CBD
Workplace-Based Assessment
Practical Implications
October 2017

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Objectives

• Discuss CBD workplace-based assessment expectancies and perceived challenges to implementation
• Describe strategies to effectively observe and document constructive feedback on resident trainee performance
• Describe the concept of entrustment as it relates to resident observation and evidence based rating scales
• Discuss past trainee observations and apply these to validated workplace-based assessment tools
• Identify features of and demonstrate ability to write high quality narratives describing resident performance in the clinical environment
Assessment

• Different but familiar

• More frequent observations that are documented

• Increased focus on rich narrative comments

• “Assessment for learning”
  • Coaching

• Standard is competent for safe independent practice
What do we want our frontline clinical teachers to do?

Coaching in the moment
Coaching in the Moment: A Process

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

RX-OCD
Where does “assessment” fit?

- **Rapport**
  - Establishes a relationship

- **Expectations**
  - Helps focus observation

- **Observe**
  - Make a decision about what you saw
    - Could they have done that alone?
    - If not, what would you say needs to improve?

- **Conversation (between clinician and resident)**
  - Identify what was done well, needs improvement, etc.
  - Provide some normative information
  - Provide direction as to how to improve

- **Document**
  - Your “assessment” of how it was performed
    - Independence is standard (entrustment scale)
  - Suggestions you gave to trainee for improvement
Focus for today

• Observation issues

• Rating scales

• Narrative observation
Part One – Observation Issues
Major Challenge

Performance in Practice
- e.g. through direct observation, entrustment, workplace based assessment

Demonstration of Learning
- e.g. via simulations, OSCEs

Interpretation/Application
- e.g. through case presentations, essays, extended matching type MCQs

Fact Gathering
- e.g. traditional true/false MCQs

Observation Strategies

- Orient the trainee to being observed

- Two approaches
  - Watch it all
  - Watch bits and pieces
    - Some aspect of history
    - Repeat physical exam
    - Provide the plan

- Introduce concept to patient
  - “I’m a fly on the wall”

- Define what you need to watch

- Make a schedule to observe
What about indirect observation?

Examples:

- Interactions with other team members
  - “I really don’t like being on call with Dr. X”

- Comments from patients and families
  - “She is wonderful… keep her!”

- Ask them why
  - Follow-up questions when needed

- Thank them for telling you
What about indirect observation?

• Inferences you make from clinical work
  • Case presentations
  • Chart review
  • Information you find out when you see patient

• Discuss your observations with trainee
  • May include having them demonstrate technique, walk you through their reasoning, etc.

• Assess their performance based on the above

• Provide feedback
Part Two – Rating Scale Anchors
Traditional rating scale anchors

• 1 – Consistently below expectations
• 2 – Sometimes below expectations
• 3 – Meets expectations
• 4 – Sometimes above expectations
• 5 – Consistently above expectations

• What works?

• What does not work?
Rating scale anchors

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

• What do you think?
Tools using these anchors

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


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


- **OBAT** – Ontario Bronchoscopy Assessment Tool
  - Tool to assess the performance of a trainee on one bronchoscopy

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

<table>
<thead>
<tr>
<th>Trainee #:</th>
<th>Level: 1 2 3 4 5</th>
<th>Staff:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure:</td>
<td></td>
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</tbody>
</table>

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

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

**Scale**

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

<table>
<thead>
<tr>
<th>1. Preprocedure plan</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathers/assesses required information to reach diagnosis and determine correct procedure required</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>2. Case preparation</th>
<th>1 2 3 4 5</th>
</tr>
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<tbody>
<tr>
<td>Patient correctly prepared and positioned, understands approach and required instruments, prepared to deal with predictable complications</td>
<td></td>
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</table>

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<thead>
<tr>
<th>3. Knowledge of specific procedural steps</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands steps of procedure, potential risks, and means to avoid/overcome them</td>
<td></td>
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<tr>
<th>4. Technical performance</th>
<th>1 2 3 4 5</th>
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<tbody>
<tr>
<td>Efficiently performs steps, avoiding pitfalls and respecting soft tissues</td>
<td></td>
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</table>

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<thead>
<tr>
<th>5. Visuospatial skills</th>
<th>1 2 3 4 5</th>
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<tbody>
<tr>
<td>3D spatial orientation and able to position instruments/hardware where intended</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>6. Postprocedure plan</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate complete post procedure plan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Efficiency and flow</th>
<th>1 2 3 4 5</th>
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<tbody>
<tr>
<td>Obvious planned course of procedure with economy of movement and flow</td>
<td></td>
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<table>
<thead>
<tr>
<th>8. Communication</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and effective communication/utilization of staff</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>9. Resident is able to safely perform this procedure independently (circle)</th>
<th>Y N</th>
</tr>
</thead>
</table>

| 10. Give at least 1 specific aspect of procedure done well |

| 11. Give at least 1 specific suggestion for improvement |   |


The purpose of this scale is to assess the trainee’s ability to safely and independently run a CLINIC IN YOUR SPECIALTY (i.e. Urology, General Surgery, etc.) at the level of a GENERALIST (i.e. certified graduate of residency program).

With that in mind please use the scale below to rate each item, irrespective of the resident’s level of training. Base your rating on the trainee’s performance across the ENTIRE CLINIC (i.e. do not base your rating on only one specific patient encounter).

Please complete the assessment IMMEDIATELY following completion of the clinic.

Scale
1—“I had to do”—i.e., Required complete guidance, unprepared to do, or had to do for them
2—“I had to talk them through”—i.e., Able to perform some tasks but requires repeated directions
3—“I had to direct them from time to time”—i.e., Demonstrates some independence, but requires intermittent prompting
4—“It needed to be available just in case”—i.e., Independence but needs assistance with nuances of certain patients and/or situations, unable to manage all patients, still requires supervision for safe practice
5—“I did not need to be there”—i.e., Complete independence, can safely manage a general clinic in your specialty

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History</td>
<td>Efficient data gathering</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Physical Exam</td>
<td>Efficient and accurate examination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Case Presentation</td>
<td>Synthesis of history and physical, clear presentation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Differential Diagnosis</td>
<td>Able to make a diagnosis and appropriately consider alternatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Management Plan</td>
<td>Able to develop relevant plan dependant on context and be decisive (i.e. appropriate investigations, procedures, etc)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Patient/Family Communication</td>
<td>Effective, sensitive, and respectful communication skills (verbal &amp; non-verbal), language appropriate to patient understanding, able to build rapport and trust</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Documentation within Clinic</td>
<td>Orders, prescriptions, forms, etc (may not include consultation report)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Collaboration</td>
<td>Works well with and/or teaches other team members as appropriate (i.e. staff, student, other healthcare professional)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
9. Time Management of Entire Clinic
   Able to economize time, manage interruptions, and modify time spent with individual patients appropriately

10. If Procedures Were Performed in Clinic: Not Applicable
    a. Technical Skills
       Safely and effectively performs appropriate clinical procedures
    b. Situational Awareness
       Non-technical aspects of procedure (i.e. insight into patient experience, respects patient comfort)

11. Concerns with Attitude or Professionalism
    (If yes please describe in suggestions for improvement below)

   Resident is safe to independently manage/run this clinic at a generalist level

13. Give at least 1 specific aspect of clinic done well

14. Give at least 1 specific suggestion for improvement
Do they work?

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

• Study with three commonly used workplace-based assessment tools
  • Changed the traditional ratings scale anchors to align with increasing independence
  • Compared the reliability of the tools with the two different rating scale anchors
    • Significantly increased reliability with new anchors

Why do these scales seem to work?
Entrustment
Potential Reasons

- Mirror how we think
  - Construct alignment
  - Less translation

- Rely on rater’s clinical expertise
  - Less reliance on rater training (which has proven unsuccessful)

- Used in low stakes, repetitive assessment

- Fit into milestone progression
  - Improved resident acceptance
  - Less reliance on knowing what a typical resident at a particular level looks like

- Formative assessment
How to Use these Tools

• Do not be afraid to assign the rating that describes the performance
  • i.e. Do NOT worry about level of training

• Prepare residents for the different approach
How to Use these Tools

• Do not be afraid to assign the rating that describes the performance
  • i.e. Do NOT worry about level of training

• Focus on today’s performance
  • i.e. Do NOT worry about what this means for the future

• Do not be so worried about how the resident will react to being told that they are not a “5”
  • i.e. Most know that they are not ready to be entirely on their own

• Prepare residents for the different approach
How to Use these Tools

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

• Discuss what the scale means in your context
  • Procedure vs non-procedure
Using Different Scales

*Example scenario A*

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

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

*Rating scale A*
1. rarely meets expectations
2. inconsistently meets expectations
3. meets expectations
4. sometimes exceeds expectations
5. consistently exceeds expectations

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

Scale A – 4 (sometimes exceeds expectations)

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

Example scenario B

PGY4 trainee needs to (perform procedure X). The resident is aware of sterile technique and how the results will assist in further management. However, they required direction on patient positioning and land-marking, as well as size of needle to use. You would have expected that a resident at their level would know and be able to complete these technical portions of the procedure.

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

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

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

Scale A – 2 (inconsistently meets expectations)

Scale B – 2 (able to perform but requires repeated direction)
Part Three – Narrative Observation
Qualitative Assessment

• Misconception
  • Subjective = Unreliable
  • Objective = Reliable

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

  Holmboe et al., Academic Medicine, 2011
Qualitative Assessment

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

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

• What is more useful?
Words and not Numbers

• Rich narrative observations of performance
  • Enhance the formative function
    • Provides the information required for guided reflection
  • Required for defensible decisions in summative assessments
  • Can be compiled
    • “reliability” obtained with adequate sampling
What do you think of this comment?

• She’s great – very confident, thorough, at expected level of training or beyond. Clinically very good, no gaps.
How could you improve it?
High Quality Comments

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

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

• Example
  • “Lazy” resident
Behaviours – Not Attitudes

• Attitude
  • Lazy

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

• Describe one aspect of performance that was done well.
  • Was this done at the level of “competent for independent practice”?
    • Yes
    • Not yet

• Describe one aspect of performance that could improve.
  • What are your suggestions for how the resident could address the above area of performance to improve?
Okay comments

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

• Responds positively to feedback. Ex) Noted that you missed a quads lag by not first checking passive ROM of the knee. Reviewed proper technique for quads testing. On observation at a later point during the clinic you had altered your physical exam appropriately.

• Tendency to use too much medical jargon when explaining issues to patients. Ex) In the patient with an abnormal lesion on the chest x-ray you said, “It could be an infiltrate, a granuloma, a malignancy…”

• Focus anatomy reading on the brachial plexus… need to be able to draw the plexus out so that neurological lesions can be mapped on the plexus

• Case presentations in clinic are succinct and include all relevant info Ex) Patient with depression and back pain… you were able to focus on the issues relevant to the question asked by the referring doctor in presenting the case
Practice

• Think of a resident or student that you recently worked with

• What verbal feedback did you give them?

• Turn that feedback into a comment

• Share the comment with a person at your table who is not in your specialty
  • Do they understand the comment?
  • Does it seem like a useful comment? Why or why not?

• Discuss with whole group
Practice

• Think of a resident or student that you recently worked with that you noted an area for improvement

• Write it in a comment

• Write your suggestion for how they should address this area for improvement

• Share the comments with a person at your table who is not in your specialty
  • Do they understand the comment and suggestion?
  • Does it seem like a useful comment and suggestion? Why or why not?

• Discuss with whole group
Summary

• Need to watch and provide verbal feedback

• Entrustment based anchors demonstrate promise with increased evidence for validity compared to tools with more traditional rating scale anchors

• Verbal feedback is the basis of good written assessment

• Good written assessment includes specific, behaviour-based comments that include examples

• Good written assessment is the key step to dealing with poor performance

• Good written assessment can guide further training
References


• Crossley J, Jolly B. Making sense of workplace-based assessment: ask the right questions, in the right way, about the right things, of the right people. *Medical Education* 2012;46:28-37.


• Dudek NL, Marks MB & Regehr G. Reluctance to fail poorly performing residents – explanations and potential solutions. *ACGME Bulletin* April 2006;45-48.
References


References


References


References


Images


• Slide # 14 Title: O-SCORE – Ottawa Surgical Competency Operating Room Evaluation; Author: Gofton W, Dudek N, Wood T, Balaa F, Hamstra S. The Ottawa Surgical Competency Operating Room Evaluation (O-SCORE): a tool to assess surgical competence. Academic Medicine. 2012; 87: 1401-1407; Source: Academic Medicine. 2012; 87: page 1407 ; License: Used with permission under Licence Agreement (insert #)

• Slide # 15 & 16 Title: A New Instrument for Assessing Resident Competence in Surgical Clinic: The Ottawa Clinic Assessment Tool (OCAT); Author: Rekman J, Hamstra S, Dudek N, Wood T; Source: Journal of Surgical Education 2016;73(4):575-582. License: Used with permission under Licence Agreement with Elsevier #4096630074894

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References

• **Slide # 36** – Title: Logo - Feedback for future learning ; Author: Glasgow Caledonian University 
  Source: [www.gcu.ac.uk/futureelearning](http://www.gcu.ac.uk/futureelearning) 
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