What should be in an early safety assessment? Lessons from the experts and RTO experience

FINAL RESEARCH REPORT

ASSOC PROF JILL BENSON AM
DR AMELIA WOODS
DR TARYN ELLIOTT
MS MICHELLE PITOT

In partnership with

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1. Executive summary

Aims and objectives

Assessing

period of supernumerary practice or closer supervision should be; how should a 'diagnosis'of a flag be made and remedied; and does an ESA and suitable remediation mean the doctor is safer in the long-term.

2. Background

The RACGP Standards for General Practice require that registrars practise within the scope of their competence to minimise threats to the safety of patients, themselves and other practitioners, the practice, and the profession. Since registrars are in a training program, it follows that their scope of competence, and awareness of this, will be less than that of Fellowed GPs. Training programs, in collaboration with practices, therefore have the responsibility to assess registrars' competence and provide guidance on how to address any gaps identified in order to ensure the registrar is practising safely.

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meaning registrar practice becomes less safe. Additionally, the provision of a list as a resource does not necessarily make it an assessment of trainee's safety, and the lack of formal monitoring of registrars' safety and how they address the supervision requirements for the items on the list, remains uncontrolled in many RTOs.

Moreover, in designing an ESA it is important to consider how safety should be assessed. While Wearne et al (Wearne 2018) proposed that, as part of the selection of GP registrars, a clinical knowledge assessment may be included so as to highlight the gaps that need addressing, this is unlikely to be adequate. Magin et al (Magin 20ygh20

5.6 Data collection

The semi-structured interviews were recorded and transcripts transferred securely to a professional transcription service. De-identified transcripts are held in secure, password-protected computers at GPEx and Flinders University with access only by the project team.

Table 1, below, outlines the mapping of the research methodology against the research questions.

Table 1: Research metholodogy mapped against the research questions

Research Question

higher failure rate. Some RTOs monitor registrars throughout their training with further MCQs, including an additional assessment in GPT1 as a comparison to their pre-training MCQ.

6.1.3 OSCE-style workshop

The OSCE-style workshop achieved consensus from the Delphi experts, but not all RTOs were familiar with OSCE-style workshops of common GP problems. For those who use them either at orientation or very early on in training, it is a potent assessment for identifying registrars who might struggle with general practice or who have specific knowledge gaps. Registrars are given qualitative feedback about their performance on the day. The OSCE stations are run by MEs, and involve simulation of common general practice scenarios such as hypertension, diabetes, early pregnancy bleeding, drivers licence assessment, immunisation, mental health, non-cardiac chest pain, paediatrics etc. Assessment involves how much supervision they might need for a similar case in real life, as well as communication style, consultation skills, cultural awareness, safety netting, professionalism etc. The development of a differential diagnosis, dealing with uncertainty and when to ask for help can also be assessed. During the workshop day a significantly struggling registrar is likely to be flagged by multiple MEs at different stations. At the discussion meeting at the end of the day, when the MEs reconvene to discuss the registrars' performance, they may see certain registrars have been flagged several times.

Along with the self-assessment tool, their supervisor in GPT1 will see the feedback from this workshop and work together with the registrar and possibly the ME to develop a learning plan.

> *"I will maintain that the early OSCE-style workshop is extremely helpful as part of an ESA. It gives further assessment information from medical educators who do not necessarily know the registrar beforehand, and are objective assessors. It allows standardisation of cases and situations, and benchmarking of registrars to their peers. In my experience the OSCE-style workshop reinforces feedback received in other direct observation assessments, and leads to some registrars being flagged who otherwise would not have been."*

It can also give the registrar more confidence as they have been 'exposed' to general practice issues that they may not have previously seen in a hospital environment.

> *"I think the OSCE workshop gives registrars lots of confidence for their first day in general practice as well. Like, for registrars that haven't spent time in general practice, I think at the end of that workshop, they feel much more like they know what they're going to expect to see, what their day is going to look like on their first day".*

6.1.4 Self

throughout training. The aim of this is to generate discussions with the registrar about learning needs, which can not only identify gaps in knowledge or practice, but can also assist in identifying the over-confident or 'unconsciously incompetent' registrar.

6.1.5 Multisource Feedback (MSF)

The use of MSF in the assessment of safety early in GP training did not reach consensus in the Delphi rounds. Some RTOs use MSF as part of their ESA, as well as at other times in training. An a7 rainth .2 / (r)-2.8 (a)3 (n)2.3(1)-37 asr

The Delphi participants agreed that there should be a period of time at the beginning of the registrar's first community placement which should be completely supernumerary, when the income for the registrar is paid for

6.2 What should be included in an ESA and how should this inform registrar flagging?

This research question was answered from the outcome of the RTO document analysis and Delphi consensus.

Table 2: Inclusions for an Early Safety Assessment

Early Safety Assessment Inclusions	
Prior to registrar community placement or at Orientation	• MCQ • OSCE-style workshop • Self-evaluation questionnaire about the level of supervision required in various topic areas • Training of supervisors in early safety assessment

Early Safety Assessment Inclusions

- A minimum of 4 patients needs to be observed during the ME/external clinical teacher observation assessment but it's important to note the content and complexity of the consultations.
  This should be between weeks 4 and 12.
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Registrar's dedicated medical educator
Training co-ordinator
Flagging and remediation committee

- Registrars should remain fl5.32 30iC-3.1 (d) Tf-18.13 -1.272 Td<3 (ld).2 (fl2.9 (raril)2.3 (d)24.5 ()2.2 a8288 55dP (la)2. 26.5000e<3 (ld

6.3 What criteria are used for flagging in each RTO, how many registrars are flagged in each domain, and is this similar or different across RTOs?

In order to answer this question, the criteria for flagging were collected from each participating RTO from the interviews with the DoTs and from the GPT1 flagging data submitted by the RTOs. The data collected showed: how many registrars were flagged, when they were flagged, how they were flagged, by whom, and why they were flagged. Given the small sample size of flagged registrars, no inferential statistical analyses were conducted.

Flagging is generally defined as a process for identifying those registrars who need more input and support in order to complete their training as safe, effective, independent, self-reflective GPs (Prentice 2021). The formal criteria that each RTO uses for flagging obvi2.6 (o)1.3 (e) (o)-6.64l0.5 (e).1 (2)-4.9 (11.)-3pinen (s)-1.3 (i2.6 (-1.3 (i-(n)2.3(

formative and low stakes assessments, especially when assessing learning needs and safety. For busy

Lack of engagement and compliance with educational activities is often one of the most important pointers to deeper issues that will lead to the flagging of a registrar. This could be by the administration staff at the RTO (training coordinators) and involves a formal escalation pathway to the supervisor, ME, flagging committee or DoT. All RTOs had a process for training coordinators to flag registrars because of compliance or behavioural issues, though this is not usually a formal part of an ESA.

Professionalism is another example of an important flag, but is much more difficult to formally assess. One DoT stated that:

All RTOs acknowledge that supervisors can also flag registrars separately from the specific assessments. Training coordinators and practice managers can bring struggling registrars to the RTO's attention as well. This might be for issues such as professional issues, behavioural issues, extended leave, or punctuality. Those RTOs that used formal Multi-Source Feedback (MSF) as part of their ESA, had not seen any registrars flagged purely via this formal process, but did have informal flagging occur from other sources.

Programmatic assessment goes some way towards addressing the issue of informal flagging:

> *"But when you add up all the elements of, oh, they've been given a chance here and given a chance here and given a chance here, then you're like, well, you told them that feedback four weeks ago. I saw them do the same thing again today. Then that paints a picture."*

6.3.3 Flagging data

As expected from the above discussion, the data from each RTO differed markedly from the others. The percentage of registrars who were flagged varied from 9.7% to 13.6%. A total of 74 of the 650 registrars who were part of this data collection (11.4%) were flagged - 46 (62%) as 'watch' or amber flags, and 28 (38%) as active flags. How many flags were 'watch' and how many 'active' differed across the data, with one RTO having 70% of the flags with some specific activity assoc

all of these factors, we ultimately decided that we could not answer this question. The decision was discussed with the Steering Group and it was agreed that this could not be included in the final report. The Delphi

Supervisors

RTOs need to select practices that have 'good' supervisors and processes, and then ensure that the supervisor feels that their assessment is respected. The supervisor is expected to sign off on an ESA as they are actually the ones who know the registrar the best. However in many busy practices, the supervisor may not have been able to spend enough time with the registrar, and their assessment may not be a realistic assessment of the registrar's safety. Such 'failure to fail' can also occur for a myriad of other reasons such as the supervisor wanting to be 'kind' or thinking they will 'get better with time'.

Supervisors will also need time and training (preferably in small groups) if assessments or processes are going to change. For example in one RTO where assessments changed from a grid with expected levels of competency to EPAs:

> *"with the EPAs, was the idea of assessing someone against fellowship standard rather than against their stage of training. So, the idea of saying to your GP1 registrar that they were below the standard expected of a fellow, they found that really difficult. In reality, that's what GPT hat(w)-5.4ful singed f fl(f)2. (i)-2.Cunowou2-3.3 (a e(DC -2.457 -1.217 Td 5)TjEMC 216 417.3 (l)-2.2BDC -2.457 -1.217 Td 6*

6.6.2 Enablers

also include such issues as: the relationship between the supervisor and registrar; support so that supervisors do not 'fail to fail'; ensuring there is adequate time for direct observations, teaching and mentoring to take place; how and why registrars are flagged etc. The hallmark of a successful ESA is where communication between all parties aids the registrar in understanding and communicating their gaps, that there is adequate support and processes in place to assist them to address those gaps, and that they develop skills in assessing and facilitating patient safety into the future.

2. Prior to commencement
   Before the registrar begins their community placement, an MCQ and self-assessment will help guide the registrar, supervisor and ME about where their gaps are. A call for help list and education plan can be developed based on these parameters and a standardised template.
3. The first 4 weeks
   This time will be tailored to the needs of the registrar, their gaps and competency, and the context of the practice. There should be 1-2 weeks of supernumerary practice when the registrar and supervisor are paid separately from their practice or Medicare billing. This will be for orientation, relationship building, shared consultations between the registrar and supervisor, discussion about the call for help list etc. Communication strategies should be established during this time.
   In the first 2-4 weeks the supervisor should review each patient seen by the registrar – initially before the patient leaves the practice, and then at the end of the day.
   The supervisor should pay particular attention to whether the registrar is asking for help appropriately.
4. Assessments
   It is recommended that the following assessments are undertaken:
   1. Knowledge oriented MCQ and self-assessment prior to commencing community practice.
   2. Supervisor direct observation before week 2, at least the equivalent of one session.
   3. ME/ECT direct observation between weeks 4 and 12 with a minimum of 4 patient consults.
   4. Global assessment triangulating information from a variety of sources.
5. Supervisors
   The supervisor should have easy access to the relevant process documentation and templates including: the high risk/call for help list, parameters for flagging, the diagnostic frameworks for flagged registrars, the processes for direct observation, random case analysis and case-based discussions, and how a global assessment can be made. It is important that IT support is provided, if

9. References

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