Ready, Set, Go: Setting up and running your competence committee
April 21st, 2021, 11-1230 EST Twitter #CC_ChairsForum

Please please please read the Royal College Competence Committee Technical Guide **here** in advance of the session. Additional documents related to this session can be found on our shared Google Drive **here**.

Possible questions (FAQ) and suggested responses compiled largely from the CC technical guide and RCPSC Website:

1. **What is the difference between the roles of the Competence Committee (CC) and the Residency Program Committee (RPC)?**
   Generally the RPC deals with program oversight, program evaluation and planning and oversight of the curriculum including training experiences/rotations and formal teaching sessions. As part of this, the RPC would manage curriculum mapping and scheduling/sequencing of rotations. In contrast, the CC is responsible for review of assessment data and recommendations regarding resident progress. However, through that role the CC may provide feedback to the RPC if training experiences are consistently not providing opportunities for assessment success or where many residents are struggling to show competence in particular EPAs. This allows the RPC to review their curriculum mapping to ensure the training experiences set the residents up for success and allows the RPC to consider if any issues need to be discussed at the national specialty committee.

2. **Can the Competence Committee have the same members as the Residency program committee (RPC)?**
   Yes with caveats. Should the competence committee be composed of some of the same members as the RPC, it is important that the minutes of both committees indicate the dual roles of members.

3. **Are there guidelines for setting up a Competence Committee?**
   The RCPSC has provided guidelines for CC terms of reference and a process and procedures document. Please check with your local CBME Lead as many schools have adapted these guidelines slightly to ensure they align with local assessment policies.

4. **Should residents be on the Competence committee?**
   Decisions regarding the role of residents members will vary based on local schools' policies and practices. Some programs may have the residents vote on whether they want a resident member as part of the committee at the beginning of each academic year. If a resident member is on the committee special attention needs to be given to mitigate the conflict of interest issues that can occur with near peer members being part of high stakes assessment recommendations.

5. **Can the program director be the chair of the competence committee?**

Generally we recommend against it. Both are big jobs and likely it is too much for one person to do both well. In addition, in many schools the assessment policies do not align with having someone make a high stakes assessment recommendation to themselves which would be the case if the chair of the competence committee was the program director, who is also the chair of the residency program committee. However it is very helpful to have the program director as a member of the competence committee to facilitate communication within the program and provide their unique context.

6. **Can we have multiple competence committees?**
   Yes but there are caveats. Each program has the prerogative to implement more than one competence committee. While this may occur more often in larger programs, such as Internal Medicine, a program does not need a minimum number of residents to form multiple committees. Each competence committee should have a holistic view of each trainee (e.g., the competence committee cannot be focused on a single rotation) and the program director should ensure consistency and communication between the committees. Examples of how this could be achieved include having the program director as a member on all competence committees and/or having sub-committee chairs active as members on each other's committees.

7. **Does the RPC need to ratify all Competence Committee meetings or just stage progressions?**
   Yes. All CC meetings. Every time the Competence Committee meets, there will be learner status decisions (e.g. progressing as expected…) and there may be additional recommendations around promotion or a learning plan etc. These recommendations must be taken to the RPC for ratification after each competence committee.
   All decisions must also be communicated to the resident after RPC ratification.

8. **Which can the competence committee make decisions on vs recommendations that need to be ratified by the RPC?**
   Competence committee decides: EPA achievement.
   RPC ratification needed: Learner status, Stage progression, Need for Learning plans/remediation, Readiness for certification exams, Readiness for unsupervised practice.

9. **Does the Competence Committee need to review and sign off on individual EPAs?**
   Yes. In addition to recommendations on resident status (progressing as expected, not progressing as expected, failing to progress, progress accelerated, etc.) and promotion decisions, the competence committee is expected to review EPAs for individual residents on a regular basis in order to decide if they can be signed off as "competent" in that EPA. This allows residents to be notified so that they can focus their subsequent feedback requests on outstanding areas. Competence committee decisions on EPA completions do not need to be ratified by the residency program committee (RPC).

10. **What do the learner status designations mean and when do I need to notify my PGME office?**
    Please see the RCPSC guidelines on learner status here.

11. **What should count as a "pass" or "achieved" for a competence committee?**
    Again, the competence committee has the autonomy to make decisions around competence, but needs evidence to back them up. A competence committee needs to use human judgement to assess competence, based on their review of not only the entrustment scores but also the breadth of contexts encountered vs expected, narrative comments, consistency of scores and other program assessments (e.g. OSCEs etc.) to ensure there is evidence of a pattern of competence.

    As far as the EPA Entrustment scores go, the goal is to find evidence of competence. While that is most easily identified with observations of "I didn't need to be there", we realize that faculty are all still learning how to use these assessments and so we need to read the narratives and look at patterns of performance to determine if the documentation is in keeping with a picture of competence. E.g. Score 4 with comment "They did a great job and I didn't add anything to the care of the patient" might be considered by the CC as evidence of competence, whereas a score of 5 with comments "The resident tells me I have to put a 5" might not be considered by the CC as evidence of competence.

    We ask that programs please not put in place blanket policies linking the achievement of competence in their EPAs to particular numeric scores, as determination of competence requires human judgement by the competence committee through comprehensive review.

    An analogy would be that we don't use numeric values alone to determine discharge of a patient (e.g. Hemoglobin = 100 so patient ready for discharge). We have to assess other aspects of context and wellness (Is the patient still actively bleeding, what is the trend, what about the living situation or co-existing issues?).

    There may be some cases in which the competence committee determines that they have enough evidence to mark an EPA as achieved for a resident who has not consistently demonstrated an entrustment rating at or near the top of the scale (e.g. 4 or 5 on the O-Score). Should this be the case, the **competence committee will be required to record justification for this decision based on the comprehensive set of information at their disposal.**

12. **Do the numbers of EPA observations in the EPA assessment guide reflect the number of observation attempts or the number of observations that show evidence that the resident is competent?**
    For the vast majority of specialties, the EPA assessment guide outlines the expected number of "achieved" EPAs with the exception of Emergency Medicine (EM) that

outlines the expected number of "observed" EPAs. EM has a higher number of expected EPAs in their guidelines due to this difference in approach. Going forward, specialty committees are writing their documents to the "number achieved" not "number observed" EPA observations.

13. **How closely do I need to follow the guidelines outlined in the EPA assessment guide for my specialty?**
    You can always ask for more evidence than the guidelines require but should document justification if you are accepting less.

    The **competence committee has the autonomy to make decisions around competence, but needs evidence to back them up.** A decision about EPA achievements must be based on the collation of multiple, documented observations that indicate to the competence committee that a resident can be entrusted to consistently complete an EPA without supervision. The discussions leading to this decision should be guided by review of the breadth of contexts expected by the specialty committee's EPA guideline document.Specialty committee recommendations on the number and context variety for the observations required to inform decision-making on EPA achievement are intended as a guide to programs. Local flexibility with good rationale is permitted. Such decisions could be due to local factors (e.g., desire to increase number of observations) or trainee factors (e.g., competence committee has competence concerns despite available observations and requests more observations to support decision making). However, programs may be asked to explain the rationale for significant and/or multiple deviations from the specialty committee suggestions during accreditation review, particularly if the committee is regularly choosing to accept a decreased number of observations.

14. **What is the difference between: "I had to be there just in case" (4) and "I didn't need to be there" (5) on the Ottawa Entrustment scale (O-score)?**
    Could the resident manage this task safely, at the stage and level of expectations described in the EPA wording, without you intervening? Give it a 5. They may not be as efficient as you, or may have completed the task differently than you, but it was done safely and correctly. It is okay (in fact it is ideal) that you may have given and documented actionable coaching feedback to facilitate their continued progression towards expertise; i.e. suggestions for future clinical opportunities to seek or alternate approaches to achieve the same endpoint.

    Do you think they were unclear about some aspects (e.g. potential risks and/or ways to manage them), resulting in the need to provide minor direction? Give it a 4.

    Ultimately, the Competence Committee will review the narrative comments and overall data to decide if the resident has demonstrated a pattern of competence in this task.

15. **Does the resident have to have completed every EPA for the stage to be promoted to the next level?**
For the most part yes. There may be rare cases in which a resident has not achieved an EPA for a given stage, but in the judgment of the competence committee, the resident is showing overall competence for that stage. Often in these cases it is recommended that the competence committee defer promoting the resident to ensure they complete the outstanding requirements before promotion. Residents may work ahead on EPAs for the next stage before promotion and so a deferral to ensure full completion of stage expectations would not slow their progress in the next stage.

The competence committee may decide to recommend that the resident be promoted to the next stage if:
 There is sufficient evidence that the resident is **on track to achieve the EPA by the next meeting of the committee**
 The **EPA is standalone**, i.e., the EPA is not a foundational task for the achievement of EPAs in the subsequent stage of training
 There is **a clear plan in place** for subsequent training experiences that will facilitate the achievement of that EPA
 The competence committee will follow up on future evidence concerning the achievement of the incomplete EPA

The competence committee would be required to record justification for this recommendation, as well as a clear plan for subsequent training experiences that will facilitate the achievement of that EPA. The requirement to achieve the EPA, as well as the plan for subsequent training experiences, must be clearly communicated with the resident.

16. **What other assessment data should the Competence Committee see/review?**
It is important that EPA observation forms are integrated with other modalities of assessment and decisions are informed by data from many sources (including EPA observations, narrative assessments, summaries of daily clinical performance, in-training tests, OSCEs, simulations sessions, etc.). Any information a program feels would be helpful, such as field notes and tools used to track residents, should be shared with the competence committee to aid in making these decisions, though it is important to note that decision-making should remain defensible and free of anecdotal information or opinions. Only information available in resident files/electronic portfolio should be discussed at the competence committee, to avoid hearsay.

Besides EPA observations, the CC should have access to any/all other assessment data that would be part of the program's expectations for assessment, e.g. ITERs, OSCEs, formal presentation assessments, written exam scores, scholarly project reviews etc.

If the program requires these assessments then they should be part of the resident's comprehensive review by the CC. Examples of things that might not be included could be personal self-reflections meant for the resident's eyes only.

17. **How do we decide if residents are senior enough to do EPA observations on other residents?**
    Generally, the principle is that the resident should have competence in the task they are observing. It is the resident's responsibility to enter a comment to explain how/why this peer observer might be competent to assess this EPA as the CC members often will not know resident observers, particularly if they are from a different program.

18. **How are learners put forward for the RC certification exam if they have not completed their core stage by the notification deadline?**
    Programs may need to make the judgement of whether a resident can be put forth for their RC exam in advance of their official stage change to TTP and the program will need to project how likely they think it will be for the resident to be ready to go to the exam. This is the same as what happened pre-CBD. If a resident turns out not to be as ready as the program thought as it gets closer to the exam the program can withdraw the resident from the exam as can happen now in pre-CBD programs.

19. **How do we ensure CCs are adopting a growth mindset?**
    This takes constant attention. Try to avoid the trap of a "problem identification" orientation in your committee rather than a "developmental" approach. What recommendations can the group provide for residents who are on track to help them improve even more? For residents who are struggling, try to keep the conversation around residents not being there ***yet***. For example, rather than "this resident is not up to standard and I don't think they're going to make it in this program..." instead "we've identified some areas where resident X is struggling to demonstrate competence, what guidance can we give for areas to focus on or for learning experiences that might support their development..."

20. **How do you ensure CCs are performing a robust review of evidence rather than cursory score checks?**
    The use of **primary reviewers** helps the committee to be efficient and guides their review but should not replace the committee's discussion or the need for them to review samples of the primary assessment data. The primary reviewer can act as a guide through the portfolio for the group highlighting representative performance and comments and also alerting the committee to outlier data. Competence committees must consider not only **EPA scores, but also context requirements, narrative comments, patterns of performance and other program assessments.**