



The Royal New Zealand  
College of General Practitioners

# **Fellowship Assessment Visit**

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Information Booklet for Candidates





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# Introduction

## The Assessment Visit

The purpose of the Fellowship assessment visit is to examine the actual practice of the candidate to ensure that it is safe, competent and meets the standards for Fellowship. Candidates are assessed by a visiting assessor against the standards set out in this booklet; all are essential standards which must be met or exceeded to gain Fellowship of the College. The assessor records their assessments in a Report on Visit to Candidate booklet, which they send to the College for consideration by the Fellowship censors. They also complete a Candidate's Performance Report, which is sent on to the candidate by the College.

The Fellowship Assessment must take place in a general practice or other practice environment that meets most of the criteria for a general practice as listed in the definition of general practice (see Appendix III: The Discipline and Speciality of General Practice). The candidate must have worked in the practice for three months (or more) in the past nine months.

Fellowship must be obtained within 18 months of the Fellowship Assessment visit.

Please be aware that the assessor sends their report to the College and 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.

General practice is a complex activity and it is impossible to give a full written interpretation of every standard. Non-objective aspects of assessment always rely to some degree on the judgement of the assessor. Fellowship Assessors are experienced and respected general practitioners, known to have high standards of practice. They are contracted by the College to undertake assessment visits. They participate in training twice a year and are required to be vocationally registered in general practice and hold a current Annual Practising Certificate.

## The Assessment Visit Module

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The Fellowship assessment visit module has been designed to be used in the assessment of candidates undertaking GPEP2 in a variety of general practice situations, whether they are locums, salaried employees or practice principals, and whether they work full-time or part-time.

Some candidates have little control over the circumstances in which they are working and the module takes this into account. However, even where a candidate is not a principal in a practice, and has limited ability to influence the standards of the practice, the obligation to meet or exceed the set standards remains. For example, as a locum or salaried employee the candidate is expected to use only safely sterilised equipment, and use only vaccines, which are known to be effective through cold-chain preservation. Similarly the candidate is expected to have available all essential equipment, even if in their personal medical bag.

In preparation for an assessment visit, the assessor is sent the most recent PRP completed by the candidate, the most recent patient survey results, the facilitator and candidate reports from the most recent facilitator visit to the candidate, and CME and Peer Review meeting reports from the candidate.

## Indicative Time Allocation

The following time allocation is suggested for the various tasks to be carried out during an assessment visit. Circumstances may require variations to this timeline.

- Observation of the premises, equipment and the practice organisation 30 minutes
- Review of medical records 30 minutes
- Sitting in on consultations 90–120 minutes
- Discussion with candidate 30–60 minutes

## The Consultations

The assessment includes observation of 6–8 consultations. The consent of each patient is required before the assessor can sit in on a consultation. The assessor will give the candidate a signed copy of a Declaration of Confidentiality during the visit.

The assessor must observe the candidate across a number and range of consultations that will provide sufficient evidence of performance. If the candidate provides insufficient opportunity for this, then another assessment visit will be required, at the candidate's expense.

Consultations need to be conducted predominantly in English or Te reo Māori, and be based on 'conventional' general practice. Alternative therapies such as herbal medicines, homeopathy, chelation etc, are outside the purview of the College, and will not contribute evidence for assessment. 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.

## The Fellowship Standards

A copy of the standards for Fellowship follows. (The notes have occasionally been annotated in this booklet for the reference of candidates, and two Appendices have been added.) The standards are divided into 12 sections. Each of Sections one to seven begins with an overall standard followed by specific standards which must be met in order for the overall standard to be met. Each standard is accompanied by notes designed to help the assessor determine whether the standard has been met.

Parts eight to eleven do not have an overall standard per se, because of the nature of what is being assessed, but still have criteria against which the candidate can be assessed.

Where there is an appropriate Indicator for a standard in the RNZCGP *Aiming for Excellence*, 3rd Edition booklet for practice accreditation (published 2009), a reference to the Indicator has been given. A copy of the 2009 edition of *Aiming for Excellence* can be obtained from the College. It needs to be noted, though, that *Aiming for Excellence* is designed for assessment of the whole practice team, so some aspects are not appropriate when assessing an individual practitioner. The *Aiming for Excellence* booklet also contains many references to where further information on a particular aspect can be found.

The outcome of the visit is recorded in Part 12. Note that the outcome is expressed, not in terms of whether the candidate has 'passed' or not, but in terms of the extent to which the assessor considers the candidate has met the standards set out in this booklet.

# 1. Practice Facilities

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The candidate protects the safety of patients in the practice setting and does not put the community at risk from his/her personal practice.

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1.1 The candidate works in a clean environment.

There is a regular and effective cleaning system, which ensures that surfaces are free of dust, walls and floors are clean, basins are clean, toilet areas are clean and deodorised.

1.2 The practice disinfection, decontamination and sterilisation procedures are appropriate for infection control.

Discuss cleaning and disinfection procedures with the practice nurse. Normal surface cleaning should be with some type of detergent. Blood and body fluid spills should be cleaned with a hypochlorite or other suitable disinfectant.

i. Reusable equipment is decontaminated and sterilised by methods known to kill all known transmissible infections.

An autoclave is now considered the 'gold standard'. Check there is an audit trail for sterilisation and the autoclave has had an external audit for adequate sterilisation. Instruments should not be packaged if the autoclave does not have a drying cycle.

ii. Instruments are stored in a manner to maintain sterility.

Observe and discuss with the practice nurse. Instruments should be stored in packets with a sterilisation indicator. The packets should be stored in a drawer or container.

Where the candidate has little control over practice policy regarding sterilisation, enquire as to how they ensure the use of only sterile equipment in their personal practice and determine if this ensures patient safety.

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***See Aiming for Excellence Indicator B.4.3***

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1.3 Hands are washed, when appropriate, to minimise the risk of the doctor being an agent for the transmission of infection via physical contact with the patient, with blood or body fluids, or with the environment.

Observe the candidate during consultations. Hands should be washed before and/or after contact with patients for examinations. Alcohol based hand wash now accepted best practice.

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***See Aiming for Excellence Indicator B.4.2***

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1.4 Single-use disposable instruments are used where practicable, and not reused.

Observe the use of instruments such as specula and proctoscopes and discuss with the practice nurse.

- 1.5 Bio-contaminated waste generated by the candidate is safely disposed of in accordance with local regulations. The candidate should be aware of local regulations.

This would usually be collected, stored and disposed of separate from other waste, e.g. paper in a special bag with a biohazard symbol. Discuss with the candidate and practice nurse.

- 1.6 Sharps disposal is safe.

Observe that disposal is in sharps disposal containers, with a biohazard symbol, which prevent accidental injury. These should be stored out of reach of children. Discuss sharps disposal policies with the practice nurse.

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***See Aiming for Excellence Indicator B.4.4***

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- 1.7 The cold chain is preserved for vaccines used by the candidate.

Observe the presence of a dedicated refrigerator for the storage of vaccines, max-min thermometer in the refrigerator, and the daily audit record. Readings should remain in the range of 2–8°C.

Discuss with the practice nurse.

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***See Aiming for Excellence Indicator B.4.5***

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- 1.8 Controlled drugs storage, where it is the responsibility of the candidate, meets legal requirements.

Discuss with candidate and practice nurse.

Controlled drugs are to be kept in a locked cupboard, or a locked compartment, that is constructed of metal or concrete or both.

Ensure the compartment or cupboard is securely fixed to, or is part of the building or vehicle it is kept in.

Ensure the key to the cupboard or compartment is kept in a safe place when not being used. If the building or vehicle is left unattended, the safe place should not be within the building or vehicle.

There is a Controlled Drugs Register in the prescribed format (exercise book not acceptable).

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***See Aiming for Excellence Indicator B.4.6***

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General comments on the practice.

## 2. Practice Equipment

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Medical equipment and resources are adequate and appropriate to ensure comprehensive primary care, safe resuscitation, and safe performance of any additional procedures offered. The adequacy and appropriateness is determined by the circumstances of the practice.

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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 there may well be other equipment considered very important, if not essential, if a long distance from a base hospital. Rural practices generally far exceed this minimum requirement.

The candidate is asked to provide in advance a checked list of equipment. The visitor will make a spot check on a few items and check some drugs and dipstix for expiry dates.

2.1 All the following equipment is available:

- Stethoscope
- Auriscope
- Ophthalmoscope
- Sphygmomanometer – calibrated within the last year if aneroid, mercury sphygmomanometer needs only rubber pipes checked
- Range of cuff sizes for sphygmomanometer –125mm, 150mm, 175mm
- Paediatric cuff for sphygmomanometer
- Spatula
- Reflex hammer
- Tuning forks – 256hz, 512hz
- Thermometers
- Measuring tape
- Height measure
- Weight scales
- Urine dipstix – protein, glucose, ketones (check expiry dates)
- Blood glucose test strips / glucometer (check expiry dates)
- Pregnancy testing kit
- Proctoscope
- Visual acuity charts – at correct distance
- Eye local anaesthetic
- Fluorescein dye for eyes
- Ear syringe or suction
- Peak flow meter
- Nebuliser – via air or O<sub>2</sub>, or large spacer device
- Cervical smear equipment
- Gloves
- Urinary catheter or other means for urgent catheterisation (e.g. referral in urban area)

- ECG readily accessible – within 10 minutes
- Syringes and needles
- Suture equipment
- Surgical instruments appropriate for any procedures carried out
- Dressings adequate to the services provided (check expiry dates)

2.2 All the following Emergency and Resuscitation Equipment is available:

(Emergency bag/trolley)

- Airways – varied sizes from 00 to adult
- Ambubag and masks – paediatric to adult
- IV Equipment (set up and infusion)
- Saline/ plasma expander (anyone of e.g.: penpaspan/crysalloid)(check expiry dates)
- Tourniquet
- Oxygen

2.3 All the following drugs are available:

- Adrenalin 1/1000 inj.
- Aspirin tabs
- Atropine inj.
- Diazepam inj/rectal
- 50% Glucose/glucagon inj.
- Antihistamine inj.
- Local anaesthetic inj.
- Penicillin inj.
- An alternative for those allergic to penicillin
- Corticosteroid inj.
- Naloxone inj.
- Antiemetic
- NaCl to check IV route prior to administration of medicines
- Water to mix powdered antibiotics
- Analgesia, e.g. voltaren, pamol, panadol

There is a system for drug maintenance and checking expiry dates of all drugs.

2.4 Candidate's Bag

The Candidate's Bag is adequately stocked with patient examination equipment, emergency drugs and appropriate forms. As in the practice itself, the essential contents of the doctor's bag will be determined by circumstances, but the list below contains the essential requirements. Out-of-date injectables are a common problem, so check a sample of dates carefully. If the doctor does not carry a stocked bag, he/she should have some satisfactory method of having all necessary equipment available for an urgent consultation out of the surgery. This may be a practice emergency bag.

The following contents of the bag are present:

- Airway
- Gloves
- Stethoscope

- Auriscope
  - Ophthalmoscope
  - Sphygmomanometer
  - Thermometer
  - Tourniquet
  - Lubricating jelly
  - Spatula
  - Alcohol wipes
  - Range of needles and syringes
  - Dressings – bandages, sling, eye patch
  - Scissors
  - Torch
  - Blood tubes:
    - red top
    - purple top
  - Urine pots
  - Laboratory swab
  - Urine dipstix
  - Blood glucose stix
  - Protective device for mouth-to-mouth resuscitation
  - Stationery:
    - prescription pads
    - letter writing paper
    - pen
    - ACC forms
  - Drugs for medical emergencies, oral and injectable – minimum as in the list above
- } optional – depending on circumstances

There is a method for checking the expiry dates of drugs.

# 3. Availability and Accessibility

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All patients are able to obtain care and advice that is timed appropriately to their needs.

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3.1 24 hour care is provided for patients.

Determine by interview with the candidate and staff that the candidate provides formalised 24 hour cover or arranges appropriate cover for patients in their care when not available. There should be a system for information feedback to the candidate regarding care provided after hours, facilitating continuity of care. This means that the care the candidate has arranged should ensure feedback. Obviously if a patient chooses to go to a care facility which does not provide feedback, that is not the responsibility of the candidate.

3.2 Patients are made aware of after hours arrangements.

Observe that there is a patient information leaflet, notice in the waiting area, notice at the front entrance, message on the answerphone or call diversion. A notice with after hours arrangements should be visible on the outside of the building.

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***See Aiming for Excellence Indicator A.2.1***

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3.3 Patients with urgent medical problems are seen as necessary.

The practice triage system can be described by staff and candidate and this appears adequate for the safety of all patients.

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***See Aiming for Excellence Indicator A.2.2***

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3.4 The candidate will visit patients who require a home visit.

Patients of the practice who are unable to attend the surgery can obtain a visit to their residence provided it is within a reasonable distance from the surgery. This will depend on the location of the practice.

This will be established by staff and candidate interview and evidenced by records of consultations by visits or by way of a practice advice sheet to patients.

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***See Aiming for Excellence Indicator A.2.1***

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# 4. Respect for the Rights and Needs of Patients

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The candidate ensures that the rights and needs of patients are respected.

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

This will be determined by staff and candidate interview.

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***See Aiming for Excellence Indicators A.1.1 and A.1.7***

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4.2 Patients are interviewed and examined in surroundings that ensure privacy and comfort.

Observation of the premises will include ensuring that the consultation room is sound-proofed, furnishings are adequate, lighting is adequate, the temperature of the room is comfortable, and the examination bed has a curtain around it.

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***See Aiming for Excellence Indicator B.4.2***

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4.3 Patients are made aware of their right to have a support person or chaperone present during a consultation. Right 8 of the Code of Health and Disability Services Consumer Rights.

Also refer to Medical Council of New Zealand statement when another person is present during a consult ([www.mcnz.org.nz](http://www.mcnz.org.nz)).

Observe if a poster and/or leaflets outlining patients' rights are available.

4.4 All communications and records pertaining to patients are treated confidentially.

The candidate is aware of the contents of the Health Information Privacy Code 1994.

Telephone conversations are private. Computer records are secure, with password entry, screen-saver, scrambler key or some other device to quickly remove records from the screen. Paper records are stored away from areas with patient access. There is long-term storage for at least 10 years, or indefinitely for child records. Confidential waste papers are shredded.

Where the candidate is unable to influence practice policy, establish how the candidate ensures confidential storage and disposal of patient information for which they are responsible. Detail this in the report.

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***See Aiming for Excellence Indicators A.1.3 and A.1.4***

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- 4.5 The candidate can describe how they deal with complaints either through the practice complaints procedure, or personally if the practice procedure does not comply with the Code of Health and Disability Consumer Rights “The Code”.

“The Code” Right 10 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 ten 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 informs the consumer of the reasons for the decision made, any actions proposed and any appeal process the provider has in place.

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***See Aiming for Excellence Indicator A.1.5***

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- 4.6 A poster and/or leaflets outlining patients’ rights are available.

By observation.

# 5. Records

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Patients records meet requirements to describe and support the management of health care provided.

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## 5.1 Patient Records

10–15 randomly selected medical records of the candidate’s work will be examined by the visitor. A worksheet to assist when checking records is provided for each visit. A copy of the worksheet is attached as Appendix I.

The selection may be random or be designed to assess specific aspects of the candidate’s clinical skills. In either case, the provisions of the Declaration of Confidentiality signed by the visitor will apply. If using computer records, either a computer terminal should be made available or a printout of the records requested should be done by the receptionist.

It is important that all of the information listed below is in the records.

There is sufficient information to identify the patient in all records.

### Demographic data

- Name of patient
- NHI number
- Gender
- Address
- Date of birth
- Contact phone number
- Ethnicity
- Registration status
- Contact in case of emergency (ICE)

### Other Demographic data

- Occupational history
- Significant relationships
- Hapu/iwi
- Aliases, maiden name

### Medical records show

- Clinically important drug reactions and other allergies (or the absence thereof)
- Directives by patients
- Problem lists (using a recognised system for disease coding)
- Past medical history
- Disabilities of the patient
- Current medications
- Clinical management decisions made outside consultations, e.g. telephone calls.

#### Consultation records

- Each entry is dated
- The person making the entry is identifiable
- The entry is legible and could be understood by someone not regularly working at the practice, e.g. a locum

#### Consultation records should also include

- Patient reason for encounter
- Examination findings
- Investigations ordered
- Diagnosis and assessment
- Management plans
- Information given to patients, including notification of recalls, test results, referrals and other contacts (and ideally patient understanding, agreement for consent will be checked and recorded when necessary)
- Medications (name, frequency) by indication
- Long-term medications are reviewed
- Intermediate clinical outcomes
- Screening and preventive care initiatives recommended

#### Risk factors are identified and appropriately acted upon

- Awareness alerts- communication requirements for specific disability e.g. language & comprehension, visually impaired, hard of hearing
- Family history
- Current smoking status
- Smoking history of patients over age 15
- Where appropriate, offer smoking cessation
- Alcohol/drug use
- Blood pressure
- Weight/height/BMI
- Immunisations

#### Referrals letters contain

- Reason for referral
- Background information and history
- Current treatment
- Key examination findings
- Problem
- Current medical warnings
- Long term medications

#### Referrals and responses are filled or are available electronically in patient medical records

- Laboratory results
- Radiology results
- Other tests
- Other health information

#### Screening

- Cervical smears
- Mammograms

## Further information

A legally defensible record:

- A record that is not altered, disguised or added to
- A record of all house calls, phone calls
- Kept for a minimum of 10 years
- Abbreviations and ticks with a glossary
- Written in ink, not pencil
- Legible handwriting (includes not using abbreviations that do not have a key)
- To be signed and dated (include times) after being checked for accuracy
- Reports are signed

The Code of Health and Disability Services Consumers' Rights 1996: <http://www.hdc.org.nz>

Ethnicity Data Protocol for Health and Disability Sector: <http://www.moh.govt.nz/moh.nsf/pagesnz/396?Open>

Health Information Privacy Code 1994; and A practical health guide – On the record: <http://www.privacy.org.nz>

Medical Council of New Zealand: Cole's Medical Practice in New Zealand (2008); and Medical Council of New Zealand: Good medical practice – A guide for doctors (2004): <http://www.mcnz.org.nz>

Privacy Act 1993: <http://www.privacy.org.nz>; or <http://www.legislation.govt.nz>

Standards New Zealand: Health Records: NZS 8153:2002

Standards New Zealand: Code of Practice for Information Security Management: AS/NZS ISO/IEC 17799:2002

Standards New Zealand: Primary Healthcare Patient Management Systems: Publicly Available Specification: SNZ PAS 8170:2005

### 5.2 Record systems:

Record systems ensure security of records and accurate maintenance of patient data for recall and follow-up as required.

- i. Confidentiality, privacy and security of patient medical records are maintained wherever this is the responsibility of the candidate.

Observe the office systems for handling, storing, destruction of records. Check the security of computer systems.

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#### **See Aiming for Excellence Indicator D.10.1**

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Requested medical investigation should have a clear pathway to an outcome – Request, results, communicate results, patient informed, action taken dated – time limited identified.

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

Establish this from interview with the candidate and practice nurse. Does the practice have a cervical smear/histology register to ensure the return of results?

- iii. The practice can demonstrate its use of a system to ensure that tests ordered have been received and any missing test can be identified.

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#### **See Aiming for Excellence Indicator D.10.3**

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iv. Where the candidate has a long term involvement in the practice the candidate has an accurate patient database.

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***See Aiming for Excellence Indicator C.6.3***

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v. Where the candidate has a long term involvement in the practice there is a system for patient recall for the candidate's patients for immunisations, cervical smears, and other national or regional health objectives.

If the candidate is a short-term assistant or locum, can the candidate describe how to establish and run an age-sex register and recall system and discuss the benefits that they provide to patients?

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***See Aiming for Excellence Indicators C.6.3, C.6.4, C.6.6, C.7.2 and C.7.3***

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General comments on the practice.

## 6. Communication

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The candidate provides adequate opportunity for patients to communicate their health problems and concerns, to receive sufficient information to enable them to make informed decisions about their care and to reach an agreed management plan.

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6.1 Consultation times are long enough to allow good quality of care.

Suggested average time is not less than 10 minutes, but most consultations requiring examination, discussion and attention to preventive care take 15 minutes. Judgement as to adequacy is made by the visitor.

6.2 Patients are provided with information so that they are able to make informed decisions about their care.

Written consent is required if there is a significant risk of an adverse effect of a procedure. Documentation of the information given is important.

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***See Aiming for Excellence Indicator A.1.2***

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6.3 Patients are informed about costs of consultations, additional treatments and indicative costs and options for special investigations or specialist consultations.

This should be observed in consultations or discuss in interview with the candidate.

6.4 Written information is available for patients and the candidate can describe how it is used.

Observe the written information available in the practice for the doctors and practice nurses.

# 7. Integration of Care

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The candidate refers appropriately to other health care providers.

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- 7.1 The candidate can describe the way they work in with a range of other health and community services in the area, to improve individual patient care.

Observe other health care providers working from the same premises. Is there a directory of other primary care agencies available locally or evidence of networking with them? Discuss at interview with the candidate and practice nurse.

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*See Aiming for Excellence Indicator C.6.1, C.8.1*

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- 7.2 The candidate recognises the limits of their expertise and referral is timely and appropriate.

Observation of consultations and records show that the doctor hands care to others where the limits of their ability have been reached or where special expertise is required. This may require a search of referral letters and interrogation of the candidate.

Refer Medical Council of New Zealand: Good Medical Practice 2004; Coles Medical Practice in NZ 2007 pg 134.

- 7.3 Referral letters provide all necessary information.

Check that referral letters are legible, contain a summary of relevant clinical information and state the reason for or expectation of the referral.

- 7.4 Continuity of care is encouraged and provided for.

The candidate provides or ensures ongoing care for patients.

Records show evidence of continuing care or where patients are seen on behalf of another doctor, treatment information is provided to that doctor wherever possible. The usual deputising service should send information about patients seen out of hours.

## 8. Consultations

A set of criteria is provided for the assessment of the candidate's consultation skills. A copy of the criteria is attached as Appendix II.

The suggested time of 90–120 minutes sitting in on consultations is given as a guide. The time you spent will depend on the nature and quality of the consultations. Remember that it is essential that most of the session be of conventional general practice consultations for this assessment to be adequate.

It is also important that the consultations have sufficient variety and complexity. Ideally there will be a mixture of ages and at least one chronic case and a new case. This is to be a normal consulting session, it is not to be altered, e.g. to have fewer patients. If there is insufficient variety in the consultations oral questioning may be used to fill the gaps. Records of the consultations observed on the day will be reviewed by the assessor.

## 9. Autonomy

Individual patient care is not compromised by the requirements of a provider organisation.

If the candidate is employed by another doctor or organisation, there are no dictates related to clinical management, budgets, referrals, that could compromise clinical care or lead to over-servicing or under-servicing of the patient population.

## 10. Professional Development

10.1 The candidate has immediate access to suitable resources for reference purposes.

Current medical, surgical and general practice reference material is immediately available in written or electronic form.

10.2 Current guidelines are available and the candidate is familiar with their use.

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*See Aiming for Excellence Indicator C.6.7, E.12.4*

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10.3 The candidate has an established method for maintaining competence.

For example, the candidate belongs to a Peer Review group; attends CME and can discuss recent sessions; reads medical literature regularly. CME and Peer Review is reported in GPEP2, but this is an opportunity to reinforce life-long learning principles.

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*See Aiming for Excellence Indicator D.11.1, E.12.1*

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# 11. Well-Being of the Candidate

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This is one of the few opportunities a candidate may have to discuss self-care with another colleague.

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11.1 The candidate makes provision for their own health maintenance.

Discuss with the candidate the stresses of practice, their own well-being and the supports he/she uses to deal with these stresses/problems. Does the candidate have his/her own health care adviser?

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***See Aiming for Excellence Indicator D.11.5***

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11.2 There are no other circumstances that may affect performance.

Is the candidate aware of any adverse effects on either their usual practice or their performance during the assessment visit, that a current or previous disciplinary or legal action may be having?

Are there any health or other problems that need to be taken into consideration in this assessment?

Note that 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.

Section 45(6) of the Act provides a statutory exclusion of liability to persons giving notice under Section 45, but if such a situation should arise, it would first be discussed with the Censor in Chief and the candidate.

# 12. Outcome of Visit

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The final section of the Fellowship Assessments: Report on Visit to Candidate booklet is as follows:

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From your assessment do you consider this candidate:

- has met or exceeded all the standards set out in this booklet.
- has met most of the standards, but the following deficiencies have been found:

The candidate is required to meet all of the standards in the booklet. If a standard has not been met indicate here the improvement which is required. The Censor concerned, in consultation with the Censor in Chief, will make the decision regarding further requirements of the candidate. The deficiency may be an item of equipment, in which case the candidate will be asked to rectify this, but may proceed to Fellowship. If the deficiency is more serious, e.g. cold chain not maintained, sterilisation not adequate, confirmation of correction of this will be required before the candidate can be considered for Fellowship.

- has deficiencies in their practice standards and a further assessment visit is recommended because (please detail reasons fully).

This recommendation is usually made when there are a number of deficiencies or the issues are regarding consultation deficiencies or safety issues. The candidate is given feedback on the issues and offered the opportunity of a follow-up visit, usually within twelve months.

# Appendix I: Medical Record Review – Recording Sheet

Assessors may use the following checklist when reviewing a candidate's medical records. (Refer to Section 5 of the Standards.)

Assessors: You may wish to use this worksheet when you are reviewing the candidate's medical records. Mark all unshaded boxes for each of the 10-15 records you review as:

- ✓ present and adequate
- IN present but inadequate
- X not present
- N/A not applicable/necessary in this case

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Met	Part met	Not met	Not applicable
<b>D.9.1 – 1 Demographic data</b>																			
Name of patient																			
NHI number																			
Gender																			
Address																			
Date of birth																			
Contact phone no																			
Ethnicity																			
Registration status																			
Contact in case of emergency (ICE)																			
<b>D.9.1 – 2 Other important demographic data:</b>																			
Occupation history																			
Significant relationships																			
Hapu/iwi																			
Aliases, maiden name																			
<b>D.9.1 – 3 Medical records show:</b>																			
Clinically important drug reactions and other allergies (or the absence thereof)																			
Directives by patient																			
Problem lists are easily identifiable (Using a recognised system for disease coding)																			
Past medical history																			
Disabilities of patient																			
Current medications list																			
Clinical management decisions made outside consultations e.g. telephone calls																			

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Met	Part met	Not met	Not applicable
<b>D.9.1 – 4 Consultation records:</b>																			
The entry is dated																			
Person making entry is identifiable																			
The entry is legible and could be understood by someone not regularly working at that practice (e.g. a locum)																			
<b>D.9.1 – 5 Consultation records should also include:</b>																			
Reason for encounter																			
Examination findings																			
Investigations ordered																			
Diagnosis and assessment																			
Management plans																			
Information given to patients, including notification of test results, referrals and other contacts																			
Medications are clearly identifiable: drug name/dose/frequency/amount/time/volume																			
Long term medications are reviewed																			
Intermediate clinical outcomes																			
Screening and preventative care initiatives recommended																			
<b>D.9.1 – 6 Risk factors are identified:</b>																			
Awareness alert – communication requirements for specific disability e. g. language & comprehension, visually impaired, hard of hearing																			
Family history																			
Current smoking status																			
Smoking history of patients over age 15																			
Where appropriate, offer of smoking cessation																			
Alcohol/drug use																			
Blood pressure																			
Weight/height/BMI																			
Immunisations																			
<b>D.9.1 – 7 Referral letters contain:</b>																			
Reason for referral																			
Background information and history																			
Current treatment																			
Key examination findings																			
Problem																			
Current medical warnings																			
Long term medications																			
<b>D.9.1 – 8 Referrals and responses are filed or are available electronically in patient medical records:</b>																			
Laboratory results																			
Radiology results																			
Other tests																			
Other health information																			
<b>D.9.1 – 9 Screening:</b>																			
Cervical smears																			
Mammograms																			

# Appendix II: 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	The overall performance – the integration of consulting and professional skills
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 Unethical or dishonest behaviour or other serious concern re candidate behaviour. (Append explanation)
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 Standard not adequate for Fellowship. Major deficiencies in skills or poor organisation and integration of consulting skills. (Explain) Requires further training.
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 Standard not adequate for Fellowship. Deficiencies in organisation and consulting skills. (Detail these) Requires feedback and then further assessment.
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 Adequate standard of performance for College Fellowship but organisational and/or consulting deficiencies which could be improved. (Detail the deficiencies)
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 Clearly suitable for College Fellowship. Practising mostly to 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 co-operation 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 Clearly suitable for Fellowship. Practising to a consistently high standard. No deficiencies noted.
OVERALL RATING	OVERALL RATING	OVERALL RATING	OVERALL RATING	OVERALL RATING

# Appendix III: The Discipline and Speciality 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 speciality orientated to primary health care. It is a first level service that requires improving, maintaining, restoring and coordinating people's health. It focuses on patients' need and enhancing the network among local communities, other health and non-health agencies. General practice:

1. Is personal, family and community oriented, comprehensive primary care that continues over time, is anticipatory as well as responsive, and is not limited by the age, gender, race, religion or social circumstances of the patient nor by their physical or mental states.
2. Is normally the point of first medical 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.
3. Makes efficient use of the health care resources through coordination of care, working with other health professionals in the primary health setting, managing the interface with other specialities, and taking an advocacy role for the patient when needed.
4. Develops a person-centred approach, orientated to the individual, as well as an approach that is responsive to the needs of the family/whanau and their community.
5. Has a unique consultation process that establishes a relationship over time, through effective communication between clinician and patient.
6. Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
7. Has a specific decision-making process determined by the needs of the patient.
8. Diagnoses and manages simultaneously both acute and chronic health problems of individual patients.
9. Diagnoses and manages illness which presents in an undifferentiated way at an early stage of its development, which may require urgent intervention.
10. Promotes health and well-being through appropriate and effective intervention.
11. Has a specific responsibility for health in the community.
12. Deals with health problems in the physical, psychological, social and cultural dimensions.