



GUIDELINES FOR JUNIOR DOCTORS USING THE NATIONAL ASSESSMENT TOOLS

This training manual contains materials which are intended to be used to assist JUNIOR DOCTORS in using the National Assessment Tools. It is intended to enable JUNIOR DOCTORS to prepare for the appraisal with Supervisors

The learning objectives are to:

- 1) Have an overview of the relationship between assessment and supervision
- 2) Understand how to use the ACF and the term description to develop a learning plan for each term at orientation
- 3) Be able to prepare for an appraisal meeting with the Supervisor
- 4) Be familiar with the documentation system used.
- 5) Have an overview of what happens when performance doesn't come up to expected levels .

This manual should be used in conjunction with the Australian Curriculum Framework for Junior Doctors.

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1. OVERVIEW

All Junior Doctors need regular feedback on their developing knowledge, clinical skills and professional behaviours. A National approach to Junior Doctor training ensures that there is consistency in the quality of both the supervision of Junior Doctors and the feedback they receive on their performance. The Australian Junior Doctor Framework (ACF) sets out the expected standards of performance of Junior Doctors. The national assessment system aims to:

- Link assessment to the ACF and term description
- Encourage direct observation of Junior Doctor performance in the workplace
- Encourage regular feedback provision to the Junior Doctor
- Encourage the Junior Doctor self reflection on performance
- Improve the rigour of the assessment process by using nationally agreed principles of assessment.

Evidence from recent research overseas suggests that the vast majority of junior doctor encounters with patients are satisfactory or better. However somewhere in the range of one to three percent of encounters are unsatisfactory. It is important for your professional development that you receive feedback on your strengths but also areas for improvement.

It is important for safe patient care that the small minority of doctors, whose performance is giving cause for concern, are identified and followed up. The junior doctor assessment framework provides an excellent opportunity for the Supervisor in each term to provide you with regular and informative feedback. You have a role in making sure you receive the feedback.

Junior Doctors should be familiar with the ACF and the National Guidelines for Assessment which outline the principles underpinning Assessment (see Appendix 1).

2. ORIENTATION

At the beginning of each term there should be an initial meeting, face to face, between the Supervisor and Junior Doctor. The purpose of this meeting is to orientate the Junior Doctor to the term including discussion of the specific training goals for the term so there is clarity for both parties regarding the areas of the ACF which could be covered. In particular, the Junior Doctor needs to know what their expected contribution to the unit is and has some written objectives to monitor his/her own performance by. The ACF will be useful in helping both the Supervisor and Junior Doctor to set these.

Also at this orientation meeting there should be discussion regarding the supervision and assessment processes for the term. Issues that should be discussed include:

- Who will be responsible for day to day supervision?
- Who will be responsible for providing feedback?
- What will be the process for gathering information to inform the assessments?
- When will the mid and end of term meetings be and how should these be organized? and

- What is the process for managing underperformance?

This ensures that the Junior Doctor is an active participant in the supervision and assessment processes.

3. THE NATIONAL ASSESSMENT TOOLS

Principles

The Supervisor needs to make an overall judgment about how well you have done both at the half way stage for the mid-term assessment and at the end of term Assessment. It is good practice to estimate (honestly) your own performance and compare this with the rating your Supervisor offers. This is a form of self assessment and allows you to reflect honestly on your strong points and those areas which you need to work on further. Supervisors have been encouraged to discuss how you rate your own performance.

The Supervisor will be rating you against others at the same stage of training i.e. they will be taking into consideration the postgraduate year and the term you are currently undertaking.

The Documentation

The form for national use is given in table 1.

CLINICAL MANAGEMENT				
1. Safe Patient Care				
2. Patient Assessment				
3. Emergencies				
4. Patient Management				
5. Skills and Procedures				
COMMUNICATION				
6. Patient interaction				
7. Managing information				
8. Working in Teams				
PROFESSIONALISM				
9. Doctor & Society				
10. Professional Behaviour				
11. Teaching and Learning				
OTHER LEARNING OBJECTIVES, AS AGREED BETWEEN JUNIOR DOCTOR AND THEIR SUPERVISOR				
12. _____				
13. _____				
14. _____				

Table 1. The mid term and end of term assessment criteria

Along each row, Supervisors are asked to rate the Junior Doctor’s performance in each of three major areas. These are:

- Clinical management,
- Communication, and
- Professionalism.

Each of these three major areas has sub topics such as “skills and procedures”. Additionally Supervisors are asked to rate specific areas that were agreed to at the orientation session at the start of term for example time management, handover, or specific clinical skills. The standards for each category of the rating scale are labeled in Table 2.

Clearly below the expected standard	Borderline	Meets the expected Standard	Clearly above the expected standard.
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Table 2 Standards for rating on the mid term and end of term assessment Tool

Having separately rated each checklist item, Supervisors are then asked to make an overall rating of the Junior Doctor. An example of differences between each standard is given in tables 3, 4, and 5.

Clinical Management: At expected level
<ul style="list-style-type: none"> • Adequate performances in most clinical interactions in urgent and non urgent settings including: <ul style="list-style-type: none"> ○ History and examination ○ Assessment and prioritisation of treatment plan ○ Ongoing management ○ Recognition of patient safety ○ Documentation • Recognition of own limitations • Skills and procedures appropriate to location/setting

Table 3 Expected Level of performance in clinical management for a Junior Doctor

Communication : At expected level
<ul style="list-style-type: none"> • Broadly acceptable history with no significant omissions • Use of varied questioning and listening techniques • Provides an adequate summary of patient presentation and progress to other members of the team • Breaks bad news clearly and compassionately

Table 4 Expected Level of performance in Communication for a Junior Doctor

Professional Behaviours

Adequate performances in most clinical interactions in urgent and non urgent settings including:

- Professional responsibility: Know the professional responsibilities relevant to your position
- Time Management: Understand how it impacts on patient care
- Personal well-being: Be aware of & optimise personal health & well-being
- Ethical Practice: Following ethical and professional codes
- Practitioner in difficulty: Recognition and knowledge of support
- Doctors as leaders: Showing an ability to work well with and lead others

Table 5 Expected Level of performance in Professional Behavior for a Junior Doctor

4. IMPROVING PERFORMANCE PLANS IPAP

The focus of the appraisal system is on safe patient care. Where this is being compromised by the performance of a Junior Doctor, that doctor will be offered additional remediation and support in order to enable them to function at the expected level. The documentation for writing up this process is called IPAP (see table 6) the Improving Performance Action Plan.

This documentation justifies, evidences and gives clear timescales to any actions set by your Supervisor and agreed by you in relation to improving performance to satisfactory levels. The IPAP approach has a long history in performance management across a number of industries. There follows a couple of examples as to how an IPAP might work in a fictional case where a Junior Doctor is having some problems.

Example 1

A Junior Doctor who is having numerous disputes and isn't fitting into the team will be reminded by the Supervisor that they should:

Demonstrate an ability to work with others and resolve conflicts when they arise

This statement lifted out of the ACF can be the basis of feedback and remediation. For some, the feedback is enough to change their behaviour, but for others more definitive action is needed. Remedial action might include "anger management", or going on a brief team-building course.

Example 2

Let's take another example. Suppose that a Junior Doctor on a surgical term had given some cause for concern around a number of safe patient care issues. The Supervisor recommends the JUNIOR DOCTOR should:

Use mechanisms that minimise error e.g. checklists, clinical pathways

In assessing the Junior Doctor, the Supervisor is likely to get specific feedback from the clinical team and from patients whether there was any evidence to support this statement of the expected standard. Table 6 shows how an IPAP would look with this example included in it.

ACF Domain	Issues related to specific domain	Actions/tasks	Evidence required)	Timeframe/Review Date
CLINICAL MANAGEMENT	<i>Concerns re safe patient care</i>	<i>Use mechanisms that minimise error e.g. checklists, clinical pathways.</i>	<i>Evidence of feedback from clinical team and patients that these are being used</i>	2 weeks
1. Safe Patient Care				
2. Patient Assessment				
3. Emergencies				
4. Patient Management				
5. Skills and Procedures				
COMMUNICATION				
6. Patient interaction				
7. Managing information				
8. Working in Teams				
PROFESSIONALISM				
9. Doctor in Society				
10. Professional Behaviour				

Table 6 IPAP – Improving Performance Action Plan

In most cases it is expected that the Junior Doctor will benefit from increased levels of supervision and performance will be improved. If not then the DCT in consultation with others will need to take additional action.

5. GETTING THE MOST OUT OF THE PROCESS

The acronym COR-CASE (Table 7) is designed as a brief performance support tool for the supervision process for Supervisors. There follows some practical advice for JUNIOR DOCTORS to get the most out of each stage.

Collate feedback from the clinical team and patients

Offer the Junior Doctor a meeting

Review the doctor's performance

Constructive feedback

Assess the standard

Sign off on the form (s)

Evaluate the process

Table 7 The one minute guide to assessing Junior Doctors within the ACF

It is useful for Junior Doctors to consider their contribution to each stage of this assessment process in order to ensure they get the most out of the appraisal. Here, each stage is described in a little more detail:

Collate feedback from the clinical team and patients

In a busy workplace the Supervisor may not have had chance to observe all aspects of your work. It is likely the Supervisor will have asked colleagues from the clinical team as well gained as impressions from patients and have collated these into a more rounded picture of your performance. It is important for the Junior Doctor to reflect on their own performance.

Offer the Junior Doctor a meeting

You need to be proactive in this, and make sure you make yourself available for meetings. You could remind your Supervisor's secretary that the appraisal is due. Remember this is your opportunity to get feedback and advice. It is a good idea to prepare some notes about what you want to get out of the meeting. These should be based on the areas in the appraisal form.

Review the doctor's performance

The Supervisor is likely to ask how you think you are going in your work. This is an opportunity to report on the things that are going well. There may be some specific activities which deserve a special mention, e.g. good patient care, being involved in extra training, doing a case presentation, or helping with an audit. It is important to raise areas where you feel things might not be going so well. This might relate to your rostering, time to undertake educational activities, relations with specific colleagues, or areas of clinical management you recognise need further development.

Constructive feedback

The rules for good feedback are that it should:

- Focus on good points first,
- Areas for improvement next, and
- Provide some suggestions for how the improvement might be achieved.

We all like to receive glowing reports of our achievements, but in reality we need an honest appraisal that acknowledges our contribution but gives us room for improvement. It is an important life long skill that you are able to discuss our own performance objectively and rationally.

Assess the standard

Detailed consideration of this issue is given above in Section 3 of this guide "The National Assessment Tools"

Sign off on the form

It is recommended that a copy of the form is kept for your own records, a copy is retained by the Supervisor and a copy of the form must go to the administrators (as per your local assessment process). If there are some issues of underperformance then it is particularly important that you receive written comments to indicate where your performance needs improvement to come up to the expected standard

In the relatively small numbers of cases where performance falls below the expected level, there is additional documentation required to support the remediation process; the Improving Performance Action Plan (IPAP). An example for completing this form is included earlier in this guide. Where an IPAP is completed the Director of Clinical Training (DCT) will need to be notified.

In general, there will be a process where the form(s) are required to be signed off by the DCT.

Evaluate the process

It is important that the appraisal is fair and that both the Junior Doctor and the Supervisor have a chance to discuss any concerns. You may be asked for your opinion as to how the appraisal process went. It is good practice to evaluate for yourself how you think the process went and how you might get more out of it in future. Already it's time to start planning some of the things that you need to get out of the next term.

APPENDIX 1 - NATIONAL GUIDELINES FOR ASSESSMENT

INTRODUCTION

Prevocational training encompasses the years following graduation, prior to entering vocational training programs, and is undertaken in the workplace. The Australian Curriculum Framework for Junior Doctors, developed under the auspices of the Confederation of Postgraduate Medical Education Councils (CPMEC), provides the framework of capabilities that are required by junior doctors to work safely in the Australian Health Care System. Postgraduate medical training must include a process of assessment¹ underpinned by clear guidelines for implementation in order to promote learning. The emphasis must be on valid and reliable formative feedback which is informed by direct observation in the workplace. There must be adequate resourcing to allow this to be undertaken effectively in the workplace.

Competence refers to the ability to demonstrate a specific capability, whereas performance refers to the ability to regularly demonstrate that capability under differing situations within the workplace. Performance based assessment becomes more important as experience increases².

This document gives guidelines for effective Assessment of prevocational doctors in the workplace and is in part derived from the United Kingdom Postgraduate Medical Education and Training Board (PMETB) document “Principles for an assessment system for postgraduate medical training” (2004) with the approval of PMETB.

GUIDELINE 1 – PURPOSE OF ASSESSMENT

The assessment system must be fit for a defined range of purposes. Moreover, to be effective in addressing these purposes, the assessments must be documented and available within the public domain. The purposes include:

1. To demonstrate doctors’ in training readiness to progress to the next stage, having met the required standard
2. To provide feedback to the doctor in training about progress and learning needs
3. To support trainees to progress through their chosen career path, at their own pace, by measuring progress in achieving competencies
4. To identify trainees who are underperforming and who may require support
5. To provide evidence for the award of unconditional registration
6. To drive and direct lifelong learning.

¹ WFME Global Standards for Quality Improvement, WFME, 2003

² Principles for an assessment system for postgraduate medical training, PMETB, 2004

GUIDELINE 2 – CONTENT VALIDITY OF ASSESSMENT

The content of the assessment will be based on the ACFJD and a national approach will be facilitated by CPMEC..

- Assessments will together systematically sample the entire content, appropriate to the stage of training, with reference to the common and important clinical problems that the trainee will encounter in the workplace and to the wider base of knowledge, skills, attitudes and behavior that doctors require.
- The blueprint from which assessments in the workplace are drawn will be available to trainees and educators in addition to assessors/examiners.

GUIDELINE 3 – METHODS OF ASSESSMENT

The assessment methods used within the program will be selected in the light of the purpose and content of that component of the framework and a national approach and standardization will be facilitated by CPMEC.

- Methods will be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning.
- The rationale for the choice of each assessment method will be documented and evidence-based.
- There will be a process of continual quality assurance of the assessment system benchmarked to international best practice.
- Assessors will have the necessary knowledge, training and competence to implement the chosen methods and participate in national standardization programs e.g. web based.
- Resourcing implications will be identified to ensure the methods of assessment can be fully implemented.

GUIDELINE 4 – ASSESSMENT STANDARD SETTING

The methods used to set standards for assessment of and decisions about junior doctor performance/competence must be transparent and CPMEC will facilitate national standardization projects e.g. web based..

- Standards for determining successful completion of pre-vocational training should be explicit.
- Standards will be set using recognised methods based on the content of the ACFJD and the judgments of competent assessors.
- Information about the degree of uncertainty around the performance of borderline junior doctors should be available and guide the need for and choice of further training and/or support.

GUIDELINE 5 – PROVISION OF FEEDBACK

Assessments must provide relevant feedback

- The policy and process for providing feedback to junior doctors following assessments must be documented and in the public domain.
- The form of feedback must match the purpose of the assessment.
- Outcomes from assessments must be used to provide feedback on the effectiveness of education and training where consent from all interested parties has been given.
- Feedback must involve open disclosure within the guidelines of relevant privacy legislation.
- The person providing the feedback must be involved in the direct observation of the junior doctor to whom they are providing the feedback. Frequent formal observations of daily encounters with patients provide valuable opportunities to guide, confirm or correct junior doctor performance.

GUIDELINE 6 – SPECTRUM OF INPUT

- There will be multi-professional and trainee input in the development, implementation and use of the assessment.
- Other health professionals, advanced trainees and community representatives may act as assessors/examiners for areas of competence they are capable of assessing.

GUIDELINE 7 - ASSESSORS

Assessors will be recruited against criteria for performing the tasks they undertake.

- The roles of assessors will be specified and used as the basis for recruitment and appointment.
- Assessors must demonstrate their ability to undertake the role.
- Assessors should only assess in areas where they have competence and where appropriate seek input from other sources.
- The relevant professional experience of assessors should be greater than that of the junior doctor being assessed.
- Assessor training will be provided in which equality and diversity training will be a core component.

- Assessor training will incorporate a national standardization program facilitated by CPMEC e.g. web based.
- The assessor must be aware of the qualified privilege implications of the role and responsibilities regarding the disclosure of information.

GUIDELINE 8 – STANDARDISATION AND PORTABILITY OF DOCUMENTATION

- Documentation will record the results and consequences of assessments and the trainee's progress through the assessment system
- Information will be recorded in a form that allows disclosure and appropriate access, within the confines of privacy legislation.
- Uniform documentation will be suitable not only for recording progress through the assessment system but also for submission for purposes of registration, performance review and application to vocational training.
- Documentation should provide evidence of compliance with and validation against the ACFJD

GUIDELINE 9 – RESOURCE REQUIREMENTS FOR ASSESSMENT

- The resources required for adequate assessment will be identified e.g. (There will be resources sufficient to support assessment). A national minimum standard will be identified by CPMEC.
- Resources and expertise will be made available to develop and implement appropriate assessment methods.
- Appropriate infrastructure at national, jurisdictional and local levels will support assessment.
- There will be a process to optimise resource provision and allocation across the continuum of clinical training.
- Accreditation of training positions should include an evaluation of the availability of resources for assessment as a component of training, and be a vehicle for improved resources.

GUIDELINE 10 – FAIRNESS AND TIMELINESS OF ASSESSMENT

- Assessment is a crucial component of prevocational education and training and should occur within normal working hours in the workplace learning environment.
- Assessment must begin early enough to allow sufficient time for underperforming junior doctors to remediate their performance.

- There will be an Appeal process available to junior doctors in order to allow contest of assessment decisions.
- Where assessment identifies underperforming junior doctors there should be provision of support to enable the junior doctor to meet the standards required of the assessment.

REFERENCES

1. WFME Global Standards for Quality Improvement, World Federation of Medical Education Publication, 2003
2. Principles for an Assessment system for Postgraduate Medical Training, Postgraduate Medical Education and Training Board (PMETB) Publication, 2004
3. Epstein, R (2007). Assessment in Medical Education. *New England Journal of Medicine*, 356;387-396

APPENDIX 2 – EXAMPLES OF PERFORMANCE AGAINST CRITERIA

The following tables are worked examples of the standards of performance for a selection of categories from the ACF, to guide Supervisors who assess Junior Doctors.

Clinical Skills

Clearly Below Expected Level	Borderline	Expected Level	Clearly Above Expected Level
<p>Major omissions in clinical interactions in urgent and non urgent settings including:</p> <ul style="list-style-type: none"> • History and examination • Assessment and prioritisation of treatment plan • Ongoing management • Recognition of patient safety • Documentation <p>Poor recognition of own limitations</p> <p>Skills and procedures require substantial supervision</p>	<p>Adequate performance in some clinical interactions in urgent and non urgent settings but omissions in several aspects of:</p> <ul style="list-style-type: none"> • History and examination • Assessment and prioritisation of treatment plan • Ongoing management • Recognition of patient safety • Documentation <p>Variable recognition of own limitations</p> <p>Skills and procedures;</p> <ul style="list-style-type: none"> • Some skills need substantial supervision (others don't) OR • require more supervision than expected 	<p>Adequate performances in most clinical interactions in urgent and non urgent settings including:</p> <ul style="list-style-type: none"> • History and examination • Assessment and prioritisation of treatment plan • Ongoing management • Recognition of patient safety • Documentation <p>Recognition of own limitations</p> <p>Skills and procedures appropriate to location/setting</p>	<p>Exceptional performance in most clinical interactions in urgent and non urgent settings including:</p> <ul style="list-style-type: none"> • History and examination • Assessment and prioritisation of treatment plan • Ongoing management • Recognition of patient safety • Documentation <p>Recognition of own limitations</p> <p>Skills and procedures appropriate to location/setting</p>

Communication

Clearly below expected level	Borderline	At expected level	Well above expected level
<ul style="list-style-type: none"> • Incomplete, inaccurate or erroneous histories • No coherence • Significant omissions • Very poor questioning techniques • Not patient centred • Presents cases poorly • Poor patient interaction and communication skills • Avoids or inappropriately breaks bad news 	<ul style="list-style-type: none"> • Occasional incomplete, inaccurate or erroneous histories • Suboptimal sequencing and cohesion of questioning, patient presentation and case summaries • Limited use of varied communication techniques, including when breaking bad news 	<ul style="list-style-type: none"> • Broadly acceptable history with no significant omissions • Use of varied questioning and listening techniques • Provides an adequate summary of patient presentation and progress to other members of the team • Breaks bad news clearly and compassionately 	<ul style="list-style-type: none"> • Complete, detailed and polished history with insightful use of questioning and listening techniques relevant to patient context and/or condition • Focused presentation of information, tailored to clinical needs of the patient •

Professional Behaviours

Clearly Below Expected Level	Borderline	Expected Level	Clearly Above Expected Level
<ul style="list-style-type: none"> • Little insight into how poor time management is impacting on patient care • Regularly late, compromising handover, safe patient care, and relationships with team. • No sense of important and urgent tasks being prioritized, nor any strategies to manage time 	<ul style="list-style-type: none"> • Some insight into poor time management but little evidence of any action. • Frequently late, but safe patient not particularly compromised. • Basic time management skills, eg task lists not being acted on. 	<ul style="list-style-type: none"> • Understand how time management impacts on patient care & hospital function • Demonstrate punctuality in the workplace • Demonstrate an ability to prioritize daily workload & multiple demands 	<ul style="list-style-type: none"> • High levels of insight and evidence of acting on priorities • Always punctual and makes arrangements/good communication if problems • High levels of sustained efficiency. Able to diplomatically negotiate workload were excessive