



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

EXECUTIVE SUMMARY

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Aims and objectives

Assessing the safety of GP registrars when they first start community practice is critical for the safety of patients, the registrar themselves and also the practice in which they are working. An Early Safety Assessment (ESA) is not only about assessing current competency, or saying the registrar is safe for independent practice, but is also about whether the registrar is able to self-assess their competency limits, and seek help appropriately when required.

This project aimed to answer the following questions about Early Safety Assessments.

1. What is currently included in each RTO's ESA and why were these assessments chosen?
2. What should be included in an ESA and how should this inform flagging of registrars at risk of safety breaches?
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?
4. What is the feasibility, acceptability and cost-effectiveness of an ESA?

Method

There were three main streams in this research.

Stream1: Interviews with the Directors of Training (DoT) at four Regional Training Organisations (RTOs) about what their RTO is currently using in an ESA, what they thought should be included in an ESA and why. This then informed the questionnaire for the first round of a modified Delphi consensus. The DoTs continued on as Delphi participants along with other experts. Three rounds of Delphi questionnaires were needed to reach consensus. The DoTs were then re-interviewed about the feasibility, acceptability and cost-effectiveness of the recommendations.

Stream 2a: Documents from the three participating RTOs used in their ESAs were collected and analysed.

Stream 2b: Flagging data was analysed from participating RTOs (based on the first semester of 2021). Data showed when registrars were flagged, by whom, the reason for the flag, the seriousness of the flag and the outcome.

Information from the three streams was triangulated to inform the final recommendations.

Summary of results

The majority of participating RTOs began their ESA before the commencement of community placement, but all ESA programmes were different. However, in the final interviews there were concerns about the feasibility of beginning an ESA before training. Very early in the placement, the ESA should include a Multiple Choice Questionnaire (MCQ) (including prior to community placement), registrar self-assessment tool, an OSCE-style workshop (though the feasibility of this was questioned by the DoTs), but not a multi-source feedback before placement, nor indeed as part of the ESA at all.

Supervisors should be given templates and guides to assist them for example with orientation, building the relationship with the registrar, direct observations, random case analysis, case-based discussions, competency frameworks, high risk/call for help lists, flagging protocols and global assessments. There was consensus that there should be a period of between 1-4 weeks when the registrar is supernumerary so they can undergo orientation, and have shared consultations. In addition, there should be between 1-4 weeks, tailored to each registrar's needs, when the supervisor discusses every patient with the registrar, and the supervisor should directly observe the registrar consulting for the equivalent of at least one session before week 2.

Similarly, the Medical Educator (ME) and/or External Clinical Teacher should have guidance templates to assist with assessing a wider range of skills and issues. They should directly observe the registrar between weeks 4 and 12, of at least four patient consultations, undertake random case analysis, and have a discussion with the supervisor and practice manager.

A global assessment such as one using an EPA-style template, should triangulate information from a variety of assessments and sources to decide whether the registrar should be 'flagged' or not. A 'diagnosis' of the reason

for the flag and what the next steps might be, and how the flag will be 'signed off', should be done in collaboration between the supervisor, medical educator, remediation committee and/or DoT depending on the severity and nature of the flag.

The ESA should end when the registrar is flagged and a plan developed, or when the triangulation of data reaches the conclusion that the registrar is 'safe to practise with the supervisor available the majority of the time'.

Domains for flagging in the participating RTOs were graded as minor (watching) or major (active) and were mostly identified by the supervisor or ME. Flags were used for concerns relating to clinical knowledge, communication, personal or family issues and professionalism. About a third of the flags were in the first 12 weeks of community placement. Opinion was that some problems will take time to reveal themselves, especially those regarding personal or professionalism issues, which can then further impact clinical or communication problems in the future.

Barriers to the implementation and ongoing conduct of an ESA include: supervisor engagement, lack of supervisor training, supervisor reluctance to make a judgement, lack of time, geography, IT issues and bureaucracy. Facilitators included: a strong relationship between the supervisor and registrar, availability of information about assessments, stable technology, adequate funding for supervisors, flexibility, training, and a longer period of time in which to assess the registrar.

Discussion

The balance between funding, time, and an adequate assessment of a registrar's safety in the early part of their training will always be a difficult one. However assessing whether a registrar is safe to see patients without direct supervision, when the context is often completely new, is essential. A suite of assessments, templates, guidance documents, training, funding, support and personnel should be embedded in any General Practice Training organisation. Flexibility to tailor the process to the needs of the registrar, the practice, the supervisor, the geography and the context should also be built into the model. Flagging processes should include the ability to identify the reason for the flag, the severity of the flag, what the next steps might be and how the flag will be 'signed off'. These processes should be transparent with an aim to support the registrar to self-reflect and improve, and not be seen as a pass/fail.

Implications

This research has highlighted the complexity of an ESA, but also the importance of having flexible and strategic processes in place that allow for all involved to be appropriately supported to assess and remedy early safety issues.

Future Research

There is a plethora of issues regarding early safety assessments that would benefit from more research. These include the optimal duration of the ESA in the first semester of GP training; which are the most useful assessments for identifying and flagging registrars at risk; what are the possible outcomes of an ESA; how long a 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.