consults seen (un-observed) by residents should be discussed with the supervisor, soon after, and this should be used as a teaching opportunity. This should only be done if the resident has attained an entrustability level of 4 or more on F2 and the patient's level of complexity is low or medium (as defined by the RCPSC complexity document). The patient should then be seen by the resident and supervisor together to clarify any unresolved details and review management plan with the patient. Supervisor should lead the management discussion during the beginning of the rotation, with increased responsibility to the resident over time.
5. PGY2 outpatient selective supervisors are expected to commit to a minimum of 2 hours/week (preferably more) of face-to-face direct observation or supervision.
6. Supervisors must routinely review documentation by residents and provide feedback.

PGY2 Inpatient Supervision Guidelines

For 2 months in PGY2 inpatient rotation, the supervisor works with resident 2d/week. Residents have 3 2-month inpatient rotations. *Please familiarize yourself with the assessment requirements (see page 4).*

Residents are to manage a **maximum of eight inpatients per day**. Please note that this is a maximum, and not a number that needs to be achieved. For example, a supervisor may feel that six would be a more appropriate case load to have if the patients are particularly complex or might have a resident manage only 5 inpatients if two of the patients are new admissions requiring full assessment.

Psychiatric complexity

	Low	Medium	High
Psychiatric comorbidity	1-2 (that affect function)	2-4 that affect function	5+ diagnoses that affect function, severe mental illness (SMI /SPMI) that is poorly controlled, polysubstance abuse Severe impact of personality disorder
Acuity	New onset/few relapses	Recurrent /episodic illness	Chronic, non-remitting severe mental illness (SMI/SPMI) that is poorly controlled Severe impact of personality disorder
Intellectual function	Normal	Low normal	ID ASD
Treatment	1-2 psychiatric medications	Suboptimal response to a class Suboptimal response to evidence based psychotherapy	Suboptimal response to multiple medications trials Suboptimal response to multiple evidence based Psychotherapeutic techniques
Treatment resistence	Treatment naïve/limited past treatments	1-3 failed trials/ supboptimal response	Multiple failed trials/suboptimal response - first and second line treatments (psychotherapy and/or medication)
Medical comorbidity	Nil, non-complicating	Moderate, non-complicating	Significant, complicating psychiatric treatment
psychosocial stressors	Minimal social	Moderate (acute-recent separation, job loss, parental separation,change in school situation, bullying)	Severe/chronic (homelessness, severe trauma etc), forensic, -under court order, Geographic islolation Social isolation related to other factors (gender, race, gender identity etc)
Communication	No barrier	Barrier overcome (interpretation)	Unable to communicate adequately
Level of functioning	Not impaired/mild acute impairment	Impaired during episodic illness return to base line	Chronic impairment Severe acute impairment(unable to complete selfcare, ADL)

		Acute impairment(unable to work, attend school,no impairment in self care/ADL)	

Maybe we should define a simple case to help in conceptualizing a complex case:

A simple case would include:

- One DSM 5 diagnosis that leads to disturbance of functioning in one or more major areas of life such as work, academics, interpersonal relatinships
- Recent onset or infrequent relapses
- Treatment naïve or limited past treatment
- No language barrier
- No significant intellectual or communication barrier
- No significant psychosocial issues

A moderate case would include:

- One to three DSM diagnoses that lead to disturbance of functioning in one or more major areas of life
- Recurrent illness
- More than one past treatment trial
- One to three psychoactive medications
- "Overcome-able" language and cultural barriers
- Fluctuating level of function with some recent periods of moderate-level functioning
- Moderate biopsychosocial complexity: see above

High Complexity

- More than three DSM 5 diagnoses that hinder function (so tobacco-use disorder cannot be included in the count)
  - Prototype complex case: PD plus addictions plus another "axis 1" diagnosis: mood or psychosis
  - Other prototypes: Severe personality disorders with mood and anxiety disorders
- Long-standing active psychiatric illness
- More than four or five regular psychoactive medications or more than ten prescribed medications
- Chronic low level of function
- Significant language or cultural barrier

11. PGY3 Curriculum Guide & Requirements

EPA Requirements	
Core of Discipline Stage	Residents should be completing EPAs from the Core of Displace stage. All Child & Adolescent and Geriatric-specific entrustable findings and contextual variables should be attained by the end of the respective rotations in PGY3 (as these EPAs will be challenging to obtain in PGY4). See **8. EPA Benchmarks** above for further details.
Longitudinal Training	
Psychotherapy Log (C6 part B EPA)	Resident is required to actively maintain a psychotherapy log. This log **fulfills the EPA C6 part B CBD requirement.** The log ("Psychotherapy Log Sheet" on One45) must be submitted prior to the CC document submission deadline for **every** CC review starting in PGY2 up until all psychotherapy requirements for the residency have been fulfilled (as confirmed by the Psychotherapy Lead and with submission of one final psychotherapy log at that time).
Psychodynamic Therapy (LONDON)	C6 part A – 1 observed EPA & ITAR required every 3 months while psychodynamic training is ongoing 1st C6 part A and ITAR are due by CC document submission deadline for the 1st CC review of PGY3 (this is September of PGY3 for most residents) 2. Resident Psychotherapy Training Handbook 2024-25 Sep edits.pdf
Psychodynamic Therapy (WINDSOR)	Psychodynamic therapy is to be started PGY 3 year and finished in PGY 4-5. 1st ITAR and C6 observation due by the document submission deadline for the 4th CC review of PGY3 (June 30th of PGY3 for most residents) C6 part A – 1 observed EPA & ITAR required every 3 months while psychodynamic training is ongoing
CBT (LONDON) (if not yet complete)	C6 part A – 1 observed EPA & ITAR required every 3 months while CBT training is ongoing
CBT (WINDSOR) (CBT Case to be started in PGY3)	1st ITAR and C6 observation due by the document submission deadline for the 1st CC review of PGY3 (Sept of PGY3 for most residents) C6 part A – 1 observed EPA & ITAR required every 3 months while CBT training is ongoing
Supportive Psychotherapy	C6A – 1 observation of achievement is to be completed by the end of PGY3 (4th Competence Committee review of PGY3). 1 ITER is to be submitted to a supportive psychotherapy supervisor by the end of PGY3 (4th Competence Committee review of PGY3).

	Note: supportive psychotherapy can count for C6A "integrating of psychotherapy interventions in regular clinical care" contextual variable but does not fulfill requirements of the "other" modality. The supportive case must have a minimum of 5-8 hours and a minimum of 5 sessions before completion of the ITAR.
Family or Group Therapy	C6A – 2 observations of achievement are to be completed by the end of PGY3 (4th Competence Committee review of PGY3). 1 ITER is to be submitted to a family or group therapy supervisor by the end of PGY3 (4th Competence Committee review of PGY3). The above listed requirements for C6A and ITER can be completed through either family therapy or group therapy.
Scholarly Project (Research)	Scholarly Activity Report Form – resident completes on One45, must be submitted by the CC document submission deadline prior to the second (mid-PGY3) and 4th (June 30th of PGY3) CC reviews of the academic year, unless the resident has completed the scholarly project. If the resident has completed their scholarly project they are to submit one final Scholarly Activity Report Form clearly indicating that the project is complete and that the scholarly project requirements for the program have been satisfied. Scholarly (Research) ITAR 1 – resident must send to research supervisor via one45 by the CC document submission deadline prior to the second (mid-PGY4) and fourth (June 30th) CC review of the academic year. If project completed, submit Final Scholarly ITAR 2 instead of ITAR 1. The submission of ITAR 2 helps inform the CC that the project has been finished.
Interview Skills	PGY3 Child & Adolescent STACER (completed during a C&A rotation with the evaluation usually being completed by the rotation supervisor) PGY3 Geriatrics STACER (completed during a geriatrics rotation with the evaluation usually being completed by the rotation supervisor)
Neurostimulation	At least one ECT treatment day & consult clinic per 3 block rotation during geriatric psychiatry rotation.
ECT Experience	C7 – at least one *entrustable* observation on parts A and B Supervision available at ECT clinic in addition to Geriatric Psychiatry rotation
Longitudinal Case	Residents are required to follow a patient with a serious and persistent mental illness for a minimum of 6 months (ideally a year). This requirement needs to be completed by the end of PGY4. Residents are encouraged to work on this in their PGY3 year to allow for a longer longitudinal experience. **See 11.1 Longitudinal Case Requirement below.**
On Call Requirements	
On Call Assessment	Minimum of 2 Adult and 1 C&A Senior On Call Assessments per 3 block CC review period; minimum 8 Adult and 4 C&A Senior On Call Assessments by end of PGY3.

	For Windsor residents, there is a minimum of 3 Adult SR On Call Assessments per 3 block CC review period and 12 Adult SR On Call Assessments by end of PGY3.
Teaching Requirements	
Academic days	Attend teaching sessions (minimum 80% of academic Thursdays sessions must be attended on non-excused days).
Teaching EPAs	A C10 EPA should be completed with any teaching activities that are observed by a psychiatrist supervisor. For Department of Psychiatry CPD teaching please contact the CPD Lead, Dr. Verinder Dua, before the presentation date.

11.1 Suggested PGY3 EPA Completion Schedule

Rotation	**Recommended EPA Observations**
Child & Adolescent Psychiatry	Per 4-week block: 1x C2, 1x C4, 1x C8 (need at least 2 “adolescent/child” C8 contextual variables during C&A rotations) Aim for at least 2x over the 6-blocks: C5, C9, C10 C6 – Part A EPAs should be getting completed regularly
Geriatric Psychiatry	Per 4-week block: 1x C3, 1x C4, 1x C8 (need at least 1x “cognitive enhancer” and 2x “older adult” contextual variables) Aim for at least 2x over the 6-blocks: C7 - part A (at least 1 with “older adult” contextual variable) and 2x C7 - part B. C6 – Part A EPAs should be getting completed regularly

Rotation Templates found within Teams:

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/CBME/Rotation%20Templates?csf=1&web=1&e=M14y64

11.2 Longitudinal Case Requirement

CBD Core of Residency training experience 1.1.6 requires for residents to engage in “longitudinal patient care, including patients with severe mental illness”. National psychiatry education groups have agreed that this requirement is met with an experience of at least 6 months, ideally up to 1 year of follow-up with a complex patient. Under most circumstances, the resident should see a specific longitudinal patient for at least 6 months.

The Schulich psychiatry program has an organized experience to meet this requirement in Core of Residency, which may be done in the PGY3 or PGY4 year. A suitable patient will ideally be found within

an SPMI rotation or with a future SPMI supervisor if the resident does not start SPMI until the latter half of the year.

Guidelines for the experience:

1. The patient should present with severe bipolar disorder or schizophrenia spectrum illness. They should have been in treatment for at least a year and still have some active symptoms of the major illness.

2. The MRP for the patient will be the supervisor for the longitudinal experience.

3. The resident will effectively see the patient on behalf of the MRP's clinic, with charting done under that clinic.

4. The patient should be met at least once per month, ideally q2 weeks (or possibly more often for a period) if indicated clinically.

5. The resident will manage all aspects of treatment, including medications, psychosocial treatment, blood monitoring and any appropriate referrals.

6. Supervision will be given at least once per month, more frequently if appropriate. The supervisor or their coverage will be available to see the patient if necessary in an emergency.

7. The ITAR is completed at the end of the experience with verbal feedback given throughout the experience during supervision.

12. PGY4 Curriculum Guide & Requirements

EPA Requirements	
Core of Discipline Stage	Resident should be completing EPAs from the Core of Displace stage. All Core of Discipline EPA requirements (entrustable EPA findings and contextual variables) must be completed by the end of the PGY4 year. See **8. EPA Benchmarks** above for further details.
Transition to Practice Stage	Residents can start obtaining the required P2 (Supervising junior trainees) EPAs in their PGY4 year. P1 and P3 should not be completed until PGY5 as these EPAs will be completed through the Junior Attending Rotation and Academic Days of PGY5.
Longitudinal Training	
Psychotherapy Log (C6 part B EPA)	Resident is required to actively maintain a psychotherapy log. This log **fulfills the EPA C6 part B CBD requirement.** The log ("Psychotherapy Log Sheet" on One45) must be submitted prior to the CC document submission deadline for **every** CC review starting in PGY2 up until all psychotherapy requirements for the residency have been fulfilled (as confirmed by the Psychotherapy Lead and with submission of one final psychotherapy log at that time).

Psychodynamic Therapy (LONDON) (if not yet complete)	C6 part A – 1 observed EPA & ITAR required every 3 months while psychodynamic training is ongoing. All C6A requirements (entrustable findings and contextual variables) must be attained by the end of PGY4. 2. Resident Psychotherapy Training Handbook 2024-25 Sep edits.pdf
Psychodynamic Therapy (WINDSOR)	C6 part A – 1 observed EPA & ITAR required every 3 months while psychodynamic training is ongoing. All C6A requirements (entrustable findings and contextual variables) must be attained by the end of PGY4.
CBT (LONDON) (if not yet complete)	C6 part A – 1 observed EPA required every 3 months while CBT training is ongoing. All C6A requirements (entrustable findings and contextual variables) must be attained by the end of PGY4.
CBT (WINDSOR) (if not yet complete)	C6 part A – 1 observed EPA & ITAR required every 3 months while CBT training is ongoing All C6A requirements (entrustable findings and contextual variables) must be attained by the end of PGY4.
Supportive Psychotherapy	C6A – 1 observation of achievement is to be completed by the end of PGY4 (4th Competence Committee review of PGY4). 1 ITER is to be submitted to a supportive psychotherapy supervisor by the end of PGY4 (4th Competence Committee review of PGY4). Note: supportive psychotherapy can count for C6A “integrating of psychotherapy interventions in regular clinical care” contextual variable but does not fulfill requirements of the “other” modality. The supportive case must have a minimum of 5-8 hours and a minimum of 5 sessions before completion of the ITAR.
Scholarly Project (Research)	Scholarly Activity Report Form – resident completes on One45, must be submitted by the CC document submission deadline prior to the second (mid-PGY4) and 4th (June 30th of PGY4) CC reviews of the academic year, unless the resident has completed the scholarly project. If the resident has completed their scholarly project they are to submit one final Scholarly Activity Report Form clearly indicating that the project is complete and that the scholarly project requirements for the program have been satisfied. Scholarly (Research) ITAR 1 – resident must send to research supervisor via one45 by the CC document submission deadline prior to the second (mid-PGY4) and fourth (June 30th) CC review of the academic year. If project completed, submit Final Scholarly ITAR 2 instead of ITAR 1. The submission of ITAR 2 helps inform the CC that the project has been finished.

	See: **19. Scholarly Curriculum for Psychiatry** below for information on scholarly project requirements during the residency program.
Interview Skills	In-rotation informal SR STACER (final) to be started within the last 3 months of PGY 4 (assessed by rotation supervisor) Second SR (final) STACER (evaluated by two faculty members) done in PGY5 (scheduled by PGE)
Longitudinal Case	Residents are required to follow a patient with a serious and persistent mental illness for a minimum of 6 months (ideally a year). This requirement needs to be completed by the end (CC4) of PGY4. **Please see section 11.1 above for further details.**
On Call Requirements	
On Call Assessment	Minimum of 2 Adult and 1 C&A Senior On Call Assessments per 3 block CC review period; minimum 16 Adult and 8 C&A Senior On Call Assessments by end of PGY4. For Windsor residents, there is a minimum of 3 Adult SR On Call Assessments per 3 block CC review period and 24 Adult SR On Call Assessments by end of PGY4.
Teaching Requirements	
Academic days	Attend teaching sessions (minimum 80% of academic Thursdays sessions must be attended on non-excused days).
Teaching EPAs	A C6 EPA should be completed with any teaching activities that are observed by a psychiatrist supervisor. For Department of Psychiatry CPD teaching please contact the CPD Lead, Dr. Verinder Dua, before the presentation date.

12.1 Suggested PGY4 EPA Completion Schedule

Rotation	Recommended EPA Observations
Serious & Persistent Mental Illness	Per 4-week block: 1x C1, 1x C5, 1x C8, 1x C9 Per 6-blocks of SPMI: At least 2x C7 – part A and 2x C7 – part B. SPMI may provide opportunity to get C9 – "restriction or limitation of rights" or "high complexity" contextual variables. C6 – Part A EPAs should be getting completed regularly
Shared Care	Per 4-week block: 1x C1, 1x C4, 1x C8 Shared Care may provide an opportunity for getting a C10 EPA (teaching to health care/multidisciplinary teams) C6 – Part A EPAs should be getting completed regularly
Consultation/Liaison Psychiatry	Per 4-week block: 1x C5, 1x C8 (resident should be getting at least **2x "Consult liaison"** contextual variables during this rotation), 1x C9

	C/L team rounds may offer an opportunity for completing a C10 EPA C6 – Part A EPAs should be getting completed regularly
PGY4 Electives	Per 4-week block: 1x C1 and 1x C8 EPAs

12. 2 Longitudinal Case Requirement

CBD Core of Residency training experience 1.1.6 requires for residents to engage in "longitudinal patient care, including patients with severe mental illness". National psychiatry education groups have agreed that this requirement is met with an experience of at least 6 months, ideally up to 1 year of follow-up with a complex patient. Under most circumstances, the resident should see a specific longitudinal patient for at least 6 months.

The Schulich psychiatry program has an organized experience to meet this requirement in Core of Residency, which may be done in the PGY3 or PGY4 year. A suitable patient will ideally be found within an SPMI rotation or with a future SPMI supervisor if the resident does not start SPMI until the latter half of the year.

Guidelines for the experience:

1. The patient should present with severe bipolar disorder or schizophrenia spectrum illness. They should have been in treatment for at least a year and still have some active symptoms of the major illness.

2. The MRP for the patient will be the supervisor for the longitudinal experience.

3. The resident will effectively see the patient on behalf of the MRP's clinic, with charting done under that clinic.

4. The patient should be met at least once per month, ideally q2 weeks (or possibly more often for a period) if indicated clinically.

5. The resident will manage all aspects of treatment, including medications, psychosocial treatment, blood monitoring and any appropriate referrals.

6. Supervision will be given at least once per month, more frequently if appropriate. The supervisor or their coverage will be available to see the patient if necessary in an emergency.

7. The ITAR is completed at the end of the experience with verbal feedback given throughout the experience during supervision.

Rotation Templates found within Teams:

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/CBME/Rotation%20Templates?csf=1&web=1&e=M14y64

13. PGY5 Curriculum Guide & Requirements

EPA Requirements	
Transition to Practice	Residents are required to complete all the Transition to Practice EPAs by the 3rd CC review of PGY5. P1 is to be completed during the Independent Practice Clinical Rotation of PGY5. P3 is to be completed during PGY5 Academic Days as part of the formal curriculum. 2 observations of achievement are required for all of Parts A, B and C.
Longitudinal Training	
Psychotherapy Log	Resident is required to actively maintain a psychotherapy log. The log ("Psychotherapy Log Sheet" on One45) must be submitted prior to the CC document submission deadline for **every** CC review starting in PGY2 up until all psychotherapy requirements for the residency have been fulfilled (as confirmed by the Psychotherapy Lead and with submission of one final psychotherapy log at that time).
Psychodynamic Therapy (LONDON) (if not yet complete)	1 ITAR required every 3 months while psychodynamic training is ongoing.
Psychodynamic Therapy (WINDSOR) (if not yet complete)	1 ITAR required every 3 months while psychodynamic training is ongoing.
CBT (LONDON) (if not yet complete)	1 ITAR required every 3 months while CBT training is ongoing.
CBT (WINDSOR) (if not yet complete)	1 ITAR required every 3 months while CBT training is ongoing
Supportive Psychotherapy	1 supportive psychotherapy case with completion of ITAR required in PGY5 year. The supportive case must have a minimum of 5-8 hours and a minimum of 5 sessions before completion of the ITAR.
Scholarly Project (Research)	Scholarly Activity Report Form – resident completes on One45, must be submitted by the CC document submission deadline prior to the second (mid-PGY5) CC review of the academic year (this is in December of PGY5 for most residents), unless the resident has completed the scholarly project. If the resident has completed their scholarly project they are to submit one final Scholarly Activity Report Form clearly indicating that the project is complete and that the scholarly project requirements for the program have been satisfied. Scholarly (Research) ITAR 2 – resident is to send this to their supervisor upon completion of the scholarly project. It is expected that residents will

	complete their scholarly project by mid-PGY5 (CC review #2). If the scholarly project is not complete by this point, the resident should submit a Scholarly Project 1 providing the CC with updates on what is still outstanding in the project and the resident's plan for completion. The resident should also consult with the Scholarly Project Lead to determine if any additional supports can be provided by the program to help ensure completion of the scholarly project before the 3rd CC review of PGY5. The submission of Scholarly Project ITAR 2 notifies the CC that the project has been finished. **Resident must consult with Program Director and Research Lead if scholarly project has not been completed with submission of Scholarly Project ITAR 2 by the end of March in PGY5 year.** See: **19. Scholarly Curriculum for Psychiatry** below for information on scholarly project requirements during the residency program.
Interview Skills	In-rotation informal SR STACER (final) to be started within the last 3 months of PGY 4 (assessed by rotation supervisor) Second SR (final) STACER (evaluated by two faculty members) done in PGY5 (scheduled by PGE)
On Call Requirements	
On Call Shifts	Resident is expected to complete their on-call shifts (as scheduled by the chief resident) prior to the completion of their residency program. A senior on-call assessment should be sent to the supervisor on One45 for every on-call shift completed.
Teaching Requirements	
Academic days	Attend teaching sessions (minimum 80% of academic Thursdays sessions must be attended on non-excused days).

Rotation Templates found within Teams:

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/CBME/Rotation%20Templates?csf=1&web=1&e=M14y64

Psychotherapy Handbook found within Teams:

2. Resident Psychotherapy Training Handbook 2024-25 Nov edits.pdf

14. Western Psychiatry Competence Committee Documents

Schulich Psychiatry

Competence Committee (CC) Guidelines:

Process and Procedures in Decision Making

Created*: 2022-01-03*

Revised by CC Chair: 2024-7-25

Reviewed by RPC: 2023-06-15

POLICY REFERENCES

- General Standards of Accreditation for Residency Programs
- Psychiatry Standards of Accreditation
- Competence by Design Technical Guide Series for Competence Committees (2020)
- Schulich School of Medicine & Dentistry PGME Resident Assessment & Appeals Policy

Please also refer to the:

- CC Terms of Reference
- Schulich CC Process and Procedures Document (below)
- RCPSC "Competence Committee Guideline"
- Psychiatry Residency Checklist Excel document
- CC File Review/Semi-Annual Review Resident Assessment form

PRINCIPLES

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

1. The Competence Committee is a sub-committee of the Residency Program Committee (RPC).
2. The Competence Committee 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.
3. The Competence Committee has authority to make decisions on individual EPA achievement. The Competence Committee presents status change determinations as recommendations to the RPC. The RPC ratifies these status recommendations with input from the Postgraduate Dean (when required); refer to the relevant statuses here
    a. Competence committee decides:
        i. EPA achievement
    b. RPC ratification needed:

i. Learner status
ii. Stage progression
iii. Need for Learning plans/remediation
iv. Readiness for certification exams (exam eligibility)
v. Readiness for unsupervised practice (certification eligibility)

4. Committee work is guided by the national specialty competence 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. Refer to the Psychiatry Specialty documents found here. Refer to the relevant policies as above.
5. The Competence Committee 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 to make holistic judgments on the progress of the resident. ***The wisdom of the Competence Committee is considered the gold standard for EPA decisions and resident status recommendations.*** Refer to the Royal College Technical Guide on Competence Committees.
6. In addition to utilizing EPAs and CanMEDS Milestones, Committee discussions will be based on all of the assessment tools and relevant evidence from the program as uploaded in an electronic portfolio.
    a. Time-based/non-CBD residents are assessed based on their demonstrated skill level as reflected on ITARs and other assessments appropriate to their level of training. These other assessments may include STACERs, OSCEs, standardized examinations (e.g. PRITE) and On Call assessments. They are also assessed on how well they are meeting their training requirements outlined in the Western Psychiatry Program Handbook.
    b. CBD residents are assessed based on their progression of skills as reflected on EPAs and ITARs appropriate to their level of training. They also are assessed for progression as reflected through other assessments including STACERs, OSCEs, standardized examinations (e.g. PRITE) and On Call assessments. They will be assessed on how well they are meeting the requirements for attainment of EPA observations and the other required training assessments as outlined in the Western Psychiatry Program Handbook.
    c. The Competence Committee will assist in the development of independent learning plans. It will also monitor the outcome of any ILP in concert with the appropriate Program Director(s) and liaising with the Postgraduate Medical Education (PGME) Office and the PGME Advisory Board as appropriate. The RPC will ratify ILPs after creation.
7. All committee discussions are strictly confidential and only shared on a professional need-to-know basis. This principle is equivalent to patient confidentiality in clinical medicine.
8. Committee decisions must be based on the evidence available in the resident's electronic portfolio at the time of the committee meeting. Individual committee member experience can only be introduced with appropriate documentation within the electronic portfolio. 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 program’s electronic portfolio system.
    a. Electronic portfolio systems can include ancillary sources outside of Elentra like spreadsheets, PDFs, Word documents, etc., that are in a shared and protected folder.

9. The functioning of the Competence Committee, including its decision-making processes, will be a focus of accreditation surveys in the future.
10. Committee work must be timely in order to ensure fairness and appropriate sequencing of training experiences.
11. Competence Committees operate with a growth mindset. This means that Committee work is done in a spirit of supporting each resident to achieve their own individual progression of competence.
12. Competence Committees have a responsibility to make decisions in the spirit of protecting patients from harm, including weighing a resident's 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. This principle is equivalent to patient handover in clinical medicine.
13. Competence Committees, when appropriate and after due process, have the responsibility to identify residents who have either met the predefined category of *failure to progress*, or residents who should be requested to leave the program. Refer to the relevant policies as above.
14. Competence Committee decisions/recommendations and their associated rationales must be documented within the program's electronic portfolio system.

PROCESS AND PROCEDURES

1. **Agenda Development:** Residents are selected for the agenda of a planned Competence Committee meeting by the Chair of the Committee, the Program Director or their delegate. This must occur 2 week(s) in advance of the Committee meeting to provide reviewers (see below) adequate time to prepare for the meeting.

2. **Frequency:** Every resident in the program must be discussed biannually at minimum (unless resident is on a prolonged leave from the program). However, **greater frequency of monitoring is desirable and the goal will be for all to be discussed quarterly.**
   - The CC meets four times a year and may meet on other occasions as required for exceptional circumstances
   - All CBD residents and all residents on an ILP, remediation or probation will be discussed at each q3 month CC meeting.
   - Those in the non-CBD/"time-based" program will have file reviews and CC discussions of progression status at a minimum every 6 months unless on ILP or remediation.

3. **Exemptions:** Residents may submit a letter of exemption with an explanation of why particular residency requirements were not completed or submitted **prior** to the Competence Committee review. These letters must be submitted prior to the deadline for the submission of documents to be reviewed by the Competence Committee. Letters of exemption will be reviewed by the Competence Committee and discussed to determine if the requested exemption will be approved.

4. **Primary Reviewer:** Each resident scheduled for review at a Competence Committee meeting is assigned to a designated primary reviewer. The primary reviewer is responsible for completing a detailed review of the progress of the assigned resident(s) based on evidence

from completed observations and other assessments or reflections included within the electronic portfolio. The primary reviewer provides an overview of recent CC decisions and discussions, considers the resident's recent progress, identifies patterns of performance from the observations, including numerical data and comments, as well as any other valid sources of data (e.g. in-training OSCE performance). At the meeting, the primary reviewer provides a succinct synthesis and impression of the resident's progress to the other Competence Committee members. After discussion, the primary reviewer proposes a formal motion on that resident's status going forward. The primary reviewer will generally change for a given resident at each review in order to have different perspectives on the resident file and decrease bias or missed opportunities for resident development. However, in circumstances where a resident is on an ILP, remediation or probation plan, the assigned file reviewer may be the Program Director who is overseeing that resident's individualized training plan.

5. **Secondary reviewers:** All other committee members are responsible for reviewing all residents on the agenda as secondary reviewers. This secondary review will generally occur at the time that the resident's file is being presented by the primary reviewer.

6. **Committee Procedures:**
    - 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.
    - Each resident is considered in turn, with the primary reviewer presenting their synthesis, displaying relevant reports from the electronic portfolio, and sharing important quotes from any observational comments about the resident. If a letter of exemption was submitted by the resident, then the primary reviewer will bring it forth for discussion with the rest of the Competence Committee. The primary reviewer concludes by proposing a status for the resident going forward in the program.
    - If a resident is on an ILP remediation plan or probation plan, the file reviewer may bring forward a recommendation on the status of that resident's individualized training plan, i.e. that the Competence Committee considers the ILP to have been successfully completed, that the resident was unsuccessfully in meeting the objectives of the ILP or that the ILP is to be continued. In situations where it has been determined that a resident was unsuccessful in meeting the objectives of their ILP, the process documented in the PGME Resident Assessment and Appeals document is to be followed.
    - 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 resident.
    - This will continue until a majority of Competence Committee members supports a status motion. For findings other than Progressing as Expected, the rationale for the recommendation must be documented in the program's electronic portfolio system.
    - The CC Resident Review Form on One45 form is completed and signed by file reviewers after the meeting and submitted.
    - The CC meeting is minuted in general terms, including the name of the resident discussed and the rationale for a decision if there is a discussion. CC members who discuss different aspects of a resident's status are not named in the document.
    - See the "Resident Status Recommendations" section for more details.

7. **Post Competence Committee meetings:** Within 4 weeks after a Competence Committee, the following must occur:
    - The progression decisions of the CC are ratified by the RPC.

- Residents who are assigned a progression status of not progressing as expected or failure to progress will be booked for a Program Director Review with a program director. This meeting will include discussion of the areas where the resident is having challenges attaining expected progression and strategies to meet their requirements. Goals on their learning plan should reflect strategies to meet program requirements. Residents are expected to submit any outstanding documentation (i.e. psychotherapy logs, Scholarly Activity Report Forms, sending Scholarly Project ITARs to supervisors) prior to the Program Director Review.
- Residents will be scheduled for a Program Director Review at least twice per year regardless of progress status, unless the resident is on leave from the program in which case the frequency may be less or the review may be deferred until after the resident has returned from leave.
- In some cases, especially after repeated findings of Not Progressing as Expected or in the case of major deficits in skills or meeting requirements, a resident may enter an Independent Learning Plan (ILP) or Remediation.
- Residents who are given a status of Failure to Progress will be started an ILP or a remediation plan.
- All remediation procedures, including Individual Learning Plans/ILP (please note difference between ILP and regular learning plans that each resident completes at the Program Director Reviews), Remediations and Probation will be implemented in accordance with the Schulich Assessment and Appeals document.

Competence Committees should flag EPAs or CanMEDS Milestones, which are inconsistently met at a defined stage for a cohort of residents to the Program Director(s). The Program Director(s), in turn, and in conjunction with the Residency Program Committee, should alert the Specialty Committee for a discussion of the appropriateness and expected time of completion of those EPAs.

8. **Appeal Process:** Refer to PGME Resident Assessment & Appeals Policy.
    - If residents bring forward additional information after the Competence Committee meeting takes place that would likely have altered the progression decision recommended by the Competence Committee, the Competence Committee Chair may, at their discretion, complete an additional file review and propose a new progression recommendation. This later file review will be shared with the Competence Committee and the proposed progression recommendation will be brought forward to a vote. This process may occur via email communication and voting rather than through the scheduling of an additional Competence Committee meeting. If approved by the Competence Committee, the new progression recommendation will be brought forward to the RPC for ratification. This process may require that a resident's progression recommendation be deferred from ratification at the initial RPC meeting to allow time for the collection of additional information, for performing an additional file review and for bringing the new finding forward to vote by the Competence Committee. The deadline for residents to request an additional file review by notification of the Competence Committee Chair is two weeks after the resident's One45 CC Resident Review Form has been submitted by the assigned Competence Committee reviewer
    - In situations where residents have identified errors made during the Competence Committee review that in the opinion of the Competence Committee Chair are unlikely to change the recommended progression decision (for example, a resident is able to clearly demonstrate that a missing requirement had been completed/submitted but was overlooked by the Competence Committee), the resident may request that the

Competence Committee Chair make corrections to the CC Resident Review Form. In this situation the Competence Committee Chair or the original Competence Committee file reviewer may amend the CC Resident Review Form using the corrected information. The deadline for residents to request corrections by notification of the Competence Committee Chair is two weeks after the resident's One45 CC Resident Review Form has been finalized by the assigned Competence Committee reviewer

RESIDENT STATUS RECOMMENDATIONS

- Status recommendations are based on the recommended duration of the stage as defined by the Psychiatry Specialty Committee. Please see the Royal College's Psychiatry Training Experiences document for further details.
- Status recommendations can only be deferred if additional information is required or if an additional review of the status finding has been requested by the resident. **However, this deferred recommendation must be revisited within 4 weeks.**
- Status Recommendations will be determined by the Competence Committee each time a resident is reviewed. The following criteria will be used by the Competence Committee for general guidance in deciding upon a status finding. Ultimately, the status finding being recommended is a determination of the Competence Committee upon holistic review of the resident's performance and the Competence Committee is not bound to rigid interpretation of these criteria:
  - Progressing as Expected
    - In the opinion of the Competence Committee, the resident is making adequate progress in attaining their required entrustable EPA findings and contextual variables as expected for their current CBD stage or time spent on particular rotations. EPA completion rates are generally in keeping with the expectations outlined in the EPA Benchmarks section of the Program Handbook. Any deviations from the EPA Benchmarks expected for the resident's training stage are felt to be relatively minor and something that the resident can get caught-up on within their current CBD training stage without significant difficulty.
    - Not missing contextual variables that are generally only attainable in a specific setting (e.g. PGY1 off-service rotations, PGY3 geriatrics rotations and PGY3 child and adolescent rotations) that the resident has already completed.
    - All non-EPA residency requirements were completed. These requirements include the following:
      - Updated psychotherapy hours log has been submitted electronically through One45. Resident's progress in obtaining psychotherapy experiences are in keep with what would be expected for their stage of training.
      - Psychotherapy ITAR(s) have been sent to the psychotherapy supervisor(s), in keeping with the requirements listed for PGY year in the Program Handbook. (Note: any assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status).
      - An updated Scholarly Activity Report Form has been submitted electronically through One45, in keeping with the requirements listed for PGY year in the Program Handbook.

        - Scholarly Project ITAR has been sent to the scholarly project supervisor, in keeping with the requirements listed for PGY year in the Program Handbook. (Note: any assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status).
        - Resident is felt to generally be "on-track" with respect to completion of their Scholarly Project (on a trajectory to finish by mid-PGY5 or have demonstrated a reasonable plan for completion of the Scholarly Project prior to the 3rd CC review of PGY5).
        - The minimum number of on-call assessments have been attained, in keeping with the requirements listed for PGY year in the Program Handbook
        - STACERs have been completed, in keeping with the requirements listed for PGY year in the Program Handbook
    - No "red flag" feedback indicating a major deficit of competence.
    - No significant concerns with respect to professionalism.
    - No clear pattern of a specific competence deficit that has been persisting across file reviews (since last CC review).
    - Feedback about resident's work and progress is generally positive (with some constructive feedback).
    - The progression status on all summative ITERs is "meets expectations".

- Not Progressing as Expected:
    - Any of the scenarios below will lead to status of Not Progressing as Expected:
        - The resident has multiple deficiencies in their currently attained enstrustable EPAs compared to what would be expected for their current CBD stage or time spent on particular rotations (based on the EPA Benchmarks in the Program Handbook). If, in the opinion of the Competence Committee, there are significant concerns, or a sustained pattern of persisting concerns is observed, an alternative finding of Failure to Progress may be made.
        - The Competence Committee has reasonable concern that the resident is not on-track to complete the EPAs or contextual variables required within their current training stage. If there are significant concerns, or a sustained pattern of persisting concerns is observed, an alternative finding of Failure to Progress may be made.
        - Two or more expected non-EPA assessments are missing. These requirements include the following:
            - Updated psychotherapy hours log has been submitted electronically through One45. Resident's progress in obtaining psychotherapy experiences are in keep with what would be expected for their stage of training.
            - Psychotherapy ITAR(s) have been sent to the psychotherapy supervisor(s), in keeping with the requirements listed for PGY year in the Program Handbook. (Note: any assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status).
            - An updated Scholarly Activity Report Form has been submitted electronically through One45, in keeping with the requirements listed for PGY year in the Program Handbook.
            - Scholarly Project ITAR has been sent to the scholarly project supervisor, in keeping with the requirements listed for PGY

year in the Program Handbook. (Note: any assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status).
- Resident is felt to generally be "on-track" with respect to completion of their Scholarly Project (on a trajectory to finish by mid-PGY5 or have demonstrated a reasonable plan for completion of the Scholarly Project prior to the 3rd CC review of PGY5).
- The minimum number of on-call assessments have been attained, in keeping with the requirements listed for PGY year in the Program Handbook
- STACERs have been completed in keeping with the requirements listed for PGY year in the Program Handbook
- Any assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status.

- The resident has not completed an important contextual variable that is only available in a particular clinical setting (e.g. CL, Child, Psychogeriatric). An EPA or non-EPA assessment that is required for promotion and should have already been attained is missing and cannot plausibly be completed by the next CC meeting.
- An EPA or non-EPA assessment expected to be completed prior to the last CC meeting is still missing at the time of the current CC review.
- Resident's number of entrustable observations are significantly lower than what would be expected for time on a particular rotation and/or stage of training.
- There is a clear pattern of a specific competence deficit that has been persisting across file reviews (since last CC review).
- Feedback about resident's work and progress is either consistently pointing out a particular competence deficit to be worked on or identifies minor professionalism issues (e.g. chronic lateness). Significant deficits in competence or significant concerns with respect to professionalism will likely result in a finding of Failure to Progress.
- If the progression status on a summative ITER is "does not meet expectations", the committee may find the resident to be Not Progressing as Expected (as opposed to Failure to Progress) if the circumstances are not severe and amenable to an independent learning plan. An interim rating of "does not meet expectations" will usually lead to a progression status of, at best, Not Progressing as Expected, unless there are other significant circumstances the committee is aware of.

- <u>Failure to Progress</u>
  - Three or more CC reviews in a row where resident is missing either a non-EPA residency requirement or EPA requirements as described in Not Progressing as Expected.
  - There are significant deficiencies in the resident's attainment of enstrustable EPAs compared to what would be expected for their current CBD stage or time spent on particular rotations (based on the EPA Benchmarks in the Program Handbook).

- Based on a review of progress, the Competence Committee has significant concern that the resident is not on-track to complete either the required EPAs or contextual variables needed for their current training stage within the expected timeframe.
- Many non-EPA assessments are missing representing a pattern of significant non-participation in assessment. (Note: an assessment that is missing on account of the assessor not filling it out does not count against the resident's progression status, provided that the resident followed the ground rules for EPAs). Several EPAs or non-EPA assessments that are required for promotion and should be completed are missing and cannot plausibly be completed by the next CC meeting.
- One non-EPA assessment or 1 expected EPA assessment missing from the past 2 CC meetings is still missing.
- Presence of "red flag" feedback indicating a major deficit of competence. Clear pattern of specific competence deficits that have been persisting across file reviews (since at least last CC review). Feedback about resident's work and progress is either consistently pointing out a major competence deficit to be worked on or identifies a significant professionalism concern.
- A rating of "does not meet expectations" on a final ITER will usually lead to a rating of Failure to Progress. A rating of "does not meet expectations" on an interim ITER may lead to a status of Failure to Progress if there are significant problems with performance or professionalism leading to this rating.

- Inactive
  - The resident is on leave (illness, parental, etc.)
- Exam Eligible
- Certification Eligible

In some cases, a CBD resident may be judged to be entrustable for specific EPAs even if they have not achieved a "4 or 5" rating if the feedback and other evidence supports that they have attained adequate skills for their level on that task and related skills.

Possible Actions for Resident Statuses

* denotes that the PGME must be notified

Please refer to the PGME Resident Assessment and Appeals Policy for further details.

- 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, or
  - The resident can be deemed eligible for RCPSC exam*, or
  - The resident can be deemed eligible for RCPSC certification*
- For residents who are Not Progressing as Expected:
  - Requires areas of deficit to be addressed as part of the resident's goals for the learning plan in Program Director Review. This action plan is then brought by a

program director to the RPC for approval and is reviewed at subsequent Competence Committee meetings.
    - A 2-week review may be offered if there are minor requirements missing, so the resident can have opportunity to make up any missing requirements before an ILP is initiated.
    - In some cases, if there is a specific deficit in competence or significant absence of expected assessments, an Independent Learning Plan (ILP) may be devised to help the resident take a structured approach to improving competence in this area.
    - If areas of deficit are not addressed, could lead to status of Failure to Progress at next CC file review. If three consecutive Not Progressing as Expected statuses are established for similar reasons, the status will generally default to Failure to Progress with an ILP (or possibly remediation, if appropriate).
    - Residents who are not meeting program requirements by the end of PGY4 will not be allowed to take elective rotations unless the elective has a clear purpose of satisfying outstanding residency program requirements.
    - If residents have not completed all of the residency program requirements by the end of their PGY5 year their residency may be extended in duration until the requirements have been obtained.
  - For residents who are given a status recommendation of Failure to Progress:
    - Action plan will be determined by a program director in collaboration with the RPC and should be informed by the Competence Committee. Results in Independent Learning Plan (ILP) at minimum, possibly Remediation plan. Remediation plans have their own set of consequences for non-completion, as described in the Schulich PGME assessment and appeals document.
    - Residents who are not meeting program requirements by the end of PGY4 will not be allowed to take elective rotations unless the elective has a clear purpose of satisfying outstanding residency program requirements.
    - If residents have not completed all of the residency program requirements by the end of their PGY5 year their residency may be extended in duration until the requirements have been obtained.
- A status recommendation and action or next steps are recorded in the resident's electronic portfolio and is communicated to the RPC for ratification.

Appendix A: CBME Glossary of Terms

Individualized Learning Plans:

Replaces modified program

Individualized Learning Plans are most appropriate when a resident has yet to attain expected objectives and/or competencies because of insufficient experience/exposure and/or the resident is progressing, however the learning trajectory is slower than expected. Individualized Learning Plans may also be appropriate when i) the resident has self-identified a learning need; ii) the resident is progressing as expected and the CC, after review of a resident’s assessments, has recommended further development in one or more specific areas that may have negative consequences for future performance if not addressed.

Individualized Learning Plans may include modifications of Learning Experiences, (for example, spending more time with a specific supervisor or additional time in a specific clinic), coaching, or other forms of educational enrichment.

15. Guidelines for Applying for Senior Electives

(Updated March 2022)

Electives are available to residents in PGY4 or 5 and form the rotations of the PGY5 year.

Electives are an opportunity to develop specialized knowledge and skills reflecting a resident's career goals. It may also be an opportunity to network in anticipation of applying for positions at Western-affiliated hospitals or other centres.

Electives must be planned well in advance and applied for. **A draft outline of proposed rotations** is to be submitted by email, **by the March 15th prior to the start of the academic year in which the elective is planned**. Elective proposals must be **finalized 3 months before an elective at the latest.**

In the event that more residents apply for a particular elective than places available at that elective, the **places will be assigned on a "first-applied, first-served" basis**.

The design and application for an elective is entirely the resident's responsibility.

Residents need to contact the supervisor(s) they intend to work with for their electives well in advance to discuss ideas for an elective, the supervisor's availability and how the elective will work with the resident and the supervisor's schedules.

Residents can plan an elective entirely "from scratch" with the agreement of a prospective supervisor. The list of options provided in the Senior Elective Guide is meant to give some idea of what is available and provide a starting point for some elective proposals.

The elective descriptions in the guide are only outlines and must be customized by each resident, with specific objectives, ITER and timetable, using the appropriate elective application form.

Electives may be full time (4d/wk) or part-time (1-3d/wk). They may be 2 blocks to 12 blocks, although residents are encouraged to consider more than one elective. Part-time longitudinal electives facilitate learning with more complex follow-up of patients, including psychotherapy.

Supervisors must agree with the elective and will have to be consulted in the design of the elective. The supervisor signs the elective form when it is ready for approval.

Please refer to the **elective proposal forms** for the specific information that is required.

All residents on elective are expected to be engaged in clinical work with patients each day of the elective, except on the academic day. (Residents on a **research elective** or other non-clinical elective are expected to engage in research activities each day except the academic day and must have **a product at the end of the elective**).

Only a limited number of residents in a given cohort can be away on elective at another academic centre at any given time. This is to ensure the integrity of the teaching schedule and to ensure that the call schedule is covered without undue burden on the other residents. The current guideline is to have no more than three PGY5 residents away on elective at a given time, but exceptions may be made, if possible. Away electives will also be given out on a first-come first served basis.

Please refer to the official **Elective Time Away Policy** (below) for further important details about away electives.

Selectives and Electives must meet the requirements of the 2015 RCPSC Psychiatry STR:

3.2. Six (6) months of selectives in Psychiatry, preferably in one (1) content area but may be comprised of two (2) content areas with experiences of no less than three (3) months each. Content areas include but are not limited to general Psychiatry, areas of specialization within general Psychiatry, Child and Adolescent Psychiatry, Geriatric Psychiatry, Psychiatry and the law, psychosomatic medicine, psychiatric research, the psychotherapies, addictions, developmental disabilities, and Psychiatry in rural and/or remote locations.

3.3. Six (6) months of electives in any aspect of training relevant to contemporary psychiatric practice, including research approved by the residency training committee. The elective may consist of an approved rotation in Internal Medicine, Neurology, or other branch of medicine relevant to Psychiatry. More than one (1) practice area may be chosen, but the duration of any experience must not be less than two (2) months each. For residents interested in training at other centres, the selective and elective may contain six (6) months of approved residency relevant to the objectives of Psychiatry, at an approved health care facility or university.

16. Elective Time Away Policy Senior Residents

1. Elective Time Away (ETA) refers to training undertaken outside of the University of Western Ontario (UWO) Department of Psychiatry Residency Training Program. Resident training salaries will continue to be paid based on the Professional Association of Residents of Ontario and the Council of Academic Hospitals of Ontario (PARO-CAHO) agreement during this time.

2. ETA is available to Senior Residents (PGY 4 and 5) and will only be considered for Junior Residents under exceptional circumstances. All requests for ETA will require the Program Director's approval.

3. The most important factor in consideration of requests for ETA will be the relevance of the elective experience to the Resident's overall research, educational, and career goals and the unavailability of an equivalent experience at Western.

4. ETA cannot be used to complete any part of a core rotation, since all core rotations must be completed at the home program (i.e. Western). Exceptions may be made in certain circumstances.

5. Residents are responsible for finding supervisors acceptable to the Program Director / PGE, as well as developing training objectives, expectations and deliverables, in conjunction with their principal supervisor and the Program Director, using the Schulich psychiatry elective proposal form.

6. The completed proposal is used as the basis for consideration of the proposed experience, consistent with the resident being eligible to undertake the RCPSC Fellowship examination at the end of PGY5 (time-based program) or PGY4 (CBD residents). Proposed electives must clearly contribute to the development of competency in psychiatry in line with the CanMEDS framework. Residents will be required to submit to the Program Director written proposal, cc'd to their proposed principal supervisor, by March 15th of the prior academic year.

7. A maximum of three Residents in the entire Program will be allowed to be on an ETA at the same time (excluding subspecialty). Exceptions to this limit may be made in some circumstances. The maximum period of ETA will be three months, however periods up to six months may be considered at the Program Director's discretion. ETA will be granted on a first come, first granted basis, so it is to the resident's advantage to plan ETA as early as possible.

8. Residents are allowed three months off the call schedule for electives. If they are absent for more than three months, they will be required to make up (bank) their call within 3 months of returning from the ETA to facilitate a longer elective period.

9. Residents are responsible for arranging necessary and sufficient malpractice coverage / licensure while engaging in clinical work outside of Canada as well as covering all direct and indirect costs, including travel arrangements. Contacting the PGME office for any related questions is strongly encouraged.

10. Residents will sign a waiver releasing the Department of Psychiatry, Schulich School of Medicine, PGME office and WESTERN University, of any and all legal responsibility for adverse events or other outcomes during their international electives. Residents are responsible for ensuring that they have adequate and appropriate medical coverage during the ETA, including attending to their personal health needs (immunizations, etc.) prior to departure.

11. Residents are encouraged to find supervisors with Canadian, American, British, or Australia / New Zealand qualifications, but this is not an absolute requirement. Supervisors with PhD or other credentials and qualifications may be acceptable but require the approval of the Program Director.

12. In all cases the Program Director reserves the right to veto Resident's eligibility for elective time away and for the acceptability of a proposed elective experience with regards to it contributing to fulfillment of residency training and examination eligibility requirements, even if all other requirements are met.

Please refer to LHSC "Western Psychiatry PGE Teams" for elective proposal templates:

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/Residents/Electives?csf=1&web=1&e=nzJIhR

17. Rotation Templates

Please refer to LHSC "Western Psychiatry PGE Teams" for a list of Rotation Templates.

https://swohealth.sharepoint.com/:f:/r/sites/WesternPsychiatry/Shared%20Documents/CBME/Rotation%20Templates?csf=1&web=1&e=M14y64

18. Policies

Please refer to LHSC "Western Psychiatry PGE Teams" for a list of Program Policies under "Policies - Committees" channel.

19. Scholarly Curriculum for Psychiatry

PREAMBLE

The specific goals and objectives for the Scholarly curriculum are divided into "core objectives" which are relevant to all residents and "proficiencies" which are relevant to those residents with more specific training objectives in research. It is anticipated that the former will provide the necessary background for those intending to engage entirely in clinical practice, whereas the latter will be of particular interest to residents intending to undertake a career which includes a stronger research component such as an academic career, industry research, etc.

For proficiency in research, see additional 'Research Track' guidelines.

As per RCPSC psychiatry Competency document 2020, the following CanMEDS competencies are relevant to the Scholarly curriculum

MEDICAL EXPERT:

1. Practise medicine within their defined scope of practice and expertise
1.3.15. Evidence-based health care
1.3.15.1 Critical appraisal
1.3.16 Principles of quality assurance and improvement
1.3.17 Research methodology
5. Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety

LEADER

1. Contribute to the improvement of health care delivery in teams, organizations, and systems
1.1 Apply the science of quality improvement to systems of patient care
1.2 Contribute to a culture that promotes safety
1.2.1 Assess and manage safety/risk for staff and care providers in all settings
1.3 Analyze patient safety incidents to enhance systems of care
1.4 Use health informatics to improve the quality of patient care and optimize patient safety
2. Engage in the stewardship of health care resources
2.1 Allocate health care resources for optimal patient care
2.2 Apply evidence and management processes to achieve cost-appropriate care
3. Demonstrate leadership in health care systems
3.1 Demonstrate leadership skills to enhance health care
3.2 Facilitate change in health care to enhance services and outcomes

HEALTH ADVOCATE

2. Respond to the needs of the communities or populations they serve by advocating with them for system-level change in a socially accountable manner
2.2 Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities

2.3 Contribute to a process to improve health in the community or population they serve
2.3.1. Identify opportunities for advocacy, health promotion, and disease prevention, applying knowledge of
2.3.1.1. Major regional, national, and international advocacy groups in mental health care
2.3.1.2 Governance structures in mental health care

SCHOLAR

3. Integrate best available evidence into practice
3.1 Recognize practice uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that can address them
3.2 Identify, select, and navigate pre-appraised resources
3.3 Critically evaluate the integrity, reliability, and applicability of health-related research and literature
3.4. Integrate evidence into decision-making in their practice
4. Contribute to the creation and dissemination of knowledge and practices applicable to health
4.1 Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in health care
4.2 Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable and marginalized populations
4.2.1 Adhere to guidelines for ethical research, including: obtaining valid consent, where appropriate; lack of coercion; and avoidance of harm
4.3 Contribute to the work of a research program
4.4 Pose questions amenable to scholarly investigation and select appropriate methods to address them
4.4.1 Conduct scholarly work, including research, quality assurance, and/or educational initiatives
4.5 Summarize and communicate to professional and lay audiences, including patients and their families, the findings of relevant research and scholarly inquiry

TRAINING EXPERIENCES (relevant to Scholarly curriculum as per stages of training recommended by RCPSC):

1. TRANSITION TO DISCIPLINE
2.3. Orientation to program, postgraduate and institutional policies, procedures, protocols, and resources

2. FOUNDATIONS OF DISCIPLINE
Required training experience
2.1.21. Principles of patient safety and quality assurance and improvement
2.1.21.1. Principles of Plan-Do-Study-Act (PDSA)
2.1.22. Principles of critical appraisal and literature review

Recommended training experience
4.2. Participation in quality improvement (QI) rounds
4.3. Scholarly activity, including research, quality assurance, or education.

3. CORE OF DISCIPLINE
Required training experience

2.4. Participation in QI rounds
2.5. Scholarly activity, including research, quality assurance, or education

4. TRANSITION TO PRACTICE
Recommended training experience
4.1. Participation in a project evaluating costs of patient treatment in different settings
4.2. Participation in a quality improvement initiative

CORE OBJECTIVES:
The resident should be able to review and synthesize a body of research literature concerning a clinical issue or problem in psychiatry formulating appropriate conclusions about what is justified by the relevant literature, what are the major shortcomings in the existent research, what would be priorities for future research and implications of the research literature for clinical practice.

The resident should be able to design, conduct, implement and report on a Quality improvement and /or patient safety project.

HOW WILL THE LEARNING EXPERIENCE TAKE PLACE?

Basic aspects of the knowledge components of core objectives should be acquired through a variety of teaching and training activities. These include the teaching sessions of the longitudinal courses in 'Research in Psychiatry' and 'Quality Improvement' held on weekly academic day, attending monthly Scholarly project Update Group, Evidence based Journal club.

The skills component of the core competencies should be acquired through completion of a Scholarly project and Reflective learning exercise.

Teaching sessions: Topics covered are as follows:

PGY1: Intro to Scholarly Project and Research in Psychiatry, Introduction to Continuous Quality Improvement, Randomized Controlled Clinical Trials, Reflective exercise on patient safety/QI incident.

PGY2: Intro to Research Design and Key Concepts, Intro to Research Ethics and Research Ethics Board (REB) Protocol Writing, Psychometrics for Psychiatrists, Observational Studies in Psychiatry, Pharmacotherapy and Non-pharmacotherapy Clinical Trials

PGY3: Introduction to Cognitive Neuroscience Techniques in Psychiatry Research, Health Services Research, Qualitative Research Methods, Knowledge Translation, Systematic Review and Meta-Analysis, Workshop on Quality improvement/patient safety QI/PS (Interactive 2 hour workshop).

PGY5/TTP: Reflective exercise on patient safety/QI incident

Scholarly Project Update group

PGY 1 to 4 are expected to attend this Group, which takes place once a month (2nd Thursday, 12 to 1 pm) at Victoria Hospital. This group provides a forum for residents to present Scholarly ideas and updates for

discussion and to receive feedback. Active researchers and QI specialists within the Department are also invited to present their work. The Group provides residents with an opportunity to learn about Scholarly activities going on within the Department and link up with mentors. The group facilitator makes every effort to keep the atmosphere informal, supportive and intellectually stimulating.

Evidence based Critical Appraisal Rounds

This takes place once a month (4th Thursday, 4.15 to 5.30pm) at B-8, 131, VH. Attendance at these seminars is mandatory for PGY 2, 3 and 4 residents. Each resident is expected to have presented at least two papers during the three years.
To optimize the educational value of journal club for all residents participating in journal club as well as to better improve residents' ability to critically evaluate the medical literature and how it applies to clinic practice, the "User's Guides to Medical Literature" series from JAMA has been incorporated into journal club presentations. Residents are assigned a specific reference from the "User's Guide", and they use their assigned reference to guide them in selecting an article, analyzing the article, and presenting it at journal club. Residents use the worksheet associated with each section in the JAMA Users' Guides to guide their discussion of each article. Each worksheet includes the specific questions that are important for analyzing and understanding the article that the resident plans to address at journal club.

Dr. Rob Nicolson conducts this session and completes assessments for residents regularly.

Residents are expected to have an F5 or C10 EPA assessment completed after presenting at these rounds.

Completion of a scholarly project during residency

Residents (enrolled 2011 onwards) are mandated to complete a scholarly project under supervision of a faculty member.

Residents may participate in a scholarly research, quality improvement, or educational project relevant to Psychiatry, **demonstrating primary responsibility** for at least one of the following elements of the project:
- Development of the hypothesis, which must include a comprehensive literature review
- Development of the protocol for the scholarly project
- Preparation of a grant application
- Development of the research ethics proposal
- Interpretation and synthesis of the result
- Literature review to conduct meta-analysis/Systematic review

The residents must start their project at the latest by PGY3 year and finish at the latest by PGY4 year. It is expected that by Christmas of PGY2 year, the resident will identify a scholarly project that they wish to work on and choose a supervisor relevant to the area of interest. If the resident is interested the scholarly project can be started in PGY1 year.

It is expected that the project will be conducted over a period of 1 to 2 years and cannot be conducted exclusively in a research selective or elective block. The residents are required to submit a report at

completion of their project and present the findings of their project at the annual spring departmental research day (June) as either a poster or podium presentation.

Starting in December of PGY2, residents must submit a scholarly activity report form (self-sent and completed by resident) before the December and June Competence Committee (CC) meetings each year they are actively completing their research requirement. Starting in June at the end of PGY2 year they must also send an ITAR to their research project supervisor prior to the December and June Competency Committee meetings. It is advised that the ITARs be sent at least a month in advance to give the supervisor time to complete the ITAR prior to the Competency Committee's file review. It is also advised to follow-up with the supervisor if the ITAR has not been completed by the deadline for document submission to the Competence Committee. When a scholarly project is completed, the resident must send a final ITAR to their research supervisor.

Research Electives:

Research selective/elective are available in the PGY1 year (minimum 1 block/4 weeks, maximum 2 blocks or 8 weeks) and during PGY4, 5 (elective: minimum 2 blocks/8 weeks, maximum 6 blocks or 24 weeks; selective : minimum 3 blocks/12 weeks, maximum 6 blocks or 24 weeks).
Selectives/electives may be used to gain experience in a specific research area, which may be an extension of the project the resident has already been involved in or a new area of interest.
The selective or elective cannot be used to complete data analysis/writing up of a paper for publication for the mandatory scholarly project. The acceptability and duration of a research selective/elective will depend upon 1)Approval of the individual resident's proposal by the supervisor and 2)Submission of a proposal (at least 3 months in advance) detailing the rationale of the work to be carried out, time frame and the learning objectives (Elective proposal application form)

Reflective learning Exercise on QI/patient safety/Ethics related incident
Residents are expected to have written reports in their portfolio on at least two incidents during their clinical experience (in PGY1 and PGY5) where they reflected on how quality of care or patient safety could have been improved using the template below.
Residents are expected to submit these reports to their clinical supervisor and get assessed via one 45 using the form designed for this purpose.

Reflective Exercise template (1-2 pages)

What to reflect on?
This can be anything. Most reflections are on things that go wrong. These situations stay in one's head and force us to begin to think about whether they could have done anything differently.
However, reflecting on things that went well can often be more rewarding and be just as useful. It can build confidence and help you to repeat it again on another occasion.

What, where, and who—the situation
Think about the situation in detail: What happened exactly and in what order, where were you at the time and who else was involved? What part did you have to play? What was the final outcome?

How did it make you feel—your emotional state
What was running through your head and how did you feel about it? Be honest with yourself: were you afraid, confused, angry or scared? If you can understand how you were feeling at the time it will help

you put together why things happened as they did, and help you to recognize similar situations in the future.

Why did it happen—making sense of the situation

Now you have thought about the situation in greater detail, and probably recognized things that would have otherwise gone unnoticed, think about why things happened as they did. How did the situation, yourself, and others interact at the time. Did the situation go well or was there room for improvement?

Could you have done anything differently—critical review and development of insight

With the help of hindsight how would you have managed the situation differently? Think about what factors you could have influenced: is there anything you could have tried that may have improved the situation, or is there anything you did that was particularly important in the situation? It is easy to remember the things that you did not do and it is often the things that you did well that are forgotten.

What will you do differently in the future—how will this change your practice

This is arguably the most important stage in reflecting. You need to pull together everything you have thought of before to learn, change your own practice, and improve. Do not only think about what you would do differently in that specific situation, but think whether you have thought of any transferable knowledge or skills you can utilize elsewhere. For example: if you reflect on a post-procedural complication do not only think of how you would manage this again but also how you would prevent it happening if you performed the procedure yourself. If you are a part of a well-led cardiac arrest do not think only of what you would do next to help, but also how you would lead an arrest in the future, or even how you would lead a team in any other situation.

Re-enforcement—what happens when you put this into practice

Test your reflections: When comparable situations happen again, do things change as you would expect them to? This is a chance to repeat the reflective cycle to refine and develop your understanding.
(**Reference**: Koshy et al. International Journal of Surgery Oncology (2017) 2:e20)

Supervisor role (Supervisor can be a faculty member from another department as long as they are willing to take following responsibilities)

- The Department of Psychiatry provides MBR points to faculty members who supervise residents for a research/quality improvement project.
- The supervisors are expected to supervise and assess the resident on the basis of the observations made during the conduct of a project; the written report and the presentation at the research day.
- The supervisors will provide feedback to their trainees every six months and complete the ITARs (June and Dec) until the end of the project when the final assessment will be completed. The residents are expected to regularly send these ITARs on One 45 to their supervisors for completion. It will be required that residents send their supervisor Scholarly Project ITARs at least twice per year (before the December and June Competency Committee meetings).
- The supervisors will ensure that the scholarly project is progressing as per schedule and will address any challenges faced by the resident in timely completion of the project.
- If the supervisor has any concerns regarding the progress of the trainee, he/she is expected to bring this to the attention of the PGE Program Director, at the earliest possible time.

SUPPORT/RESOURCES AVAILABLE FOR RESIDENTS

- Half academic day (Thursdays) every 6 weeks in PGY2-4 years is available as protected time for Scholarly activities. Afternoon sessions on Thursdays are shortened to 2 hours to allow time for psychotherapy and scholarly activities.
- Residents have access to an academic fund of $150 per year to support their scholarly activities, which can be used yearly or can be accumulated over the 5 years to be used as and when needed. Residents are regularly made aware by e-mail of other opportunities for academic awards, announced by Schulich School of Medicine and Dentistry, Canadian Psychiatric Association, Royal College of Physicians and Surgeons of Canada and other academic organizations in North America.
- Dr. Arlene MacDougall, Director of Research is available to provide consultations re research methodology/statistics or mentorship
- The residents' research representative works collaboratively with the Residency Program Committee to advocate for research related needs of the residents
- Annual Best resident researcher award
- Consider introducing an award for best QI project conducted by resident.
- All PGY1s during their orientation month in July receive a 45 min session on Introduction to Scholarly curriculum.

Residents can become familiar with opportunities available in the department in several ways:

- Look up the Research section and Annual Report at the Department of Psychiatry website, which provides details of ongoing research in various divisions of the department http://www.schulich.uwo.ca/psychiatry/research/index.html
- Watch out for the opportunities for scholarly/quality improvement projects available within the department; regular emails are sent out when such opportunities arise; also check out weekly newsletter from the office of the Research director.
- Attend the Scholarly Project Update Group, which is held once a month.
- Consult with the Scholarly Portfolio lead and/or Director of Research to discuss appropriate mentors for any specific areas of interest that a resident may have.

Lawson Mandatory Training Requirements for Clinical Research

All residents are mandated to complete training requirements, developed by Lawson health Research Institute.
As part of the Quality Management System, Lawson has developed a Training Requirement Toolkit. These requirements are designed to provide direction for education and training in accordance with Lawson's policies and Standard Operating Procedures (SOPs).
Contact the Quality Assurance and Education Team at QAEP@lawsonresearch.com to request your copy of the Training Requirement Toolkit.

ASSESSMENT OF CORE OBJECTIVES (Overseen by Competence Committee)

Attendance is mandatory at all of the above teaching and training activities.

The **Residents' scholarly experience** will be assessed on the basis of the regular ITARs (In-Training Assessment Reports) completed by their supervisors and the 'scholarly activity report form' submitted by the resident prior to the quarterly review by the Competence Committee.

Two written reports on reflective learning Exercise on QI/patient safety/Ethics incident (PGY1 and PGY5 years)

PROFICIENCY IN RESEARCH: Resident Research Track (available for Residents starting July 2020)

A Resident Research Track is available for qualified candidates with previous experience in research and a clear interest in pursuing an academic career in psychiatry.

The Research Track offers residents dedicated research time and training from PGY2 to the completion of residency while ensuring the resident meets the full clinical training requirements of the Royal College of Physicians and Surgeons of Canada:

1. PGY2-3: half-day per week of protected research time
2. PGY4: one day per week of protected research time
3. PGY4-5: research electives vs. Clinician-Investigator Program based on availability and preference (see below for more information)

When possible, clinical training placements for Research Track residents will be organized to allow integration with research.

Graduate Degree Training:

Research Track residents will have an opportunity to apply to a graduate degree program (masters or start a PhD) during their PGY4-5 years.

The Schulich School of Medicine & Dentistry offers the Royal College of Physician and Surgeons of Canada's accredited Clinician Investigator Program (CIP), which supports residents to engage in a minimum of 24 months of continuous, intensive research training. At Schulich, the CIP provides 2 years of financial support for residents to complete a graduate program offered through one of Schulich's basic science departments (e.g., Epidemiology and Biostatistics, Anatomy and Cell Biology, Medical Biophysics, etc.). As part of the CIP, residents also participate in a research seminar series focused on the development of clinical investigators. Note that the CIP is a competitive program with only 2-4 spots available per year. Applications are typically due early January. Please go to: https://www.schulich.uwo.ca/research/student_trainee_programs/clinical/clinical_investigator_program.html for more information on Schulich's CIP including contacts and the application process.

Residents who are not part of the CIP but who want to complete a graduate degree as part of their Research Track will need to secure / self-fund their own graduate degree tuition costs.

Expectations and Assessment: (In addition to the expectations to achieve Core competencies detailed above)

As part of the Resident Research Track, residents will be provided with opportunities to develop greater proficiencies in various research knowledge and skills, including:

- Developing and maintaining databases
- Elements of writing research proposals, reports and grant applications
- Preparation and submission of a research ethics protocol
- Analyze data using appropriate methods and common computer programs for statistical analysis including more advanced statistical methods such as multiple and logistic regression, analysis of covariance, data reduction techniques (eg. factor analysis, cluster analysis), survival analysis and multivariate analysis.
- Formulate appropriate conclusions on the basis of the data.
- Competently use one or more advanced research methods, for example those related to psychophysiology, imaging, psychometrics, genetics, formal modeling, etc.
- Write one or more papers for publication in a peer-reviewed indexed journal

Research Track residents are expected to achieve the following deliverables:

1. At least two first author conference abstracts (national/international conferences).
2. At least one first author manuscript publication in indexed peer-reviewed journal.

Although research track residents are encouraged to engage in primary data collection for their project, secondary data analysis projects will be considered. Systematic reviews and meta-analyses are welcomed but are not considered a sufficient deliverable alone for the resident research track.
An expected timeline for the Research Track is as follows:

PGY1: research electives to find a supervisor, gain exposure to area(s) of interest and identify research project(s) and submit an application to Research Track.

PGY2: formal start to Research Track and start/continuation of projects identified in PGY1. Expected submission of one project summary in the form of a conference abstract for presentation at a local conference.

PGY3-4: expected submission of another project summary in the form of a conference abstract for presentation at national or international conference(s). Complete work directed towards first author manuscript for publication in indexed peer-reviewed journal.

PGY5: expected submission of first author manuscript in indexed peer-reviewed journal.

Research Track residents are expected to complete an assessment by their supervisor every 3 months beginning in PGY2 (using **Research Track Assessment** Tool).

How to Apply:

Interested candidates in the Research Track are strongly encouraged to complete a research elective (1 - 2 months) in PGY1. This elective time offers an opportunity for residents to identify, consult and work with potential Research Track Supervisors, and to prepare their Research Track proposal. The Department of Psychiatry’s Scholarly Portfolio Lead - Residents Program Committee and the Director of Research will be available to assist interested candidates in identifying and connecting with potential Research Supervisors.

Research Track Applications must be submitted by March 31st of the PGY1 year to the Psychiatry Postgraduate Education Office (email PGEPsychiatry). Up to two Research Track positions can be accommodated each year. Candidates will be evaluated on their prior demonstrated research activity/productivity, their clear interest and proposed pathway to an academic career in psychiatry, and the strength of their research proposal including the research mentor/supervisor identified. Successful candidates will be notified by May 31st of the PGY1 year.

Components of the Application:

A. Candidate cover letter.

B. Proposal (maximum 4 pages). The proposal must include:
- Project Title
- Name of Research Supervisor
- Lay person summary: brief project summary that is easy to understand for the lay public without medical background
- Rationale/background: why is the topic important? What is known thus far? What are the gaps that should be addressed?
- Purpose, aims and hypotheses: what is the overarching goal of the research? How will it advance knowledge? What aspects are novel? What are the specific hypotheses to be tested?
- Methods: list specific aspects of study design including measures, timelines, sample characteristics, and description of analytic approach for hypothesis testing. Has the data already been collected?
- Environment: what resources and support are in place to assist the candidate? Who are the other members of the research team, in addition to the supervisor? What is the specific role of the candidate within the project and the supervisor's program of research?
- Graduate training: Is the candidate planning to do a graduate degree? If so, what graduate degree program? Does the candidate meet the proposed graduate program admission requirements? How does the applicant plan to fund their graduate training? Is the candidate planning to apply to Schulich’s Clinician Investigator Program?
- Anticipated deliverables including first-author conference presentations and publications (be as specific as possible)
- Anticipated challenges to project and/or role of the resident within project, and approach to mitigating these challenges

C. Candidate CV.

D. Research Supervisor CV (brief / shortened CV is sufficient).

E. One reference letter from a prior research supervisor.

The application will be evaluated by the PGE program director/associate director, the PGE Scholarly Curriculum Lead, the Director of Research and two senior resident representatives.