Entrustable Professional Activities (EPAs) for Psychiatry

These summaries describing the various EPAs may inform entrustment decisions in the clinical workplace and feedback comments for learners.

EPA 1: Obtain a history and perform a physical examination adapted to the patient's clinical situation.

Pre-entrustable

- Misses pertinent positive or negative details that would assist with problem solving and determining the differential diagnosis when obtaining data
- Is disorganized in his/her history taking skills which is not appropriately detailed
- Performs a physical examination which is disorganized or missing components relevant to the clinical case
- Fails to establish rapport with the patient/ family /caregiver/ advocate, leading to missed data within the history or physical examination

Entrustable

- Obtains the appropriate data from the patient (family/caregiver/ advocate) for the specific patient encounter
- Establishes a rapport with the patient (family/ caregiver/advocate)
- Performs a physical exam appropriately tailored to the clinical case
- Demonstrates specific physical exam skills appropriate to the patient case
- Integrates all these elements along with other sources of information

EPA 2: Formulate and justify a prioritized differential diagnosis.

Pre-entrustable

- Relies on limited aspects of his/her assessment to generate the differential diagnosis, failing to integrate elements across the history, physical examination, and investigative studies
- Identifies one or two sensible diagnostic possibilities for clinical presentations, but misses important, common diagnoses
- Has trouble identifying the most likely etiology when a differential diagnosis is generated
- Selects differential diagnoses which typically lack adequate justification and prioritization
- Does not routinely consider determinants of health in generating or prioritizing the differential diagnosis

Entrustable

- Lists diagnostic possibilities by integrating elements from the history, physical examination, and investigative studies
- Identifies the major diagnostic possibilities for common clinical presentations
- Justifies and prioritizes a most likely diagnosis based on information from his/her clinical assessment
- Incorporates major determinants of health for the patient when generating and prioritizing the differential
- Balances the tendency to be too all encompassing yet avoids errors of premature closure

EPA 3: Formulate an initial plan of investigation based on the diagnostic hypotheses.

Pre-entrustable

- Orders tests that are not relevant or helpful in the clinical situation
- Does not discuss with patients the possible consequences of ordering certain tests
- Does not take into account the potential adverse effects of the ordered tests
- Does not justify the selection of the tests according to best practices
- Does not ensure a follow up of the tests

Entrustable

- Orders (or decides not to order) tests considering their features and limitations (e.g., reliability, sensitivity, specificity), availability, acceptability for the patient, inherent risks and contribution to a management decision
- In case of social implications of positive results, discusses the selection of the tests with patients/ family/ caregiver/ advocate when ordering them (e.g. HIV, pregnancy in an adolescent)
- Identifies levels of uncertainty at each step of the diagnostic process and do not over-investigate or under-investigate
- Chooses diagnostic interventions using evidence or best practice/ guidelines according to costs and availability of resources taking into consideration the way in which care is organized
- Identifies who will be responsible for the follow-up of the test results

EPA 4: Interpret and communicate results of common diagnostic and screening tests.

Pre-entrustable

- Is unable to recognize significant urgent or abnormal results or common normal variations in results
- Is unable to form a preliminary opinion about the significance of results
- Does not communicate significant normal or abnormal results in a timely manner to other team members
- Is unable to summarize and/or interpret the meaning of results to other team members
- Does not communicate results in a clear manner to patients (family/ caregiver/advocate)
- Does not seek help to interpret results when necessary

Entrustable

- Recognizes significant urgent or abnormal results
- Distinguishes between common normal variations in results and abnormal results
- Formulates an appropriate preliminary opinion about the potential clinical impact of results
- Communicates significant results in a timely and appropriate manner to other team members
- Summarizes and interprets the meaning of the results to other team members
- Communicates results in a clear manner to patients (family/ caregiver/advocate)
- Seeks help to interpret results when necessary

EPA 5: Formulate, communicate and implement management plans.

Pre-entrustable

- Proposes initial management plans that are inappropriately expansive or significantly incomplete in scope
- Proposes management plans that do not reflect an adequate understanding of patient's context, values and illness experiences
- Proposes management plans that lack approach, prioritization or organization
- Proposes management plans that do not take into account opinions of other healthcare professionals
- Omits pertinent information of the initial proposed plan when discussing with the more senior members of the medical team
- Incompletely or inaccurately documents approved management plans in the form written/electronic orders and prescriptions
- Incompletely or inaccurately communicates approved management plans to patients and other healthcare team members
- Does not implement management plans in the form of verbal and written/electronic orders and prescriptions in an accurate and timely manner
- Writes incomplete consults/referrals, orders or prescriptions, or that could impact patient safety

Entrustable

- Proposes evidence informed, holistic initial management plans that include pharmacologic and non-pharmacologic components developed with an understanding of the patient's context, values and illness experience
- Prioritizes the various components of the management plans
- Considers other health care professionals advice in proposing a management plan
- Reviews the initial plan with more senior team members to formulate an approved management plan
- Documents approved management plans in the form written/electronic orders, prescriptions and consultations/referrals
- Communicates approved management plans with patients and other healthcare team members that results in mutual agreement and understanding
- Uses the electronic medical record when available to keep the team informed of the up-to-date plans
- Follows principles of error reduction including discussions of indications/contraindications of treatment plans, possible adverse effects, proper dosage and drug interactions
- Writes consults/referrals, orders or prescriptions which are complete, incorporate patient safety principles and that can be understood by all the members of the team, including the patient

EPA 6: Present oral and written reports that document a clinical encounter.

Pre-entrustable

- Presents a summary which is unfocused, inaccurate, disorganized and lacking important information
- Does not demonstrate shared understanding among patient, the health care team members and consultants
- Documents findings in an unclear, unfocused or inaccurate manner

Entrustable

- Presents a concise and relevant summary of a patient encounter to members of the healthcare team
- Presents a concise and relevant summary to the patient, and where appropriate, the patient's family (caregiver/ advocate)
- Specifies the patient context in the report
- Demonstrates a shared understanding among the patient, the health care team members and consultants through oral and written reports
- Documents findings in a clear, focused and accurate manner

EPA 7: Provide and receive the handover in transitions of care.

Pre-entrustable

When providing handover, the learner

- Delivers variable information from patient to patient, not following a consistent structured handover template for verbal communication
- Omits key components, such as severity of illness in the handover information
- Does not completely update electronic handover tools
- Transmits erroneous information about patients
- Does not appropriately emphasize key points
- Does not use closed-loop communication to verify that the receiver of information has understood
- Does not question the timing of a handover in conditions where it would not be appropriate

When receiving handover, the learner:

- Receives information passively without asking clarifying questions
- Does not use closed-loop communication to verify important information
- Does not accept responsibility for the transfer of care

Entrustable

When providing handover, the learner

- Conducts handover communication that minimizes known threats to transitions of care (e.g., by ensuring to engage the listener, avoiding distractions)
- Documents and updates an electronic handover tool
- Follows a structured handover template for verbal communication
- Provides succinct verbal communication that conveys, at a minimum, illness severity, patient demographics and wishes regarding care, a concise medical history, current problems and issues, pertinent and/or pending laboratory, radiological and other diagnostic information, situation awareness, action planning, anticipatory guidance and upcoming possibilities and contingency planning
- Demonstrates respect for the patient's privacy and confidentiality
- Questions the timing of handover and discusses appropriate actions with team

When receiving handover, the learner:

- Provides feedback to the transmitter to ensure informational needs are met
- Asks clarifying questions
- Repeats the information just communicated to ensure closed-loop communication
- Communicates with the health care team and patient (family/ caregiver/ advocate) that the transition of responsibility has occurred
- Elicits feedback about the most recent handover communication when assuming primary responsibility for the patient
- Accepts responsibility for required care until responsibility is transferred to another team member
- Demonstrates respect for the patient's wishes regarding their care, privacy and confidentiality

EPA 8: Recognize a patient requiring urgent or emergent care, provide initial management and seek help.

Pre-entrustable

- Does not recognize an urgent or emergent case
- Does not initiate an assessment and/or management of an urgent or emergent case
- Is unable to perform CPR
- Does not ask for help when appropriate
- Does not appropriately document patient assessments and necessary interventions in the medical record
- Does not update patient's status to family members (caregiver/advocate)
- Does not clarify goals of care

Entrustable

- Utilizes early warning scores, or rapid response team / medical emergency team criteria to recognize patients at risk of deterioration and mobilizes appropriate resources urgently
- Performs basic life support when required including CPR in cardiac arrest
- Asks for help when uncertain or requiring assistance
- Involves team members required for immediate response, continued decision making, and necessary follow-up
- Initiates and participates in a code response
- Rapidly assesses and initiates management to stabilize the patient
- Documents patient assessments and necessary interventions in the medical record
- Updates family members/caregiver/ advocate to explain patient's status and escalation-of-care plans
- Clarifies patient's goals of care upon recognition of deterioration

EPA 9: Communicate in difficult situations.

Pre-entrustable

- Provides information without verifying that relevant permissions have been obtained
- Communicates in a public or crowded space with others around, which may impact confidentiality
- Does not show sensitivity to patient preference (alone, with family, etc.) as applicable
- Does not introduce him/herself and/or does not explain the purpose of the visit
- Uses medical jargon when communicating
- Does not provide information in an organized, logical manner
- Is not attentive to the patient's concerns and/or interrupts patient
- Does not verify for understanding or does not address concerns
- Does not make any follow up plan
- Does not seek help in managing the difficult situation

Entrustable

- Verifies who should be present and is aware of what information can and cannot be shared without permission
- Plans the encounter and communicates in a private setting
- Introduces him/herself, their role in the patient's care and explains the purpose of the conversation
- Positions him/herself to communicate comfortably
- Speaks in non-jargon language, through a translator if necessary
- Listens actively
- Verifies for understanding and addresses concerns
- Makes a plan that is understood, with next steps articulated
- Works with and includes (where relevant) other health team members to manage the difficult situation
- Assesses safety of the situation and seeks help as needed

EPA 10: Participate in health quality improvement initiatives.

Pre-entrustable

- Is passive during morbidity and mortality rounds
- Is careless in daily safety habits
- Does not demonstrate alertness for situations threatening patient safety
- Does not admit errors of commission or omission until the errors are recognized by others

Entrustable

- Participates in morbidity and mortality rounds
- Enters information in an error-based system
- Engages in daily safety habits (e.g., universal precautions, hand washing, time-outs)
- Recognizes one's own errors to the supervisor/team, reflects on one's contribution, and develops his/her own learning plan or quality improvement plan
- Identifies a risky situation for the safety of a patient
- Participates in a quality improvement exercise/project

EPA 12: Educate patients on disease management, health promotion and preventative medicine.

Pre-entrustable

- Does not question the patient about lifestyle habits
- Uses a level of language which is not understood by the patient
- Does not provide examples to promote change
- Does not assess the patient's and/or family's readiness to change
- Does not coordinate with other health care team members potentially leading to mixed messages to the patient
- Does not identify potential risky behaviours or living situations that may jeopardize the safety of the patient
- Does not document the discussion properly

Entrustable

- Enquires about the patient's lifestyle habits
- Educates using language that is understood by the patient
- Encourages the patient to ask questions
- Verifies for understanding of the education provided
- Provides examples of concrete changes that could be implemented to improve healthier habits
- Assesses patient's readiness to change
- Coordinates with other health care team members to ensure appropriate and consistent messaging
- Identifies potential risky behaviours or living situations that may jeopardize the safety of the patient
- Documents the discussion and the planning of the next steps

EPA 13: Collaborate as a member of an interprofessional team.

Pre-entrustable

- Focuses on his/her own performance, making it difficult for him/her to recognize and prioritize team goals over his/her own
- Identifies roles of other team members but only fully understands and appreciates the contributions of other physicians
- Seeks guidance from physicians only, adhering only to their recommendations and directives
- Communicates largely in a unidirectional way, in response to a prompt, with limited ability to modify content based on audience, venue, receiver preference or type of message
- Has difficulty reading, anticipating or managing his/her own or others' emotions, especially responses such as anger, confusion or misunderstanding
- May demonstrate lapses in professionalism such as disrespectful interactions, especially in times of stress and fatigue
- Functions as a passive member of the team and acts independently of input from the health care team
- Is unaware of resources available to and needed by patients within a given community or health care system
- Has a limited ability to help coordinate and improve their care as a member of the interprofessional team

Entrustable

- Actively strives to integrate into the team
- Recognizes the value and contributions of all team members
- Seeks input and help from all team members as needed
- Adapts communication strategies to the recipient in content, style and venue, contributing to good interactions with team members
- Listens actively and elicits ideas and feedback from all team members
- Anticipates and responds to emotions in typical situations
- Rarely shows lapses in professional conduct except in unanticipated situations that evoke strong emotions, and has insight to use experience to learn to anticipate and manage future triggers
- Works towards achieving team goals, although this may be more difficult when personal goals compete with team goals
- Usually involves patients, families and other members of the interprofessional team in goal setting and care plan development
- Shares his/her knowledge of community resources with patients, families and other members of the interprofessional team
- Is actively involved in care coordination

EPA 14: Incorporate relevant social determinants of health (SDoH) and cultural safety in relation to patient's illness and management planning[1,2].

Pre-entrustable

- Does not identify relevant SDoH.
- Does not identify structural barriers to health and wellness.
- Does not ask questions to explore the patient's lived experiences, and related structural barriers to health and wellness.
- Does not demonstrate awareness of evidence- based approaches to care for key populations such as refugees, homeless populations, Indigenous Peoples, etc.
- Makes judgments or assumptions or demonstrates bias regarding the patient's ability to follow advice or be part of the management plan.
- Does not demonstrate principals of culturally safe practice or trauma informed care.
- Does not use patient's preferred pronouns.
- Does not take a holistic or patient-centred approach to incorporating SDoH into the management plan.
- Fails to include the impact of rural residence in management planning, where applicable.
- Does not consider the role of traditional/cultural values, knowledge, and healing preferences, Indigenous knowledge, and principles of truth and reconciliation in encounters with patients where relevant.
- Does not demonstrate collaboration with allied health care professionals and other members of the health care team, social services, community agencies, or family members or caregivers in management planning.

Entrustable

- Identifies relevant SDoH, including structural barriers to health and wellness. Asks questions to explore the patient's lived experiences. Makes patient care decisions based on evidence-based equity-oriented clinical practice guidelines (e.g. Canadian Guidelines for Refugee Health[3], Indigenous Health Primer[4], Clinical Guidelines for Homeless and Vulnerably Housed[5], and others appropriate to key populations).
- Demonstrates a nonjudgmental and unbiased attitude towards patients, families, and colleagues.
- Demonstrates principals for culturally safe practice and trauma informed care in clinical care and decision-making.
- Uses patient's preferred pronouns.
- Demonstrates evidence of patient advocacy in the workplace.
- Takes a holistic and patient centred approach to developing a management plan that addresses SDoH, including rural residence where applicable.
- Considers traditional/cultural values, knowledge and healing preferences, Indigenous knowledge, and principles of truth & reconciliation in encounters with patients where relevant.
- Collaborates with allied health care professionals and other members of the health care team, social services, community agencies, and/or family members or caregivers in developing the management plan.

[1] SDoH include but are not limited to socio-economic status, gender, age, sexuality, race, ethnicity, language, religion, education, ability, literacy, employment, place of residence, access to health care, social supports, personal health practices, and childhood experiences.

[2] Structural barriers include racism, misogyny, homophobia or transphobia, religious discrimination, agism, ableism, weight bias, gender discrimination and discrimination based on mental health and addictions.

[3] Canadian Guidelines for Immigrant Health https://www.cmaj.ca/canadian_guidelines_for_immigrant_health

[4] Indigenous Health Primer. file:///Users/jillallison/Downloads/indigenous-health-primer-e.pdf

[5] Clinical guidelines for homeless and vulnerably housed people, and people with lived homelessness experience. https://www.cmaj.ca/content/cmaj/192/10/E240.full.pdf