Calgary Residency Program
Progress Review Report

Resident: Date:
Primary Preceptor:

Preceptor Completing Report (if different from Primary Preceptor):

Reporting Period: to

Start Date of Focused Learning Plan if Initiated:

PART 1: Preparation ahead of meeting

PRECEPTOR

Review the following data provided:

1. the number of assessments since the last progress review meeting;
2. the assessments included for the period covered;
3. any Focused Learning Plan (FLP) that is currently active and
4. the Resident’s Informed Self-Assessment of the progress form (iSAP).

The Resident is responsible for completing Part A of this form i) to iv), and for submitting this to you at least 1 week ahead of the meeting along with their completed iSAP and the top copies of ALL field notes up until the end of each identified 4 block period.

The Program will send you copies of all completed ITER’s, PCSF’s, 8-wk mid-term Reports, the last Progress Report you completed, and any other assessment data available (e.g. MSF and PSQ summaries) for your Resident over the 4 block period being reviewed.

In reviewing your Resident’s submission, comment in Part A of the report on the Resident’s learning and progress since the last progress review in relation to the 6 skill dimensions (patient-centered approach; communication skills; professionalism; clinical reasoning; selectivity and procedural skills), the learning objectives for any Focused Learning Plan (FLP) that is in place and review the adequacy of assessments covering the phases of the clinical encounter and the Domains of Clinical Care (DOCC).

Please also make a note about any questions you wish to ask the Resident at the time of the meeting.

The Resident is presenting evidence through their portfolio of progress made since the last review, including evidence of having met the learning objectives of any FLP.

Wherever possible, link your comments and questions to specific assessments you have reviewed in the portfolio (note: no additional information can be considered at the meeting once the portfolio has been reviewed by the Preceptor, except any new completed ITER’s).

RESIDENT

At least 1 week ahead of the 4 month progress review meeting:

1. Complete and submit your iSAP (informed self-assessment of progress)
2. Complete Part A i) to iv) of this form
3. Submit the top copies of all field notes and DOPs forms for the 4 block period being reviewed.
**Assessment elements and data over the last 4 blocks**

i) Adequacy of number and **skill domains** covered by submitted field notes since last progress review meeting

<table>
<thead>
<tr>
<th>Skill domain</th>
<th>Number of Field notes or DOPs forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Patient centered approach</td>
<td></td>
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<tr>
<td>2 - Communication skills</td>
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<tr>
<td>3 - Professionalism</td>
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<tr>
<td>4 - Clinical Reasoning Skills</td>
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<tr>
<td>5 - Selectivity</td>
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<tr>
<td>6 - Procedures (DOPs)</td>
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</table>

ii) Adequacy of number and **phases of clinical encounter** covered by submitted field notes since last progress review meeting

<table>
<thead>
<tr>
<th>Phase of clinical encounter</th>
<th>Number of Field notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - History</td>
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<tr>
<td>B - Physical</td>
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<tr>
<td>C - Hypothesis</td>
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<tr>
<td>D - Diagnosis</td>
<td></td>
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<tr>
<td>E - Investigation</td>
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<tr>
<td>F - Management and treatment</td>
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<tr>
<td>G - Follow-up</td>
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<tr>
<td>H - Referral</td>
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iii) Number of field notes by **domain of clinical care** field since last progress review meeting

<table>
<thead>
<tr>
<th>Domain of clinical care (DOCC)</th>
<th>Number of field notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Maternity Care and Care of newborn (including intrapartum care field notes)</td>
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<tr>
<td>2 - Care of the child and adolescent</td>
<td></td>
</tr>
<tr>
<td>3 - Care of the adult</td>
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<tr>
<td>4 - Care of the elderly</td>
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<tr>
<td>5 - Palliative Care and end of life care</td>
<td></td>
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<tr>
<td>6 - Behavioural Medicine &amp; Mental health</td>
<td></td>
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<tr>
<td>7 - Care of indigenous populations</td>
<td></td>
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<tr>
<td>8 - Care of vulnerable and underserved populations</td>
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</tbody>
</table>

iv) Number of **other assessment** elements submitted since last progress review meeting

<table>
<thead>
<tr>
<th>Assessment element</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITER’s</td>
<td></td>
</tr>
<tr>
<td>PCSF</td>
<td></td>
</tr>
<tr>
<td>Multi-Source Feedback (MSF)</td>
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<tr>
<td>Patient Survey Questionnaire (PSQ)</td>
<td></td>
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<tr>
<td>US Family Practice Board Exam results (optional) – Block 8 PGY1 and PGY2</td>
<td></td>
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</tbody>
</table>
v) Notes on samples of assessments submitted and reviewed by you – relate your comments and questions to specific assessment data in the portfolio. If the Resident is on a Focused Learning Plan (FLP), ensure you also review the assessment elements looking for evidence that the Resident has met the listed learning objectives.

**Please write legibly.

<table>
<thead>
<tr>
<th>Assessment element</th>
<th>Comments/Questions for meeting</th>
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</thead>
<tbody>
<tr>
<td>General comments including specific questions for meeting</td>
<td></td>
</tr>
<tr>
<td>Patient-centered approach (Field notes; ITER’s, PSQ, PCSFs)</td>
<td></td>
</tr>
<tr>
<td>Communication skills (Field notes; ITER’s; PSQ; MSF, PCSFs)</td>
<td></td>
</tr>
<tr>
<td>Professionalism (Field notes; ITER’s; MSF)</td>
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</tr>
<tr>
<td>Assessment element</td>
<td>Comments/Questions for meeting</td>
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<tr>
<td>-------------------------------------</td>
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<tr>
<td>Clinical reasoning (Field notes; ITER’s; MSF)</td>
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</tr>
<tr>
<td>Selectivity (Field notes; ITER’s)</td>
<td></td>
</tr>
<tr>
<td>Procedural skills (DOPs forms; Procedures Log Book; ITER’s)</td>
<td></td>
</tr>
</tbody>
</table>
vi) Notes on review of informed self-assessment of progress (iSAP) form.

Based on review of this Resident’s portfolio, do you feel they are accurate in their informed self-assessment in terms of learning and progress since the last progress review?

Comment on any areas of concern or divergence that you have identified and wish to explore with the Resident at the time of the meeting.
PART 2: At the meeting – Guidance for Preceptor on how to run a Progress Review meeting

Part A: GOAL – Engage the Resident and build comfort with the feedback process.

1. Introduction to the goals for this session and the process that will be followed:

   GOAL: “Discuss your sense of how you are performing, provide opportunities to discuss improvement and come to consensus regarding progress across the skill dimensions, clinical domains, and the level of performance based on entrustable professional activities (“EPA’s”) for your stage of training.”

   PROCESS: Explain how the session is structured, the frequency of the process and expectations of the review. (These two issues will only need to be explored in the first session)

   - Inform the Resident that you have already reviewed their portfolio and the completed informed self-assessment of progress (iSAP) form.
   - The discussion will begin with the Resident’s overview and then proceed to a review of your summation.
   - The focus is on identifying areas that relate to concerns about the Resident’s learning and to develop approaches to address these issues
   - You would also like to know if there are any issues relating to intimidation, harassment or discrimination.

Issues/concerns (raised by Resident):

SELF REVIEW:

   - How did they find the process of completing the review and iSAP form? What challenges did it pose, what opportunities did it present?
   - Move to the specifics of their review & in particular their iSAP
     - Are there areas for which they have inadequate information (need to get more field notes in a specific domain)
     - Ask them to highlight areas in the portfolio that were surprising or of most concern. Where do they see the gaps in their performance?

YOUR REVIEW:

   - Work through your comments and questions from Part 1.iv) above, and agree on any areas of concern requiring focused work and development. Also identify for the Resident areas of more significant performance deficiency.
   - Where possible link your discussion with the Resident to their iSAP to help the Resident identify divergence and to consider why this might be the case.
Part B: GOAL – Explore reactions to and perceptions of feedback

Check with the Resident that your comments and feedback are credible and understood.

- Clarify anything that is unclear
- Questions to consider (if needed):
  - What does the feedback mean to you?
  - What is the biggest surprise?
  - What parts fit and any parts that did not?

If feedback is discordant with their own view, consider use of the ECO model

Questions & comments to consider:

- “It sounds like this feedback was a surprise to you. Can you tell me more about that?”
- “Most people find it tough when they first receive feedback that differs from their own perceptions.”
- “Because it’s a surprise it often takes a little while to adjust to it.”
- “We all think we’re doing our best and it’s hard when others give us a different view.”
- “Are there specific aspects of it that are difficult for you? Tell me about them.”

Part C: GOAL – Explore interpretation of feedback content

1. Complete the EPA grid (below) based on your review of the portfolio, your own observations of the Resident, and your discussion with the Resident today. (See “Help with deciding on EPA level” on pg. 9

2. Discuss with the Resident the EPA supervision levels and explain how and why you made your decision about each, based on your review of the Resident’s performance over the last 4 months, including reference to the following additional factors that must also be considered when deciding about maintaining and especially reducing your level of supervision for a particular EPA:

   - Trustworthiness (of the Resident and those who have contributed to the Resident’s assessment)
   - Conscientiousness
   - Discernment (ability to self-recognize when they need help and willingness to ask for it even in uncomfortable learning settings)
   - Safe assessment and management of several patients in the relevant EPA category (“several” = enough that I as a Preceptor can be confident that this Resident will safely handle the next patient in this category such that I can reduce my supervision by one level)
   - This is the level of supervision that will maximize this Resident’s learning

3. Complete the “Recommendation” statement choosing from one of the following 3 options:

   - “Focused attention needed (FAN)” – Preceptor and Resident together complete Focused Learning Plan (FLP), either at the time of meeting, or very soon after (within 1 week). This may or may not involve the Division Director and/or the Associate Program Director (remediation).
   - “Refer to Resident Progress Sub-Committee (RPS)” – summarize reasons for this with Resident.

If the Resident has been on a Focused Learning Plan, review the objectives and decide if the Resident has met these objectives.
Part D: GOAL – Coaching for performance change – To engage in ‘change talk’ and develop an action plan that is achievable.

The goal now is to have "change talk" out on the table and to summarize that in a constructive way that enhances the person’s commitment to take action. This stage combines principles of motivational interviewing with evidence of the domains influencing behaviour change.

- If “on track” – Develop learning objectives and update learning plan in progress report.

- If “focused attention needed” – Work on developing a Focused learning Plan (FLP)
  This plan may include others but should at least begin with discussion in this setting;
  - “What is the most compelling goal/issue to work on”?
  - “What actions would you take to achieve that goal”?
  - “How ready are you to do this”?
  - “What factors might enable this change, what might get in the way”?
  - “What resources might you need to draw on”?

- Complete report to be signed by both parties.

(Special thanks to University of Alberta and University of Ottawa Family Medicine Residency Programs for their help in developing this process)
## EPA GRID

<table>
<thead>
<tr>
<th>Expected level of supervision</th>
<th>Compare for this Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of 5 blocks (R1)</td>
<td>End of 9 blocks (R1)</td>
</tr>
<tr>
<td>End of 13 blocks (R1)</td>
<td>End of 17 blocks (R2 blocks 1-4)</td>
</tr>
<tr>
<td>End of 21 blocks (R2 Blocks 5-8)</td>
<td>End of 26 blocks (R2 blocks 9-13)</td>
</tr>
</tbody>
</table>

1. Assess, manage, and follow-up patients with common presenting complaints and undifferentiated symptoms.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

2. Recognize and appropriately refer for emergent conditions.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 3  
   - End of 13 blocks (R1): 4  
   - End of 17 blocks (R2 blocks 1-4): 4  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 3  
   - End of 13 blocks (R1): 4  
   - End of 17 blocks (R2 blocks 1-4): 4  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

5. Manage and follow-up patients with common chronic conditions.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

6. Care for pregnant patients throughout pregnancy.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

7. Manage postpartum mothers and their newborns in the first few weeks of life.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

8. Manage the elderly patient with multiple co-morbidities.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

9. Identify diagnose and manage common mental health symptoms and disorders.  
   - End of 5 blocks (R1): 2  
   - End of 9 blocks (R1): 2  
   - End of 13 blocks (R1): 3  
   - End of 17 blocks (R2 blocks 1-4): 3  
   - End of 21 blocks (R2 Blocks 5-8): 4  
   - End of 26 blocks (R2 blocks 9-13): 4

10. Care for underserved populations.  
    - End of 5 blocks (R1): 2  
    - End of 9 blocks (R1): 2  
    - End of 13 blocks (R1): 3  
    - End of 17 blocks (R2 blocks 1-4): 3  
    - End of 21 blocks (R2 Blocks 5-8): 4  
    - End of 26 blocks (R2 blocks 9-13): 4

11. Demonstrate general key features for procedural skills  
    - End of 5 blocks (R1): 2  
    - End of 9 blocks (R1): 3  
    - End of 13 blocks (R1): 4  
    - End of 17 blocks (R2 blocks 1-4): 4  
    - End of 21 blocks (R2 Blocks 5-8): 4  
    - End of 26 blocks (R2 blocks 9-13): 4
HELP WITH DECIDING ON SUPERVISION LEVEL:

Notes on Expanded Levels of Supervision (built on those originally defined by Ten Cate & Scheele):

- **Level 1** – has acquired knowledge and skills, but insufficient to perform. May observe a more senior learner or preceptor, but is not allowed to perform the activity themselves.

- **Level 2** – may perform an activity under full, proactive supervision: the supervisor decides about the intensity of supervision. The preceptor must also assess the patient in one of the following ways:
  - by observing the interaction between the resident and patient (directly in the examining room or by video monitor);
  - or by interacting directly with the patient, e.g., repeating or supplementing parts to the history and/or physical examination;
  - or by first hearing the resident’s case presentation and then seeing the patient.

- **Level 3** – may perform an activity under qualified, reactive supervision: the Resident asks for the supervision. This assumes that the preceptor is comfortable with the Resident’s ability to judge their need for assistance. (If not, the Resident is at Level 2.)

- **Level 4** – may perform an activity with “back stage” supervision, ie. case discussion or chart review at the end of the day. This is threshold of competence. Once this level is reached, the activity may be safely entrusted to the resident – ie. Independent practice.

- **Level 5** – may provide supervision to others, i.e., is functioning at least at level 4, and has sufficient skill and experience to teach and supervise more junior learners.

In deciding on maintaining a supervision level for a listed EPA or when considering reducing a level of supervision and especially when deciding if the required competency level for graduation has been achieved (EPA level 4 or 5), the following factors must also be considered in the decision-making process around this-

1. Personal Attributes

   - **Trustworthiness** (of the Resident and those who have contributed to the Resident’s assessment). For the Resident-You can trust that what they said or recorded are accurate reflections of what they actually did. They are honest about their confusion or lack of knowledge. They do not modify their presentations simply to impress you.

   - **Conscientiousness**. The Resident goes the extra mile for patients when necessary and takes responsibility for their actions. The Resident does not cut corners in ways that might compromise patient welfare. The Resident is effective at “self-directed assessment seeking”.

   - **Discernment** (ability of the Resident to recognize when they need help and willingness to ask for it even in uncomfortable learning settings). The Resident is aware of their limits and when they need help and will take appropriate steps to get assistance, demonstrating a degree of vulnerability in so doing. Patient welfare is their first concern and is more important than “looking good” in the eyes of a supervisor. The Resident is aware of their personal beliefs, attitudes and emotions that may impair their judgment.
2. Basic Clinical Skills

- Interviewing, history taking, physical examination, clinical reasoning, record-keeping and case presentation skills. Safe assessment and management of several patients in the relevant EPA category (“several” = enough that I as a Preceptor can be confident that this Resident will safely handle the next patient in this category such that I can reduce my supervision by one level)

3. Content and Context

- The Resident must demonstrate ability across a range of presentations in each EPA category such that once the Preceptor has seen a Resident perform well in managing several patients with a range of conditions, it is reasonable to assume that they will do well with the next patient. This will be based on evidence of the Resident’s applied knowledge and skills and how transferable this might be to different settings. Often this will reference the CFPC priority topics, their key features, the phases of the clinical encounter and the skill dimensions.

- Other context factors to consider when deciding on supervision levels include - the seriousness of any patient’s condition, the complexity of multiple co-morbidities, challenging behavioral or social factors, the clinical environment in which the supervision occurs, and the experience of the Preceptor.

- This is the level of supervision the Preceptor believes will maximize this Resident’s learning.

- **Note:** At all levels, if the patient requests to also be seen by the preceptor, then this request should be honoured. Also, no matter what the level the resident is capable of, the preceptor may choose to see patients to maintain their relationship with the patient or to reassure patients that their care is being carefully monitored.
PART 3: At the end of the meeting – Recommendation

Based on review of the elements submitted in the learning portfolio, including the Resident’s Focused Learning Plan (where appropriate), the Resident’s self-assessment, my own observations, and today’s discussion, I recommend that the Resident:

<table>
<thead>
<tr>
<th>Check (√) Category</th>
<th></th>
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<tbody>
<tr>
<td><strong>Is on track.</strong> (Set new learning objectives for next 4 months)</td>
<td></td>
</tr>
<tr>
<td><strong>Has some identified areas where focused attention is needed.</strong> Write a Focused Learning Plan (FLP) with Resident using template, either at meeting or within one week (if the Resident has already been on a FLP, this requires the writing of a new FLP).</td>
<td></td>
</tr>
<tr>
<td><strong>Be referred to the Resident Progress Sub-Committee (RPS) for review</strong> due to identified areas of significant concern around performance (summarize areas of concern below).</td>
<td></td>
</tr>
</tbody>
</table>

1) Summarize areas of strength and any areas of concern. If “on track” use this space to update learning objectives for the next 4 months based on your discussion around Goal D above.
**RESIDENT:** I agree / disagree with the recommendations made. If you disagree, please provide reasons:

Comments/questions

Resident signature: ___________________________ Date: ___________________________
Primary Preceptor signature: ___________________________ Date: ___________________________
Division Director signature: ___________________________ Date: ___________________________

Please submit this report, as well as the top copies of the Field Notes and iSAP form, **AS SOON AS COMPLETED** to your Program Coordinator:

Northwest: Joy Hodgson, Sheldon Chumir
Northeast: Christine Serpico, Sunridge
South: Tannis Dorscht, South Health Campus