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ReCEnT: Instructions for registrars on completing the 'Encounter Form'

Introduction

These instructions are written to complement face to face orientation and training on your participation in the ReCEnT project. **It is important to read through these instructions in full prior to commencing data collection.**

Background

Clinical encounters are the core learning activity of general practice training in Australia. However, exposure to different patient demographics and presentations is highly variable between registrars and practices. This has a clear impact on the nature and quality of training.

The ReCEnT project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations. You will record details of *sixty* consecutive consultations on three occasions during your training time. Educational factors related to the encounter will be recorded along with consultation details.

For the first time, the project has been documenting the content and nature of Australian GP registrars' clinical consultations over time. This information will be of great value in supporting both your individual learning, as well as informing your education and training program overall. The study will also provide a platform for further research and audit activity by GP registrars.

Between 1998 and 2015, the BEACH (Bettering the Evaluation and Care of Health) program, coordinated by the Family Medicine Research Centre at the University of Sydney, collected information on the clinical activity of Australian general practice. In order to make the two sets of data comparable, the ReCEnT Patient Encounter form and instructions have been made as comparable as possible with the equivalent BEACH resources (with permission).

General Instructions

Consecutive consultations

Please complete an encounter form for every one of a total of sixty (60) consecutive clinical encounters. There are only two exceptions to this:
1. when you see a patient and ask them to return later that day for review e.g. you see a child with a suspected fracture after a fall, send them off for an X-ray and ask them to return with the films – in this case, please use a single form and complete it as if it was conducted all in one consultation
2. consultations involving patients who decline involvement (see below).

Forms must be completed during the data collection period as advised.

Please record all consecutive consultations; in particular, do not leave out more complex interactions which might take a little longer to record. Excluding more complex consultations will minimise the breadth of clinical encounters recorded and potentially bias the data returned to you in your ReCEnT feedback report and the wider project results.

Only record consultations conducted in the general practice setting i.e. DO NOT record consultations conducted in a nursing home, or on a home visit. As well, do not record consultations as part of a specialised clinic e.g. immunisation, flu-needle clinic, or Women's Health clinic.

If you work at more than one practice, please choose ONE of the practices (the practice you work at most) and complete ALL of your sixty (60) consecutive clinical encounters there.

Patients who decline involvement

The process to ensure that patients are informed should be as follows:
- Reception staff to provide patients with the 'Patient Information Sheet' (copies included in registrar's ReCEnT pack) **NB. You do NOT need to individually discuss the project with each patient.**
- Patients will inform registrars if they do not want data recorded – i.e. this is an opt-out process.
- You need to record number of patients who decline to have ReCEnT information recorded by marking off a circle on the sheet attached to the front of the encounter pad.
- You should **NOT** record ReCEnT data for patients who decline to participate.

Made a mistake?

There are a few spare forms at the end of the pad in case you make a mistake and wish to start with a new form. Please ensure you enter the relevant encounter number in the top left corner.

Complete all questions

Please respond to every question on the form. Though it is tempting to leave a question blank if the answer is 'no', we have no way of knowing whether it is truly 'no' or whether it was left out by accident.

Not enough space to record everything?

Occasionally there may not be enough room on the form for you to write in everything regarding an individual consultation. For example, patients may present with more than four reasons for the encounter, or you may need to order more than 12 pathology tests. If this occurs, please use your judgement to decide which are the *most important* items to include.

Abbreviations/Acronyms

Unless it is a very well established abbreviation or acronym, please write out in full. For example, SCC always means squamous cell carcinoma, but SK could mean solar kerotosis or seborrhoeic kerotosis.

Handwriting

Please write as clearly as possible in order for your data to be correctly entered.

The encounter form

You will be familiar with the format of the encounter form from your ReCEnT project orientation session. The following is a reminder on how to complete each element of the form and, in some cases, the rationale for doing so. Some elements are self-explanatory and therefore not included below.

Registrar ID

Each registrar has been given a unique numerical code to protect their privacy. Only your medical educator and supervisor and (if you agree to your data being used for research purposes) the researchers involved in the project will have access to information which might identify you. No information will be reported which allows individuals to be identified.

Encounter number

The encounter number is pre-stamped onto your pad of forms from 01-60. There are four extra forms in case you make a mistake. Please ensure that you complete a total of 60 forms and that you complete a new form for every clinical encounter, regardless of whether you have seen the patient previously in the data collection period.

Patient demographics

DOB and gender

Self explanatory.

Non-English Speaking Background (NESB)

In order to identify NESB status, please ask the patient "Do you speak a language at home other than English?". If the patient is from a NESB i.e. primary language spoken at home is NOT English, tick the 'Yes' box. Otherwise, tick the 'No' box. You will have to directly ask about the language spoken at home to obtain this information.

Patient Details	Yes	No
New patient to practice	☐₁	☐₂
New patient to registrar	☐₁	☐₂
Non-English Speaking Background (NESB)	☐₁	☐₂
Aboriginal	☐₁	☐₂
Torres Strait Islander	☐₁	☐₂

Aboriginal and Torres Strait Islander

Aboriginal and Torres Strait Islander Australians have a substantially greater burden of illness than their non-Indigenous counterparts. Identifying Indigenous status is an important element of the consultation.
In order to identify Indigenous status, please ask the patient "Do you identify as an Aboriginal or Torres Strait Islander?" and tick the boxes as appropriate. The patient may answer "Yes" to either or both.

For more information on identification of Indigenous status, see the following link
http://www.healthinfonet.ecu.edu.au/health-facts/health-faqs/identification

Consultation factors

Duration of Consultation

The duration of the consultation is an important feature of quality of care in general practice. Longer consultations are associated with a number of factors - higher patient satisfaction, opportunistic preventive care, and identification and management of psychosocial problems.

Please record the duration of the consultation as accurately as possible to the nearest minute.

> TIPS
> - *Use the electronic timer in your medical record software*
> - ***Avoid rounding up or down*** *to five minute increments*
> - *Include in your recorded time the time it takes to write your notes as well as the patient contact time.*

New patient to practice

Continuity of care is very closely related to patient satisfaction. The ReCEnT study will investigate the degree of continuity of care in GP training.

If this is the patient's first visit to this practice, tick the 'Yes' box. Otherwise, tick the 'No' box.

New patient to registrar

If this is the first time you have seen the patient, tick the 'Yes' box. Otherwise, tick the 'No' box.

Medicare item numbers

Please record up to four Medicare item numbers. If unsure, please describe type and level of consultation, or type of service e.g. level D, ECG etc. Only include item numbers for services where the patient is actually seen in the consultation room i.e. do not record home or NH visits, or where the patient is not seen e.g. case conferences.

Billing

- **Private:** Tick this box if the patient paid a co-payment.
- **Bulk Bill:** Tick this box if the visit was bulk billed.
- **Workers Comp:** Tick this box if the visit was covered under WorkCover.
- **No Charge:** Tick this box if the visit was free to the patient and there was no Medicare billing.
- **Other:** Tick this box if the encounter is being paid for by another source e.g. insurance company, overseas patient, work or employment medical.

Billing	
Private	☐1
Bulk Bill	☐2
Workers Comp	☐3
No Charge	☐4
Other	☐5

Problem/provisional diagnosis

Problem/Prov. Diagnosis 1:	Prob. Status
....	New ☐₁ Old ☐₂

We are interested in the range of clinical conditions that registrars are exposed to during their training. In this box, please write your single most likely provisional diagnosis, or if there are a number of separate diagnoses/problems, write them in separate boxes. Record *at least one* and up to four problems.

Please do not list the differential diagnosis - for the purpose of this study, it does not matter if you are uncertain of the diagnosis and it turns out to be something else later. In particular, please do not use question marks e.g. *chest pain ?ischaemia*, as this makes coding very difficult.

> TIPS
> - *Use one provisional diagnosis/problem box for each diagnosis/problem.*
> - *Please be as specific as possible with your provisional diagnosis i.e. record at the highest level possible with the information available. For example, for diabetes, differentiate between IDDM/NIDDM etc.*
> - *In cases where there is no clear provisional diagnosis, it is OK to record:*
>   - *ill-defined conditions (e.g. "cough", "chest problem"),*
>   - *preventive care (e.g. "pap smear", "contraception", "immunisation" or "checkup"), and*
>   - *social problems (e.g. "problems with spouse").*
> - *Only record problems actually dealt with at this encounter - you don't need to list all the patient's known diagnoses.*
> - *The order in which you record the problems is not significant.*
> - *If more than four problems are managed at the consultation, record the four problems that best describe the breadth of the consultation.*
> - *Again, please DO NOT use question marks.*

Problem status

Problem status refers to whether the problem is new or old TO THE PATIENT.

Tick 'New' if:
- this is a new problem to the patient, or
- this is a new episode of a recurrent problem (e.g. UTI), or
- the patient has not been treated for that problem by any medical practitioner before.

Tick 'Old' if the patient has been seen before by ANY medical practitioner for this chronic problem or this episode of an acute problem.

Medications prescribed

Record medications when
- a prescription is written at this encounter,
- you recommend that the patient take an "over the counter" (OTC) medication,
- you administer or supply a medication/vaccine e.g. If 'Immunisation' is the problem managed, please enter drugs administered at this encounter, (e.g. CDT, DTP) or any drug samples you provide.

Drug name and Route of Administration
- Write the brand or generic name of the medication and its route of administration e.g. Nexium tablets po. For vaccinations, specify the brand name, e.g. "HB VAX II", instead of "hepatitis B vaccine"

Drug status
- If the medication is being used for the management of this problem for the first time then tick the 'New' box. If it is a continuation or repeat of previous therapy then tick the 'Cont' box.

Problem (s)
- Circle the number of the problem for which each medication was prescribed.

> TIPS
> - *Only record medications that were prescribed / advised / supplied at this encounter*

Medications ceased

There is an increasing emphasis in GP training on registrars reviewing patients' treatment regimens and ceasing medicines that are *no longer indicated*. Medicines might also be ceased because of *side effects* or because of recognition of *drug interactions* or because the patient no longer wishes to take the medicine (or has already self-ceased the medicine: for ReCEnT purposes we classify both these circumstances as '*non-compliance*') or recognition that the drug isn't working (*lack of efficacy*). Or there may be more than one reason for de-prescribing.

Record when you cease prescribing any medications and circle which problem the ceased medication relates to.

Also tick the box or boxes (it could be for more than one reason) for whether the drug cessation was for:
- being *no longer indicated* and/or
- *side effects* and/or
- *drug interactions* and/or
- '*non-compliance* and/or
- *lack of efficacy*

Also tick 'Yes' or 'No' (as appropriate) for whether the patient was on the medication for more than three months or not.

> TIPS
> - *Only record medications that were ceased **at this encounter***

Medication dose reduced with a view to later ceasing

If you intend to cease a medication in the future but need to commence by reducing the dose as a way of weaning it, then please record that medication here. Also record its route of administration, the associated problem and choose the applicable reason(s) (there may be more than one). If you are reducing more than two medications, then just choose the two that you regard as most important.

You do not need to record medications where you reduce the dose but do not intend to cease later.

FRESH Questions

Complete this question **only** if you prescribed or recommended an antibiotic at this encounter, otherwise leave blank.

If you did prescribe or recommend an antibiotic at this encounter, tick the most correct option.

Complete this question **only** if you performed an Absolute Cardiovascular Risk (ACVR) assessment during this encounter, otherwise leave blank.

If you did perform an ACVR assessment, tick the most correct option (low, moderate, high or clinically determined high risk).

Pathology

Pathology (write one test/line)	Problem(s)		Problem(s)
1._____	1 2 3 4	7._____	1 2 3 4
2._____	1 2 3 4	8._____	1 2 3 4
3._____	1 2 3 4	9._____	1 2 3 4
4._____	1 2 3 4	10._____	1 2 3 4
5._____	1 2 3 4	11._____	1 2 3 4
6._____	1 2 3 4	12._____	1 2 3 4

Give details of up to twelve pathology tests ordered at the encounter. Document one test per line. Circle the associated problem number(s).

> **TIPS**
> - *For single tests, write the test name (e.g. HbA1c, pap smear). If ordering a set of tests such as a FBC or LFT or lipids or TFTs, record them in this grouped form. You don't need to list each of the individual tests incorporated in the set.*
> - *Do not record simple urine dip stick tests.*
> - *Link each test to the appropriate problem.*

Imaging/other referred tests

Referred imaging/other tests	Body site	Problem(s)
1._____		1 2 3 4
2._____		1 2 3 4
3._____		1 2 3 4

For imaging, write the name of the test (e.g. x-ray, ultrasound) and body site and circle the number(s) of the diagnosis/problem which is being investigated.

For other referred tests e.g. nerve conduction studies, allergy testing etc, specify the type of test and circle the relevant diagnosis/problem number(s).

> **TIPS**
> - *If you referred the patient for an ECG or spirometry (rather than performed it yourself) it should appear as an "other test".*

Previously seen for this problem

Seen by you *for this problem/s* ever before? Yes ☐₁ No ☐₂ **Problem(s)** 1 2 3 4
If yes, for which problem/s? (circle all that apply)

Another area of continuity of care we are looking at in ReCEnT is seeing a patient for the same problem as previously. If you have seen the patient for the problem/s *at any time* before, please tick the box marked 'Yes'. Circle the associated problem number(s). If not, please tick the box marked 'No'.

Procedures

Procedure/s performed by me during this consultation?	Problem(s)
If yes, which problem/s did it relate to? (circle all that apply)	1 2 3 4
Details: _____	1 2 3 4

We are very interested in the opportunities that registrars have for procedural training in the practice setting. The 'Procedures performed by me' box relates to diagnostic and therapeutic procedures that YOU actually provided during the encounter.

Include in this section procedures such as pregnancy tests, ECG, spirometry, pap smears, injections, excisions and ear syringing that have been done in the consultation. Document one procedure per line. Circle the associated problem number(s).

TIPS

- *Do NOT include in this section history taking; routine physical examinations e.g. blood pressure checks; routine urinalysis; referrals, imaging, pathology or other tests ordered (there are specific sections for these); or ECG or spirometry that is not included in patient management as part of this consultation. Please write the procedure in this box even if you refer to it in problem/diagnosis. For example, a patient might present for a pap smear, and diagnosis might be 'pap smear', but you should still record this here if you performed or assisted (you may have assisted a practice nurse or another GP in your practice). Another example is for immunisations. This might be the diagnosis, but you should still write it under procedure if you performed or assisted in the immunisation.*

Referral

Referral (mark all that apply)	Problem(s)
1. Public Clinic/Specialist (specify) ———————	1 2 3 4
2. Private Specialist (specify) ———————	1 2 3 4
3. Private Allied Health (specify) ———————	1 2 3 4
4. Other agency (specify) ———————	1 2 3 4
5. ED/Hospital (specify) ———————	1 2 3 4

Referral to other practitioners is an important aspect of patient management. If you referred the patient, specify to whom and for which problem. For example, if you referred the patient to a private physiotherapist, this would be 'Private Allied Health', write '*physio*' and circle the number(s) of the problem for which the referral was made.

Scheduled follow up

Scheduled Follow up (mark all that apply)	Problem(s)
1. GP appointment - with you	1 2 3 4
2. GP appointment - with another Dr in the Practice	1 2 3 4
3. Practice Nurse appointment	1 2 3 4
4. Telephone	1 2 3 4

- Follow up and safety-netting are core aspects of good clinical practice.
- For each problem, record the plan for *scheduled* follow up.
- Do **not** record it if you merely tell the patient to come back if they get worse, or are concerned etc.
- More than 1 option may apply for some problems.
- There is no option available for no planned follow-up. Please only circle the problems for which *formal* follow-up is scheduled.

Educational aspects

There are two educational aspects of the consultation we want to identify - the source(s) of immediate information /assistance accessed <u>during</u> the consultation, and any learning goals developed for review <u>afterwards</u>.

Sources of Information

Sources of information for patient care *during this consultation* (mark all that apply)	Problem(s)	Diagnosis	Management
1. ☐ Supervisor/other Dr in practice	1 2 3 4	☐₁	☐₂
2. ☐ Specialist	1 2 3 4	☐₁	☐₂
3. ☐ Other health professional (specify)	1 2 3 4	☐₁	☐₂
4. ☐ Electronic Resources (specify)	1 2 3 4	☐₁	☐₂
5. ☐ Book/s (specify)	1 2 3 4	☐₁	☐₂
6. ☐ Other (specify)	1 2 3 4	☐₁	☐₂

If you sought information or assistance <u>during the consultation</u> for either diagnosis or management, please indicate the source and the relevant problem number(s). Be as specific as you can, particularly in relation to electronic resources and clinical guidelines.

More than one option may apply for some problems.

Learning Goals

Learning Goals	
Did you generate any learning goals?	Yes ☐₁ No ☐₂
If yes, which problems did they relate to? (circle all that apply)	Problem(s) 1 2 3 4

For the purposes of the ReCEnT project, learning goals are defined as 'expected educational outcomes as a result of the clinical encounter'. This does **NOT** include information accessed at the time of the consultation (this should be recorded in **Sources of Information, as above)**. Rather, it refers to plans to look information up or seek advice about following the consultation or at some time in the future.

Tick the 'Yes' box if you generated any learning goals and circle the relevant problem number(s).