National Institute for Health Specialties
United Arab Emirates

Framework for Entrustable Professional Activities (EPAs) in NIHS Training Programs

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Stakeholders:	▪ DIOs, GMECs, PDs, administrative staff, faculty of NIHS accredited programs ▪ Trainees of NIHS accredited programs ▪ Chairs and members of NIHS Committees ▪ NIHS Employees or Staff

Modification History

Version	Date	Summary of Revisions	Responsibility	Signature
V 1.0	26.01.2024	Guideline Created	NIHS Assessment Dept.	
V 1.1	08.01.2025	Correction of terminology Guideline	NIHS Assessment Dept.	

Contents

EXECUTIVE SUMMARY

The judicious entrustment of professional activities is the essence of clinical teaching and practice based learning and improvement. Effective clinical teaching and supervision require a formal approach to entrustment that should exemplify a broader, organizational approach to patient safety and quality improvement. Faculty often subconsciously make entrustment decisions based on needed level of supervision, however there is a need to formalize this process.

Entrustment in clinical practice can be defined as the decision to grant the ability to perform an activity at a desired level of performance without direct supervision. Trust is based on directly frequent observed, consistent performance over time resulting in a comprehensive image of learners' competence.

EPAs are not an alternative for competencies, but a mean to translate competencies into clinical practice. Competencies are descriptors of physicians, EPAs are descriptors of work. Carrying out most of these EPAs requires the possession of several competencies/milestones.

Incorporating EPAs within residents'/fellows' evaluation make sense to faculty, trainees, and the public and ensure that each learner is an active participant in the entrustment process: aware of expectations, engaged in gathering and review of performance evidence, and generating individualized learning plans to attain entrustment. It situates competencies and milestones in the clinical context and align what we assess with what we do.

Furthermore, it adds meaning to assessment by focusing on integration of competencies in care delivery and through clustering of milestones into meaningful professional activities.

In practice, entrustment decisions are affected by 4 groups of variables:

(1) attributes of the trainee (tired, confident, and level of training);

(2) attributes of the supervisors (e.g., lenient or strict);

(3) context (e.g., time of the day, facilities available); and

(4) the nature of the EPA (rare versus common, easy versus complex).

Entrustment decisions can be further distinguished as ad hoc (e.g., happening during a night shift) or structural (establishing the recognition that a trainee may do this activity at

a specific level of supervision from now on). Summative entrustment decisions formally acknowledge that a trainee has passed a threshold that allows for decreased supervision.

EPAs that lead to Summative entrustment decisions should involve broad-based responsibilities and create a longitudinal view of each learner's performance. via, at minimum, aggregated performance evidence. It ensures a process for formative feedback along the trajectory to entrustment to provide opportunities for both remediation and potential acceleration of responsibilities.

PURPOSE

This guideline aims to provide a practical framework, based on the concept of EPAs, for all residency/fellowship NIHS accredited programs to implement the processes of:

- Building a competency-based workplace curriculum around EPAs.
- Structured longitudinal assessment for residents'/fellows' credentials, performance, experience and competencies.
- Granting EPAs to residents/fellows.

GUIDELINE

- This guideline is applicable each NIHS residency/fellowship program and ensure graded level of supervision and responsibilities based on structured operational process.
- GME trainees in NIHS accredited residency/fellowship programs must be under the supervision and responsibility of the attending faculty and program director (PD).
- Granting EPAs to residents/fellows is managed by the program and is not connected to local/hospital Credentialing and Privileging Committee which privilege the hospital medical staff.
- Clinical responsibilities must be conducted in a properly supervised and graded manner, allowing resident/fellow to assume progressively increasing responsibility in accordance with their demonstrated level of education, ability, and experience.
- The entrustment of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the PD, faculty members and Clinical Competency Committee (CCC) after assessment of relevant competencies/milestones.

- The program is responsible for developing descriptions of the level of responsibility accorded to each resident considering the clinical rotation and PGY level.

  These descriptions must include identification of the mechanisms by which the resident's supervisor(s) and PD make decisions about each resident's progressive involvement and conditioned independence in specific patient care activities.

- The PD must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific milestones.

- Senior residents may be given the responsibility for supervising junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.

SCOPE

This guideline applies to all NIHS GME programs.

RESPONSIBILITY

V.1. NIHS Specialized Scientific Committees

At the level of Specializes Scientific Commiees, there must be designed specific EPAs following the model described bellow.

The number and extension of EPAs must cover, at the minimum, the core medical activities required for an independent practice in the specific (sub)specialty.

V.2. GMEC

As per the NIHS Institutional Requirements, the GMEC should monitor programs' supervision of residents/fellows and ensure that supervision is consistent with:

- Provision of safe and effective patient care;
- Educational needs of residents/fellows;
- Progressive responsibility appropriate to residents'/fellows' level of education, competence, and experience;
- Other applicable Foundational and Advanced Specialty/Subspecialty-specific Program Requirements;

- Institutional GMEC shall design and implement an institutional EPAs policy and obtain the hospital's appropriate cooperation.

V.3. Program Director

- At the program level, there must be designed implementation actions specific for EPAs.

- PD must assign the PGY level for appropriate procedures and authorize the level of supervision according with the resident's/fello's ability to serve in a appropriate clinical level capacity, including teaching/supervisory. This is in conjunction with faculty feedback and CCC evaluation.

- Each learner's assignments and authorizations, along with the evaluations must be recorded in each resident's/fellow's file/portfolio and made available for faculty and hospital pertinent staff. These files must be visible and reportable to NIHS.

- Ensuring that supervising faculty are appropriately fulfilling their responsibilities to provide and document supervision to residents/fellows.

V.4. Supervising Physician

Faculty and/or attending physician is responsible for ensuring appropriate level of supervision when residents/fellows perform any clinical activity (cognitive or procedural), but especially those procedures that are high risk or technically complex. This requires that the supervising physician be knowledgeable of the residents'/fellows' abilities and assigned level of responsibility (entrustment).

V.5. Resident/Fellow

- Each resident/fellow is responsible for knowing the limits of their scope of authority, or clinical entrustments, and the circumstances under which they are permitted to act with conditional independence (without direct supervision).

- In recognition of their responsibility to the institution and commitment to adhere to the highest standards of patient care, resident/fellow physicians shall routinely notify the responsible attending physician based on the guidelines noted above.

DEFINITIONS

- **Competencies:** Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs.

- **Entrustment**: The decision to grant the ability to perform an activity at a desired level of performance without direct supervision.

- **Entrustable Professional Activities (EPAs)**: Units of professional practice, defined as tasks or responsibilities to be entrusted to the execution by a trainee without direct supervision once he or she has attained sufficient specific competence. EPAs are independently executable, observable, and measurable in their process and outcome, and therefore, suitable for entrustment decisions.

- **Milestones:**

  Milestones simply describe the learning trajectory within the Core Competencies.

  The Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents/fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.

ABBREVIATIONS

NIHS	National Institute for Health Specialties
CBME	Competency-based medical education
CCC	Clinical Competency Committee
GME	Graduate Medical Education
GMEC	Graduate Medical Education Committee
G&O	Goals and Objectives
PD	Program Director
PGY	Postgraduate year

PROCEDURE

VIII.1. NIHS level

- Specialized Scientific Committees review the specialty requirements and identify relevant EPAs mapped to domains of competence, competencies, and their respective milestones.

  Each residency/fellowship Committee must identify and design the specialty specific EPAs inclusive of the procedures and document them in a specific form made available on NIHS webpage.

- The EPAs may be divided into core groups, further subdivided specifically to authentic tasks and procedures of a discipline.

- The committees shall design a Faculty and Learners' Guide meant to describe the specific steps of implementation and a common understanding ground for both learners and supervisors.

- For each EPA there must be identified and designed:

  - One-page schematic of each EPA:

    1. **Title** of EPA reflects the medical task (unit of work).

    2. **Description**: actual activities, specific components which are necesarely to completely form an EPA.

    3. **Required Knowledge, Skills, and Attitudes (KSAs)**: applicable competency domains, KSA or milestones necesarely for execution.

    4. **Information to assess progress**: observations, products, monitoring of knowledge and skill, multisource feedback.

    5. **When is unsupervised practice expected to be achieved**: Estimated level of PGY when full entrustment for unsupervised practice is expected; this information is a major tool for shaping an individual workplace curriculum.

    6. **Basis for formal entrustment decisions**: number of documented times must the EPA be executed proficiently for unsupervised practice; form and level of supervisor.

  - Required assessment tools (specific to EPA)

- Formal aknoledgement from both faculty and learner for each EPA encounter and assessment.

VIII.2. Institutional level

Each Sponsoring institution in collaboration with GMEC must adopt a local policy which acknolege and support all operational activities derived from EPA educational framework implementation.

Each Sponsoring institution in collaboration with GMEC must adopt an implementation and monitoring plan including:

- Hospital wide information and obligativity to comply with the standards and procedures of this policy.
- GMEC shall provide a system of monitoring and feedback about the effectiveness of competency-based EPA training.

VIII.3. Program level

- Under the PD guidance, faculty need to be trained and prepared to provide EPA-based assessments. Each activity claimed by resident/fellow in the log-book or case logs, needs to have proper observational and feed-back documentation. For activities which necessitate procedural or surgical skills, assessment must be provided using proper tools (i.e., OSATS).
- Complex procedures including those requiring surgical skin incision may be performed only by residents who possess the required knowledge, skills, and judgment, and under an appropriate level of defined supervision. Supervising physicians, with guidance from the PD, will be responsible for authorizing the performance of such procedures or operations on a case-by-case basis. The name of the supervising physician performing and/or directing the performance of a procedure must appear on the informed consent form and operative note.

  For surgical and other high risk procedures that must be individually authorized, the level of resident's supervision shall be documented in the patient's chart.
- During CCC meetings, at a minimum every 6 months (recommended 3 months) the EPAs will be discussed and used as an additional tool in assessing trainees.

The key question is: "Can the trainee be trusted to execute this EPA?" The answer may be translated into 5 levels of supervision for the EPA or any other stepwise level of supervision as relevant to the specialty:

1. Observation without execution, even with direct supervision.
2. Execution with direct, proactive supervision (may act under direct full supervision and guidance)
3. Execution with indirect (reactive) supervision, i.e., on request and quickly available.
4. Act with oversight supervision and/or post hoc (may act with conditioned independence)
5. Trusted to perform independently without supervision Can supervise junior colleagues (may act as supervisor and instructor)

- For all EPAs there are predesgined recommended conditions for entrustment. However, the CCC, and ultimately the PD, will decide the level of entrustment with each EPA according to their direct experience with each trainee.
- The specialty specific Competency-based EPAs decissions shall be made available for trainees. The assigned level of trust/responsibility must be updated at a minimum of six months and documented in resident's file.
- In collaboration with CCC, the PD will certify, at a minimum of every six months, the level of trust achieved by resident/fellow in eaxch designed EPA and when the resident/fellow has demonstrated the ability to perform the procedure and/or activity without direct supervision.
- For those activities that cannot be delegated to residents to initiate and perform independently, the Supervising Physician will determine on a case-by-case basis the level of supervision required and in what capacity a resident may function. Supervising residents/fellows may also be authorized to act as teachers/supervisors for specific procedures and surgical operations provided that they have previously obtained entrustment.
- Senior Level Residents/chief residents (last PGY of residency) may perform virtually all diagnostic and therapeutic procedures not usually performed by subspecialists, without immediate supervision, provided that the residents/ fellows have previously obtained entrustment. These include some technically complex or high risk procedures as would normally be performed by individuals

trained in the (sub)specialty. The supervising physician has great latitude in determining which cases are suitable for the individual in the senior year to perform, or to act as a senior resident.

- Emergency Situations:

  An "emergency" is defined as a situation where immediate care is necessary to preserve the life, or prevent serious impairment of the health of a patient. In such situations, any resident/fellow shall, consistent with UAE Medical Liability Law, be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate supervising physician will be contacted and apprised of the situation as soon as possible. The resident/fellow will document the nature of this discussion in the patient's record.

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