

Curriculum Framework for the Internship Programme in Ireland

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CURRICULUM FRAMEWORK FOR THE INTERNSHIP PROGRAMME IN IRELAND



Medical Intern Board



NATIONAL
DOCTORS
TRAINING
& PLANNING



Comhairle na nDochtúirí Leighis
Medical Council

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Medical Intern Board

The Medical Intern Board (MIB) was established in October 2017 with responsibility for the governance and strategic direction of the internship on a national basis. The purpose of the MIB was to establish a national governance structure for the medical intern training programme in Ireland. The MIB initiates and facilitates the development of a centralised approach including, inter alia facilitating the development of a national, outcomes-based medical intern training programme that meets Medical Council standards for intern training. One of the early tasks undertaken by the Medical Intern Board was the specification and initiation of the Modernisation of the Internship project.

Medical Intern Unit

To support the Medical Intern Board, the Medical Intern Unit (MIU) was established in 2018 to oversee and manage the operational delivery of the internship as well as to implement strategic recommendations of the Board. The Clinical Lead within the Medical Intern Unit has led the operational delivery of the Modernisation of the Internship project.

Acknowledgement

The authors gratefully acknowledge all those consulted during the design and writing of this Curriculum Framework. It is an accumulation of input from various sources, as noted throughout the document and in the acknowledgements section at the end. Special thanks to those who participated in the consultation process and provided feedback, especially the medical students and Interns.

Preface

This document has been prepared by Prof. Gozie Offiah and Dr. Josephine Boland on behalf of the Medical Intern Board (MIB), and represents the culmination of successive stages in preparing the Curriculum Framework for the internship.

This Curriculum Framework presents the outcome of development work initiated and led by the MIB and undertaken by the Medical Intern Unit (MIU) team and Curriculum Development Working Group (CDWG) during 2018-2022. It also includes development work completed (2015-2022) as individuals and/or teams and part of the Modernisation of the Internship projects:

- Commissioned and funded by the Medical Council, and led by Prof. Dara Byrne (development of the Entrustable Professional Activities)
- National Doctors Training and Planning HSE development funding project led by Dr. Natasha Slattery (stakeholder consultation on the BE pillar of the curriculum)
- National Doctors Training and Planning HSE development funding project led by Prof. Ger Curley (support and remediation process for the intern programme)

The context for the revision of the intern curriculum is provided in **Appendix A**. The curriculum development and consultation process during 2015-2022 is outlined in **Appendix B**. This led to the preparation of the Draft Curriculum Framework Consultation Document, approved by the Medical Intern Board in July 2022 for external review and wide stakeholder consultation. A summary of the external reviewers' reports is provided in **Appendix C**. The extensive consultation process undertaken in 2022-2023 is described in **Appendix D**, with a summary of key feedback. These external reviews and the consultation process have informed the finalisation of the Curriculum Framework for the Internship.

The Curriculum Framework for the Internship Programme in Ireland (2023) represents the conclusion of work stream three of the Modernisation of the Internship project. It serves as the point of reference for the piloting phase and the subsequent implementation of the Curriculum Framework.

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List of Abbreviations

CBD	Case based discussion
CBME	Competency-based medical education
CP	Case presentation
DML	Dublin Mid-Leinster Intern Training Network
DNE	Dublin Northeast Intern Training Network
DO	Direct observation
DOH	Department of Health
DSE	Dublin Southeast Intern Training Network
EC	Entrustment Committee
EPA	Entrustable professional activity
ES	Entrustment scale
HALO	High acuity and low occurrence
HSE	Health Service Executive
IMSC	Irish Medical Schools Council
INE	Intern Network Executive
IRP	Intern Remediation Panel
KG	Knowledge guide
KSA	Knowledge, skills and attitudes
MIB	Medical Intern Board
MIU	Medical Intern Unit
MWT	Mid-West Intern Training Network
NCHD	Non-Consultant Hospital Doctor
NDTP	National Doctors Training and Planning
NITP	National Intern Training Programme
NRS	National Recruitment Service - HSE
PA	Portfolio advisor
PIF	Professional identity formation
RACP	Royal Australasian College of Physicians
SHO	Senior house officer
SPCP	Strategy and Policy Sub-Committee - Medical Council
STH	South Intern Training Network
WBA	Workplace based assessment
WNW	West Northwest Intern Training Network

Foreword

When a student graduates with a medical degree from a Council-approved Irish medical school, they must complete one year of intern training before they become a fully-fledged medical practitioner and can go on to specialist training. The internship introduces them to supervised clinical practice and is the first time they are faced with the responsibility of treating and caring for patients.



Dr. Suzanne Crowe
President, Medical Council

I found my intern year daunting! It was a year of rapid personal and professional development, when challenges came at me thick and fast. Having the support of friends, family and colleagues was a big help as I acclimatised to the medical workplace and the demands placed on me. By the end of the year, I felt differently about many aspects of life, including my choice of future specialty. You will not be the same person at the end of your intern year – you will be a doctor who has cared for patients and their families.

The Medical Council quality assures the continuum of medical education and training in Ireland from undergraduate degree to internship and on to specialist training. Defining what is expected at each stage of medical education and training allows for authentic requirements and expectations to be set at each stage of a doctor's training, ensuring better learning outcomes and preparedness for the next phase of their career. Currently, the intern training curriculum is an apprenticeship model focusing on completing rotations in general medicine and general surgery, with the option of completing the remainder of their training in some other specialties, to reach a total of twelve months' duration.

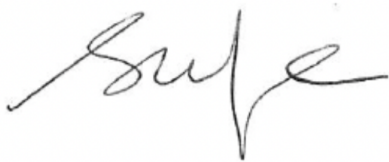
The Council's trainee experience survey - 'Your Training Counts' - has consistently highlighted the intern experience as the lowest scoring in terms of satisfaction. Council inspections of clinical training sites have revealed inconsistencies in intern trainee experiences. In our Statement of Strategy 2019-2023, the Council committed to ensuring consistency in application of quality-assured standards across the continuum of education, training, and lifelong learning. The Council fosters an outcomes-based approach towards medical education and training in Ireland with the aim of ensuring smoother and safer transitions between stages of training. Outcomes-based education focuses on prescriptive outcomes which are to be achieved following the completion of a programme of study.

Having commissioned the development of a set of Entrustable Professional Activities (EPAs) in consultation with key stakeholders in 2015, the Medical Council decided that they would form the basis of a competency-based medical intern training programme. We are very grateful to the National Doctors Training and Planning Directorate of the Health Service Executive for funding and driving forward the development of a new outcomes-based national intern curriculum.

We would like to thank the members of the MIU Curriculum Development Working Group, and in particular Dr. Gozie Offiah and Dr. Josephine Boland, for their steadfast commitment and hard work in developing this curriculum. This could not have been achieved without the support of the Medical Intern Unit team at NDTP.

We wish all those involved in developing and delivering intern training across the country every success in implementing this curriculum and we are sure that they will do so to the very best of their abilities.

Lastly, we hope that all interns participating in the programme will benefit greatly from this carefully designed curriculum and that it will provide an excellent foundation for a fulfilling career in medicine.

A handwritten signature in black ink, appearing to read 'Suzanne', written in a cursive style.

Dr. Suzanne Crowe, President, Medical Council

Foreword

We are at a significant crossroads in the path that is the intern year. The internship is in a period of transition and the framework document before you is one of the work streams of the Modernisation of the Intern Year project. The ambition of those whose task it is to deliver this year is that our interns, setting out on the shores of their professional life, will experience a world-class intern year. This framework and the Modernisation of the Intern year project will be the guide to deliver that excellent training.



Prof. Brian Kinirons
Medical Director, National
Doctors Training & Planning

As medical director of NDTP, I welcome and congratulate Dr. Gozie Offiah and the Medical Intern Unit Curriculum Development Working Group on the launch of the Curriculum Framework for the Internship Programme in Ireland. I would also like to acknowledge the work of the wider stakeholder community in the genesis and delivery of this document. The Integrated Competency-based framework is supported by a competency-based curriculum.

The three key pillars of the Curriculum Framework are Do, Know and Be. 'Do' focuses on the essential work tasks trainees need to gain competence in, perform safely, and be entrusted by their supervisors to do in the workplace. 'Know' exemplifies the ability to integrate knowledge into practice and to commit to the lifelong learning of a significant body of evolving knowledge. 'Be' provides guidance into professional behaviours, values and practices expected of a trainee as they adopt the professional identity of a physician; aligned with the eight Medical Council domains of good professional practice.

The ambition of the Curriculum Framework is to deliver world-class intern training through a competency-based curriculum which is measured using Entrustable Professional Activities (EPAs).

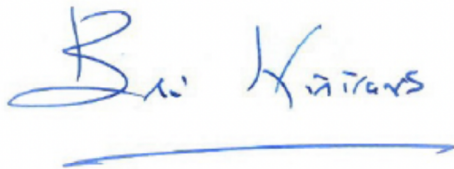
We measure what we value. Whilst in this transition process, the internship has been the subject of much scrutiny, which has resulted in the production of multiple reports. Reports in the recent past include:

- 1) The EY Report - Review of the Intern Allocation Process
- 2) The Crowe Horwath Report - Review of the National Number of Medical Intern Posts
- 3) The Gallen Report - Review of the Academic Track Intern Programme
- 4) The Gallen Review of Internship Governance

The Medical Council has commissioned a qualitative review of Intern training, which is phase 2 of the previous quantitative review by Crowe Horwath. The outcome of these reports will no doubt standardise and improve the experience for our interns.

The internship is the foundation stone of postgraduate training and this framework document and the Intern modernisation project will ensure a solid foundation for future professional growth. The changes that we must embrace will ensure that our interns are ready to meet the challenges of our health service, both for today and for the future.

It is not only our interns that will benefit but also ultimately the patients that we have the privilege of serving.



Prof. Brian Kinirons, Medical Director, National Doctors Training & Planning

Foreword

Every three-metre square of the world can be located using a unique combination of three words (What3words). If I had to choose three words to describe the overall vision of the Medical Intern Board for the internship modernisation project it has been leading since 2018, they would be: transition, continuity, and entrustment.



Prof. John Jenkins
Medical Intern Board Chair

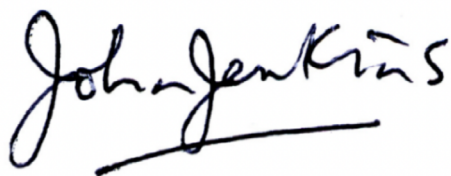
Internship is the period of transition from medical student to registered medical practitioner, eligible to seek entry to a specialist training programme. As such, it is a critical stage in every doctor's professional development. The current curriculum for the internship in Ireland has been in place since 2011, providing a combination of education, training and supervised clinical responsibility. Following review by the Medical Council in 2015, work has been ongoing with active engagement of all six intern networks, to collaboratively design a national outcomes-based Curriculum Framework for the future.

In doing so, all involved have taken careful account of the context of the internship within the continuity of medical education and training. All entrants to the intern programme need to have demonstrated the outcomes of undergraduate medical education, as defined by the Medical Council and delivered by Medical Schools. The internship then needs to also have clearly defined outcomes which have to be demonstrated in order to progress to full registration and further postgraduate training and practice in Ireland.

The curriculum will utilise a framework of outcomes for the internship using the model of Entrustable Professional Activities (EPAs). Entrustment is a concept which is increasingly recognised internationally as appropriate for description, implementation and assessment of the key capabilities required of doctors as they progress in their careers, including a clear focus on the safety and quality of the care provided. It supports formative learning in the clinical environment and enables evaluation of not only technical abilities, but also the professional attributes expected in clinical practice. As commissioned by the Medical Council, this framework has been developed by experienced academic and clinical educators throughout the Irish health system, with additional international expertise.

On behalf of the Medical Intern Board, I wish to acknowledge the determination and perseverance of all those identified as contributing to this process. We also wish to express our thanks to the external reviewers who provided very comprehensive reports in a short timeframe: Dr. Aileen Barrett, Prof. H. Carrie Chen, Prof. Jill Thistlethwaite, Dr. J Clare M van Hamel and Prof. Olle ten Cate. Their reports have been enormously helpful and constructive, providing many actionable recommendations, not only for the framework document but also wider aspects, including the piloting and implementation phases of this key element of the overall Modernisation Project. It has been revised to take account of the external reviews and feedback from extensive consultation over recent years.

As a Board, we believe that the Curriculum Framework offers a compelling vision of how intern training can - and must - be transformed to meet the current and future needs of interns, supervisors, patients and society. It also recognises that successful implementation will require commitment of resources, development of the necessary technological systems and ownership by intern networks and all other key stakeholders, including of course interns themselves.

A handwritten signature in black ink, reading "John Jenkins". The signature is written in a cursive style with a long horizontal stroke at the end.

Prof. John Jenkins, Medical Intern Board Chair

Executive Summary

Internship in Ireland is the period of transition from medical student to a registered medical practitioner. Intern training is a critical stage in a doctor's professional development. The internship programme is delivered by the six Intern Training Networks, affiliated to the six medical schools in Ireland. The programme normally lasts for one year and provides new medical graduates with a combination of education, training and clinical responsibility that enables them to develop the professional and personal competencies that result in good patient care and provide a basis for lifelong learning. The current curriculum for the internship was devised by the Intern Training Networks in 2010, and revised in 2011.

The Medical Council carried out a review of training in 2014 which identified several aspects in need of reform within internship. A move away from a purely time-served apprenticeship model to an outcomes-based approach was agreed upon, incorporating a more systematic and robust approach to assessment. The Medical Council commissioned the development of a framework of outcomes for the internship, using the model of Entrustable professional activities (EPAs).

EPAs are an approach to operationalising a competency-based approach to medical education and training. EPAs are units of professional practice or essential tasks that a trainee can be trusted to perform without direct supervision, once sufficient competence has been demonstrated. As trainees progress through their training, they are capable of performing these tasks with greater autonomy and decreasing levels of supervision. Seven EPAs were developed for the internship programme, following research, development and consultative process, and adopted by the Medical Council in 2016 as the most appropriate organising framework for the internship programme. By the end of internship training, interns should be able to carry out all seven EPAs independently with distant supervision. The seven EPAs are:

No.	EPA Title	Description
1.	Clerking a patient	Clerking a patient in the outpatient and day care setting, admitting a patient to the ward and understanding decision to admit criteria and protocols.
2.	Requesting and interpreting basic investigations	Requesting and interpreting basic diagnostic laboratory, radiological and other investigations. Rationalising the requirement and the request.
3.	Performing essential procedural skills	Performing the essential procedural skills as listed in the EPA.
4.	Managing the work of in-patient care	Managing the daily workload. Prioritising, performing, sharing and delegating tasks to advance patient flow while delivering patient-centred care.

5.	Prescribing and monitoring drugs and fluids	Prescribing safely to comply with the legal requirements in hospital, and for community settings.
6.	Recognising and managing the deteriorating/ acutely unwell patient	Identification, responding and managing the acutely unwell patient. Escalating the care to the team and senior colleagues as required.
7.	Handing over and discharging a patient	Handing over and receiving hand-overs to/from colleagues. Managing the patient discharge and transfer processes and ensuring continuity of care.

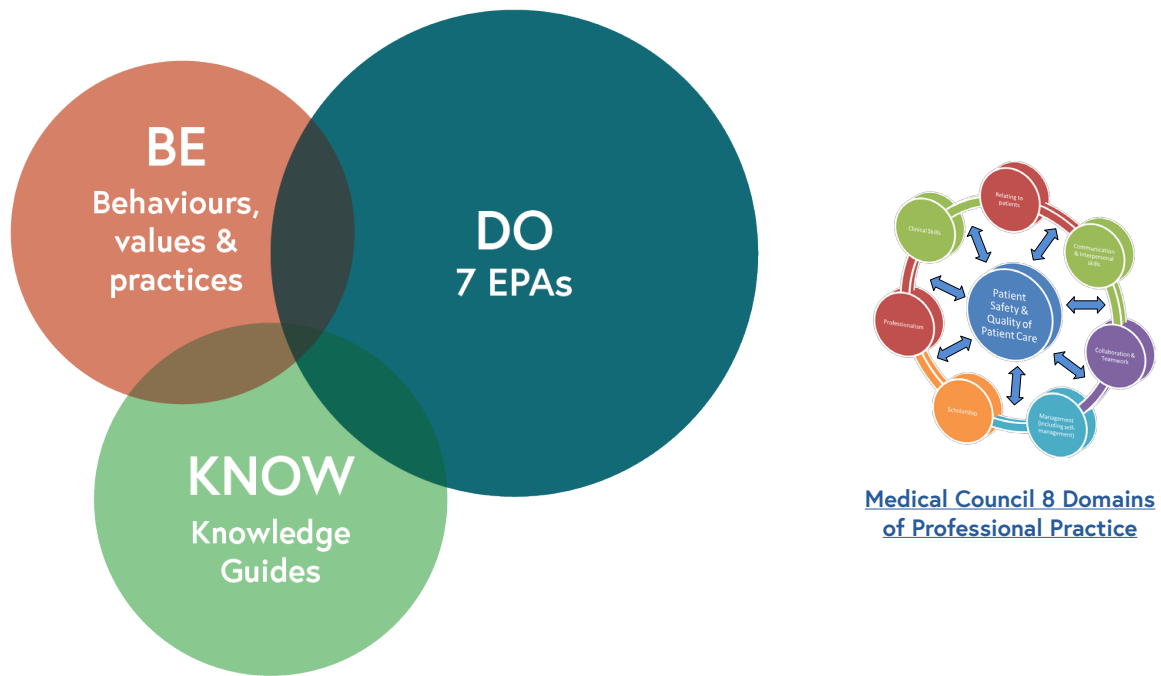
In response to the need to address issues with the internship, the Medical Intern Board (MIB) initiated the Modernisation of the Intern Year project in 2018. One of the four workstreams was the development of a new national Curriculum Framework for the internship, which aligns with the internship EPAs and incorporates professionalism and knowledge domains. In 2018, the MIB approved the model for a new Curriculum Framework for the internship programme, which sets the standards for the planning and delivery of the curriculum at the local level.

The outcomes-based Curriculum Framework for the internship specifies the core competencies to be achieved to the standard of junior doctor, prior to achieving registration on the trainee specialist division or the general division of the Medical Council. The model chosen for the new Curriculum Framework for the internship has been adapted from the Royal Australasia College of Physicians (RACP) framework of DO, KNOW and BE.

DO	Units of professional practice or essential tasks that an intern can be trusted to perform independently with distant supervision.	7 EPAs
KNOW	Knowledge Guides are a guide to the underpinning knowledge that interns need to safely carry out the EPAs.	Knowledge Guides 1 for each EPA 1 on Patient Safety
BE	Describes the behaviours, values and practices expected of an intern, as they adopt the professional identity of a doctor.	The BE pillar

For the Irish internship, an integrated curriculum framework for the internship has been adopted with EPAs as the cornerstone, as illustrated below:

Model for the Curriculum Framework approved by Medical Intern Board



Model for the Curriculum Framework Approved by the Medical intern Board

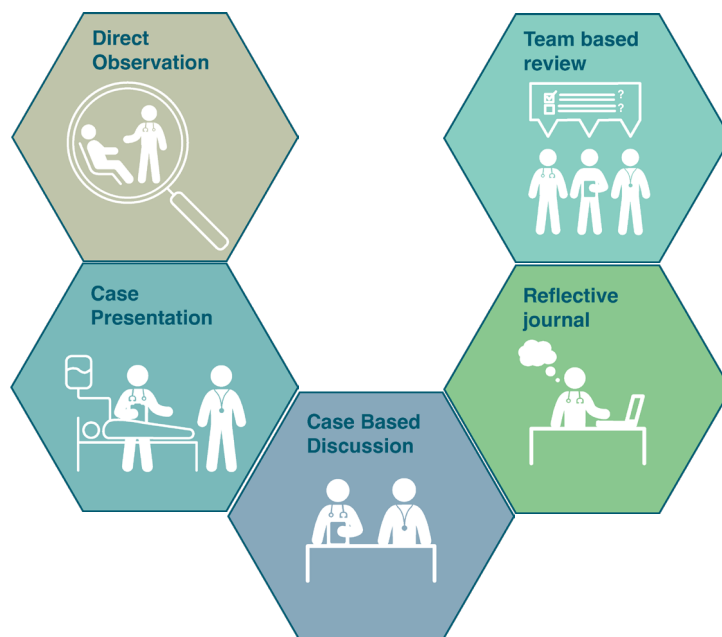
The Curriculum Framework also contains the following elements:

- **Programme goals:** high-level statements regarding the expectations of doctors upon completion of their intern training. These will be informed by the outcome of a Medical Council project developing a set of graduate outcomes for the undergraduate programme.
- **Teaching, learning and experience:** teaching and learning strategies will be the responsibility of the intern networks to lead on, devise and deliver. The experience requirements will be informed by the outcome of the Medical Council review of the quality and configuration of Intern posts.
- **Assessment:** a strategy for programmatic assessment with details on processes leading to the award of a Certificate of Satisfactory Completion of Intern Training (CSCIT).

The Curriculum Framework provides the cognitive, practical and behavioural context within which each intern network will plan and deliver individual placements and rotations, ensuring that all key curriculum content is adequately covered for all interns during the programme.

While the Curriculum Framework provides for flexibility in the delivery of the programme – taking into account opportunities available in some but not all settings - the system of programmatic assessment will deliver a consistent national standard. Entrustment decisions, utilising the full range of workplace based tools will reflect a demonstration of relevant knowledge, skills and behaviours, as set out in the Curriculum Framework.

In a system of programmatic assessment, information about an intern's performance is collected using frequent low-stakes assessments from multiple assessors, where the focus is on providing good narrative feedback. This provides multiple sources of rich data for high-stakes summative entrustment decisions at key transitions and at the end of training.



Five tools of workplace based assessment (WBA) have been identified for use in the internship programme. Details are provided on the conduct of Direct Observations, Case Presentations and Case Based Discussions. Provision is also made in the strategy for the introduction of periodic assessment by team members, completed anonymously (Team Review) and the maintenance of records of reflective practice (Reflective Journal).

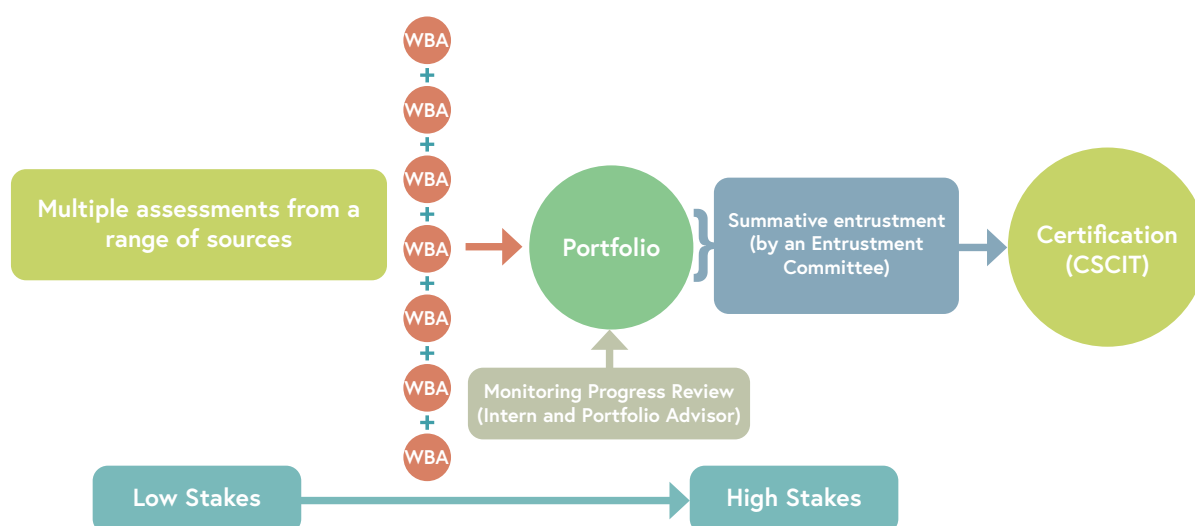
Processes for the support and remediation of interns through structured and defined periods of supervision, support and assessment are also part of the framework.

Intern Support and Remediation



Processes which lead to the award of a Certificate of Satisfactory Completion of Intern Training (CSCIT) are outlined, including how various roles (e.g., trainee, assessor, portfolio advisor, programme director and an Entrustment Committee) would be fulfilled in a fully-functioning certification system for the internship programme.

Overview of the Process



Given the nature and extent of the changes associated with the new Curriculum Framework, a programme of continuing professional development for faculty, supervisors and for interns, will be critical to successful implementation, commencing with socialisation of the concept, rationale and vision amongst key stakeholders. A range of potential approaches for CPD/ faculty development are identified. A number of digital resources have been developed by the MIU to support implementation, which are available to intern training networks and medical schools for use in network-based CPD, as well as for self-directed learning.

The new Curriculum Framework for the internship offers a vision of how intern training can be transformed to meet the current and future needs of interns, supervisors, patients and society. It represents the cumulative development work commissioned by the Medical Council and the NDTP/HSE, over the period 2015-2022, and completed under the aegis of the Medical Intern Board. Its development has involved educational, academic and clinical expertise from Ireland and internationally including engagement and consultation with stakeholders. In consultation with key stakeholders, a piloting strategy has been devised for a phased implementation, which will require a commitment of significant resources, development of the necessary technological systems, ownership by intern networks and effective change management to ensure success.

Overview of the document

Chapter 1: provides an overview of the Curriculum Framework for the internship programme and the rationale for the model. It describes three interconnected pillars of the framework: DO, KNOW and BE.

Chapter 2: presents the seven Entrustable Professional Activities (EPAs) for the internship programme.

Chapter 3: presents the supporting Knowledge Guides (one for each EPA) and a specific Knowledge Guide on Patient safety.

Chapter 4: presents the BE pillar of the Curriculum Framework, which describes the behaviours, values and practices expected of an intern, as they adopt the professional identity of a doctor.

Chapter 5: outlines a range of potential teaching and learning strategies. This element of the framework will be the responsibility of the intern networks to lead on, devise and deliver.

Chapter 6: outlines a strategy for programmatic assessment for the internship programme including details of the workplace based assessment tools which have been devised.

Chapter 7: outlines processes which will lead to the award of a certificate of satisfactory completion of intern training (CSCIT).

Chapter 8: concludes with a summary, and recommendations for a phased approach to implementation of the Curriculum Framework.

Appendices provide background material, details of the development work and consultation processes, a summary of the external reviews, and the guidelines for intern support and remediation.

A **Glossary** of terms used in this document is provided.

Chapter 1

Overview of the model for the Curriculum Framework

1.1 Introduction

A curriculum is a statement of the intended aims and goals, content, assessment, experiences, outcomes and processes of a programme of learning, including a description of the expected methods of learning, teaching, assessment, feedback and supervision. Competency-based medical education (CBME) is an educational approach where learning, teaching and assessment activities are organised around achievable outcomes, derived from patient and societal needs. It de-emphasizes time-based training and promises greater accountability, flexibility, and learner-centeredness¹. A competency-based curriculum is therefore outcomes-focused and states clearly what is expected of interns for successful completion of the programme.

The five core components of competency-based medical education (CBME)² are as follows:

- 1. Framework:** An outcomes competency framework where competencies required for practice are clearly articulated and are identified based on societal needs.
- 2. Progression:** Competencies and their developmental markers are sequenced progressively in a way that supports a learner's progression from novice to master clinician.
- 3. Tailored experiences:** Learning experiences that resemble the practice environment, facilitate the development of competencies, and are flexible enough to accommodate variation in individual rates of progression.
- 4. Competency-focused instruction:** Teaching practices (especially observing and coaching behaviours) that promote the developmental acquisition of competencies and emphasise learning through experience and application, as well as knowledge acquisition.
- 5. Programmatic assessment:** Assessment practices support and document the developmental acquisition of competencies and emphasise workplace based observation as well as meaningful feedback.

1.2 A national Curriculum Framework

A national **Curriculum Framework** will set the standards for the planning and delivery of the curriculum at local network level. The Curriculum Framework guides the design of intern training at local level and ensures national coherence in the provision of high-quality training.

¹ Frank, J, Mungroo, R, Ahmad, Y and Wang, M. (2010) Toward a definition of competency-based education in medicine: A systematic review of published definitions. *Medical Teacher*. 32. 631-7.

² Van Melle E, Frank J, Holmboe E, et al: A core components framework for evaluating implementation of competency-based medical education programs. *Academic Medicine*. 2019, 94(7):1002–1009

Each intern network is responsible for planning and implementing the local *curriculum as delivered*, while ensuring alignment with expectations set out in the accreditation standards of the Medical Council³ and the Curriculum Framework approved by the Medical Council⁴. The Curriculum Framework also guides the learning plans of interns and supports them as they prepare to demonstrate that they meet these expectations in the course of their training.

The Curriculum Framework for the internship is outcomes-based, stating the core competencies to be achieved to the standard of junior doctor prior to achieving entry to either the trainee specialist or general division of the Medical Council register. Core competencies must be achievable by all trainees, irrespective of the network or intern posts where they train. The Curriculum Framework also guides the acquisition of the broad and evolving knowledge base of medicine and indicates the scope of practice of an intern. It also attends to the teaching and learning processes which characterise intern training, and the range of experiences required.

The Curriculum Framework includes a strategy for programmatic assessment which includes an appropriate range of assessment methodologies by which intern progress can be determined, recorded and monitored for the purpose of demonstrating evidence of competence. The resultant data needs to be accessible to those best in a position to respond and support trainees at all times and to determine that they meet the standards for the award of a Certificate of Satisfactory Completion of Intern Training (CSCIT). The award (currently called a 'certificate of experience') has been renamed in this document to reflect that it will attest to the satisfactory achievement of the outcomes specified in the Curriculum Framework. Moreover, the term "certificate of satisfactory completion of training" is well-recognised internationally and it aligns with the title of certificate granted at the end of postgraduate training in Ireland.

This certificate will be granted by the awarding body, which is currently the Medical Council. This document also describes the processes which, in a fully functioning new certification system, will lead to the award of a CSCIT.

³ New accreditation standards for undergraduate, intern and post graduate medical education and training and for clinical training sites are currently in development by the Medical Council

⁴ Responsibility for approval of the curriculum may be revised pending the review of governance arrangements for the internship

Functions of the Curriculum Framework for the Internship Programme

- Enhance the quality of the internship programme as a key element of the modernisation project
- Ensure comparability of the internship experience across networks
- Guide each Intern Network when devising their local curriculum for their internship programme
- Guide individual interns as they take responsibility for their learning and professional development
- Provide a framework for programmatic assessment, including the use of workplace based assessment tools
- Provide a basis for curriculum mapping of local network training programmes
- Facilitate quality assurance of the internship programme as delivered in training networks

1.3 Elements of the Curriculum Framework for the internship

The Curriculum Framework for the internship programme in Ireland comprises:

- Programme goals
- Entrustable professional activities (EPAs)
- Knowledge guides
- Professional competencies
- Teaching, learning and experience
- Programmatic assessment

Programme goals are high level statements within the curriculum for a programme of learning. The Medical Council is currently planning the development of a set of national outcomes for graduates which reflect the expectations of graduates upon completion of their undergraduate programme. Accompanying guidelines will demonstrate what outcome achievement may look like.

These outcomes will inform the development of the programme goals for the internship programme, the next phase in the continuum of medical education and training. Programme goals for the internship will be developed at that stage and subject to stakeholder consultation. They are not included in the Curriculum Framework for the internship programme at this stage. The remaining elements are detailed in subsequent chapters.

1.4 The model for the Curriculum Framework

The three interconnected pillars of the Curriculum Framework for the internship (DO, BE and KNOW) support one another, with Entrustable Professional Activities (EPAs) as the cornerstone, and a programmatic approach to assessment. The Curriculum Framework is modelled on that developed by the Royal Australasian College of Physicians (RACP)⁵. The RACP framework includes three pillars:

- **DO** focuses on the essential work tasks trainees need to gain competence in, perform safely, and be entrusted by their supervisors to do in the workplace
- **KNOW** exemplifies the ability to integrate knowledge into practice and to commit to the lifelong learning of a significant body of evolving knowledge
- **BE** provides guidance into professional behaviours, values and practices expected of a trainee as they adopt the professional identity of a physician

The RACP model was selected as the basis for the Curriculum Framework for the internship in Ireland after an appraisal of international models of competency-based curricula in medical education and training. As outlined above, in terms of chronology, the EPAs for the internship were already developed and adopted since 2018. These EPAs address the **DO** pillar of the RACP framework.

In many other contexts where EPAs have been adopted, they have been developed alongside a pre-existing detailed curriculum with extensive details about the knowledge, skills and attitudes expected of a trainee⁶. No such level of detail existed for the internship curriculum in Ireland at that time. There was a consensus that the EPAs, which focus on performance in clinical tasks, do not provide sufficient guidance about the underpinning knowledge required or the range of professional behaviours and values which are deemed to be essential to the development of a competent and professional intern, ready for progression to specialist training. The RACP model provided a way of incorporating those pillars into a Curriculum Framework well suited to the unique context of the internship programme.

The model for the Curriculum Framework for the internship was adapted from the RACP framework to reflect its integrative nature, as illustrated below.

⁵ <https://www.racp.edu.au/trainees/basic-training/curricula-renewal/standards>

⁶ For example, the EPAs developed by the Irish College of General Practitioners have been mapped to a comprehensive pre-existing curriculum.

Model for the Curriculum Framework approved by Medical Intern Board

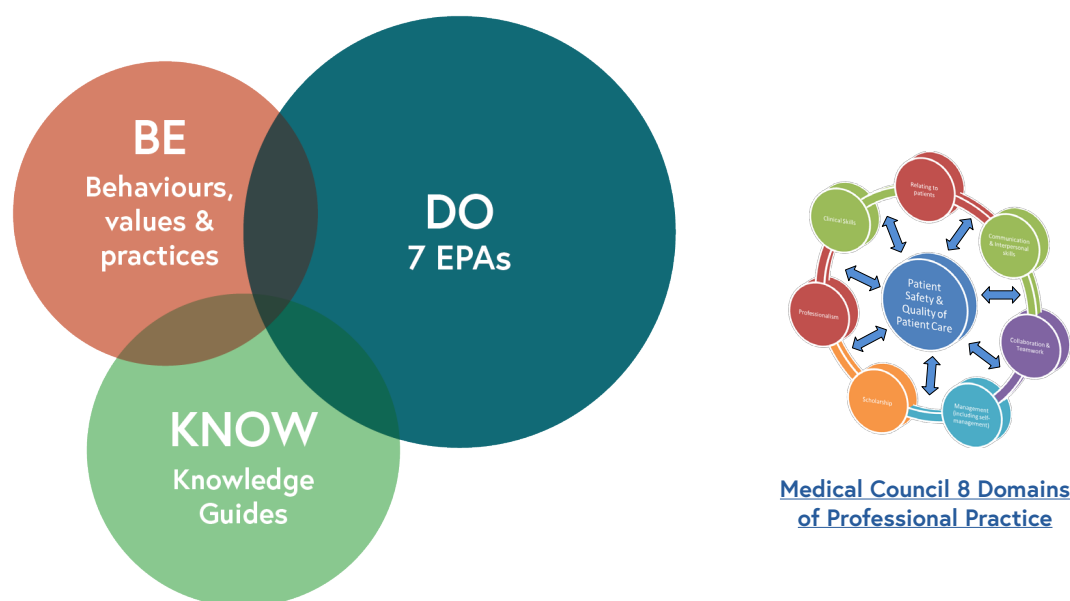


Fig. 1. An integrated Curriculum Framework for the internship

One of the adaptations made to the RACP model was to develop a Knowledge Guide for each EPA for the internship, rather than organise guides based on disciplines (e.g., cardiology, dermatology, endocrinology etc.) as in the RACP model. The aim was to avoid duplicating the details of the medical school curriculum. Hence the Knowledge Guides for the internship Curriculum Framework are designed specifically to support the performance of the EPAs, building on the knowledge acquired in medical school. A specific Knowledge Guide on Patient safety, which is relevant to all EPAs, has been added in light of its critical importance in the performance of EPAs.

In order to contextualise the model for Ireland, the Irish Medical Council Eight Domains of Good Professional Practice were used in elaborating the **BE** pillar, instead of the ten domains of the RACP Professional Practice Framework. Themes and competencies are identified per domain, as in the RACP model. Additionally for the internship, learning outcomes (knowledge, skills and attitudes) have been elaborated for each competence, to guide the design and delivery of the curriculum at the local intern network level.

The model for the Curriculum Framework was approved by the Medical Intern Board in 2018. A draft template and sample content was presented to stakeholders for consultation in December 2020. The feedback from the consultation informed the further development of the framework and constituent pillars, as documented in **Appendix B**.

1.5 DO: The Entrustable Professional Activities (EPAs)

The Medical Council commissioned the development of a framework of outcomes for the internship in 2015. Building on a review of intern training and an analysis of needs within the sector, and drawing on international practice and literature, Entrustable Professional Activities (EPAs) were proposed as the organising framework for competencies required for effective and safe practice by interns in Ireland at the end of their training⁷. The rationale for EPAs and the details of their development for the internship have been comprehensively [documented](#)⁸ and [published](#)⁹. The process for developing the EPAs is summarised in **Appendix B**. They were adopted by the Medical Council in 2016 as the framework for the curriculum for the internship programme.

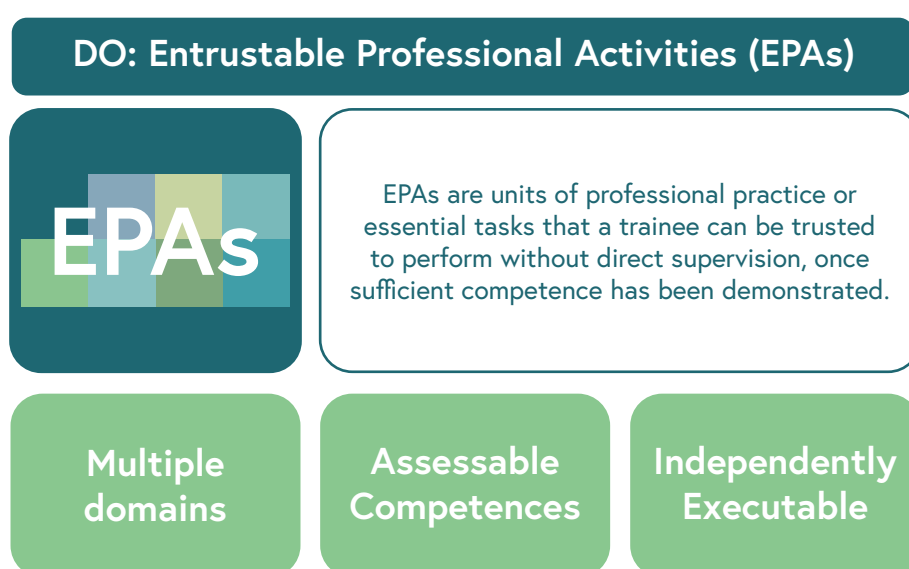


Fig. 2 Entrustable Professional Activities

EPAs focus on clinical work and offer the advantage of being directly observable and measurable, integrating knowledge, skills and attitudes into authentic professional tasks.

EPAs provide a means of operationalising the implementation of an outcomes-based framework and support a robust system of assessment. The key characteristics of an EPA¹⁰ are listed below.

⁷ Boland, J., O' Connor, P., Offiah, G., and Byrne, D. (2015) 'Draft Framework of Outcomes for Intern Training in Ireland' Dublin: Medical Council. Report:

⁸ Byrne, D., Lydon, S., Madden, C., O'Dowd, E., Boland, J. & O'Connor, P. (2018). The development of entrustable professional activities for the Irish intern year. Galway: NUI Galway.

⁹ O'Dowd, E., Lydon, S., O'Connor, P. et al. (2022) The development of a framework of entrustable professional activities for the intern year in Ireland. *BMC Medical Education* 20, 273

¹⁰ ten Cate, O., Chen, H. C., Hoff, R. G., Peters, H., Bok, H., & van Der Sheaf, M. (2015). Curriculum development for the workplace using Entrustable Professional Activities (EPAs): AMEE Guide No. 99. *Medical Teacher*, 1-20. 8

Key Characteristics of EPAs



- Represent a professional unit of work of the speciality
- Require adequate knowledge, skills and attitudes
- Are independently executable within a time frame
- Are observable and measurable
- Reflect one or more domains of competence
- Are suitable for focused entrustment

Fig. 3 Key characteristics of EPAs

The EPA - based framework for the internship programme

The following video provides an overview of the EPA framework for the Irish internship.

The Introduction to the EPA Framework for the Internship Programme

The internship in Ireland is being modernised with a new competency-based framework of Entrustable Professional Activities (EPAs), with a set of tools for workplace based assessment. This [presentation](#) provides an overview of the new framework, the rationale for change and what it means for interns and supervisors.

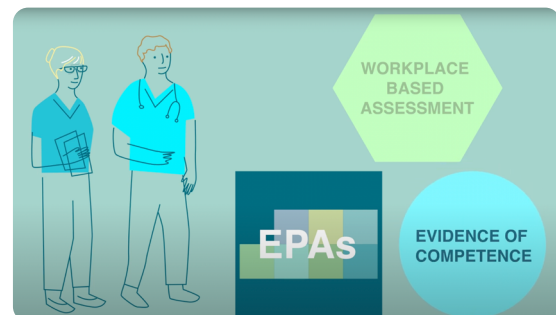


Fig. 4 The EPA Framework

The EPAs for the Internship:

Seven EPAs form the cornerstone of the Curriculum Framework for the internship in Ireland.

The seven EPAs for the internship are described as the following:

The Entrustable Professional Activities – EPAs

The internship in Ireland is being modernised with a new competency-based framework of Entrustable Professional Activities (EPAs), with a set of tools for workplace based assessment. This [presentation](#) provides an overview of the new framework, the rationale for change and what it means for interns and supervisors.



Fig. 5 The 7 EPAs for the internship

No.	EPA Title	Description
1.	Clerking a patient	Clerking a patient in the outpatient and day care setting, admitting a patient to the ward and understanding decision to admit criteria and protocols.
2.	Requesting and interpreting basic investigations	Requesting and interpreting basic diagnostic laboratory, radiological and other investigations. Rationalising the requirement and the request.
3.	Performing essential procedural skills	Performing the essential procedural skills as listed in the EPA.
4.	Managing the work of in-patient care	Managing the daily workload. Prioritising, performing, sharing and delegating tasks to advance patient flow while delivering patient-centred care.
5.	Prescribing and monitoring drugs and fluids	Prescribing safely to comply with the legal requirements in hospital, and for community settings.
6.	Recognising and managing the deteriorating/acutely unwell patient	Identification, responding and managing the acutely unwell patient. Escalating the care to the team and senior colleagues as required.
7.	Handing over and discharging a patient	Handing over and receiving hand-overs to/from colleagues. Managing the patient discharge and transfer processes and ensuring continuity of care.

Fig. 6 Descriptions of the EPAs for the internship

Evaluating and revising the EPAs

In 2020, the MIU decided to engage in a process of confirming and enhancing the quality of EPAs prior to wider implementation, by using quality control rubrics to determine that they align with established quality standards for EPAs. The EPAs were evaluated, using the EQual criteria.¹¹ See **Appendix B** for details of the criteria and a summary of findings and recommendations. The EPAs were subsequently reviewed and amended in 2022 in response to the evaluation and to bring them up-to-date with the revised recommended description of an EPA¹².

¹¹ Taylor, D. Park, Y.S., Egan, R, Chan, M-K, Karpinski, L, Touchie, C., Snell, L and Tekian, A. 92017) Equal, a novel rubric to Evaluate Entrustable Professional Activities for Quality and structure *Academic Medicine* 92 ;92: S110–S117

¹² ten Cate O, Taylor D.R. (2022) The recommended description of an entrustable professional activity: AMEE Guide No. 140. *Medical Teacher* 9:1-9.

Recommended description of an EPA

- Specifications¹³
- Potential risks in case of failure
- Most relevant competency domains
- Required knowledge, skills and attitudes (KSA)
- Required experience¹⁴
- Information sources to assess progress and support summative entrustment
- When is which entrustment level expected?
- Expiry date

Entrustment

Entrustment is central to the concept of an EPA-based Curriculum Framework. Entrustment is the act of assigning responsibility for something valued or important to a person, such as the decision to entrust a learner with a task or an EPA. Entrustment decisions can be made *ad hoc* or *summatively*.

An "ad hoc entrustment decision" is the act of placing trust in another person to perform a particular activity in the moment of working with them. Ad hoc entrustment decisions are context-dependent and made by an individual supervisor.

A "summative entrustment decision" for an EPA signifies the general permission to deliver the contribution to health care that this EPA represents, independently with distant supervision, at or before the completion of training. This decision is made and recognised by a relevant supervisory team, such as a clinical competency committee, and is based on varied information including multiple prior observations involving multiple credible observers¹⁵.

¹³ While the recommended description of an EPA includes "specifications and limitations", following a review of the EPAs for internship, limitations were excluded.

¹⁴ In the recommended description an EPA, experience is included in this same section as knowledge, skills and attitudes. For the EPAs for the internship required training experience is indicated as a separate field.

¹⁵ Schumacher, D.J., ten Cate, O., Damodaran, A., Richardson, D., Hamstra, S.J., Ross, S., Hodgson, J., Touchie, C., Molgaard, L., Gofton, W., and Carraccio C. on behalf of the ICBME Collaborators (2021): Clarifying essential terminology in entrustment, *Medical Teacher*, 43(7):737-744

EPA-based curricula generally include a five-level scale to describe a recommended level of supervision for a learner (in the case of an ad hoc entrustment decision) or an agreed level of supervision (in the case of a summative entrustment decision). This generic scale has been adapted to reflect the range of supervision levels afforded to an intern in the course of their training.

As interns progress through their training, they are capable of functioning with more autonomy and can be trusted with decreasing levels of supervision. Interns will always have some level of supervision when in training but they are expected to be able to perform each EPA **independently, with distant supervision** by the end of their training i.e. to level 4.

Level	Entrustment Supervision Scale ¹⁶	
1.	Intern has the relevant knowledge and skills, but not enough to perform the activity unaided. The supervisor and intern perform the activity together.	Pre-practice
2.	Intern may perform an activity under close, direct supervision, with the supervisor in the same room, deciding the intensity of supervision required.	Close supervision
3.	The intern may perform an activity with indirect, intermittent supervision as necessary and the intern asks for supervision as required. Supervision is available close by.	Indirect supervision
4.*	The intern may perform an activity independently with mainly informal, remote or distant supervision providing oversight. Supervision is available on-site.	Distant supervision
5.	Intern may provide supervision and instruction to junior learners.	Experienced

* Level 4 is the threshold level expected of interns, for each EPA, by the end of internship

Fig. 7 Entrustment supervision levels for the internship¹⁷

The table above describes levels of supervision for an EPA in its entirety and are used for summative entrustment decision-making. When conducting a low-stakes, formative workplace based assessment of an individual task/procedure the levels are used to describe the nature of the supervision required for that task/procedure alone (as explained in **Chapter 6** and in **Appendix H**).

¹⁶ Adapted for the context of the Irish internship context from ten Cate, O, Hart, D., Ankel, F. Busari, J. Englander, R. Glasgow, N, Holmboe, E. Lobst, W, Lovell, E. Snell, L.S., Touchie, C. Van Melle, E., Wycliffe-Jones, J. on behalf of the International Competency-Based Medical Education Collaborators (2016) Entrustment Decision Making in Clinical Training *Academic Medicine* 91(2):191-8

¹⁷ Further details of how this scale is used in a system of programmatic assessment is provided in Chapter 7

1.6 KNOW: the Knowledge Guides

Knowledge Guides are a guide to the underpinning knowledge that interns need to safely carry out the EPAs by the end of their training. Each Knowledge Guide indicates what an intern needs to know to be able to perform the relevant EPA independently with distant supervision by the end of training.

Knowledge Guides:

- Extend the medical school curriculum in practice
- Help identify common and important presentations/conditions which an intern is likely to encounter, acknowledging that it is an indicative rather than exhaustive list and that other topics and concepts may be encountered in the course of the internship

There is one Knowledge Guide per EPA. A Knowledge Guide should be read in conjunction with the associated EPA. The Knowledge Guides follow a common format. Each section is prefaced with the statement "in order to be able to perform EPA X, the intern needs to *know...*"

For each Knowledge Guide interns are expected to be able to also apply relevant knowledge included in:

- Themes within the domains in the BE pillar of the curriculum
- The Knowledge Guide on Patient safety

Each guide is organised in sections which are relevant to that particular EPA, e.g. Clinical Knowledge, Policies, Procedures, Guidelines and System, Principles of Safe Prescribing.

There is one specific *Knowledge Guide on Patient safety* which describes the knowledge required by an intern which is relevant to all EPAs. There are 10 Patient safety domains (PSD) as follows:

1. Culture of Safety
2. Patient Safety
3. Reliability of Health Care Delivery
4. Care Transitions
5. Improvement Methods

6. Performance Measurement and Transparency
7. Quality of Care
8. Medication Safety
9. Infection Control
10. Preparedness for Transition

Sources consulted in the process of developing the Knowledge Guides are listed in **Appendix B**.

1.7 BE: Behaviours, Values and Practices

The BE pillar of the curriculum describes the **behaviours, values and practices expected of an intern as they adopt the professional identity of a doctor**. This part of the curriculum is organised according to the Medical Council Eight Domains of Good Professional Practice.

1. Patient Safety and Quality of Patient Care
2. Relating to Patients
3. Communication and Interpersonal Skills
4. Collaboration and Teamwork
5. Management and Self-management
6. Scholarship
7. Professionalism
8. Clinical Skills

The Medical Council description of these domains is provided in **Appendix E**.

The BE pillar is organised as a table, as follows:

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S), & Attitudes (A) The intern should be able to...

Within each domain, themes are identified e.g. the theme of "Trust and respect" in the domain of "Relating to patients".

Within each theme, **competencies** are identified. These are the observable abilities of a health professional related to a specific activity that integrates knowledge, skills and attitudes. Each theme has one or more competencies. Many of these competencies underpin how trainees conduct themselves while performing EPAs. These competencies are clearly communicated to supervisors, trainers, assessors and interns, as well as to the intern networks.

For each of the competencies, the underpinning **learning outcomes** are identified. These state what an intern should be able to demonstrate following a learning experience or training programme. Learning outcomes can be classified as knowledge, skill or attitudinal. Knowledge, skills and attitudes, when integrated, are the constituent elements of a competency. Learning outcomes are provided to intern networks to guide the curriculum as planned and delivered within the network.

1.8 Relationship between pillars in an integrated framework

The Curriculum Framework for the internship comprises three pillars, DO, KNOW and BE which are closely integrated, as illustrated in Fig 1 above, with EPAs as the cornerstone.

EPA and the Knowledge Guides

Each EPA is accompanied by a Knowledge Guide which details the underpinning knowledge that interns need to safely carry out that EPA. The Knowledge Guide on Patient safety applies to all EPAs.

Knowledge Guides and the BE Pillar

Each Knowledge Guide states that interns are expected to be able to also apply relevant knowledge included in themes within the competency domains in the BE pillar of the curriculum.

EPAs and the BE pillar

Within each EPA the most relevant competency domains from the BE pillar are identified, in keeping with the recommended description of an EPA, as illustrated below.

Mapping 7 EPAs against domains		Domains of Good Professional Practice							
EPA No.	Entrustable professional activity	Patient Safety & Quality of Patient Care	Relating to Patients	Communication & Interpersonal Skills	Collaboration & Teamwork	Management (including Self-Management)	Scholarship	Professionalism	Clinical Skills
1.	Clerking a patient		X	X				X	X
2.	Requesting and interpreting basic investigations	X					X	X	X
3.	Performing essential procedural skills		X					X	X
4.	Managing the work of inpatient care				X	X		X	
5.	Prescribing and monitoring drugs and fluids	X						X	X
6.	Recognising and managing the deteriorating/acutely unwell patient	X			X			X	X
7.	Handing over and discharging a patient	X		X	X			X	

Fig. 8 Mapping of EPAs against competency domains

Chapter 2

The Entrustable Professional Activities

2.1 Introduction

An **Entrustable Professional Activity** is "a unit of professional practices or essential tasks that a trainee can be trusted to perform without direct supervision, once sufficient competence has been demonstrated". Upon completion of the internship programme, doctors are expected to be able to perform the **seven EPAs** independently with mainly informal, remote or distant supervision. The seven EPAs are as follows:

No.	EPA Title	Description
1.	Clerking a patient	Clerking a patient in the outpatient and day care setting, admitting a patient to the ward and understanding decision to admit criteria and protocols.
2.	Requesting and interpreting basic investigations	Requesting and interpreting basic diagnostic laboratory, radiological and other investigations. Rationalising the requirement and the request.
3.	Performing essential procedural skills	Performing the essential procedural skills as listed in the EPA.
4.	Managing the work of in-patient care	Managing the daily workload. Prioritising, performing, sharing and delegating tasks to advance patient flow while delivering patient-centred care.
5.	Prescribing and monitoring drugs and fluids	Prescribing safely to comply with the legal requirements in hospital and for community settings.
6.	Recognising and managing the deteriorating/ acutely unwell patient	Identification, responding and managing the acutely unwell patient. Escalating the care to the team and senior colleagues as required.
7.	Handing over and discharging a patient	Handing-over and receiving hand-overs to/from colleagues. Managing the patient discharge and transfer processes and ensuring continuity of care.

Fig. 9 EPAs for the Internship

The prerequisites for all EPAs for the internship programme are that the intern:

- Meets eligibility criteria for recruitment to the internship
- Has completed the Basic Life Support (BLS) Certification

Each EPA is accompanied by a **Knowledge Guide**. These are guides to the underpinning knowledge that interns need to safely carry out the EPAs by the end of their training. Each Knowledge Guide indicates what an intern needs to know to be able to perform the relevant EPA independently with distant supervision by the end of training. There is one Knowledge Guide per EPA, and a specific Knowledge Guide on Patient safety, which is relevant to all EPAs. [Refer to the Knowledge Guides for the internship Curriculum Framework – **Chapter 3**]

The performance of each EPA is underpinned by the behaviours, values and practices expected of an intern as they adopt the professional identity of a doctor.

These are detailed in the **BE pillar of the Curriculum Framework** for the Internship. [Refer to the BE pillar of the internship Curriculum Framework – **Chapter 4**]

2.2 EPA 1 Clerking a patient

EPA	No. 1	1. Clerking a patient 
Title	Clerking a patient	
Specifications	Qualification for this EPA includes clerking a patient in the outpatient and day care setting, admitting a patient to the ward and understanding decision to admit criteria and protocols. Also includes: - Recording a focused history, a thorough physical examination and any pathological findings. There must be sufficient basis for requesting laboratory and radiological investigations and consultations that are pertinent to the case, rationalised and reflect best practice. The clinical note/document is logically structured and includes prioritised diagnoses, interpreted investigations and a treatment plan. - Communicating a summarised case to colleagues and other healthcare professionals. - Recognising complex cases early followed by seeking more senior, expert help.	
Potential risks in case of failure	Breach of patient confidentiality; loss of continuity of care; risk of error to patient; loss of sense of self-efficacy and stress for the intern	
Most relevant domains	Domains: 2 Relating to Patients; 3 Communication and Interpersonal Skills; 7 Professionalism; 8 Clinical Skills	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Establish rapport with the patient	
2	Consider factors that may affect the patient's capacity to describe their symptoms or understand questions and/or give informed consent	
3	Take a focused history in a range of contexts and conditions	
4	Recognise complex cases and seek help	
5	Obtain a history from other sources as required (e.g. collateral, own doctor, pharmacy, clinical notes)	
6	Share patient information only as appropriate with relevant parties	
7	Perform a fluid and sequential clinical examination	
8	Demonstrate respect for the patient's privacy, dignity and culture	
9	Identify abnormal clinical findings	
10	Request laboratory and radiological investigations and consultations that are pertinent to the case and reflect best practice	

11	Act on conditions and presentations that require immediate intervention, instigate initial resuscitation/treatment and call for senior help
12	Formulate a differential diagnosis
13	Devise a treatment and further management plan for review by senior clinician
14	Document all findings in the patient chart to comply with good professional practice
15	Follow prescribing protocols and discuss medications with senior colleagues
16	Recognise patients at risk of deterioration
17	Communicate with senior colleagues and nursing staff to ensure all have a shared mental model of the patient's condition and needs
18	Communicate openly and honestly with families and relatives of patients
Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Direct Observation • Case Presentation • Case Based Discussion • Reflective Journal • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 1** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

2.3 EPA 2 Requesting and interpreting investigation

EPA	No. 2	2. Requesting and interpreting basic investigations 
Title	Requesting and interpreting basic investigations	
Specifications & Limitations	Qualification for this EPA includes requesting and interpreting basic diagnostic laboratory, radiological and other investigations. Rationalising the requirement and the request. Also includes requesting and interpreting basic diagnostic laboratory and radiological investigations (plain films, basic haematology, biochemistry & microbiology panels for example) and includes: • Explaining and rationalising the requirement for investigations to the patient and medical team • Communicating the indications to the relevant laboratories and departments, team and patient • Formulating the most likely diagnosis and prioritisation of differential diagnoses • Using results to treat the patient and/or to inform the need for further investigations	
Potential risks in case of failure	Unnecessary tests requested; over or under investigation; misdiagnosis or delayed diagnosis; inefficiencies; loss of continuity of care; waste of resources	
Most relevant domains	Domains: 1 Patient Safety and Quality of Patient Care; 6 Scholarship; 7 Professionalism; 8 Clinical Skills	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Request investigations and screening tests based on patient information, best practice and team consultation	
2	Work together with patients so they can be involved in the decision-making process	
3	Correctly identify the patient and patient details so as to prevent error	
4	Factor in cost-effectiveness and risk-benefit analysis to the choice of investigation	
5	Communicate the clinical situation and rationale for the investigation to laboratory, radiology or other departments	
6	Actively seek the result of the investigation, including follow through on the request, as necessary	
7	Interpret the results of basic radiology reports and images and basic laboratory reports required for the area of practice	
8	Record the results of investigations in patient notes and the implications of the results in the patient's further care and management plan	
9	Communicate results and their meaning to the medical team	
10	Explain investigation results and their meaning to the patient and/or family, other than for cases requiring senior clinician involvement	
11	Identify further investigations or screening as required	
12	Act immediately on abnormal results and seek assistance as appropriate	

Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Case Based Discussion • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 2** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

2.4 EPA 3 Performing essential procedural skills

EPA	No. 3	3. Performing essential procedural skills 
Title	Performing essential procedural skills	
Specifications	Qualification for this EPA includes Performing the essential procedural skills as listed in the EPA. Includes: • Performing hand hygiene • Donning and doffing of PPE • Venepuncture • Peripheral intravenous cannulation • Taking blood cultures from a peripheral vein • Sampling arterial blood gas • Performing an electrocardiogram (ECG) • Inserting a nasogastric tube • Inserting a urinary catheter • Preparing, reconstituting, diluting and administering intravenous drugs • Blood sampling culturing from central line and tunnelled lines • Setting up a sterile field • Putting on sterile gloves Interns may have the opportunity to perform other procedures	
Potential risks in case of failure	Harm/injury to the patient; infection risk; risk to the doctor; inaccurate results/outcome; risk to continuity of care; waste of resources.	
Most relevant domains	Domains: 2 Relating to patients; 7 Professionalism; 8 Clinical skills.	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Describe the indications and contraindications for a procedure	
2	Perform procedures cost-effectively, based on patient information and preferences, and maintaining patient privacy	
3	Recognise own limitations in potentially complex patient cases and call for help	
4	Perform 5 moments of hand hygiene	
5	Use aseptic non-touch technique	
6	Obtain verbal informed consent from the patient by explaining the indications, alternatives, potential complications and implications of failure of the procedure	
7	Put the patient at ease and establish trust	
8	Adopt standard operating procedures and national standards for clinical practice guidelines	
9	Set up a sterile field, maintain aseptic and sterile conditions	
10	Apply needle stick injury protocols	
11	Dispose of hazardous and clinical waste as per protocols	
12	Recognise any immediate failures or complications of the procedure and act immediately	
13	Document the indications and events of the procedure in the clinical notes	
14	Communicate the further treatment plan to the nursing staff and patient	

Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Direct Observation • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training.
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 3** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

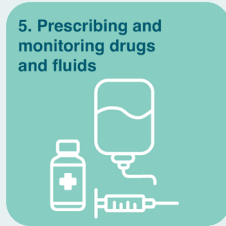
2.5 EPA 4 Managing the work of in-patient care

EPA	No. 4	4. Managing the work of in-patient care 
Title	Managing the work of in-patient care	
Specifications	Qualification for this EPA includes managing the daily workload. Prioritising, performing, sharing and delegating tasks to advance patient flow while delivering patient-centred care. Also includes: • Requesting investigations and following up the results • Using written and electronic forms of communication • Generating flow sheets to formulate a management plan • Working with teams and colleagues and communicating by listening to and sharing information and advice • Knowing limitations and seeking senior input and advice when appropriate • Communicating openly and honestly with the patient and families	
Potential risks in case of failure	Harm to patient; risk to continuity of care; inefficiencies and inadequate prioritisation; waste of resources; work overload; stress and burnout.	
Most relevant domains	Domains: 3 Collaboration and Teamwork; 5 Management (Including Self-Management); 7 Professionalism.	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Prepare and consolidate information in advance of ward rounds and theatre/procedure lists	
2	Communicate patient status and data effectively to the team	
3	Keep good records in clinical notes – SOAP and flow sheets	
4	Prioritise and delegate tasks	
5	Contribute to patient management and recognise cases or situations requiring senior clinician involvement	
6	Review patients and communicate their daily progress plan to healthcare staff	
7	Review, record and report trends and changes in laboratory and radiological investigations	
8	Respond to requests from team and nursing staff in a timely manner	
9	Consent patients on behalf of a senior doctor and in line with MC guidelines, and appreciate the extent of a patient's autonomy over healthcare decisions	
10	Contribute to the management of long-term conditions during episodes of acute care	
11	Take account of the input of other healthcare providers - their views, knowledge, skills and experiences - to work as an effective team	
12	Respond to acutely deteriorating patient (including using NEWS)	
13	Identify their level of clinical experience to patients and family when discussing patient care and defer to a more senior clinician	
14	Manage challenging patient encounters and situations with senior support	
15	Pronounce death of patients and follow local procedures	
16	Discuss options with patients and their families to enable shared decision-making, other than for cases requiring senior clinician involvement	
17	Deal with patient issues in a sensitive and non-judgmental manner	
18	Consider the mental state of a patient during their stay on the ward	

19	Participate in breaking of bad news to patient and family in a compassionate manner, with a senior clinician
20	Disclose serious and adverse events or harm done in the course of healthcare to patients and families, for procedures for which they are responsible and know the reporting mechanisms
21	Complete an incident report form, as per local procedures
22	Maintain patient data, confidentiality and trust
Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Case Presentation • Case Based Discussion • Reflective Journal • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 4** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

2.6 EPA 5 Prescribing and monitoring drugs and fluids

EPA	No. 5	
Title	Prescribing and monitoring drugs and fluids	
Specifications & Limitations	Qualification for this EPA includes prescribing safely to comply with the legal requirements in hospital and for community settings. Also includes: • Rationalising the prescriptions • Taking an accurate medication history • Prescribing blood products, oxygen and fluids • Following safe prescribing practices (checking expiry dates, using double validation and patient identification) • Reviewing and prescribing patient medications and fluids, based on assessment of the patient and in the context of the patient's clinical status (for example, age weight, renal function, hydration status, cardiac status etc.)	
Potential risks in case of failure	Patient harm; medication error; waste of resources	
Most relevant domains	Domains: 1 Patient Safety and Quality of Patient Care; 6 Scholarship; 7 Professionalism; 8 Clinical Skills.	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Communicate effectively with the ward pharmacist, haemovigilance officer, nursing staff and microbiology department	
2	Take a medication history from patient and other available sources	
3	Adjust medication and fluid doses according to age, weight, height, renal function, cardiac function etc. in consultation with senior clinician	
4	Explain drug, blood and fluid treatment and administration, to patients, including side effects and interactions	
5	Demonstrate a shared decision-making approach with senior support	
6	Check a patient's adherence to prescription	
7	Prescribe blood, fluids and medications legibly and correctly	
8	Consult medication guidelines when reconstituting drugs	
9	Document all allergies and ADRs in the notes and on the prescription	
10	Manage anaphylaxis with a senior clinician	
11	Document medication changes and the indications for medication changes in the clinical notes	
12	Review medications including appropriate discontinuation or tapering where relevant (for example - IV to Oral switch) in consultation with senior clinician	
13	Prescribe and administer fluids and blood having elicited symptoms and signs of clinical need (e.g. dehydration, anaemia)	
14	Recognise the need to monitor potentially organ toxic drugs (vancomycin, gentamicin)	
15	Request blood products according to best practice and hospital ordering schedules	
16	Manage common transfusion reactions	
17	Ensure correct patient identification when prescribing medications, fluids and blood	

18	Review the requirement for newly started medications based on patients' clinical progress – thromboprophylaxis, antibiotics, in consultation with senior clinician
19	Use recognised analgesia guidelines to prescribe and step-down pain medication, in
20	Use and prescribe appropriate oxygen therapies and review response
21	Recognise, address and inform patient, pharmacy and risk managers of medication errors
22	Write or complete a discharge prescription in accordance with legislation and local
23	Communicate medication changes to patient, family and general practitioner
Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Case Based Discussion • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 5** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

2.7 EPA 6 Recognising and managing the deteriorating/acutely unwell patient

EPA	No. 6	6. Recognising and managing the deteriorating/acutely unwell patient 
Title	Recognising and managing the deteriorating/acutely unwell patient	
Specifications	Qualification for this EPA includes identification, responding and managing the acutely unwell patient. Escalating the care to the team and senior colleagues as required. Also includes: • Rapidly determining a working diagnosis based on taking a focused history and examining the patient, interpreting data, gathering information and being situation-aware • Commencing initial management based on clinical reasoning and decision-making skills and assessing the patient's response to treatment • Reviewing response to treatment and adapting management as required • Recognising limitations and initiating a call for assistance from seniors and team members • Recognising the need to transfer care • Reviewing and reflecting with the team on the outcomes of acute care cases • Keeping up to date with international practice and management guidelines (for example ACLS and sepsis six guidelines)	
Potential risks in case of failure	Harm to patient; risk to continuity of care	
Most relevant domains	Domains: 1 Patient Safety and Quality of Patient Care; 3 Collaboration and Teamwork; 7 Professionalism; 8 Clinical Skills	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Recognise the severity of a patient's condition utilising track and trigger systems and situation awareness	
2	Receive a handover from nursing staff and be aware of the patient's recent clinical course	
3	Take a focused history and examination	
4	Determine a working differential diagnosis	
5	Call for help from senior clinicians, escalate care and give a handover on phone or in person	
6	Apply the principles of standardised protocols and clinical guidelines as indicated (NEWS, ACLS, ATLS, PALS, sepsis six bundles)	
7	Review patient response to initial treatment and respond, act on and adapt treatment as required, in consultation with senior clinician	
8	Communicate the situation to team members involved in patient care, patient, and update family members with a senior clinician	
9	Delegate to others in the team	
10	Document the events in the clinical notes in a well-structured format	
11	Formulate a further care plan to address prioritised differentials with a senior clinician	
12	Participate in breaking of bad news to patient and family in a compassionate manner, with a senior clinician	
13	Debrief with the team and review the outcomes	
14	Reflect on outcomes and performance, and identify areas for improvement	

Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Case Presentation • Case Based Discussion • Reflective Journal • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 6** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

2.8 EPA 7 Handing over and discharging a patient

EPA	No. 7	
Title	Handing over and discharging a patient	
Specifications	Qualification for this EPA includes handing over and receiving hand-overs to/from colleagues. Managing the patient discharge and transfer processes and ensuring continuity of care. Also includes: - Communicating, summarising and documenting a review of the patient's clinical course - Highlighting the changes made to previous medications and treatment plans - Explaining the reason for discharge/transfer to receiving clinician, family and patient - Ensuring all up-to-date records and results are available to the receiving clinician	
Potential risks in case of failure	Harm to patient; loss of continuity of care; loss of follow up with the patient; medication not reconciled	
Most relevant domains	Domains: 1 Patient Safety and Quality of Patient Care; 3 Collaboration and Teamwork; 7 Professionalism; 8 Clinical Skills	
Required Knowledge, Skills, Attitudes (KSAs)		
1	Communicate the clinical situation in an open, honest and effective manner with medical staff, patient and family	
2	Use clinical judgment to recognise the need for handover or transfer/discharge	
3	Plan in advance for patient discharge and ensure supports are in place to facilitate discharge (for example home supports and assistance)	
4	Summarise a clinical case verbally, electronically/in writing in the clinical notes using a structured system such as ISBAR when handing over patient care	
5	Perform a fluid handover of patients at end of and change of shifts at the appointed time and place	
6	Record a diagnosis as well as active and inactive secondary diagnoses accurately	
7	Formally refer patients to further specialist or tertiary services	
8	Communicate the situation to team members involved in patient care, patient, and update family members, with a senior clinician	
9	Determine patient fitness to work (and return to work) in consultation with the team	
10	Participate in transfer of patient to another healthcare receiver (ward, theatre, ICU, GP) and/or family	
11	Discharge patients verbally, electronically and in the notes from hospital	
12	Respond to queries from a patient's family doctor following discharge	
13	Ensure follow-up arrangements are in place as appropriate	

Required experience	<i>To be determined following the review of intern posts and piloting of WBA</i>
Information sources to determine progress and support summative entrustment	• Direct Observation • Case Based Discussion • Reflective Journal • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i>
When is which ES-level expected	The intern should be able to perform the activity independently with distant supervision (Level 4) by the end of intern training
Expiry date	Trust in the ability to perform this EPA with distant supervision is maintained as long as the doctor is involved in clinical work. Otherwise, it expires in three years.

See **Knowledge Guide for EPA 7** for what an intern needs to know to be able to perform this EPA. See the **BE pillar** for the competencies which underpin how interns conduct themselves while performing EPAs.

Chapter 3

The Knowledge Guides

3.1 Introduction

Knowledge Guides are guides to the underpinning knowledge that interns need to safely carry out the EPAs by the end of their training. Each Knowledge Guide indicates what an intern needs to know to perform the relevant EPA independently with distant supervision by the end of training. There is one Knowledge Guide per EPA. A Knowledge Guide should be read in conjunction with the associated EPA. There is one specific *Knowledge Guide on Patient safety* which describes the knowledge required by an intern which is relevant to all EPAs.

3.2 Knowledge Guide for EPA 1

Knowledge Guide for EPA 1: Clerking a patient

Knowledge required by the intern:

In order to be able to perform EPA 1 interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

1. Clinical knowledge

In order to be able to perform EPA 1, the intern needs to know:

- Basic and clinical science relating to their patients' presenting conditions and co-existing conditions and the natural history of common conditions
- The principles of chronic disease-management, including the role of the patient as an expert in their health and the importance of a holistic approach, taking into account the physical, social and psychological needs of the patient during acute hospital care, discharge planning and in non-acute healthcare settings
- The importance of recognising and addressing co-existing conditions, including mental health conditions and other chronic illness on the assessment and management of patients

- The principles of history-taking including focused history-taking, in addition to the importance of gathering and synthesising information from other sources (e.g. collateral, own doctor, pharmacy, clinical notes, local electronic records and systems within the hospital)
- The principles of clinical examination
- The role of commonly-used standardised assessments e.g. frailty score, mental state, pain scores etc.
- The local admission pathways for common conditions e.g., diabetic foot, chest pain, neurology etc.
- The importance of rational use of investigations in the generation of a differential diagnosis
- The principles of pre-operative assessment
- How to synthesise a differential diagnosis and management plan based on professional knowledge, established guidelines and legislative requirements, and seek senior help in a timely manner
- The role of the intern in preventative medicine and promoting public health
- The initial management of commonly encountered urgent situations, the importance of recognising one's own limitations and calling for help - either physical or senior help - in a timely manner

2. Policies, procedures, guidelines and system

In order to be able to perform EPA 1, the intern needs to know:

- Local ICT and paper-based systems, including how to access patient clinical records, including clinical notes, medications, investigations and results
- The communication procedures and protocols in the local hospital e.g., referrals and consults pathways, radiology, phlebotomy etc.
- The ISBAR3 and the importance of standardised handover in accordance with the national clinical guidelines no. 5 and no. 11
- The National Early Warning Systems, their interpretation and the appropriate escalation pathways related to same
- How to access local clinical guidelines e.g. pre-operative assessment guidelines and national guidelines such as MBOS – maximum surgical blood ordering schedule guidelines
- How to prescribe and monitor drugs and fluids in accordance with EPA 5
- Safeguarding guidelines

3.3 Knowledge Guide for EPA 2

Knowledge Guide for EPA 2: Requesting and interpreting basic investigations

Knowledge required by the intern:

In order to be able to perform EPA 2, interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

1. Requesting an investigation

In order to be able to perform EPA 2 the intern needs to know:

- Basic and clinical science relating to their patient's presenting condition and co-existing conditions and the natural history of common conditions
- The investigation(s) appropriate to a patient's presentation/signs or symptoms and in accordance with evidence-based protocols, guidelines and recommendations where available
- The indications, contraindications and risks associated with the investigation
- The resource implications of ordering investigations (cost and human resources)
- The waste and sustainability implications of requests
- Consent protocols for that investigation

2. Interpreting an investigation

In order to be able to perform EPA 2 the intern needs to know:

- Relevant basic and clinical science relating to the patients' presenting condition and coexisting conditions, including the natural history of common conditions
- Recognise abnormal and potentially dangerous abnormalities of bedside diagnostic tests (e.g. ECG, SpO₂, peak flow) and escalate accordingly
- How to interpret results and reports from other departments based on the clinical context, previous results, reference ranges and recommendations from laboratory/radiology or other departments

- How to synthesise a differential diagnosis
- The management of common abnormalities and the importance of escalating in a timely manner in accordance with their limitations and level of experience
- The impact of illness and disease on patients and their quality of life

3. Policies, procedures, guidelines and systems

In order to be able to perform EPA 2 the intern needs to ***know***:

- Local processes and ICT systems required for requesting, retrieving, and documentation of investigations
- The communication structures in the local hospital and community e.g. escalation pathways, handover, bleep systems, radiology, involvement of multidisciplinary team, etc.
- Procedures for following up, recording (e.g. flow sheets), reporting and keeping senior colleagues informed of abnormal results with the appropriate level of urgency or in a timely fashion
- Relevant local or national policies or regulations relating to investigations and know and understand the importance of adhering to these e.g. haemovigilance

3.4 Knowledge Guide for EPA 3

Knowledge Guide for EPA 3: Performing essential procedural skills

Knowledge required by the intern:

In order to be able to perform EPA 3 interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge guide on **Patient safety**

1. Knowledge of the procedure

In order to be able to perform EPA 3 the intern needs to ***know***:

- The anatomy relevant to each procedure
- Indications, contraindications, risks, alternatives, potential complications of each procedure, and implications of a failed procedure

- The signs and symptoms associated with each potential complication of the procedure and the immediate management of same
- The resource implications of ordering investigations (cost, time and human resources including clinical and laboratory time)
- The waste and sustainability implications of the procedure
- The role of the intern in requesting and interpreting investigations in accordance with EPA 2

2. Knowledge of the task (a standard operating procedure (SoP) such as a task analysis or similar)

In order to be able to perform EPA 3 the intern needs to know:

- Infection prevention and control measures including 5-moments of hand hygiene, aseptic non-touch technique, setting up and maintaining a sterile field, appropriate use of PPE, risk of cross infection and the steps for ensuring personal safety
- The correct SoP/task analysis for each skill in keeping with local guidelines and in the context of locally available equipment under the following headings:
 - ▶ Selecting equipment
 - ▶ Preparing equipment
 - ▶ Preparing oneself
 - ▶ Preparing the patient
 - ▶ Procedural steps
 - ▶ Documentation
 - ▶ Post-procedural care
 - ▶ Troubleshooting
- Waste management policies and the role of individuals in ensuring correct waste management in a safety, environmental and financial context
- Local laboratory guidelines for collecting, labelling, transporting samples and correct usage of any point of care tests such as ABG machine
- Local policies on management of indwelling devices (cannulas, catheters, nasogastric tubes) with respect to documentation, dressings and removal dates
- Appropriate escalation pathways in the event of procedural difficulties or complications

Refer to an appropriate Standard Operating Procedure (SOP) or Task Analyses for essential procedural skills, see for example: Irish Centre for Applied Patient Safety and Simulation (2022) [A Compendium of the Steps Required to Complete 13 Essential Clinical Procedures](#), Galway: NUI Galway¹⁸

3.5 Knowledge Guide for EPA 4

Knowledge Guide for EPA 4: Managing the work of inpatient care

Knowledge required by the intern:

In order to be able to perform EPA 4, interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

EPA 4 knowledge guide focuses on the day-to-day work of in-patient care and excludes aspects of patient care which are covered more comprehensively in other EPAs.

1. Clinical knowledge

In order to be able to perform EPA 4 the intern needs to know:

- Basic and clinical science relating to common conditions
- The principles of chronic disease-management, including the role of the patient as an expert in their health and the importance of a holistic approach taking into account the physical, social and psychological needs of the patient during acute hospital care, discharge planning
- The importance of recognising and addressing co-existing conditions including mental health conditions and other chronic illnesses in the assessment and management of patients
- The role of the collateral history
- How to carry out a focussed contextualised assessmentThe role of commonly used standardised assessments e.g. frailty score, mental state, pain scores etc.
- The importance of accurate and regular documentation of the patients' clinical journey through the use of structured clinical notes and SOAP notes

¹⁸ Completed as the outcome of a NDTP-funded development project (Ref 25INT205). Implementing competency-based education on clinical site. How can we make training and assessment accessible for trainees? Funded NDTP 29.06.2021

- How to present a patient's clinical history and status succinctly
- The role of the intern in preventative medicine and promoting public health
- The immediate management of the critically ill patient and when to seek advice
- The process for assessing and managing a patient wishing to leave the hospital against medical advice
- Principles of end-of-life care including:
 - I. The dying process
 - II. The importance of establishing and documenting resuscitation status and ceilings of care, where appropriate, and in a timely manner by the appropriate member of the team
 - III. Strategies for dealing with difficult questions
 - IV. The importance of prescribing anticipatory medication for the last days of life
 - V. The stages of the grieving process
 - VI. Strategies for responding to emotion in oneself and others
 - VII. Medicolegal and practical aspects relating to pronouncing death, post-mortems and the coroner
- The processes for pronouncing death in accordance with local and national policies relating to post-mortems and the coroner

2. Policies, procedures, guidelines and system

In order to be able to perform EPA 4, the intern needs to know:

- The use of the ICT on the clinical site, the training requirement for access, and the password policies
- The communication structures in the local hospital e.g. laboratory and radiology results, referrals and consults pathways, escalation pathways, handover, bleep systems, radiology, incident reporting etc.
- Local and national processes relating to pronouncing death, documentation and the role of the coroner
- Open disclosure policy
- HSE guidelines on the provision of an interpreting service and local resources
- Safeguarding principles
- National Sepsis Guidelines
- National Early Warning Systems
- Local handover policies using ISBAR3 devised based on national clinical guidelines
- Dignity at work policy

- Local handover structures in accordance with relevant National Clinical Guidelines
- The layout of the clinical site including the location of wards, departments and facilities
- The structure and daily timetable of the clinical team

3.6 Knowledge Guide for EPA 5

Knowledge Guide for EPA 5: Prescribing and monitoring drugs and fluids

Knowledge required by the intern:

In order to be able to perform EPA 5, interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

1. Principles of safe prescribing

In order to be able to perform EPA 5, the intern needs to know:

- How to establish the correct dosing, drug regulations and local prescribing guidelines for all drugs, fluids, blood products and oxygen
- They are limited to prescribing for patients in their care
- The drugs that they are not registered to prescribe
- How to take a medication history, including a collateral history, including allergies and reactions to medications and therapies
- The layout and sections of the inpatient prescriptions available on the clinical site
- How to correctly document medications including start & stop dates, decreasing doses, doses, units etc.
- The indications, contraindications, side effects, special precautions, allergies and basic pharmacokinetics and pharmacodynamics for commonly prescribed medications including:
 - ▶ Analgesia (WHO analgesic ladder)
 - ▶ Antibiotics
 - ▶ Anti-coagulants
 - ▶ Anti-emetics
 - ▶ Insulin and other anti-glycaemic drugs
 - ▶ Laxatives

- ▶ Sedation
 - ▶ Oxygen
 - ▶ Fluids
 - ▶ Electrolytes
 - ▶ Steroids
 - ▶ Blood products
-
- Relevance of age, weight, renal/cardiac status, drug blood levels etc. for prescriptions and adjustments of medication
 - Which medications require routine monitoring of blood levels, and the appropriate time intervals for checking
 - How to establish target levels of oxygen saturation patient's condition
 - How to communicate changes in prescriptions and the monitoring requirements to the clinical team including nursing and health and social care professionals (HSCPs)
 - How to recognise and initiate management of common blood product transfusion reactions
 - How to recognise and initiate management of anaphylaxis
 - Procedures for recording and incident reporting adverse drug reactions, medication errors, transfusion reactions, near misses
 - The risk of drug dependency when prescribing benzodiazepines, opiates or other drugs with addictive potential
 - Safe prescribing practices with knowledge of how to prescribe for a wide variety of patients including in pregnancy, breastfeeding, CKD etc.

2. Medicine reconciliation

In order to be able to perform EPA 5 the intern needs to know:

- How to apply principles of multidisciplinary communication with staff (microbiology, nursing, general practitioners and pharmacy including community pharmacy and with family (collateral history) to the prescribing of medications
- To document all medications in the patient's drug record, including over-the-counter medications, herbal and homeopathic medications and medications administered via nonoral routes e.g. nasal sprays, ear drops, eye drops etc.
- The importance of regular medication review and how to carry out a medication review to rationalise treatment

- Local standardised procedures for medication prescribing both inpatient (e.g. hospital medication record/s, medications, chemotherapy, insulin and anti-coagulants) and community prescriptions such as medication discharge prescriptions or special prescriptions for home oxygen etc.
- The layout and sections of the inpatient prescriptions/s available on the clinical site
- How to correctly document medications including start & stop, including those for regular medications, chemotherapy, insulin and anti-coagulants) and community prescriptions such as medication discharge prescriptions or special prescriptions for home oxygen etc.
- How to communicate details regarding medications using handover and discharge protocols

3. Policies, procedures, guidelines and systems

In order to be able to perform EPA 5 the intern needs to **know**:

- Local standardised procedures for inpatient medication prescribing (e.g. hospital medication record/s, regular dates review, decreasing doses, units etc.)
- Protocols for controlled drug and high-tech prescribing in accordance with legislation and local procedure

3.7 Knowledge Guide for EPA 6

Knowledge Guide for EPA 6: Managing the deteriorating or acutely unwell patient

Knowledge required by the intern:

In order to be able to perform EPA 6 interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

1. Clinical knowledge

To be able to perform EPA 6, the intern needs to **know**:

- How to interpret EWS in a clinical context

- Basic and clinical science of common conditions including the natural history of the condition, how to recognise, assess and manage complications
- The basic, clinical science and differential diagnosis relating to common on-call scenarios, including appropriate investigations
- The principles of chronic disease management, including the role of the patient as an expert in their health and the importance of a holistic approach taking into account the physical, social and psychological needs of the patient during acute hospital care
- The importance of recognising and addressing co-existing conditions including mental health conditions and other chronic illnesses in the assessment and management of patients
- The principles of focused history-taking in addition to the importance of gathering and synthesising information from other sources
- The principles of clinical examination
- The importance of rational use of investigations in the generation of a differential diagnosis
- The role of commonly used standardised assessments e.g. frailty score, mental state, pain scores etc.
- How to synthesise a differential diagnosis and management plan, based on professional knowledge, established guidelines and legislative requirements, and where necessary in the context of diagnostic uncertainty while recognising one's own limitations and seeking senior help in a timely manner
- Prepare a differential diagnosis and management plan based on knowledge guidelines and legislative requirements e.g. in the case of a confused patient
- The ABCDE approach to treating the deteriorating patient
- The initial management of commonly encountered urgent situations, the importance of recognising one's own limitations and calling for help either physical or senior help in a timely manner
- ACLS protocols
- How to monitor response to treatments

2. Policies, procedures, guidelines and system

To be able to perform EPA 6, the intern needs to know:

- The local EWS policy
- The local on-call staffing arrangements and escalation policies

- Local policies for accessing investigations, consults and referrals in normal time and during on-call periods e.g. access to radiology, laboratory
- Emergency phone numbers e.g. cardiac arrest, stroke call, massive transfusion
- How to access prescribing guidance
- How to access local and national clinical policies, protocols and guidelines e.g. EWS, Sepsis 6, ACS, hyperkalaemia, DKA
- Local handover structures in accordance with relevant National Clinical Guidelines

3.8 Knowledge Guide for EPA 7

Knowledge Guide for EPA 7: Handing over and discharging a patient

Knowledge required by the intern:

In order to be able to perform EPA 7, interns are expected to apply knowledge included in:

- Relevant themes/domains in the **BE pillar** of the curriculum
- The Knowledge Guide on **Patient safety**

1. Underlying medical condition/s:

In order to be able to perform EPA 7, the intern needs to know:

- The reason for hospital admission
- The aetiology, pathophysiology, clinical features, diagnosis, treatment and prognosis of the patient's primary medical condition which resulted in hospital admission
- Any co-morbidities if present, whether they are active or inactive, and how they interact to affect the patient's overall clinical condition
- How to write a problem list identifying patients' current/active medical issues and the management plan for each
- Where to seek expert advice for less common conditions or complex cases,
- How to communicate the course of patients' hospital stay with the patient and carers/family on discharge

2. Investigations and diagnosis

In order to be able to perform EPA 7 the intern needs to know:

- The investigations carried out on the patient and their indications - both in general and as applied to the patient
- The relevant results of investigations carried out and any significant pending investigations
- How the patient's diagnosis was made with reference to the relevant investigations
- Possible differential diagnoses for the case
- Potential adverse effects of invasive investigations
- Additional investigations that may be indicated and scenarios which might trigger additional investigation (e.g., further spike in temperature)
- How to discuss relevant findings with the patient and carers/family on discharge

3. Treatments and procedures

In order to be able to perform EPA 7, the intern needs to know:

- The procedures the patient underwent during their inpatient stay, including the indications, outcomes for this patient and any potential adverse effects in the context of the patient's condition
- Patient's current medications and any changes to medications during the inpatient stay, the indication for the changes, planned duration of treatment, potential adverse effects and any follow-up or specific monitoring required
- The current management plan and how this plan might be adapted, depending on changes in the patients' condition
- How to discuss medication changes with the patient and family
- Transfer protocols and who to contact at the transferring and receiving hospital

4. Procedures and protocols relating to effective communication

In order to be able to perform EPA 7, the intern needs to know:

- How to prepare for handover, including which patients to highlight, what information to hand over, who to hand over to

- How to prepare for discharge, including who to communicate the discharge information to and what information to include
- Strategies to effectively include the patient and family in the discharge planning process
- How to ensure members of the multidisciplinary team involved in the care of the patient are kept informed of discharge plans
- How to communicate a handover, including the structure of a good discharge letter, handover note, referral letter, transfer note and the additional information required (e.g. scans)
- The use of the ISBAR3 communication tool
- The use of SPIKES or similar protocol for breaking bad news
- Local policy relating to efficient discharge or transfer of patients
- Local policy in relation to effective handover of patients
- Local policy in relation to documentation of handover or discharge in patient records

5. Follow-up procedures on discharge

In order to be able to perform EPA 7, the intern needs to know:

- The plan for follow-up of patients who have been discharged
- How to refer to outpatient clinics as needed
- How to refer to specialist or tertiary services as needed
- What community supports are available
- How to identify patients in need of additional support and ensure this support is coordinated with the patient's discharge
- The clinical conditions and occupational hazards which could delay or prevent a patient from returning to work

6. Synthesis of knowledge towards clinical decision-making

In order to be able to perform EPA 7, the intern needs to know:

- How to synthesize their knowledge of the patient and understanding of the patient's medical condition in order to:
 - ▶ Identify patients who should be highlighted during handover
 - ▶ Identify patients who are ready for discharge
 - ▶ Plan for discharge in advance, identifying those patients who are likely to require additional supports

- ▶ Mobilise the multidisciplinary team to plan and support a patient's discharge where indicated

3.9 Knowledge Guide on Patient Safety for all EPAs

Knowledge Guide on Patient safety: For all EPAs

Avoidable patient harm continues to occur in healthcare settings internationally. One key approach to addressing this issue is through developing knowledge and skills relating to Patient safety and quality improvement among medical students and interns to better prepare them for safe and effective practice.

There are 10 Patient safety domains (PSD)

1. Culture of safety: *This is how an organisation shows that it is committed to safety.*

In order to be able to perform the EPAs, the intern needs to know:

- What is meant by safety culture?
- Different terms used when describing Patient safety e.g. error, adverse event, harm
- The role of the intern in recognising and addressing threats to Patient safety
- How medical error affects patients and their families
- The open disclosure policy
- The importance of truthfully communicating with patients when an error occurs and how to effectively do this
- The organisational and governance structures in the hospital and the HSE

2. Patient safety: *This is about preventing errors from happening to patients.*

In order to be able to perform the EPAs, the intern needs to know:

- The role of the intern in recognising and addressing threats to Patient safety
- Different terms used when describing Patient safety e.g. error, adverse event, harm
- The theory behind error and systems failure from other industries and how shortcomings in the healthcare system can impact Patient safety
- How to analyse a Patient safety incident and recognise contributory factors to the incident

3. Reliability of health care delivery: *This is about ensuring that the processes in healthcare are reliable.*

In order to be able to perform the EPAs, the intern needs to know:

- The role and expertise of other members of the healthcare team in the hospital and community setting - including but not limited to - nurses, pharmacists, health and social care professionals, porters, laboratory staff, general practitioners, administrative and support staff
- How risky organisations operate reliably to prevent error including identity checks and following protocol and procedures
- The role of protocols and guidelines
- The non-technical skills required to provide safe care in a complex healthcare system
- The importance of standardised handover using ISBAR in accordance with the national handover guidelines
- The importance of non-technical skills in the management of the deteriorating patient including; team-working, decision-making, situation awareness and leadership

4. Care transitions: *This is about transferring patient care to another healthcare setting or colleague.*

In order to be able to perform the EPAs, the intern needs to know:

- Common transition areas in healthcare where safety gaps can happen
- Importance of standardised handover using ISBAR in accordance with the national handover guidelines
- Local handover structures
- Importance of accurate and timely communication with the general practitioner on discharge
- How to communicate effectively with patients and families in providing information advice and support when they are being discharged
- Importance of standardised handover using ISBAR in accordance with the national handover guidelines

5. Improvement methods: *This is about considering methods for improving care.*

In order to be able to perform the EPAs, the intern needs to know:

- What quality improvement is and why it is important in healthcare
- How to use different tools for quality improvement
- Using a worked example, identify a quality gap and plan a quality improvement project in an area
- The importance of reflective practice in identifying improvement ideas

6. Performance measurement and transparency: *This is about measuring and responding to Patient safety.*

In order to be able to perform the EPAs, the intern needs to know:

- How to measure Patient safety in different healthcare settings
- The importance of reliable incident reporting systems if a medical error occurs
- How to use incident reporting systems

7. Quality of care: *This is the relation of care to the six domains of quality.*

In order to be able to perform the EPAs, the intern needs to know:

- What is meant by the 6 domains of quality and examples of issues relating to each of these:
 - ▶ Safe care, effective care, efficient care, timely care, equitable care and patient-centred care

8. Medication safety: *This is about safety in prescribing and dispensing medicine.*

In order to be able to perform the EPAs, the intern needs to know:

- The principles of prescribing
- How to recognise the common types of medication error
- How to recognise the factors that commonly contribute to error
- The common types of medication errors and how often they occur

- Factors that contribute to medication errors
- Causes and effects of medication error
- Safe prescribing practices as outlined in KG for EPA 5

9. Infection control: *This is about the actions that are taken to reduce the risk of patient infection while receiving care.*

In order to be able to perform the EPAs, the intern needs to know:

- What is meant by healthcare acquired infections (HCAI) and how to prevent them
 - ▶ How infections are passed on to patients in healthcare settings
 - ▶ The seriousness of poor hygiene and infection control for patients
 - ▶ The 5 moments of hand hygiene
- How to prevent HCAI amongst patients
- The principles of Aseptic Non-Touch Technique (ANTT)
- Contact precautions that should be used when caring for a patient with known or suspected infection to prevent transmission

10. Preparedness for transition: *This is about ensuring interns feel prepared for transitioning to senior house officer (SHO) level.*

In order to be able to perform the EPAs, the intern needs to know:

- The role of an SHO and the tasks an SHO is expected to do
- The challenges of being an SHO
- How to recognise one's own limitations in conjunction with one's level of experience and call for help
- How to recognise opportunities for professional development and building resilience
- How to protect one's wellbeing

Chapter 4

The BE Pillar of the Curriculum Framework

4.1 Introduction

The BE pillar of the Curriculum Framework describes the **behaviours, values and practices** expected of an intern as they adopt the professional identity of a doctor.

This pillar is organised according to the Medical Council Eight **Domains** of Good Professional Practice¹⁹. Within each domain, **themes** are identified. Within each theme, **competencies** are identified. These are the observable abilities of a health professional related to a specific activity that integrates knowledge (K), skills (S), and attitudes (A). These competencies underpin how trainees conduct themselves while performing EPAs.

For each of the competencies, the underpinning **learning outcomes** are identified. These state what an intern should be able to demonstrate following a learning experience or training programme. Learning outcomes can be classified as knowledge (K), skills (S), and attitudes (A). Learning outcomes guide the curriculum as planned and delivered locally by intern networks.

See **Appendix B** for an account of the development of the template and content of the BE pillar of the Curriculum Framework and points for consideration.

4.2 Domain 1: Patient safety and quality of patient care

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PATIENT SAFETY AND QUALITY OF PATIENT CARE	1.1 Promoting patient safety	Take responsibility for the safe care of individual patients Prioritise protection of children & vulnerable individuals	• Make patient safety a priority in clinical practice • Work within clinical governance frameworks to deliver healthcare under senior/consultant direction • Recognise the potentially vulnerable patient (e.g.: children, elderly, those with neurodevelopmental disorders, potential victims of abuse and those in need of extra support) • Recognise that physical and mental health assessment is an essential component in ensuring wellbeing and resilience in patients

¹⁹ These eight domains are described in **Appendix E**

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PATIENT SAFETY AND QUALITY OF PATIENT CARE	1.2 Practice management	Promote safe working practice & participate in quality improvement	- Understand clinical governance as the overarching framework that unites a range of quality safeguarding standards and quality improvement mechanisms that underpin clinical practice - Understand limitations of clinical pathways and seeks advice regarding deviating from these in certain individual patient circumstances - Practice correct patient identification protocols when approaching patients, engaging in bedside procedures - Practice basic hand-washing and infection control precautions as per local protocols and national guidelines - Practice hemovigilance in accordance with local protocols and national guidelines - Understand appropriate pre-theatre/procedure checks, including WHO safe surgery checklist - Take part in morbidity and mortality meetings and in 'debrief' sessions following significant events - Be aware of and acts upon public health information and safety alerts - Be aware of local major incident planning and is aware of their potential role in such an incident - Participate in the development of Quality Improvement in response to significant events
	1.3 Prevention & management of risks & potential harm	Participate in recognition of and reporting on adverse events and errors to improve healthcare systems	- Know mechanisms to report: near events, critical incidents/near misses/device-related adverse events/adverse drug reactions to appropriate national centre, and complete reports as required (K) - Recognise when patient safety is at risk and use local incident reporting processes to raise concerns, and is aware of mechanisms to escalate these if required (K) - Know how to use Q pulse (K) - Understand how mechanisms of reporting facilitate the analysis to identify the root cause (A)

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PATIENT SAFETY AND QUALITY OF PATIENT CARE	1.4 Confidentiality	Maintain confidentiality in all aspects of patient care	• Know the principles of confidentiality in accordance with Medical Council guidelines • Know the implications of GDPR (K) • Appropriately use only encrypted approved platforms for digital communication of patients' personal and medical information (K) • Respect patients' rights to privacy when clinical details are discussed, recorded in notes or stored electronically (A)
	1.5 Documentation & information management	Comply with organisational policies for timely and accurate documentation in accordance with legal requirements and IMC guidance	• Practice correct patient identification (3-point check: name, DOB, hospital number or address) protocols in history, note taking and documentation of patient records • Use correct/standard nomenclature in all patient documentations (S) • Write legible, accurate and concise notes to include all pertinent information and ensure continuity of care • Comply with legal & institutional requirements for health records • Maintain original, contemporaneous, patient records with entries signed (with Medical Council Number number) and dated/timed • Document content of discussions with patients and telephone communications/ consultations with family/carers • Produce timely, legible discharge summaries that identify principal diagnoses, key treatments/ interventions, discharge medications and follow-up plan • Use appropriate clarity, structure and content for specific correspondence (e.g. referrals, investigation requests, GP letters)

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PATIENT SAFETY AND QUALITY OF PATIENT CARE	1.6 Open disclosure	Practice in accordance with HSE policy for open disclosure	- Follow procedures in accordance with HSE's open disclosure policy: (K) - Provide patients with a sincere and meaningful apology when they are harmed as a result of a Patient safety incident under guidance of Consultant Trainer (K/S) - Begin the communication process within 24–48 hours of the incident occurring or becoming known to the health services provider or as soon as possible after the incident happens under guidance of Consultant Trainer (K/S) - Recognise and report on adverse event and errors (K)
	1.7 Complaints	Respond appropriately to patient complaints	- Follow local procedures for dealing with complaints including processes for escalation (S) - Listen empathetically to complaints without getting defensive (A) - Act to minimise or prevent factors that would otherwise lead to complaints (A) - Appreciate the bounds of their responsibility when dealing with complaints (A) - Adopt behaviours such as good communications designed to prevent complaints (A)
	1.8 Human factors	Recognise role of human factors in medical errors and take steps to minimize these	- Question/raise concerns over other's practices if perceived to be unacceptable (A) - Display situational awareness in clinical situations and modify own behaviour to mitigate potential negative impact of human factors

Domain 2: Relating to patients

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
RELATING TO PATIENTS	2.1 Patient-centred approach	Adopt a holistic patient-centred approach to care	- Consider patient as whole, respecting personal circumstances, dignity, autonomy, individual needs and right to privacy (A) - Provide care that is in patient's best interest (A) - Consider care pathways and the process of care from patients' perspectives (K) - Work with patients to develop individual care plans and to manage patients' acute and long-term conditions (A)
	2.2 Compassion & empathy	Demonstrate a caring attitude towards patients	Demonstrate a caring attitude towards patients (A)
		Address Patients', families' and carers' physical and emotional health needs	Demonstrate an awareness of and caring attitude towards patients', families', and carers' physical and emotional health needs (A)
	2.3 Trust & respect	Establish a trusting and respectful partnership between doctor and patient; and between the medical profession and society	- Demonstrate and maintain trustworthiness, integrity, and reliability in all interactions with patients (A) - Demonstrate respect toward the patient in all circumstances and all interactions (A)
	2.4 Cultural competency	Practice in an unbiased manner, sensitive to context in support of patient dignity	- Recognise and respect the influence of diverse cultural and religious backgrounds, attitudes and beliefs and socioeconomic backgrounds, when managing and treating patients (K,A) - Identify and act on cultural bias or inequity within health care services (A) - Maintain a non-judgmental approach so that personal views do not affect professional relationships with respect to gender, marital status, family status sexual orientation, religion, age, disability, race and membership of the traveller community (A)

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
RELATING TO PATIENTS	2.5 Advocacy	Promote patient's preferences and autonomy as central to the provision of high- quality care Advocate for fair use of resources for overall benefit of all patients	- Identify how physical or cognitive disability can limit patient's access to healthcare services (K) - Advocate/demonstrate a non-discriminatory patient-centred approach to care (A) - Promote patient's expertise and help them to acquire knowledge of their condition (A) - Encourage and empower patients to make informed decisions about their care (A) - Respect the right of patients to refuse treatment and to decline involvement in research projects (A)

4.4 Domain 3: Communication and Interpersonal skills

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COMMUNICATION AND INTERPERSONAL SKILLS	3.1 Communication skills	Use effective appropriate verbal, non-verbal and written communication skills at all times	- Apply the HSE-approved model of communications (S) - Adopt appropriate verbal and non-verbal communication techniques (S) - Build rapport with a patient (S) - Demonstrate active listening (S) - Use various questioning techniques to elicit information from the patient (S)

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COMMUNICATION AND INTERPERSONAL SKILLS	3.2 Communication with patients, families and carers	Communicate effectively, collaboratively, and empathetically with patients and carers	• Consider the significance of context and culture (K) • Communicate effectively with people from culturally and linguistically diverse backgrounds (S) • Use appropriate verbal and non-verbal language (S) • Be aware of unconscious bias in communication with patients (A) • Adopt a holistic approach (A) • Communicate clearly, politely, and considerately (S) • Provide necessary/desired information effectively with understanding and empathy (A) • Follow HSE guidelines on provision of an interpreting service and be aware of local resources • Ensure sufficient time and appropriate environment for communication • Ensure privacy when discussing sensitive issues • Support patients in interpreting information and evidence relevant to their condition • Explain options clearly and check patient's understanding • Recognise that patients may have unspoken concerns and seek to elicit and address these • Enable patients to express concerns and preferences, asks questions and make personal choices • Respond to patients' queries or concerns • Convey and discuss information on risks and benefits of tests or treatments (S) • Deal effectively with patients in distress (S) • Close a consultation (S) • Source further information for patients (K) • Use lay terms for medical jargon

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COMMUNICATION AND INTERPERSONAL SKILLS	3.3 Communication with professionals and professional bodies	Communicate effectively and collaboratively with professional colleagues across disciplines and professional bodies	• Communicate effectively within multidisciplinary teams (S) • Complete an effective referral (S) • Apply communication skills to facilitate effective handover and transfer of care (S) • Communicate effectively with health administration (S) • Recognise the interrelatedness of the health and care sector, and promote effective communication across the care pathway (A)
	3.4 Communication in challenging circumstances	Recognise that alternative styles of communication may be necessary in certain contexts	• Recognise when additional time is required and make arrangements to continue discussions in more appropriate environments • Seek advice/assistance promptly with queries or concerns outside the limits of their experience • Know when to involve outside agencies to assist with communication and understanding, and use alternative means of communication where necessary • Recognise that acute or chronic mental or physical conditions may affect communication, and to take this into account when communicating/examining patients, and provide additional support • Manage concerns of angry or dissatisfied patients • Break bad news compassionately and supportively (A) • Involve others in team when breaking bad news • Follow local/national guidelines on the use of advocates and interpreters (K)

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COMMUNICATION AND INTERPERSONAL SKILLS	3.5 Handover	Participate in safe and effective handover procedures to ensure continuity of care	• Know local policies for handover (K) • Demonstrate features of clinical handover that ensure Patient safety and continuity of care (S) • Perform effective handover in a structured format (S) • Demonstrate effective communication with patient, family and patient's GP at time of discharge (S)
	3.6 Telemedicine	Engage in telemedicine practice in accordance with MCI guidelines for telemedicine	• Identify self by name when giving clinical advice online • Take all reasonable steps to make sure information or advice given online is accurate and valid and that information about the services offered is factual and verifiable

4.5 Domain 4: Collaboration and teamwork

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COLLABORATION AND TEAMWORK	4.1 Collaboration	Work effectively with healthcare professionals from other disciplines and teams to improve patient outcomes	• Integrate and interact appropriately with colleagues • Work effectively with others toward a common goal • Accept directions and allocation of tasks from senior colleagues • Be aware of work pressures on others and be willing to support other staff, organise and allocate work to optimize effectiveness as required
	4.2 Inter-professional teamwork	Ensure a combined action and cooperation towards a common goal of high-quality patient care	• Respect all members of the multi-disciplinary team • Recognise strength of inter-professional collaboration • Contribute to the multidisciplinary team (MDT) meetings • Make referrals across various specialities and healthcare institutions

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
COLLABORATION AND TEAMWORK	4.3 Accountability	Ensure that systems of accountability are in place among healthcare workers to protect patients	To be drafted
	4.4 Dignity in the workplace	Recognise the right of all colleagues and staff to be treated with dignity and respect Commit to ensuring a safe working environment; free from all forms of bullying and harassment	To be drafted

4.6 Domains 5: Management and self-management

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
MANAGEMENT & SELF- MANAGEMENT	5.1 Management	Manage ward, clinic, and on-call duties with prioritisation or delegation of clinical tasks efficiently & effectively	- Prioritize workload to maximize patient outcomes and health service function - Demonstrate punctuality - Manage their time
	5.2 Sustainable healthcare	Use resources responsibly while considering the needs of patients	- Use resources responsibly - Promote fair distribution of limited resources - Demonstrate basic awareness of sustainability in medical practice

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
MANAGEMENT & SELF- MANAGEMENT	5.3 Physician well-being	Maintain personal health and wellbeing, and consider the health and safety of peers, junior and senior colleagues and other health professionals	- Understand how personal physical & mental health affects other healthcare professionals, the healthcare system and society as a whole - Engage in appropriate strategies to ensure self-care - Engage when required with a GP to assist in general health (both physical & mental) maintenance - Monitor personal physical & emotional wellbeing & seek early assistance if any concerns arise or if experiencing significant stress - Refrain from self-diagnosing or prescribing - Demonstrate a caring & sensitive approach towards peers - Provide support & assistance to fellow Interns, medical students & senior colleagues in a compassionate, caring & confidential manner

4.7 Domain 6: Scholarship

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
SCHOLARSHIP	6.1 Reflection	Engage in a review of their practice and has an awareness of scope of practice Reflect critically on all challenging interactions, and any personal shortcomings with a constructive approach to personal development	To be drafted

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
SCHOLARSHIP	6.2 Role modelling	Display personal comportment and behaviour consistent with the values outlined in the IMC Guide to Professional Conduct & Ethics; with reference to both the formal and informal ('hidden') curriculum	To be drafted
	6.3 Teaching	Use appropriate resources and educational best practice to promote understanding of health and disease amongst patients, colleagues, other healthcare professionals and medical students	To be drafted
	6.4 Mentorship	Facilitate the professional development of students and peers in a safe and supportive environment	To be drafted
	6.4 Leadership	Demonstrate the ability to lead in clinical practice	To be drafted
	6.5 Life-long learning	Refer to evidence-based clinical guidelines, commit to continuous professional development, and acquire an understanding of research	- Apply the principles of evidence-based practice and hierarchy of evidence - Use best available evidence in clinical decision-making - Critically appraise evidence and information - Demonstrate an understanding of the limitations of evidence and the challenges of applying research in daily practice

4.8 Domain 7: Professionalism

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PROFESSIONALISM	7.1 Medical ethics & the law	Practice in accordance with current community and professional ethical standards and legal requirements	• Interpret the Medical Council Pillars of Professionalism in the context of the duties of an intern • Be familiar with Irish Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Professionals • Comply with legal requirements inpatient care (e.g. death certification, mental health act) • Complete appropriate medicolegal documentation • Liaise with legal and statutory authorities, including mandatory reporting where applicable • Behave in ways that acknowledge the ethical complexity of practice and follow professional ethical codes
	7.2 Honesty & integrity	Be aware of personal beliefs and attitudes, and reflect critically on how these can affect patient care Conduct oneself with honesty, report accurately, refrain from plagiarizing, and acknowledge personal errors Recognise, openly state or address conflict of interest	• To be drafted

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
PROFESSIONALISM	7.3 Responsibility & participation	Recognise and respect personal and professional integrity, roles, and contribution of peers Practice within one's limits and within ethical and professional frameworks, seeking help as required	To be drafted
	7.4 Social media conduct	Engage with social media platforms in accordance with MCI guidelines for social media usage	- Maintain professional standards expected in other forms of communication - Be cognisant of possible impact on colleagues, patients or public's perception of the profession before posting comments on social media sites - Treat patients and colleagues with respect and avoid abusive, unsustainable malicious or defamatory comments or in breach of the law when posting online - Avoid communicating with patients through social media networking sites - Avoid publishing patient information or images, or discussing and commenting about patients on publicly available platforms - Avoid giving information that would identify patients when using closed professional networks to gain expert advice, share case studies or participate in learning groups - Minimize risk by ensuring that closed professional networks have effective security settings and privacy policies to minimize risk of patient information becoming more widely available - Maintain separation of professional and personal use of social media - Minimize risk by opting for conservative privacy settings for personal social media content - Consider how personal information and/or images posted might be viewed by patients or public if they were to become widely available

4.9 Domain 8: Clinical skills

Note: See EPA 1-7 for further details of clinical skills which are relevant to each EPA.

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
CLINICAL SKILLS	8.1 Acute management	Recognise acutely unwell patients, initiate management and escalate as appropriate	- Recognise and promptly assess the acutely ill, collapsed or unconscious patient using an Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach - Use the GCS or Alert, Voice, Pain, Unresponsive (AVPU) to quantify conscious level - Interpret clinical and noninvasive monitoring of vital signs - Calculate National Early Warning System (NEWS) score and organises escalation in monitoring and care accordingly - Recognise and promptly assess the patient who presents an acute risk to themselves or others in the context of mental disorder, incapacity or incompetence (See Knowledge Guides for details for each common emergency)
	8.2 Synthesis	Gather all relevant data (e.g. clinical context, age and/or presence of comorbidities) to inform the development of a differential diagnosis	- Recognise the symptom - Identify relevant epidemiology, pathophysiology, and clinical science - Take a relevant history - Conduct an appropriate examination - Establish a differential diagnosis - Plan and arrange appropriate investigations - Consider the impact of illness and disease on the patients and their quality of life
	8.3 Clinical management plan	Formulate management plan in partnership with patients and families/carers; in collaboration with the multidisciplinary health care team, applying a patient-centred and integrated care approach	- Interpret investigations - Provide appropriate management - Stabilise a patient - Prescribe therapies tailored to patients' needs and conditions - Recognise potential complications of disease and management and initiate preventative strategies and/or escalate care when necessary - Involve multidisciplinary teams - Demonstrate the application of integration of care in the management of patients with chronic disease and complex comorbidity

Domain	Theme	Competency	Learning Outcomes Knowledge (K), Skills (S) & Attitudes (A) The intern should be able to...
CLINICAL SKILLS	8.4 Broader factors	Identify individual, social and cultural factors, and the impact of these on diagnosis and management	- Identify the potential impact of specific to each patient and recognise the impact of these on diagnosis and management - Facilitate/arrange appropriate supports/support networks as necessitated

Chapter 5

Teaching, Learning and Experience

5.1 Introduction

One of the core components of a Curriculum Framework is the design of tailored learning experiences for the learner²⁰. Individual intern networks are responsible for devising a programme of teaching and learning for their network, which enables their interns to acquire the professional competencies, perform the activities and gain the underpinning knowledge stated within the curriculum.

Teaching and learning processes

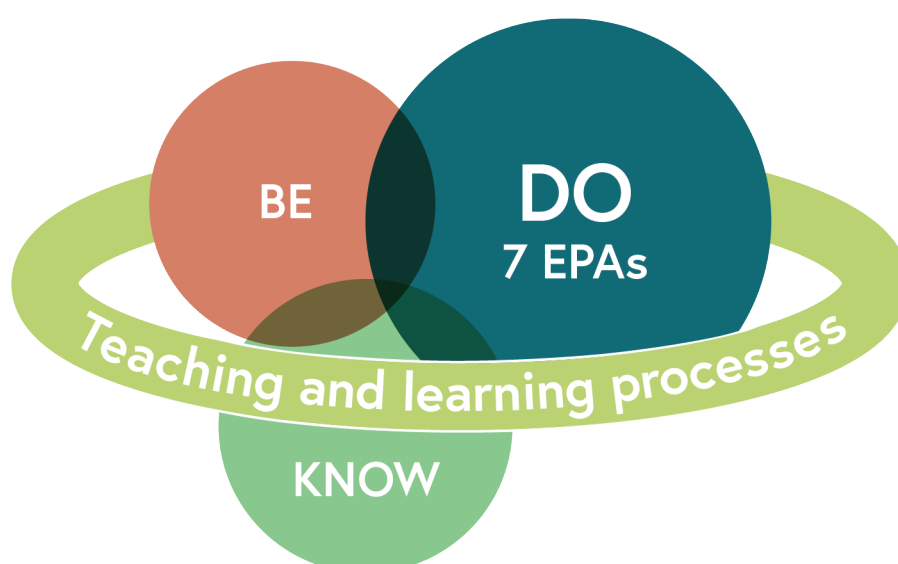


Fig. 10 Teaching and learning processes to support learning

There are six Intern Training Networks affiliated to the six medical schools in Ireland, and they are as follows:

- West/Northwest (National University of Ireland, Galway)
- Dublin/Northeast (Royal College of Surgeons in Ireland)
- Dublin/Mid-Leinster (University College Dublin)
- Dublin/Southeast (Trinity College Dublin)
- South (University College Cork)
- Mid-West (University of Limerick)

²⁰ van Melle, E. (2016) Describing the core components of CBME, paper presented to Ottawa conference. Perth, Australia

Each network is led by an Intern Network Coordinator who is a consultant doctor with educational experience. The Coordinator is responsible for organising and overseeing intern training within their Network, and for ensuring the provision of appropriate, agreed educational programmes for interns. A number of approaches to curriculum mapping have been adopted in medical education and training²¹. Curriculum mapping enables a programme provider to indicate – to trainees, to trainers and to programme accrediting bodies – how and where different elements of the curriculum are being delivered. A curriculum map illustrates which teaching and learning strategies are being deployed to provide opportunities to interns to achieve the competencies expected of them. Curriculum mapping offers greater transparency and accountability in the delivery of the curriculum at local level. Templates and tools for the curriculum mapping process which are best suited to the internship programme will be developed in consultation with intern training networks (as the programme providers) and the Medical Council (as the accrediting body for intern programmes).

5.2 Teaching and learning strategies

Teaching and learning strategies for the internship programme include a blend of experiential learning in clinical sites, structured learning opportunities and self-directed learning. Indicative teaching and learning strategies for the internship programme are illustrated below.

Examples of teaching and learning processes

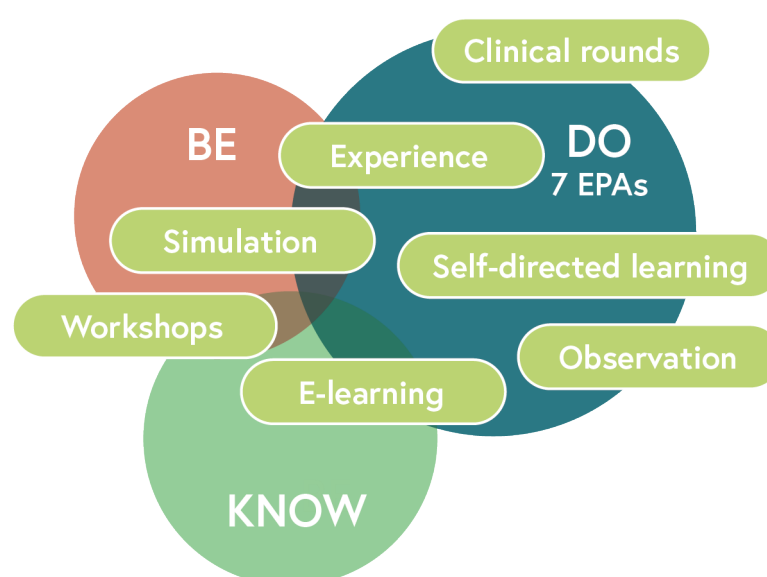


Fig. 11 Examples of teaching and learning processes to support learning

²¹ Harden, R.M. (2001) AMEE Guide No. 21: Curriculum mapping: a tool for transparent and authentic teaching and learning. *Medical Teacher* 23(2):123-137.

The selection and design of teaching strategies will be a matter for Intern Networks. There is a history of collaboration between networks in the development of modules to be delivered at local level. Further opportunities exist to develop new modules on a collaborative basis, by the intern networks. The development of a Safety & Quality of Care Module was recommended, for example, by Slattery (2022)²² arising from the consultation conference relating to the BE pillar of the curriculum. This could be achieved by the collaborative development of a module with teaching and learning strategies to enable interns to acquire the competencies detailed in the Knowledge Guide on Patient safety. Competencies identified within the BE pillar of the curriculum such as leadership, sustainability, and physician well-being could be included as formal teaching sessions delivered as elearning or as virtual sessions to enable attendance regardless of working patterns/locations. Building on the history of collaborations between intern networks, the networks could create a set of e-learning, workshops or simulation cases to supplement clinical experiences (in particular addressing less common problems) as part of a core curriculum.

A range of potential of strategies for teaching professionalism and promoting professional identity formation (PIF) were identified by Slattery (2022). Challenges to the implementation of these teaching methods were identified by stakeholders at the Stakeholder Consultation Conference for the BE pillar. The Slattery (2022) report also noted that further research is needed within the Irish context to establish the feasibility and acceptability of teaching strategies designed to promote professionalism.

Where an intern is in the support and remediation process, an individualised plan is prepared in consultation with the intern. The plan includes a range of appropriate teaching and learning strategies which respond to the specific issues raised and include the use of workplace based assessment tools to determine that learning goals and competencies have been achieved.

5.3 Training experience requirements

The Curriculum Framework for the internship programme will involve specifying certain processes and experiences that are recommended or mandatory e.g. minimum duration of specific clinical rotations, specific experience required e.g. time spent on-call. These requirements are outside the scope of the development work undertaken by the MIU to date.

²² Slattery N. (2022), Stakeholder Feedback on Proposed Be Template and Content: Dissemination and feedback on a proposed template and content for the Be component of the intern curriculum framework (unpublished report)

Currently, intern training is for a minimum of 12 months which encompasses a minimum of three months in General Surgery and three months in General Medicine. Thereafter, there are a further two 3-month rotations in any of the following specialities: Emergency Medicine, General Practice, Obstetrics and Gynaecology, Paediatrics, Psychiatry, Anaesthesiology and Radiology. In the case of an academic internship post, one of the rotations must also include a rotation to their academic internship, as well as the three months in General Surgery and three months in General Medicine.

The Medical Council commenced a review, in 2023, of the quality and configuration of Intern posts, which may lead to a revision of Medical Council guidelines on intern rotations. The outcome of that review process will inform the determination of experience requirements for the internship programme at a national level and the standards for accreditation of delivery of the programme within networks. It is anticipated that this review of the quality and configuration of intern posts will provide a better understanding of the educational environment and the learning opportunities within the intern rotations, and thus the experience required to achieve the defined EPAs. These details will ultimately be provided in any revision to the requirements for internship training.

Chapter 6

Programmatic Assessment

6.1 Introduction

Competency-based medical education (CBME) is an approach to the design, implementation, assessment and evaluation of medical education and training programmes. EPAs are a way of operationalising CBME. The Curriculum Framework for the internship programme is competency-based, with a focus on outcomes. Outcomes are specified at programme level, informed by graduate outcomes (when elaborated by the Medical Council), and learning outcomes - as detailed within the BE pillar of the curricula framework - to guide delivery at network level. EPAs (DO) are at the cornerstone of the framework, with knowledge (KNOW) and professional competences (BE) which underpin the performance of those tasks elaborated. The premise of CBME is that competence is not assumed after a certain length of time spent in training but instead requires trainees to demonstrate that they can synthesise the knowledge, skills, and attitudes to perform the tasks of a qualified physician. The adoption of a competency-based approach, focused on outcomes, inevitably involves transforming the culture of assessment²³. **Programmatic assessment** has become a defining feature of competency-based medical education and training, including when implementing EPAs, as a more appropriate alternative to traditional forms of high-stakes assessment at the end of a training period.

6.2 Programmatic assessment - key features of a system

Programmatic assessment is an educational approach where information about trainee performance is collected using a range of frequent, carefully-chosen assessment methods during the course of training. Each assessment aims to provide a snapshot of trainee progress and feedback for further improvement. Each assessment event is low stakes, formative and an integral part of the teaching and learning process. Collectively, these snapshots span the breadth of the standards within a curriculum framework. Decisions about trainee progression and completion are made, based on aggregated assessment data. Programmatic assessment is based on the assumption that no single assessment tool can capture all the complex capabilities that a physician needs to acquire^{24 25}.

²³ Griffiths J, Dalgarno N, Schultz K, Han H, van Melle E. (2019) Competency-Based Medical Education implementation: Are we transforming the culture of assessment? *Medical Teacher*. 41(7):811-818

²⁴ Van Der Vlueten, Schuwirth, Driessen, Dijkstra, Tigelaar, Baatman, & Van Tartwijk (2012) A model for programmatic assessment fit for purpose *Medical Teacher* 34(3): 205–214.

²⁵ Schuwirth LWT and Van der Vleuten CPM. (2011) Programmatic assessment: From assessment of learning to assessment for learning. *Medical Teacher*. 33(6):478-85

The purpose of programmatic assessment is twofold. Firstly, to inform the trainee and their supervisor/mentor as to their progress towards achieving competence. Secondly, to provide data for high-stakes summative decisions, at key stages and/or at the end of a training phase.

In programmatic assessment, each assessment event produces meaningful feedback to the learner. This feedback may be quantitative, qualitative or both. Increasingly, there is a focus on the importance of good quality narrative feedback. Each individual assessment is relatively "low-stakes" for the trainee but is used by them to analyse their performance, formulate specific learning goals, and demonstrate that they have attained them.

A continuous dialogue between the trainee and a dedicated staff member (called either portfolio advisor, mentor, supervisor, clinical supervisor or coach in different contexts) further scaffolds the focus on feedback, analysis of competence development, support, remediation and personal development. This dialogue generally takes place at scheduled, periodic reviews of progress, with information available from within a trainee's portfolio.

Flexible and user-friendly assessment tools are needed for use during routine clinical workflow. Mobile technologies offer the means for carrying out workplace based assessments in **real time**. Internet-enabled mobile devices such as smartphones and tablets have become ubiquitous and are being used with increasing frequency in the implementation of competency-based medical education. Dashboards facilitate monitoring the completion of assessments and progress by a trainee and their advisor/mentor.

Individual assessments are collated in a portfolio and then analysed by a team or committee to provide a rich diagnostic picture that will allow defensible high-stakes decisions, at key progression points and/or at the end of training. All relevant information is reviewed for higher-stakes summative decisions, combining information from various sources. This includes the outcomes of workplace based assessments, and potentially other data such as logs of clinical experience as well as input from members of a committee.

Principles of Programmatic Assessment²⁶

1. Every (part of an) assessment is but a data-point
2. Every data-point is optimised for learning by giving meaningful feedback to the learner
3. Pass/fail decisions are not given on a single data-point (i.e. low-stakes)
4. There is a mix of methods of assessment
5. The method chosen should depend on the educational justification for using that method
6. The distinction between summative (assessment of learning) and formative (assessment for and as learning) is replaced by a continuum of stakes
7. Decision-making on learner progress is proportionally related to the stake
8. Assessment information is triangulated across data-points towards an appropriate framework
9. High-stakes decisions (promotion, graduation) are made by a committee in a credible and transparent manner, using a holistic approach
10. Intermediate review is made to discuss and decide with the learner on their progression
11. Learners have recurrent learning meetings with (faculty) mentors/coaches using a self-analysis of all assessment data
12. Programmatic assessment seeks to gradually increase the learner's agency and accountability for their learning through the learning being tailored to support individual learning priorities

Fig. 12 Ottawa 2020 consensus statement for programmatic assessment

²⁶ Heeneman, S. de Jong, LH Dawson LJ Wilkinson TJ, Ryan, A. Tait GR, Rice, N., Torre, D. Freeman, A and van der Vleuten, CPM. (2021) [Ottawa 2020 consensus statement for programmatic assessment – 1. Agreement on the principles](#). *Medical Teacher* 43(10): 1139-1148.

6.3 A programmatic approach for the internship

A programmatic approach to assessment for the internship programme reflects these principles, using a range of tools of workplace based assessment which will address competencies across all three pillars of the curriculum.

Programmatic assessment for the internship

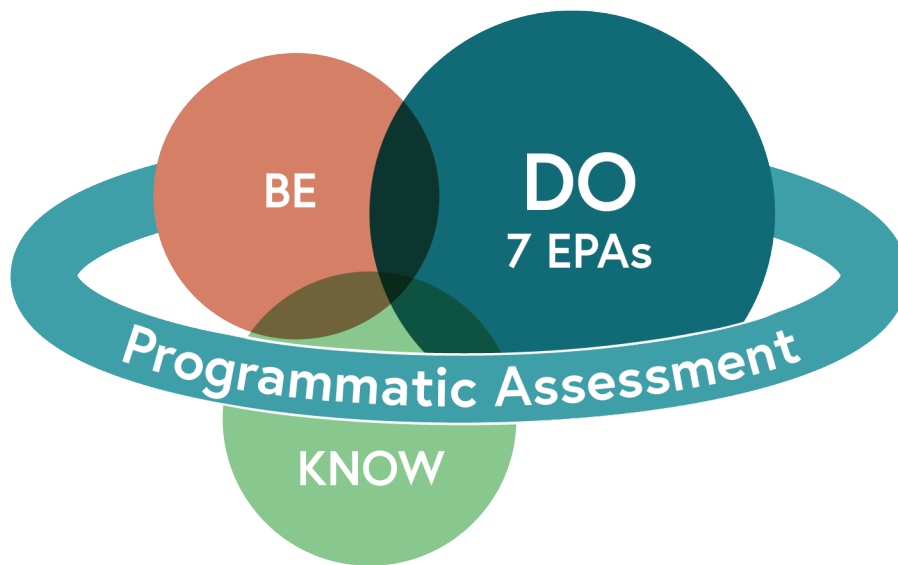


Fig. 13 A programmatic approach to assessment

Tools for workplace based assessment:

Five **tools** have been identified for the assessment of interns.

1. Case Presentation (CP)

A Case Presentation is a formal communication between health care professionals. An intern presents a patient's case to a supervisor and/or another member of the clinical team.

A Case Presentation usually takes place alongside routine clinical care on a ward round, or in an out-patient or GP setting. It assesses a trainee's ability to communicate, gather data (including from the physical examination), provide a differential diagnosis and present a management plan. The supervisor hears the presentation, probes for clarification, and provides feedback.

2. Direct Observation (DO)

- I. Clinical tasks
- II. Procedural skills

A Direct Observation is a tool used for observing an intern's performance of a clinical task (e.g. taking a history or receiving a handover) or a procedure (e.g. inserting a urinary catheter). Direct observations take place as a routine part of clinical work with patients or in a simulated environment (e.g. for high acuity and low occurrence [HALO] events) The observation is carried out by a health professional who provides feedback.

3. Case Based Discussion (CBD)

A case based discussion is a discussion between a health professional and an intern about a selected patient case. A CBD can assess an intern's application of knowledge, their clinical reasoning, decision making, problem solving, patient management skills, leadership skills and time management skills. A CBD is carried out by a supervisor or other health professional who acts as the reviewer and provides feedback. CBDs are scheduled as meetings arranged by intern and supervisor.

4. Reflective Journal (RJ)

A Reflective Journal provides the intern with an opportunity to provide evidence of their learning and insight. With regular and contemporaneous journal entries, the intern describes and analyses an event and records their reflection and insights on aspects of their practice. These are completed by the trainee on an ongoing basis.

5. Team Review (TR)

Team Review is a multi-source method of assessment – sometimes including self-assessment – in which interns are provided with feedback on their observed performance, including professional behaviour (e.g. by doctors, nurses, peers, patients and administrators) and where they reflect on their learning and progress. Team reviews are carried out by raters, i.e. those invited to participate in the review, at defined points in training, e.g. towards the end of each rotation.

It is anticipated that implementation of workplace based assessment for the internship will be phased – with Case Presentation, Direct Observation and Case Based Discussion introduced initially.

6.4 Selecting the most appropriate tool

While WBA tools can be deployed to assess competencies across different pillars of the curriculum, certain tools are more relevant to some pillars and types of competencies. **Direct Observation (DO), Case Presentation (CP) and Case Based Discussion (CBD):** most relevant for assessing performance on the EPAs. **Team Review (TR):** appropriate for assessing professional competencies (in the BE pillar of the curriculum) and some competencies stated for the EPAs. **Reflective Journal (RJ):** provides evidence of capacity to reflect on professional competencies and performance in certain EPAs.

Programmatic assessment using workplace based assessment tools

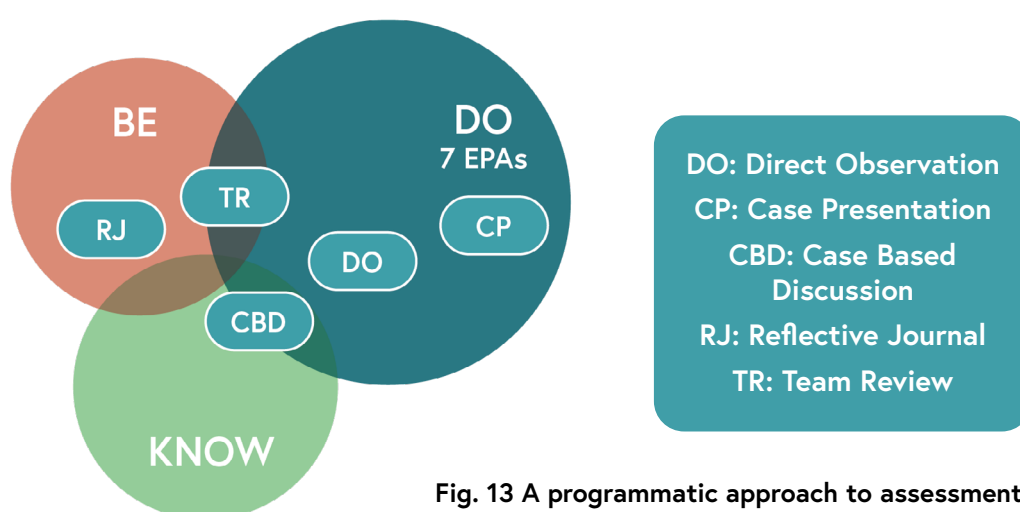


Fig. 13 A programmatic approach to assessment

Certain tools are more appropriate for assessing performance in each EPA as follows:

EPA No.	Entrustable Professional Activity	DO	CP	CBD	RJ	TR
1.	Clerking a patient	X	X	X	X	Holistic and multi-source
2.	Requesting and interpreting basic investigations			X		
3.	Performing essential procedural skills	X				
4.	Managing the work of in-patient care	X	X	X	X	
5.	Prescribing and monitoring drugs and fluids			X		
6.	Recognising and managing the deteriorating/acutely unwell patient	X	X	X	X	
7.	Handing over and discharging a patient	X		X	X	

Fig. 15 Workplace based Assessment Tool for EPA

Tools for workplace based assessment can also be differentiated in terms of whether they are carried out in real time during clinical workday or carried out retrospectively.

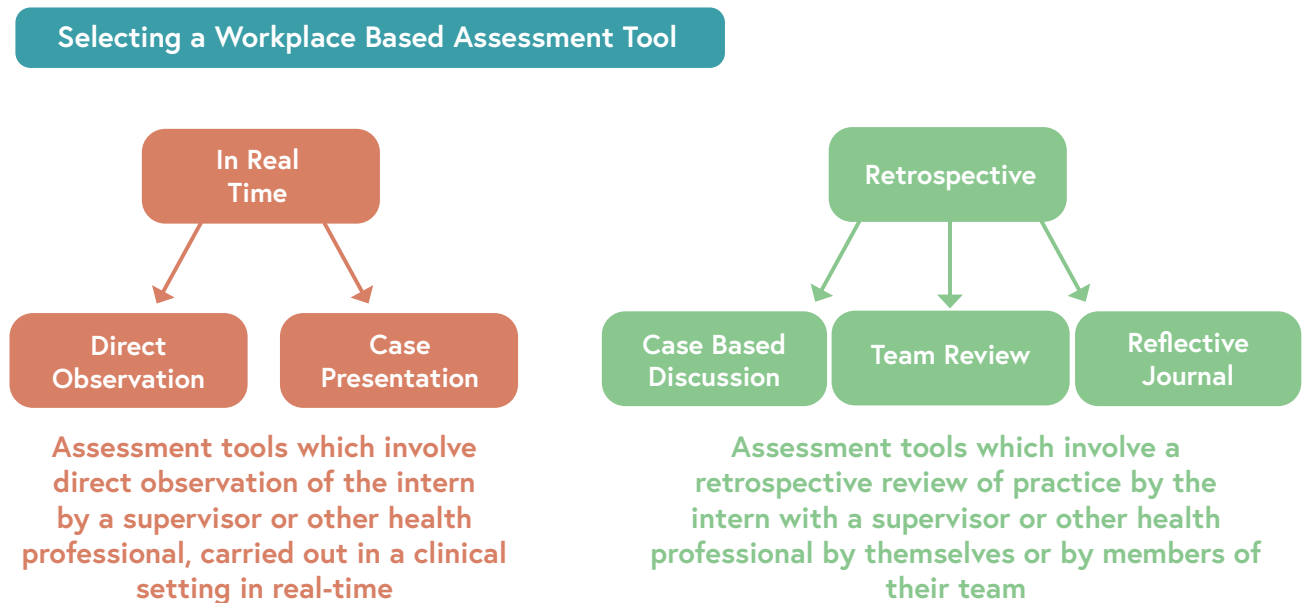


Fig. 16 Selecting a Workplace Based Assessment Tool

6.5 Conducting Workplace Based Assessment

The processes for conducting Direct Observation, Case Presentation and Case Based Discussion are illustrated below:

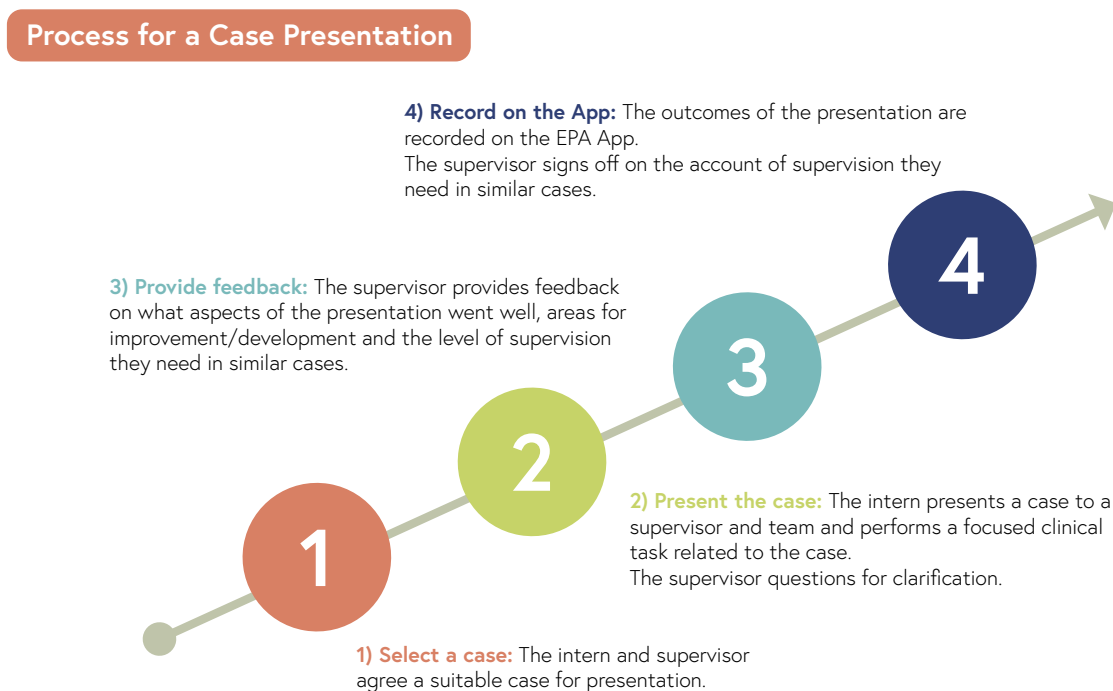


Fig. 17 Process for a Case Presentation

How to do a Case Presentation

This animation explains to interns and supervisors when a case presentation is appropriate and how to conduct it, have the feedback conversation, and record the outcome. The benefits of case presentations for interns and their supervisor are outlined.



Demonstration of a Case Presentation

This video explains how to conduct a case presentation effectively, have the feedback conversation, and record the outcome.



Process for a Direct Observation



Fig. 18 Process for a Direct Observation

How to do a Direct Observation

This animation explains to interns and supervisors when a direct observation is appropriate and how to conduct a direct observation, have the feedback conversation and record the outcome. The benefits of direct observations for interns and their supervisor are outlined.



Demonstration of a Direct Observation of a clinical procedure

This video, involving an intern and a healthcare professional, demonstrates how to conduct a direct observation effectively, have the feedback conversation, and record the outcome.



Demonstration of a Direct Observation of clinical task

This video, involving an intern and a healthcare professional, demonstrates how to conduct a direct observation of a clinical task effectively, have the feedback conversation and record the outcome.



Process for a Case Based Discussion

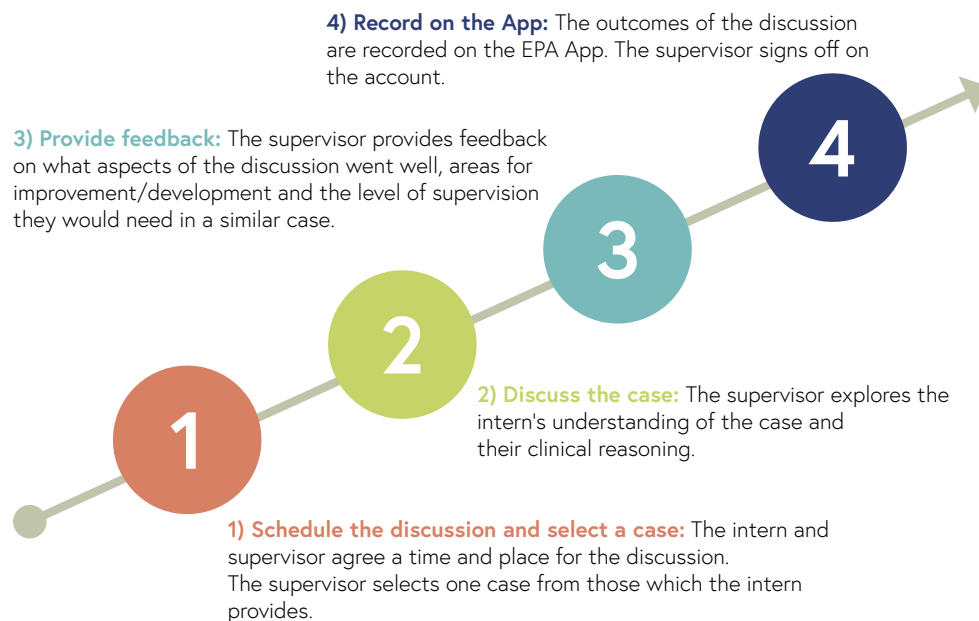


Fig. 19 Process for a Case Based Discussion

How to do a Case Based Discussion

This animation explains to interns and supervisors when a case based discussion is appropriate and how to conduct the discussion, have the feedback conversation and record the outcome. The benefits of case based discussions for interns and their supervisor are outlined.



Demonstration of a Case Based Discussion

This video demonstrates to interns and health professionals, how to conduct a case based discussion effectively, have the feedback conversation, and record the outcome.



6.6 The importance of the feedback conversation

The feedback conversation features a key element in the process of completing workplace based assessments. Feedback can be described as a structured conversation designed to improve work performance. Regular, high-quality formative feedback that is informative, behaviour- and task-specific, based on direct observation, and timely provide trainees with essential information with which they can direct their behaviour.

When giving feedback on routine workplace based assessments within the internship (specifically DO, CP and CBD), the supervisor uses narrative comments to indicate what went well and what areas need improvement or development. As part of the feedback, they indicate the level of supervision the intern needed.

It is possible to distinguish between how entrustment supervision levels are used when observing and giving feedback on an individual task, case or procedure, as described in the processes above (ii) when referring to an EPA in its entirety. This relates to the distinction made in the EPA literature between context-specific 'ad hoc' entrustment decisions and 'summative' entrustment decisions, as identified in **Chapter 1**.

- An "ad hoc" entrustment decision is the act of placing trust in another person to perform a particular activity in the moment of working with them. Ad hoc entrustment decisions are context-dependent and made by an individual supervisor.
- A "summative" entrustment decision for an EPA signifies the general permission to deliver the contribution to health care that this EPA represents, independently with distant supervision, at or before the completion of training. This decision is made and recognised by a relevant supervisory team, such as a clinical competency committee, and is based on varied information, including multiple prior observations involving multiple credible observers²⁷.

²⁷ Schumacher, D.J., ten Cate, O., Damodaran, A., Richardson, D., Hamstra, S.J., Ross, S., Hodgson, J., Touchie, C., Molgaard, L., Gofton, W., and Carraccio C. on behalf of the ICBME Collaborators (2021): Clarifying essential terminology in entrustment, *Medical Teacher*, 43(7):737-744.

See **Appendix H** for a description of how these levels are used when conducting individual workplace based assessment and giving feedback on a task/procedure/case, and samples of language used by a supervisor.

6.7 Making A RICH entrustment decisions

As noted in **Chapter 2**, *entrustment* is central to the concept of an EPA-based curriculum framework. Entrustment is the act of assigning responsibility for something valued or important to a person, such as the decision to entrust a learner with a task or an EPA²⁸. Entrustment decisions stem from judgments of a trainee's competence and include the permission to act with a higher level of responsibility or autonomy and a lower level of supervision. Assessment framed with questions such as 'Can I entrust this trainee with this activity?' brings supervision to the forefront and increases its reliability²⁹. This is the question supervisors ask themselves, in the interest of patient care. Making entrustment decisions differs from regular assessment of trainees, which usually has no consequences beyond marking trainee progress because it puts patient care to the forefront. There is evidence that supervising clinicians generally weigh factors other than capability when making an entrustment decision.

The term A RICH entrustment decision (derived from an acronym of the factors involved) was coined by Prof. Olle ten Cate to describe this process.

²⁸ Schumacher et al (2021) *op cit*,

²⁹ Weller JM, Masur M, Nicolson S, Morris J, Ure S, Crossley J, Jolly B. (2014). Can I leave the theatre? A key to more reliable workplace based assessment. *British Journal Anaesthesia*. 112(6):1083–1091

Ingredients of A RICH entrustment decisions³⁰

Agency

Proactive attitude towards work, team, safety and personal development that includes awareness of and acting upon the need for action even when outside of the strict definition of one's responsibilities and practice of adaptive expertise. Agency can manifest within the context of one or more of the other four factors.

Reliability

Consistent, predictable, and conscientious behaviour driven by a sense of accountability and responsibility.

Integrity

Truthfulness, benevolence, and patient-centeredness, where expertise is employed to benefit patients and decisions are motivated by concern for and made in the best interest of patients.

Capability

The ability to perform a specific task in a variety of contexts and within an appropriate time frame, requiring a reasonable understanding and overall view of the clinical situation and ability to communicate and work effectively with others within a system.

Humility

Discernment of one's limitations; willingness and ability to ask for help and feedback; receptivity to insights of patients and co-workers; and ability to learn and develop from mistakes, feedback, and the expertise of others.

Fig. 20 Ingredients of A RICH entrustment decisions

ten Cate *et al* advocate that thoughtful entrustment decisions may be enriched by considering these five features. These factors can be brought to bear when making ad hoc entrustment decisions, by an individual supervisor, or when an Entrustment Committee makes a summative entrustment decision, described in **Chapter 7**. In this way, making entrustment decisions can take into account many of the competencies which are directly linked to professionalism, and included in the BE pillar of the Curriculum Framework.

In the training of assessors and orientation of interns, the importance of A RICH attributes will be highlighted. Assessors, especially supervising consultants, will be encouraged to comment on these attributes e.g., in the course of the feedback conversation, if and when appropriate. To achieve this, the development of feedback literacy (on the part of those giving

³⁰ ten Cate, O. Chen H.C., (2020): The ingredients of A RICH entrustment decision, *Medical Teacher*,; 42(12):1413-1420

and receiving it) will be critical in both assessor and intern training. There are additional ways to capture information on these important professional attributes e.g., Team Review (as described in 6.9 below).

6.8 Using routine workplace based assessment tools to gather feedback on behaviours, values and practice

The BE pillar of the Curriculum Framework describes the **behaviours, values and practices** expected of an intern as they adopt the professional identity of a doctor Within each domain, **themes** are identified. Within each theme, **competencies** are identified. These are the observable abilities of a health professional related to a specific activity that integrates knowledge (K), skills (S) and attitudes (A). **These competencies underpin how trainees conduct themselves while performing EPAs.**

The approach to programmatic assessment for the internship means that, collectively, workplace based assessment tools can also be used to provide feedback on domains and competencies within the BE pillar. When completing a routine workplace based assessment (i.e. a direct observation, case based discussion or case presentation) with respect to the performance of an EPA, assessors also give narrative feedback on domains from the BE pillar. This is in addition to a global feedback on performance of the EPA and the supervision level required.

A data field on the WBA report form prompts the assessor to add comments, where appropriate, for the most relevant domains e.g., relating to patients, communication, collaboration and teamwork. A pop-up window can be made available on an App to remind them of the themes/competences within each domain. e.g. for the domain of "Relating to Patients".

Patient centred approach	Adopt a holistic patient centred approach to care
Compassion & empathy	Demonstrate a caring attitude towards patients Address patients', families' and carers' physical and emotional health needs
Trust & respect	Establish a trusting & respectful partnership between doctor and patient; and between the medical profession and society
Cultural competency	Practice in an unbiased manner sensitive to context in support of patient dignity
Advocacy	Promote patient's preferences and autonomy as central to the provision of high-quality care Advocate for fair use of resources for overall benefit of all patients

Fig. 21 Themes within the Relating to Patients domain

Assessors are advised to select and comment only on the domain/s most relevant. Narrative feedback only will be sought. In this way, feedback with respect to each domain are recorded, on the app, and can be collated in a portfolio, across all EPAs. This data is visible to the intern on their dashboard and shared with their portfolio advisor³¹ for review. A summary report may be generated, as necessary, for high-stakes summative entrustment decisions.

6.9 Other tools

Team Review

Team review is one of the tools of workplace based assessment for the internship. It is a form of multi-source feedback (or 360-degree appraisal) which is completed anonymously by those in position to provide feedback on an intern's performance and behaviour. Data is collated to provide valuable information to the intern. Team Review will be particularly relevant for assessing competencies within the BE pillar of the curriculum, and garnering feedback on A RICH attributes (agency, reliability, integrity, capability, humility). In the UK, Team Assessment of Behaviours (TAB) has proven to be the most reliable indicator of foundation level doctors needing support³².

³¹ The portfolio advisor monitors an intern's rate of completion of WBAs, reviews their portfolio on regular basis and advises on progress. The role is described in 7.2 below

³² Schumacher, D.J., ten Cate, O., Damodaran, A., Richardson, D., Hamstra, S.J., Ross, S., Hodgson, J., Touchie, C., Molgaard, L., Gofton, W., and Carraccio C. on behalf of the ICBME Collaborators (2021): Clarifying essential terminology in entrustment, *Medical Teacher*, 43(7):737-744.

Options for the appropriate design and implementation of Team Review within the internship will be explored and developed as a priority in the piloting phase. A Team Review is ideally conducted before the end of each 3-month rotation, while the intern is assigned to a clinical team. Data from that process should be reviewed by the intern and facilitated by a portfolio advisor who is trained in how to mediate this process. Guidelines will be necessary on the required mix of raters to ensure a valid and meaningful team review. Strategies to minimise the administrative load will be important in the design of team review processes. There is a wealth of guidance available in the literature on the optimal design of team review tools³³. How data which is collated by the team review process contributes to summative entrustment decisions is a matter for further consideration. A summary of feedback from a Team Review, for example, could be included in the Progress Report compiled by the Portfolio Advisor. Any serious cause of concern identified should be addressed through the Intern Support and Remediation process, as described in 6.13 below.

Reflective Journal

Reflective journal is identified as one of the tools of assessment for the internship – a well established practice to support the development of reflective practitioners. The importance of expert guidance by a facilitator and training for interns in the skills of reflective practice is recognised. How best to use reflective journals in the system of programmatic assessment for the internship will be carefully considered, with due regard to potential data protection and medico-legal issues. Consideration will need to be given, for example, to who can read and edit a reflection, and whether reflections should be private or always shared e.g., with clinical supervisors or portfolio advisors.

6.10 Assessment of underpinning knowledge

Underpinning knowledge is assessed implicitly, and at times explicitly, in the course of the conduct of a workplace based assessment for an EPA. Case based discussions and case presentations, for example, can explore clinical reasoning and include "what if" questions which can explore an intern's underpinning knowledge. There are no plans to assess knowledge independently, for example, with a knowledge test/examination in the internship programme.

6.11 A trainee-led approach

Learner agency is regarded as important in the successful implementation of a programmatic approach to assessment, as highlighted in the list of key principles outlined above and, in

³³ Wood L, Hassell A, Whitehouse A, Bullock A, Wall D. (2006) A literature review of multi-source feedback systems within and without health services, leading to 10 tips for their successful design. *Medical Teacher* 28(7):e185-91.

the factors, leading to A RICH entrustment decision. Interns are ultimately responsible for providing evidence of their developing competence in their portfolio. Interns can identify opportunities, in the course of daily clinical work, to have their performance observed and assessed, and take the initiative in making requests for feedback. Trainers/supervisors can also initiate workplace based assessments, where appropriate, and as valuable teaching and learning opportunities arise. Summary reports which will be accessible to interns on their portfolio dashboard will enable them to monitor their progress and ensure an appropriate rate of completion of workplace based assessments.

Learner agency is recognised as difficult to achieve and needs a significant change, not just in curriculum and assessment design, but in creating a culture that promotes the development of a "growth mindset" on the part of interns. The right instructional practices and learning environments can foster the skills and strategies necessary for trainees to be partners in their learning as they develop their competence and the skills for lifelong learning. Agency, however, is hard work³⁴. Enhancing learner agency thus requires careful attention to learner support. Mentorship that both helps learners to identify appropriate learning paths and shields them from the pull of social and professional expectations and patterns of learned behaviour may be necessary.

Another potential strategy for enhancing agency on the part of the intern is to conceive of the portfolio as having two separate functions: (i) as a repository of assessment and feedback data, owned by the trainee and shared with their portfolio advisor for progress reviews, and (ii) as a curated collection of mandatory elements presented by the intern for summative assessment, with a summary reflection and self-assessment by the intern. This approach could support the goal of encouraging individual interns to take responsibility for their own learning and professional development. It could also reinforce their role and agency throughout the entire assessment process.

6.12 Support and remediation process

An essential component of the curriculum framework for the internship is a process to support interns to fully achieve their potential and meet the standards for certification. The internship is a formative year and can pose many challenges to junior doctors commencing their careers as working professionals. While many individuals cope well with such challenges, a small minority require periods of enhanced supervision and training as part of a formal support and remediation programme.

³⁴ Watling C, Ginsburg S, Ladonna K, Lingard L, Field E. (2021). Going against the grain: an exploration of agency in medical learning *Medical Education* 55(8): 942-950

The support and remediation process is designed to enable each network to fulfil their responsibility to ensure that interns recommended for the award of the Certificate of Successful Completion of Intern Training (CSCIT) will provide high quality, safe, professional care³⁵.

The Intern Support and Remediation process provides guidelines for the implementation and management of support and remediation of intern doctors, in a series of three stages and an appeal process. Provision is made for an Education and Training Plan and an Intern Remediation Panel (IRP), a proposed sub-committee of the Entrustment Committee.

The support and remediation process aim is to identify and remedy any issues(s) identified and return the doctor to satisfactory practice. Every effort is made to identify any issues in intern performance at an early stage to ensure appropriate and timely support, and remediation where necessary. The term 'issue' refers to a deficit in knowledge, procedural or clinical skills, communication or other matters of professionalism. Support and remediation is a space of learning, self-improvement, personal development, resilience building, an opportunity to practise with feedback, and to develop the adaptive capacity needed by all medical professionals in the current era.

See **Appendix F** Support and remediation for interns: National guidelines for a three-stage process.

The three stages are outlined as follows:

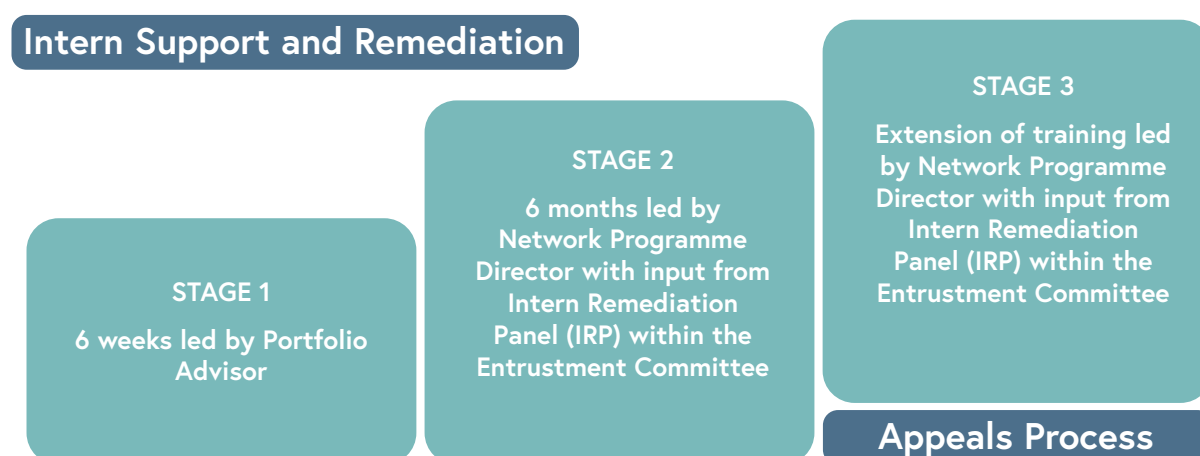


Fig. 22 Intern Support and Remediation 3-stage Process

³⁵ Friel, O. and Curley, G. (2022) Proposal around revision of intern remediation in Ireland (unpublished paper)

The development of the support and remediation process involved extensive research and wide consultation, detailed in **Appendix B**. The draft document was circulated as part of the national consultation process detailed in **Appendix D**. It was reviewed and revised further in light of the provisions of the Curriculum Framework. The guidelines for support and remediation were approved by the Medical Intern Board and endorsed by the Medical Council for use on a national basis.

6.13 A web-based portfolio and mobile App

The development of a web-based portfolio and a mobile app are prerequisites to the implementation of the workplace based assessment for a competency-based curriculum for the internship programme. This is a key objective of one of the work streams of the modernisation project. Pending identification of a supplier and the development of an appropriate technological infrastructure to support the conduct and storage of EPA Workplace Based Assessment (WBA) reports, a field-testing of paper-based versions of the forms was undertaken in 2019. The purpose of the field-testing phase of the EPA project was to:

- Field-test the proposed design of the fields on the WBA Tools for EPAs
- Determine the adequacy of the draft guidelines on how to complete WBA
- Pilot the processes and content of the training of consultants as observers/reviewers
- Commence development/sourcing of relevant training resources for the pilot phase
- Inform the specifications of the app for the technology company
- Gauge the time commitment required
- Get an early sense of any potential issues/challenges in implementation
- Identify potential future EPA champions for the pilot and/or implementation phase

The process and outcomes are documented in the MIU (2019) Progress Report on the Modernisation of the Internship Year Project. See **Appendix B** or a summary of the lessons learned from an evaluation of that process.

The content and format of the report form for routine workplace based assessment (Direct Observations, Case Presentations and Case Based Discussion) was revised in 2023, in light of the lessons from the field-testing and to reflect provisions for programmatic assessment within the Curriculum Framework. This format for the report form will inform the design of an app for the collection of data recorded during assessment carried out in the workplace. See **Appendix H**.

6.14 What programmatic assessment means in practice

What programmatic assessment means in practice³⁶

Interns:

- Undertake frequent, meaningful, authentic, low-stakes assessments based on what they are expected to DO, KNOW and BE
- Have their progress judged more on their day-to-day work
- Obtain continuous, targeted and structured feedback on areas for improvement
- Focus their training on improving core competencies

Supervisors:

- Have a better picture of intern progress against clear expectations
- Provide more direct, structured feedback using simple assessment tools
- Better identify interns' needs and support their learning
- Maintain better continuity with their interns

Intern networks:

- Make more robust judgements around interns' progression based on evidence that is aligned to the outcomes of the programme*
- Enable more timely remediation
- Better link learning and assessment with expected programme outcomes
- Enable the development of doctors who are better prepared for work in evolving healthcare teams and environments

*The process of making robust judgments about interns' progress is detailed in Chapter 7

Fig. 23 What programmatic assessment means in practice

³⁶ Adapted from RACP [Curricular renewal: Assessment: A programmatic approach at a glance](#)

Chapter 7

Processes Leading to Award of a Certificate of Satisfactory Completion of Intern Training (CSCIT)

7.1 Introduction: overview of the process

Within the strategy for programmatic assessment for the internship, decisions are made at a series of stages in the process, as illustrated below.

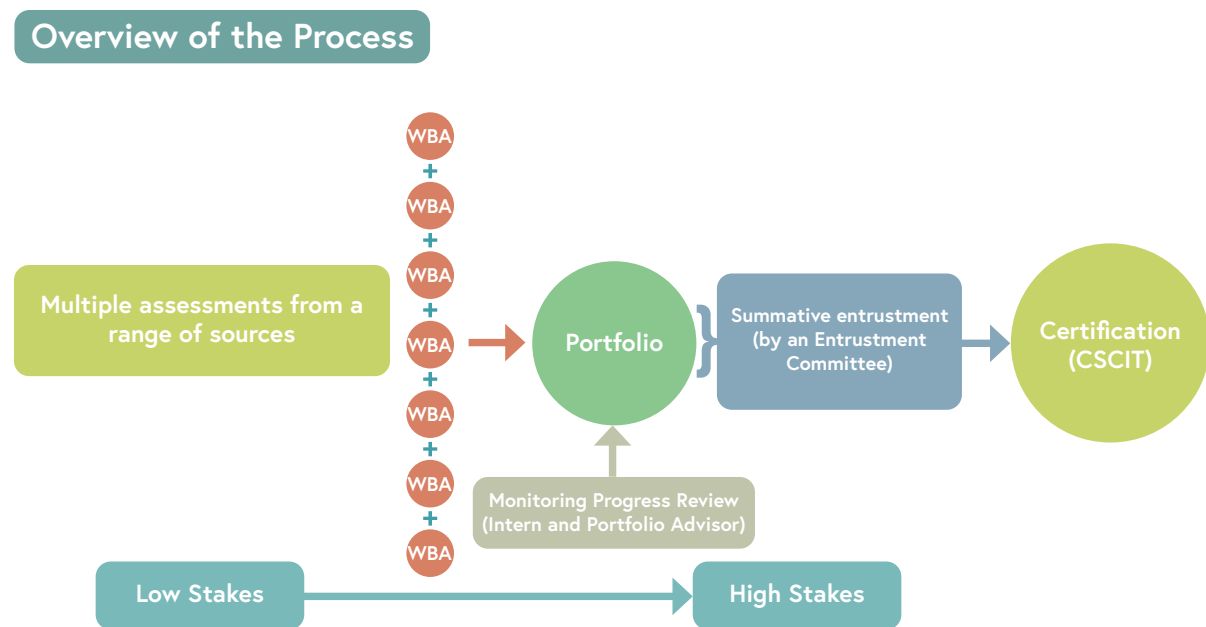


Fig. 24 Overview of the programmatic assessment process

7.2 Elements, processes and stakes within the assessment framework

(i) Routine workplace based assessments (i.e. direct observations, case presentations and case based discussions)

- Carried out by multiple assessors (supervisors and other health professionals)
- Made during multiple assessment events
- Without immediate consequence for the intern (low-stakes)
- Initiated by intern or by assessor
- Completed using a mobile app to allow completion in real-time
- With a focus on narrative feedback
- Using the EPA entrustment supervision scale

- ▶ Retrospectively (level of supervision needed for that task/case/procedure), based on an observation³⁷
 - ▶ Prospectively (indicating level of supervision the intern would require in the future), where an assessor can determine this e.g., after conducting a thorough case based discussion³⁸
- Providing feedback on relevant domains/competencies from the BE pillar and attributes from the A RICH framework, as appropriate
 - With an option to raise "red flag" if serious concerns arise
 - Data recorded by intern or by assessor e.g., using smart technology
 - With intern's response to feedback and action plan – added at or after the assessment event
 - Report verified and signed off by assessor
 - Reports stored in portfolio and visible on dashboard

(ii) Periodic workplace based assessments (i.e. Team Reviews)

- Carried out at defined intervals (e.g., towards end of each rotation)
- Using an on-line survey instrument (developed or adapted from other models)
- Involving both self-assessment by intern and peer-assessment
- Raters recruited by the intern (from clinical team, other health professionals, administrators and, potentially, patients)
- Completed anonymously by contributors
- Comments collected per criterion/section
- Including statements based on domains/competencies within the BE pillar and attributes from the A RICH framework
- Data aggregated in a report (scores and comments)
- Results reviewed by intern and portfolio advisor at progress review meetings
- Summary of results and/or reflection on the outcome recorded in a Reflective Journal and/or portfolio
- How Team Review contributes to progress reviews and/or high-stakes summative decisions will be explored

³⁷ A **retrospective scale** is a tool/mechanism for evaluating observed behaviour in a retrospective process focused on what an individual has already done. Retrospective scales include anchors such as: 'I had to be there,' 'I provided help,' and 'I could have left the room.'

³⁸ A **prospective scale** is a tool/mechanism for estimating or recommending readiness for future practice. Prospective scales include anchors such as: 'I judge (or estimate) this learner to be ready for indirect supervision,' or, if used summatively, 'From tomorrow, this learner is allowed to practice this EPA under supervisory oversight only.' ten Cate 2020 Note: Prospective scales for use in individual WBAs can be adapted to relate to a similar task/case/procedure only, rather than for an entire activity i.e., the EPA

(iii) Record of reflective practice

Within a Reflective Journal, the intern records evidence that they engage in reflective practice. With minimum requirements established rather than grading the content and "quality" of the reflection.

Note: The level of "stakes" for Reflective Journals is to be determined i.e., if and how evidence of engagement in the reflective process contributes to high-stakes summative decisions. Records of reflective practice may be more appropriately retained and accessible by the intern only.

(iv) Progress reviews

- Carried out at intervals in training (e.g., at mid-point and towards end of rotations)
- Between intern and their portfolio advisor
- Based on evidence stored in portfolio
- Generate end-of-rotation reports for inclusion in the portfolio
- Provide feedback to intern on their progress
- Monitor progress towards achievement of EPAs
- Include review of outcome of Team Review process
- Review evidence of reflective practice in Reflective Journal
- Plan for further learning opportunities
- Identify support and/or remediation needed for struggling interns
- Outcome of progress review recorded in portfolio
- Feed forward overview of intern's progress to next rotation
- With possible consequences for progression and/or remediation (intermediate stakes)

(v) High-stakes summative assessment

- Made by an Entrustment Committee
- At mid-point in training year and end of programme
- Based on an accumulation of WBA evidence and other relevant information in a portfolio
- Informed by input from portfolio advisor, supervisor(s) and network coordinator
- May lead to the award of entrustment for individual EPA(s)
- Records milestones achieved e.g., achievement of an EPA to certain level

- Leads to certification on successful completion of the internship at end of training
- Recommends intern status to the Medical Council, for award of certification

7.3 Entrustment Committees (ECs)

Entrustment Committees (ECs) use the collective input of multiple people to improve the validity and reliability of summative decisions. These are modelled on the concept of a clinical competency committee, as described in the CBME and EPA literature. The term "Entrustment Committee", however, more accurately reflects the nature of the decisions made, and has already been adopted in some contexts^{39 40 41}.

The EC allows for an informed group decision-making process, where patterns of performance can be collated to reveal a broad picture of a trainee's progression towards entrustment⁴². The Intern Remediation Panel (IRP) will be a sub-committee of the EC⁴³.

Details of the functioning of ECs within each network (e.g., composition, governance and processes) are to be developed in consultation with the training programme providers and the national programme director. These will include an appeals process to ensure fairness and transparency. General guidelines on how an Entrustment Committee can function most effectively include the following^{44 45}:

- Define the committee's guiding purpose
- Identify and collate assessment data from multiple sources
- Recruit the right members
- Conduct regular committee member training

³⁹ Keeley, M.G., Bray, M.J., Bradley, E.B., Peterson, C.M., Waggoner-Fountain, L.A., Gusic, M.E. (2020) Fidelity to Best Practices in EPA Implementation: Outcomes Supporting Use of the Core Components Framework From the University of Virginia Entrustable Professional Activity Program. *Academic Medicine* 97(11):1637-1642.

⁴⁰ Brown, D.R., Moeller, J.J., Grbic, D., Biskobing, D.M., Crowe, R., Cutrer, W.B., Green, M.L., Obeso, V.T., Wagner, D.P., Warren, J.B., Yingling, S.L., Andriole, D.A. (2022) Core Entrustable Professional Activities for Entering Residency Pilot. Entrustment Decision Making in the Core Entrustable Professional Activities: Results of a Multi-Institutional Study. *Academic Medicine*. 97(4):536-543.

⁴¹ Schumacher, D.J., Michelson, C., Winn, A.S., Turner, D., Elshoff, E. and Kinnear B. (2021) Making prospective entrustment decisions: Knowing limits, seeking help and defaulting *Medical Education* 56 (9)

⁴² Hauer, K. E., Cate, O. T., Boscardin, C. K., Lobst, W., Holmboe, E. S., Chesluk, B., Baron, R. B., & O'Sullivan, P. S. (2016). [Ensuring Resident Competence: A Narrative Review of the Literature on Group Decision Making to Inform the Work of Clinical Competency Committees](#). *Journal of Graduate Medical Education*, 8(2), 156–164.

⁴³ Friel, O. and Curley, G. (2022) Remediation for the Internship Ireland (unpublished report)

⁴⁴ Ekpenyong A, Baker E, Harris I, Tekian, A. Abram's, Reddy S & Park YS (2017) How do clinical competency committees use different sources of data to assess residents' performance on the internal medicine milestones? A mixed methods pilot study *Medical Teacher* 39(10)

⁴⁵ Kinnear, Warm, and Hauer (2018) Twelve tips to maximize the value of a clinical competency committee in postgraduate medical education *Medical Teacher* 40(11):1110-1115.

- Develop methods for real-time sharing of assessment data during EC meetings
- Establish ground rules for committee meetings
- Use a structured format for committee discussion
- Employ strategies for time-efficient member participation before and during the meeting
- Integrate the EC into a programme of assessment
- Have standard EC output for stakeholders (programme, learner, and accrediting bodies)
- Use a standard framework to provide feedback on performance and planning for learning
- Engage in continuous quality improvement of the committee

7.4 Information sources to determine progress and support summative entrustment by an Entrustment Committee

For each and every EPA, the information sources to be used by an EC to determine progress and support summative entrustment are identified:

Information sources to determine progress and support summative entrustment	• Case Presentation • Case Based Discussion • Reflective Journal • Team Review <i>The recommended range and number of completed workplace based assessments will be determined following piloting of WBA</i> <i>(Example from one EPA)</i>
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The recommended range and number of completed workplace based assessments will be determined following piloting of workplace based assessment, which is a priority aspect for piloting. Emerging best practice from the literature advocates a qualitative approach to determining, for each intern, if there is sufficient evidence to support entrustment of an EPA, rather than a quantitative approach with a pre-determined number of workplace based assessments to be completed.

Progress Reports from the intern's Portfolio Advisor will also be considered by the EC. This can include summary data from Team Reviews with information about the intern concerning attributes within the A RICH framework. A level 4 summative entrustment decision is only made if there is sufficient data, including from Team Review, to support it. In this way the A RICH framework is used explicitly in summative entrustment decision-making.

7.5 Certification of Satisfactory Completion of Intern Training (CSCIT)

The national body responsible for accrediting Intern Training (the Medical Council) sets the standards for intern training and establishes the criteria for the award of certification attesting to successful completion of training. A programmatic approach to assessment, based on EPAs, will lead to certification by the awarding body based on evidence of satisfactory completion of the programme provided by the medical schools/intern networks.

Governance arrangements relating to the internship programme are currently under review. It is anticipated that these arrangements will make provision for quality assurance of the internship programme, including reviewing how intern networks implement and provide oversight for the system of programmatic assessment.

The relationships between elements of a system of programmatic assessment can be illustrated as below, including some new roles that will be needed to support implementation.

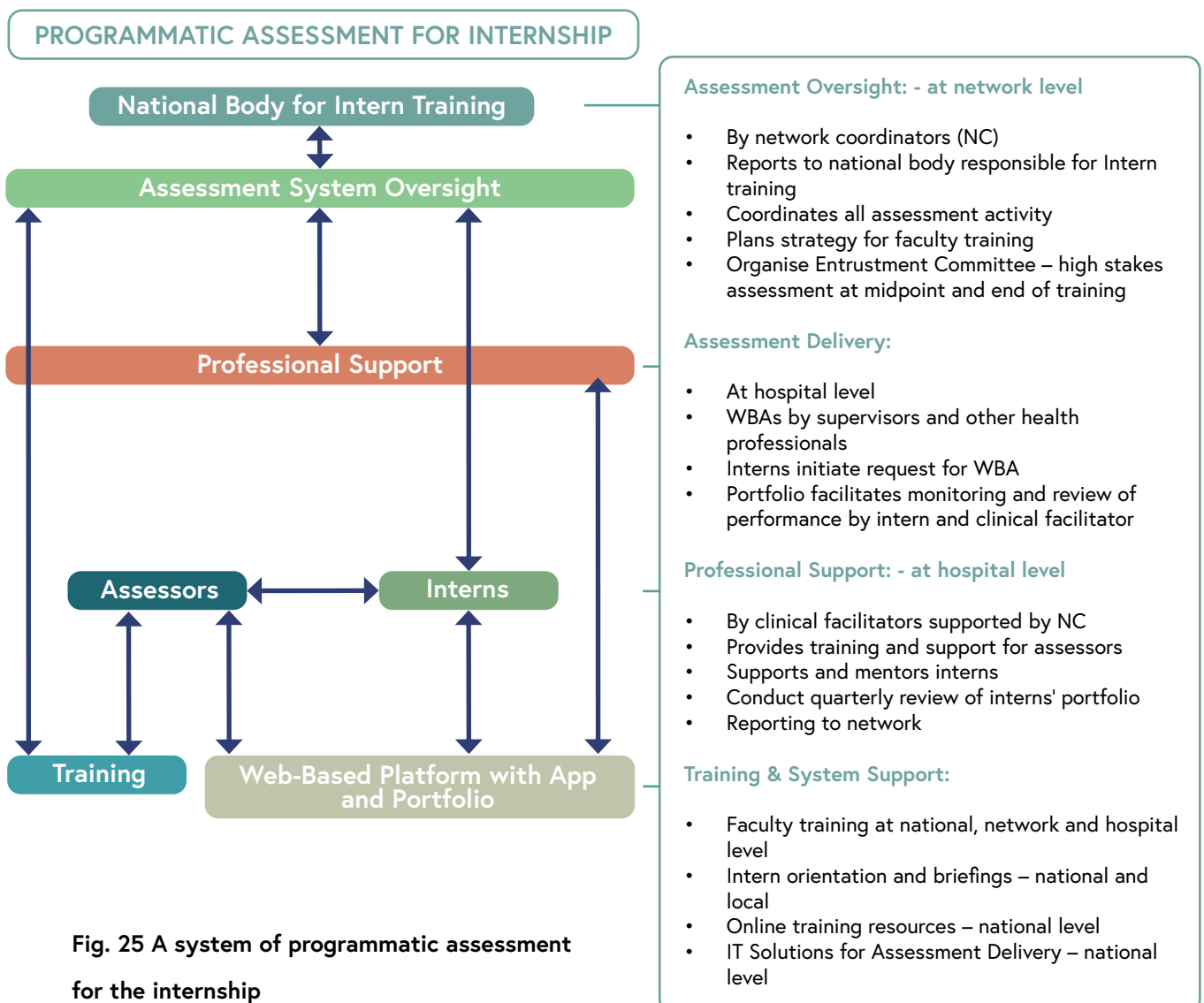


Fig. 25 A system of programmatic assessment for the internship

7.6 Roles and responsibilities for a system of programmatic assessment

Generic roles and responsibilities which are typically carried out with respect to implementation of a system of programmatic assessment for an EPA-based programme can be identified, as listed below, together with how these roles could be fulfilled within the internship programme.

Portfolio advisors within internship networks will be critical to the successful implementation of the programmatic assessment strategy. Regular meetings between an intern and their portfolio advisor will be important. Supervising consultants, members of the clinical team and other health professionals, however, have the primary responsibility for carrying out our workplace based assessments.

Roles and responsibilities relating to the delivery of the programme and quality assurance of intern training are to be elaborated as part of the governance review of the internship programme.

Generic Role in EPA-based systems	Typical responsibilities/functions in relation to programmatic assessment within an EPA framework	Applied to the Internship in Ireland*
Trainee	- Collects, monitors and reviews evidence of their developing competence - Identifies opportunities to have their performance observed/reviewed, using routine workplace based assessments - Initiates requests for feedback from supervisors and other health professionals - Responds to suggestions from others for opportunities to complete routine WBAs - Enters information relating to routine WBA in their portfolio using a mobile app - Responds to feedback received and identifies action plan arising - Sends completed routine WBA reports to the assessor for verification - Completes periodic self-evaluation - Recruits raters for their periodic peer evaluation - Engages in reflective practice - Maintains a log of their clinical experience - Monitors the completion of all WBAs on their dashboard with their portfolio advisor - Makes their assessment data available (in their portfolio) for review by clinical advisor/mentor and by a committee	Interns Routine workplace based assessments = Direct Observations, Case Presentations and Case Based Discussions Team Review = Periodic self and peer evaluation Reflective Journal = means to record evidence of reflective practice Data is owned by the trainee and shared with the portfolio advisor and the Entrustment Committee ⁴⁶

⁴⁶ Requirement for appropriate sharing of data by interns, including from each element of their rotation to the next will need to be secured in training agreements.

Generic Role in EPA-based systems	Typical responsibilities/functions in relation to programmatic assessment within an EPA framework	Applied to the Internship in Ireland*
Supervisor	- Provides supervision to the intern - Carries out routine low-stakes assessment in response to request from interns - Identifies an intern in need of support remediation	Medical practitioner of at least SHO level or equivalent
Assessor	- Carries out routine low-stakes workplace based assessments in response to request from trainees - Identifies struggling trainees using a red flag process, if necessary - Identifies other opportunities to carry out routine WBAs during clinical workflow - Verifies and signs off on WBA reports to which they contributed - Contributes to periodic assessments as requested by intern	Supervising consultants, members of the teaching team, members of the clinical team and other health professionals Hospital-based (hub and satellite) Routine WBAs = Direct Observations, Case Presentations and Case Based Discussions Periodic assessment = Team Review
Portfolio advisor	- Monitors rate of completion of WBAs by trainee - Reviews a trainee's portfolio on regular basis - Advises on progress - Provides advice, coaching and mentoring - Refers intern for support and remediation (Stage 1), if necessary - Reviews and advises on training plan - Provides feed-forward report for intern's transition to next rotation - Conduct workplace based assessment to complement WBA by other assessors (i.e. supervisors, clinical team and other health professionals)	Portfolio advisor A portfolio advisor will be appointed for each intern, within a network, for the duration of their training Responsibility for the role will be assigned by the network Criteria for eligibility and resourcing of the role will be determined by the NDTP in consultation with the programme providers The optimum ratio of interns: portfolio advisor will be explored in piloting

Generic Role in EPA-based systems		Applied to the Internship in Ireland*
Programme director	- Oversees implementation of the Curriculum Framework within the network - Arranges/provides training for assessors - Briefs trainees as to expectations re assessment - Initiates support and remediation process (Stage 2 and 3), if necessary - Chairs the Entrustment/Clinical Competency Committee - Reports outcomes of trainees' summative assessment to awarding body - Compiles summary report on performance of cohorts of trainees in the programme - Reports to national programme director	Network programme director (network coordinator – in collaboration with intern tutors)
National programme director	- Oversees strategic planning and implementation of the framework - Ensures monitoring and evaluation of the programme - Ensures consistency of the decision-making by the Network based ECs - Ensures quality of faculty training and trainee orientation for the programme - Deals with the appeals process	National programme director (role to be established)
Administrators	- Provides administrative and technical support for trainees, assessors and programme director - Manages portfolio system on the web-based platform - Prepares reports for the Entrustment Committee on each intern – in advance of meeting - Secretary to Entrustment Committee - Contributes to Team Review of interns	Network administrator Network-based
Clinical competency/ Entrustment committee	- Reviews summary reports on intern portfolios at intervals in training - Makes progression decisions - Supports Phase 3 of the support and remediation process - Makes summative entrustment decisions - Makes recommendations for the award of CSCIT - Reviews longitudinal data to contribute to quality assurance	Entrustment Committee Network-based
Entrustment Committee (EC) chair	- Convenes and chairs the EC meetings - Plans training for members to ensure a shared mental model of standards expected - Manages meetings to arrive at consensus on each intern - Provides feedback to trainee on outcome of summative entrustment decisions - Reports results to network and awarding body, with recommendations for certification	Entrustment Committee (EC) chair: Programme director/ Network coordinator as chair

Generic Role in EPA-based systems	Typical responsibilities/functions in relation to programmatic assessment within an EPA framework	Applied to the Internship in Ireland*
Entrustment Committee members	- Engages in training - Prepares for EC meetings - Reviews data provided on interns - Contributes to decisions on intern's progress and recommendations certification	Entrustment Committee members At Network level Supervisors, other health care professionals, lecturers, tutors, educationalists With others, with appropriate expertise e.g., from other training bodies, and relevant insights e.g. trainee (post-internship) representative, patient advocate
Awarding body	- Establishes principles, procedures and protocols for assessment system - Deals with appeals relating to the network EC decisions or process - Awards the certificate of competence on successful completion of training requirements and meeting of standards for certification – on the basis of reports from the Entrustment Committee within the Intern Network - Carries out quality assurance of assessment processes within networks	Currently the Medical Council Award: Certificate of Satisfactory Completion of Intern Training (CSCIT)

*Elaboration of roles subject to further discussion and consultation within the context of the Internship programme in Ireland

Fig. 26 Roles and responsibilities in a system of programmatic assessment.

Chapter 8

Conclusion

8.1 Rationale and context

The development of the new Curriculum Framework for the internship was initiated by the Medical Intern Board in response to a clearly identified need to reform the internship programme and move from an apprenticeship, time-based model to an outcomes-based approach. This is in keeping with contemporary developments in competency-based medical education and training internationally. A key goal of the reform has been to incorporate a systematic approach to the assessment of interns, to support certification based on documented evidence of performance. This represents a transformative development for the future training of interns in Ireland.

This Curriculum Framework represents the outcome of two inter-connected workstreams of the Modernisation of the Intern Year Project. The modernisation project aims to deliver a world-class internship to meet the needs of key stakeholders. The implementation of the new Curriculum Framework will contribute significantly to that aim. The model chosen for the framework (DO, KNOW, BE) ensures that due attention is devoted to performance on essential tasks, the underpinning knowledge required and the values, behaviours and practices of an intern as they adopt the professional identity of a doctor.

8.2 Cumulative development work 2015-2022

The Curriculum Framework brings together the cumulative development work of the Medical Intern Unit/NDTP, projects commissioned by the Medical Council and projects funded by the NDTP/HSE which were carried out over the period of 2015-2022. The outcome is a tribute to the educational, academic and clinical expertise of all those involved in the development process. Their commitment to the development process reflects their dedication to the enhancement of the internship programme, in the interest of both interns and patients. The extent to which quality of patient care and Patient safety features within all three pillars of the framework reflects its critical importance in the intern training programme.

The lead developers for the constituent parts of the framework deserve particular credit for their leadership and commitment to the development process over an extended period of time, namely Prof. Dara Byrne, Dr. Orla Mongan, Dr. Natasha Slattery and Prof.

Ger Curley. Numerous members of the internship training community have devoted their expertise and time to participating in working groups and creating the content for the Curriculum Framework. They have done so on the basis of their professional experience and their extensive research on best practice and contemporary developments, in Ireland and internationally. Peer review of development work by members of the CDWG has been an important feature of the approach taken.

With their extensive range of experience and expertise, the panel of external reviewers (Dr. Aileen Barrett, Prof. Jill Thistlethwaite, Prof. H. Carrie Chen, Dr. J. Clare van Hamel and Prof. Olle ten Cate) provided invaluable international insights. They affirmed the model adopted, commended the curriculum work undertaken and offered constructive suggestions on the enhancement of the framework. We are also grateful to other international experts who have provided support and advice, in particular Prof. Olle ten Cate and members of the faculty team of the International Course on The Ins and Outs of EPAs.

8.3 Consultation process leading to the finalisation of the Curriculum Framework

An extensive stakeholder consultation process was undertaken, commencing during the development work and culminating in a series of consultation meetings, as outlined in **Appendix B** and **Appendix D**. Stakeholders from the internship training community, the wider medical education and training community, as well as NCHDs, interns and senior medical students provided invaluable feedback through the various development and consultation processes which were undertaken September 2022 – March 2023, leading to the finalisation of the Curriculum Framework. The active engagement of interns and NCHDs has been especially valuable and important, both in the curriculum development work and in the consultation processes.

8.4 Planning for Implementation

Planning for implementation of the Curriculum Framework involves a range of activities and strategies. Prior to national implementation of the Curriculum Framework, systematic piloting will be essential to determine feasibility, acceptability and resourcing requirements. Piloting can also help identify challenges associated with the changes in culture and practice involved for interns, supervisors and assessors and ways to address them.

The *Curriculum Framework Piloting Task and Finish Group* was established in December 2022 by the Medical Intern Board. Its purpose was to provide a collaborative forum of relevant expertise in order to devise a strategy for the piloting of elements of the Curriculum Framework and to report to the Medical Intern Board with a proposed strategy, including criteria for prioritisation.

The preparation of digital resources to support implementation has already been undertaken and resources circulated. (See **Appendix I**). A number of faculty orientation sessions have been delivered (See **Appendix J**) Some further development work – including of the technological infrastructure for programmatic assessment – will be necessary in advance of piloting, in preparation for implementation as noted in **Appendix G**.

8.5 Changes in culture and practice

Given the nature and extent of the changes associated with the new Curriculum Framework, the EPAs and workplace based assessment, a programme of faculty development for faculty, supervisors, and assessors, and effective orientation of interns, will be critical to successful implementation.

The Medical Council is currently developing standards and criteria for quality assuring medical education and training in Ireland. One set of accreditation standards will address continuing professional development and, specifically, the training of clinical supervisors and assessors.

A range of potential approaches for CPD/faculty development can be identified. There is a wealth of international experience to draw on, in developing a strategy^{47 48 49}. Approaches adopted range from the relatively passive to more active learning strategies for faculty development and preparation of trainees.

A strategy for the modernisation of the internship will require an appropriate mix of strategies, using a blend of delivery methods, from face-to-face, virtual and online. Targeted

⁴⁷ Bray MJ, Bradley EB, Martindale JR, Gusic ME.(2020) Implementing Systematic Faculty Development to Support an EPA-Based Program of Assessment: Strategies, Outcomes and Lessons Learned. *Teach Learn Med.* 33(4):434-444:

⁴⁸ Lupi CS, Ownby AR, Jokela JA, Cutrer WB, Thompson-Busch AK, Catallozzi M, Noble JM, Amiel JM;(2018) Association of American Medical Colleges Core Entrustable Professional Activities for Entering Residency Faculty Development Concept Group. Faculty Development Revisited: A Systems-Based View of Stakeholder Development to Meet the Demands of Entrustable Professional Activity Implementation. *Academic Medicine.* 93(10):1472-1479

⁴⁹ Favreau MA, Tewksbury L, Lupi C, Cutrer WB, Jokela JA, Yarris LM; AAMC Core Entrustable Professional Activities for Entering Residency Faculty Development Concept Group. (2017) Constructing a Shared Mental Model for Faculty Development for the Core Entrustable Professional Activities for Entering Residency. *Academic Medicine.*92(6):759-764

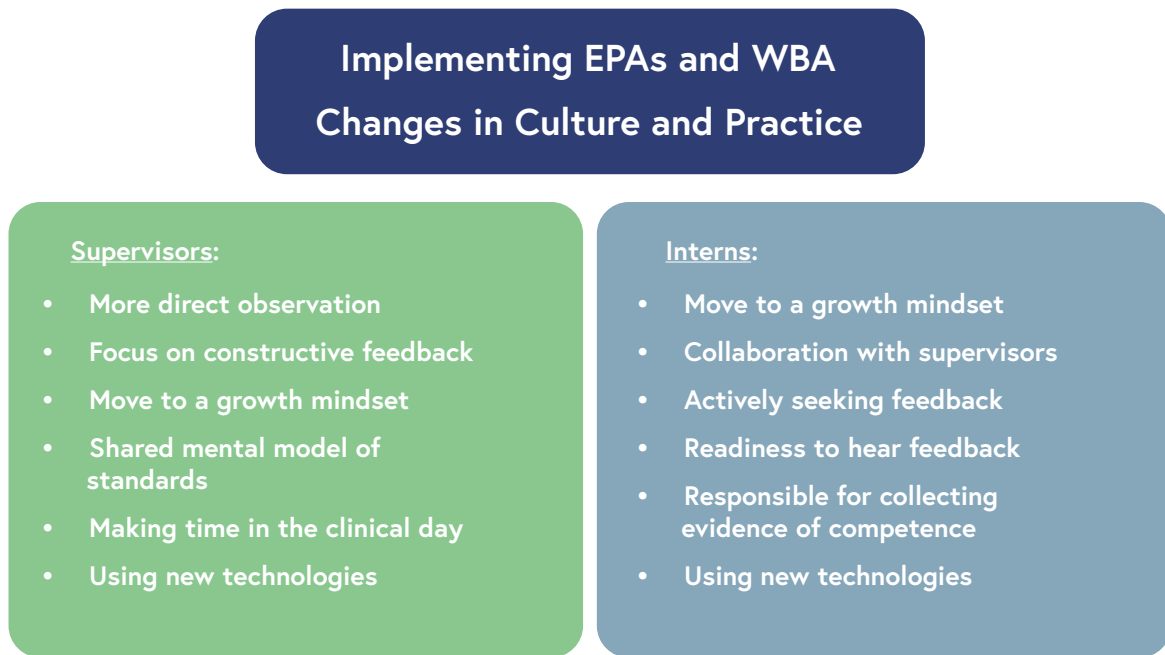


Fig. 27 Changes in culture and practice for supervisors and interns

training will be essential prior to piloting and implementation for all those directly involved in implementation:

- Consultants
- Lecturers and tutors who engage with interns
- Interns
- Clinical facilitators
- Network programme directors
- Portfolio advisors
- Members of Entrustment Committees
- Network administrators
- Other health professionals who assess interns

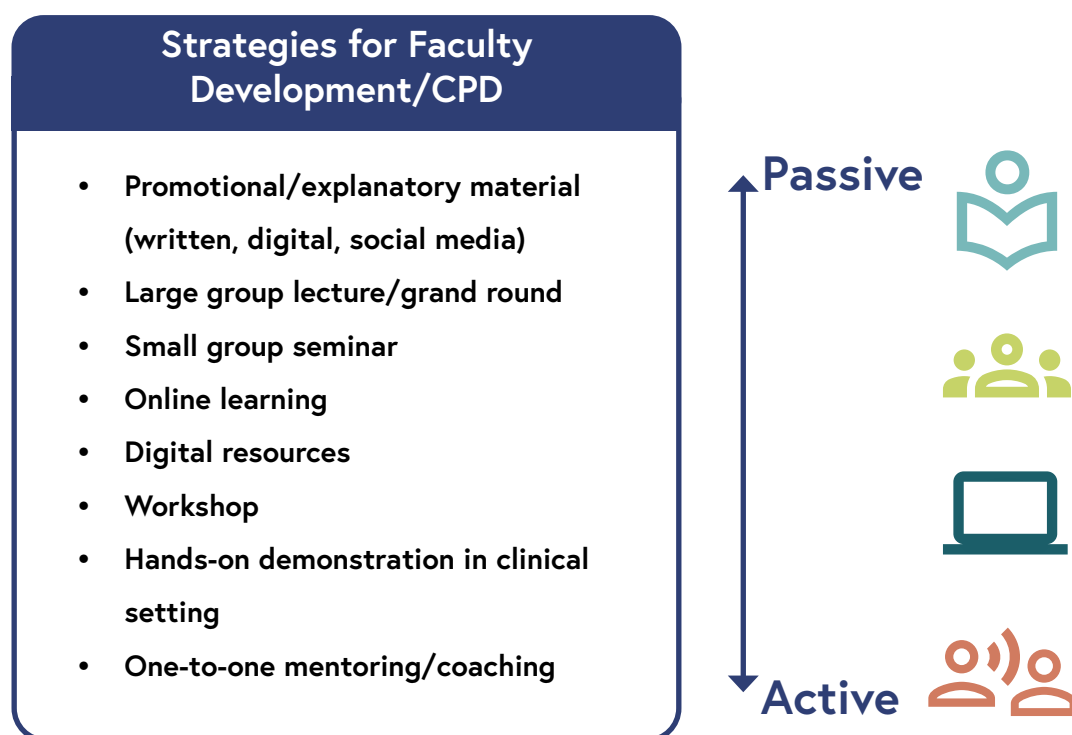


Fig. 28 Strategies for faculty development

8.6 The value of research and an evidence-based approach

There is a rapidly expanding corpus of international literature that provides valuable insights into issues of implementation of CBME, EPAs and programmatic assessment. The implementation of the Curriculum Framework for the internship programme will present rich opportunities to contribute to that body of research, and to inform future directions for Ireland. Research has already been carried out in Ireland, to assess self-reported level of entrustment in - and frequency of - performance of the seven EPAs comprising the framework for interns in Ireland⁵⁰.

Longitudinal research will be important to help determine the extent to which the Curriculum Framework is fulfilling some of its key functions e.g.

- Enhancing the quality of the internship programme and the experience of interns
- Ensuring comparability of the internship experience across networks
- Guiding Intern Networks and supporting them in devising their local programmes
- Enabling interns to take responsibility for their own professional development with a sense of agency as reflective practitioners
- Providing a valuable framework for programmatic assessment
- Facilitating quality assurance of the internship programme delivered in training networks

⁵⁰ O'Connor P, Lydon S, Mongan O and Byrne D. (2022) Longitudinal survey of self-reported level of entrustment across the first year of clinical practice [version 1; peer review: 1 approved] *HRB Open Research* 5:9

8.7 An enabling framework with phased implementation

This national Curriculum Framework will guide the delivery of intern training at network level. As an enabling framework, it empowers intern networks to use their expertise as programme developers and as trainers to create learning experiences for their interns that enable them to acquire the necessary competencies, and become the best doctors they can be. The strategy for programmatic assessment also promotes agency on the part of interns, who are given licence to initiate requests for feedback as they gather evidence of their competence. It also aims to develop the skills of reflective practice and lifelong learning amongst doctors committed to their own continuing professional development.

Experience from other contexts where CBME, EPAs and programmatic assessment have been implemented confirms the value of a phased approach to implementation. Planning of these phases will involve collaboration and cooperation on the part of all stakeholders. Implementation science has much to offer in considering the next stage of implementation planning. Even where a proposed curriculum change is supported by the majority of stakeholders, there are factors that play a role in how well the change is received, implemented and sustained⁵¹. Constraining factors include inertia, resistance to change and poor internal communication. Empowerment and engagement will be essential enabling conditions, together with significant change in organisational culture.

The Curriculum Framework offers a vision of what the intern training programme will look like, once all the provisions and processes of the framework are implemented in full. A plan for phased implementation, including piloting, is critical to establishing its feasibility and acceptability. Phased implementation of the Curriculum Framework will require planning and collaboration by all key stakeholders, in particular intern networks, who will need to take ownership of the process. Commitment of significant resources will be essential to support piloting and phased implementation. Development of the necessary technological infrastructure is a priority to facilitate the conduct of workplace based assessment and support summative entrustment decision-making by Entrustment Committees. Faculty development for supervisors, assessors and orientation of interns will be critical to enabling them to respond to the necessary changes in culture and practice.

⁵¹ Thomas, A, Ellaway, R.H. (2021) Rethinking implementation science for health professions education: A manifesto for change. Perspectives in *Medical Education* 10 (6):362-368.

The Curriculum Framework for the internship represents a major development with transformative potential for intern-training in Ireland, aligning it with best practices, and international medical education and training standards. This Curriculum Framework represents the finalisation of a key stream of the Modernisation project and will serve as the point of reference for piloting and the subsequent implementation.

Glossary of Terms

Ad hoc entrustment	The act of placing trust in another person to perform a particular activity in the moment of working with them. Ad hoc entrustment decisions are context dependent and made by an individual supervisor.
A RICH	The A RICH framework describes the attributes of a trainee as: agency, reliability, integrity, capability and humility.
Assessment: low-stakes	Low-stakes assessments have no direct consequences for an intern arising from the outcome of a single observation or review of their performance. Evidence of an intern's developing competence is generated through multiple low-stakes events using direct observation and/or review of practice. These are carried out by supervisors/trainers in clinical practice and in simulated settings and are used to provide relevant feedback. (Also referred to as 'formative assessment' or 'assessment <i>for</i> learning').
Assessment: high-stakes	High-stakes assessments are those where the outcome has consequences for an interns' progress and/or graduation. High-stakes assessment is carried out at the end of the training programme and, in some cases, may occur at defined intervals during the course of a programme (Also referred to as 'summative assessment' or 'assessment <i>of</i> learning').
Assessor	A health professional who carries out a workplace based assessment of an intern's practice and provides them with feedback on their performance.
Case based discussion	A case based discussion is a discussion between a health professional and an intern about a selected patient case.

Competency-based medical education (CBME)	Competency-based medical education (CBME) is an educational approach where learning, teaching and assessment activities are organised around achievable outcomes, derived from patient and societal needs.
Competencies	Observable abilities of a health professional related to a specific activity that integrates knowledge, skills and attitudes.
Curriculum	A curriculum is a statement of the intended aims and goals, content, experiences, outcomes and processes of a programme of learning, including a description of the expected methods of learning, teaching, assessment, feedback and supervision.
Curriculum model	A diagrammatic representation, that depicts the structure and components of the curriculum.
Curriculum Framework	The Curriculum Framework guides the design of intern training at local level and ensures national coherence in the provision of high-quality training. The Curriculum Framework for internship is organised in terms. • Programme Goals • DO (Entrustable Professional Activities) • KNOW (Knowledge Guides) • BE (Professional Behaviours, Values and Practices) • Teaching and learning processes and experience • Programmatic assessment
Direct observation	A direct observation is a tool used for observing an intern's performance of a clinical task (e.g., taking a history or receiving a handover) or a procedure (e.g. inserting a urinary catheter).

Domains	Domains are broad, distinguishable areas of competence that - in the aggregate - constitute a general descriptive framework for a profession. Examples include the Medical Council Eight Domains of Good Professional Practice.
Domains of Good Professional Practice	These domains, established by the Medical Council, describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence.
Education and Training plan	An education and training plan is prepared when an intern is in the support and remediation process. It states the issue(s) which have resulted in commencement of the process and details the action plan to address these issues.
Entrustable Professional Activity	An entrustable professional activity (EPA) is a unit of professional practice or essential task that a trainee can be trusted to perform without direct supervision, once sufficient competence has been demonstrated.
Entrustment	The act of assigning the responsibility for something valued or important to a person.
Entrustment Committee	An Entrustment Committee makes summative assessment decisions, using an informed group decision-making process where patterns of performance can be collated from evidence in a portfolio, to reveal a broad picture of an intern's progression toward competence.
HALO events	High acuity and low occurrence events which may be observed, and performance assessed using simulation.
Healthcare professional	A provider of health care treatment and advice, based on formal training and experience.

Intern Remediation Panel	The Intern Remediation Panel (IRP) constitutes a subcommittee of the Entrustment Committee set up for the purpose of consulting and advising on periods of intern support and remediation for individuals whose clinical and/or professional issues have failed to be resolved during stage 1 support and remediation.
Knowledge guide	Knowledge guides are a <u>guide</u> to the underpinning knowledge that interns need to safely carry out the EPAs by the end of their training. Each knowledge guide indicates what an intern needs to <u>know</u> to be able to perform the relevant EPA independently with distant supervision by the end of training.
Learning outcomes	Learning outcomes state what an intern should be able to demonstrate following a learning experience or training programme. Learning outcomes can be classified as knowledge, skill or attitudinal outcomes. Knowledge, skills and attitudes/values, when integrated, are the constituent elements of a competence.
National programme director	The national programme director oversees the strategic planning, implementation of the Curriculum Framework across all intern networks. They ensure monitoring and evaluation and the quality of faculty training and trainee orientation for the programme. They deal with the appeals process regarding summative entrustment decisions and the support and remediation process.
Professional competencies	Professional competencies provide guidance on what an intern needs to 'BE' i.e., professional behaviours, values and practices.
Professional identity formation	Professional identity formation is a complex and transformational process of internalising a profession's core values and beliefs.

Programmatic assessment	Programmatic assessment is an approach to assessment that provides for multiple sources of evidence of a trainee's performance and their progress towards independent practice.
Programme director	The programme director oversees implementation of the Curriculum Framework within the network.
Portfolio advisor	The portfolio advisor supports the intern and monitors their progress, and provides advice, coaching and mentoring.
Proactive supervision	Supervision that is provided through physical presence. Proactive supervision is synonymous with direct supervision.
Prospective scale	A tool/mechanism for estimating or recommending readiness for future practice. Prospective scales include anchors such as: 'I judge (or estimate) this learner to be ready for indirect supervision,' or, if used summatively, 'From tomorrow, this learner is allowed to practise this EPA under supervisory oversight only.' Prospective entrustment is a tautology, as all entrustment decisions are prospective.
Reactive supervision	Supervision that is provided on request by the learner or another member of the team. Reactive supervision is quickly available when requested. Reactive supervision is synonymous with indirect supervision.
Reflective journal	A reflective journal provides the intern with an opportunity to provide evidence of their learning and insight.
Remediation	The process of addressing behavioural, performance or educational difficulties that may arise during the course of internship through structured and defined periods of supervision, support and assessment.

Retrospective scale	A tool/mechanism for evaluating observed behaviour in a retrospective process focused on what an individual has already done. Retrospective scales include anchors such as: 'I had to be there,' 'I provided help,' and 'I could have left the room.'
Summative entrustment decisions	A summative entrustment decision is a decision for an EPA that signifies the general permission to deliver the contribution to health care that this EPA represents, without, or with limited supervision, at or before the completion of training. This decision is made and recognised by a relevant supervisory team, such as an Entrustment Committee, and is based on varied information including multiple prior observations involving multiple credible observers.
Supervisor	A health professional providing oversight for an intern as they perform in the clinical workplace.
Supervision	The provision of guidance and support in learning and working effectively in health care. by observing and directing - when necessary - the execution of tasks or activities to ensure that they are done correctly and safely, from a position of being in charge.
Supervising consultant	The consultant doctor leading the clinical team in which an intern is assigned. They are responsible for supervising the intern.
Team review	Team review is a multi-source method of assessment – which may include self-assessment – in which interns are provided with feedback on their observed performance, including professional behaviour (e.g., by doctors, nurses, peers, patients and administrators) and where they reflect on their learning and progress.

Trust

The willingness of a party to be vulnerable to the actions of another party on the basis of the expectation that the other will perform a particular action important to the trustor, irrespective of the trustor's ability to monitor or control that other party.

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See **Appendix B** for all those who contributed to the development and consultation processes for

(i) The Curriculum Framework

(ii) The EPAs

(iii) The BE pillar

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Prof. Gozie Offiah is the Clinical Lead of Medical Intern Unit, National Intern Training Programme, National Doctors Training and Planning, Health Service Executive. Gozie is an Associate Professor and the Director of Curriculum at RCSI, University of Medicine and Health Sciences, where she is leading the implementation of the transformed undergraduate medical curriculum. She holds positions at Medical Protection as a Council member and Non-Executive Director, chair of the cross-cultural group of tEACH, the International Association of Communication in Healthcare and co-chair of the Race Equality Forum at RCSI.



**Prof. Gozie Offiah
Clinical Lead (MIU)**

Prof. Gozie Offiah practised medicine (with a background in Surgery) for over 15 years in the Health Service Executive (HSE). Along with her Medical degree from RCSI, she also has a Master's in Medical Education from Queen's University Belfast, a Doctor of Medicine (MD) in Surgery from RCSI exploring the role of JAM-A in Breast cancer, and a Doctor of Philosophy (PhD) in Medical Education from the University of Dundee with a thesis entitled: "Women in Surgery: Exploring stakeholders lived experiences in the Irish and Scottish Healthcare systems." She has published more than 30 peer-reviewed journal articles and has delivered invited lectures, keynotes and workshops at many national and international meetings.

Her teaching experience spans undergraduate, postgraduate and continuing medical education in health professions education and training. Her teaching interest includes curriculum design, delivery and faculty development. Her research interests include qualitative research methodologies with a particular interest in innovations in qualitative data analysis in medical education research, such as discourse and narrative analysis and social constructionism approaches. Research areas include constructed identities and intersectionality, especially the intersections between gender, age, ethnicity and professional identities, career transitions and surgical cultures in the workplace. Gozie has a special interest in the role of mentoring and role models in the delivery of health care.

**BA Hons (UCD), PG Dip Town and Country Planning,
(QUB), MSc in Education and Training Management (DCU),
Doctorate in Education (University of Edinburgh)**

Dr. Josephine Boland is an educationalist and researcher with over 35 years' experience within medical education, higher education, teacher education, vocational education and community engagement. In the past 10 years she has specialised as a medical education consultant, engaged in curriculum development, research and evaluation in support of strategic planning and change management in medical education and training.



**Dr. Josephine Boland
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Dr. Boland has supported postgraduate medical education and training bodies in the implementation of competency-based medical education, the development of Entrustable Professional Activities (EPAs), design of workplace based assessment, design and delivery of faculty development and development of digital training resources. Within Ireland she has worked as a medical educationalist for the Medical Intern Unit of the NDTP/HSE, the College of Anaesthesiologists of Ireland, the Irish College of General Practitioners, the Faculty of Radiologists (RCSI), the Royal College of Physicians of Ireland, the College of Psychiatrists of Ireland and the Medical Council. She is a member of the core faculty team for the International Course on the Ins and Outs of EPAs, led by Prof. Olle ten Cate, developing content for the course and delivering it face-to face and online. She has led a number of NDTP-funded development projects, including design of competency-based frameworks using EPAs, the development of data management systems and mobile technology to support implementation of work-based assessment and design digital resources.

Within higher education, she served as Senior Lecturer in the School of Education and in the School of Medicine in the University of Galway. She was programme director for the Masters in Clinical Education, supporting medical education research. Her specialist area in education was curriculum and assessment, informed by experience and expertise gained when developing national curricula for the vocational education sector with the National Council for Vocational Awards. Dr. Boland served as Senior Development Officer for TEASTAS, established by the Department of Education to develop the legislative underpinning for the national framework of qualification for Irish higher and further education. This provided invaluable experience and insights into policy formation, framework design and quality assurance.

Appendices

- A. Background to the revision of the curriculum for the Internship**
- B. Curriculum development and consultation process (2015-2022)**
- C. External review of the Curriculum Framework (2022)**
- D. National Consultation process (Dec 2022-March 2023)**
- E. Medical council eight domains of good professional practice**
- F. Support and remediation for Interns**
- G. Preparation for implementation**
- H. The workplace based assessment report from**
- I. Digital resources to support implementation of the Curriculum Framework**
- J. Faculty development session**

Appendix A

Background to the revision of the curriculum for the Internship

1	Internship training in Ireland
2	The current curriculum for the internship
3	A review of intern training (2015)
4	Medical Intern Board (MIB)
5	Modernisation of the intern year project
6	Revision of the curriculum for the internship

1. Internship training in Ireland

Internship is the period of transition from medical student to a registered medical practitioner. An intern is a medical doctor who has completed their medical degree and is on the intern register practising medicine in supervised intern training posts.

Internship is a significant change for recent medical graduates since, for the first time, they become registered medical practitioners. They hold clinical responsibility for patient care under appropriate supervisory arrangements, they are employees of the health service, they are full members of the clinical team and they continue to train and develop as doctors.

The internship programme provides new medical graduates with their first experience of being a doctor responsible for patients. It is the foundation of a doctor's professional development, providing a combination of education, training and clinical responsibility enabling interns to develop the professional and personal competencies that result in good patient care and provide a basis for lifelong learning.

Following successful completion of this training, the intern is awarded a certificate of experience by the Medical Council, which - in conjunction with their medical qualification - provides the doctor with formal qualifications as having completed basic medical education. They then have an entitlement to registration on the trainee specialist division or the general division of the Medical Council.

Intern training is a critical stage in doctors' professional development. There have been significant reforms in intern training in Ireland in the last decade to bring about improvements for the benefit of trainees, health services and ultimately the public.

2. The current curriculum for the internship

Standards and guidelines were developed and introduced a decade ago to support the Medical Council in fulfilment of its responsibilities under Part 10 of the Medical Practitioners Act 2007 to *"specify and publish in the prescribed manner the standards for training and experience for interns which are required for the granting of a certificate of experience"* and *"prepare and publish in the prescribed manner guidelines on medical education and training for interns"*. The [National Intern Training Programme](#) overview includes the curriculum and assessment system developed at that time.

The current intern curriculum was devised by the intern training networks and the Medical Council approved a revision in April 2011. This curriculum was incorporated into three overlapping and interdependent modules each of which emphasises specific aspects of Intern Core Competencies and includes the Guide to Professional Conduct and Ethics for Registered Medical Practitioners adopted by the Medical Council. From these three modules, each Intern Network took responsibility for devising content for specified modules which were made available to all networks, forming the basis of the National Intern Training Programme (NITP).

3. A review of Intern Training (2015)

A review of intern training in Ireland was undertaken by the Medical Council through the Strategy and Policy Subcommittee of its Education, Training and Professional Development Committee. A number of steps were completed:

- Data from 'Your Training Counts' 2014 were examined with more specific detailed analyses.
- Current arrangements for intern training in Ireland were analysed, and the strengths and weaknesses were appraised.
- A Review of Intern Training in Ireland was conducted by the Medical Council's Strategy and Policy Subcommittee 2015 and published to inform a consultation process
- Reform of equivalent arrangements for intern training in other health systems was reviewed.
- A stakeholder study was commissioned and undertaken by Amárach Research. The study qualitatively analysed the views of current interns (those commencing and those

completing intern training), trainees who recently completed intern training, those involved in undergraduate education, intern training and postgraduate training and those involved in the funding and regulation of medical education and training. See the report [Stakeholder Study](#).

- A research group led by Dr. Dara Devitt, Director of Simulation Saolta University Health Care Group, Senior Lecturer in Medical Education, NUI Galway and Intern Network Coordinator, were commissioned to examine and appraise models for learning outcomes and to develop a [Draft Framework of Outcomes for Intern training in Ireland](#).
- An Education and Training Symposium was hosted by the Medical Council in September 2015, to bring together relevant stakeholders to discuss issues related to intern training in Ireland. A report of that Symposium is available ["Supporting the Transition from Student to Doctor"](#).
- A [consultation](#) on supporting the transition from medical student through intern training to fully registered doctor was carried out. To inform the process a consultation document was provided [Improving Intern Training in Ireland, 2015](#).

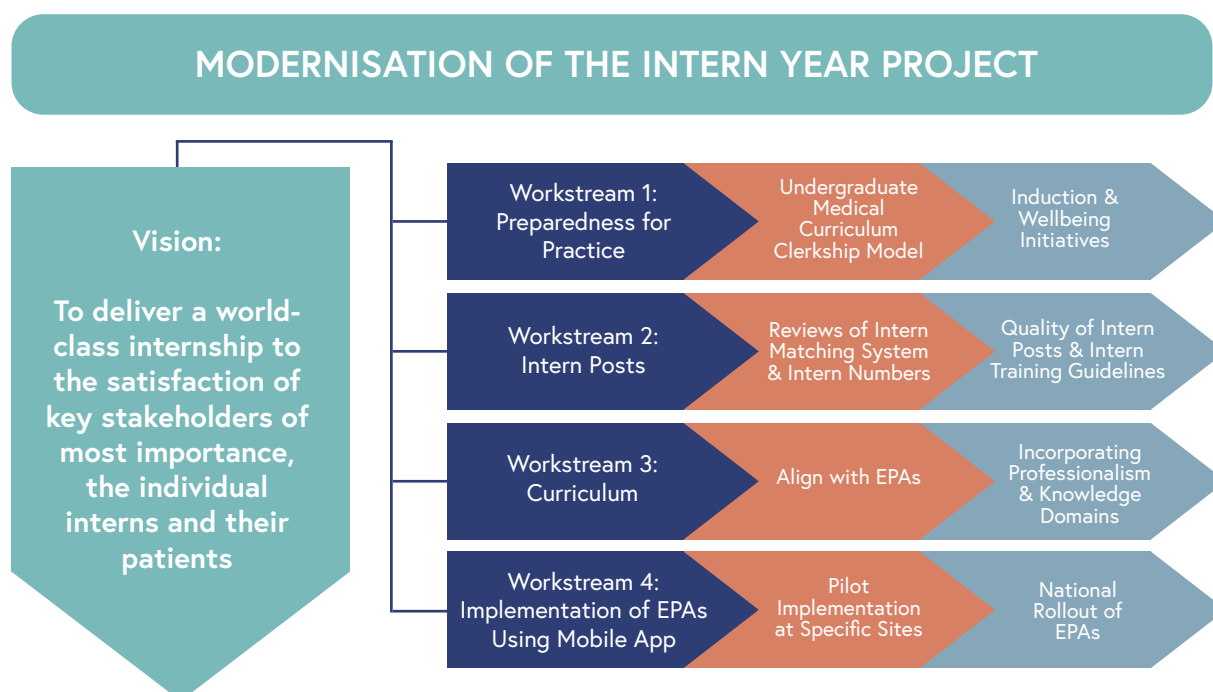
This review of Intern Training in Ireland identified several aspects of intern training which would benefit from further development. The Medical Council recognised the need for improved delivery of consistent, quality education and training across the intern training networks in Ireland and hence the proposal for an outcomes-based approach to intern training.

Following an international appraisal of the concept of competency-based medical education, a review of research literature and a consultation process with key stakeholders, Entrustable Professional Activities (EPAs) were adopted and developed as the organising framework for competencies required for effective and safe practice by interns in Ireland at the end of their training. See [The Development of EPAs for the intern Year](#).

4. Medical Intern Board (MIB)

The Medical Intern Board (MIB) was established in October 2017 with responsibility for the governance and strategic direction of the internship on a national basis. The purpose of the MIB is to establish a national governance structure for the medical intern training programme in Ireland. The MIB initiates and facilitates the development of a centralised approach which include inter alia., facilitating the development of a national, outcomes-based medical intern training programme which meets Medical Council standards for intern training.

To support the Medical Intern Board, a Medical Intern Unit was established in 2018 to oversee and manage the operational delivery of the internship as well as to implement strategic recommendations of the Board. One of the early tasks undertaken by the Medical Intern Board was the specification and initiation of the Intern Modernisation Project.



5. Modernisation of the intern year project

As a result of the Medical Council 2014 survey, 'Your Training Counts', several areas were highlighted that required attention with regard to intern training, and thus a review of the internship was commenced by the Medical Intern Unit. The Modernisation of the Intern Year project was initiated in August 2018 under the direction of the Medical Intern Board (MIB). There was a scoping review of the internship to identify challenges for review. Following input from multiple stakeholders including MIB members, several aspects of internship training from intern recruitment to intern posts to preparedness for practice were added to the project. In addition, there were also other areas highlighted following the Medical Council regional inspection of some healthcare groups that were added to the Modernisation project like increase in intern numbers. A Project Proposal for the Modernisation of the Intern Year was approved by the Medical Intern Board on 11th December 2018 and four different workstreams were identified, below:

- **Workstream 1** – Preparedness for Clinical Practice
- **Workstream 2** – Intern Posts to include Matching Process, quality of posts, increase numbers and intern training guidelines
- **Workstream 3** – Development of a curriculum which aligns with the internship Entrustable Professional Activities (EPAs) and incorporates professionalism and knowledge domains
- **Workstream 4** – Implementation of Entrustable Professional Activities (EPAs)

Members of the Intern Network Executive, Medical schools, Medical Council representatives, Chair and members of the MIB, NCHDs, and staff of National Doctors Training and Planning have been involved in this project since approval.

A key element of this has been the recognition that the existing curriculum does not meet the changing needs of the intern programme, or of the Medical Council for its accreditation role. The National Intern Programme curriculum needed review and revision to bring it in line with international educational standards and to support an outcomes-based competency framework.

Since then, the development of a national Curriculum Framework, including Entrustable Professional Activities (EPAs) and associated assessment tools for the Internship have been a high priority for the Board. The proposed implementation of EPAs offers the opportunity to revisit the curriculum, and relevant accreditation standards in a coherent, coordinated manner, in collaboration and partnership with intern training networks.

6. Revision of the curriculum for the internship

The National Intern Programme curriculum needs review and revision to bring it in line with international standards and to support an EPA-based competency framework, which incorporates a more systematic and robust approach to assessment. The Medical Council and the Medical Intern Board have committed to the development of a national curriculum to achieve this.

"As part of the Intern Year Reform efforts, the assessment of outcomes for Interns for preparation for practice continues to be a major focus. Development of 'Entrustable Professional Activities' (EPAs) commenced in 2015. A move to competency-based assessment over the traditional apprenticeship time-based model of intern training

in Ireland was agreed in the format of EPAs. This process has involved and continues to involve wide stakeholder consultation and collaboration. Although this project was commissioned by the Medical Council, this work is now overseen by the Medical Intern Board, with the specification for a pilot currently in development"⁵².

There are currently a number of organisations that share responsibility for the content and delivery of intern training. These organisations include the medical schools and associated Intern Training Networks, the Medical Council, the Health Service Executive (HSE), and the Medical Intern Board. Statutory responsibilities for intern training, including the curriculum, however, reside with the Medical Council and the HSE as set out in the [Medical Practitioners Act \(MPA\) 2007 Part 10](#).

The Medical Intern Unit, under the direction of the Medical Intern Board, was tasked with a review of the intern year. Since its establishment in May 2018, the MIU has been reviewing different aspects of the internship with input from multiple stakeholders including the Intern Network Executive and the Medical Schools.

The Modernisation of the Internship Project aims to deliver a world-class internship to the satisfaction of key stakeholders. One of the workstreams in the modernisation project has been the **Development of a Curriculum Framework** which aligns with the internship **Entrustable Professional Activities (EPAs)** and incorporates both professionalism and knowledge domains. EPAs were developed as the organising framework for competencies required for effective and safe practice by interns in Ireland at the end of their training and adopted in 2018. See [The Development of EPAs for the intern Year](#)⁵³.

The proposed implementation of EPAs offers the opportunity to revisit the curriculum and relevant accreditation standards in a coherent, coordinated manner, in collaboration and partnership with intern training networks. It also provides an opportunity to identify gaps in the curriculum such as health disparities and cultural competence, quality improvement and Patient safety etc. The final development of the Curriculum Framework will require alignment with the revised accreditation standards currently being developed by the Medical Council. Once the new Curriculum Framework is approved, its implementation will need to be supported by the provision of necessary additional resources.

⁵² Report to the New Medical Council on the Role and Achievements of the Strategy and Policy Sub-committee 45 (SPSC) of the Medical Council (2015)

⁵³ Byrne, D., Lydon, S., Madden, C., O'Dowd, E., Boland, J., & O'Connor, P. (2018). The development of entrustable 46 professional activities for the Irish intern year. Galway: NUI Galway.

Appendix B

Curriculum development and consultation processes (2015-2022)

This appendix details the development work and consultation processes undertaken, 2015-2022, which led to the preparation of the Draft Curriculum Framework Consultation Document in May 2022.

1	The EPAS
1.1	Summary of the development and consultation process (2015-2022)
1.2	Evaluation of the field-testing of the paper-based version of forms for assessing the EPAs (2019)
1.3	Evaluating the EPAs (2021)
2	The DO, KNOW, BE model
2.1	Development and consultation process with respect to the DO, KNOW, BE model for the Curriculum Framework for the internship
2.2	Establishing the templates with samples of content (2019)
3	Stakeholder consultation meeting (December 2020)
3.1	Agenda
3.2	Feedback from the break-out groups
4	The BE pillar and the Knowledge Guides
4.1	Development and consultation process for the KNOW and BE pillars of the Curriculum Framework
4.2	Further development and review of the BE pillar of the Curriculum Framework
5	Sources used in the development of the curriculum
5.1	Sources used in development of the Entrustable Professional Activities
5.2	Sources used in development of the Knowledge Guides
5.3	Sources used in development of the BE pillar of the Curriculum Framework
6	Support and remediation
6.1	The development and consultation process
7	Contributors to the curriculum development and consultation processes (2015-2020)
7.1	The Curriculum Framework
7.2	The EPAs
7.3	Field-testing of the EPA workplace based assessment tools
7.4	The Knowledge Guides
7.5	The BE pillar of the curriculum
7.6	Support and remediation

1. EPA

1.1 Summary of the development and consultation process with respect to the EPAs

Development and consultation process

The EPAs were developed following a decision by the Medical Council, to commission the development of EPAs for the internship year. The process has involved using approaches recommended in the literature for their development and validation namely: (1) identifying initial EPAs; (2) expanding the initial EPAs to include detailed descriptions and associated competencies; and (3) validating the framework of EPAs and competencies using a variety of methods. This process resulted in eight discrete stages in the consensus-building process, as comprehensively described in Byrne D, et al (2018) leading to their publication and adoption in 2018.

2015

1. Medical Council commissioned development of EPA for the internship
2. Research and development work commenced by D. Byrne et al
3. Research undertaken on comparable competency frameworks and programmes
4. Selection of experts for development of the EPAs for the internship
5. Scoping out and identification of the core EPAs for the internship
6. EPAs described in detail
7. Validation of EPAs using an online survey of independent stakeholders
8. Tools of workplace based assessment for EPAs identified

2016

9. EPAs brought to a wider stakeholder consultation workshop hosted by the Medical Council
10. EPAs benchmarked against competency frameworks for comparative programmes
11. Framework of Outcomes for the End of Internship (the EPAs) adopted by the Medical Council

- 2018**
12. Publication of Byrne et al (2018) "The Development of Entrustable Professional Activities for the Internship" (NTDP-funded project)
 13. Medical Intern Board approves the Modernisation of the Internship Project, which includes Workstream 3: Development of a curriculum and 4: Implementation of EPAs
 14. Update provided to the reformed Education and Training Committee (ETC) of the Medical Council, highlighting EPA development work
- 2019**
15. Field-testing of workplace based assessment tools in paper-based format, by the MIU/NDTP
 16. Development work commenced on the integrated Internship curriculum (DO, KNOW, BE)
- 2021**
17. Evaluation of the EPAs in a collaborative project between the MIU/NDTP and the Irish College of General Practitioners (ICGP) [See details below, and MIU (2022) *Evaluation of the EPAS for the Internship: A report on the Process and Outcomes*]
- 2022**
18. Review of the EPAs by a short-life working group, in light of the (i) the updates recommended format for EPAs, refined by ten Cate 2020 (ii) outcome of the evaluation and the development (iii) need for amendments arising from development of the Knowledge Guides

1.2 Evaluation of the field-testing of the paper-based version of forms for assessing the EPAs (2019)

Pending development of an appropriate technological infrastructure to support the conduct and storage of workplace based assessment of EPAs it was decided to engage in field-testing of paper-based versions of the forms (then called Observation and Review Reports). The purpose of the field-testing phase of the EPA project was to:

- Field-test the proposed design of the fields on the workplace based assessment tools for EPAs
- Determine the adequacy of the draft guidelines on how to complete the process
- To pilot the processes and content of the training of consultants as observers/reviewers
- Commence development/sourcing of relevant training resources for the pilot phase
- Inform the specifications of the app for the technology company
- Explore how many competencies can be observed and to gauge time commitment required
- Get an early sense of any potential issues/challenges in implementation
- Identify potential future EPA champions for the pilot and/or implementation phase

All intern networks were contacted and invited to participate in field testing process, with an explanation of the purpose of the phase. With follow-up personal contact and encouragement, volunteers (consultants and interns) were successfully recruited from:

- Dublin Mid-Leinster Intern Training Network
- West Northwest Intern Training Network
- Dublin Northeast Intern Training Network
- Mid-West Intern Training Network

An evaluation of the process was carried out using three approaches:

- ▶ An online survey to elicit the views of consultants and interns
- ▶ A review of completed WBA Forms
- ▶ Focus group meeting with participating consultants and interns

Lessons learned, some challenges and implications

It was challenging to engage participants in the evaluation process, at a busy time of year for the internship (July). From the limited data available, however, it is possible, to identify some challenges experienced in the field-testing phase and some lessons for the future.

- The paper-based forms and attachments were difficult to manage
- Forms were not always accessible when opportunities arose to give feedback
- Interns were reported as reluctant to take the initiative to seek feedback
- Most participants did not manage to complete the anticipated six forms in the period
- Some forms were used to report on multiple EPAs in one observation
- There was difficulty in identifying opportunities for undertaking observations, in particular with respect to case presentations
- It took 10-15 minutes to complete an observation, 5-20 minutes to complete the feedback dialogue and 5 minutes to complete the form
- Participants were able to identify the competencies which had been observed/reviewed
- Consultants had no difficulty in interpreting and using the supervision scale when providing feedback
- The feedback provided on the forms was relatively limited in scope, with general comments lacking in specificity
- Consultants had difficulty identifying areas for improvement e.g., noting instead that there were "no concerns"
- Feedback was sometimes reported to relate to multiple domains of professional practice, where they had been asked to indicate the ONE most relevant domain
- The sequence of the fields on the forms was reported to be in need of re-ordering, although no specific suggestions were offered
- The written guidelines provided were deemed useful
- Use of the video resources, with guidance on the conduct of observations and giving feedback, after the training day, was limited (links to videos were circulated by email only)
- There was no feedback received on the clarity and comprehensiveness of the EPAs

Some implications that arose include the need to:

- Develop a mobile app to be available in advance of any further field-testing or piloting
- Provide more practical and active workshops on the skills of giving feedback
- Develop training resources which are more specific to the context of the Irish internship and the types of observations/reviews to be undertaken
- Make digital training resources available on a more accessible online platform

1.2 Evaluating the EPAs (2021)

Introduction

In 2020 the MIU/NDTP decided to engage in a process of confirming and enhancing the quality of EPAs prior to wider implementation, by using quality control rubrics to determine that they align with established quality standards for EPAs. The evaluation was carried out in 2021, as a collaborative research project in partnership with the Irish College of General Practitioners. See MIU (2022) ***Report on the Evaluation of the Entrustable Professional Activities for the internship*** for a full account of that process, methodology and findings.

The EQual Rubric

There is an emerging consensus on good practice in the process of developing them and in how they should be described⁵⁴. Noting the diversity, however, in published EPAs in the degree to which they meet the defining qualities of EPAs, Taylor et al identified a need for a tool to assist in evaluating EPA quality, to ensure that they can fulfil their purpose⁵⁵.

They developed and validated the EQual rubric – a criterion-based tool for measuring EPA quality – that is tied closely to the defining features of EPAs, as well as to common misconceptions of EPAs, as described in the peer-reviewed literature. Arising from their evaluation of the rubric's performance Taylor et al suggest that it provides a valuable tool for those developing and evaluating EPAs by providing specific information regarding areas of strengths and weaknesses in the structure and content of EPAs. The tool has been endorsed by international leaders in the CBME field and is advocated in the International Course on the Ins and Outs of EPAS, led by Prof. Olle ten Cate, as a valuable quality assurance mechanism when developing and validating EPAs.

Criteria in the EQual rubric

The criteria within the EQual rubric are organised in three sections as follows:

- **EPA as Discrete Units of Work**
- **EPAs as Entrustable, Essential and Important Tasks of the Profession**
- **EPAs' Curricular Role**

⁵⁴ ten Cate O, Taylor Dr.. The recommended description of an entrustable professional activity: AMEE Guide No. 140. Med Teach. 2020 Nov 9:1-9. doi: 10.1080/0142159X.2020.1838465. Epub ahead of print. PMID: 33167763

⁵⁵ Taylor, D. Park, Y.S., Egan, R, Chan, M-K, Karpinski, L, Touchie, C., Snell, L and Tekian, A. 92017) Equal, a novel rubric to Evaluate Entrustable Professional Activities for Quality and structure *Academic Medicine* 92 ;92: S110–S117

EPAs as Discrete Units of Work
This EPA has a clearly defined beginning and end
This EPA is independently executable to achieve a defined clinical outcome
This EPA is specific and focused
This EPA is observable in process
This EPA is measurable in outcome
This EPA is clearly distinguished from other EPAs in the framework
EPAs as Entrustable, Essential and Important Tasks of the Profession
This EPA describes work that is essential and important to the profession
Performing this EPA leads to recognised output or outcome of labour
The performance of this EPA in clinical practice is restricted to qualified personnel
This EPA addresses professional work that is suitable for entrustment
EPAs' Curricular Role
This EPA requires the application of knowledge, skills, and/or attitudes (KSAs) acquired through training
This EPA involves application and integration of multiple domains of competence
The EPA title describes a task, not the qualities or competencies of a learner
This EPA describes a task and avoids adjectives (or adverbs) that refer to proficiency

Descriptive anchors were created for each item to capture the degree of achievement across a five point scale. For each criterion, evaluators award a score of 1-5. There are 14 criteria, each with a maximum score of 5. The maximum total score for an EPA is 70, which when divided by 14 gives an average score for the EPA.

The cut score for a quality EPA

Taylor et al have recommended 4.07 as the cut-off average score for an EPA to meet the minimum threshold for quality. They applied an Angoff approach to set the cut score for each item. Members of the education scholars' team in their study individually examined each item in the rubric and selected the score she/he felt represented the minimum score that would

be considered consistent with the standard for EPAs. They then discussed their reasoning to address differences of opinion until consensus was achieved for each item. The consensus cut score for each item on the rubric, and therefore, represented the minimum score for which the associated descriptive anchor would still be considered consistent with the defining qualities of EPAs. These items cut scores were averaged to determine an overall cut score for the rubric.

Summary of findings from the evaluation of the EPAs (2021) which informed the review of the EPAs (2022)

- All the internship EPAs meet the threshold for quality (i.e., with a quality score exceeding 4.09), other than EPA 4 (Manage the work of in-patient care), and thus reflect the key defining characteristics of EPAs.
- All the EPAs scored well on criteria associated with being entrustable, essential and important tasks of the profession (other than for one criterion for one EPA).
- All the EPAs involve application and integration of multiple domains of competence
- All EPAs were deemed to have a clearly defined beginning and end, other than EPA 4 (Manage the work of in-patient care).
- There was consensus, however, that EPA 4 (Manage the Work of In-Patient Care) describes work that is essential and important to the profession i.e., this represents core work of an intern. It was also deemed to be professional work that is suitable for entrustment. The activity, however, was deemed to be less likely to lead to recognised output or outcome.
- EPA 4 scored lowest on the criteria in the category "EPA as a discrete unit of work", reflecting its level of interdependence on other activities. There was considerable spread of scores awarded for these criteria, however, suggesting a lack of consensus on this issue.
- EPA 2 (Perform Essential Procedural Skills) scored highly in terms of the extent to which the EPA is independently executable to achieve a defined clinical outcome and terms of being clearly distinguished from other EPAs in the framework.
- All EPAs (other than EPA 2) have some degree of interdependence on other EPAs in the framework.
- EPA 1 (Clerk a patient) and EPA 3 (Perform essential procedural skills) were deemed most specific and focussed.
- EPA 4 (Manage the work of inpatient care) and EPA 6 (Recognise & manage the deteriorating acutely unwell patient) achieved lower scores in terms of being observable in process – which has potential implications for the use of direct observation as a means of assessment.

- All EPAs have a clear curricular role, in terms of application and integration of knowledge, skill and attitudes, acquired through training, involving multiple domains of competence and describing tasks rather than qualities of the learner.
- The performance of the EPAs was deemed to be "restricted to qualified personnel" in all but two EPAs EPA 1 (Clerk a patient) and EPA 3 (Perform essential procedural Skills).
- EPA 2 (Request & interpret basic investigations, EPA 5 (Prescribe & monitor drugs & fluids) and EPA 7 (Hand-over and discharge a patient).
- EPA 1 (Clerk a patient) was the only EPA which scored below the threshold in terms of avoiding adjectives (or adverbs) that refer to proficiency. "Communicate openly and honestly with families and relatives of patients" is the only competence which includes an adverb.

2. The DO, KNOW, BE Model

2.1 Development and consultation process with respect to the DO, KNOW, BE model for the Curriculum Framework for the internship

2018

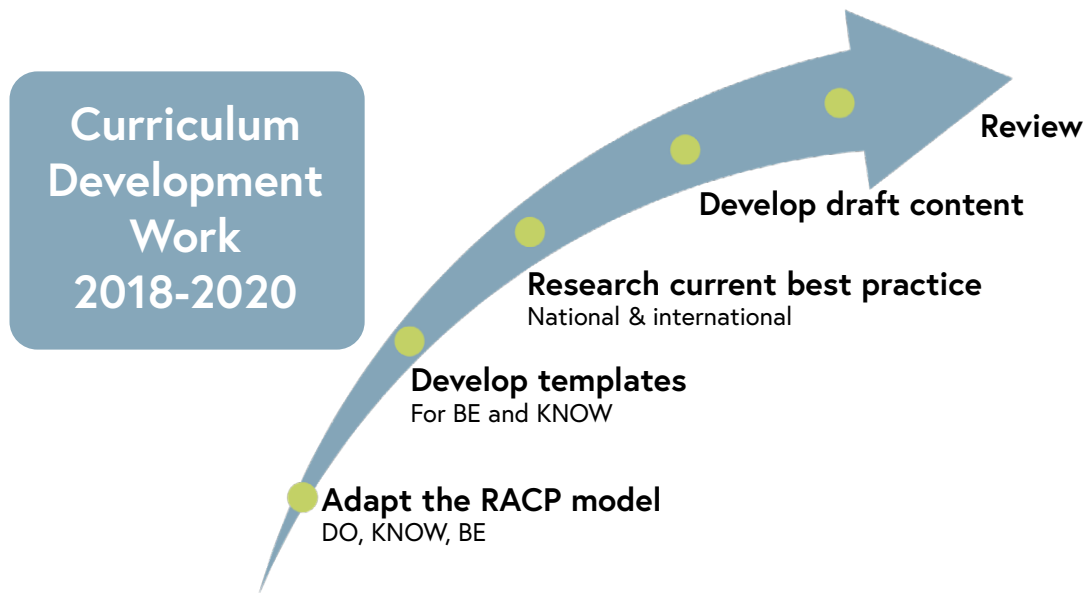
1. Appraisal of international competency-based curriculum frameworks
2. Curriculum development workshop held, and the proposal for the curriculum framework presented and agreed
3. The adoption of the RACP framework approved by the MIB
4. Curriculum development working group was created, to be led by the INE

2019

5. MIU Curriculum Development Working group established (Dr. Orla Mongan, Dr. Ellen Walsh, Dr. Natasha Slattery, Dr. Gozie Offiah and Dr. Josephine Boland)
6. Intern curriculum progress report, including the "BE, DO, KNOW" framework presented to the MIB
7. NDTP development funding call to support aspects of the project

2020

8. Curriculum stakeholder consultation with engagement from Intern Network coordinators and administrators, intern lecturers and tutors, medical and clinical Educators, medical schools, postgraduate training bodies, the Medical Council, interns and NCHDs. Presenting development work on the model with draft templates for BE and KNOW and sample content.



2.2 Establishing the templates with samples of content (2019)

An initial working group of appropriate expertise – subject matter and education – was convened. Meetings were held in NUIG, UL, MIU/NDTP, in person and by Zoom. The initial curriculum development work involved adapting the RACP model and designing templates for the development of the BE and KNOW pillars, in the context of the Irish internship programme. This development phase was carried out by a small working group of Drs. Gozie Offiah, Natasha Slattery, Orla Mongan, Ellen Walsh and Josephine Boland. This phase involved conducting research on comparable frameworks internationally and reviewing current practices within intern networks in Ireland.

The outcomes from Phase 1 were as follows:

- The aims and elements of a curriculum standards framework for the internship were outlined
- A model for development of the curriculum standards framework was elaborated
- A template for describing competencies (the BE pillar of the curriculum) was drafted
- A template for describing Knowledge Guides was drafted
- Curriculum materials provided by Intern Network were reviewed
- Exemplar content was drafted for (i) The BE pillar and (ii) Knowledge Guides
- An initial draft consultation document was prepared for review, prior to wider consultation

The Curriculum Framework and sample content from each pillar were presented at a stakeholder consultation meeting in December 2020, convened by the MIU/NDTP, including Intern Network coordinators and administrators, intern lecturers and tutors, medical and clinical Educators, medical schools, postgraduate training bodies, the Medical Council, interns and NCHDs.

3. Stakeholder consultation meeting (2020)

**The National Curriculum for the Internship Programme
Stakeholder Consultation Meeting (by Zoom)
10th December 2020 (4.30pm-6pm)**

3.1 Agenda

Prof. John Jenkins (Chair) Dr. Gozie Offiah	Introduction and background A competency-based curriculum for the Intern Year
Dr. Orla Mongan Dr. Ellen Walsh Dr. Natasha Slattery	Curriculum development work to date: Knowledge Guides, and the BE pillar
Dr. Gozie Offiah	Knowledge Guides, and the BE pillar Questions for clarification
Prof. John Jenkins (Chair)	Breakout Session 1: in 6 facilitated rooms Q 1-3: The curriculum
Dr. Josephine Boland	Programmatic assessment Questions for clarification
Prof. John Jenkins (Chair)	Breakout Session 2: in 6 facilitated rooms Q 4-6 Programmatic assessment
Prof. John Jenkins (Chair)	Plenary discussion Conclusion

There were two separate breakout discussion sessions held during the consultation meeting, of 15 minutes each. Five groups comprised a mix of stakeholders from different contexts e.g., intern networks, training leads, medical schools, postgraduate training bodies and the Medical Council. One group comprised intern representatives solely. Specific questions were posed and circulated in advance of the meeting and all groups addressed the same set of questions. One breakout session focussed on the curriculum (Q 1-3), and one focussed on assessment (Q 4-6). A rapporteur was appointed within each group, and they provided feedback to the plenary session. This feedback was recorded and subsequently transcribed. This feedback has been organised thematically by question. The responses of the intern group have been identified in italics.

Questions posed to the groups:

- Does the curriculum provide you with sufficient/too much detail?
 - DO (the EPAs)
 - KNOW
 - BE
- How could a Network programme be organised using these details?
 - Teaching and learning opportunities
 - Clinical experience
- How can we promote self-directed learning by interns?
- How could workplace based assessment tools be used across all three pillars of the curriculum: i.e., KNOW and BE as well as DO?
- What will be needed in order to carry out the workplace based assessments? (e.g., training, time, technology)?
- How can summative assessment decisions be made at Network level?

3.2 Feedback from Stakeholder Consultation Meeting break-out groups

Question	Theme	Feedback
Q 1. Does the curriculum provide you with sufficient/too much detail?	Level of detail	Overall, we felt that there was lots of detail in the curriculum, and definitely enough for us to kind of start planning our teaching from that - it was very useful overall.
		At first glance, the curriculum sample provided looked quite onerous and detailed. But we came to the conclusion that it's appropriate to itemise with detail both the "KNOW" pillars of the curriculum.
		Very, very detailed, as has been mentioned, but that was okay. Particularly in the beginning, does the detail then automatically become part of the assessment? And how does that play out?
		From the point of view of network coordinators and lecturers and those actually delivering the training and assessment, it's probably sufficient amount of detail.
	Guide for teaching	The supervisors and the interns can look to the curriculum for reference and what we might do is highlight areas which are either overly trained or overly taught, and those that are also often neglected.
	KNOW	The knowledge part is intuitive, and it is simple and organised. What was liked was that the common and important was put together. And then less common.
	BE	The "BE" part of the curriculum is intuitive and simple and organised, perhaps a bit of slight duplication there. And perhaps some of which needs to be marked as essential.

	EPAs	<i>The EPAs and the description of them was quite clear, it was obvious what everyone was expected to be able to do. In relation to the curriculum content, it was very comprehensive.</i>
		The EPAs: being confident and having these competencies does aid resilience for the intern. And that itself would be a hugely positive thing.
	Detail for interns	Regarding the level of detail in the curriculum, we wondered whether it was going to be available to be interns themselves, and if so it was likely too detailed, and they will be primarily interested in the "DO" part of this.
		If the entire curriculum was made available to intern trainers, it might actually almost be off-putting due to just the volume of information that they'd be receiving. So, we need to, I guess, safeguard against that.
		<i>Concerned that maybe it might be too onerous, and large documents for interns to sort of you know, read themselves. So, it was suggested that maybe it could be delivered to them in sort of teaching sessions to sort of explain the pertinent points of the curriculum to them and what they're expected to achieve.</i>
	Continuum of education and training	If we use this sort of approach to the "BE" as well, focusing on the professional domains, both outlining in detail, the "KNOW" and the "BE" may be useful down the line in terms of dovetailing with medical school professional domains or, and even for other postgraduate in the specialist training further on down the line. It will be a lot of work may be useful, not only for the intern program, but others down the line.
	Need for flexibility	There was some agreement in terms of a curriculum being too prescriptive in terms of the trainers delivering it that it would be it wouldn't be necessary to have it overloaded with too much detail.
		Important not to be so prescriptive that it wouldn't allow for any discretionary addressing of the contents by each network, depending on what the interns were experiencing on the ground. There would have to be some flexibility in that. So that all those aspects could be addressed appropriately and depending on the specialty in which each intern was placed.
Q. 2 How could a Network programme be organised using these details?	Teaching opportunities	Regarding delivery, standardized teaching, and standardized lectures, and online modules could probably address a lot of the "KNOW" part of it, the clinical experience piece is a bit trickier because intern posts can differ so much.
	Mandatory training	Once things are kind of mandatory, and it's expected that they are to attend this and it's part of their curriculum, the same as your CPD, and their mandatory modules that, we will be able to facilitate interns taking part in this training. And that's been our experience.
	Protected time	<i>Teaching and how it could be organised: structured teaching sessions was very important. And then also having protected time to attend those sessions.</i>

	Clinical teaching	<i>People also talked about the value of work based teaching.</i>
	Challenges	<i>The difficulty in having time within the interns' working day to be part of teaching.</i>
	Simulation	<i>Simulation was also mentioned as a good means.</i>
		<i>We recently integrated simulation into our curriculum and interns have been able to attend almost 100%.</i>
	Role of tutors	<i>Having kind of tutors going around sort of backfilling gaps and making sure everyone's covered, each part of the curriculum could be possible but probably would be very resource intensive.</i>
	Quality of teaching	<i>There's a very wide disparity between individual interns experiences about the quality of that teaching, depending on which team they're on. The quality of the teaching, the amount and frequency of the teaching sessions per clinical sites, in one site it might be delivered weekly, other sites they don't need to go to teaching sessions in five months.</i>
	Small group learning	<i>The value of small group learning. That could be facilitated by NCHDs on the team who maybe had an interest in teaching and that small groups could maybe simulate ward-based teaching in some situations.</i>
Q. 3 How can we promote self-directed learning by interns?	Blended learning	<i>Teaching might need to be delivered in more of a hybrid form that the essential sessions would need to be recorded on to be made available online.</i>
		<i>For interns who couldn't attend, because they're working nights or they're on annual leave, there might be some kind of platform where they could be held. And then if people had questions about the content or wanted more information, they could contact the tutor then afterwards.</i>
	Promoting	<i>Small group teaching can promote self-directed learning as well. That could be facilitated, the group could decide what they wanted to learn, and then come back later on in the week, having prepared topics to present to the group.</i>
	Time	<i>A bit of concern about interns having to dedicate time for self-directed learning. I think that's definitely a valid concern. And that's something we think about having some projected time for them during the week.</i>
	Expectations	<i>Avoid being too prescriptive about it and give them a minimum amount to do.</i>
		<i>Interns' workloads need to be considered about expectations around time and hours of self-directed learning are they expected to do - that could be very difficult, because based on specialties and rotations, the working hours can vary quite, quite widely.</i>

Q. 4 How could workplace-based assessment tools be used across all three pillars of the curriculum:	Be	The "BE" assessment would need to be work-based
		The particular challenges around interns, where there's insight problems, assessing that "BE" part of the curriculum.
	CBD	<i>Case based discussions would be good for the "KNOW".</i>
		Case based discussions can be very different experience depending on who is actually doing it, whether it's a Reg. or consultant. So, for consistency, you would hope that consultants would have protected time.
		Case based discussion would allow good assessment of a "KNOW" aspect of the curriculum.
	Direct observations	The direct observations are easy to assess, and, you know, a procedure type competency. And so, we're very happy to support that.
	Team review	The activities that interns perform on-call will be captured through the EPA, some of the activities of the EPA. One of the EPA is looking at the deteriorating patient or managing the inpatient care. So, all those kind of things will be captured within those EPAs. Some of those assessment tools, like the multi-source feedback, will also gather the data around their on call abilities, and all call activities on what they actually do. So, I think that's probably where we will see that being pitched and being collected.
		The team review can certainly look at how people perform at three in the morning, or whenever they may not be formally under review. But I think that's an important aspect of it. And so, I think there are ways that each of the three domains can be assessed using the breadth of the workplace based assessments. And but you're right, Evan, we need to make sure that we do that. And then we don't just focus on some aspects and ignore others.
		<i>Some reservations expressed about the idea of Peer Assessment. But in other industries, business as a broad term, feedback is gained from multiple different areas from multiple different levels, and that if people knew that they were getting feedback from different areas, they would be more conscious of their professionalism.</i>

Q. 4 How could workplace-based assessment tools be used across all three pillars of the curriculum: (contd.)	Team review(contd.)	For the team review tool and the issues arising, interns may not always be on a rotation that regularly sees the same faces in terms of the multidisciplinary team. As a remedy to that believed the tool is designed to be not as frequent, perhaps as the case presentations, or case-based discussions. It can be something done maybe twice a year or something of that nature. And generally, it should be driven by the influence of the intern, who identify those that they have worked closely with, and they would form the team that would provide feedback. Team review and this form of assessment can have a negative connotation because it's often used in the form. And when someone is not up to par, once one is not up to standard, that's when that kind of feedback is given. Our focus was to use this as a formative step, not only an assessment as well.
	Reflective journal	Correcting the reflections is actually quite a difficult thing to do and has to be considered as to how that would happen.
	Programmatic	Careful mapping across the three pillars will be important. So that one tool would be assessing more than just one small piece.
		A blend of different types of assessments will be needed to get an overall picture of how the intern's doing.
		Stuff that happens on call is often very difficult to observe in practice, and some of those EPAs and the competencies within it will be tricky to observe. And it's difficult to see somebody make a decision. And I think the programmatic approach, and the regular formative piece and the variety of tools are a way to try and make sure that nothing slips through the net.
	Simulation for assessment	There is a real opportunity to use simulation to observe people doing things that we can't observe under normal conditions. So, you can't observe somebody, you know, managing an acutely unwell patient, and speaking to the nurse and picking up the phone to the relative, which you can do it in the simulator. So, I think we need to be smart about how we assess things. And we need to carve off the pieces that we can do in clinical practice. And then know the pieces that we can't and look for other tools to do it, and the resources.
	Timing	When does the assessment take place? Is it done at the time sort of intermittently throughout? Or at the end? When does that happen?
	Who to do WBAs	<i>Some form of preceptorship would work in that more senior NCHDs who have an interest in teaching would take on that role (of assessment).</i>

	Who to do WBAs (contd.)	It needs to be decided who is actually going to be responsible for doing workplace based assessments. Assessment should be expanded outside of consultants which I think is what a lot of people have alluded to educators, Reg's, SHOs and even CNNs, people who they're working with on-call.
	Challenge	The EPAs: there are 2,500 consultants, and how can we standardize the assessment best to fine-tune as we move ahead, and the biggest challenge will be how to roll out an assessment. But added to that, at the end, that being confident and having these competencies does aid in resilience for that intern. And that itself would be a hugely positive thing.
	On-call	The on-call space is currently not a space that is in any of the assessment processes, it's not captured. So, I'm wondering, is that something that should be planned for within the curriculum development, you know, the on-call competencies? Would they be the same? As you know, would there be a need for something specific that that looks at performance on call, whether it's, you know, extended days or nights or weekends?
	Risks	Important to reduce the volume of assessments, and avoid the assessments becoming a tick-box approach, and assessments to be done at the time of an assessment so that it's relevant and assess the intern independently from the consultant supervisor. There is experience of workplace based assessments becoming like a tick box exercise. So, I suppose the need to try and avoid that happening.
Q. 5 What will be needed in order to carry out the workplace based assessment?	App	<i>An app is required, that functions and not a beta form or an old tech.</i>
		Definitely the app
		A really well-functioning app that would need to be easy to use for consultants in terms of time.
	Culture	We spoke to one of our own interns, there isn't really a culture of that (feedback). And I think it's how do we change the tide? How do we encourage interns to seek that feedback? Because that's where an increased growth might happen.
		Use of assessment for learning rather than an assessment of learning. So, kind of that shift in the culture away from it being an assessment of what they know.
		And perhaps it submitting evidence that you've gained competency rather than showing all of the different times that you weren't competent? And, again, the assessment for learning?

	Buy-in	To carry out work-based assessments, the most important thing is buy-in from all stakeholders, which includes the interns, and that there's some structure put in place as to what the processes would be.
	Resources	Resources, which would be technology and people and training.
		This will be a very resource-intensive exercise.
	Human resources	A dedicated educator, for example, SPR education, as another healthcare sectors already mentioned, they might be on an educator track, maybe doing a master's in education.
		So maybe have one assessor, you know, X number of interns to be assessed.
		What's needed a big expansion of clinical education and tutors is what was noted.
	Time	If consultants are to be doing this, they probably don't have enough time. Or the intern tutors or others would be in a position to do it, but it's likely to be resource-intensive.
		The role of intern's own consultant in giving them feedback should be protected.
	Drivers	The one thing we kept dwelling on was just the fact that all of this is very resource heavy. How do we work around that? And I think that the conclusion we came to was that interns should be the driver for their feedback there.
	Pilot	There should be a meaningful pilot, a group of interns with the clinical facilitator in different clinical sites, perhaps a teaching hospital in an urban centre versus somewhere else.
	Training	<i>Training needs to be provided in how to assess people. I suppose, especially if this is a new addition to intern year and if it's going to have some assessment or a bearing on someone's progression. But that appropriate training needs to be provided to those who are going to assess.</i>
		Assessors need to be trained.
	Legal issues	The medical legal aspects of having somebody who perhaps has not passed their assessment, and still needs to go on call, or is still working? How does that get handled?
	Organisation	Perhaps splitting larger sites, lots of Interns, into groups of 10 and having a dedicated tutor that does a lot of their assessments as well as some cross-cover.
	Risks	Trainers and assessors might not actually know kind of terminology, like so much of assessment what that actually means. So just be careful about use of terminology.

Q. 6 How can summative assessment decisions be made at Network level?	Group process	<i>Summative decisions can be made with a combination of documentation and feedback, and there should be some sort of group quorum to analyse this.</i>
		Networks could do the bulk of the summative assessment. On top of that would sit a competency-based committee that would maybe randomly select a number, and maybe deal with the trickier assessment.
	Academic supervisor	What would happen if there was an issue? In Canada, where they have one academic supervisor who's a clinician overseeing the training for a small group of interns, that they will kind of be the person to delve into the narrative feedback and be practically looking at the data continuously.
	Multiple sources	The decision-making would probably be challenging. And the assessment occurring throughout the year appropriate training for the trainees, this is probably what's most important to hear, as well as multiple assessors of the intern rather than, you know, a single teacher asking the same intern all year so that it's more well-rounded.
	Data	<i>With regards to documentation and feedback, data-wise, how would this be housed? And are there any issues that might relate to that?</i>
		<i>Issues about data, who has access to it, what is going to be shared are very important ones, which we will need to give very serious consideration to.</i>
		The assessment information where is that held? The intern hub was suggested.
		Concerns around in the governance of the data, where would it sit, the reflective journal.
	Struggling interns	<i>And most people will be fine. But if there are any question marks over some candidates that this needs to be talked about in the group.</i>
		Not just to focus on when it all goes well, but the people who will require remediation, and or the people who are maybe tricky to assess, and decisions have to be made that additional resources would need to be provided for those and a structure put in place that would support the networks to get those interns through.
		It takes a couple of hours for internal remediation using this process, based on knowledge from a previous pilot.
		The EPAs are extremely good for those that are in remediation.

Q and A	Academic track	All that we've been talking about applies to interns who happen to be on the academic track, we think it's important to remember that the academic track is still part of the overall intern program. So, the same curriculum, the same learning outcomes will still need to be applied. But of course, there may be additional things that would be wanted, and which could be identified as being part of this. So, I think it's important that Martina, yourself, others are involved in the planning of the curriculum, so that we can ensure that it is relevant to all of the interns, although some parts of it may need to be particularly targeted to those on the academic track.
		I do I think there's some great work going on about research based EPAs, which might work for this for the specifics of the academic track. But there's also a great value to importing concepts around critical inquiry into the general EPA as well, you know, I do think so the desire to learn or acquire or ask questions about processes and so on, I think is valid for all interns.

4. The BE pillar and the Knowledge Guides

4.1 Development process for the KNOW and BE pillars of the Curriculum Framework

Developing the content for the BE and KNOW (2019-2022)

Further development on the curriculum was progressed in two parallel processes, with some overlapping membership of project/working groups to ensure a coherent approach and integrated curriculum.

The BE pillar	The Knowledge Guides
- Development of the content of the BE pillar of the curriculum was commissioned in December 2019 as an NDTP-funded development project. This project was undertaken by the Mid-West Intern Network, led by Dr. Natasha Slattery⁵⁶. - A stakeholder consultation conference was convened in October 2021, presenting a draft BE template and content for review by stakeholders. - Draft BE pillar provided to the CDWG developing the Knowledge Guides. To enable identification of domains from the BE pillar most relevant for each Knowledge Guide.	- An expanded Curriculum Working Group was convened in 2021 to prepare drafts of the Knowledge Guides. Terms of reference were agreed. - Members volunteered to lead on the development of one Knowledge Guide and to engage in peer review with another member of the group. - Members researched comparable curriculum frameworks, curricula from comparable programmes and the documentation provided by the Intern Networks. - Successive drafts were developed by members, mostly working in pairs, reviewed by all members of the group and updated after each meeting.

⁵⁶ 'Know, Be, Do'; the Modernization of the Intern Curriculum-stage 2: Dissemination and feedback of the 'Be' pillar of the framework. Ref 15-19 funded 20.12.19.

- The report from the stakeholder consultation was issued in June 2022⁵⁷. The report describes how the proposed template and content for the 'BE' was informed by a literature review, appraisal of current Intern guidebooks and the National Intern Training Programme curriculum, international benchmarking, and feedback from key stakeholders including a patient representative, and national and international experts. - The BE pillar was updated by the MIU team in June 2022 in light of the report, with some amendments to ensure alignment with the Medical Council Eight Domains of Good Professional Practice. Contributors to the stakeholder consultation process are listed in Appendix B.	- Most relevant domains from the BE pillar were identified for each Knowledge Guide. - Knowledge Guides completed in May 2022. - Members of the Curriculum Development Working Group who developed the Knowledge Guides were as follows: Dr. Gozie Offiah Prof. Dara Byrne Dr. Orla Mongan Dr. Natasha Slattery Dr. Neil Wrigley Dr. Lorcan O'Brien Dr. Aaron Duncan Dr. Alyssa Verrelli Dr. Elaine Burke Dr. Josephine Boland
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4.2 Further development and review of the BE pillar of the Curriculum Framework

The draft template for the BE pillar and sample content for each domain were the outcome of development work completed by the Curriculum Development Group, with Dr. Natasha Slattery as the lead developer. Further development of the template and content was undertaken by Dr. Slattery as an NDTP-commissioned project, "*Dissemination and Feedback of the 'BE' Pillar*" and reported on in June 2022⁵⁸.

The BE template and content have been revised, by the MIU team, in light of the Slattery (2022) report. Points of consensus and recommendations from the stakeholder consultation, which are relevant to the BE pillar, have been incorporated in this draft. Points which were

⁵⁷ Slattery N. (2022), Stakeholder Feedback on Proposed Be Template and Content: Dissemination and feedback on a proposed template and content for the Be component of the intern curriculum framework

⁵⁸ Slattery N. (2022), Stakeholder Feedback on Proposed Be Template and Content: Dissemination and feedback on a proposed template and content for the Be component of the intern curriculum framework (unpublished report)

identified as in need of further discussion are listed below in the table. Medical Council nomenclature for the Eight Domains of Good Professional Practice has been adhered to here, pending any future review by the Medical Council of those domains.

This pillar of the Curriculum Framework is presented with the following caveats:

- The national stakeholder consultation process had its limitations, as acknowledged by Slattery (2022). The wider consultation process with respect to the entire Curriculum Framework provided further opportunities for stakeholders to contribute to the refinement of the BE pillar.
- The learning outcomes are included here to guide intern networks on the design and delivery of the curriculum at local level. They may be further developed in collaboration with intern networks.
- A process of mapping the content of the BE pillar and the DO pillar (the EPAs) was undertaken in 2019, to identify gaps, redundancies and unnecessary duplication. The EPAs were evaluated and reviewed, 2021-22 and the Knowledge Guides were completed in 2022. This mapping process between the three pillars on the Curriculum Framework needs to be repeated to confirm a coherent and integrated framework.

4.3 Points for noting and further consideration regarding the BE pillar

A number of points in the report on the stakeholder feedback are worthy of noting and further consideration.

- The draft template provided to the stakeholders included proposals for changes to the nomenclature for some of the domains. There was no reported consensus on this issue. Review of the domains (and nomenclature) will be a matter for the Medical Council.
- There was consensus about the inclusion of cultural competence within the framework, but no consensus on whether it should be a theme or a separate domain. It has been included here as a theme within the domain of Relating to Patients.
- Sustainable Healthcare was confirmed as important to include. There was a lack of consensus on whether it should be an additional domain or be included as a theme. It has been included as a theme within the domain of Management and Self-management).
- Scholarship was confirmed as an important domain for professional practice and lifelong learning, enhancing the delivery of patient care. There was a lack of consensus, however, on the proposed themes within the domain; *Reflection, Role Modelling, Teaching, Mentorship, Leadership, Life-Long Learning*. It was suggested that these competencies need dedicated guidance for development at every stage of medical training, including at the foundational Intern level.

- There was a lack of consensus on Leadership as a theme within the framework. Some considered this an advanced competency that should be developed beyond Internship.
- Physician Well-being was identified as important. There was a view it could be labelled Physician Self-Management, as a broader term including other important elements such as time management. While it was proposed as a new domain, Physician Wellbeing is included here as a theme within the domain of Management and Self-management.
- There was a lack of consensus on the most appropriate domain within which to incorporate the theme of Social Media Conduct. It has been included in the domain of Professionalism.
- While there was a consensus that a focus on professionalism is important within the framework, there were concerns that many of the competencies associated with professionalism are too advanced or aspirational.
- There was a consensus that Patient safety is fundamental to delivering high-quality patient care and should be incorporated into all three pillars of the framework. Mapping of the competencies within the BE pillar and the Knowledge Guide on Patient safety has ensured that the importance of Patient safety is reinforced through the curriculum.

5. Sources used in the development of the Curriculum

5.1 Sources used in development of the Entrustable Professional Activities

Refer to the bibliography of the following report, for sources used in development of the EPAs
Byrne, D., Lydon, S. Madden, C, O'Dowd, E. Boland, J and O'Connor, P. (2018) [The Development of Entrustable Professional Activities for the Irish Intern Year](#). Galway, Ireland: National University of Ireland, Galway.

5.2 Sources used in development of the Knowledge Guides

- Intern Handbooks from the networks in Ireland (supplied on request)
- Beaumont Hospital Intern Handbook (2018-2019)
- Beaumont Hospital Drugs & Therapeutics Committee Brief Prescribing Guide, July 2018
- Connolly Hospital Intern Handbook (2018-19)
- Intern Networks South (2016/2017)
- Mid-West Intern Handbook (2018/2019)
- Our lady of Lourdes Hospital Drogheda Intern Handbook (2018-2019)
- St James's Intern Guide - The William Stokes Post Graduate Intern Guide in conjunction with St James's Hospital (June 2015)
- UCD Intern Handbook (2019)

- University Hospital Galway Intern Handbook (2018-19)
- University Hospital Waterford Intern Handbook (2018-19)

Other sources:

- [Australian Medical Council Guide to Intern Training](#)
- [Confederation of Postgraduate Medical Education Council Intern standards](#)
- [Development of EPAs for the internship](#)
- [GMC UK Internal Medicine Stage 1 training](#)
- [Health Services Executive – Communication modules](#)
- [Institute for Healthcare Improvement \[IHI\]. Patient Safety 102: Human Factors and Safety Summary Sheet, 2010](#)
- [Intern Induction Hub](#)
- [Irish College of General Practitioners Curriculum](#)
- [Irish Medical Council, Eight Domains of Good Professional Practice as devised by Medical Council, 2010](#)
- [Medical Council Guide to Professional Conduct and Ethics, 8th Edition](#)
- [Medical Council of New Zealand Prevocational Medical Intern Training Guide](#)
- [RCPI BST GIM Curriculum, 2021](#)
- [Royal Australasia College of Physicians Curricula Standards Framework](#)
- [Royal College of Physicians in Ireland \(RCPI\), Quality Improvement, 2021](#)
- [UK Foundation Programme Assessments](#)
- [UK Foundation Year Curriculum](#)
- [WHO Patient Safety Curriculum Guide](#)

5.3 Sources used in development of the BE pillar of the Curriculum Framework

Refer to the bibliography of the following report, for sources used in development of the BE pillar.

Slattery N. (2022), *Stakeholder Feedback on Proposed BE Template and Content:*

Dissemination and feedback on a proposed template and content for the BE component of the intern curriculum framework (unpublished report).

6. Support and Remediation

The development and consultation process Prof. Ger Curley and Dr. Oisín Friel (RCSI) led the project to develop a set of guidelines for the support and remediation of interns in Ireland in September 2020.

With regards to this task, the steps involved in the process from then to its completion are broadly outlined below.

1. The first aspect of this project involved completing an analysis of the existing remediation programme in Ireland, with a focus on its shortcomings, particularly the lack of a clear timeframe and any substantial degree of guidance around how to facilitate completion of remediation for those individuals at stage 2 and 3.
2. Following on from this, a scoping study was undertaken of the various remediation programmes in existence in countries which apply a similar standard of medical education to that of our own. These included the United Kingdom, New Zealand, Australia, Canada and the United States. A review was also undertaken of the policies around remediation within some of the postgraduate training bodies, such as RCPI.
3. An extensive literature review was undertaken to further supplement the above material and assess current international best practice on the topic of remediation of intern doctors. This involved a review of nearly 200 documents on the topic.
4. Next, input was sought from other each of the other intern networks to garner their experience with stage 2 and 3 remediation in Ireland and establish what changes they might like to see in an updated remediation document. Aspects of the scoping study and literature review which were felt to be possibly applicable to remediation in Ireland were also discussed and feedback sought.
5. A working relationship was established with Prof. Derek Gallen, President of the Academy of Medical Educators in the United Kingdom, who was able to offer excellent insight into the remediation programme that exists in the UK as well as advice around the development of our own updated document. Various discussions were had with him over the course of the development process of the support and remediation document. Colleagues were also consulted in Australia, where Dr. Friel had spent time working.

6. On the topic of professionalism, input was sought from Prof. Denis Harkin, chair of medical professionalism at RCSI.
7. Throughout this process, communication was maintained with Dr. Gozie Offiah to ensure alignment of thought processes and ultimate end goals. This helped in our efforts to complete this process in a timely manner.
8. As well as speaking with individuals within the various networks, both in Ireland and internationally, meetings were had with others involved in intern education and training to garner their input. This included HBS recruit, medical manpower, occupational health and undergraduate university fitness-to-practice panels.
9. Having spent a substantial amount of time researching the topic, an initial draft document was put together which was reviewed in detail with Prof. Ger Curley, the individual overseeing this aspect of the modernisation project.
10. The document was presented at the INE on 27/10/2021 and a copy sent to the INE members for feedback. Suggested changes were applied as appropriate before further review with Prof. Curley, Dr. Offiah and Dr. Josephine Boland between April and May 2022 to ensure alignment with the proposed curriculum framework. A meeting was had on 10/6/22 to further discuss the document with the suggested changes applied.
11. Following a presentation of the draft Curriculum Framework to the MIB on 13/7/22, a further review of the proposed support and remediation process took place to ensure alignment of both documents.
12. Following the stakeholder consultation process during the period September 2022-March 2023 (outlined in **Appendix D**) and a further review, the final document retitled "*Support and Remediation Process for Intern: A three stage process*" was prepared, with support from Dr. Offiah and Dr. Boland. This was included as an Appendix to the Curriculum Framework, for submission to the Medical Intern Board in May 2023.

7. Contributors to the development and consultation processes (2015-2022)

7.1 The Curriculum Framework

A. Curriculum Development Working Group Workshop

Date: 18 December 2018

Venue: NDTP, Sancton Wood, Heuston South Quarter, Dublin 8

Participants:

Dr. Gozie Offiah	HSE, Medical Intern Unit (MIU)
Dr. John Jenkins	Chair, Medical Intern Board (MIB)
Dr. Finbar O'Connell	Intern Co-ordinator (TCD)
Dr. Paula O'Leary	Intern Co-ordinator (UCC)
Prof. Ger Curley	Intern Co-ordinator (RCSI)
Assoc. Prof. Suzanne Donnelly	UCD School of Medicine
Dr. Rory Plant	Academic Track Intern
Dr. Josephine Boland	Medical Educationalist (Facilitator)
Dr. Dara Byrne	Intern Co-ordinator (NUIG)
Dr. Natasha Slattery	Clinical Fellow (Mid-West Intern Network)
Marie Gunning	Medical Intern Unit

B. Curriculum Framework Stakeholder Consultation Meeting

Date: 10 December 2020

Venue: NDTP, Sancton Wood, Heuston South Quarter, Dublin 8

Name	Role	Institutional affiliation
Prof. John Jenkins	MIB	Chair RCSI
Prof. Ger Curley	Intern Network Coordinator DNE	RCSI
Dr. Helena McKeague	Course Director BMBS programme	UL GEMS
Dr. Owen Thorpe	Intern Lecturer	TCD
Mr. Evan Blake	Intern Admin DSE	TCD
Dr. Claire Sheehy	Consultant Rheumatologist	UHW
Dr. Rosemary Geoghegan	Lecturer in Paediatrics	NUIG
Ms. Jennifer Clarke	Intern Tutor	RCSI
Dr. Katie Nolan	Academic Track Intern	RCSI
Dr. Gozie Offiah	Clinical Lead MIU NDTP	HSE
Prof. William Plant	Intern Network Coordinator STH	UCC
Ms. Una O'Rourke	Director of Education	Medical Council
Dr. Alyssa Verrelli	Intern Lecturer	UCC
Ms. Sinead Cleary	Intern Admin DML	UCD
Dr. Cormac Kennedy	Clinical Senior Lecturer	TCD

Dr. Catherine Fleming	Clinical Training Lead	NUIG
Dr. Paul O'Hara	SpR	PUH
Caroline Kehoe	Intern	
Dr. Josephine Boland	Medical Educationalist	MIU/NDTP
Prof. Margaret O'Connor	Intern Network Coordinator MWT	UL
Prof. Arnold Hill	Head of School	RCSI
Ms. Sylvia McDonagh	Intern Admin WNW	NUIG
Dr. Isweri Pillay	Consultant Geriatrician	CUH
Ms. Aine Wade	Undergraduate Programme Manager	TCD
Prof. John Cooke	Clinical Senior Lecturer	UCC
Dr. Eithne Nic an Riogh	NCHD	UCD
Dr. Orla Mongan	Intern Lecturer	NUIG
Prof. Donal O'Shea	Intern Network Coordinator DML	UCD
Ms. Chloe Ryder	Admin	Medical Council
Mr. Daragh Moneley	Consultant Vascular Surgery	Beaumont Hospital
Dr. Brian McEllistre	Director Specialist Training Scheme	ICGP
Dr. Elaine Burke	Research Fellow	TCD
Dr. Robert Eager	Adjunct Senior Clinical Lecturer	UL
Dr. Oisin Friel	NCHD	RCSI
Dr. Natasha Slattery	Clinical Fellow	UHL
Prof. Dara Byrne	Intern Network Coordinator WNW	NUIG
Ms. Susanne Lalor	Intern Admin DNE	RCSI
Prof. Martina Hennessy	Director of Internship	TCD
Prof. Denise Sadlier	Intern Tutor	UCD
Joshua Skeens	Intern	TCD
Prof. Greg Swanwick	Clinical Training Lead	TCD
Mansi Shah	Intern	NUIG

7.2 The Entrustable Professional Activities

A. EPA development workshop

Date: 3 July 2015

Venue: G Hotel, Galway

The development group comprised:

- two intern network coordinators
- eleven NCHDs
- three hospital consultants
- two medical educationalists

Including the following:

Dr. Dara Byrne, NUI Galway

Dr. Gozie Offiah, RCSI

Dr. Paul O Connor, NUI Galway

Ms. Carmel Malone, NUI Galway

Prof. Anthony O Regan, NUI Galway

Dr. David Devlin

Dr. Lyle McVicker

Dr. Orla Mongan, NUI Galway

B. EPA Consultation Workshop

Date: 10 June 2016

Venue: Medical Council, Kingram House, Kingram Place, Dublin 2

List of Participants:

Dr. Gozie Offiah, Senior Clinical Lecturer RCSI, Intern Coordinator DNE and Workshop Facilitator

Prof. M Larvin, Head of School GEMS, University of Limerick

Dr. David Devlin, SPR Anaesthetics

Dr. Keshav Sharma, SPR Respiratory Medicine

Dr. Hugh O' Callaghan, SPR Anaesthetics

Dr. Dara Byrne, Senior Lecturer NUI Galway, Intern Coordinator WNW and Workshop Facilitator

Dr. Carmel Malone, Senior Lecturer NUI Galway, Consultant Breast Surgeon, University Hospital Galway

Dr. Daragh Moneley, Consultant Vascular Surgeon, Beaumont Hospital, Intern Coordinator DNE

Dr. Helen Hynes, Lecturer in Medicine, UCC

Dr. Niall Connolly, Intern WNW (UL graduate)

Dr. Catherine Diskin, SPR Paediatrics, NCHD Lead

Ms. Una O' Rourke, Head of Education, Training and Professionalism, Medical Council

Dr. Paul O' Connor, Lecturer in GP, NUI Galway and Workshop Facilitator

Dr. Rebecca Russell, Intern WNW (UCD graduate)

Dr. Sophie Van Der Puten, Intern WNW (UCD graduate)

Dr. Ryan Sugrue, Intern WNW (NUI Galway graduate)

Dr. Martina Hennessy, Professor of Medical Education, School of Medicine TCD

Dr. Daniel Kane, Intern DNE (RCSI graduate)

Dr. Elaine Walsh, Intern DSE (TCD graduate)

Dr. Josephine Boland, Independent Education and Engagement Consultant and Workshop Facilitator

Dr. John Jenkins, Chair of Strategy and Policy Subcommittee, Medical Council

Prof. Ellen O' Sullivan, Chair of the Forum of Irish Postgraduate Training Bodies

Dr. Margaret O' Connor, Consultant Geriatrician Limerick University Hospital and Intern Coordinator MW

Dr. Brian Daly, Intern South (UCC graduate)

C. Evaluation of the EPAs

Date: May- August 2021

By online survey

Background	Number who evaluated the internship EPAs
Internship training community	3
General practice training community	10
Other medical education context (Ireland) (i.e. Medical Schools Academic institutions and Health Research)	3
International expertise in EPA development	3
TOTAL	19

Collaborators in the EPA evaluation project:

- Dr. Karena Hanley, General Practice Training & Innovation & Development Lead, ICGP
- Dr. Brian McEllistrem, Curriculum Development Fellow, ICGP

7.3. Field-testing of the EPA workplace based assessment tools

Date: 23 May 2019 (workshop)

Venue: NDTP, Sancton Wood, Heuston South Quarter, Dublin 8

Name	Role	Institutional affiliation
Dr. Claire Sheehy	Consultant Physician	University Hospital Waterford
Dr. Diarmuid Hilton	Consultant Physician	University Hospital Limerick
Dr. Paul O'Hara	Specialist Registrar	Portiuncula University Hospital
Dr. Frank Fogarty	Intern	UCD – DML Intern Training Network
Dr. Craig Joyce	Intern	NUIG – WNW Intern Training Network
Dr. Eithne Nic Riogh	Intern	NUIG – WNW Intern Training Network
Dr. Martin O'Donnell	Intern	UCD – DML Intern Training Network
Dr. Natasha Slattery	Clinical Fellow	Mid-West Intern Training Network
Prof. Dara Byrne	Intern	Network Coordinator WNW Intern Training Network
Dr. Josephine Boland	Educationalist to the MIU	MIU/NDTP
Dr. Gozie Offiah	Clinical Lead of Medical Intern Unit, National Intern Training Programme, National Doctors Training and Planning (NDTP), HSE	MIU/NDTP

D. International experts advising on the review of the EPAs (2020)

Prof. Olle ten Cate, Professor of Medical Education at University Medical Centre Utrecht, the Netherlands. Lead on the Ins and Outs of EPAs international course.

Prof. H. Carrie Chen, Associate Dean of Assessment and Educational Scholarship and Professor of Paediatrics at Georgetown University School of Medicine, Faculty member on the Ins and Outs of EPAS international course.

Prof. Claire Touche, Professor of Medicine, University of Ottawa, faculty member on the Ins and Outs of EPAS international course.

Dr. David Taylor, Senior Advisor, Department of Medicine, Queen's University, Kingston, Canada, faculty member on the Ins and Outs of EPAS international course.

7.4 The Knowledge Guides

Development team	
Knowledge Guide for EPA 1	Dr. Neil Wrigley, Intern Lecturer, DML Intern Network, UCD Dr. Lorcan O'Brien, Intern, SVUH
Knowledge Guide for EPA 2	Dr. Orla Mongan, Intern Coordinator, WNW Intern Network, University of Galway, Dr. Ellen Walsh, SHO, UHG
Knowledge Guide for EPA 3	Dr. Orla Mongan, Intern Network, University of Galway Prof. Dara Byrne, School of Medicine, University of Galway
Knowledge Guide for EPA 4	Dr. Aaron Duncan, SHO, OLOL Drogheda Dr. Orla Mongan, WNW Intern Network, University of Galway
Knowledge Guide for EPA 5	Dr. Alyssa Verrelli, Intern Lecturer, South Intern Network, UCC
Knowledge Guide for EPA 6	Dr. Aaron Duncan, SHO, OLOL Droghed Dr. Gozie Offiah, Medical Intern Unit, NDTP
Knowledge Guide for EPA 7	Dr. Elaine Burke, Research Fellow, DSE Intern Network, TCD
Knowledge Guide on Patient safety for all EPAs	Prof. Dara Byrne, School of Medicine, University of Galway and The Irish Centre for Applied Patient Safety and Simulation (ICAPSS)

7.5 The BE pillar of the Curriculum Framework

A. Participants in the stakeholder consultation conference

Date: 1-2 October 2021

Venue: Barberstown Castle, Kildare

STAKEHOLDER NAME	ORGANISATION/ROLE
Dr. Anne Merrigan	Co-Coordinator MWIN, UL, RCSI
Prof. Frank Murray	Prior President RCPI & Director NDTP, Consultant in Hepatology & Gastroenterology, Beaumont Hospital Dublin & Bon Secours Hospital Dublin
Mr. Leo Kearns	CEO Medical Council Ireland
Prof. Tom O'Dowd	Past Chairman of the Education Committee of the Medical Council, Professor & Chair of General Practice
Prof. Ed McKone	Director of Education & Training, Institute of Medicine Board, RCPI, Respiratory Physician SVUH, UCD
Prof. Brian Kinirons	Medical Director NDTP, Consultant Anaesthesiology, GUH
Prof. Derek Gallen	National Academic Track Lead, UK
Prof. Martina Hennessy	Welcome HRDB-Clinical Research Facility, St. James' Hospital
Prof. John Jenkins	Medical Intern Board Chair
*Prof. Mike Watts	Associate National Director of Higher Specialist Training, RCPI
Prof. Michael Gill	Dean Trinity College Dublin (Professor of Psychiatry of Head of Discipline)
Mr. William Kennedy	Director of Regulation Department, Solicitor, Medical Council Ireland
Dr. Brian McEllistrem	ICGP Curriculum Development Fellow
Dr. Eva Doherty	Director of Human Factors in Patient Safety, RCSI, National Representative & Co-Chair Intl. Assoc. for Communication in Healthcare, Clinical Psychologist
Dr. Michael Griffin	Director Mid-West Specialist Training Scheme in General Practice, Consultant Trainer General Practice
Dr. Karena Hanley	ICGP General Practice Training & Innovation & Development Lead
Dr. Joshua Skeens	NCHD SHO Trinity College Dublin/Academic Track (recent intern)
Dr. Elaine Burke	TCD/DSE Network, PhD (candidate)
Prof. Margaret O'Connor	Co-Coordinator MWIN, UL
Prof. Paula O'Leary	Dean of Medicine, UCC prior Chair of INE
Prof. Deirdre McGrath	Dean UL HoS
Mr. Paul Burke	Chief Academic Officer, ULHG, Mid-West
Dr. Orla Burke	Paediatrics Lecturer, UL
Dr. Helena McKeague	BMBS Course Director, UL
Dr. Elyssa Hamza	BST SHO Paediatrics Galway (recent intern)
Dr. Sarah O'Connell	Associate Clinical Director, Consultant Trainer, ULHG
Dr. Rachel McNamara	NDTP Spark Lead
Mr. Evan Blake	TCD/DSE Network, INE Administrator Representative

*Prof. Paul Finucane	Past Dean of Medicine, UL, past member of Irish Medical Council
Dr. Ahmed Gabr	SpR Medicine & Masters in clinical Medical Education, PhD (candidate)
Dr. Paul O'Hara	Training Lead, Med Ed, Ballinasloe Hospital & Saolta Hospital Group
Dr. Aoife Leahy	Lead NCHD, SpR, PhD (candidate)
Dr. Basil Mat	SpR Psychiatry, Psychiatry Mental Health, TCD
Prof. Rose Galvin	Professor of Physiotherapy, UL, HRB Research Leader Awardee
*Dr. John McManus	NDTP Training Lead, Mid-West
*Dr. Diarmuid Hilton	Consultant Trainer, Acute Medicine, UHL
*Dr. Colin Quin	Consultant Trainer, Geriatrician, UHL
*Dr. Majed Henin	Consultant Trainer, General Medicine, UHL
*Dr. Catherine Peters	Clinical Director, Consultant Trainer, General Medicine, UHL
*Dr. Elaine Shanahan	Consultant Trainer, UHL
Dr. Aileen Paterson	Curriculum Advisor/Asst. Prof. Medical Ed, Surgery, TCD
Dr. Caroline Herron	National Lead NCHD/NDTP Fellow 2021-2022/Spr General Surgery
Ms. Louise Barry	Qualitative Researcher, UL
Ms. Sheila Carew	Advanced Nurse Practitioner, MSc
Ms. Colette Devlin	Research Nurse, Health Research Institute, UL
Ms. Gillian Corey	Research Nurse, Health Research Institute, UL
Ms. Ida Carroll	Advanced Nurse Practitioner, Qualitative Researcher, UL
Ms. Nora Cunningham	Advanced Nurse Practitioner, PhD (candidate), UL
Dr. Orla Mongan	GP, Tutor WNWIN, Lecturer in Intern Education, NUIG
Dr. Gozie Offiah	Clinical Lead MIU/NDTP, RCSI
Dr. Josephine Boland	External Educational Consultant
Dr. Natasha Slattery	MEHP Fellow, Clinical Educator, MWIN, UL
<i>*Denotes stakeholders who attended pre-conference 60-90 minute interviews/focus groups</i>	

B. International experts contributing to the stakeholder consultation conference

Date: 1-2 October 2021

Venue: Barberstown Castle, Kildare

- Richard L. Cruess, researcher on professionalism and professional identity formation in medicine
- Sylvia R. Cruess, researcher on professionalism and professional identity formation in medicine
- Stan Hamstra, Royal College of Physicians and Surgeons of Canada
- Robert Sternszus, Hospitalist Paediatrician and Assistant Professor of Paediatrics and Health Sciences Education at McGill University
- Olle ten Cate, Professor of Medical Education at University Medical Centre Utrecht, the Netherlands

7.6 Support and Remediation

Development

Dr. Oisín Friel, Basic Specialist Trainee in General Internal Medicine, Beaumont Hospital

Prof. Ger Curley, Professor of Anaesthesia and Critical Care, Royal College of Surgeons in Ireland

Consultation

Prof. Derek Gallen, President of the Academy of Medical Educators in the United Kingdom

Prof. Denis Harkin, chair of medical professionalism at Royal College of Surgeons in Ireland

Intern networks

The Intern Network Executive

Dr. Gozie Offiah, Clinical Lead of Medical Intern Unit, National Intern Training Programme, National Doctors Training and Planning (NDTP), HSE

Prof. John Jenkins, Chair of the Medical Intern Board

Dr. Josephine Boland, Medical educationalist to the MIU/NDTP

Participants in the stakeholders consultation process 2022-23 (detailed in **Appendix D**)

Appendix C

The External Review of the Curriculum Framework

1	Introduction
2	Overview
3	The Curriculum Framework's potential to fulfil its function
4	Actionable comments and recommendations
5	Points for further consideration

1. Introduction

The draft *Curriculum Framework Consultation Document* (dated July 2022) was prepared for the Medical Intern Board (MIB). In parallel with the initial consultation with MIB and management committees, the document was sent to a number of external reviewers. These were selected on the basis of their expertise, experience and credentials in relevant contexts, nationally and internationally; namely, comparable programmes to the internship; competency-based medical education; the DO, KNOW, BE curriculum model; entrustable professional activities and workplace based assessment. The following individuals were invited to contribute to the review, accepted the invitation and provided detailed written reports.

Dr. Aileen Barrett (Ireland)

Assistant Scheme Director, South East GP Training
Health Professions Education Consultant, Lighthouse Communications
Editor-in-Chief, The Clinical Teacher

Prof. H. Carrie Chen (USA)

Associate Dean of Assessment and Educational Scholarship
Professor of Paediatrics, Georgetown University School of Medicine

Prof. Jill Thistlethwaite (Australia)

Adjunct Professor, University of Technology Sydney
Health and Education Training Institute, NSW Health

Dr. J. Clare M. van Hamel (UK)

Consultant Anaesthetist
Head of Severn Foundation School – Heath Education England
Associate Post Graduate Dean - Heath Education England

The brief given to the external reviewers was to review the extent to which the Curriculum Framework will be able to fulfil its functions, namely:

- Enhance the quality of the internship programme as a key element of the modernisation project
- Ensure comparability of the internship experience across networks
- Guide each Intern Network when devising their local curriculum for their internship programme
- Guide individual interns as they take responsibility for their learning and professional development
- Provide a framework for programmatic assessment, including the use of workplace based assessment tools
- Provide a basis for curriculum mapping of local network training programmes
- Facilitate quality assurance of the internship programme as delivered in training networks

2. Overview

The four reports received from the external reviewers were comprehensive, constructive and very thorough, responding to the brief given. Their full reports from the external reviewers were provided for information to the Board.

There was a significant level of consensus amongst the reviewers on most issues discussed. They offer specific advice and recommendations, in many instances supported by evidence from the literature. Not surprisingly, given their experience and expertise many extended beyond the scope of the brief and made some valuable specific suggestions relating to details within various elements of the curriculum.

Some general points:

- There was unanimous support for the adoption of a competency-based curriculum framework, based on the model of three integrated pillars of DO, KNOW and BE. The model was described as comprehensive, easily understandable, and practical. It was noted that it addresses concerns about working solely with an EPA framework, where the KNOW and BE competency expectations are not explicit and can be overlooked in entrustment decisions, despite being necessary for entrustment.

- The Curriculum Framework was affirmed for its basis in current thinking, educational theory and best practice in competency-based medical education (CBME), Entrustable Professional Activities (EPAs) and programmatic assessment. It was commended for its research approach and the effective use of supporting literature.
- The process of developing the framework – as a collaborative project with clinical and educational expertise and active involvement of stakeholder – was commended. Reviewers were impressed with the amount of work and careful thought that has gone into its development over many years.
- Continued active involvement of interns in the further development, review and consultation was advocated. They will be key drivers of the changes necessary. The need to involve patient/consumers/community members was also highlighted as important in any further development and consultation processes.
- The extent to which the Curriculum Framework is prescriptive or a set of guidelines for programme providers was not entirely clear to the reviewers. A number of questions posed by the reviewers highlight the need to address and clarify issues relating to quality assurance, programme accreditation and governance.
- The strategy for programmatic assessment and use of clinical competency (entrustment) committees was affirmed as consistent with best practices and recommendations for competency-based medical education. It was acknowledged that implementation of these processes represents a significant and ambitious change to intern training. Implementation of programmatic assessment for the internship year also needs to bear in mind their dual service and education/training commitments. Programmatic assessment will require significant changes in culture, practices and mindsets for all involved, as well as appropriate resources.
- The issue of supervision of interns was raised; its importance, the role of the supervisor, and level of supervision appropriate in intern training. One reviewer suggested amending the description of Level 1 in the EPA Entrustment Supervision Scale to better reflect the context of intern training. The nomenclature and description of supervision levels will be reviewed in the consultation process.
- The opportunity to empower interns and enable them to take more responsibility for their learning was identified as a fundamental benefit of the EPA approach to operationalising

CBME. It was noted that it will take time to engender the growth mindset required and to counteract deep-rooted perceptions of assessment, learned from their experience of high-stakes assessment throughout their education, from secondary school to medical school. Interns will need to be supported through this transition.

- The BE pillar of the curriculum was recognised as an important statement of behavioural competencies to be developed by the intern which are not fully reflected in the EPAs. The reviewers' comments provide valuable points to consider in its further development. Further consideration is also required on if and how these competencies are to be assessed.
- A number of enabling conditions for successful implementation of the framework were identified which relate to conditions of service for interns and/or contracts for supervisors which are the responsibility of the employer the HSE e.g., protected self-directed time for interns; mandatory training for assessors.
- A review of competency-based curricula for intern/foundation programmes (Ireland, Australia and the UK) undertaken by one reviewer suggests that expectations of what is to be achieved by interns in Ireland (in one year) may be ambitious.

Some areas of differing opinion

There was a very high degree of consensus among the reviewers, which was apparent from the reiteration of points of advice and recommendation across a number of reports. There were very few issues on which opinions differed or conflicting advice was offered.

Two such areas were as follows:

- The Knowledge Guides were broadly welcomed as very valuable for the intern. There were differing opinions, however, regarding the addendums – the lists of scenarios, investigation, abnormalities/results and procedures. There were some reservations about their inclusion (the risk of time expiry was noted), some reorganisation was recommended, and it was suggested that further details would be helpful (symptoms, presentations, disease entities or scenarios). It has been clarified that these lists are indicative, non-exhaustive, subject to updating and are not intended to define or limit the scope of practice of an intern. The inclusion, content and organisation of the addendums will be subject to wider consultation.

- The absence of details on frequency, number and range of workplace based assessments required for entrustment was commented on. It was noted that trainees seek clarity and certainty about such numbers. Research evidence was cited, however, that it is counterproductive to have top-down mandatory requirements on how much or what type of assessment information is required. This concurs with recent trends, internationally in EPA- based programmes, favouring a qualitative rather than quantitative approach to reviews of trainees' portfolios of evidence. Details on criteria for entrustment and how to approach this issue have yet to be determined, following further consultation, piloting, review.

3. The Curriculum Framework's potential to fulfil its function

Reviewers were asked specifically to comment on the Curriculum Framework's capacity to fulfil its stated function. The general consensus was that it has the capacity, with some provisos as follows:

- **Enhance the quality of the internship programme as a key element of the modernisation project?**
 - ▶ This Curriculum Framework adopts current best practice in the design of competency-based medical education and training
 - ▶ It provides a clear picture of what trainees should be able to do, know and be on completion of their intern year
 - ▶ It will facilitate the design of a higher quality, more structured year with better outcomes for interns
- **Ensure comparability of the internship experience across networks?**
 - ▶ The framework provides detailed guidance on the training interns require
 - ▶ Some details are not included and should be added to the framework once determined e.g. mandatory experience requirements
 - ▶ Implementation of effective quality assurance processes will be essential to ensuring comparability of their experience across networks
 - ▶ The quality of the intern experience will need to be monitored and evaluated

- **Guide each Intern Network when devising their local curriculum for their internship programme?**
 - ▶ The framework provides for a degree of autonomy for training providers to determine teaching and learning strategies – this was identified as both a strength and a potential risk
 - ▶ Continued collaboration between intern training networks, e.g., in design of teaching and learning strategies/materials will be valuable
- **Guide individual interns as they take responsibility for their learning and professional development?**
 - ▶ The framework provides detailed information on what is expected of interns it provides for enhanced agency on their part as they take more responsibility for their learning
 - ▶ Interns will need to be guided to make this transition and actively supported when taking the initiative to gather evidence of their competence
- **Provide a framework for programmatic assessment, including the use of workplace-based assessment tools?**
 - ▶ The provisions with respect to programmatic assessment align with best practice in the design of competency-based medical education and training
 - ▶ Further details on the operation of specific processes will be needed prior to implementation
 - ▶ Significant investment in training, technology and resources will be required
- **Provide a basis for curriculum mapping of local network training programmes?**
 - ▶ The Curriculum Framework provides a detailed basis, for the first time, for mapping intern programmes delivered at local level
 - ▶ Further guidance on how training providers are expected to map their local programme against the national Curriculum Framework will be needed

- **Facilitate quality assurance of the internship programme as delivered in training networks**

- ▶ The framework provides a detailed and valuable point of reference for a funding body and/or accrediting body when implementing quality assurance processes for intern training

One reviewer provided a useful summary of her response to those questions, together with risks, challenges and requirements.

Functions of the CF	Ability to fulfil?	Risks/challenges/requirements
Enhance the quality of the internship programme as a key element of the Modernisation project	Yes – the programme is in line with current thinking on medical education: CBME, programmatic assessment. Content is comprehensive.	Engagement with patients/communities; number/level of competencies to be achieved in one year; flexibility; more detail on processes needed; evaluation of outcomes required.
Ensure comparability of the internship experience across networks	Probably – networks have choice in teaching strategies; comparison will be needed and communication amongst networks.	Check for equality of opportunity, learning and WBA; case mix; supervisory input; frequency and quality of WBA episodes; intern feedback.
Guide each Intern Network when devising their local curriculum for the internship programme	Yes - to a great extent; curriculum matrix/blueprint required.	How much flexibility is ok? Curriculum is detailed and what is essential? Needs to meet accreditation standards.
Guide individual interns as they take responsibility for their learning and professional development	Yes – but interns will vary in the support required to do this. Needs specific curriculum guide for interns.	Curriculum perceived as overwhelming; development of self-assessment and self-regulation skills; easy access to digital resources; usable technology; orientation package
Provide a framework for programmatic assessment, including the use of workplace based assessment tools	Partially – content is valid; process requires more details. Programmatic assessment with WBA and EPAs is valid – measures what it is supposed to measure.	Assessment burden; supervisory burden; quantity and quality of WBA; quality of feedback dialogue; 'failure to fail'; understanding of entrustment; support for interns in difficulty; remediation; continuity of assessor versus multiple raters to reduce bias; role of portfolio advisor; role of reflection; agreement on meaningful evidence base for entrustment/competency committee; supervisor training.
Provide a basis for curriculum-mapping of local network training programmes	Yes – if appropriate and relevant data collected.	Whose responsibility? Agreed curriculum blueprint template.
Facilitate quality assurance of the internship programme as delivered in training networks	Probably – need to agree on data collection.	To complement accreditation standards; feedback loop: seen to be acting on feedback received from stakeholders; transparent processes in place to raise and deal with concerns.

4. Actionable comments and recommendations

Many of the comments made by the external reviewers were actionable in the process of revising the Curriculum Framework Consultation Document, in advance of circulation for the wider stakeholder consultation process. Over forty amendments were made to the document in response to their specific suggestions and recommendations. These are noted in *Amendments made to the July 2022 Draft of Curriculum Framework Consultation Document*, which was provided to the MIB. The amended document was approved by wider circulation and stakeholder consultation as *Curriculum Framework for the Internship Programme in Ireland: Consultation Document* (September 2022).

5. Points for further consideration

The reviewers noted many points, identified issues or posed questions which did not result in amendments to the Curriculum Framework consultation document, but will deserve further consideration. A number of these can be considered and addressed in the final Curriculum Framework to be prepared, following a review of the outcome of the wider consultation process.

The reviewers provided important valuable advice which can inform the further development of specific elements and processes relating to the framework. Some of their questions concern details not yet determined (e.g., frequency of workplace based assessments). These details will only be confirmed following the evaluation of a piloting process. Many of the comments are pertinent to training regulations and experience requirements, which are currently under review. Some aspects of the processes leading to certification will be further developed in consultation with key stakeholders. Specific recommendations with respect to support for struggling interns have been referred to the team responsible for drafting a support and remediation policy. Reviewers also identified aspects needing clarification regarding accreditation process and the quality assurance of training programmes delivered by local intern networks. Valuable advice has been provided that can inform the implementation process and identify potential strategies for change management. In terms of the future development and consultation processes, the recommendation to involve patient/consumers/community members is particularly noteworthy. Finally, a number of the issues which were raised are pertinent to the future governance arrangements for the internship.

These points for further consideration were organised by theme, as listed below. Some are reproduced verbatim while others are paraphrased from the reports. (these were provided to the MIB in an Appendix). Once reviewed by the MIB, these themed points can:

(i) Be referred to the following groups/bodies, where relevant:

Groups:

- Curriculum development working group (CDWG)
- Working group designing the technology (WGIT) – term of reference already drafted
- Developers of the remediation policy for the internship – work in progress
- Curriculum Framework implementation group (CFIG) – to be established
- Designers and evaluators of the piloting process – to be established

Bodies

- Medical Council
- NDTP
- Intern Network Executive
- Deans of Medical Schools
- Forum for Postgraduate training

(ii) Inform questions posed to stakeholders in the consultation process

(iii) Guide the implementation, evaluation and review of the Curriculum Framework in the future

The themes adopted for the compilation, with details provided to the MIB, were organised as follows:

1. The model for the Curriculum Framework
2. The Entrustable Professional Activities
3. The Knowledge Guides
4. The BE pillar
5. Intern training
6. Supervision
7. Delivery of the curriculum at network level
8. Workplace based assessment tools
9. Programmatic assessment
10. Entrustment Committees
11. Remediation
12. Technology
13. Roles within the Curriculum Framework

14. The interns
15. Continuing professional development
16. Implementation
17. Evaluation
18. Accreditation and quality assurance

Consideration of these points contributed to the subsequent preparation of the final Curriculum Framework.

Appendix D

Consultation Process (September 2022 - March 2023)

1	Introduction
2	Consultation September 2022 - March 2023
3	Summary of feedback from the consultation process • Comments • Questions • Concerns
4	Preparation of the Curriculum Framework
5	Points for further consideration

1. Circulation of Draft Curriculum Framework Consultation Document

The Draft Curriculum Framework for the Internship Programme in Ireland: Consultation Document (July 2022) was amended in light of recommendations from the external reviewers' reports, as described in **Appendix C**.

The Curriculum Framework for the Internship Programme in Ireland: Consultation Document (September 2022) was prepared. It was circulated to the following with an invitation to provide written feedback:

- Intern networks
- Supervising consultants
- Interns and NCHDs
- Medical schools
- Postgraduate training bodies
- Patient//public representatives
- Medical Council
- NDTP/HSE
- Others

The proposed Support and Remediation process for the internship was also widely circulated and was the subject of stakeholder consultation, in addition to the process detailed in **Appendix B**.

2. Consultation meetings

An extensive set of consultation meetings was undertaken from December 2022 - March 2023. The purpose of the consultation meetings was to:

- Engage directly with stakeholders
- Share the vision and explain the rationale for the new competency based curriculum
- Provide information about the curriculum framework, the provisions regarding programmatic assessment and the support and remediation policy
- Give stakeholders an opportunity to have a voice, ask questions, raise concerns and make suggestions
- Encourage participants to read the consultation document and respond with any further feedback
- Prepare stakeholders for the changes in culture and practices involved

A series of consultation meetings were held as follows:

- (a) Townhall meeting re: the Irish Internship Curriculum Framework
- (b) Regional meetings in the six Intern Networks
- (c) A meeting with interns and final year medical students

(a) Townhall Meeting

Date & Time:	12th December 2022, 15:00-17:00
Venue:	via Zoom
Presenters:	Prof. John Jenkins (Medical Intern Board) Mr. Martin McCormack (PGTB Forum) Dr. Suzanne Crowe (Medical Council) Prof. Brian Kinirons (NDTP) Dr. Gozie Offiah (MIU/NDTP) Dr. Clare van Hammel (Head of Foundation School at Severn Deanery, UK) Dr. Oisin Friel (RCSI) Prof. Finbar O'Connell (TCD-DSE)
Participants:	Presidents of the PGTBs, CEOs of the PGTBs, Medical Council, Deans of Medical Schools, Head of Schools, Programme Directors, Medical Directors, Medical Manpower Managers, HR Managers, Intern

Co-ordinators, Intern Network Administrators, Consultants, Clinical Supervisors, NCHDs, Intern Lecturers, Intern Tutors, Interns, and any other professional involved in intern training.

Facilitator: Ailbhín McCrann, External facilitator, Communiqué International.

The *Curriculum Framework for the Internship Programme in Ireland: Consultation Document* (September 2022) and a document outlining the proposed *Remediation Policy* were both circulated in advance.

(b) Regional consultation meetings in the Intern Networks

Meetings were held in each network region and broadcast to other hospital sites within the network. The Curriculum Framework Consultation Document and Remediation Policy were circulated in advance. The meetings were organised by the local network.

Presenters: Prof. John Jenkins – Independent Chair Medical Intern Board
Dr. Gozie Offiah – Clinical Lead, Medical Intern Unit, NDTP

Participants: Head of School, Intern Co-ordinators, Intern Administrators, Consultants, Clinical Supervisors, NCHDs, Intern Lecturers/Tutors, Interns, and Final Year medical students.

Facilitator: Ailbhín McCrann

Goals: Main goals were to:

- Present the key aspects of the Curriculum Framework
- Respond to queries or concerns people may have
- Delve into issues associated with operationalising the new Curriculum Framework

The *Curriculum Framework for the Internship Programme in Ireland: Consultation Document* (September 2022) and the proposed *Remediation Policy* were both circulated in advance.

Date	Network	Venue	Participants (in person and online)
3rd Feb 2023, 13:00-15:00	WNW Intern Training Network	Clinical Science Institute – Lecture Theatre, University Hospital Galway	In-person: 21 Remotely: 20
8th Feb 2023, 08:00 – 09:00	DML Intern Training Network	Old Lecture Theatre, St Vincent's University Hospital	In-person: 56 Remotely: 22
16th Feb 2023, 12:30-14:00	STH Intern Training Network	Main Auditorium, Cork University Hospital	In-person: 39 Remotely: 16
14th Mar 2023, 08:00 – 09:00	DML Intern Training Network	McAuley Lecture Theatre, the Mater Misericordiae University Hospital	In-person: 28 Remotely: 36
24th Mar 2023, 08:00 – 09:00	MWT Intern Training Network	CERC Auditorium, University Hospital Limerick	In-person: 72 Remotely: 49
30th Mar 2023, 08:00 – 09:00	DNE Intern Training Network	Robert Adams Lecture Theatre, Beaumont Hospital	In-person: 18 Remotely: 22
31st Mar 2023, 08:00 – 09:00	DNE Intern Training Network	Robert Smith Lecture Hall, Trinity Sciences Building, St. James's Hospital	In-person: 21 Remotely: 27

(c) A meeting with interns and final year medical students

A further meeting was undertaken with interns and senior medical students only, representing the various intern networks and medical schools, to enable the voice of the intern and student to be heard in a 'safe' environment, where they would have an opportunity to feedback their views more frankly.

Intern networks were asked to nominate 3 intern representatives and Medical schools were asked to nominate 3 senior medical student representatives. A summary version of the Consultation Document was circulated in advance to participants. The meeting was held in Dublin with remote access for those unable to attend. A presentation was made by Dr. Gozie Offiah, (Clinical Lead of Medical Intern Unit, National Intern Training Programme, National Doctors Training and Planning (NDTP), HSE) and the meeting was facilitated by the external

Date	Network/Medical School	Venue	Participants (in person and online)
29th Mar 2023 18:00-19:30	All	RCSI, 26 York Street, Dublin	In-person: 10 Remotely: 16

3) Compilation of feedback from the consultation process

The following comments from participants were noted at the regional meetings and the meeting with interns and medical students. Questions posed were responded to at the meetings, with clarifications from the provisions of the Curriculum Framework. The concerns expressed were noted, many of which will need to be addressed in the piloting and implementation phases.

(i) Comments

The Curriculum Framework

- The Curriculum Framework is an excellent initiative that will bring greater structure and clarity to the intern programme
- This is a very welcome change in training
- This is an admirable framework
- If implemented appropriately, this will be a very good development
- Consistency is key for a national programme - many of the networks are doing some or part of this, but we need more uniformity
- The task is gargantuan but necessary for Patient safety
- We need transparency. Interns need to know what is expected of them. For consultant trainers too – we need time to meet with them and engage
- Piloting will be important
- Significant resources will be needed to implement this

Assessment

- For assessment and feedback, little and often (formative) is to be encouraged. That is much better than a single summative decision (satisfactory/not satisfactory), which can be unfair.
- This will be positive if it makes assessment a more frequent and easier thing to do. Twenty sessions of short feedback is better than a single end-of-rotation form.
- Include self-assessment by intern – to identify stressed interns with low confidence and those who overestimate their ability.

Interns

- Good that interns take ownership
- This approach should encourage interns to proactively seek feedback

- EPAs are good in providing clear expectations of what we (interns) need to achieve
- This is what we (interns) do - the framework gives an opportunity to be assessed on what we do
- EPAs are a great idea, so that we (interns) will get feedback on the learning process
- Great idea to have progress documented as we go along
- Nights are the most daunting. Someone in charge for people on nights would be very important - someone to supervise, it's scary by yourself

Culture change

- Trust is the essence of what this is. The biggest challenge will be to get interns to see this as important, rather than just ticking boxes.
- We need a new culture to accept this new process. Experienced consultants went through the old system.
- The first few years of implementation will not be easy. It will require a lot of change for supervisors and assessors.
- We need to avoid being overly formalised – avoid internship assessment being another Final Medical year. Need to capitalise on what already happens in practice.

Roles of assessors, supervisor and portfolio advisor

- It is critical that other NCHDs, not just consultants, can engage in training and assessment. This implies collective responsibility.
- An organised and valued career path as clinical educator will be very important
- We need to value and reward assessment work done.
- New contracts for consultants should contain protected time for teaching and assessment.
- The Portfolio Advisor needs to be a supportive person who sits down at the start of a rotation, to establish goals etc. That person should be a mentor.
- Research from academic track project suggests that ad hoc entrustment decisions are made by people more proximate to the intern, i.e., not necessarily the supervising consultant.
- Negative feedback will be more difficult to give if the intern is being assessed by an SHO. That needs to come from supervising consultant.

Remediation

- We have used EPAs for implementing remediation – they have been very useful.
- I'm completely sold on having a standardised framework to help interns in remediation. This is a good place to start, with a small cohort and clear objectives.
- We need to avoid stigmatising remediation.
- Terminology of 'remediation' is not appropriate – need to reflect more supportive approach.

Quality of training

- We are conscious of the interface between service and training and we need to achieve a better balance.
- If a clinical team is privileged to have an intern then there are responsibilities that go along with that. The burden should be taken away from teams who cannot fulfil that responsibility.
- Need more granular emphasis on what happens with trainers and removing unsupportive trainer, if necessary. For those who do not comply, sanctions are necessary.
- We need to address the relevance of teaching. We (interns) need better teaching, especially on EPA 6.

Design of the IT system

- You need a system that is relatively simple
- Look at other systems, to learn from what's been done elsewhere and works
- You need to get user-involvement in design of the digital system
- A global app for WBA for EPAs is needed – not just one for Ireland (HSE Apps are locked to Ireland)

Relationship with medical school

- We need to start workplace based assessments in final year medical school, to reduce the time we have to do those in the intern year.
- Medical schools differ on how trained we are in clinical skills. If there was a standardised final year med exam, that would eliminate the need to do some of these EPAs. That will put pressure on final med students to be good at procedures and should help standardise the medical schools.
- We do a lot of preparatory work in medical school, e.g., the preparedness to practice unit with a logbook. We get a lot of these things ticked off. So, this could be repetitive.

(ii) Questions

Internship and final medical school

- How does the new curriculum overlap with clinical training in final med?
- We are developing the undergraduate curriculum to at least partially reflect these EPAs. We aim to get students out at level 2-3. Has it been discussed where one should start from at beginning of internship?
- Some medical schools have done a lot of this. Can students be signed off in medical school?
- Are we introducing something to intern year that should be part of final year?

Assessors

- Who can carry out assessments?
- WBAs need to be done consistently by every consultant. What are the processes to train people in advance of doing any low states assessment?
- Where people have already done mandatory training for WBA for other training bodies will there be cross-over recognition?
- Feedback is an art. Has there been any thought given to training in giving effective feedback?
- Is there a plan for a faculty training programme for BST consultants as well as intern supervisors?

Portfolio advisor

- Who can be a Portfolio Advisor?
- How is the role to be filled?
- Will Portfolio Advisors have protected time?
- In terms of practicalities, what happens when interns rotate?

Workplace based assessment

- What plans are in place to ensure supervisors support interns and provide feedback?
- How many WBAs will interns have to log over the course of a year?
- Do interns have to perform all EPAs in all rotations?
- Is there a pre-determined time for doing the assessments?
- Which ones will be done early on? Some should be assessed early in the year
- How can intern performance while on-call be assessed, or when caring for the rapidly deteriorating patient?
- Can simulation be used for assessing the care of deteriorating patients?

The app and e-portfolio

- How will the app work?
- Who has the app?
- How can assessment be verified if the report is completed on an intern's device?
- Will the e-portfolio for intern and for specialist training be aligned (speak to one another)?

Entrustment levels

- Can entrustment for an EPA be awarded during training or only at the end of training?
- What are the implications of levels 1, 2 and 3 for interns' work practice? If you have evidence that they are graded level 2, how can they work at night?
- Should I (as an intern) be rostered on call if I am on level 2 for recognising deteriorating/acutely unwell patient?

Clinical competence (entrustment) committees

- Is there a framework for a clinical competence (entrustment) committee? If someone has difficulty with assessment there needs to be tightly governed processes. Who will house documents, and for how long?

Remediation

- 95% of interns are great. The real challenge is for a small percentage of interns – where their knowledge level is insufficient. It's hard to remediate them in the intern year. Can assessment processes address this and identify knowledge gaps which are a risk to Patient safety?
- Separate piece about remediation – concerned about endless documents. How will it be acted upon in – how is need for remediation activated?

Flexibility

- 10 % of students have a disability. For some interns we would like to plan a 2-year programme as the gruelling nature of internship will not suit them. Are you planning that?
- Everyone progressing at own pace: how much will that happen in reality?
- How many assessments will an intern need to achieve level 4 star?

Modelling, piloting and evaluation

- Has any modelling been done in terms of time for trainers and for SPRs and other members of the team?

- When will piloting start?
- Are you just piloting in places where people ask, or everywhere?
- Is there potential for bi-lateral assessment? Interns assessing their trainer and the quality of the training environment. Give trainers CPD points based on feedback from interns.
- Is there a tool to evaluate performance of interns who complete this year and performance of future interns after this is implemented - to see if it makes a difference?
- How will you measure success – what are the KPIs?

(iii) Concerns

Challenges

- This is a new comprehensive assessment process which will be very time-consuming for trainers and trainees.
- This will involve considerably more effort and engagement by consultants and the clinical team.
- Because of EWTD – there is a relative lack of face-to-face time. So, it seems unrealistic. There is an undiscussed area; more formal supervision is needed on morning after on-call.
- There is an issue with compliance; people who are not engaged are not addressed. There is an overemphasis on the responsibility of the intern. We need to focus on trainers. Currently there are no consequences for them. So, the responsibility for assessment will be shifted down to Regs and SPRs.
- Risk of fragmentation if signing-off is by done a committee.
- We have serious concerns about anything involving technology.

Training and service

- Unless we create more opportunities for training – by reducing the service component, increasing intern numbers, or increasing physical assistants – we can't do this.
- The model is very tight. There is a secondary impact, if we are in difficult conversations with interns in remediation, there are consequences for service arising from putting them through remediation. Service already takes precedent. Need to factor that in, we need more interns.
- The current role of the intern is service not training.

Levels

- Irish interns generally see themselves coming into internship at level 2 and 3; coming in as a full-time junior doctor. We need to be careful not to belittle what they can do. They can do certain tasks with some degree of autonomy.
- Interns concerned about the 5 levels. Level 1 -3 is already achieved in medical school. Level 1 is regarded as 'childish' if you can only observe.
- Level 4 at EPA by end of internship is not a high bar.

Interns

- It looks like a lot more work, involving going over recommended hours. Will some current things we have to do be taken out?
- There are workplace pressures everywhere. So, it seems unrealistic. People are running off the ward, we interns are left alone.
- Getting assessment on tasks – regs are running out the hospital. You'll get regs signing off without assessing them.
- The intern position is a downgrade on the medical student position: they get lots of feedback. As interns we become administrative workers (admission, discharges, cannulations) with lots of paperwork.
- The practicalities of getting consultants or other to take time out of their day.
- If onus for getting feedback falls on the intern this could be challenging.
- It's brilliant but the workload on teams is massive. It's a lot to ask me to do anything on top of this current workload. Some teams are not interested and don't even have the app.
- What if the consultant has it wrong? I wonder about the power imbalance.
- Concerned about supervision – some interns feel unsupervised.
- Consultant changes every two weeks. I haven't been working with my consultant, I only worked with him for four weeks in the whole rotation.

Assessment

- The length of time taken to carry out assessments is concerning
- Much will fall to SHOs and registrars who are already stretched
- Relying on consultant to download an app may be challenging
- Reflective practice (e.g., completing a journal) would add to an intern's workload outside the clinical day. Caring for a deteriorating patient is often done on call, and very hard to get feedback

Remediation

- When people are not performing well it is always an issue about professionalism and teamwork. They struggle with showing up, communicating well. It's difficult to capture when they are not playing their part in a team.

Risk of a tick-box approach

- We should not throw out the baby with the bathwater. There's a risk of WBA becoming a tick-box exercise.
- Interns are already very busy. SHOs do this – none of them think it's a good idea. There's a risk of it becoming an exercise in box-ticking.
- It will become tick-box with interns getting signed off for things they have not done.

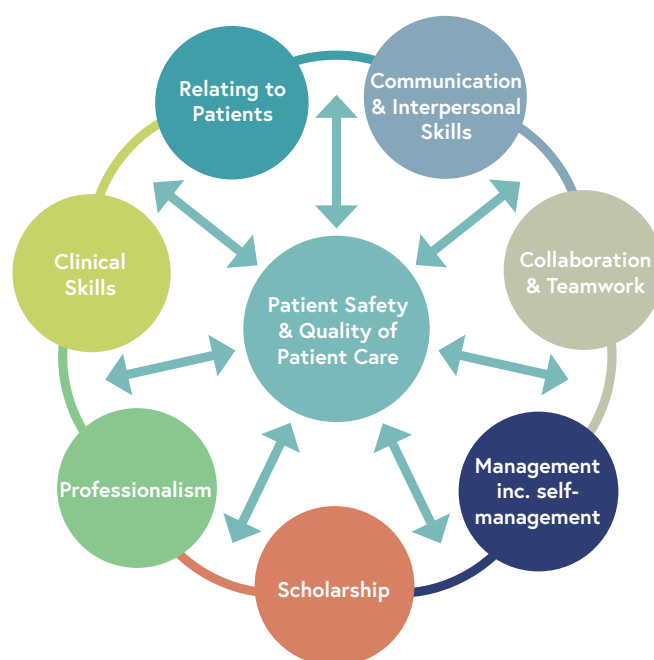
4) The Curriculum Framework for the Internship Programme in Ireland (May 2023)

The Curriculum Framework was revised (March-May 2023) with amendments and clarifications made in response to:

- A review of comments, questions and concerns during the consultation process
- Recommendations from the external reviewers' reports which had not already been actioned feedback from Prof. Olle ten Cate
- Deliberations of the Curriculum Framework Task and Finish Group
- Consideration of specific details by the MIU team

Appendix E

The Medical Council Eight Domains of Good Professional Practice



Patient Safety and Quality of Patient Care: Patient safety and quality of patient care should be at the core of the health service delivery that a doctor provides. A doctor needs to be accountable to their professional body, to the organisation in which they work, to the Medical Council and to their patients, thereby ensuring the patients whom they serve receive the best possible care.

Relating to Patients: Good medical practice is based on a relationship of trust between doctors and society and involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

Communication and Interpersonal Skills: Medical practitioners must demonstrate effective interpersonal communication skills. This enables the exchange of information, and allows for effective collaboration with patients, their families and also with clinical and non-clinical colleagues and the broader public.

Collaboration and Teamwork: Medical practitioners must cooperate with colleagues and work effectively with healthcare professionals from other disciplines and teams. He/she should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients.

Management (including Self-Management): A medical practitioner must understand how working in the healthcare system, delivering patient care and other professional and personal activities affect other healthcare professionals, the healthcare system and wider society as a whole.

Scholarship: Medical practitioners must systematically acquire, understand, and demonstrate the substantial body of knowledge that is at the forefront of the field of learning in their specialty, as part of a continuum of lifelong learning. They must also search for the best information and evidence to guide their professional practice.

Professionalism: Medical practitioners must demonstrate a commitment to fulfilling professional responsibilities by adhering to the standards specified in the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

Clinical Skills: The maintenance of professional competence in the clinical skills domain is clearly specialty-specific, and standards should be set by the relevant postgraduate training body, according to international benchmarks.

Source: Medical Council (2010). [**Eight Domains of Good Professional Practice**](#)

Appendix F

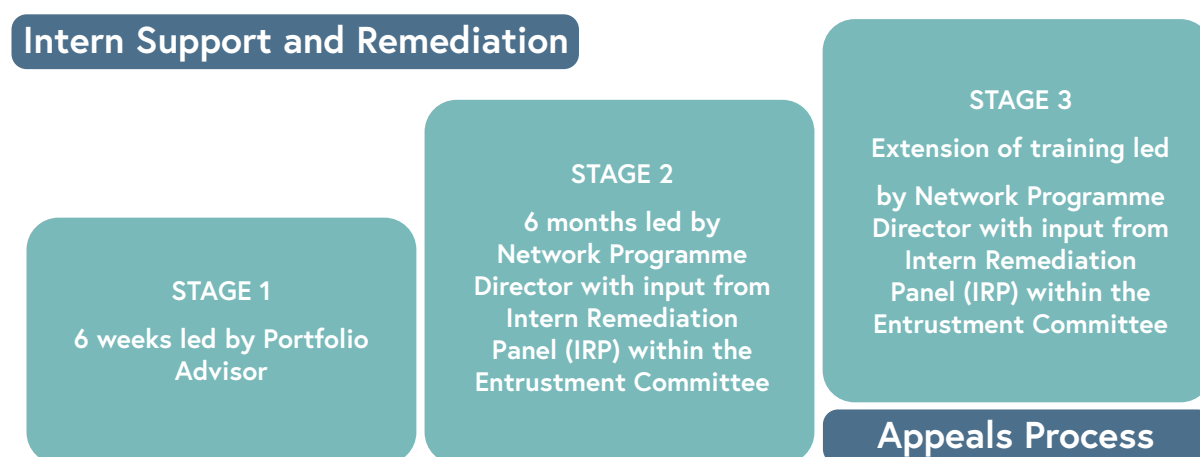
Support and remediation for interns: National guidelines for a three-stage process

Introduction

This document presents guidelines for the support and remediation of intern doctors, to be approved by the Medical Intern Board, and endorsed by the Medical Council for use on a national level. These guidelines are the outcome of an NDTP-funded project⁵⁹ which was commissioned by the Medical Intern Board, as part of the Modernisation of the Internship project. A document⁶⁰ was prepared for consultation with stakeholders, with details of current best practices on the remediation of post-graduate doctors and proposed guidelines for the implementation and management of a process for the support and remediation of interns.

The guidelines have been prepared in the context of the ongoing modernisation of the internship and align with the new Curriculum Framework for the internship programme in Ireland. These guidelines have been the subject of extended stakeholder consultation, including with all the intern networks and were presented to the Medical Intern Board. The consultation process relating to the new Curriculum Framework (December 2022-March 2023) provided a further opportunity for a wider group of stakeholders to give feedback on this process, which is an integral part of the strategy for programmatic assessment. In response to feedback from the consultation, the process was retitled, **Support and Remediation**, to reflect the emphasis on support, especially in the early stages of the process.

The support and remediation process involves three stages and an appeals process, as follows.



⁵⁹ Modernisation Project Workstream 2 – Intern posts – Intern training guidelines Ref. 07-19 funded 20.12.19 Curley, G. and Friel O. 2022, Proposal around revision of intern remediation in Ireland

⁶⁰ Curley, G. and Friel O. 2022, *Proposal around revision of intern remediation in Ireland*

Remediation

Remediation is "an intervention, or suite of interventions, required in response to assessment against threshold standards of performance"⁶¹. As the term implies, the aim is to remedy an issue and return the doctor to safe practice within a supportive learning environment. Every endeavour should be made to identify issues in intern performance at an early stage to ensure appropriate and timely commencement of support and remediation and subsequent resolution of deficits. The term 'issue', in the context of this document, shall refer to a deficit in knowledge, procedural or clinical skills, communication or other matters of professionalism. We advocate, as far as possible, destigmatizing remediation and highlighting it as a unique space of learning, self-improvement, personal development, resilience building, and an opportunity to practise with feedback, all to develop the adaptive capacity needed by all medical professionals in the current era.

Aims of the guidelines

This updated set of guidelines for the support and remediation of doctors in intern programme aims to facilitate early identification and support of struggling interns. Portfolio advisors, Entrustment Committee members, the network programme director and assessors, the roles of whom are outlined in the Curriculum Framework for the Internship in Ireland document are actively encouraged to utilise the guidelines outlined in this document to facilitate completion of stage 1 and/or stage 2 support and remediation as required. Examples of issues which should prompt consideration of the need for stage 1 support and remediation, or direct progression to stage 2, can be found in **Appendix A**.

This early intervention will facilitate timely and effective management of deficits, optimising Patient safety and ultimately enabling young clinicians to maximise their learning experience during the intern programme and facilitate progression to general or specialist trainee registration with the Medical Council.

Stage 1 - Process managed by portfolio advisor

Initiation

- This initial stage of support and remediation is characterised by a strengthening of the existing educational and supervisory supports present within the clinical team to which the intern is attached and should take place in the clinical learning environment in which the intern is currently practising.

⁶¹ Kalet A, Guerrasio J, Chou CL. Twelve tips for developing and maintaining a remediation program in medical education. *Med Teach*. 2016 Aug;38(8):787-92.

- Consideration around commencement of this initial stage of support and remediation should take place following identification of an issue in an intern's performance which have come to the attention of the portfolio advisor. Such issues may be identified directly by the portfolio advisor during review of the intern's portfolio. Similarly, issues may be brought to the attention of the portfolio advisor by other assessors (supervising consultant, pharmacist, nurse manager, etc) via the intern's portfolio or by discussing an issue with the intern's supervising consultant, who, in turn, can involve the portfolio advisor should they deem it necessary. In cases where the portfolio advisor also happens to be the supervising consultant, input can be sought from the network programme director, should it be felt necessary.
- The portfolio advisor should then arrange a meeting with the intern, during which they should:
 - ▶ Assess the intern's perception of the problem(s).
 - ▶ Screen for factors such as concomitant life stressors, burnout, mental health issues, substance abuse and learning disability and refer to the appropriate services (occupational medicine, General Practitioner, etc.) if deemed necessary and with the permission of the intern.
 - ▶ Conduct a review of the deficits outlined in referring the intern to the attention of the portfolio advisor.
 - ▶ Discuss with the intern whether additional supportive information may be gained from a review of records from the undergraduate institution. This requires the written permission of the intern. A signed and dated record of this permission should be retained.

Implementation

- Following this initial meeting, should the portfolio advisor decide to formally implement stage 1 support and remediation, a meeting should be arranged with the intern and their current supervising team consultant and an Education and Training Plan should be devised. This document, which is available in **Appendix B**, should clearly state the issue(s) which have resulted in commencement of the support and remediation process and detail the action plan to address these issues. The events of this meeting should be clearly documented and recorded, and the network programme director should be informed that an intern is commencing stage 1 support and remediation. The network programme director will not, however, be involved in the facilitation and management of this initial stage of support and remediation unless at the period of support and remediation, consideration needs to be given to this during the planning phase.

- ▶ If the intern is scheduled to remain in the same site following changeover, the supervising team consultant for that next rotation should also attend the initial meeting with the portfolio advisor and current supervising team consultant. This aims to ensure continued optimal delivery and effectiveness of the support and remediation programme during the changeover period by limiting disruptions to the interns training programme as outlined in the Education and Training Plan.
- ▶ If changeover involves the intern moving to a new training site, the intern's future supervising team consultant at that training site should attend the initial meeting with the portfolio advisor and current supervising team consultant. This meeting could be arranged remotely if face-to-face is not feasible. As above, this aims to ensure continued optimal delivery and effectiveness of the support and remediation process during the changeover period by limiting disruptions to the intern's training programme as outlined in the Education and Training Plan.
- In cases following evaluation, where the education and training supports are felt too numerous to be remediated successfully in a six-week period, or there are serious concerns for Patient safety and/or professionalism, the portfolio advisor can consider proceeding directly to stage 2 support and remediation by escalating the case to the network programme director, who can then discuss the case with the Intern Remediation Panel (see **Appendix C**). See **Appendix A** for examples of scenarios that might constitute direct commencement of stage 2 support and remediation.

Duration

- Stage 1 support and remediation comprises a six-week training and assessment programme

Support

- During the period of support and remediation, the intern should have regular meetings with the portfolio advisor (e.g., once every two weeks). This can be decided upon and documented within The Education and Training Plan which details all the activities to be undertaken. There should be enhanced supervision by the current supervising team consultant during this period, particularly around those areas of practice for which the intern is receiving support and remediation. The events of all tuition and workplace-based assessments done using the workplace based assessment report form for a Case Presentation, Direct Observation or Case Based-Discussion should be documented in the intern's portfolio.

- Assessment of professionalism is a key part of Stage 1. The workplace based assessments mentioned above should also document aspects of the Be pillar using the team review and case based discussion tools, see curriculum framework document **Chapter 6**.
 - ▶ The intern should be required to complete an online module(s) in the issue(s) that have necessitated remediation. Such issues might include communication, professional issues on the ward and self-management. Modules relating to such issues can be accessed via the Medical Protection Society (MPS) and British Medical Journal (BMJ) websites, links for which are provided in **Appendix D**. Other similar platforms can be utilised at the discretion of the portfolio advisor and/or network programme director.
 - ▶ A team review should be utilised before and after completion of the support and remediation period. This should be completed by a variety of staff members the intern works closely with (consultant, registrar, CNM, allied health services), and all reviews should be reviewed by the portfolio advisor.
 - ▶ Depending on the nature of the particular issue, the portfolio advisor, with input from the network programme director as required, may consider referral to other services such as occupational health, clinical psychology, educational psychology or counselling services.
- Decisions around whether the intern can safely complete on-call duties during this stage 1 support and remediation period should be made on a case-by-case basis.
- It is important for the portfolio advisor to have regular communication with occupational health physicians and the support of this service should be offered to the intern at this early stage of support and remediation. Similarly, consideration should be given to referral to a General Practitioner by the occupational health physician should relevant concerns - such as mental health concerns - exist.

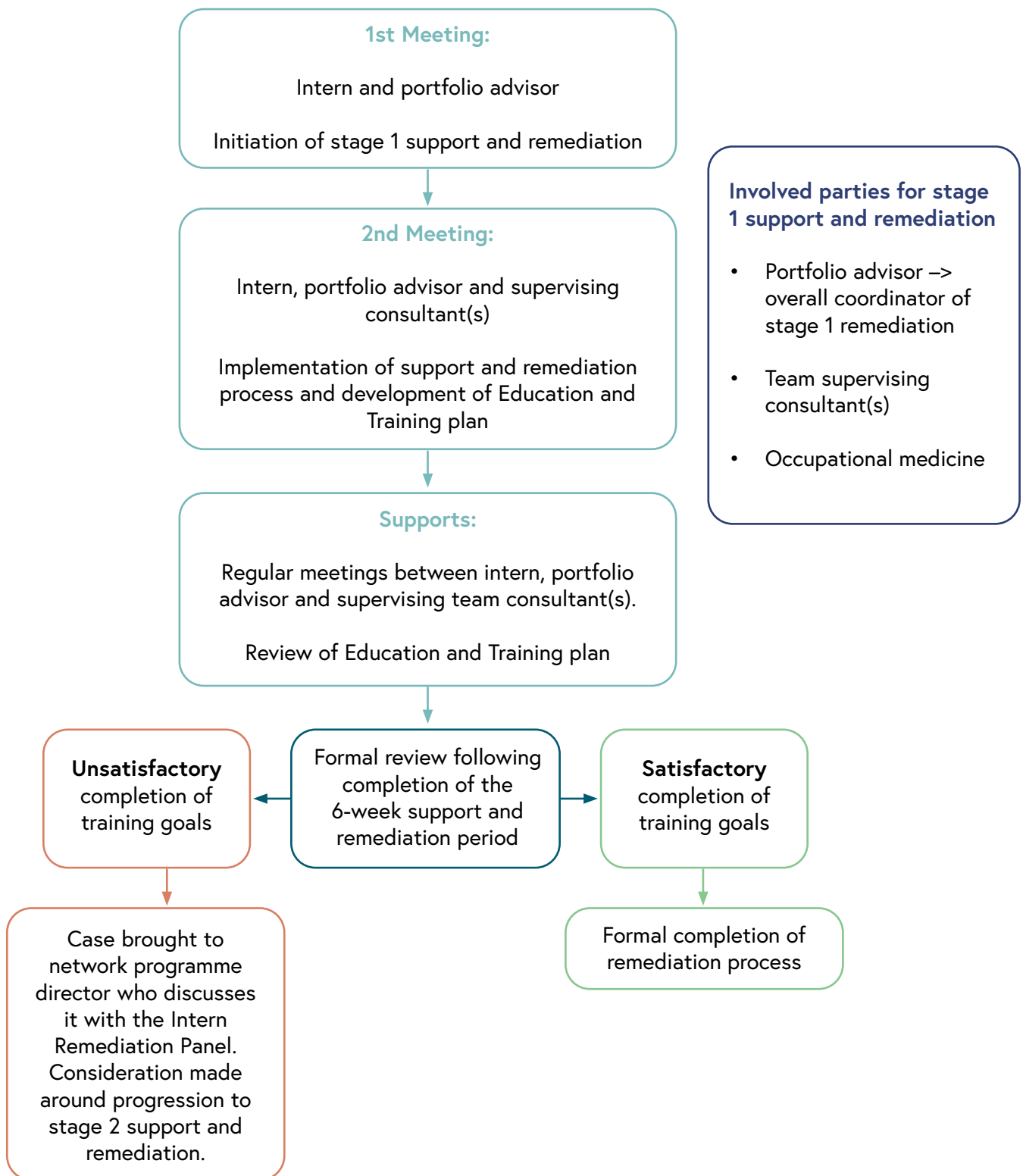
Evaluation

- Following completion of the six-week support and remediation period, a meeting should take place involving the portfolio advisor, the supervising team consultant(s) and the intern. At this stage, the Education and Training Plan should be reviewed, and a decision made to formally end the support and remediation process if there has been satisfactory completion of those goals outlined within the Education and Training Plan. After this meeting, satisfactory completion of stage 1 must be documented within the Education and Training plan by the portfolio advisor and the Network programme director notified.

Of note, for individuals for whom stage 1 support and remediation coincides with a change of rotation, the portfolio advisor should review documentation of intern progress from both training sites/teams. Portfolio advisor

- If completion of those goals outlined within the Education and Training Plan has been unsatisfactory, the case, along with all supporting documentation, should be referred to the network programme director. The network programme director should review the documentation (+/- arrange a meeting with the involved intern) and discuss the case with the Intern Remediation Panel, following which a decision is made around progression to stage 2 support and remediation.

Stage 1: Intern Support and Remediation



Stage 2 - Escalation to the Network programme director and Intern Remediation Panel

Initiation

- The second stage of the support and remediation process is instituted following escalation of the case by the network programme director to the Intern Remediation Panel (IRP). The members and responsibilities of this group are documented in **Appendix C**. Following a review of the events that resulted in commencement of stage 1 support and remediation, as well as the reasoning behind unsatisfactory completion of this programme, the IRP can advise for or against commencement of stage 2 support and remediation, at which point the network programme director can make a formal decision in this regard. This decision to commence stage 2 support and remediation is relayed to both the IRP and the Entrustment Committee.

Duration

- Stage 2 support and remediation comprises a six-month education, training and assessment process.

Implementation

- Following the decision to proceed with stage 2 support and remediation, a meeting should be arranged between the intern, the portfolio advisor and the network programme director. During this initial meeting, the intern should be informed of the need for ongoing support and remediation and made aware of the training pathway associated with stage 2 of the support and remediation process. As with stage 1, an Education and Training Plan should be availed of during the support and remediation period, and input should be obtained from the intern as to how the Education and Training Plan can best cater to their specific needs or concerns.
- Following completion of the Education and Training Plan by the network programme director, a further meeting should be arranged between the intern, the network programme director, and the supervising team consultants the intern will be affiliated with for the upcoming six months. The purpose of this meeting is to ensure clarity and satisfaction around the structure and content of the Education and Training Plan and make any necessary amendments prior to its implementation. A copy of the Education and Training Plan should be provided to the intern as a point of future reference.

Education and Training Plan for stage 2 support and remediation:

1. It should be completed by the network c programme director, following input from the intern, portfolio advisor and the IRP, as required.
2. The details of this programme should be clear and transparent and include an explanation of the reasons for failure of stage 1 support and remediation and clear documentation of those issues for which ongoing support and remediation is required.
3. It should clearly state that the intern is now undergoing stage 2 support and remediation.
4. It should detail a structured Education and Training Plan for the upcoming six months, with particular focus on the initial three months. The intern will continue to avail of their online portfolio as a means to record and monitor training and assessment. This portfolio will be routinely reviewed by the network programme director to ensure progress is being made in line with the goals defined in the Education and Training Plan. This is not a 'one-size-fits-all' model, and the Education and Training Plan can be altered according to the needs of the individual.
5. It should clearly document means of assessment during the support and remediation programme. Such assessment modalities include workplace based assessment tools for the internship programme, including direct observation, case presentation, case based discussions, team reviews and a reflective journal. Training and assessment modalities that might be availed of can be viewed within the Curriculum Framework for the Internship Programme in Ireland document.
6. It should document the frequency of meetings with the network programme director and supervising team consultant.

*** Of note, following the decision to commence stage 2 support and remediation, the overall management of the support and remediation process is now the responsibility of the network programme director, with additional input and advice from the IRP and portfolio advisor as needed.

- Stage 2 support and remediation should ideally commence at the start of a rotation to facilitate as streamlined a process as possible. Access to the listed supports is essential to ensure successful completion of this second stage of support and remediation. This will require placement in the Intern Network's main hospital, thus facilitating access to the resources and supports.

- This, however, may not be feasible in peripheral hospitals, where removal of an intern can place a significant additional burden on colleagues and teams. In such instances, the network programme director should engage with the intern's portfolio advisor and supervising consultants for the upcoming six months to facilitate the effective implementation of the support and remediation programme at that training site. To ensure continuity, the intern's allocated portfolio advisor should be their only portfolio advisor for the duration of their training and will be responsible for reporting to the Network programme director during this stage of support and remediation. However, if the intern's portfolio advisor is not available when the intern will be completing stage 2 support and remediation, the network programme director can consider involving another portfolio advisor as an additional means of support.

Support

- During the period of support and remediation, it is advisable that intern posts are equipped with the necessary resources to engage appropriately in the support and remediation process. At a minimum, such teams should have one Senior House Officer and one Registrar. If the intern is scheduled to rotate through a team that lacks such supports during the support and remediation period, consideration can be made around moving the intern to a post with such supports, while still ensuring the criteria for completion of internship and receipt of the Certificate of Satisfactory Completion of Intern Training (CSCIT) are met. The supervising team consultant will nominate a registrar to aid as a point of contact, tuition, and supervision for the intern on the ward. The registrar should be made aware of the confidential nature of the remediation programme.
- An ongoing link with occupational health physicians is important and a referral to such services should be strongly encouraged at this stage of the support and remediation process to assess other potential factors impacting on intern performance.
- As per stage 1, should the portfolio advisor and/or network programme director feel additional supportive information may be gained from speaking with the undergraduate institution the intern attended, this can be done following permission from the intern to do so. A signed and dated record of this permission should be kept.
- The intern should meet on a regular basis (e.g., every two weeks, initially) with the network programme director. The exact timeframe can be defined within the Education and Training Plan. The agreed outcomes of all such meetings should be clearly documented and added to an intern file. A review of the Education and Training Plan should take place regularly to ensure continued improvement in those areas in need of support and remediation and facilitate any necessary amendments in a timely and efficient

manner. These meetings will also offer the intern an opportunity to address any concerns surrounding the programme and/or its components.

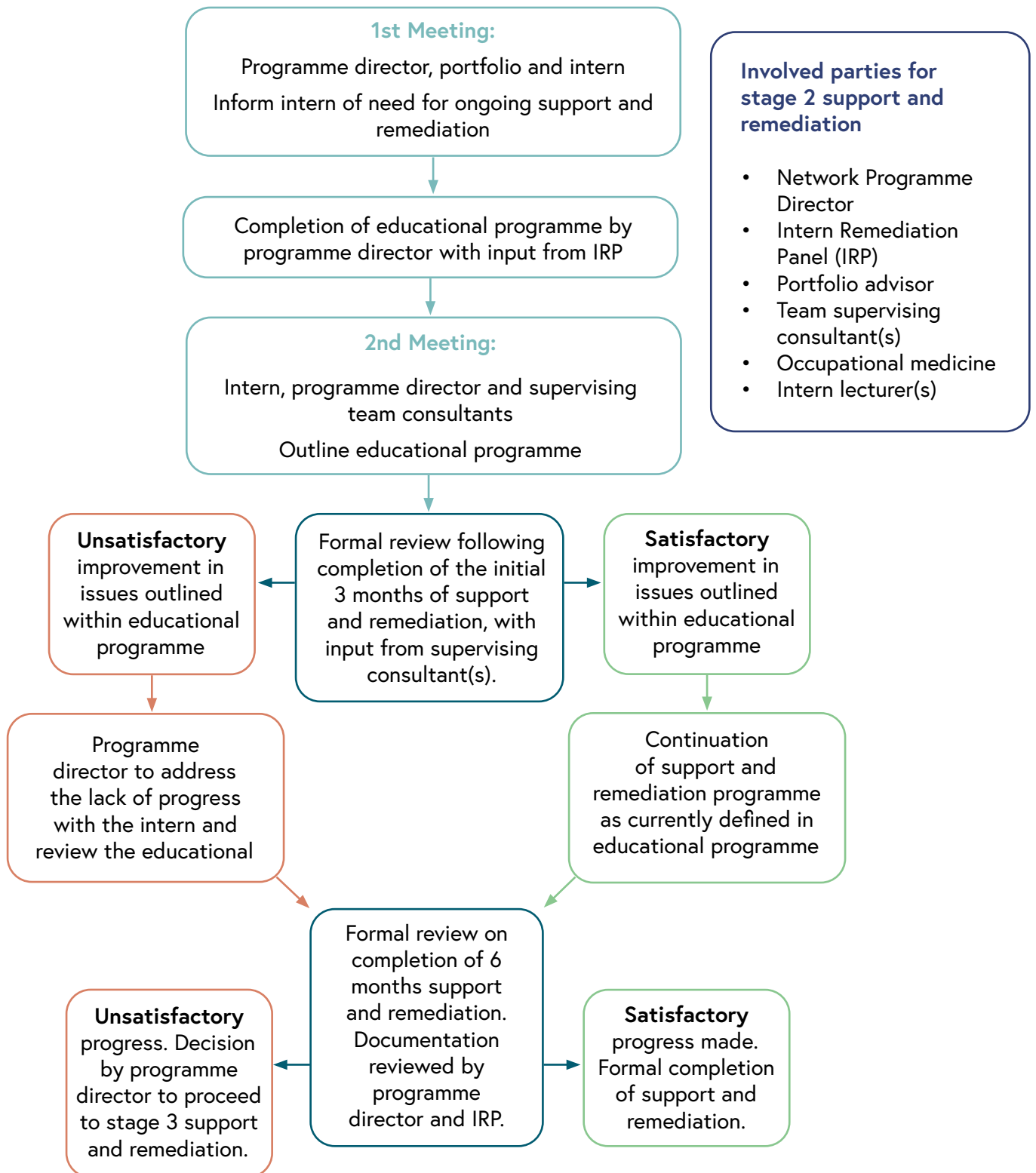
- Alongside regular meetings with the network programme director and ward-based support from the supervising team consultant(s) and allocated registrar, the intern should, where possible, be assigned an intern lecturer(s), who will meet weekly with the intern and provide additional support in the form of tuition and assessment during the remediation period. As with stage 1 support and remediation, the education and training plan should be reviewed regularly to ensure activities identified are progressing accordingly. The events of workplace based assessments should be documented in the portfolio using the workplace based assessment report forms for Case Presentation, Direct Observation or case based discussion, as appropriate.

Evaluation

- A formal review should be undertaken following the initial three months of the stage 2 support and remediation process to assess progress made to date.
 1. At this time, the network programme director should meet with the supervising team consultant(s), portfolio advisor (if they are involved) and intern lecturer(s) (if they are involved) to discuss the progress made to date, review documentation and assess areas requiring increased/continued attention. The nominated supervising team consultant for the upcoming rotation should also attend this meeting and be updated on the support and remediation case and its progress by those present. A meeting should then be arranged with the involved intern to discuss areas requiring continued improvement and answer any queries the intern may have. If the degree of improvement has been found to be suboptimal, or performance issues have worsened, the network programme director should highlight this to the intern and try to help them understand why this has been the case. Concerns and/or issues around the programme structure should be taken into consideration and amendments made to the Education and Training Plan as appropriate to facilitate optimal outcome from the remaining period of support and remediation. Following this meeting, the network programme director should inform the IRP of the progress the intern has made to date and obtain additional input from the panel if needed. Any other issues separate to the programme structure that arise should be dealt with in whatever manner the network programme director deems most appropriate.

2. If a satisfactory degree of improvement is evident, the Education and Training Plan can continue as initially defined. Of note, if the intern was otherwise scheduled to complete a rotation in a peripheral site within the network, consideration can be made at this stage to allow the intern to complete the final three months of remediation at that site, under continued supervision from their portfolio advisor. As the process continues and the intern becomes increasingly competent, should no further issues arise, the frequency of meetings with the network programme director /supervising consultant/lecturer(s) can become less frequent. The role of such individuals during this time can begin to shift to a supportive role, facilitating increased independence in practice for the intern.
 3. If the decision was made for stage 2 support and remediation to take place outside the networks tertiary centre, and on completion of the three-month review it becomes apparent that the progress made to date has been suboptimal, or indeed the performance issues have worsened, strong consideration should be given to moving the intern to the networks tertiary centre for the final three-month period of the stage 2 process.
- A further review should be undertaken at the end of the six-month period, involving the network programme director, the supervising consultants, the portfolio advisor (if they are involved) and intern lecturer(s) (if they are involved). During this review, a discussion should be had around the interns' progress and an opinion sought as to whether the intern can safely complete the support and remediation process and proceed with training. Prior to this meeting, all documentation of encounters between the intern those involved in the stage 2 process should be reviewed by the network programme director.
 - The opinions of those involved in the stage 2 support and remediation process, as well as the relevant supporting documentation, should then be brought by the network programme director to the IRP, who should advise around whether remediation of the individual can be safely completed or whether there is a need for ongoing intervention and support.
 - The network programme director, following input from the IRP, will then decide to formally end the support and remediation process or progress to stage 3 support and remediation. This decision is relayed to the IRP and the Entrustment Committee.
 - This decision is relayed by the network programme director to the intern.

Stage 2: Intern Support and Remediation



Management of Stage 2 support and remediation identified beyond the second rotation

- In cases where individuals are identified as requiring stage 2 support and remediation after the second rotation (i.e., following completion of at least six months of internship), this should be discussed with the IRP. While a six-month remediation period for stage 2 is desirable to ensure optimal completion of training goals, in cases such as this, the Education and Training Plan can be altered (if appropriate) to target completion of training within the confines of the standard internship, while simultaneously ensuring that a minimum period of at least three months remediation is completed. Upon completion of this abridged period of remediation, if the intern has achieved the goals outlined within the Education and Training Plan and no interval issues arise, following successful completion of the remainder of their internship training, they can proceed to be granted a CSCIT.
- It should be noted that such cases are not desirable and, as stated previously, all endeavours should be made to identify individuals requiring remediation at as early a stage as possible during internship, via escalation by supervising consultant(s), poor intern feedback, etc. Some factors to consider when managing cases such as this include:
 1. Whether the intern being remediated can reasonably complete the goals of training outlined within the Education and Training Plan during this shortened remediation period or whether it is determined that a further period of training will be required. In such cases, a full six-month Education and Training Plan should be instituted, and arrangements should be made to extend training.
 2. Increased frequency of meetings with the network programme director and review of the Education and Training Plan to ensure optimal effectiveness in management of the outlined issues during this shortened period of remediation.

Management of on-call duties during stage 2 support and remediation

- Decisions around on-call duties for interns engaged in stage 2 must be made by the portfolio advisor, the supervising consultant and the network programme director, with additional input from the IRP as necessary. Options to consider are outlined below:
 1. The network programme director can avail of a 'buddy system'. Following commencement of the support and remediation programme, the intern may continue to complete on-call duties but will shadow another buddy 'intern-on-call' for a period

of six weeks. This buddy may be a senior house officer, intern lecturer or registrar, but may not be a fellow intern. Following this initial six-week period, and if no interval issues arise, the roles should be reversed, with the buddy individual then shadowing the intern being supported and remediated for a period of six weeks. During this initial period, the intern should partake in daytime call only and at most once per week. The nominated buddy will be selected by the network programme director. It is important that the intern buddy be informed of the highly confidential nature of the support and remediation process and maintain this both throughout and after the period of supervised training. Following completion of the three-month buddy system and a review of the progress made, if deemed appropriate by the network programme director, the intern can resume on-call duties independently.

2. The intern can be removed from on-call duties during the initial three months of the support and remediation process, ensuring focus is maintained wholly on the issues being addressed. Following the three-month review, should the relevant senior clinicians and network programme director feel the progress made to date has been sufficient and no safety concerns are present, the intern may resume on-call duties. At this stage, a buddy system (as described in option 1) might be availed of, or a gradual re-introduction to on-call duties (i.e., daytime call only for the initial period), if felt appropriate by the network programme director.

Stage 3: Intern Remediation

Initiation

- Should an intern fail to make satisfactory progress during stage 2 support and remediation, following discussion and consultation with the IRP, a decision can be made by the network programme director to proceed to stage 3 support and remediation. This decision is relayed to the IRP and the Entrustment Committee.

Duration

- A further period of support and remediation of minimum six months and extending to a maximum of 24 months post-commencement of internship (i.e., a further 12 months maximum beyond completion of a standard intern year) can now be implemented. It is important to note that at this stage of support and remediation, an extension of training will be required.

Implementation

- Stage 3 support and remediation should take place in the network's main hospital, facilitating access to the resources and supports required to ensure successful completion of the training programme.
- Following the decision to commence stage 3 support and remediation, the network programme director should meet with the involved intern and inform him/her of said decision. It is important to note the potential ramifications such a decision will have for the intern from a mental well-being point of view and as such, occupational health physicians can play an important role in this stage of support and remediation and their input should be strongly encouraged, if not already sought in prior stages of support and remediation. As with stages 1 and 2, consideration should be given to referral to a general practice by occupational medicine should relevant concerns exist.
- Stage 3 support and remediation should continue to avail of an Education and Training Plan defining timelines, training plans and means of assessment. The Education and Training Plan should be amended from that of stage 2 support and remediation and highlight those areas in which continued deficits exist. Further attention should be given as to how best to manage tuition and assessment following input from the intern, intern lecturer(s), supervising consultant(s), network programme director and IRP.
- Education and Training Plan for stage 3 support and remediation:
 - ▶ It should be completed by the programme director, following input from the intern, stage 2 supervising consultants and IRP. Additional input may be sought from intern lecturer(s), portfolio advisor(s) and occupational medicine, if felt necessary by the programme director.
 - ▶ As with stage 2, the details of the Education and Training Plan should be clear and transparent and include an explanation of the reasons for unsatisfactory completion of stage 2 support and remediation and clear documentation of those issues for which ongoing support and remediation is required.
 - ▶ It should clearly state that the intern is now undergoing stage 3 support and remediation.
 - ▶ It should detail a structured training plan for the upcoming period of support and remediation. During this time, the intern will continue to avail of their online portfolio as a means to record and monitor training and assessment. This portfolio will be routinely

reviewed by the network programme director to ensure progress is being made in line with the goals defined in the Education and Training Plan.

- ▶ The Education and Training Plan, as per stage 2, should clearly document means and frequency of assessment during the support and remediation process.
 - ▶ It should document the frequency of meetings with the network programme director and supervising team consultant. In the initial period of stage 3 of the support and remediation process, meetings should be held on a regular basis to ensure continued progress and address any issues arising with tuition, assessment and/or the Education and Training Plan in a timely manner.
 - ▶ Once completed, a copy of the Education and Training Plan should be given to the intern.
-
- Decisions regarding rotations the intern should undertake should be made by the network programme director with input from those supervising consultants involved in the stage 2 support and remediation process, as well as any other services that have been employed in the support and remediation process to date (occupational medicine, educational psychology, etc.).
 - On-call duties should adopt a similar approach to stage 2. It is important to remember that, to be granted a CSCIT, an intern must complete on-call duties in a competent and independent manner.
 - During stage 3 support and remediation, the intern should be placed on posts equipped with the resources to engage appropriately in the support and remediation process. To that end, posts should be identified and resourced accordingly for this purpose following the decision to commence stage 3 support and remediation. At a minimum, teams should have one senior house officer and one registrar. The supervising team consultant will nominate a registrar to aid as a point of contact, tuition, and supervision for the intern on the ward. The registrar should be made aware of the confidential nature of the remediation programme.
 - Additional tuition and support should be provided by intern lectures, who should meet at a minimum once weekly with the intern, as in stage 2.
 - An ongoing link with occupational health physicians is important and a referral to such services should be strongly encouraged at this stage of the support and remediation

process, if not previously done, to assess for other potential factors impacting on intern performance.

- As per stage 1 and 2, should the network programme director feel additional supportive information may be gained from speaking with the undergraduate institution the intern attended, this can be done following permission from the intern to do so. A signed and dated record of this permission should be kept.
- Clear documentation of all meetings with the intern, as well as training and assessment.

Support

- During stage 3 support and remediation, the intern should be placed on posts equipped with the resources to engage appropriately in the support and remediation process. To that end, posts should be identified and resourced accordingly for this purpose following the decision to commence stage 3 support and remediation. At minimum, teams should have one senior house officer and one registrar. The supervising team consultant will nominate a registrar to aid as a point of contact, tuition, and supervision for the intern on the ward. The registrar should be made aware of the confidential nature of the remediation programme.
- Additional tuition and support should be provided by intern lectures, who should meet at minimum once weekly with the intern, as in stage 2.
- An ongoing link with occupational health physicians is important and a referral to such services should be strongly encouraged at this stage of the support and remediation process, if not previously done, to assess for other potential factors impacting on intern performance.
- As per stage 1 and 2, should the network programme director feel additional supportive information may be gained from speaking with the undergraduate institution the intern attended, this can be done following permission from the intern to do so. A signed and dated record of this permission should be kept.

Evaluation

- A formal review by the network programme director and IRP should be undertaken approximately halfway through stage 3 of the support and remediation period. This meeting should involve a review of the intern's portfolio and assess progress made to date based on training encounters, input from supervising consultants, team review, etc. The Education and Training Plan should be reviewed, and consideration should be given to alterations, as deemed necessary, based on the progress made by the intern. The outcome of this meeting should be relayed to the intern by the network programme director along with any proposed changes to the Education and Training Plan.
- A formal review by the network programme director and IRP should be undertaken approximately halfway through stage 3 of the support and remediation period. This meeting should involve a review of the intern's portfolio and assess progress made to date based on training encounters, input from supervising consultants, team review, etc. The Education and Training Plan should be reviewed, and consideration should be given to alterations, as deemed necessary, based on the progress made by the intern. The outcome of this meeting should be relayed to the intern by the network programme director along with any proposed changes to the Education and Training Plan.
- Following this review process, the IRP must decide on the outcome of the support and remediation process. If the progress has been satisfactory, a decision is made to formally end the support and remediation process and satisfactory completion of stage 3 is issued. This decision is relayed to the intern, the portfolio advisor, the network programme director, the National programme director and the Entrustment Committee.
- If it is decided that the progress made by the intern during the support and remediation period has been unsatisfactory, a decision is made by the IRP to permanently terminate intern training. The decision to terminate intern training must be relayed to the intern, the portfolio advisor, the network programme director, the National programme director and the Entrustment Committee.

At the end of training, following satisfactory completion of the support and remediation process and successful completion of the remainder of their internship training as determined by the Entrustment Committee, the intern can be awarded a Certificate of Satisfactory Completion of Intern Training (CSCIT) as defined by the Irish Medical Council and Curriculum Framework for the Internship Programme in Ireland.

Appeals process

- If, on completion of stage 3 support and remediation, there is a recommendation that the intern has not satisfactorily completed their training and subsequently should not be issued with a Certificate of Satisfactory Completion of Intern Training, the intern has a right to appeal the recommendation.
- To make an appeal, the intern must submit a written application to the IRP, no later than 21 working days after the date they have been informed of the recommendation which is the subject of the appeal. The IRP should forward a copy to the Network programme director, National programme director and the Entrustment Committee.
- An Advisory Group should then be convened consisting of a minimum of two representatives from the IRP and Entrustment Committee, a representative from the employer's HR Department and a representative from the Irish Medical Council. A nominee from the university or medical school which awarded the intern's basic medical qualification may also be appropriate.
- The intern may invite a union representative or another individual to attend during this meeting.

The Advisory Group will consider all the evidence available and may ask for additional information to be presented from those individuals involved in the support and remediation process. The advisory group will report to the Entrustment Committee, who in turn will report the outcome of the appeal in writing to the intern, the National programme director the Network programme director and the Irish Medical Council for future reference.

Appendix A to Support and remediation process

Please see below examples of issues that may warrant consideration around commencement of stage 1 intern support and remediation:

- Difficulty in organisation and prioritisation of tasks and responsibilities
- Issues with verbal and/or written communication with other colleagues
- Issues with requesting patient investigations
- Issues in documentation of ward round notes
- Issues in efficient and safe completion of procedural skills
- Issues with time management
- Deficits in clinical knowledge that can be addressed over a six-week period
- Issues with aspects of professionalism that can be addressed in a six-week period e.g.:
 - ▶ Poor punctuality
 - ▶ Failure on at least three occasions to attend mandatory, protected teaching without a reasonable excuse
 - ▶ Disrespectful language towards colleagues or patients
 - ▶ Persistent failure to carry out tasks requested by senior members of the medical/surgical team

The following are examples of scenarios that would warrant consideration of immediate commencement of stage 2 intern support and remediation.

- A multitude of concurrent issues in intern performance which cannot be addressed over the course of a six-week period - these may include deficits in knowledge and skillset combined with issues in professionalism
- Marked deficits in clinical knowledge threatening Patient safety
- Behavioural issues which threaten Patient safety
- Significant issues with professionalism such as harassment, inappropriate actions towards colleagues or working under the influence of alcohol or drugs

Appendix B to Support and remediation process

Education and Training Plan for Stage 1 Intern Support and Remediation

(The following fields will be included in an electronic version of this document)

Intern name: MCRN: Current training hospital:

Initial meeting date: Support and remediation commencement date: Date for follow-up meeting on completion of support and remediation:

Portfolio advisor: Current team intern affiliated with: Supervising team consultant:
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IMC domains of professional practice	Issue(s) identified
Patient safety, quality of patient care	
Relating to patients	
Communication & interpersonal skills	
Collaboration & teamwork	
Management (incl. self-management)	
Scholarship	
Professionalism	
Clinical skills	

Issues identified concerning A RICH attributes	
Agency	
Reliability	
Integrity	
Capability	
Humility	

Action plan

Supervising team consultant comments

Portfolio advisor comments

Outcome of support and remediation process
Completion: Progression to stage 2:

Intern	
Name (print):	
Intern signature:	
MCRN:	
Date:	

Portfolio Advisor	
Name (print):	
Intern signature:	
MCRN:	
Date:	

Education and Training Plan for Stage 2 Intern Support and Remediation

(The following fields will be included in an electronic version of this document)

Intern name: MCRN: Current training hospital: Dates of stage 1 remediation:
--

Meeting date: Support and Remediation commencement date: Training site(s) in which support and remediation will take place: 3-month review date: Review date at completion (6 months):
--

Network Programme Director: Team intern will be affiliated with: Supervising team consultant:

Please document reasons for unsatisfactory completion of stage 1 support and remediation.

IMC domains of professional practice	Issue(s) identified
Patient safety, quality of patient care	
Relating to patients	
Communication & interpersonal skills	
Collaboration & teamwork	
Management (incl. self-management)	
Scholarship	
Professionalism	
Clinical skills	

Issues identified concerning A RICH attributes	
Agency	
Reliability	
Integrity	
Capability	
Humility	

Action plan

- Frequency of meetings with network programme director: - Frequency of meetings with supervising team consultant: - Assigned supervising registrar: - Intern lecturer(s) involved in training: - Will the intern be continuing on-call duties? Yes: ___ No:___

Training plan

Assessment structure:
1) How often will the intern be assessed? 2) Who will be involved in intern assessment? 3) How will the intern be assessed?

Additional details/comments:

Formal review at 3 months:

Supervising team consultant progress notes

Network programme director progress notes

Changes to educational training plan

Network programme director	Intern
Name	Name
Signature	Signature
MCRN	MCRN
Date	Date

Formal review on completion six (6) months support and remediation:

Supervising team consultant progress notes

Network programme director progress notes

Recommendation of intern remediation panel

Network programme director	Intern
Name	Name
Signature	Signature
MCRN	MCRN
Date	Date

Additional details/comments:

Education and Training Plan for Stage 3 Intern Support and Remediation
(The following fields will be included in an electronic version of this document)

Intern name: MCRN: Current training hospital: Dates of stage 1 remediation:
--

Meeting date: Support and remediation commencement date: Duration of support and remediation period: Training site(s) in which support and remediation will take place: Mid-point review date: Review date at completion:
--

Network Programme Director: Team intern will be affiliated with: Supervising team consultant:

Please document reasons for unsatisfactory completion of stage 2 support and remediation.

IMC domains of professional practice	Issue(s) identified
Patient safety, quality of patient care	
Relating to patients	
Communication & interpersonal skills	
Collaboration & teamwork	
Management (incl. self-management)	
Scholarship	
Professionalism	
Clinical skills	

Issues identified concerning A RICH attributes	
Agency	
Reliability	
Integrity	
Capability	
Humility	

Action plan
- Frequency of meetings with network programme director: - Frequency of meetings with supervising team consultant: - Assigned supervising registrar: - Intern lecturer(s) involved in training: - Will the intern be continuing on-call duties? Yes: ___ No: ___

Training plan:

Assessment structure:
1) How often will the intern be assessed? 2) Who will be involved in intern assessment? 3) How will the intern be assessed?

Additional details/comments:

Formal mid-point review:

Supervising team consultant progress notes

Network programme director progress notes

Changes to educational training plan

Network programme director	Intern
Name	Name
Signature	Signature
MCRN	MCRN
Date	Date

Formal review on completion of stage 3 support and remediation:

Supervising team consultant progress notes

Network programme director progress notes

Recommendation of intern remediation panel

Network programme director	Intern
Name	Name
Signature	Signature
MCRN	MCRN
Date	Date

Additional details/comments:

Appendix C to Support and remediation process

Intern Remediation Panel (IRP)

- The Intern Remediation Panel (IRP) constitutes a subcommittee of the Entrustment Committee set up for the purpose of consulting and advising on periods of intern support and remediation for individuals whose clinical and/or professional deficits have failed to be resolved during stage 1 support and remediation. As such, the IRP should only become involved in intern support and remediation if an intern requires stage 2 support and remediation. As such, the IRP will meet only when cases of stage 2 support and remediation arise. In such circumstances, the training body will convene within two weeks of referral.
- In cases where additional advice is felt necessary by the programme director (e.g., at the request of a portfolio advisor during stage 1 support and remediation), the IRP can and should be consulted, regardless of the stage of support and remediation. The IRP can in turn seek counsel from the Irish Medical Council in cases where uncertainty remains regarding appropriate management of support and remediation cases.
- The panel should include representatives from the Entrustment Committee who are directly involved in intern training. It can also recruit the services of clinical psychologists, educational psychologists, additional experts in medical education, counsellors or other specialty services that are deemed necessary as part of the support and remediation programme.
- In situations where an intern does not satisfactorily complete stage 1 support and remediation, the case should be escalated by the programme director to the IRP, who, by virtue of their shared experience in the management of intern training, will advise to proceed or withhold commencement of stage 2 support and remediation. Such advice is delivered following an extensive review of previous documentation from the stage 1 process with additional input as required from those involved in the support and remediation programme to date (portfolio advisor, supervising consultant, etc.). The IRP serves to support both interns and programme directors and standardise the training process on a national level through ensuring support and remediation cases follow a consistent pathway. Their shared experience will continue to aid in the management of future challenging cases of intern support and remediation.

- Should an intern not satisfactorily complete stage 2 support and remediation, the IRP can advise progression to stage 3 remediation. Such advice is delivered following extensive review of previous documentation from stage 1 and 2 support and remediation.
- If continued issues arise or it is felt on completion of this period of support and remediation that deficits still exist, the IRP, on further review of the case with supporting documentation and consultation, will move to permanently terminate training for the involved intern. This decision is relayed to the intern, the National programme director, the Medical Intern Unit and the Irish Medical Council.

Appendix D to Support and Remediation process

References

- The Medical Protection Society

<https://www.medicalprotection.org/uk/hub/education>

- The British Medical Journal

https://learning.bmj.com/learning/course-intro/communication-skills.html?courseId=10063160&locale=en_GB

https://learning.bmj.com/learning/course-intro/.html?courseId=10060271&locale=en_GB

- The American Board of Internal Medicine

<https://www.abim.org/program-directors-administrators/assessment-tools/mini-cex.aspx>

Appendix G

Preparation for Implementation

1	Introduction
2	Piloting Task and Finish Group: Terms of Reference
3	Development work and consultation required in advance of piloting

1. Introduction

Prior to national implementation of the Curriculum Framework, systematic piloting will be essential to determine feasibility, acceptability and resourcing requirements. Piloting can also help identify challenges associated with the changes in culture and practice involved for interns, supervisors and assessors and ways to address them.

The **Curriculum Framework Piloting Task and Finish Group** was established in December 2022 by the Medical Intern Board. Its purpose was to provide a collaborative forum of relevant expertise to devise a strategy for the piloting of elements of the Curriculum Framework and to report to the Medical Intern Board with a proposed strategy, including criteria for prioritisation.

The group was tasked with:

- Identification of priority areas for piloting of the Curriculum Framework
- Providing guidelines on aspects of the Curriculum Framework being piloted
- Ensuring a coordinated and coherent approach
- Identifying the resource requirements for piloting activities
- Suggesting projects as potential areas for NDTP development funding

Criteria for membership of the Task and Finish group were circulated to relevant stakeholders (INE, IMSC, PG forum and interns) who were invited to submit a small number of names of those interested in participating in and willing to commit to effective engagement in the work of the group.

The group was formed from those nominated, taking account of the need for balance e.g., in experience, expertise, current/recent roles, gender and geography. The group included representation from the following:

- National Doctors Training and Planning, Medical Intern Unit
- Intern network coordinators
- Consultant Intern tutors (hospital-based)
- Intern lecturers (network-based)
- Intern network administrators
- Interns/NCHDs
- Postgraduate training bodies
- Medical educationalist
- Initial EPA development team

Piloting activities are designed to evaluate the feasibility and practicality of implementing the provisions of the Curriculum Framework. Aspects for piloting are those prioritised by the Task and Finish Group. Such activities do not constitute 'research' requiring ethical approval. In all cases, piloting includes conducting evaluation of and reporting on the process and outcome of the piloting.

The Piloting Task and Finish Group met monthly, December 2022 - June 2023, under the chairperson, Dr. Gozie Offiah. The report was presented to the Medical Intern Board, with priority themes for piloting, in July 2023 and approved. The themes identified will form the basis for Piloting of the Curriculum Framework.

Membership:

Dr. Gozie Offiah	MIU/NDTP	Project lead
Prof. Donal O'Shea	DML/UCD	Intern Network Coordinator
Dr. Ruth Pilkington	DML/UCD	Medical Doctor, Beacon Hospital
Dr. Caoilfhionn O'Donoghue	DML/UCD	Consultant physician and Geriatrician, Colmcille Hospital
Dr. Elaine Burke	DSE/TCD	Research Fellow
Dr. Niamh Coakley	STH/UCC	Senior Lecturer
Evan Blake	DSE/TCD	Intern Network Administrator
Dr. Orla Mongan	WNW/University of Galway	Intern Network Coordinator
Dr. Karena Hanley	Postgraduate Training Bodies representative	National director innovation in GP training, ICGP
Prof. Dara Byrne	Evaluation/QI	Professor of simulation education in healthcare, University of Galway

Dr. Josephine Boland	MIU team	Medical Educationalist
Prof. Declan de Freitas	DNE/RCSI	Consultant Nephrologist and Intern Tutor Beaumont Hospital
Dr. Tommy Tun	DNE/RCSI	Consultant Endocrinologist and Intern Tutor Connolly Hospital
Dr. Ellen Walsh	NCHD representative	SPR, University Hospital Galway

2. Piloting Task and Finish Group: Terms of Reference

The purpose of the Task and Finish Group is to provide a collaborative forum of relevant expertise to devise a strategy for the piloting of elements of the Curriculum Framework and to report to the Medical Intern Board with a proposed strategy, including criteria for prioritisation.

1. Chairpersons and Membership

Chairperson: Clinical Lead Medical Intern Unit

The chairperson is responsible for coordinating the meetings and ensuring the Task and Finish remains on task and within its remit.

2. Membership of the group

Criteria for membership of the Task and Finish group was circulated to relevant stakeholders (e.g., INE, IMSC, PG forum and interns) who were invited to submit a small number of names of those interested in participating in and willing to commit to effective engagement in the work of the group.

The group has been formed from those nominated, taking account of the need for balance, e.g., in experience, expertise, current/recent roles, gender and geography.

The group includes representation from the following:

- National Doctors Training and Planning, Medical Intern Unit
- Intern network coordinators
- Consultant intern tutors (hospital-based)
- Intern lecturers (network-based)
- Intern network administrators
- Interns / NCHDs

- Postgraduate training bodies
- Medical educationalist
- Initial EPA development team

Appointments to the group shall be for the period of six months, up until July 2023.

Additional members may be co-opted onto the group as deemed necessary. The Chair of the Medical Intern Board shall attend the first meeting of the group, to welcome and brief the group. The MIB chair is not a member of the group.

3. Secretary of the group

Section officer of the Medical Intern Unit

The Secretary of the Task and Finish Group will ensure that the group receives information and papers in a timely manner to enable full and proper consideration to be given to the issues.

4. Frequency of Meetings

The Task and Finish Group shall meet at least once per month and as otherwise required and agreed.

Meetings will be held online, using TEAMS.

5. Notice of Meetings

Meetings of the group shall be arranged by the Secretary of the group at the request of the Chairperson. Unless otherwise agreed, notice of each meeting confirming the time and date together with an agenda of items to be discussed, shall be forwarded to each member of the group (and any other person invited to attend) no later than three working days before the date of the meeting.

Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

The Secretary of the Task and Finish Group shall minute the proceedings and resolutions of all meetings including recording the names of those present and in attendance. Minutes of the meetings shall be circulated to all members.

7. Duties

Objectives

A piloting strategy for the Curriculum Framework will involve a range of coordinated pilot studies carried out over a period of time, commencing July 2023, that contribute to evaluating feasibility and planning for implementation of the framework. Piloting activities can be carried out at a range of scales, from local to national and on a range of levels e.g., by a clinical team or service, a hospital or a network.

The purpose of the Task and Finish Group is:

- Identify priority areas for piloting of the Curriculum Framework
- Provide guidelines on aspects of the Curriculum Framework being piloted
- Ensure a coordinated and coherent approach
- Identify the resource requirements for piloting activities
- Suggest projects as potential areas for NDTP development funding

Responsibilities

The Task and Finish Group shall be fully informed about the Curriculum Framework and will keep itself up to date and fully informed about strategic issues and changes affecting the project.

The group may, from time to time, establish sub-groups as are necessary to assist it in the performance of its duties. They may include additional members if specialist skills are required.

Where a sub-group is put in place the Task and Finish Group shall receive regular reports from such sub-group.

8. Reporting Responsibilities

The Task and Finish Group shall keep the Medical Intern Board informed of matters arising. The final report will be submitted to the Medical Intern Board no later than July 2023.

9. Other

The Task and Finish Group shall, within the six-month period, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and implement any changes it considers necessary.

3. Development work and consultation required in advance of piloting

In the course of the deliberations of the Curriculum Framework Piloting Task and Finish Group and arising in the review of feedback from the consultation process, it was clear that some development work, scoping and consultation needs to be carried out in preparation for the piloting process. In each case the body/bodies responsible for leading the work are identified.

(i) Select a vendor for the development of the web-based portfolio and mobile app for intern assessment

This will be undertaken by the Medical Intern Board in collaboration with the NDTP. It will involve briefing potential vendors on the context of the internship, the provisions for programmatic assessment within the Curriculum Framework and the functionality required for an IT system to implement it. A vendor will be selected in accordance with HSE/NDTP procurement procedures.

(ii) Develop a web-based portfolio and mobile app for intern assessment

This development work will be commissioned by the NDTP, in accordance with HSE/NDTP procurement procedures. It will be carried out by the successful applicant in collaboration with the IT developer selected by the MIB/NDTP and in consultation with stakeholders and users of the system. Significant preparation work has been undertaken to brief those undertaking this development work (with guidelines on the design of the workplace based assessment report form provided in this Appendix)

(iii) Consultation with other health professionals

To achieve the proposed involvement of other health professionals e.g., nursing, pharmacy in the conduct of workplace based assessments it will be necessary to:

- Engage and consult with relevant professional bodies
- Explore how other health professionals can be recruited and supported

This consultation will be led by the Forum of Postgraduate Training Bodies as part of its strategy for a multidisciplinary approach to training.

(iv) Clarify who can undertake the role of the Portfolio Advisor

The role of Portfolio Advisor will be a matter for further consultation with intern networks and NDTP. This will be led by the MIU in consultation with the INE and the NDTP. This will involve:

- Clarifying who is eligible to be a Portfolio Advisor (PA)
- Exploring various ways in which the role can be filled within a network, ideally with a PA assigned to an intern for the entire year.
- Considering how the role of the PA is to be resourced (e.g., remuneration, back-filling) and explore non-monetary ways of recognising and rewarding the role
- Developing general guidelines for the conduct of Progress Reviews

(v) Determine details for Entrustment Committees (ECs)

Details of the functioning of ECs within each network (e.g., composition, governance, procedures and processes) are to be developed in consultation with the training programme providers. This will be led by the MIU in consultation with the INE. This will involve:

- Researching international best practice in Entrustment/Clinical Competence Committees
- Developing national standards and procedures for Entrustment Committees for the internship programme (including terms of reference and description of roles)
- Exploring ways of reviewing interns' portfolios using a qualitative approach to making entrustment decisions as a binary decision i.e., meets criteria for entrustment or not
- Determining the weight to be afforded to data from different sources (e.g., individual routine WBAs, results from Team Reviews and Progress Reports and other sources) which can facilitate A RICH entrustment decisions.

Appendix H

The workplace based assessment report form

1	Introduction
2	The design of the WBA Report Form on the App
3	Specification for WBA report form and rationale
4	The fields for a WBA report form
5	Use of entrustment supervision levels

1. Introduction

The workplace based assessment report paper-based form was reviewed in light of the field testing carried out in 2019. The report form was revised in 2022-23, in a consultative process, to align it with the provisions of the Curriculum Framework. This design will inform its development as an App. The guidelines for the use of entrustment levels when conducting workplace based assessments were also revised to reflect the provisions of the finalised Curriculum Framework.

2. The design of the WBA Report Form on the app

The WBA report form is designed to:

- Facilitate early piloting of the workplace based assessment (WBA) process
- Explore the acceptability and feasibility of certain fields and features during the piloting process
- Provide the user with guidance on fields to be completed e.g., the entrustment supervision scale, domains in the BE pillar of the curriculum)
- Facilitate monitoring of performance by the intern's portfolio advisor
- Gather data that can support summative entrustment decision-making by an Entrustment Committee (this data will be anonymised in the piloting phase)
- Gather data that can contribute to the evaluation of the pilot

The proposed design of the WBA report form has been informed by:

- Lessons from the field-testing process of EPA observation and review tools (2019)
- Considerations by the Piloting Task and Finish Group
- Recent developments in best practice in EPA-based assessment

- Recommendations from the external reviewers and other feedback
- The need to gather data that will contribute to the evaluation of the pilot

Arising from a review of the proposed data fields and guidelines for the workplace based assessment report form (2023) by the MII/NDTP team and the Piloting Task and Finish Group, a number of points were noted. These include the following:

- The app should facilitate multiple, short, low-stakes assessments carried out by a range of health professionals
- The low-stakes nature of any single WBA should be evident to all users i.e., it reports on an **individual** observation/presentation/discussion and does not reflect an intern's competence and the level of supervision needed for that EPA
- The WBA report form should be capable of being completed on either the intern's or the assessor's device
- Voice recognition would facilitate ease of completion
- Include the MC domains (from the BE pillar) to gather narrative feedback on domain/s where relevant
- Include intern self-assessment of performance including the supervision level they believe they needed
- Use a retrospective scale when assessors indicate supervision level (on a direct observation and case presentation)
- Include option of using a prospective scale in a case based discussion (where it is feasible for the assessor to do so)
- Avoid making the form too long e.g., advise assessors that they don't have to give feedback on ALL domains
- Consider the sequence of sections; look for global feedback first, then more detailed narrative feedback
- The WBA report used for piloting should seek information on time taken to complete it

3. Specification for WBA report form and rationale

The following specifications are relevant to the design of the app. The rationale for each data field is provided below.

- One single WBA report form can be used for any of the routine WBAs which involve observation or review of an intern's performance by an individual assessor, namely:
 - ◊ Direct observation
 - ◊ Case presentation
 - ◊ Case based discussionand carried out with respect to any single EPA.

Rationale:

- ▶ These are the priority for piloting.
 - ▶ A separate tool (web-based or mobile app) will be developed to capture data from Team Reviews, which are not specific to any single EPA.
- A separate WBA report form should be used if more than one EPA has been observed/ reviewed, with any feedback recorded in relation to another EPA recorded on another report form.

Rationale:

- ▶ Each completed WBA needs to be tagged to an EPA for the purpose of collating evidence of performance. That collection of data (in a portfolio) will support summative entrustment decision-making by Entrustment Committee (EC) per individual EPA.
 - ▶ Assessors are expected and encouraged to focus on a specific EPA when giving feedback on individual low-stakes assessments.
- Clinical context is recorded. Sampling across clinical contexts will be something a portfolio advisor will advise on and that the EC will consider when making summative entrustment decisions.
 - Complexity of case is recorded. This provides valuable information to aid interpretation of the outcome of WBAs in a qualitative approach to summative entrustment decision-making. It is also designed to encourage interns to select complex as well as routine cases on which to receive feedback.
 - The assigning of an entrustment supervision level by the assessor makes provision for both a retrospective judgement (required) and a prospective judgment (where possible).

- ◇ *A retrospective judgment*: the level of supervision the intern needed for that case/task/procedure. This does not necessarily reflect upon the intern's ability to carry out the activity in future.
- ◇ *A prospective judgement*: the level of supervision the assessor believes an intern would require if undertaking a similar task/case/procedure again (where it is possible to judge that).

Note: If level 4 is indicated, this does not necessarily mean that an intern can perform the entire EPA independently with distant supervision – that is a summative decision by an Entrustment Committee.

Rationale:

- ▶ The piloting process provides an opportunity to determine the feasibility, acceptability and value of asking assessors to make prospective judgements.
- The WBA process and the WBA report form promote self-evaluation by the intern of their own performance, including the opportunity for them to indicate the level of supervision they felt they needed for the task/case procedure.

Rationale:

- ▶ To encourage self-evaluation and promote reflective practice
- ▶ To ascertain the level of supervision interns believe they need
- ▶ To prompt dialogue and discussion between the assessor and intern regarding any difference in their judgments of level of supervision needed
- Narrative feedback from the assessor involves identifying specific points that identify aspects of good performance and suggested areas for development. Assessors are provided with a copy of each EPA, to guide their observation and discussion and to prompt specific narrative feedback with reference to the knowledge, skills and attitudes identified for that EPA. When training assessors (especially supervising consultants) they are encouraged to comment on A RICH attributes (agency, reliability, integrity, capability, humility) where appropriate and relevant. This can be a valuable way of identifying concerns and/or providing feedback on important attributes.
- Provision is made for providing feedback about domains and competencies from within the BE pillar of the curriculum framework. Assessors are provided with themes and competencies for each domain within BE (e.g., in pop-ups) to guide that feedback. They

are guided to focus any narrative feedback on the most relevant domains only, and where relevant – not on all of them.

Rationale:

- ▶ This can be a valuable way of recording additional feedback which relates to behaviours, values and practices which are not specific to any one EPA and are not captured by Team Review.
- Provision is made for identifying any concern that should be notified to the relevant individual (the intern's supervisor, portfolio advisor or network coordinator, depending on the nature of the concern).
 - ◊ During the piloting process WBAs are "zero-stakes" and will not be used for summative entrustment decision-making. During the piloting phase, however, assessors are still responsible for notifying any serious cause for concern to the relevant individual.
 - ◊ During the piloting process remediation, where identified as necessary, will continue in accordance with prevailing practice.
- The WBA report form requires interns to respond to the feedback provided and to identify a specific learning plan. Actions taken in pursuit of specific learning plans can be reviewed by the intern's portfolio advisor and considered when preparing their progress report. In an electronic version of a WBA this section could be completed after the intern has had time to reflect on the feedback.

Rationale:

- ▶ This is an important step in promoting learning, response to feedback and action on reflection.
- The WBA form collects information on time taken to:
 - ◊ Conduct the observation/presentation/discussion
 - ◊ Have the feedback conversation
 - ◊ Complete the details on the form

Rationale:

- ▶ This is important information for the evaluation of the piloting process.

- Once the WBA report form is completed, the assessor verifies the contents and the intern agrees the contents.
 - ◊ An assessor can request an amendment prior to verifying the WBA report
 - ◊ An intern can request a review of a WBA report

Rationale:

- Verification of reports by the assessor is necessary, especially when entered on the intern's device.

Digital resources are already available to demonstrate the process of conducting WBAs and providing feedback. Guidelines will be prepared for assessors and interns on how to record details on the WBA report form.

4) The fields for a WBA report form on the App

Workplace Based Assessment Report Form (2023) For Case Presentation, Direct Observation or Case Based Discussion

Sections completed by the assessor	Sections completed by the intern
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1. Workplace based assessment (WBA) tool

Case Presentation		Direct Observation		Case Based Discussion	
-------------------	--	--------------------	--	-----------------------	--

2. Details

Intern:		Assessor:	
MCRN:		MCRN:	
Rotation:		Site:	
Stage:(Q 1,2,3,4)		Date:	

3. The EPA

EPA (tick one*)		Clinical context	
1. Clerking a patient		General Surgical	
2. Requesting and interpreting investigations		General Medical	
3. Performing essential procedural skills		Specialist case	
4. Managing the work of in-patient care		Other	

5. Prescribing and monitoring drugs and fluids		Complexity	
6. Recognising and managing the deteriorating/acutely unwell patient		Routine	
7. Handing over and discharging a patient		Complex	

***If more than one EPA is observed/reviewed then complete a separate WBA form**

4. Case/procedure/task details

Brief description of the case, procedure or task
NOTE: Do not include details which identify a patient

5. Self-evaluation

How do I feel I performed (as the intern)?

6. Feedback from assessor on performance on the EPA [Refer to relevant EPA for required knowledge, skills and attitudes]

Aspects of good performance
Suggested areas for development

7. Additional specific feedback from assessor on Domains of Good Professional Practice

This section is completed where necessary/relevant. Refer to the themes and competencies within the domains of the BE pillar of the curriculum.

Domain	Feedback
Patient safety and Quality of Patient Care	
Relating to Patients	
Communication and Interpersonal Skills	
Collaboration and Teamwork	
Management and Self-management	
Scholarship	
Professionalism	
Clinical Skills	

8. Level of supervision (See guidelines on levels overleaf)

The level of supervision.....		...that I felt I needed for this task/case/procedure (self-evaluation)	...that I felt was necessary for this task/case/procedure (retrospective)	...that I feel would be necessary for a similar task/case/procedure in the future* (prospective)
1	Pre Practice			
2	Close Supervision			
3	Indirect Supervision			
4	Distant Supervision			
5	Experienced Intern			

* a prospective judgment is made where it is possible for the assessor to do so.

9. Concerns (refer any concerns to the intern's supervisor or portfolio)

Any concerns (indicate none if n/a)

10. Intern response

My response to the feedback
My specific learning plan

11. Notes

Any other notes:

Finally, please estimate the time spent on:

	Mins
Conducting the observation/presentation/discussion	
The feedback conversation	
Completing the WBA report form	

Verified (by assessor): _____

Date: _____

Agreed (by intern): _____

Date: _____

Use of Entrustment Supervision Levels (for further elaboration during/post piloting)

		Summative Entrustment	Low-stakes formative assessments			Level indicated for the task/ procedure/ case
		At end of training or at mid-year	For individual WBA: In relation to a task/ procedure/ case			
			Examples of feedback from a supervisor			
Level	Description	In relation to an EPA Based on multiple sources of evidence By an Entrustment Committee	Direct Observation (task or procedure)	Case Presentation	CBD	Level
1	Pre Practice	Intern has the relevant knowledge and skills, but not enough to perform the activity unaided. The supervisor and intern perform the activity together.	"I had to do it with you."	"You are not ready to present this case alone"	"... you are not ready to undertake a case like this alone."	Pre Practice
2	Close Supervision	Intern may perform an activity under close, direct supervision, with the supervisor in the same room, deciding the intensity of supervision required.	"I had to talk you through the task/ procedure."	I needed to ask for clarification and check your findings	"... you could actively contribute to a case like this, with close supervision."	Close Supervision
3	Indirect supervision	The intern may perform an activity with indirect, intermittent supervision as necessary and the intern asks for supervision as required. The supervisor is available close by.	"I needed to prompt you from time to time."	"I needed to ask for some clarification"	"... you could manage a case like this with indirect supervision."	Indirect Supervision
4*	Distant Supervision	The intern may perform an activity independently with mainly informal, remote or distant supervision providing oversight. The supervisor is on site.	"you undertook this task/ procedure independently, but I was available, just in case."	"you presented this case competently and independently" or 'you managed this case independently with distant supervision'		Distant Supervision
5	Experienced	Intern may provide supervision and instruction to junior learners	"I did not need to be there and you could instruct others how to do this task/ procedure."	"... you presented this case like an experienced intern"	"you could supervise or teach a junior how to manage a case like this."	Experienced

NOTES:

Summative entrustment decisions are based on multiple sources of evidence from a number of supervisors relating to an EPA. Such decisions are made by an Entrustment Committee, not any one supervisor.

Level 4 is the threshold level of competence for an intern. Once this level is reached, the activity may be safely entrusted to the intern to carry out independently, once distant supervision is available on site, providing appropriate oversight.

Low-stakes formative assessments are carried out by multiple assessors using a number of different tools. Records of these observations of performance and reviews of practice contribute to an overall picture of an intern's developing competence over a period of time and inform the summative entrustment decision. Individually they have no immediate consequence for an intern.

- When providing feedback on an intern's performance in a **direct observation** the supervisor indicates the level of supervision the intern needed for that task/procedure. This does not necessarily reflect upon the intern's ability to carry out the activity in future.
- When providing feedback on an intern's performance in a **case presentation** the supervisor indicates the level of supervision the intern needed when presenting that case. This does not necessarily reflect upon the intern's ability to carry out the relevant activity in future.
- When conducting a **case based discussion**, the supervisor can indicate what level of supervision the intern may need a similar case in the future, based on how they demonstrate an understanding the case discussed. This does not necessarily imply that they can carry out an activity with that level of supervision.

Terminology

Activity:	The 7 EPAs
Case:	An individual patient case (e.g., an adult with acute respiratory failure)
Task:	An aspect of an EPA (e.g., to take a focussed history is one aspect of EPA 1 (Clerking a patient))
Procedure:	One of the procedures listed in EPA 3 (Performing essential procedural skills)

Appendix I

Faculty development session

During the consultation period, orientation sessions were delivered by the MIU project team and locally based facilitators from the intern training community. Participants included consultants, supervisors, NCHDs, lecturers and tutors who engage with interns. The format for these initial sessions was a small group seminar, face-to-face in the intern network hub hospital, or adjacent academic institution. Internal CPD points were awarded to participants.

The goals of the sessions were to:

- Familiarise participants with the new framework for the internship and the seven EPAs
- Introduce participants to the main tools for workplace based assessment (WBA) which they will be using (Direct Observation, Case Presentation, Case Based Discussion)
- Engage directly with those responsible for teaching and assessment of interns, to hear their views
- Explore opportunities for implementing WBA in practice in the clinical setting
- Encourage the practice of observation of interns' practice and of giving effective feedback
- Provide an overview of the vision for programmatic assessment of interns
- Generate interest in participating in further continuing professional development

These orientation sessions were offered to all Intern Networks and provide a framework for future such sessions. See **below** for an outline of a sample session.

Grand Rounds presentation:

'Are they ready?' Future models for the assessment of competencies in Medical Interns and other Training Grades'

Participants: Consultants, supervisors, NCHDs, lecturers and tutors who engage with interns

Date: 27 April 2022, 12.45- 14.00

Venue: Cork University Hospital and broadcast by TEAMS

Presenters: Liam Plant, Gozie Offiah, Natasha Slattery, Josephine Boland

Goals: The goals of the presentation were to

- Familiarise participants with the new EPA framework for the internship and the seven EPAs
- Introduce participants to the main tools for workplace based assessment

(WBA) which they will be using (Direct Observation, Case Presentation, Case Based Discussion)

- Provide participants with access to digital resources to support implementation
- Engage directly with participants, to hear their views
- Generate interest in participating in future faculty development

Workshop: Workplace Based Assessment for the Internship

Participants: Consultants, supervisors, NCHDs, lecturers and tutors who engage with interns

Format: Practical and experiential workshop with opportunity for consultation

Date: 27 April 2022, 14.00-15.30 (90 min. face-to-face workshop)

Facilitators: Liam Plant, Gozie Offiah, Josephine Boland

Goals: The goals for the session were to:

- Demonstrate good practice in conducting workplace based and providing feedback (specifically direct observation, case presentation and Case based discussion)
- Provide participants with an opportunity to provide feedback on intern performance
- Explore opportunities and challenges in implementing workplace based assessment in the internship
- Encourage the practice of routine observation and review of intern's practice and of giving effective feedback

Appendix J

Digital resources to support the modernisation of the internship in Ireland

A range of digital resources has been developed to support implementation. These are designed for use in faculty development and intern training, in face-to-face sessions, remotely and self-directed learning online. The resources include multi-media explanatory presentations on the EPA framework and on the seven EPAs for the internship, animations describing how to use the WBA tools and video demonstrations of good practice in assessing interns and giving feedback.

The resources have been created under a creative commons licence i.e., free to use for educational purposes, with the Medical Intern Unit of the NDTP, HSE acknowledged. The digital resources are hosted on the HSE YouTube Chanel and are accessible via the links below. Two infographics were produced for circulation to users of the EPA framework, to facilitate easy access to the resources via QR codes.

Entrustable Professional Activities for Internship



Introduction to the EPA Framework for the Internship Programme



Click on QR Code to view video

The internship year for training in Ireland is being modernised with a new competency-based framework of Entrustable Professional Activities (EPAs), with a set of tools for workplace-based assessment.

Entrustable Professional Activities – EPAs



Click on QR Code to view video

Entrustable Professional Activities (EPAs) are units of professional practices or essential tasks that a trainee can be trusted to perform without direct supervision, once sufficient competence has been demonstrated.

EPAs

1. Clerk a patient



2. Request and interpret basic investigations



3. Perform essential procedural skills



4. Manage the work of in-patient care



5. Prescribe and manage drugs and fluids



6. Recognise and manage the deteriorating/acute unwell patient



7. Handover and discharge patient



Workplace Based Assessment for Internship

NDIP
Medical Intern Unit
COLLABORATE EMPOWER EDUCATE



How to do a Case Based Discussion



A Case Based Discussion is a tool for reviewing a trainee's performance and providing feedback. It is a discussion between a health professional and a trainee about a selected patient case.

Case Based Discussion

DEMONSTRATION



How to do a Case Presentation



A Case Presentation is a tool for reviewing a trainee's performance and providing feedback. A Case Presentation is a formal communication between health care professionals.

Case Presentation

DEMONSTRATION



How to do a Direct Observation



A Direct Observation is a tool used by a supervisor for observing a trainee's performance of a procedure or a clinical task and providing feedback.

Direct Observation of a clinical procedure

DEMONSTRATION



Direct Observation of clinical task

DEMONSTRATION



Click on the
QR Codes to
view videos



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