



# GUIDELINES FOR SUPERVISORS USING THE NATIONAL ASSESSMENT TOOLS

**Collate feedback from the clinical team and patients**

**Offer the Junior Doctor a meeting**

**Review the Junior Doctor's performance**

**Constructive feedback**

**Assess the standard**

**Sign off on the form(S)**

**Evaluate the process**

This training manual contains materials which are intended to be used to assist Supervisors in using the National Assessment Tools. It is intended to supplement the face to face training session provided.

The learning objectives are to:

- 1) Have an overview of the relationship between assessment and supervision
- 2) Be able to conduct an appraisal meeting with the Junior Doctor
- 3) Practice "difficult" appraisals on simulated cases
- 4) Be familiar with the documentation system used
- 5) Be able to manage doctors performing below the expected standard.

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

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## 1. OVERVIEW

The Mid-Term Appraisal and End of Term Assessment is more than a form to complete. In effect it is a sign-off that the Junior Doctor under your supervision is performing at an expected level. This level is clearly set out in the Australian Curriculum Framework for Junior Doctors (ACF). Importantly, it is an opportunity to provide an appraisal of a Junior Doctor under your supervision who is embarking on a life-long career in medicine.

Evidence from recent research in the United Kingdom 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 the professional development of Junior Doctors that they receive feedback on their 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 National Junior Doctor Assessment framework provides an excellent opportunity for the Supervisor in each term to provide regular and informative feedback to the doctors they supervise.

Supervisors 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 PROCESS

The acronym COR-CASE (Table 1) is designed as a brief performance support tool for the supervision process

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 your supervision

Table 1: The one minute guide to assessing Junior Doctors within the ACF

Here, each stage of the COR CASE performance support tool, is described in a little more detail:

#### **Collate feedback from the clinical team and patients**

Observation of the Junior Doctor in the workplace is a crucial component of a valid and reliable assessment process. Observations can be made in a number of areas to sample across the ACF domains. However, in an intense service-driven environment you may not have had a chance to observe all of the domains of the Junior Doctor's work. It is good practice to ask colleagues and collect impressions from patients, and collate these into a more rounded picture.

#### **Offer the Junior Doctor a meeting**

Offering up an appraisal meeting of approximately half an hour allows an unrushed and useful opportunity to review all of the issues including providing the Junior Doctor with feedback. Ideally there will be three meetings with the Junior Doctor. At the beginning of the term (orientation), at around the mid-term mark (to allow the Junior Doctor an opportunity to improve or build on the feedback provided), and again at the end of term (summative assessment).

#### **Review the doctor's performance**

Asking the Junior Doctor how they think they are going is a good place to start. They are encouraged to self-assess their own performance before the meeting using a self-assessment form. Focus initially on the things that are going well, before asking about the things that are not going so well. A lot of patient history-taking communication strategies, (for example, asking open questions and looking interested), can be helpful. If there are particular issues that need to be brought up e.g. feedback from nursing staff, the Junior Doctor's interpretation of that feedback can be elicited.

## **Constructive feedback**

There are a number of “rules” for providing good feedback of which you will be aware. In summary these are:

- Ensure an appropriate environment e.g. quiet and private.
- Be prepared – think about exactly what you would like to say and make sure you have the examples from observation to support your comments.
- Structure the feedback – usually recommended that you discuss good points first, areas for improvement next and some suggestions for how the improvement might be achieved to finish.
- Actively listen to the Junior Doctor and encourage their interpretation of what is observed rather than providing your own interpretation.

## **Assess the standard**

Detailed consideration of this issue is given below in Section 4 of this guide “Setting Standards”

## **Sign off on the form**

It is recommended that a copy of the form is kept for your own records, a copy is given to the Junior Doctor and a copy of the form must go to the administrators (as per your local assessment process). It is particularly important to offer written comments to indicate where the Junior Doctor’s performance needs improvement in order to come up to the expected standard, or to reinforce particularly good performance.

In the relatively small numbers of cases where performance falls below the expected level, there is additional documentation required on the National Assessment Tools, to support the remediation process; the Improving Performance Action Plan (IPAP). An example for completing this form is included later 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 good practice to ensure that the Junior Doctor felt the assessment process was fair. It is also good practice to be reviewing your own methods of supervising, if only to understand more about the Junior Doctor experience during their term with you. There may be ways to improve the clinical experience of the Junior Doctors and update your own skills in supervision. Most supervision is a rewarding experience but learning how to deal with things that go wrong is an important and life-long skill.

## 4. SETTING STANDARDS AND MAKING DECISIONS ABOUT PERFORMANCE

### Principles

When deciding the level of performance of a Junior Doctor, you need to make an overall judgement about how well they have been performing. This occurs both halfway through the term, (for the mid-term appraisal) and by the end of term, (for the end of term assessment). It is usually easier to rate a Junior Doctor's performance when you are clear what standards you are rating against, and there is a consequence to the decision. For example Supervisors are very good at rating whether a Junior Doctor can perform a technical procedure by rating the amount of supervision they would need if the Junior Doctor were asked to do that skill on their own.

You need to consider the Junior Doctor's performance relative to other Junior Doctors at the same stage of training i.e. the same postgraduate year and the same term being undertaken e.g. Term 2.

### The Documentation

The form for national use is given in table 2.

<b>CLINICAL MANAGEMENT</b>				
1. Safe Patient Care				
2. Patient Assessment				
3. Emergencies				
4. Patient Management				
5. Skills and Procedures				
<b>COMMUNICATION</b>				
6. Patient interaction				
7. Managing information				
8. Working in Teams				
<b>PROFESSIONALISM</b>				
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 2: 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 3.

Clearly below the expected standard	Borderline	Meets the expected Standard	Clearly above the expected standard.
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Table 3: 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. After a short intensive training session and/or based on experience most Supervisors will be comfortable in identifying those Junior Doctors that meet the expected standard of performance for the term. An example of differences between each standard is given in table 4, table 5, and table 6.

<p><b>Clinical Management: At expected level</b></p> <p>Adequate performances in most clinical interactions in urgent and non-urgent settings including:</p> <ul style="list-style-type: none"> <li>• History and examination</li> <li>• Assessment and prioritisation of treatment plan</li> <li>• Ongoing management</li> <li>• Recognition of patient safety</li> <li>• Documentation</li> </ul> <p>Recognition of own limitations</p> <p>Skills and procedures appropriate to location/setting</p>
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Table 4: Expected Level of performance in clinical management for a junior doctor

<p><b>Communication : At expected level</b></p> <ul style="list-style-type: none"> <li>• Broadly acceptable history with no significant omissions</li> <li>• Use of varied questioning and listening techniques</li> <li>• Provides an adequate summary of patient presentation and progress to other members of the team</li> <li>• Breaks bad news clearly and compassionately</li> </ul>
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Table 5: Expected Level of performance in Communication for a junior doctor

<p><b>Professional Behaviours</b></p> <p>Adequate performances in most clinical interactions in urgent and non urgent settings including:</p> <ul style="list-style-type: none"> <li>• Professional responsibility Know the professional responsibilities relevant to your position</li> <li>• Time Management: Understand how it impacts on patient care</li> <li>• Personal well-being: Be aware of &amp; optimise personal health &amp; well-being</li> <li>• Ethical Practice: Following ethical and professional codes</li> <li>• Practitioner in difficulty: Recognition and knowledge of support</li> <li>• Doctors as leaders: Showing an ability to work well with and lead others</li> </ul>
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Table 6: Expected Level of performance in Professional Behaviour for a Junior Doctor

## Examples of rating

How does one decide, the difference between a Junior Doctor who is “borderline” and “one clearly below the standard?” Some Supervisors find it easier to judge the standard of a Junior Doctors’ clinical management skills e.g. history and examination skills but find it harder to define differing standards of communication or professionalism skills. Supervisors find it hard to combine ratings in clinical skills with professionalism as the scales are measuring different things. Some Supervisors are not confident they are able to justify their decision to transmit a rating of borderline to either the Junior Doctor or to the Director of Clinical Training. The decision has to be based on Patient Safety issues rather than assuming the Junior Doctor will probably become satisfactory in later terms. In justifying a “borderline” or “clearly below standard” decision, it is useful for Supervisors to refer to the more detailed ACF. This will provide the detail of the expected level of performance in the areas that the Junior Doctor is struggling with.

### Example 1

For example a problem Junior Doctor who is having numerous disputes and isn’t fitting into the team should be reminded 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. Looking at what the ACF says about this we can find the statement

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

In assessing the Junior Doctor one could get specific feedback from the clinical team and from patients whether there was any evidence to support this statement of the expected standard.

## Improving Performance

However, it remains the case that Supervisors still have difficulties in labelling trainees as “borderline” or “clearly below the expected standard.” They find it hard to justify such a level of intervention in a Junior Doctor’s training. It is important that there is consultation with experienced colleagues and the DCT, and vital that there is a written record of the process agreed upon for remediation. The focus must be on safe patient care. The documentation for writing up this process is called IPAP (see table 7) the Improving Performance Action Plan.

Without this documentation, it will be very difficult to justify any actions you may wish to take in relation to improving performance to satisfactory levels. The IPAP approach has a long history in performance management across a number of industries. For illustration, the data from example two has been included in the IPAP in table 7.

ACF Domain	Issues related to specific domain	Actions/tasks	Evidence required)	Timeframe/Review Date
<b>CLINICAL MANAGEMENT</b>	<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				
<b>COMMUNICATION</b>				
6. Patient interaction				
7. Managing information				
8. Working in Teams				
<b>PROFESSIONALISM</b>				
9. Doctor in Society				
10. Professional Behaviour				

Table 7 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. MORE ON BEING AN ASSESSOR

Let us have a look at the decision making process from a different perspective. In deciding what is serious and what is not, we can learn a lot from the world of sport in assessing performance. Have a look at Table 8. This is a rating scale for assessing the performance of a football (soccer) player (man or woman).

<b>Red Card or two (or more) yellow cards</b>	<b>Call for the Video Referee</b>	<b>Solid Performance</b>	<b>Man of the Match</b>
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Table 8: Rating scale for Performance of a Soccer Player

This type of scale is appreciated the world over and generally works very well in the age of television viewing.

Assessment Standards	Criteria	Outcomes
<b>Red Card or Multiple Yellows</b>	Serious violation worthy of disciplinary action or several less serious incidents	Disciplinary action for the player
<b>Video referee</b>	Potentially serious violation, but not certain at the time and more information from other sources required	Further information leads to decision of whether there was significant violation or not. If significant violation then disciplinary action follows.
<b>Solid Performance</b>	All round contribution to performance	Satisfaction of job well done in the circumstances. Trains to do as well or better next time
<b>Man of the match</b>	Exemplary performance in a number of areas	Deserving of a prize. Trains to remain at peak of performance.

Table 9: Descriptors for each level of the football rating scale

In table 9 more detail is added to explain the rationale for the scale and to carefully describe the rules for each standard, i.e. of a red card (or multiple yellows), a solid performance and man-of the match. Serious violations of the rules of the game bring disciplinary action. Violations can either be major, for example a bad foul, resulting in a red card or several less serious violations resulting in one or more one yellow cards. Sometimes things happen, and it is hard to make a decision at the time and the video referees look at the performance and decide whether the violation was minor or was in fact more serious than first thought. If it was serious then disciplinary action is recommended. Finally the man of the match is awarded to players who have given a great performance in a number of important areas.

What has this got to do with the clinical rating of Junior Doctors? The principles of assessment are the same, but the context is different. Let us take an example. Consider a doctor who ignores supervision requirements and contributes to a near fatal mishap. They may get the equivalent of a red card and be investigated as part of disciplinary procedures, with remedial action to follow if appropriate. In another example, a doctor who is abusive to nursing staff might get a yellow card and if this behaviour is persistent they may accumulate several yellow cards which would result in them getting a red card. That doctor also goes through to disciplinary procedures. Consider a less clear cut case, for example a doctor who is persistently late, off hand with patients, and doesn't write up records. This situation may require a more detailed investigation of his/her performance to gather the evidence that this is a clearly underperforming doctor who needs performance management (IPAP) or one who has been sloppy and just needs feedback and review.

### More Guidance on Standard Setting and Decision Making

So applying these basic principles to the Assessment of Junior Doctors brings us to Table 10. This is a matrix that is designed to help Supervisors in applying the standards of the ACF to the Junior Doctors they are responsible for. However where Junior Doctors are rated "borderline" or "clearly below expected standards", reference to the full version of the ACF is recommended to inform both the feedback to the Junior Doctor and a written justification to the DCT and other key senior management.

## Assessing Junior Doctors

<b>Junior Doctor Assessment Standards</b>			
<b>Clearly Below Expected level.</b>	<b>Borderline</b>	<b>Meets Expected Level</b>	<b>Much better than expected level</b>
<i>Sports performance equivalent</i>			
<i>Red Card or Multiple Yellows</i>	<i>Video Referee- more information</i>	<i>Applaud a solid performance</i>	<i>Man-of-the-match</i>
<i>One Serious violation or several less serious violations of the code rules</i>	<i>Didn't see it, so not sure and need more information to decide whether serious or not</i>	<i>A reasonable effort in the circumstances</i>	<i>A prize or other recognition of a job very well done</i>
<b>Junior Doctor Assessment Criteria</b>			
An isolated serious incident or several examples of significant under-performance in one or more areas of the ACF.	Significant concerns have been raised about under-performance in one or more areas of the ACF. More information is required from a number of sources to make a decision. Could meet the expected level with remediation and an IPAP	Demonstrates appropriate behaviours in each of the areas of the ACF.	In addition to the expected level demonstrates superior or exemplary behaviour in several areas of performance.
<b>Examples of performance at each standard level</b>			
For example, ignores supervision requirements and goes beyond limits of competence and e.g. significantly compromises patient safety. There may be several areas of significant omissions concerning communication with patients and staff including abuse and aggression. IPAP may be one course of action in consultation with DCT.	For example reports of patient concern over examination skills, or nurse reports of poor technique in basic technical skills. Further monitoring of the Junior Doctor and a remediation plan using the IPAP is required to meet expected standards.	The majority of Junior Doctors will fall into this area. Targeted feedback will acknowledge areas they are doing well and give them some areas to improve.	For example, demonstrates superior time management skills, a superior standard of professional practice, or is a role model for ethical practice. These doctors will also benefit from constructive feedback on developing areas of excellence.

Table 10: A matrix for guiding assessors to make decisions on the performance of Junior Doctors in clinical management, communication and professionalism

## 6. CASE SCENARIOS

It is useful to practice on some cases before going “live” on the real thing (a lesson from teaching a clinical skill). The following scenarios are designed to illustrate some of the challenges to assessing Junior Doctors that might come up. These can be used for reflection by the reader, be the basis of group discussion or role plays with a facilitator.

### Case Scenario One

A Junior Doctor has had good reports from patients and staff about his/her performance. However he/she was involved in a root cause analysis for an adverse event during the term. The incident involved the ordering of two units of blood on receiving notification early in the morning about a patient who had had abdominal surgery. The analysis determined that criteria for the giving of blood had not been met, and that Junior Doctor needed to be more aware of the criteria. The patient had recovered and appeared satisfied with the explanation at Open Disclosure. You are considering their end of term assessment. How would you deal with this?

Figure 1 Case scenario 1: an adverse event

#### *Points to consider*

This is a doctor who has performed at the expected standard across all of the domains but has appeared to have made a single mistake. This occurred on a single occasion that you know of. It was fully investigated by the hospital and the patient was fully informed of what happened. The doctor appears to have been performing to the expected standard since the event. Although patient safety wisdom might be that such mistakes are an issue of system failure, doctors can be very sensitive to perceptions of having made a mistake. Yet patient safety is paramount.

### Case Scenario Two

A mature aged PGY1 has been late on several occasions in the mornings over the previous four weeks. The nursing staff say they have had to ring him to chase him up. He is popular with staff and patients. His wife has just had their third child and the family needs more of his attention. It is now the mid term assessment. How would you deal with this?

Figure 2 Case scenario 2: looking after the family

#### *Points to consider*

The issue here is the mature Junior Doctor with family commitments. It is important to gather more information from staff, both medical and nursing to determine the extent of the problem. Is safe patient care being compromised? Are there other examples of behaviour of a similar nature? It is important to hear the story of the Junior Doctor. Is this a short term situation secondary to family? Are there longer term issues of time management? Whilst the Supervisor might expect to mark as “Borderline,” for professional behaviours, constructive feedback needs to be given to ensure the JMO know what he needs to do to turn things around in terms of time management and professional responsibility.

### Case Scenario Three

A junior doctor is having difficulties earning respect in his/her team. In summarising emergency cases to the registrar he/she has on several occasions omitted significant parts of the history. Nursing staff have suggested his/her examination technique can be rough at times. On ward rounds he/she has often appeared to have incomplete knowledge of the investigations of patients under his/her care.

Figure 3 Things are not going well

#### *Points to consider*

This doctor appears to have global deficiencies, but have not so far resulted in any tangible compromise to safe patient care. You have several reports from multiple sources of concerns that the doctor is failing to perform at the expected level. The key requirement in this scenario is to ensure documentary evidence has been collected about the doctor's performance. It is important to interview the doctor and ask him/her how he/she thinks they are going. It is then important to give the feedback about your concerns and to initiate a plan for how the doctor may improve their performance. More formally an IPAP should be commenced and documentation started tracking the performance against the IPAP. There are a number of other people who must be informed.

## 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 assessment<sup>1</sup> 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 increases<sup>2</sup>.

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.

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<sup>1</sup> WFME Global Standards for Quality Improvement, WFME, 2003

<sup>2</sup> 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 behaviour 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"> <li>• History and examination</li> <li>• Assessment and prioritisation of treatment plan</li> <li>• Ongoing management</li> <li>• Recognition of patient safety</li> <li>• Documentation</li> </ul> <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"> <li>• History and examination</li> <li>• Assessment and prioritisation of treatment plan</li> <li>• Ongoing management</li> <li>• Recognition of patient safety</li> <li>• Documentation</li> </ul> <p>Variable recognition of own limitations</p> <p>Skills and procedures;</p> <ul style="list-style-type: none"> <li>• Some skills need substantial supervision (others don't) OR</li> <li>• require more supervision than expected</li> </ul>	<p>Adequate performances in most clinical interactions in urgent and non-urgent settings including:</p> <ul style="list-style-type: none"> <li>• History and examination</li> <li>• Assessment and prioritisation of treatment plan</li> <li>• Ongoing management</li> <li>• Recognition of patient safety</li> <li>• Documentation</li> </ul> <p>Recognition of own limitations</p> <p>Skills and procedures appropriate to location/setting</p>	<p>As per the expected level. Additionally there is exceptional performance in most clinical interactions in urgent and non-urgent settings including:</p> <ul style="list-style-type: none"> <li>• History and examination</li> <li>• Assessment and prioritisation of treatment plan</li> <li>• Ongoing management</li> <li>• Recognition of patient safety</li> <li>• Documentation</li> </ul>

## Communication

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

## Professional Behaviours

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