Fellowship Assessment

STANDARDS AND GUIDELINES FOR CANDIDATES

2017

The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Contents

Definition of general practice

General practice is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity. It is a clinical specialty orientated to primary health care. It is a first-level service that involves improving, maintaining, restoring and coordinating people's health. It focuses on patients' needs and enhancing links between local communities and other health and non-health agencies.

General practice:

- is personal, family and community-oriented, comprehensive primary care that continues over time, is anticipatory as well as responsive
- is not limited by the age, gender, ethnicity, religion or social circumstances of the patient, nor by their physical or mental states
- is normally the point of first contact within the health system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, gender, culture or any other characteristic of the person concerned
- makes efficient use of health care resources through coordination of care, working with other health professions also in a primary health setting, managing the interface with other specialties, and taking an advocacy role for the patient when needed
- develops a person-centred approach, orientated to the individual, as well as an approach that is responsive to the needs of the family/whānau and their community
- has a unique consultation process that through effective communication between doctor and patient over time establishes a relationship
- is responsible for providing longitudinal continuity of care as determined by the needs of the patient
- has a specific decision-making process determined by the needs of the patient
- diagnoses and manages both acute and chronic health problems of individual patients
- diagnoses and manages illness that presents in an undifferentiated way at an early stage of its development, which may require urgent intervention
- promotes health and wellbeing through appropriate and effective intervention
- has a specific responsibility for health in the community
- deals with health problems in the physical, psychological, social and cultural dimensions.

Introduction

The Royal New Zealand College of General Practitioners (the College) provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice in New Zealand. Fellowship of the College is the recognised qualification leading to vocational registration in the scope of general practice.

Candidates for Fellowship of the College are assessed via a Fellowship assessment visit. This document details the standards used in the Fellowship assessment process. It also provides guidance and information for candidates who are about to undergo a Fellowship assessment visit.

Process

The pathways to Fellowship of the College are outlined in the College Fellowship Regulations, available on the **College website**. Candidates are eligible for a Fellowship assessment visit once they have completed the requirements of the relevant Fellowship pathway and met the requirements outlined in section 4.1.2 of the Fellowship Regulations.

The purpose of the Fellowship assessment visit is to examine the candidate's actual practice to ensure that it is safe, competent and meets the standards for Fellowship of the College.

In the Fellowship assessment process, candidates are assessed by a visiting assessor against the standards that are set out in this booklet. All indicators listed are essential, and must be met in order for the candidate to gain Fellowship of the College.

In addition to evidence collected during the visit, the assessor has available to them other education programme materials, activities and assessments that relate to the candidate. This includes medical educator reports, patient and colleague feedback survey results, audits, and examination results.

Fellowship assessors and censors

Fellowship assessors and censors are senior members of the College who are experienced and respected general practitioners, known to have high standards of practice. They are required to be vocationally registered in general practice and to hold a current practising certificate. They are required to participate in ongoing assessment-related professional development activities.

Assessors are contracted by the College to undertake assessment visits and to write a Fellowship assessment visit report for the candidate that they visit.

The role of the censors is to examine each Fellowship assessment visit report provided by the Fellowship assessors and all other available information regarding the candidate's performance on the training pathway. They then make a recommendation to the Censor-in-Chief regarding whether the candidate has met the required standards for Fellowship.

The assessment visit

The Fellowship assessment visit must take place in a general practice or other practice environment that can meet the criteria for a general practice as listed in the definition of general practice (see above). The candidate must have worked in the practice for at least three months (full-time equivalent) in the past nine months.

Indicative time allocation

The Fellowship visit is likely to take between four and five hours. The approximate time required for each components of the visit is as follows, but these times may vary depending on the specific circumstances of the visit:

Introduction	Up to 30 minutes
Sitting in on consultations	Up to 150 minutes
Review of medical records	Up to 30 minutes
Discussion with the candidate	Up to 60 minutes
A check and discussion about the premises, equipment and the practice organisation	Up to 30 minutes

The order in which the activities occur will be decided between the candidate and the assessor before or during the visit.

Preparation for the visit

There are a number of things you need to do to prepare for your visit:

Make sure that the practice manager and staff know that there is to be a visit, what it entails and how important it is to your qualifications. Reception staff will need to greet the assessor on arrival and will need to be able to answer any patient questions that may be asked. The practice nurse may be needed to help explain systems that are delegated to her that you may not be familiar with.

The consulting room must be ready for the observation of consultations. Ensure that the room is clean and tidy, and that there is a chair with room for the assessor to sit with minimal interference to your consultations.

Notices must be put up in the practice informing patients that there is an assessment visit taking place. Also ensure that patients are provided with and complete the necessary consent forms to allow an observer. If a patient does not wish an observer to be present, the visitor will usually take this time to complete other aspects of the visit.

You need to ensure that the practice complies with all legal obligations. These are outlined in the *Aiming for Excellence: The RNZCGP standard for New Zealand general practice* (2016), and are identified as Foundation criteria.

You must have made arrangements to ensure the privacy of your patients during physical examinations and the privacy of your computer notes, by ensuring the only visible notes are those of the patient in the room and by using a computer screensaver and adequate password protection.

You should have a set of consultations booked for the assessor to observe (see 'Consultation observation', p.5). These should not be patents selected by you and should reflect your normal booking practices.

You will need to ensure that there is a computer terminal available for the assessor to view your clinical records and referral letters, bearing in mind that this may be required during any consultation where your patient does not wish to have an observer present. If your practice uses a patient portal, you also need to ensure that the assessor is able to view your patient portal notes. You should consider doing a self-audit of your referral letters prior to the visit. A tool for this is available on the College website.

Check that all required equipment and medicines are available, calibrated, and non-expired. Complete the **required equipment and medicines** checklist (Appendix A) and have this available for the assessor on the day.

Ensure that you have prepared for the visit by:

- establishing a hand sanitising and washing routine
- using systems for the safe and reliable management of test results and recalls
- demonstrating, if requested, how you access and use clinical guidelines and local referral pathway
- demonstrate how you assist patient care with written health information (including patient handouts, contact information for organisations that may be able to assist the patient and useful websites to view)
- demonstrating, if requested, how you consult high-quality reference resources
- being able to describe the legal requirements for practice processes to deal with complaints and critical/sentinel events
- being able to describe how the practice meets local requirements for the safe disposal of medical waste
- being able to describe how both you and the practice ensure the safe operation of equipment
- being able to demonstrate the triage of unwell patients by the practice and your role in this
- being able to explain how you meet your responsibility to ensure adequate after-hours care for patients under your care
- being able to demonstrate how you and the practice meet all legal requirements to prevent unauthorised access to controlled drugs
- being able to describe your role in the governance of the practice, including evidence of your attendance at practice meetings
- providing, if requested, a copy of the patient consent form that you use for procedures, including minor surgery
- being able to describe the emergency drill for the practice.

Your visitor may have travelled a long distance. Please consider offering them a beverage and light refreshment.

Read through this book carefully and think about other ways in which you can prepare for your visit. There is a checklist provided at the back of this book that will help to ensure you are ready.

Consultation observation

The assessment includes observation of up to eight consultations. We suggest you book six to eight consultations, then a break of an hour for the discussion session, then a further two to four consultations that the assessor can view if the initial session is not sufficient for assessment purposes.

The assessor must observe a range of consultations that will provide sufficient evidence of your performance. Ideally, this will include a mixture of patients, with at least one long-term care and one acute. Patients for the session should be booked sequentially as you would for your normal schedule. Occasionally patients will not consent to an observer and the assessor may take this opportunity to review records or meet with staff.

It is important that the consultation session be as 'normal' as possible. Do not schedule fewer patients than usual (to give longer consultation times), and do not set up specific patients (including those with 'interesting' health problems) for this assessment. This is usually obvious, does not provide assessors with what the visit must achieve, and may lead to a second visit being necessary (which would be at your expense).

Remember that the assessor's time is likely to be constrained by travel requirements and other responsibilities. It is up to you to ensure this time is spent well for the purpose of demonstrating your achievement of Fellowship standards. This is a unique opportunity for you to display your skills. Don't take shortcuts. If your visitor does not see your skills, they could assume they are lacking.

If there is insufficient variety in the consultations, discussion and review of medical records may be used to fill the gaps.

This is a summative assessment process. The assessor's focus during the visit will be on observing sufficient consultations to assess your consultation skills. If consultation observation runs over time, the opportunity for discussion may be limited. Most candidates really value the discussion session.

The suggested average time for consultation is not less than 10 minutes, but consultations that require examination, discussion, and attention to preventive care usually take 15 to 20 minutes.

If the outcome of the visit is that achievement of the expected standards has not been demonstrated, a further visit will be required at your expense.

Consultations need to be conducted predominantly in English or te reo Māori. Candidates who offer consultations predominantly in te reo Māori, or another language other than English, are asked to discuss this with the College when requesting an assessment visit. If a consultation on the day is conducted in another language (without a translator being used), the consultation may not be suitable for assessment purposes, and the assessor may require further consultations for viewing.

Alternative therapies that are not usually within the recognised domain of general practice are outside the purview of the College and will not be assessed. It is therefore essential that most of the session be conventional general practice consultations for this session to be adequate for assessment. If the efficacy of an alternative therapy that you are providing is controversial, or at variance with current scientific understanding, you may be asked to justify your treatment and its evidential base.

The consent of each patient is required before the assessor can sit in on a consultation (an example of a patient consent form is available from the College). The assessor is also required to sign two copies of a Declaration of Confidentiality, and to provide one of these to the candidate at the beginning of the visit and retain the other for the College.

Note that the discussion session with the Fellowship assessor will usually take place once all consultations have been observed. The assessor will not usually discuss cases or provide feedback between consultation sessions in case this interferes with normal conduct of the session.

A copy of the consultation observation guide criteria is attached as Appendix B.

A copy of your consultation records from the patients seen during the visit will be requested by the assessor and must be provided before the end of the visit.

Evidence available to the assessor and censor

The evidence portfolio that is available to the assessor and censors encompasses all learning activities and assessments submitted over the course of the GPEP programme. This includes RNZCGP clinical record review checklist, Colleague Feedback Survey results, Patient Survey results, examination results and in-practice visit reports. This evidence may be consulted by the assessor in their assessment of any indicator, or by the censors in assessment of overall performance.

The outcome of the visit

The assessor will provide a report on the visit to the College. This report is considered by two College censors, along with other evidence of the candidate's performance in the training programme. The censors will then make a recommendation to the College Censor-in-Chief, which the Censor-in-Chief will consider in deciding the visit outcome.

If the Censor-in-Chief sees fit, he or she may request additional information and otherwise investigate further before making his or her decision on the outcome.

If the two censors cannot agree on what recommendation to make in a particular case, the Censor-in-Chief may consult Fellowship assessors and censors as a group regarding the issue or issues giving rise to the difference of opinion between the censors, before making his or her decision on the outcome. Alternatively, the Censor-in-Chief may decide not to do this, and instead make a decision on the outcome after considering the information available to the censors, and their views.

In any such consultation, the information available to the censors and Censor-in-Chief (including the assessor's report) will be available to the Fellowship assessors and censors attending the meeting. The assessor who carried out the relevant assessment visit will present his or her report to the group, focusing on the particular matter or matters at issue. Both censors will then provide their views, and the Censor-in-Chief may provide his or her preliminary view. Following that, there will be a group discussion, in which the assessor who carried out the relevant assessment visit, the censors involved in the assessment, and the Censor-in-Chief, may participate. The views expressed during that discussion will be taken into account by the Censor-in-Chief in making his or her decision.

Please be aware that it may take up to six months for a decision to be made on the outcome of a visit. The Censor-in-Chief's decision is final, and there is no appeal process following this decision.

Note that the assessor does not make the decision on visit outcomes. Candidates should not contact the assessor about the visit outcome.

There are three possible outcomes from the visit:

1. The candidate **has met** all the indicators set out in the Fellowship standards.

   If this result is received, the candidate may proceed to Fellowship. The requirements for Fellowship, outlined in section 2.2 of the Fellowship Regulations, must be met before Fellowship can be awarded.

2. The candidate **has met most** of the indicators set out in the Fellowship standard, with minor areas of remediation required, as determined by the censors and/or Censor-in-Chief.

   If the candidate has met most requirements, with only minor areas of remediation required, the candidate may be provided a period of time in which to remedy the deficiency, without necessarily requiring another full visit.

   Evidence that the issue has been addressed will be required before the candidate may proceed to Fellowship. The candidate will be informed of what is necessary at the time that they receive their visit results.

3. The candidate **has not demonstrated that they meet** the standards for Fellowship or, in the view of the Censor-in-Chief has revealed substantial deficiencies in one or more areas of practice.

   If the candidate has not met the indicators set out in the Fellowship standards, or if major deficiencies have been identified in one or more areas of practice, a further assessment visit will be required. The candidate will be given reasons for the decision, and feedback on the issues to be addressed. In some instances, further conditions may be set. These may include a requirement to undertake education activities in specific areas of practice.

Process for the award of Fellowship

The Censor-in-Chief is responsible for notifying the candidate of the outcome of the visit and whether they have completed the requirements for Fellowship. An assessor's report to candidates will be made available to the candidate.

All requirements for Fellowship (listed in section 2.2 of the Fellowship Regulations) must be satisfied within 18 months of a successful Fellowship assessment visit. If this is not achieved, a further visit at the candidate expense, will be required.

Concerns

The following sets out what may occur if concerns arise during the assessment process.

a. Concerns during a consultation

The assessor's role is to observe the consultations and they will not normally intervene during the consultation in any way. However, if they become concerned that a course of investigation or treatment is not appropriate, or about patient safety during the course of a consultation, they may raise a point during the consultation or may discuss with you after the patient has left the room.

b. Health concerns

Section 45 of the Health Practitioners Competence Assurance Act (2003) makes it mandatory for a medical practitioner who has reason to believe that another medical practitioner is not fit to practise medicine because of some mental or physical condition to give notice to the Registrar of the Medical Council of New Zealand of such belief. The assessor will notify the College if this situation arises.

c. Competence concerns

If an assessor has concerns that the candidate may pose a risk of harm to the public by practising below the required standard of competence, the assessor will discuss those concerns with the Censor-in-Chief. Following that discussion, the assessor or the Censor-in-Chief may report those concerns to the Registrar of the Medical Council pursuant to section 34(1) of the Health Practitioners Competence Assurance Act (2003). The Medical Council will instigate its own review process. The report to the candidate will reflect that concerns have been raised with the Medical Council.

The RNZCGP standards for Fellowship assessment

The RNZCGP standards for Fellowship assessment comprises 13 indicators in 11 sections.* These are:

1. **Communications skills**
   - Indicator 1: Communication with patients is competent, sensitive and facilitates optimum care.
2. **Clinical skills**
   - Indicator 2: The candidate demonstrates competent clinical skills.
3. **Medical records**
   - Indicator 3: Medical records meet requirements to describe and support the management of health care provided.
   - Indicator 4: The practice management system is used effectively for tracking results and for follow-up and recall of patients.
4. **Integration of care**
   - Indicator 5: Referrals to other health care providers are appropriate, timely and provide sufficient information.
   - Indicator 6: The candidate works effectively as a member of the primary care team.
5. **Practice system and facilities**
   - Indicator 7: The safety of patients in the practice setting is assured.
6. **Medical equipment**
   - Indicator 8: Medical equipment and resources are available and maintained to meet patient needs.
7. **Availability and accessibility**
   - Indicator 9: Patients are able to obtain care and advice that is appropriate to their needs.
8. **Respect for the rights and needs of patients**
   - Indicator 10: The rights and needs of patients are respected.
9. **Professionalism and ethics**
   - Indicator 11: The candidate maintains professional integrity.
10. **Scholarship and professional development**
    - Indicator 12: The candidate can show he/she considers and applies the most up-to-date evidence in delivery of patient care.
11. **Health and wellbeing**
    - Indicator 13: The candidate is fit for work and has mechanisms for self-management and self-care.

The Fellowship assessment standards are detailed below. For each section, the following is listed:

- the criteria that you will be assessed against
- the sources of evidence that will be examined
- guidelines regarding assessor expectations, and how you should prepare for the visit
- reference to other sources of information (where relevant).

1. Communication skills

Indicator 1: Communication with patients is competent, sensitive and facilitates optimum care.

The candidate:

1.1 displays an open, alert manner, appropriate empathy and effective responses to patient cues to establish and maintain the rapport necessary for a good therapeutic relationship.

1.2 allows the patient sufficient time to speak before commencing specific questioning.

1.3 displays an awareness of cultural factors that may impact on patient care and takes these into account in the provision of care.

1.4 efficiently elicits information from the patient (and sometimes a support person) to identify their concerns and reasons for attendance.

1.5 summarises and checks their understanding with the patient.

1.6 takes a patient-centred approach, taking into account their health literacy and illness model, to enable joint decision making in a partnership of care.

1.7 provides relevant explanations and information aided, as required, by assisting the patient with access to relevant digital and written material or via a third party.

Evidence

- Consultation observation
- Patient Feedback Survey results
- Evidence from discussion as to how you assist patients with access to further advice
- Observation of culturally aware patient care

Guidelines

To assess these criteria, the Fellowship assessor will observe your consultations and will look at specific aspects of your practice. Read the information provided regarding the requirements for consultation observation on pages 5–6 of this document.

The assessment criteria that the assessor will use to assess both the communication and the clinical aspects of your consultations observation is attached as Appendix B. Read through the criteria to ensure that you understand what the assessor will be looking for. These requirements should not be new to you: they relate to communication skills that you have been developing throughout GPEP.

As background information, the results of the patient surveys that you have undertaken during GPEP will be available to the assessor. This will provide the assessor with further information about your interpersonal and communication skills.

The assessor will also be looking for evidence that patients are referred to appropriate additional sources of information – these may be electronic or written, and may be spoken of in the consultation or available in the practice. If the opportunity to discuss additional sources of information does not come up in the observed consultations, you may be asked about the sources of information that you recommend to patients. Documentation of the information given to the patient is important.

2. Clinical skills

Indicator 2: The candidate demonstrates competent clinical skills.

The candidate:

2.1 performs an accurate and efficient assessment of the patient's condition, with sufficient history and clinical examination to ensure competent management.

2.2 acquires consent to examine and does so in a well-targeted, gentle and respectful way.

2.3 summarises findings and demonstrates effective prioritisation, synthesis of the information gathered and hypothesis generation to commence a competent diagnostic process.

2.4 avoids premature closure and demonstrates competent clinical judgment in forming differential diagnoses.

2.5 demonstrates sound clinical judgment in determining further management, safety-netting and follow-up.

2.6 prescribes in accordance with established practice and can justify any prescribing patterns that appear to differ from the norm.

2.7 investigates judiciously.

2.8 refers in a timely manner.

2.9 takes opportunities to provide brief health interventions and screening as appropriate.

2.10 structures the consultation effectively to cover the essentials of management in the time available.

2.11 demonstrates the broad expertise necessary for high-quality general practice.

Evidence

- Consultation observation
- Case discussion
- Spot check on medical records
- Prescriptions audit.

Guidelines

Much of the evidence that will be used in the assessment of your clinical skills will come from the consultation observation, with the assessor using the same criteria matrix as was used for Indicator 1 (see Appendix B). The assessor will supplement this as necessary with information from the patient records reviewed, and with discussion about cases seen. If necessary, the assessor may pose some hypothetical questions to you during the case discussion. This would typically take the form of 'What if…' questions (eg 'What if the patient had been female/a child/on other medication?' etc).

3. Medical records

Indicator 3: Medical records meet requirements to describe and support the management of health care provided.

The candidate's medical records meet the standard required for general practice records:

3.1 Patient records are electronic, secure and traceable.

3.2 Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements.

3.3 The record is objective (non-judgmental), contemporary, and sources are identified.

3.4 Clinical notes can be understood by someone not working regularly at the practice.

3.5 Important medical warnings (or the absence of any) are displayed on all records.

3.6 Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point.

3.7 The recorded history is relevant and sufficient for both safe management and evidential purposes.

3.8 The record of the examination includes all findings essential to diagnosis and management.

3.9 The working diagnosis/differential is apparent and consistent with the supporting information.

3.10 The patient management plan is clear with uncertainty and conjecture identified and addressed as necessary.

3.11 The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent.

3.12 Clinical management decisions and any interventions provided are recorded.

3.13 The record identifies all medication treatment provided, including the type, dosage, and total amount of any medications prescribed.

3.14 The record identifies all investigation requested and tracks high-risk tests.

3.15 The record supports effective and timely referral for treatment and transfer/continuity of care.

3.16 Follow-up arrangements are clearly documented and actions are recorded.

3.17 Screening history and results (or patient decline) are recorded.

3.18 Immunisation history and status is recorded.

3.19 There is a systematic record of individual risk factors.

3.20 Where a patient portal is used, this meets current criteria for shared patient information.

Evidence

- RNZCGP Clinical Record Review self-audit checklist
- A spot check and review of records by the assessor
- Patient portal notes (if used).

Guidelines

The RNZCGP Medical Record Review self-audit tool is provided in Appendix C. Instructions are provided on the tool itself. You are required to conduct a random audit on 10 patient records, and to complete the Report and Plan template provided. This should be provided to the College before the visit.

During the visit, the assessor will request to see your patient records, including the day's records for the patients that you see under observation.

If your practice is using a patent portal and consultation notes are available to patients, you need to ensure that the records accessed by patients are suitable to be read by them. They should not be offensive or biased, but can contain medical terms. The assessor may ask to view a sample of your patient portal records.

You need to ensure that:

- a computer terminal is available for the assessor to use to review records at any time during the visit
- you complete your write-up of the notes for the patients seen with the assessor while the assessor is still on the premises. They will request a copy to include in your report.

A legally defensible record:

- is an accurate representation
- is not altered, disguised or added to unless this is identified
- records all house calls and phone calls
- is kept for a minimum of 10 years
- uses no unusual abbreviations without an explanation
- does not use autotexting to the detriment of veracity
- is author identified and dated (include times).

(Records should be maintained electronically. Any notes which are handwritten should be legible and in ink, not pencil).

Further information

- RNZCGP: **Aiming for Excellence (Indicator 21.1)**
- **The Code of Health and Disability Services Consumers' Rights 1996**
- **Ethnicity Data Protocol for Health and Disability Sector**
- Medical Council of New Zealand: **Cole's Medical Practice in New Zealand (2011)**
- Standards New Zealand: Health Records: NZS 8153:2002
  - Code of Practice for Information Security Management: AS/NZS ISO/IEC 17799:2002
  - Primary Healthcare Patient Management Systems: Publicly Available Specification: SNZ PAS 8170:2005

Indicator 4: The practice management system is used effectively for tracking results and for follow-up and recall of patients.

The candidate:

4.1 has a system for follow-up and recall of patients with abnormal test results.

4.2 can demonstrate how they identify, track and follow up investigations and significant recalls.

4.3 can describe (and if necessary critique) how the practice recalls registered patients for immunisations, cervical smears and other national or regional health objectives.

Evidence

- Discussion
- Spot check and review of medical records.

Guidelines

The assessor has to be assured that you have an adequate system in place to track and follow up test results and to recall patients with abnormal test results (or normal test results that fail to explain the patient's problem).

The practice that you are working in may have policies and systems for dealing with these issues. If that is the case, you need to know and be able to describe what the policy or system is and how you work within it.

If the practice does not have policies or systems to deal with these issues, you will need to demonstrate to the assessor that you have developed a system for your own practice that ensures that all relevant follow-up and recall occurs.

You also need to be able to describe how you and the practice recall patients for screening tests, immunisations and any other clinically necessary follow-up.

4. Integration of care

Indicator 5: Referrals to other health care providers are appropriate, timely and provide sufficient information.

The candidate:

5.1 recognises the limits of their expertise and referral is timely and appropriate.

5.2 writes referral letters that provide all necessary information in a form that allows the referred provider to determine urgency, the nature of the problem and the expectation from the referral. The minimum requirements include:

- patient identification and contact information (usually this will include the name, address, date of birth and NHI)
- the intended recipient
- the urgency of the care requested and essential information for triage
- the reason for referral, the clinical question being asked of the recipient or the anticipated outcome of the referral
- the history of the current problem with emphasis on any acceleration of symptoms
- significant past history
- a list of the patient's important current and past health problems
- all current medications (including whether there are no current medications)
- allergies including, if appropriate, that there are No Known Drug Allergies (NKDA)
- current smoking status
- (investigations may not need to be included if the recipient has other means of access to these)
- any other issues pertinent to the referral (social situation, deafness, translator required, mobility and transport issues, infectious status etc).

Evidence

- Consultation observation
- Case discussion
- Spot check on referrals letters
- Referrals audit (available in candidate's portfolio)
- Colleague Feedback Survey results (available in candidate's portfolio).

Guidelines

The assessor will need to assure themselves that your referrals are appropriate and that your referral letters contain all necessary information.

The assessor is likely to ask you to show a copy of a recent high-quality referral. You must be able to access some referrals on demand.

The assessor will also look at your Colleague Feedback Survey results (available in your portfolio) and your task lists, and may wish to discuss the quality or punctuality of your referrals.

Indicator 6: The candidate works effectively as a member of the primary care team.

The candidate:

6.1 contributes towards governance and collegiality in the practice.

6.2 seeks professional advice when needed.

6.3 is familiar with and easily able to access the practice's significant events register and can describe how this is used as a quality process in the practice.

6.4 can describe how the practice systems ensure safe transfer of patient care.

6.5 takes responsibility for all patients seen to ensure appropriate follow-up actions are taken.

6.6 can provide evidence of working with a range of other health and community services in the area, to improve individual patient care.

Evidence

- Colleague Feedback Survey results (available in candidate's portfolio)
- Evidence of attendance at practice meetings and/or meetings with senior colleagues in the practice
- Discussion with the candidate
- Practice observation
- Consultation observation
- Spot check of medical records.

Guidelines

The assessor will observe you working in the practice and may ask questions regarding your collegial relations within the practice.

It is important that you know how the practice's significant events register is used in quality processes: you may be asked to provide an example of an incident in the practice registrar, and how this has been used to improve practice.

You need to be able to discuss the arrangements made to ensure safe transfer of care. This may include transfer of care to locums and to secondary care and the management of incoming discharge letters.

Medical records should demonstrate support for continuing care. Where patients are seen on behalf of another doctor, consultation notes should be provided to that doctor wherever possible.

You must also know how the patient results management system ('Inbox') works and must be able to describe how you use it by way of:

- checking the 'Inbox' for all results for which you may be held responsible
- annotating incoming patient results, and where they are normal, indicating this
- taking responsibility for ensuring that test results are communicated to the patient. (This may be directly by the candidate or by auditable instructions (usually via the PMS to a responsible practice member).

5. Practice systems and facilities

Indicator 7: The safety of patients in the practice setting is assured.

The candidate:

7.1 is aware of the infection control measures used by the practice and can discuss how they protect the health and safety of patients and practice members. This includes:

- the maintenance of the practice environment in a clean and hygienic manner
- the use of hand hygiene practices that minimise the risk of the doctor being an agent for the transmission of infection.
- Where reusable medical and surgical instruments and equipment are used, that these are sterilised as per manufacturer's specifications, and stored in a manner that maintains sterility. The sterilisation trail is auditable.
- Where single-use disposable instruments are used, that these are not re-used.

7.2 ensures that requirements for the safe storage and disposal of health care waste, including sharps, are met both in the office and the environment.

7.3 can discuss the practice's cold chain monitoring and maintenance procedures, and how these comply with the Ministry of Health Protocol.

7.4 can demonstrate the procedures and mechanisms used by the practice to prevent unauthorised access to controlled drugs. Requirements include:

- Drugs are kept in a locked metal or concrete container that is securely fixed to, or is part of, the building it is kept in.
- The key to the cupboard or compartment is kept in a secure place when not being used.
- The candidate is aware of the need to have safe and auditable processes regarding the use of controlled drug prescription pads, and takes steps to ensure that these are in place.

Evidence

- Practice observation
- Consultation observation
- Discussion.

Guidelines

The criteria for Indicator 7 are strongly linked to practice requirements outlined in the *Aiming for Excellence: the RNZCGP standard for New Zealand general practice* (indicators 13–16).

If your practice is CORNERSTONE® accredited or Foundation Standard certified, an assessor will already have checked that the practice complies with these criteria. It is your responsibility to ensure that you know what arrangements are in place, and to act in accordance with them.

If the practice you are in is not CORNERSTONE® accredited or Foundation Standard certified, you will need to take greater responsibility for ensuring that the practice meets the requirements. If you are not able to directly set systems up in the practice, you must at least demonstrate that your own practice complies, and that you have engaged with the practice management regarding their policies and systems.

Note that hands should be washed or hand sanitiser used before touching a baby and after a patient examination where there is any risk of contamination. Provided hands are not soiled, there is no requirement to combine a washing schedule with hand sanitiser use.

Further information

- RNZCGP: **Aiming for Excellence (indicators 13–16)**
- AS / NZS 4815:2006: **Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment**
- AS / NZS 4304:2002: **Management of Healthcare Waste**
- Ministry of Health: **Annual Cold Chain Management Guide and Record**
- **Misuse of Drugs Act 1975** and **Misuse of Drugs Regulations 1977**
- **New Zealand guidelines on handwashing**
- RNZCGP: **Greening your practice toolkit**
- Worksafe New Zealand: **Health and Safety at Work Act 2015**

6. Medical equipment

Indicator 8: Medical equipment and resources are available and maintained to meet patient needs.

The candidate:

8.1 takes steps to ensure that within the practice all essential emergency and resuscitation equipment is calibrated, in working order and non-expired.

8.2 is aware of all other essential equipment that is required and takes steps to ensure that it is available and in working order.

8.3 takes steps to ensure that within the practice all essential basic and emergency medicines are available.

8.4 can describe the system for maintenance and checking expiry dates of drugs held in the practice cupboard and in the emergency bag.

8.5 has ready access to portable emergency equipment.

8.6 understands their expected response to an emergency.

Evidence

- Required equipment and medicine checklist provided by candidate (available in Appendix A)
- A spot check of equipment and available medicines by the assessor
- Discussion.

Guidelines

The medical equipment and resources in the practice should be sufficient to support comprehensive primary care, safe resuscitation, and safe performance of any additional procedures offered.

You need to be assured that any equipment you are using is safely sterilised, that any vaccines that you are using have been stored using cold-chain preservation, and that drugs that you are using have retained effectiveness (this is a function of both storage conditions and expiry dates).

A list of equipment and medication to be available in the practice is provided in Appendix A. You will need to check that all items on the list are present, in working order and within recommended usage dates. The ticked-off list must be provided to the College before the visit. The assessor will spot check for items on the list and, where applicable, any expiry dates.

You need to be aware of the practice systems for maintaining equipment and checking expiry dates – the assessor will ask you to describe these systems.

If some of the equipment and medication on the list is not available in the practice, or if the practice does not have a system for maintaining equipment and checking expiry dates, you should be able to demonstrate how you have taken steps to ensure that the situation is remedied. For example, discuss the situation with practice staff, and follow up on your discussion with an email confirming the action taken.

You are also required to show that you understand the role expected of you in an emergency and how this fits within the practice policy for response to emergencies.

Further information:

- RNZCGP: **Aiming for Excellence** (Indicator 17)

7. Availability and accessibility

Indicator 9: Patients are able to obtain care and advice that is appropriate to their needs.

The candidate:

9.1 ensures that patients are informed about the costs of a standard consultation and any variation in costs for non-standard consultations and treatment.

9.2 can provide patients with indicative costs of referred services if these are in the private sector.

9.3 ensures that time allocated to the patient is sufficient to allow for good quality care.

9.4 can describe how patients with urgent medical problems are identified, triaged and managed in a timely and appropriate manner.

9.5 is able to explain how their responsibility to ensure adequate after-hours care for patients under their care is met and how patients are advised of these arrangements.

9.6 will appropriately undertake visits to homes, rest-homes and hospitals as necessary.

Evidence

- Practice observation
- Consultation observation
- Patient Feedback Survey results (available in the candidate's portfolio)
- Discussion.

Guidelines

Patients need to be informed about the costs of consultations and additional treatments, and should be given indicative costs and options for special investigations or specialist consultations. Much of this information may be provided in a poster at the reception desk showing the costs of practice services. If the management plan that you propose has additional cost implications, these should be discussed in the consultation.

The suggested average time for a consultation is not less than 10 minutes and consultations that meet the expected standards are likely to average 15 minutes. It is important that the assessor gets to view what you do on a usual day. The assessor will verify this in their review of your records and make a judgment as to whether your practice on the day is representative of your usual practice.

You need to be aware of the practice triage system and your role in this system. You must have a current ACLS certificate (to be awarded Fellowship, this needs to be assessed and at a minimum at the level of the CORE Immediate course) and must know the location of the closest defibrillator (this should ideally not be more than five minutes away).

Fulfilling your obligations for the follow-up and safety of patients for whom you are providing care means that you must ensure they have a clear understanding of what they are to do when you are not available. This requires that:

- you ensure 24-hour care is available
- you inform your patients of your after-hours care arrangements
- you provide any information necessary for the safe hand-over of care
- you are prepared to visit patients under your care who cannot reasonably access your practice
- you have in place means to assure your safety if this is necessary for the visit.

8. Respect for the rights and needs of patients

Indicator 10: The rights and needs of patients are respected.

The candidate:

10.1 provides care to all patients regardless of age, sex, race, religion or social circumstance.

10.2 ensures that patients are made aware of their right to have a support person or chaperone present during a consultation.

10.3 is aware of the contents of the Health Information Privacy Code 1994 and can discuss the arrangements made to ensure confidentiality of patient records by the practice.

10.4 is familiar with the practice system for dealing with patient complaints and can describe how this system complies with the Code of Health and Disability Services Consumers' Rights, and how it is used for practice improvement.

10.5 can discuss how any complaints relating to their own, or their colleagues', practice have been managed in the practice, the support that has been available, and how the complaint has been used for practice improvement.

10.6 ensures that patient dignity and privacy is maintained at all times.

10.7 obtains patient consent for procedures, where relevant.

10.8 acts as an advocate for patients in their dealings with the health system.

10.9 discusses possibly controversial topics such as complementary medicines or PSA screening with patients in a value-free but evidence-informed manner, when relevant.

Evidence

- Practice observation
- Consultation observation
- Discussion
- Patient consent form
- Spot check of medical records.

Guidelines

General practice teams must provide care that meets the needs and rights of patients, and be accountable.

New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers' Rights (1996). You need to be aware of this Code and should also be aware of the Information Privacy Code 1994.

You need to take responsibility for ensuring that a copy of The Code of Health and Disability Services Consumers' Rights 1996 is displayed in the practice. You also need to ensure that signage regarding the right to have a chaperone is displayed in a visible area, preferably close to the examination couch. The wording of the sign should focus on meeting the needs of the patient rather than be a legalistic statement.

The assessor will be looking at how you ensure patient privacy during the consultation. During intimate examinations, you should ensure that the patient is not visible to anyone opening the consultation room door. You should also ensure that telephone conversations are private and that computer records are secure, with password protection, screensaver, scrambler key or other means to quickly hide records and ensure privacy.

You must be aware of the patient's right to complain, and should be able to provide and discuss the practice's policy for dealing with complaints.

Written consent is required from patients if there is a significant risk of an adverse effect of a procedure. You will need to provide a copy of the consent form/s (minor surgery or equivalent) that are used to obtain patient consent.

Right 10 of The Code states that every consumer has the right to complain in any form appropriate to the consumer. Among the requirements of the Code are that:

- every provider must have a complaints procedure
- every provider must facilitate the fair, simple, speedy and efficient resolution of complaints
- the provider must inform the consumer about progress on the consumer's complaint at intervals of not more than one month
- a complaint must be acknowledged in writing within five working days of receipt
- the complainant is informed of any relevant internal and external complaints procedures
- the consumer's complaint and the provider's actions regarding the complaint are documented
- the consumer receives all information held by the provider that is or may be relevant to the complaint
- within 10 working days of giving written acknowledgement of the complaint, the provider must decide whether the provider accepts that the complaint is justified, whether more time is needed to investigate the complaint, and, if more than 20 days is required, inform the consumer, and as soon as practicable inform the consumer of the reasons for the decision made, any actions proposed and any appeal process the provider has in place.

Further information

- **The Code of Health and Disability Services Consumers' Rights 1996**
- **Health Information Privacy Code 1994**
- Privacy Commissioner: **On the Record** health guide

9. Professionalism and ethics

Indicator 11: The candidate maintains professional integrity.

The candidate:

11.1 displays personal attributes necessary to maintain probity and patient trust.

11.2 deals appropriately with ethical dilemmas and conflicts between competing values when these arise.

11.3 uses resources ethically and equitably, avoiding the unnecessary or inappropriate use of medication or publicly funded investigations.

11.4 ensures that the care they provide is not compromised by the requirements of a provider organisation, including through over-servicing, over-booking, conflicts of interest, or perverse incentives.

Evidence

- Consultation observation
- Practice observation
- Colleague Feedback Survey results (available in candidate's portfolio)
- Patient Feedback Survey results (available in candidate's portfolio)
- Medical educator reports (available in candidate's portfolio)
- Spot check of medical records
- Discussion.

Guidelines

The assessor will be watching during the visit, and particularly during consultation observation, for evidence of your professional skills and values, and your ability to deal with difficult situations and conflicts of interest (for example, around the treatment of family members, or in cases where another doctor's judgment could be questioned).

10. Scholarship and professional development

Indicator 12: The candidate can show they consider and apply the most up-to-date evidence in delivery of patient care.

The candidate:

12.1 is familiar with and can demonstrate their use of current clinical practice guidelines and clinical information sources.

12.2 makes provision for professional development and takes responsibility for maintaining their competence.

Evidence

- Consultation observation
- Practice observation
- Professional development plans (available in the candidate's portfolio)
- Audits of medical practice (available in the candidate's portfolio)
- Discussion.

Guidelines

During the practice visit, the assessor will be looking for evidence that information regarding current clinical practice guidelines (including local, regional or national guidelines as appropriate) and referral pathways is available and is used.

The assessor will want to know how you ensure that your knowledge remains current and you maintain your competence. Evidence will include your membership of a peer group and your record of continuing medical education. The assessor will also evaluate the medical, surgical and general practice reference material immediately available to you, whether in written or electronic form.

11. Health and wellbeing

Indicator 13: The candidate is fit for work and has mechanisms for self-management and self-care.

The candidate:

13.1 makes provision for their own health maintenance and work–life balance.

13.2 has considered factors that affect their performance and has arrangements in place to manage these.

Evidence

- Colleague feedback results
- Discussion
- Candidate presentation.

Guidelines

The assessor will want to discuss the arrangements you make for self-care and for a good work–life balance. You are expected to have your own GP, and should not prescribe for or treat your family members, except in extenuating circumstances. The assessor may touch on how you recognise and deal with stress, the support mechanisms you have in place, and any strategies you have for building resilience.

You should acquaint the assessor with any current issues for your health, family or circumstances that may impact on your performance. Please inform the assessor if you have any outstanding disciplinary or legal actions against you. These are not necessarily a barrier to Fellowship, but a failure to disclose could be.

The Health Practitioners Competence Assurance Act 2003 Section 45 makes it mandatory for a medical practitioner who has reason to believe that another medical practitioner is not fit to practise medicine because of some mental or physical condition to give notice to the Registrar of the Medical Council of New Zealand of such belief.

APPENDIX A

Required equipment and medicine list

This list of equipment is a minimum requirement, which has been decided on after considerable input from practitioners in various types of practices. In rural practices, depending on remoteness, additional equipment may be considered very important or essential.

NOTE: You will receive a fillable version of this form in your Fellowship assessment pack.

☑ General equipment

- ☐ Auriscope
- ☐ Automated external defibrillator – should be accessible within 5 minutes and a team member should know how to read the tracings
- ☐ Blood glucose test strips/glucometer – expiry dates must be current; check calibration of glucometer to number on strip
- ☐ Cervical smear equipment
- ☐ Dressings (adequate to the services provided)
- ☐ Means for removal of wax and foreign bodies from ear canal
- ☐ A means for the examination of skin lesions under magnification
- ☐ Eye local anaesthetic
- ☐ Fluorescein dye for eyes
- ☐ Disposable gloves
- ☐ Height measure
- ☐ Measuring tape
- ☐ Monofilament for sensory testing
- ☐ Ophthalmoscope
- ☐ Peak flow meter/spirometer
- ☐ Pregnancy testing kit
- ☐ Protoscope
- ☐ Reflex hammer
- ☐ Spacer devices
- ☐ Spatulae
- ☐ Sphygmomanometer – extra-large and paediatric cuffs – calibrated within the last year if aneroid; mercury sphygmomanometer needs only rubber pipes checked
- ☐ Stethoscope
- ☐ Surgical instruments appropriate for procedures provided
- ☐ Suturing equipment
- ☐ Syringes and needles
- ☐ Thermometer
- ☐ Tuning forks – 256 hz, 512 hz
- ☐ Urinary catheters and local anaesthetic gel for urgent catheterisation (this may be by referral in urban area)
- ☐ Urine dipstix – protein, glucose, ketones (check expiry dates)
- ☐ Visual acuity charts – at the specified distance / colour vision charts
- ☐ Weight scales – adult, paediatric

☑ Essential emergency and resuscitation equipment

- ☐ Airways and/or laryngeal masks – varied sizes, 00 to adult
- ☐ Ambubag and masks – paediatric to adult
- ☐ Emergency bag/trolley
- ☐ IV equipment – set up and infusion
- ☐ Oxygen
- ☐ Saline
- ☐ Tourniquet

☑ Essential basic and emergency medicines

- ☐ Adrenalin 1/1000 inj.
- ☐ Analgesia, eg paracetamol, diclofenac, ibuprofen
- ☐ Antiemetic
- ☐ Antihistamine inj.
- ☐ Acetylsalicylic acid tablets
- ☐ Atropine inj.
- ☐ Corticosteroid inj.
- ☐ Diazepam inj./rectal
- ☐ Furosemide
- ☐ 50% glucose/glucagon inj.
- ☐ Local anaesthetic inj.
- ☐ Naloxone inj.
- ☐ Trinitroglycerin spray
- ☐ Penicillin inj. – some need refrigeration and in addition powdered version for off-site emergencies
- ☐ An alternative for those allergic to penicillin
- ☐ Sodium chloride (NaCl) for injection
- ☐ Sterile water for injection

APPENDIX B

Criteria for assessing consultations

Establishing and maintaining a therapeutic patient–doctor relationship	Defining the problems and reasons for patient's attendance	Performing an appropriate examination	Providing appropriate management	Clinical thinking, organisation and professionalism
0 Damaging aspects to the relationship with the patient, including concerns about cultural competence.	**0** Life-threatening problems appear to have been missed.	**0** Absent or very inadequate examination for the major problems; safety concerns. Patient consent to examination not established.	**0** A dangerous management plan, including dangerous omissions. Effect of cultural differences not considered.	**0** Serious deficiencies in thought or organisation. Unethical or dishonest behaviour or other serious concern regarding candidate behaviour.
1 The patient is not being heard. Responds to immediate reason for consultation but misses obvious patient cues. Not patient-centred.	**1** Presenting complaint poorly identified or other major problem(s) may have been missed.	**1** Poor examination technique, patient consent to examination not established.	**1** Unclear, or poorly justified management for major problem(s) with potential safety risks. Effect of cultural differences not considered.	**1** Major deficiencies evident in clinical thinking or organisation, or in professional or ethical behaviour.
2 Patient heard but not at ease. Responds to obvious cues but not exploring concerns or feelings of the patient. Not patient-centred.	**2** Presenting and other major problems probably identified but without verification with patient. Prioritisation unclear.	**2** Examination not adequate for the major problems, patient consent to examination uncertain.	**2** Safe management for the major problem(s), doubt remains about the patient's agreement to the management and/or the impact of cultural differences.	**2** Deficiencies observed in clinical thinking, organisation or professional behaviour which are of concern.
3 A therapeutic relationship is established. Limited expression of patient concerns and feelings. Exploration limited. Mostly patient-centred.	**3** Presenting and major problems defined, verified with patient, and safely prioritised. Associated problems or preventive care opportunities missed.	**3** Adequate examination for the major/ life-threatening problems, patient consent to examination established, no examination for associated problems.	**3** Sound management for the major problem(s), with agreement of the patient. Management of associated problems ignored. Cultural differences factored in.	**3** Some improvement could be made to clinical thinking, organisation or professional behaviour. Concerns are not significant.
4 Therapeutic relationship clearly established. Open expression of concerns and feelings. Some weaknesses noted. Patient-centred.	**4** Most major and associated problems identified, verified with patient and safely prioritised. Preventive care issues may have been missed.	**4** Adequate examination for most problems with clear consent of the patient, but some omissions from the ideal examination.	**4** Clear and sound management plan for most problems, including all major problems; clear patient agreement. Minor omissions in plan.	**4** Clinical thinking, organisation and professional behaviour observed are mostly at a high standard. Minor deficiencies noted.
5 Strong therapeutic relationship clearly established. Mastery of relationship skills to a high level. Clearly patient-centred.	**5** All relevant problems, concerns and preventive care opportunities clearly identified, verified with patient and safely prioritised.	**5** Examination clearly adequate for all problems, with clear consent and full cooperation of the person with authority to provide consent.	**5** Clear, sound and comprehensive management plan with clear patient agreement, addressing all problems with no significant omissions.	**5** Clinical thinking, organisation and professional behaviour observed are of a high standard. No deficiencies noted.

APPENDIX C

RNZCGP Clinical Record Review self-audit checklist

Introduction

General practices deliver a service that must be managed effectively to ensure that it meets the needs of patients. The patient's clinical record is integral to maintaining good patient care and continuity of care.

Patient records should describe and support the health care that has been provided. They should be understandable to a newcomer to the practice. The structure of the records should allow information to be obtained easily. It is important that adequate information is recorded for each consultation and that the person making the entry is identified – this includes telephone consultations.

Conducting a record review helps to establish and improve the quality of clinical records and supports the safe care of patients.

This clinical record review self-audit checklist can be used by practices that are conducting self-assessments in preparation for practice accreditation processes. The checklist enables doctors, practice nurses and practices to ensure that they are meeting Indicator 21 of *Aiming for Excellence: The RNZCGP standard for New Zealand general practice*: 'Patient records meet requirements to describe and support the management of health care provided'. The criteria in this checklist also link to a number of other criteria in the Standard.

This clinical record review self-audit checklist is also a component of the General Practice Education Programme (GPEP) and can be used as an audit activity for the continuing professional development programme (CPD/MOPS).

The tool has two parts:

- **MODULE 1** includes requirements for the practice patient record system and the demographic details that it records. This module should be undertaken for **practice accreditation purposes**.

  If this module has been done in the practice within the past three years, it does not need to be completed by doctors undertaking Module 2 for the training programme or for professional development purposes. The module contains both foundational and advanced criteria.

- **MODULE 2** contains criteria that should be assessed for **practice accreditation, training programme and professional development purposes**. The module contains both foundational and advanced criteria.

The bullets alongside criteria in the tool indicate the following:

- F These are basic criteria that must be assessed in the **Foundation Standard** process. These criteria indicate that the clinical record meets minimum legal, regulatory and professional standards and is sufficient for safe practice. These criteria are found in both modules 1 and 2.
- A These are advanced criteria that must be assessed as part of the **CORNERSTONE®** assessment process. These criteria indicate that the clinical record is complete. These criteria are found in both modules 1 and 2.

Both basic and advanced criteria are completed for the **training and continuing professional development programmes**.

Instructions

Modules 1 and 2 of the checklist require a random audit of **10** patient records.* Applications that generate lists of random numbers are available online. However, the easiest way to generate a random sample is to select consecutive patient appointments, beginning at a random time on a randomly selected day.

Patient records should be electronic. All records selected should have an entry in the past 12 months. The review should not focus on a single consultation but rather on a series of the most recent consultations for a particular record.

Module 1 can be completed by practice administration staff. Module 2 must be completed by the clinician whose notes are being audited.

Modules 1 and 2

- Randomly select 10 patient clinical records.
- Complete the Module 1 or Module 2 template attached by marking the boxes in the columns numbered 1 to 10 for each of the records reviewed as follows:
  - **Y** present and adequate
  - **IN** present but inadequate
  - **N** not present
  - **N/A** not applicable/necessary in this case
- Evaluate each of the criteria by selecting 'met', 'part met', 'not met' or 'n/a' (not applicable) for each of the rows.
- Complete the Report and Plan template, identifying areas for development and a plan for improvement.

GPEP registrars

It is your responsibility to check whether the practice has completed Module 1 of the checklist in the past three years, and if not, to compete it as part of your audit requirements. If your practice has completed Module 1, please provide a copy with your completed Module 2.

You are required to submit the completed clinical record audit checklist to the College. Complete and return both the Recording Sheet and the Report and Plan sheet to your GPEP Programme Advisor. **You are encouraged to discuss the results of this audit activity with your medical educator, collegial relationship provider, or a peer**.

Please note: A fillable pdf version of this document is available on the website (Learning Zone). If you complete the form electronically, please ensure that you make a back-up copy and print your completed form. Some computer software may result in compatibility issues.

Clinician's name:

MCNZ/NCNZ number:

Date:

MODULE 1

Patient record system†

NOTE: You will receive a fillable version of this form in your Fellowship Assessment pack.

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
1.	**Patient records are electronic, secure and traceable:**														
	All clinical information is:														
F	recorded electronically														
F	password protected														
F	reliably backed up														
	Clinical notes:														
F	are dated														
F	reliably identify the author														
2.	**Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements:**														
	Information stored for each patient includes:														
F	NHI number														
F	name														
F	gender														
F	address														
F	date of birth														
F	ethnicity														
F	registration status														
	Information held for enrolled patients includes:														
F	contact phone number														
F	contact in case of emergency (ICE)														
F	next of kin – where applicable														
A	significant relationships														
A	hapū/iwi for Māori patients														
A	primary language if not English														
	Need for an interpreter:														
A	Any need for an interpreter is flagged for patients with English as a second language														

† This module is completed at practice level as part of the Foundation Standard and CORNERSTONE® accreditation process. Provided it has been done at practice level in the past three years, it does not need to be completed by doctors undertaking Module 2 for other purposes. If not doing this section themselves, GPEP2/3 registrars must attach a copy of the completed Module 1 done by their practice.

MODULE 2

Clinical record review

Clinician's name:

MCNZ/NCNZ number:

Date:

NOTE: You will receive a fillable version of this form in your Fellowship Assessment pack.

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
1.	**The record is appropriate, contemporaneous and sources are identified:**														
F	Notes are completed as soon as possible after contact, and any delay is identifiable.														
F	Information is recorded objectively and does not contain inappropriate, judgmental comment.														
F	When information is provided other than by the patient, the source is identified.														
2.	**Clinical notes can be understood by someone not working regularly at the practice:**														
F	The notes are logical, intelligible and sequential.														
A	The use of keywords or templates does not compromise the validity of the notes.														
3.	**Important background issues, warnings and alerts are displayed for all records:**														
F	Past medical history is available.														
F	Significant social history is included.														
F	The PMS is used to effectively display important warnings, and alerts.														
F	Allergies or the absence of known allergies is recorded for each patient.														
4.	**Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point:**														
F	Patient needs recorded include any directives by patient, disabilities, drug dependencies, end of life and special needs (eg communication, mental health issues).														
5.	**The recorded history is relevant and sufficient for both safe management and evidential purposes:**														
F	The reason(s) for the encounter recorded or apparent from the notes.														
F	The record includes date, place of consultation (if different from usual) and mode of contact if not face to face.														
6.	**The record includes all findings essential to diagnosis and management:**														
F	Sufficient positive and negative history and examination findings are present to justify management decisions.														
F	Objective measurements (BP, pulse, temp., respiratory rate, PaO2 etc) are recorded, where relevant.														

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
7.	**The working diagnosis/differential or problem being managed is apparent and consistent with supporting information:**														
F	The diagnosis (and any differential) and level of certainty is clear from the notes.														
8.	**The patient management plan is clear and identifies and addresses uncertainty and conjecture:**														
F	The plan for care can be identified from the record.														
F	Important assumptions and remaining uncertainties in diagnosis and management are noted.														
9.	**The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent:**														
F	Notification of test results and clinical findings is recorded.														
F	The record supports adequate consenting processes.														
10.	**All important clinical decisions and interventions are recorded:**														
F	Treatment plans, including interventions, contingency plans, safety netting and follow-up arrangements are recorded as necessary.														
F	Clinical management decisions made outside consultations (eg telephone calls) and off-site contacts (home visit, aged care facilities etc) are recorded.														
11.	**The record identifies all medication treatment provided, including the type, dosage and total amount of any medications prescribed:**														
F	There is a record of all prescriptions issued, including drug name, administration instructions and quantities ordered.														
F	Medications initiated or changed outside the practice are reconciled with the PMS.														
A	Current and long-term medications are differentiated and the status is clear.														
A	Where long-term medications are changed, reasons for alteration or discontinuation are clear.														
12.	**The record identifies all investigations requested and tracks high-risk tests:**														
F	All requests for tests and investigations are recorded.														
F	High-risk tests (eg histology, cervical smears) are tracked for completion.														
13.	**The record supports effective and timely referral for treatment or transfer of care:**														
F	The record shows that referrals are completed within a reasonable time frame.														
F	Copies of referral letters to and from the practice, certifications, referrals and responses, discharge summaries and test results are included in the patient PMS record or accessibly filed.														

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
F	Referrals include urgency, reason/ expectation of referral, relevant findings, classifications, warnings and current treatment.														
A	The transfer of responsibility for care can be verified from the records.														
14.	**Follow-up of test results is clearly documented and actions recorded:**														
F	Follow-up actions on test results and referrals are recorded.														
15.	**Screening history and results (or declined screening) are recorded:**														
F	Screening history and results (including declines) are evident for routine screening areas (eg cervical smears, mammograms, cardiovascular risk assessment, diabetes screening).														
F	Screening recall status can be easily tracked.														
A	There is evidence of patient risk assessment and opportunistic screening for high-risk conditions.														
16.	**Immunisation history and status is recorded:**														
F	There is evidence that recommended immunisations are provided in accordance with the national schedule.														
A	Records show advice given and immunisation status for non-scheduled immunisations.														
17.	**There is a systematic record of individual risk factors:**														
A	Diseases are classified for chronic conditions, including all conditions for which the patient is on long-term treatment.														
A	Family history for major risk factors, such as diabetes, early CVD, bowel and breast cancer etc.														
A	Current employment (where relevant) and any history of at-risk occupations.														
A	Blood pressure monitoring as clinically indicated.														
A	Baseline weight/BMI and monitoring as clinically indicated.														
A	Smoking status and history and cessation support offered, where relevant.														
A	Alcohol and drug usage.														
A	Regular review of chronic conditions as per current best practice (eg INR, diabetes, CVR).														

APPENDIX D

Checklist prior to practice visit

Before the visit

- [ ] Have you completed and returned your details for Fellowship assessment visit form to the College?
- [ ] Have you completed the RNZCGP Clinical Record Review self-audit checklist and sent it through to the College?
- [ ] Have you completed and submitted the required equipment and medicines checklist?
- [ ] Have you conducted a self-audit of your referral letters (recommended, but not a requirement)?
- [ ] Ensure that you know how you are expected to respond in an emergency.

The practice

- [ ] Is the practice clean and tidy for the day?
- [ ] Is there an H&DC poster and/or pamphlets outlining patients' rights in place in the waiting room?
- [ ] Is there a notice or other means of advising patients of the costs of consultations and any additional charges?
- [ ] Have you prepared the staff so that they understand what this visit is about and that they will make the visitor feel welcome?
- [ ] Have you arranged for someone to offer a beverage and considered offering a bite to eat if the visit is scheduled to run through lunch?

The consulting room

- [ ] Does your consulting room have all essential fittings, adequate soundproofing, sufficient light and a suitable level of comfort and privacy for safe practice?
- [ ] Is the room big enough to have an observer sitting in?
- [ ] Have you an extra chair in the room for the visitor, placed so as to minimise intrusion on your consultations? (You do not need to video this session.)
- [ ] Do you have a notice in place inviting a chaperone and can you describe your chaperone policy?
- [ ] Have you ensured there is password protection on all the terminals you use and a means to stop notes being visible when you leave your terminal?

Consultations

- [ ] Have you a notice in place and will each patient receive and sign a form demonstrating their consent to the visitor sitting in?
- [ ] Have you allowed for observation of at least eight consultations and sufficient debriefing time?
- [ ] Will this be a range of usual general practice consultations (avoiding special interest or alternative medicine consultations)?
- [ ] Have you established a habit of cleansing your hands (water or alcohol) before touching a baby and after a patient examination where there is a risk of contamination?
- [ ] Have you organised a computer terminal (and paper files if necessary) to be available for the records check?
- [ ] Do you have a reliable system in place for management of routine test results?
- [ ] Can you show that you have ready access to reference advice and guidelines?
- [ ] Can you demonstrate the way you provide your patients with clinical information to supplement your consultations?
- [ ] Can you describe the way you ensure adequate safety-netting, including follow-up, after-hours care home visits and transfer of care as necessary?

Practice systems

- [ ] Are you familiar with practice surface and instrument cleaning procedures?
- [ ] Can you demonstrate how you ensure sterilising procedures work as intended?
- [ ] Are instruments for invasive procedures stored in sterile packs with sterilisation indicators?
- [ ] Can you demonstrate that all biological waste is stored safely and disposed of in compliance with local regulations?
- [ ] Are sharps kept out of reach of children and discarded safely?
- [ ] Do you discard all single-use instruments (ear pieces, tongue blades, specula etc) after single use?
- [ ] Can you verify cold-chain compliance by way of a current Immunisation Accreditation Certificate? (Minimum requirements include protection in transport, a dedicated fridge, daily temperature readings and computer printout from a temperature logging device.)
- [ ] Are controlled drugs stored in a metal or concrete safe securely fixed to the building with the key securely stored?
- [ ] Can you demonstrate the practice procedures for controlled access to restricted drugs?
- [ ] Have you a knowledgeable nurse available on the day to help explain any of the above systems that you might not be familiar with?
- [ ] Can you demonstrate how your patients know about and receive 24-hour cover and how they are informed of the care they receive after hours?
- [ ] Can you describe the practice triage system for urgent medical problems?
- [ ] Can you demonstrate that there is a complaints procedure and that you know the procedure and timelines as per Health Consumer Right 10?
- [ ] Do you have a reliable patient recall system?
- [ ] Can you demonstrate how abnormal test results are followed up?
- [ ] Do you have access to mobile emergency equipment?

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