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

FELLOWSHIP ASSESSMENT

Standards and guidelines for candidates

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The Royal New Zealand College of General Practitioners
Level 4, 50 Customhouse Quay, Wellington 6011
PO Box 10440, Wellington 6140
+64 4 496 5999 | rnzcgp@rnzcgp.org.nz
www.rnzcgp.org.nz

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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 oriented 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 professionals 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, oriented 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 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 component 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 maybe 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 Foundation Standard.

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 patients 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 the 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's censor in chief, which the censor in chief will consider in deciding the visit outcome.

If the censor in chief sees fit, they may request additional information and otherwise investigate further before making their 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 their 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 their 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 their 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 their decision.

Please be aware that it may take up to eight weeks 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; however, if you believe the process has been unfair, you can lodge an appeal against the process using **this form.**

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 (via the College) 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's 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) requires a health practitioner to inform the Registrar of the responsible authority, which in this context would be the Medical Council of New Zealand, if they have reason to believe that another health practitioner is not fit to perform the functions required for the practice of their profession because of some mental or physical condition. If this situation arises, the assessor must notify the College and let the candidate know that the Medical Council of New Zealand have been notified.

c. Competence concerns

Section 34(1) of the Health Practitioners Competence Assurance Act 2003 relates to notification that practice below the required standard of competence. If a health practitioner (health practitioner A) has reason to believe that another health practitioner (health practitioner B) may pose a risk of harm to the public by practising below the required standard of competence, health practitioner A may give the Registrar of the authority that health practitioner B is registered with, written notice of the reasons on which that belief is based.

If the assessor is concerned that the candidate poses a risk of harm to the public by practising below the required standard of competence, the assessor will discuss their concerns with the censor in chief so that the College-appointed representative is kept informed. Following that discussion, the assessor who has highlighted the concerns may report these concerns to the Registrar of the Medical Council (Health Practitioners Competence Assurance Act 2003, section 32(1)). The Medical Council will instigate its own review process.

The RNZCGP standards for Fellowship assessment

The Royal New Zealand College of General Practitioners' (the College's) standards for Fellowship assessment comprise 13 indicators in 11 sections. These are:

Communication skills

- **INDICATOR 1:** The candidate's communication with patients is competent and culturally safe, and facilitates optimal care.

Clinical skills

- **INDICATOR 2:** The candidate demonstrates competent clinical skills.

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 to track results and follow up and recall patients.

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.

Practice system and facilities

- **INDICATOR 7:** Patient safety in the practice setting is assured.

Medical equipment

- **INDICATOR 8:** Medical equipment and resources are available and maintained to meet patient needs.

Availability and accessibility

- **INDICATOR 9:** Patients can obtain care and advice that is appropriate to their needs.

Respect for the rights and needs of patients

- **INDICATOR 10:** The candidate respects the rights and needs of patients.

Professionalism and ethics

- **INDICATOR 11:** The candidate maintains professional integrity.

Scholarship and professional development

- **INDICATOR 12:** The candidate can show they consider and apply the most up-to-date evidence in their patient care.

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).

Indicator 1: Communication skills

Indicator 1: The candidate's communication with patients is competent and culturally safe, and facilitates optimal care

The candidate:

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

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

1.3 demonstrates culturally safe patient care

1.4 shows they are knowledgeable about Māori consultation models and skilfully uses them in their practice

1.5 summarises and checks their understanding with the patient

1.6 takes a patient-centred approach, taking the patient's health literacy and illness model into account, and enabling them to make joint decisions in a care partnership

1.7 gives the patient relevant explanations and information and helps them or a third party to access relevant digital and written material.

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 consultation 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.

Indicator 2: Clinical skills

Indicator 2: The candidate demonstrates competent clinical skills

The candidate:

2.1 assesses the patient's condition accurately and efficiently, with sufficient history and clinical examination to ensure they can competently manage their condition

2.2 acquires the patient's consent to examine them, and conducts a well-targeted examination that is gentle and respectful

2.3 summarises their findings, effectively prioritises and synthesises the information gathered, and generates a hypothesis 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 and evidence-based medicine in determining what further management, safety-netting and follow-up is needed in order to advance health equity

2.6 prescribes according to best practice and health equity data. Is able to justify any prescribing patterns that appear to differ from the norm

2.7 undertakes any investigations judiciously and equitably

2.8 refers patients equitably to specialists as required in a timely manner

2.9 takes opportunities to provide brief health interventions and appropriate screening

2.10 structures the consultation effectively, so that in the time available they cover the essentials of managing the patient's condition

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

2.12 demonstrates culturally safe patient care.

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. (e.g. 'What if the patient had been female / a child / on other medication?' etc.)

Indicator 3 and 4: 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.

3.1 Patient records are electronic, secure and traceable.

3.2 The patient's record contains sufficient basic demographic information, including ethnicity, to identify them and meet national enrolment requirements.

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

3.4 Clinical notes can be understood by someone who does not regularly work at the practice.

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

3.6 A patient's specific needs and instructions are recorded and are easy to access from the clinically relevant point within their records.

3.7 The patient's recorded history is relevant and sufficient for their condition to be safely managed and for evidential purposes.

3.8 The record of a patient's examination includes all findings essential to the diagnosis and management of their condition.

3.9 The candidate's working diagnosis/differential is apparent in the patient's record and consistent with the supporting information.

3.10 The patient's management plan is clear; uncertainty and conjecture are identified and addressed as necessary.

3.11 The patient's record identifies information they were given (this includes information about the risks and benefits of treatments) and their consent, where relevant.

3.12 The patient's record includes clinical management decisions and details of any interventions provided.

3.13 The patient's record includes all medication treatment they have been given, including the type, dosage and total amount of any prescribed medications.

3.14 The patient's record identifies all investigations requested and tracks high-risk tests.

3.15 The patient's record supports the candidate's decisions or recommendations for effective and timely referral for treatment, and transfer or continuity of care.

3.16 The patient's record clearly documents follow-up arrangements and actions.

3.17 The patient's record includes a history of screening and results, or a record of the patient declining screening.

3.18 The patient's record includes their immunisation history and status.

3.19 The patient's record includes a systematic record of their individual risk factors.

3.20 Where a patient portal is used, it 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**. 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 patient 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 anytime 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 auto texting 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

- **The Code of Health and Disability Services Consumers' Rights 1996**
- **Ethnicity Data Protocol for Health and Disability Sector HISO 10001:2017 Version 1.1**
- 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 to track results and follow up and recall patients

The candidate:

4.1 has a system for following up and recalling 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 to advance health equity.

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 best 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.

Indicator 5 and 6: 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 makes timely and appropriate referrals

5.2 writes referral letters that include all necessary information, and allows the referred provider to determine the expectations and urgency of the referral, and the nature of the problem. At a minimum, a referral letter must include:

- patient identification and contact information (this will usually be the patient's name, address, date of birth, ethnicity and NHI)
- the intended recipient
- the urgency of the care requested and essential information for triage
- the reason for referral, and the clinical question to the recipient or anticipated outcome of the referral
- the history of the current problem with emphasis on any acceleration of symptoms
- any significant previous history
- a list of important current and past health problems
- all current medications, or a note that there are no current medications
- allergies, or a note that there are no known drug allergies (NKDA)
- current smoking status
- investigations, if the recipient has no other access to them
- any other issues pertinent to the referral, such as social situation, deafness, requirement for a translator, mobility and transport issues or infectious status.

Evidence

- Consultation observation
- Case discussion
- Spot check on referral 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 they need it

6.3 is familiar with, and can easily access, the practice's significant events register, and can describe how the practice uses the register as a quality process

6.4 can describe how the practice's systems ensure patient care is safely transferred

6.5 takes responsibility for ensuring that appropriate follow-up actions are taken for all the patients they see

6.6 can provide evidence that they work with other local health and community services to improve the care of individual patients and communities.

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).

Indicator 7: Practice systems and facilities

Indicator 7: Patient safety in the practice setting is assured

The candidate:

7.1 is aware of the practice's infection-control measures and can discuss how they protect the health and safety of patients and practice staff. The measures must include:

- maintaining a clean and hygienic practice environment
- using hand-hygiene practices that minimise the risk of the doctor being an agent for transmitting infection
- sterilising reusable medical and surgical instruments and equipment as per manufacturer specifications, and storing them in a manner that maintains sterility, and having an auditable sterilisation trail
- not reusing single-use disposable instruments

7.2 ensures that requirements are met to safely store and dispose of health care waste (this includes sharps) in the office and into the environment, and patient identification and contact information (this will usually be patient names, addresses, dates of birth and NHIs)

7.3 can discuss the practice's cold-chain monitoring and maintenance procedures, and how they comply with the Ministry of Health protocol

7.4 can demonstrate the practice's procedures and mechanisms to prevent unauthorised access to controlled drugs. The procedures must include:

- keeping drugs in a locked metal or concrete container that is securely fixed to, or is part of, the building it is kept in
- keeping the key to the metal or concrete container in a safe place, when the container is not being used
- the candidate knowing the practice must have safe and auditable processes for using controlled drug prescription pads and taking steps to ensure these processes are in place.

Evidence

- Practice observation
- Consultation observation
- Discussion.

Guidelines

The criteria for Indicator 7 are strongly linked to practice requirements outlined in the Foundation Standard.

If your practice is 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 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: **Foundation Standard (see indicators 7.3, 10.1, 12.1 and 12.2)**
- 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**

Indicator 8: 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 the practice's essential emergency and resuscitation equipment is calibrated and in working order, and has not expired

8.2 knows what other essential equipment the practice needs and takes steps to ensure it is available and in working order

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

8.4 can describe the system for maintaining the drugs held in the practice cupboard and emergency bag and trolley and checking their expiry dates

8.5 has ready access to portable emergency equipment

8.6 understands how they are expected to respond 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: **Foundation Standard Indicator 11**

Indicator 9: Availability and accessibility

Indicator 9: Patients can 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 the indicative costs of referred services if these are in the private sector
9.3	ensures that the time they allocate to the patient is enough to give them 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	can explain how they fulfil their responsibility to ensure patients have adequate after-hours care and how patients are told about this care
9.6	will visit homes, rest homes and hospitals when it is necessary and appropriate
9.7	can describe how they address barriers to health care access for Māori.

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.

Indicator 10: Respect for the rights and needs of patients

Indicator 10: The candidate respects the rights and needs of patients

The candidate:

10.1 understands patient rights under Te Tiriti o Waitangi, applies Te Tiriti principles to general practice in a culturally safe environment, and strives to provide patients equitable health care access and outcomes

10.2 provides equitable care to all patients, which acknowledges and is appropriate for their age, gender identity, ethnicity, religion, social circumstance

10.3 ensures that patients know of their right to have a support person or chaperone present during a consultation

10.4 knows the contents of the Health Information Privacy Code 2020 and can discuss the practice's arrangements to ensure confidentiality of patient records

10.5 understands the practice's system for dealing with patient complaints, and can describe how it complies with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and how it is used to improve practice

10.6 can discuss how the practice has managed complaints about their, or their colleagues', practice, what support has been available to those involved and how the complaints have been used to improve practice

10.7 ensures that they maintain patients' dignity and privacy at all times

10.8 obtains patient consent for procedures, where relevant

10.9 advocates for patients in their dealings with the health system

10.10 discusses potentially controversial topics (such as complementary medicine or PSA screening) with patients in an informative but non-judgmental way.

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 Health Information Privacy Code 2020.

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 acknowledgment 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 2020**
- Privacy Commissioner: **On the Record** health guide

Indicator 11: Professionalism and ethics

Indicator 11: The candidate maintains professional integrity	
The candidate:	
11.1	understands the causes of health inequities and their professional and moral responsibility to promote health equity for all groups, especially Māori as a partner of Te Tiriti o Waitangi
11.2	uses resources ethically and equitably and where inequities are discovered, reallocates resources appropriately. Avoids unnecessary or inappropriate use of medication or publicly funded investigations
11.3	displays the necessary personal attributes to maintain probity and patient trust
11.4	deals appropriately with ethical dilemmas and conflicts between competing values when these arise
11.5	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).

Indicator 12: Scholarship and professional development

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

The candidate:

12.1 understands current clinical practice guidelines and clinical information sources, and can demonstrate that they use them

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

12.3 understands how colonisation, racism, migration and other cultural factors affect equitable health outcomes; identifies potential inequities by using relevant marginalisation data and uses the findings to address inequities.

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.

Indicator 13: 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 to maintain their own health 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 you 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 College prior to your visit 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 practice 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 medicines checklist

All medical equipment, resources and medicines must be suitable for supporting comprehensive primary care, resuscitation and any additional procedures offered. All essential medical equipment, resources and medicines must be available when needed, and members of the practice team must know how to use the equipment. Equipment must be calibrated, in working order, and servicing expiry dates must be current.

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

- [x] **All basic equipment is required and available within the practice including:**
- [ ] Auriscope
- [ ] Blood glucose test strips/glucometer
- [ ] Blood taking equipment
- [ ] Cervical smear equipment
- [ ] Digital camera or other secure method of taking photos (e.g. smartphone app)
- [ ] Dressings adequate to the services provided
- [ ] Electrocardiogram (ECG) or access to a local ECG screening facility
- [ ] Eye local anaesthetic
- [ ] Fluorescein dye for eyes
- [ ] Personal protective equipment (PPE)
- [ ] Height measure
- [ ] Ishihara colour blindness test book (or online version if available)
- [ ] Monofilament
- [ ] Ophthalmoscope
- [ ] Peak flow meter
- [ ] Pregnancy testing kit
- [ ] Proctoscope
- [ ] Reflex hammer
- [ ] Spacer device
- [ ] Spatula
- [ ] Sphygmomanometer (extra wide and paediatric cuffs)
- [ ] Spirometer (or ability to refer patients for spirometry)
- [ ] Stethoscope
- [ ] Surgical instruments (if needed)
- [ ] Suction equipment
- [ ] Suture equipment
- [ ] Syringes and needles
- [ ] Thermometer
- [ ] Tuning fork (256 Hz or 512 Hz)
- [ ] Urinary catheters and local anaesthetic gel
- [ ] Urine dipstick – protein, glucose, ketones
- [ ] Visual acuity chart
- [ ] Weight scales (adult and baby)

- [x] **All necessary emergency and resuscitation equipment are available including:**
  - [ ] Automated external defibrillator (AED)
  - [ ] Airways and/or laryngeal masks (varied sizes, paediatric to adult)
  - [ ] Ambu bag and masks (both paediatric and adult)
  - [ ] Emergency bag/trolley
  - [ ] IV equipment (set up and infusion)
  - [ ] Oxygen
  - [ ] Saline, or Pentaspan (pentastarch) or crystalloid
  - [ ] Tourniquet

- [x] **All essential basic and emergency medicines are available in stock or in the bag/clinical bag or portable emergency kit:**
  - [ ] Adrenalin 1/1000
  - [ ] Alternative for those allergic to penicillin
  - [ ] Analgesia
  - [ ] Antiemetic injection
  - [ ] Antihistamine injection
  - [ ] Aspirin tablets
  - [ ] Atropine injection
  - [ ] Ceftriaxone
  - [ ] Corticosteroid injection
  - [ ] Diazepam injection/rectal
  - [ ] Furosemide (lasix) injection
  - [ ] 50% glucose/glucagon injection
  - [ ] Local anaesthetic injection
  - [ ] Naloxone injection
  - [ ] Nitrolingual spray
  - [ ] 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 There are damaging aspects to the candidate's relationship with the patient, including lack of any evidence of cultural awareness, sensitivity, or competence.	**0** The candidate appears to have missed life-threatening problems. Culturally unsafe practice, e.g. racism, bias evident within the consultation.	**0** They do not establish the patient's consent to an examination. Absent or very inadequate / inappropriate examination for major problems. Culturally or medically unsafe. Patient consent not sought.	**0** The candidate's management plan is dangerous and has omissions. Culturally unsafe practice.	**0** There are serious deficiencies in the candidate's clinical thinking or organisation. Their behaviour is unethical or dishonest or raises other serious concerns. Displays bias or racism. Lack of cultural awareness or competence. Lack of understanding of health inequity.
1 The patient is not being heard. The candidate responds to immediate reason for consultation but misses obvious patient cues. Not patient centred. May demonstrate an awareness of cultural issues but limited evidence for cultural sensitivity or cultural safety.	**1** The candidate poorly identifies the presenting complaint or misses another major problem(s). No attempts made to address cultural competence or safety, which may impact flow of information from the patient.	**1** The candidate's examination technique is poor. Patient consent to examination is assumed but not clearly established. Chaperone not offered when appropriate to do so. Inattention to patient privacy or dignity. Does not demonstrate cultural competency.	**1** The candidate's management plan for the major problem(s) is unclear, or poorly justified, and has potential safety risks. Limited cultural awareness and management plan is not patient centred.	**1** There are major deficiencies in the candidate's clinical thinking or organisation, or in their professional or ethical behaviour. May display some cultural awareness but lacks cultural competence. Limited understanding of health inequity.
2 The patient is heard but not at ease. The candidate responds to obvious cues but does not explore the patient's concerns or feelings. Not patient centred. Demonstrates some evidence of cultural sensitivity and competence but little or no evidence of cultural safety.	**2** The candidate probably identifies the presenting and other major problems but does not verify them with the patient. Prioritisation unclear. Attempts to gather information in culturally competent manner.	**2** Examination is limited or inadequate to ensure a safe outcome. Patient is given limited opportunity to fully consent. Some opportunities to provide a culturally appropriate examination are missed.	**2** The candidate's management plan for the major problem(s) is safe, but there is doubt about the patient's agreement to it. Demonstrates cultural awareness, but this is not incorporated into the management plan.	**2** There are deficiencies in the candidate's clinical thinking, organisation, or professional behaviour, which are of concern. Displays some cultural competence but little evidence of cultural safety. Health inequity not addressed.

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
3 A therapeutic relationship is established. Limited expression of concerns and feelings by the patient, and limited exploration of them by the candidate. Mostly patient centred. Demonstrates sound levels of cultural sensitivity and competence. Evidence of cultural safety is also demonstrated but limited skill set or application. Attempts whaka-whanaungatanga.	**3** The candidate defines the presenting and other major problems, verifies them with the patient and safely prioritises them. Associated problems or preventative care opportunities are missed. Demonstrates culturally safe consultation and attempts to integrate aspects of a Māori model of health.	**3** The candidate's examination is limited to major/life-threatening problems only and excludes patient's associated concerns. Consent is obtained. Some demonstration of cultural competency.	**3** The candidate negotiates a sound management plan for the major problem(s), with agreement of the patient. Management of associated problems not addressed. Demonstrates cultural competency and incorporates aspects of Māori models of health into the management plan.	**3** The candidate could improve their clinical thinking, organisation, or professional behaviour, but the concerns are not significant. Culturally competent; some understanding of health inequity.
4 A therapeutic relationship is clearly established. The patient openly expresses their concerns and feelings. Some weaknesses noted in verifying patients concerns. Patient centred. Demonstrates sound cultural safety skills. Utilises whaka-whanaungatanga effectively.	**4** The candidate demonstrates a culturally safe consultation, with integration of Māori models of health, enabling most major and associated problems to be identified, then verifies them with the patient and safely prioritises them. Preventative care opportunities may have been missed.	**4** The candidate's examination is appropriate and adequate for most problems but with some minor omissions that do not preclude a safe outcome. Consent is obtained, including specific consent for sensitive examination. Chaperone offered where relevant.	**4** The candidate's management plan for most problems is clear and sound. The patient clearly agrees with it. There are minor omissions in the plan. Develops a culturally safe management plan which fully incorporates Māori models of health.	**4** The candidate's clinical thinking, organisation and professional behaviour are mostly of a high standard. Some minor deficiencies observed. Culturally safe practice. Competent use of Māori models of health in consultation. Good understanding of health equity.
5 A strong therapeutic relationship is clearly established. The candidate shows mastery of relationship skills. Clearly patient centred. Demonstrates expertise of cultural safety skills, including incorporating the Hui Process naturally into the consultation.	**5** The candidate demonstrates a culturally safe consultation with skillful integration of Māori models of health, enabling all relevant problems, concerns, and preventative care opportunities to be identified, verifies them with the patient, and safely prioritises and addresses them.	**5** The candidate's examination is considerate, appropriate, and thorough for all problems, conducted in a culturally competent manner. Examination is culturally safe and conducted with clear consent, and any variations are negotiated. Chaperone is offered where relevant.	**5** The candidate creates a complete, sound, and comprehensive management plan with clear patient agreement, addressing all problems. Develops a culturally safe management plan that expertly incorporates Māori models of health and is clearly negotiated, understood, and agreed with the patient and their whānau. Takes the opportunity to explore wider health issues.	**5** The candidate's clinical thinking, organisation and professional behaviour are of a high standard. No deficiencies observed. Displays culturally safe, pro-equity and advocacy behaviour in observed practice. Skillful use of Māori models of health. Applies the principles of Te Tiriti o Waitangi to their practice.

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 is optional but can be used by practices for self-auditing and improvement purposes.

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 (Te Whanake/CPD).

The tool has two parts:

- **PART 1** includes requirements for the practice patient record system and the demographic details that it records.

  If this has been done in the practice within the past three years, it does not need to be completed by doctors undertaking Part 2 for the training programme or for professional development purposes.

- **PART 2** contains criteria that should be assessed for **practice accreditation, training programme and professional development purposes**.

Instructions

Parts 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.

All records should be electronic and 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.

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

Parts 1 and 2

- Randomly select 10 patient clinical records.
- Complete the Part 1 or Part 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
  - **NA** 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.
- Identify areas for development and a plan for improvement.

GPEP registrars

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

You are required to submit the completed clinical record audit checklist to the College. Complete and return both the recording sheets 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 (Te Ara). 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.

PART 1

Patient record system†

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.	**Patient records are electronic, secure and traceable:**														
	All clinical information is:														
	recorded electronically														
	password protected														
	reliably backed up														
	Clinical notes:														
	are dated														
	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:														
	NHI number														
	name														
	gender														
	address														
	date of birth														
	ethnicity														
	registration status														
	Information held for enrolled patients includes:														
	contact phone number														
	contact in case of emergency (ICE)														
	next of kin – where applicable														
	significant relationships														
	hapū/iwi for Māori patients														
	primary language if not English														
	Need for an interpreter:														
	Any need for an interpreter is flagged for patients with English as a second language														

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

PART 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:**														
	Notes are completed as soon as possible after contact, and any delay is identifiable.														
	Information is recorded objectively and does not contain inappropriate, judgmental comment.														
	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:**														
	The notes are logical, intelligible and sequential.														
	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:**														
	Past medical history is available.														
	Significant social history is included.														
	The PMS is used to effectively display important warnings, and alerts.														
	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:**														
	Patient needs recorded include any directives by patient, disabilities, drug dependencies, end-of-life and special needs (e.g. communication, mental health issues).														
5.	**The recorded history is relevant and sufficient for both safe management and evidential purposes:**														
	The reason(s) for the encounter recorded or apparent from the notes.														
	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:**														
	Sufficient positive and negative history and examination findings are present to justify management decisions.														
	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:**														
	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:**														
	The plan for care can be identified from the record.														
	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:**														
	Notification of test results and clinical findings is recorded.														
	The record supports adequate consenting processes.														
10.	**All important clinical decisions and interventions are recorded:**														
	Treatment plans, including interventions, contingency plans, safety netting and follow-up arrangements are recorded as necessary.														
	Clinical management decisions made outside consultations (e.g. 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:**														
	There is a record of all prescriptions issued, including drug name, administration instructions and quantities ordered.														
	Medications initiated or changed outside the practice are reconciled with the PMS.														
	Current and long-term medications are differentiated and the status is clear.														
	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:**														
	All requests for tests and investigations are recorded.														
	High-risk tests (e.g. histology, cervical smears) are tracked for completion.														
13.	**The record supports effective and timely referral for treatment or transfer of care:**														
	The record shows that referrals are completed within a reasonable time frame.														
	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
	Referrals include urgency, reason/ expectation of referral, relevant findings, classifications, warnings and current treatment.														
	The transfer of responsibility for care can be verified from the records.														
14.	**Follow-up of test results is clearly documented and actions recorded:**														
	Follow-up actions on test results and referrals are recorded.														
15.	**Screening history and results (or declined screening) are recorded:**														
	Screening history and results (including declines) are evident for routine screening areas (eg cervical smears, mammograms, cardiovascular risk assessment, diabetes screening).														
	Screening recall status can be easily tracked.														
	There is evidence of patient risk assessment and opportunistic screening for high-risk conditions.														
16.	**Immunisation history and status is recorded:**														
	There is evidence that recommended immunisations are provided in accordance with the national schedule.														
	Records show advice given and immunisation status for non-scheduled immunisations.														
17.	**There is a systematic record of individual risk factors:**														
	Diseases are classified for chronic conditions, including all conditions for which the patient is on long-term treatment.														
	Family history for major risk factors, such as diabetes, early CVD, bowel and breast cancer etc.														
	Current employment (where relevant) and any history of at-risk occupations.														
	Blood pressure monitoring as clinically indicated.														
	Baseline weight/BMI and monitoring as clinically indicated.														
	Smoking status and history and cessation support offered, where relevant.														
	Alcohol and drug usage.														
	Regular review of chronic conditions as per current best practice (e.g. 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 printed two copies of the Fellowship Assessment Declaration of Confidentiality form to be signed by the assessor during the visit?
- [ ] 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?