

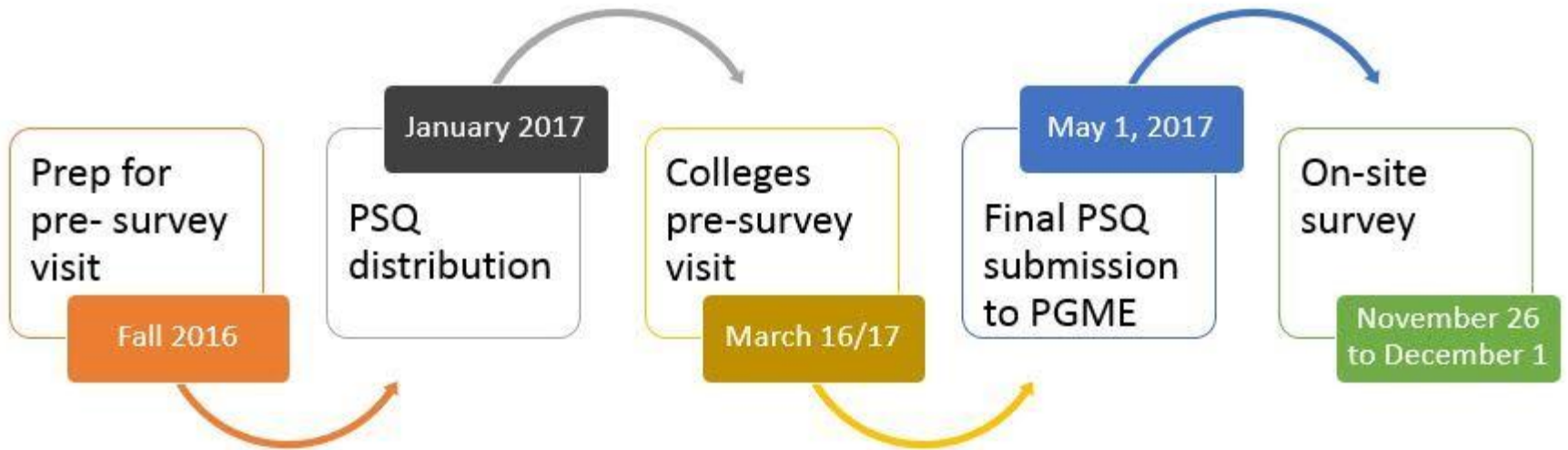
# ACCREDITATION SURVEY 2017

## B STANDARDS PITFALLS

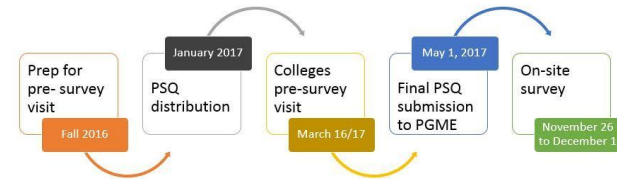


# 2017 Survey Timeline at U of A

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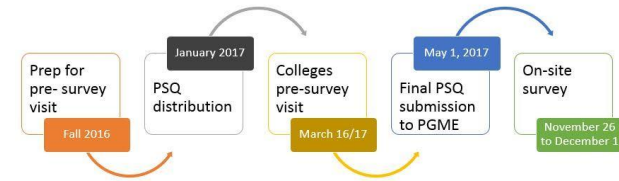
# Objectives



You will be able to:

- Understand and interpret B Standards as it relates to Accreditation
- Be aware of the common pitfalls for each B Standard

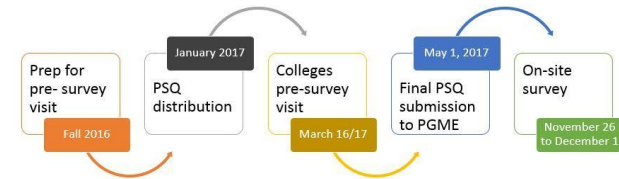
# “B” Standards



## Standards for EACH residency program

- B1 Administrative Structure
- B2 Goals & Objectives
- B3 Structure and Organization of the Program
- B4 Resources
- B5 Clinical, Academic & Scholarly Content of the Program
- B6 Assessment of Resident Performance

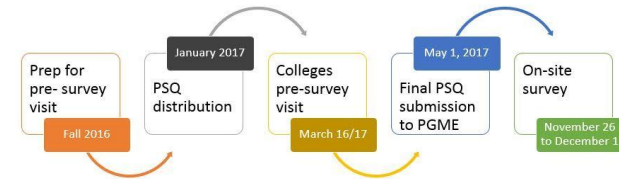
# B1 – Administrative Structure



## 1.1 Program Director

- Overall responsibility for program
- Acceptable qualifications
  - ▣ Royal College certification – should
- **Sufficient time & support**
  - ▣ Generally interpreted as non-clinical time for program administration
  - ▣ **Impact** to operation of program

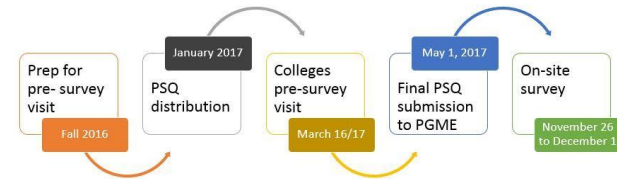
# B1 – Administrative Structure



## 1.2 Residency Program Committee (RPC)

- Representative from **each site & major component**
- Resident member of Committee
  - **Elected by the residents**
  - Accountability
- Meets 4 times/year; keeps minutes
- Communicates regularly with members of program, department, residents
- RPC members responsible for **bilateral flow of communication** with the specific constituencies they represent

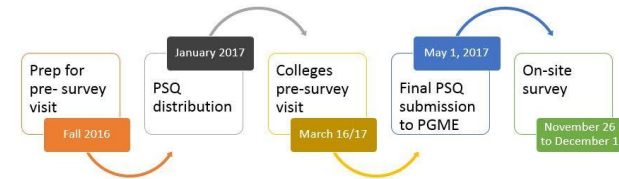
# B1 – Administrative Structure



## 1.3 Responsibilities of RPC

- Planning and operation of program
- Opportunities for residents to attain competencies
- Selection of residents
- Assessment & promotion of residents
- Appeal mechanism
- Career planning & counseling
- Manage stress and wellbeing

# B1 – Administrative Structure

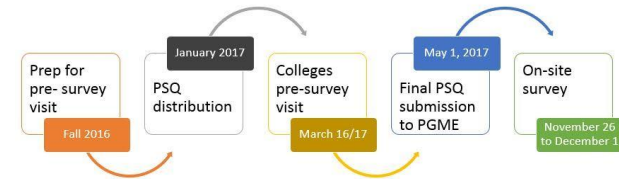


## 1.3 Responsibilities of RPC

- ❑ **Ongoing program review**
  - ❑ Clinical and academic components
  - ❑ Resources and facilities
  - ❑ **Teachers**
    - ❑ Feedback mechanisms
  - ❑ Learning environment
  - ❑ Anonymous
- ❑ Resident safety
  - ❑ Written policy
  - ❑ Program-specific



# B1 – Administrative Structure



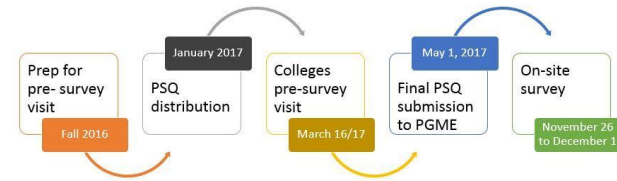
## 1.4 **Site Coordinator**

- Active liaison

## 1.5 **Research coordinator**

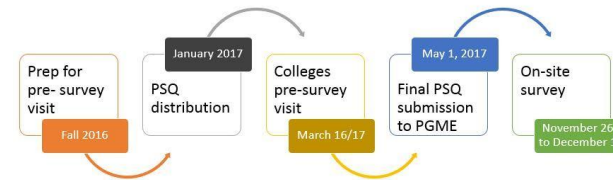
## 1.6 **Environment of inquiry and scholarship**

# B1 – Administrative Structure Pitfalls”



- Program director autocratic
- Residency Program Committee dysfunctional
  - Unclear Terms of Reference (membership, tasks and responsibilities)
    - Agenda and minutes poorly structured
    - Poor attendance
  - Department/Division head unduly influential
  - RPC is conducted as part of a Dept/Div meeting
- No resident voice

# B2 – Goals & Objectives



2.1 Overall statement

2.2 Structured to reflect the CanMEDS competency

- Used in planning & assessment of residents

2.3 **Rotation specific**

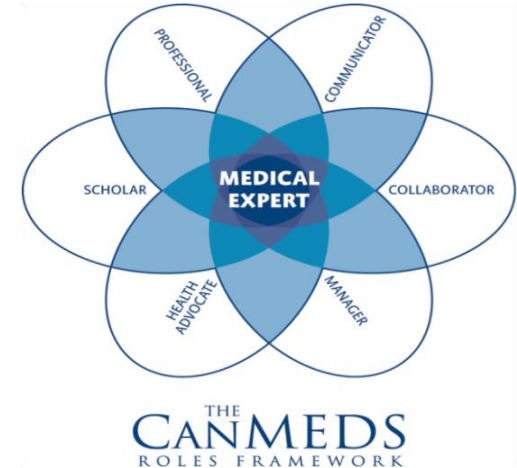
- Used in planning & assessment of residents

2.4 Resident & staff know and use them

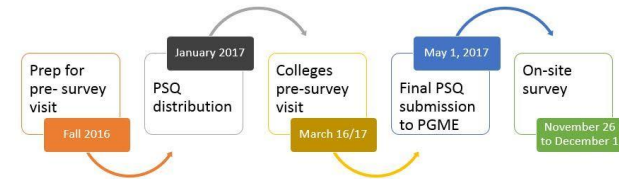
- Used in teaching, learning, assessment
- Learning strategies developed at start of rotation

2.5 **Regular review**

- At least every 2 years

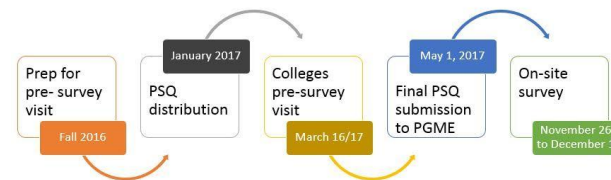


# B2 – Goals & Objectives Pitfalls”



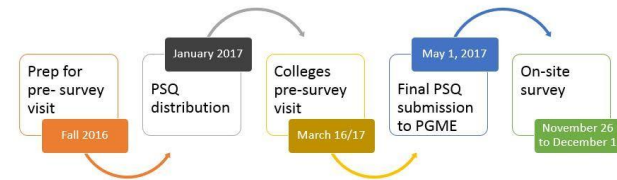
- ❑ Missing CanMEDS roles in overall structure
  - ❑ Okay to have rotations in which all CanMEDS roles may not apply (research, certain electives)
- ❑ **Goals and objectives not used by faculty/residents**
- ❑ Goals and objectives not reflecting resident level of training
- ❑ **Goals and objectives dysfunctional – does not inform assessment**
- ❑ Goals and objectives not reviewed regularly

# B3 – Structure & Organization



- 3.1 Program provides all components of training as outlined in the specialty-specific documents (STR)
- 3.2 Appropriate supervision
  - According to level of training, ability/competence and experience
- 3.3 **Increasing professional responsibility**
- 3.4 Senior resident role
- 3.5 **Balance of service and education**
  - Ability to attend academic sessions

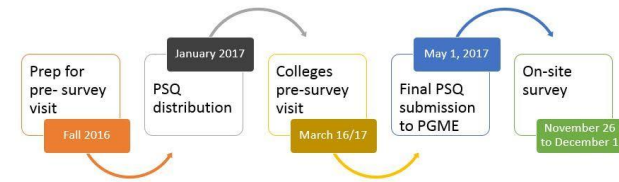
# B3 – Structure & Organization



- 3.6 Equivalent opportunity for each resident
- 3.7 Opportunity for electives
- 3.8 Role of each site clearly defined
- 3.9 Safe learning/educational environment
  - ❑ **Free from intimidation, harassment or abuse**
  - ❑ Promotes resident safety
- 3.10 Collaboration with other programs whose residents need to develop expertise in the specialty

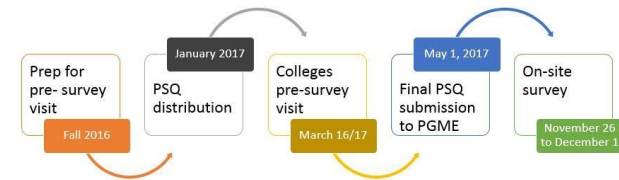
# B3 – Structure & Organization

## “pitfalls”



- ❑ Graded responsibility absent
- ❑ Service/education imbalance
  - ❑ Service provision by residents should have a defined educational component including evaluation
- ❑ Educational environment poor

# B4 – Resources



## 4.1 Sufficient teaching staff

- ❑ From appropriate health professions

## 4.2 **Appropriate number and variety** of patients, specimens and procedures

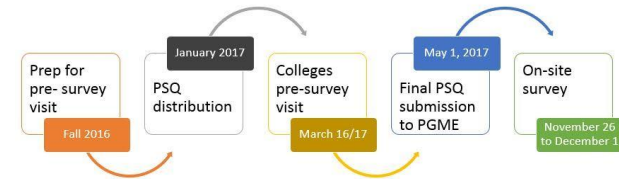
- ❑ Refer to specialty-specific documents

## 4.3 Clinical services organized to achieve educational objectives

- ❑ Training in collaboration with other disciplines
- ❑ Inpatient, emergency, ambulatory, community
- ❑ Age, gender, culture, ethnicity



# B4 – Resources



## 4.4 **Adequate educational resources**

- ❑ Access to computers, on-line references
- ❑ Close proximity to patient care areas

## 4.5 Access to physical and technical resources in the setting where they are working

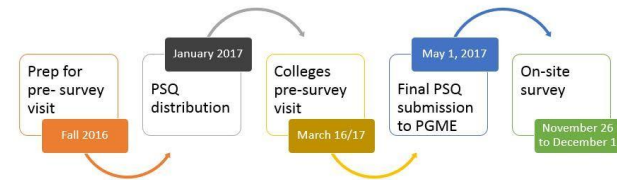
- ❑ Direct observation/privacy for confidential discussions
- ❑ Adequate space for residents

## 4.6 Adequate supporting facilities

- ❑ ICU, diagnostic, laboratory

# B4 – Resources

## “Pitfalls”



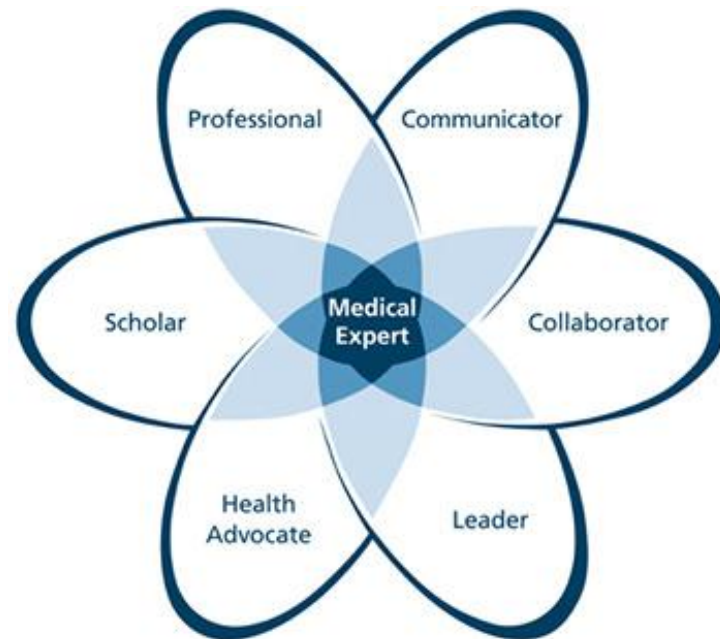
- ❑ Insufficient faculty for teaching/supervision
- ❑ Insufficient clinical/technical resources
- ❑ Infrastructure inadequate

# B5 – Clinical, Academic & Scholarly Content of Program



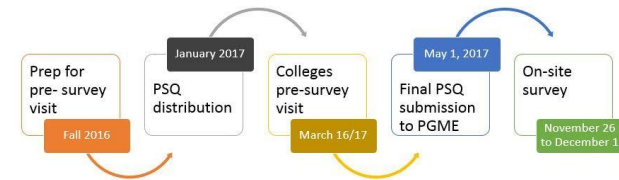
## *Evidence of teaching each of the CanMEDS roles*

- Medical Expert
- Communicator
- Collaborator
- Leader
- Health Advocate
- Scholar
- Professional



CANMEDS

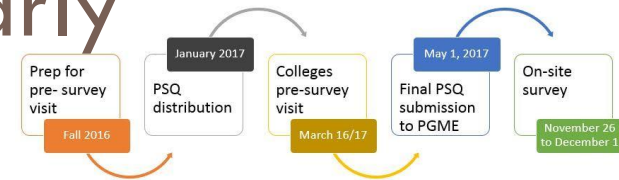
# B5 – Clinical, Academic & Scholarly Content of Program



## Academic program

- ❑ Organized curriculum
- ❑ Organized teaching in basic & clinical sciences

# B5 – Clinical, Academic & Scholarly Content of Program – “pitfalls”



- ❑ **Organized academic curriculum lacking**  
or entirely resident driven
  - ❑ Poor attendance by residents and faculty
- ❑ Teaching of intrinsic (non-medical expert)  
CanMEDS roles missing
- ❑ Role modeling is the only teaching  
modality

# Remember the 2015 OTR Special Addendum!



## CanMEDS 2015 OTR Special Addendum

The CanMEDS 2015 Special OTR Addendum is a generic document that will supplement the Objectives of Training for the 58 disciplines transitioning to Competence by Design (CBD) in cohorts 3 or later (see list at the end of this document). Therefore, this document should be read in conjunction with the discipline-specific Objectives of Training (OTR) listed below.

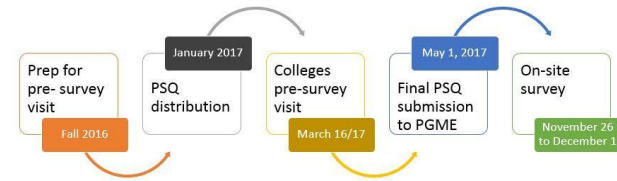
The addendum focuses on major NEW content areas in the CanMEDS 2015 Physician Competency Framework, which will be implemented into the training standards of specific Canadian residency programs on July 1<sup>st</sup>, 2016.

Program Directors will be responsible for demonstrating that their programs incorporate the CanMEDS 2015 Special OTR Addendum into their teaching and assessments of residents.

Once a discipline has transitioned to CBD and begins to accept trainees into its revised competency based training programs this addendum will no longer apply because the new competency based program will have new national standards based on CanMEDS 2015.

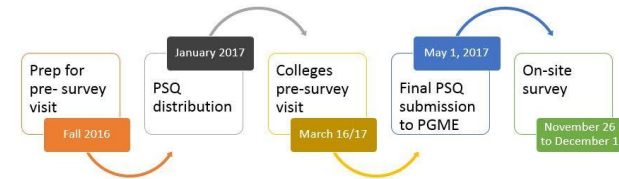
# CanMEDs 2015

## 3 Key Themes



1. Patient safety, Quality improvement & Resource stewardship
2. eHealth and Technology
3. Leadership and Physician Health

# B6 – Assessment of Resident Performance



## 6.1 **Based on Goals & Objectives**

- ❑ Identified methods of evaluation
- ❑ Level of performance expected

## 6.2 Assessment consistent with competencies being assessed

- ❑ Based on specialty-specific requirements

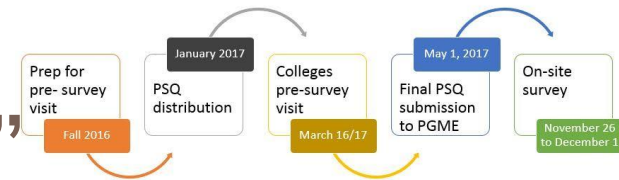
## 6.3 **Timely, regular, documented feedback**

- ❑ Face-to-face meetings

## 6.4 Residents informed of serious concerns



# B6 – Assessment of Resident Performance – “pitfalls”



- ❑ Mechanism to monitor, promote, remediate residents lacking
- ❑ Formative feedback not provided and/or documented
- ❑ Assessment not timely (particularly when serious concerns identified), not face to face
- ❑ Summative summative (ITER) inconsistent with formative feedback, unclear documents concerns/weaknesses

# Questions?

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