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34 Using the QSAT to Generate Multi-Source Feedback on an Adult Simulation Case

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Background: The Accreditation Council for Graduate Medical Education (ACGME) lists multi-source feedback (MSF) as a suggested evaluation method for 10 of the 23 Emergency Medicine (EM) Milestones. To date, there has been little study comparing EM resident MSF on a specific patient encounter. The Queen’s Simulation Assessment Tool (QSAT) has been validated as being able to, with faculty feedback, discriminate between resident performances in a simulation setting.

Objectives: Using the QSAT, this simulation study seeks to determine the degree of agreement of MSF on a single simulation case.

Methods: This IRB approved study was conducted at a single, dually approved, four year EM residency which trains 13 residents a year. An adult simulation resuscitation case was developed with specific behavioral anchors on the QSAT, which provides feedback on a 1-5 scale in each of 5 categories. Performance on the simulation case was gathered from each of 6 participants or observers in the simulation. The resident leading the case self-evaluated. The resident received MSF feedback from each of a junior resident peer, a nurse, an EMS provider, and two attending faculty members. Reported are the mean scores and standard deviation for each.

Results: A total of 34 (12 female, 22 male) residents were enrolled to serve as the case leader. At the time of enrollment, 4 were PGY 2, 10 were PGY 3, and 20 were PGY 4. The single peer evaluator began the study as a PGY 1. The 34 nurses (30 female, 4 male) averaged 6.4 years of experience. The EMS provider has 13 years of experience. The faculty members have 14 and 15 years of experience respectively. Table One demonstrates that the residents routinely evaluated themselves more critically than they were evaluated by any of the other groups. If the faculty are used as the gold standards, the scores in each category for each source of MSF of the QSAT overlapped within a standard deviation.

Conclusions: In this single site cohort residents rated themselves lower on the QSAT than other sources of MSF did. It appears that the QSAT can be used to provide MSF wherein each source of feedback is similar to that of a faculty member. If the relationship is further validated, this may allow for MSF on specific resident performance from a variety of sources which would mirror a faculty evaluation of that encounter.

Table One. Reported means and standard deviations (N of 34 for all cells)

Role	Self	Faculty 1	Faculty 2	Peer	Nurse	EMS
QSAT Category						
Primary Assessment	4.06 (.49)	4.88 (.33)	4.94 (.24)	4.79 (.48)	4.56 (.50)	4.76 (.50)
Diagnostic Actions	3.79 (.69)	4.62 (.49)	4.56 (.66)	4.18 (.80)	4.29 (.68)	4.41 (.61)
Therapeutic Actions	4.06 (.81)	4.50 (.66)	4.12 (.98)	4.26 (.55)	4.62 (.59)	4.47 (.71)
Communication	4.09 (.67)	4.88 (.41)	4.88 (.33)	4.62 (.55)	4.68 (.59)	4.71 (.58)
Overall Assessment	3.88 (.59)	4.74 (.45)	4.47 (.79)	4.38 (.65)	4.41 (.50)	4.50 (.75)

35 USMLE Scores Do Not Predict Ultimate Clinical Performance in an Emergency Medicine Residency Program

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Background: “High-stakes” multiple choice exams such as the United States Medical Licensing Examination® (USMLE) are widely used to gauge mastery of basic and clinical science knowledge. Scores on these exams are important screening and applicant ranking criteria, used by residency. This study attempts to clarify the relationship between performance on two USMLE exams (Step 1, Step 2CK) with global clinical performance in an Emergency Medicine (EM) residency program.

Objectives: We tested the hypothesis that USMLE scores do not predict clinical performance after residency training.

Methods: All graduating residents from our University-based EM residency program between the years 2008 and 2015 were eligible for inclusion. Residents that had incomplete USMLE records, were terminated, transferred out of the program, or did not graduate within this timeframe were excluded from the analysis.

Clinical performance was defined as a gestalt of the residency program’s leadership (program director, associate program director, and assistant program director) during the specified years. They were initially blinded to each other’s grouping selections and classified the residents into three sets: top clinical performer, average clinical performer, and lowest clinical performer. Dissimilarities of the rankings were adjudicated during a consensus conference. The residents’ files were then accessed and the residents’ USMLE scores were obtained.