The ARCADO Manual

Adding Random Case Analysis (RCA) to Direction Observation (DO) in the External Clinical Teaching Visit (ECTV)
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1 Acronyms

ACRRM  Australian College of Rural and Remote Medicine
ARCADO  Adding Random Case Analysis to Direct Observation
DO  Direct Observation
ECTV  External Clinical Teaching Visit
FLI  Focused Learning Intervention
GP  General Practitioner
RACGP  Royal Australian College of General Practice
RCA  Random Case Analysis
RTP  Regional Training Provider
2 Introduction

2.1 Background

The external clinical teaching visit (ECTV) has been part of Australian General Practice training since the 1980s when it was first introduced in Western Australia to augment in-practice teaching. The ECTV was subsequently adopted by all States and Territories and underwent evaluation by the RACGP in the mid-1990s.\(^1\) The review noted considerable variation in the conduct of the ECTV across the country and suggested this may impact upon educational outcomes. Several recommendations were made including developing written guidelines to improve consistency, arranging selection of patients to increase validity, and further evaluation of the educational merit of the ECTV program. The advent of regionalisation in 2001 reversed the consolidation of the conduct of the ECTV. A survey in 2005 noted that 40% of Regional Training Providers (RTPs) did not have an ECTV manual, 35% provided no training for visitors and 30% did not use the visit to assess registrars.\(^2\)

Despite concerns about its variability and the lack of recent evaluation of educational outcomes, the ECTV continues to be highly rated by visiting medical educators and registrars and remains a mandatory component of vocational general practice training.\(^3\) There is also strong support in the educational literature for workplace-based formative assessments.\(^4\) Most registrars have five ECTVs during their training, a significant investment of time and money.

Traditionally, the external clinical teaching visit (ECTV) has been based on a visiting medical educator or a General Practitioner (GP) supervisor from another practice observing a registrar consulting. Other methods of assessment used within ECTVs have included observation of video recorded consultations or discussions with the supervisor about the registrar’s progress.

This manual has been developed to reflect recent findings of the authors and their research teams following investigation into the use of an ECTV assessment combining random case analysis (RCA) and direct observation (DO) as a workplace-based formative assessment within general practice training.

2.2 Purpose of the manual

To provide a framework for Australian RTPs to adopt a recently developed, multi-modal, formative assessment tool – ARCADO (Adding Random Case Analysis to Direct Observation), for use within the ECTV. RTPs may adapt this manual to conform to their local context.

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3  ARCADO (Adding Random Case Analysis to Direct Observation) in External Clinical Teaching Visits

An ARCADO ECTV consists of observation of a GP registrar while they are consulting and a review and discussion of their recent medical records. The visitor is either a medical educator or a GP supervisor from another training practice.

3.1 What is Random Case Analysis (RCA)?

RCA is an assessment and learning method where patient records are selected at random (not directed by the registrar) and the visitor reviews and directs discussion related to the record. RCA can be used to explore all domains of general practice but has particular strengths in providing a time-efficient assessment of clinical knowledge and reasoning, and adequacy of the medical record. As the registrar does not direct the selection of clinical records, areas where the registrar does not recognise a clinical knowledge gap, so-called ‘unknown unknowns’, are more readily identified.

RCA enables review of an increased number and diversity of clinical presentations compared to using DO alone in the ECTV. If the record being reviewed is very straightforward or the presentation is similar to a previous case, the visitor can quickly move onto the next record. RCA also enables a review of the registrar’s management of a patient over time. Finally, RCA provides the medical educator with the opportunity to appreciate the case load of the registrar, and if necessary, provide feedback to the practice about assisting the registrar to expand their exposure to specific types of patients.

Although, RCA has educational utility for all stages of registrar training and across all levels of registrar competence, RCA can be impacted when the registrar’s medical records are poor, opening the door for embellishment of what occurred during the consultation. If records being reviewed are not of recent consultations it may be difficult for the registrar to recall the detail of the consultation and the clinical reasoning behind decisions made.

3.2 What is Direct Observation (DO)?

DO is the traditional backbone of the ECTV. DO consists of a visitor sitting in with a registrar whilst the registrar consults with a patient. DO can be used to assess all domains of general practice but has particular utility in observing consultation and communication skills. These skills are rightly seen as core skills.

In DO, if patients do not attend, or their presentations are very similar, the learning opportunities during an ECTV may be curtailed. Also as an assessment, DO is impacted by the registrar knowing they are being observed. DO can become more an assessment of what the registrar knows how to do rather than an assessment of what they actually do in practice.


3.3 Why do both?

Current educational theory recommends increasing the number and types of assessments to improve the overall validity of assessment. Findings from a qualitative study of ARCADO were that using both RCA and DO together in an ECTV was highly acceptable to both registrars and ME visitors. The participants noted that the perspectives provided by RCA and DO were complementary. DO had a greater emphasis on consultation and communication skills while RCA provided a more time-efficient review of clinical knowledge and reasoning. In general, they considered ARCADO provided a more valid assessment.

The addition of RCA to DO was noted by participants in the study to provide a more flexible assessment. It was possible to conduct RCA when a patient failed to attend for a consultation or whenever the consultation was briefer than expected. The addition of RCA helped overcome some of the artificiality of an assessment based solely on DO and it became more an assessment of ‘does’ than ‘shows how’.

3.4 Formative versus summative assessment

In the Australian General Practice Training Program summative assessment is conducted by the RACGP and ACRRM towards the end of training. This is assessment of learning. Formative assessment is assessment during training and is conducted by the RTPs. Formative assessment is assessment for learning rather than assessment of learning. It is primarily about providing feedback to the registrar and suggestions for improvement.

An assessment can be a hurdle that must be overcome before a learner can progress to the next level. Formative assessment in an ECTV is not a hurdle assessment. Although there is a judgement of how the registrar is progressing compared to the expected standard, the intent is to use information gained from the assessment to assist and guide learning, rather than to impede progress.

A registrar is not prevented from progressing to the next stage of training based upon a single ECTV formative assessment. If concerns are raised about a registrar’s competence for their current stage of training a more detailed assessment would be required.

3.5 Structure of ARCADO ECTV

The ARCADO ECTV is conducted over a 3 hour session during which two assessment methods are used – RCA and DO.

During the DO component three consultations are observed. Observing fewer than three consultations does not allow sufficient assessment of communication and consultation skills. The practice is advised to book a range of patients and is encouraged to avoid, when possible, booking simple consultations such as routine childhood immunisations. Similarly cases where a patient may not consent to a visitor being present, such as a Pap smear examination, should be avoided. Practices are instructed to book patients 30 minutes apart to enable ample time for discussion and feedback between cases. Registrars are advised to still see the patient in a time similar to their current booking schedule, with the remaining time left for feedback and discussion with the visitor.
The number of files reviewed during the RCA component varies dependent upon the complexity of records selected and the learning needs identified. In the research conducted into ARCADO, medical educators reviewed between two and seven records.

Conducting the DO component first was the consensus decision of the research group. This allows RCA to be undertaken if a patient fails to attend and potentially allows time for another patient to be booked later during the ECTV. If the DO component runs over time, the RCA component can be managed around this. Finally, if a clinical area that was observed to be well managed during DO is then encountered during RCA, it is possible to skip to another record. This is not possible if RCA was conducted first.

3.6 ARCADO in the ACRRM and RACGP training pathways

The ARCADO ECTV can be used with registrars training towards FACRRM and FRACGP.

ACRRM does not require registrars to have ECTVs during training to obtain fellowship of the college. As part of the ACRRM formative assessment program every registrar must have at least six mini-CEX assessments. A mini-CEX involves the direct observation of a registrar’s consultation and completion of the mini-CEX assessment form. Some or all of the DO consultations in ARCADO could simultaneously be used to meet the ACRRM formative mini-CEX requirement.

RCA can be used to explore and assess ACRRM domains not easily formatively assessed by DO. For example, by selecting relevant records it is possible to assess management of hospital patients, management of emergencies, and management of culturally diverse and disadvantaged groups. A guide for RCA questions based on ACRRM domains is provided in the appendix to this manual. (Appendix 7.8)

RACGP currently requires all registrars to have five ECTVs during training to obtain fellowship of the college. There is no specific detail provided regarding the format of the ECTV other than they should contain “direct or videotaped observation of registrar consultations with verbal and written feedback to the registrar delivered by medical educators”. The ARCADO ECTV meets this requirement.

A guide for RCA questions based on RACGP domains is provided in the appendix to this manual (Appendix 7.9)
4 Conducting an ARCADO ECTV

4.1 Prior to the visit – practice preparation

Practice administrative staff should be educated about the purpose, structure, and privacy provisions prior to being involved in the ECTV booking process. The appendices of this manual contain example patient and visitor confidentiality forms, and practice information sheets and posters (Appendices 7.4, 7.5, 7.6 and 7.7).

The ECTV booking process is improved when practices allocate one staff member to be the ECTV contact. Practice staff should arrange time for feedback between the visitor and the registrar’s current supervisor, preferably at the end of the ECTV.

4.2 Regional Training Provider (RTP) role

The RTP has a role ensuring that all medical educator or GP supervisor visitors are familiar with the ARCADO assessment and are trained in providing feedback and workplace-based formative assessment.

RTPs should have clear policies and guidelines detailing the responsibilities of those involved in the ECTV process. The RTP matches the registrar and visitor taking into consideration both registrar learning needs and the location, availability and skills of the visitor. If the RTP is arranging the booking of the ECTV, dedicated staff who understand the complexities of ECTV management are essential.

Ideally, the practice manager, registrar and supervisor should have a minimum of 4 weeks’ notice prior to an ECTV to ensure booking schedules are in place. Planning should commence early in the registrar term. Rescheduling ECTVs is difficult given the number of parties involved. It is recommended that the practice, visitor and registrar are supplied with the relevant ARCADO ECTV guides (Appendices 7.1, 7.2 and 7.3) prior to the visit.

The ARCADO ECTV Formative Assessment Report (Appendix 7.10) should be available for the visitor, and preferably set up to facilitate electronic uploading onto the RTP’s online learning platform. RTPs should have systems in place to report to the Colleges and the Department of Health on registrar training status and ECTV completion.
Step one – arranging ARCADO ECTVs

**Match registrar and visitor**
- Consider registrar learning needs, range of visitors to increase exposure to different educators, geographical limitations

**Confirm availability of visitor**
- Generally, this directs the scheduling of the ECTV

**Book ECTV or confirm booking**
- Email registrar, practice and visitor minimum 4 weeks prior to ECTV
- Reminder email 2 weeks prior to ECTV

Step 2 – Conducting and reporting ARCADO ECTVs

**ARCADO ECTV conducted**
- Verbal feedback given to registrar and supervisor on day of ECTV

**Visitor completes ARCADO ECTV report**
- To be completed within 1 week of ECTV
- Report is consistent with original verbal feedback

**ARCADO ECTV report reviewed by RTP**
- If issues identified, RTP makes contact with registrar and supervisor to discuss further action

**ARCADO ECTV report uploaded to RTP online education platform**
- For access by registrar and supervisor
- For reporting to Dept of Health

4.3 ARCADO ECTV schedule

**Suggested 3 hour visit ARCADO ECTV scheduling:**

- 15 minutes Registrar and visitor discussion (no patients to be booked)
- 30 minutes Consultation patient one and feedback
- 30 minutes Consultation patient two and feedback
- 30 minutes Consultation patient three and feedback
- 45 minutes Review of medical records (Random Case Analysis)
- 20 minutes Complete assessment and update learning plan
- 10 minutes Feedback from/with supervisor

4.4 Booking of patients

- Registrars are responsible for ensuring their practice books three consultations for their ECTV
- Patient consultation time should match the registrar’s booking schedule. The thirty minute timing **includes** feedback time after the patient has left
- The practice should ensure that patients booked for an ECTV session are advised when they make the booking that an observer will be present. This minimises the risk of them refusing to be observed when they attend
• Practices should avoid booking pap smear, removal of suture and immunisation appointments as these are unlikely to provide significant learning opportunities

• The practice should seek written consent from patients when they arrive for the ECTV appointment

• The practice should not book extra patients during ECTV sessions

• The practice should, where possible, minimise interruptions during the ECTV.

4.5 Consent from patients for DO and RCA

All patients being observed must provide consent.

Ideally this occurs three times:

• Verbally, when the patient rings to make the appointment,

• In writing, on arriving for the appointment and

• Verbally, when the registrar calls the patient into the room.

A sample consent form is available in Appendix 7.7 of this guide.

Consent for review of medical records as part of RCA is covered under relevant state based health records legislation. For example, in Victoria the Health Records Act 2001 (Vic) (HRA) accepts such access when ‘the use or disclosure (is) for the purpose of…… monitoring, improvement or evaluation of health services; or training provided by a health service provider to employees or persons working with the organisation…. and (when) it is impracticable for the organisation to seek the individual's consent to the use or disclosure’.  

Practices are advised to include in their ‘collection statement’ that records may be reviewed by a third party as part of training. Practices are encouraged to display posters explaining the nature of a training practice. Example collection statements and practice posters are included in this manual (Appendices 7.5 and 7.6). Similar provision should be made for review of hospital inpatient or outpatient records when these will be used during RCA.

Visiting medical educators should ensure that patient details are de-identified by only using patient initials and age on the ARCADO ECTV Formative Assessment Report (Appendix 7.10).

4.6 Setting up the room

To enable observation of both registrar and patient, the visitor is ideally located equidistant from both. To reduce the impact of the visitor upon the consultation, the visitor should be seated as far away as the room allows. If the room shape does not allow the visitor to be distant from the patient and doctor, it is preferable for the visitor to be located towards the periphery of the patient's field of vision.

7 Health Records Act 2001 (Vic) Act no. 2/2001 Schedule 1, Section 19 The Health Privacy Principles
http://www.legislation.vic.gov.au/domino/web_notes/dms/pubstatbook.nsf/f93b2b60241ec77fca256e0d0000a23be/e57a0a1ddc0389fca256e0b0021314d/$FILE/01-002a.pdf
4.7 The visitor’s role

The visitor should clarify with the registrar that the intent is for them to be an observer only. The registrar should ask for assistance only when they would have asked their supervisor to assist. Some visitors request that the registrar still contact their supervisor for assistance, in which case the supervisor needs to be alerted to this requirement and to the presence of the visitor.

Visitors should only intervene in consultations when there are concerns for patient safety. Even then, unless the concern is immediate, it may be better to raise concerns after the patient has left. The registrar can then make contact with the patient after the visitor’s concerns have been considered. This avoids undermining the relationship between the registrar and the patient.

4.8 Conducting Direct Observation (DO)

Before the consultation commences, the visitor should be advised if the patient is new to the registrar. If it is a review consultation, the visitor should establish what the registrar knows about the patient prior to the consultation commencing.

When calling the patient into the room, the registrar should double-check that the patient is aware another doctor is present before the patient enters the room. The patient should already be aware that the visitor is present, but checking outside the room provides a last minute failsafe to enable the patient to refuse rather being presented with a fait accompli.

At the conclusion of the consultation the registrar can write any further consultation notes whilst the visitor considers their questions and feedback. The visitor enters brief notes into Section 2 of the worksheet of the ARCADO ECTV Formative Assessment Report (Appendix 7.10).

The visitor is encouraged to use questioning to explore the registrar’s approach to the consultation and the registrar’s clinical reasoning in the observed consultation. Sample questions are:

- What were you thinking at this time?
- What other investigations or treatments did you consider?
- What do you think the patient expected?
- What were you concerned not to miss?
- Did the patient understand?

4.9 Conducting Random Case Analysis (RCA)

The findings of the ARCADO research were that it was important that the reviewed records were selected by the visitor and not by the registrar. Also, medical records needed to be of recent consultations. If not, the value of RCA was compromised as some registrars had difficulties with recall.

To conduct RCA, the visitor asks the registrar to open up the appointment book to a session within the previous week and commences to select and read records from that session. The visitor uncovers what the registrar knew of the patient prior to the consultation and asks the registrar what they recall of the selected consultation. If a record is relatively straightforward and does not appear to contain new learning opportunities, the visitor can progress to another record.
The brief guide to RCA (Appendices 7.8 and 7.9) provides a framework of questions that can be used. Broadly the questions can be divided into those used to explore across all domains of general practice and the ‘what if’ questions to further explore clinical reasoning. The visitor selects a number of questions appropriate to the case. There are many more questions in the brief guides than are needed and many will not be relevant to the particular case. The visitor needs to be mindful of avoiding leaving the registrar feeling that they have been cross-examined.

The visitor records brief details about each RCA into Section 2 of the worksheet of the ARCADO ECTV Formative Assessment Report (Appendix 7.10).

The number of records reviewed will vary depending upon the time available after the consultation observation component is complete and the complexity of the records reviewed.

4.10 Formative assessment

Providing feedback is the foundation of formative assessment. It is through the provision of effective and balanced feedback that the assessment drives learning. Handled well, the provision of constructive feedback can be a powerful stimulus for learning. Handled badly, the provision of critical feedback can be damaging. Feedback should be delivered in a respectful and constructive manner, with a focus on behaviour rather than the person or personality. Feedback should reinforce what is being done well and provide suggestions for improvement.

The next component of formative assessment involves summarising the identified learning needs and considering how they might be addressed. These should be recorded in the registrar learning plan.

The final component of the ARCADO formative assessment is a determination by the visitor of whether the registrar is at the expected standard for the stage of training. Although this assessment will not be used to impede training progress, the assessment is still useful as it helps the registrar to understand how they are progressing towards becoming a competent GP. This assessment should be discussed with the registrar prior to the visitor leaving the practice. If the formative assessment report cannot be completed at the time of the visit, it should be completed within one week. Visitors should not record anything in the ARCADO ECTV report that was not discussed with the registrar during face to face feedback. The report should be completed and sent to the RTP. The ECTV report should be uploaded onto the RTPs online learning platform so that it can be accessed by the registrar and the supervisor. An example of a completed form is included in Appendix 7.11.

More hints on providing appropriate and safe feedback are provided in the guide for the visitor (medical educator or external supervisor) (Appendix 7.1).

4.11 Link to learning plan

The ECTV schedule includes time for the visitor to assist the registrar in the development of their learning plan and to update any new learning needs and activities.

The supervisor should be informed of any learning plan updates.
4.12 Supervisor/practice manager communication

Time with the supervisor should be scheduled in the ECTV booking to enable the visitor to discuss the assessment with the supervisor. If supervisors have concerns, these may also be discussed during the same meeting. However, if a supervisor has significant concerns about a registrar they should be discussed with the RTPs Director of Training.

4.13 Registrar training term and registrar ability

The ARCADO research found that both RCA and DO have relevance for all stages of registrar training and for both high and low performing registrars. The research did not investigate altering the mix of RCA and DO according to registrar stage of training or registrar ability, but participants in the research considered this might be of value. For example, the number of DOs could be reduced once a registrar has demonstrated proficiency in their consultation and communication skills, and the RCA proportion could be increased. There was strong support to maintain some DO within all ECTV assessments, as DO remains useful even with higher performing and experienced registrars to support ongoing self-reflection and development of communication and consultation skills.

4.14 Within the placement

The impact on the registrar’s learning of the timing of the ECTV within the registrar term should be considered when booking ECTVs. If ECTVs are booked early in a registrar placement, the registrar may be:

- Less likely to see patients with chronic conditions
- More likely to see new patients
- Less likely to know local resources, referral pathways and operation of the practice
- Less likely to secure three consecutive patient bookings for the DO component.

Earlier in a training term, when a registrar may not have a load of complex patients, the “what if” questions in RCA can be used to enrich the learning experience.

5 During Focused Learning Intervention (FLI) or within Remediation

Registrars in remediation or undertaking focused learning intervention (FLI) were excluded from the ARCADO research. Learning interventions need to be individualised for registrars with identified skills or performance deficits. ARCADO is a useful addition to the remediation toolbox as a formative assessment option, but, at this stage, not a necessary or mandated part of FLI or remediation.
6 Education of the visitor

The quality of the ECTV experience for registrars is important, not only to maximise the learning potential of the visit, but to support registrars' wellbeing. Anecdotally, registrars have related that there is a range of quality of ECTV experiences which they link to the skill of the visitor.

There is a range of strategies employed by RTPs to prepare medical educators and supervisors to conduct ECTVs. It is recommended that RTPs review and evaluate their ECTV training and consider the following:

- All ECTV visitors to be trained in the ECTV ARCADO process prior to conducting ECTVs
- An online component that includes videos of example cases is developed for use during or prior to attending training
- Specific training in provision of feedback involving role play is included in the training. The use of actors should be considered to increase the fidelity of training
- RTPs to evaluate visitors through registrar assessment or peer review
- ECTV visitors to attend regular refresher courses to maintain accreditation.
Appendices

Appendix 7.1

ARCADO - Adding Random Case Analysis (RCA) to Direct Observation (DO) in the External Clinical Teaching Visit (ECTV)

7.1 Guide for the Visitor (Medical Educator or External GP Supervisor)

General Information

An ARCADO External Clinical Teaching Visit (ECTV) consists of observation of a GP registrar and a review and discussion of their recent medical records by a visiting medical educator or a GP supervisor from another training practice. The ARCADO ECTV provides a teaching and learning experience that focuses both on consultation skills and clinical reasoning. Most registrars have five ECTVs during their training.

What is a Formative Assessment?

In the Australian General Practice Training Program summative assessment is conducted by the RACGP and ACRRM towards the end of training. This is assessment of learning. Formative assessment is assessment during training and is conducted by the Regional Training Providers (RTPs). Formative assessment is assessment for learning rather than assessment of learning. It is primarily about providing feedback to the registrar and suggestions for improvement.

An assessment can be a hurdle that must be overcome before a learner can progress to the next level. Formative assessment in an ECTV is not a hurdle assessment. Although there is a judgement of how the registrar is progressing compared to the expected standard, the intent is to use information gained from the assessment to assist and guide learning, rather than to impede progress.

A registrar is not prevented from progressing to the next stage of training based upon a single ECTV formative assessment. If concerns are raised about a registrar’s competence for their current stage of training a more detailed assessment would be required.

Structure of ECTV

The ARCADO ECTV is conducted over a 3 hour session during which two assessment methods are used – RCA and DO.

- DO is conducted first, RCA can be conducted if patients fail to attend and replacement patients can be booked for later in the assessment
- Three consultations are observed
- The practice has been instructed to avoid booking simple consultations such as routine childhood immunisations.
- The practice has been instructed to avoid cases where a patient may not consent to a visitor being present, such as a Pap smear examination
- Practices are advised to book patients 30 minutes apart to enable ample time for discussion and feedback between cases
• Registrars are advised to still see the patient in a time similar to their current booking schedule, with the remaining time left for feedback and discussion with the visitor.

You may be requested to contact the registrar and book the ECTV yourself or the RTP staff may arrange the ECTV for you. If the RTP is arranging the ECTV, they will send you an email confirming the time and date of the scheduled visit, the practice location and the name of the registrar. The RTP will ensure that you have online access to this registrar's profile so you can upload the ARCADO report.

**Patient consent for observation and record review**

All patients being observed must provide consent.

Ideally this occurs three times:

- Verbally, when the patient rings the practice to make the appointment;
- In writing, on arriving for the appointment and
- Verbally, when the registrar calls the patient into the room.

A sample consent form is available in Appendix 7.7 of this guide.

Consent for review of medical records is covered under state based health records legislation. For example, the Health Records Act 2001 (Vic) (HRA) in Victoria accepts such access when "the use or disclosure (is) for the purpose of…… monitoring, improvement or evaluation of health services; or training provided by a health service provider to employees or persons working with the organisation…. and (when) it is impracticable for the organisation to seek the individual's consent to the use or disclosure". ^8^ Practices are recommended to advise patients in their “collection statement” that records may be reviewed by a third party as part of training and encouraged to display posters explaining the nature of a training practice. Example confidentiality statements are included in the appendix 7.6 of this manual.

You may be asked by the practice to sign a confidentiality statement (Appendix 7.4) and all reporting of consultation details must be de-identified. We suggest you use patient initials and age on the ARCADO ECTV report.

**Suggested ARCADO ECTV scheduling:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>Registrar and visitor discussion (no patients to be booked)</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Consultation patient one and feedback</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Consultation patient two and feedback</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Consultation patient three and feedback</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Review of medical records (Random Case Analysis)</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Complete assessment and update learning plan</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Feedback with supervisor</td>
</tr>
</tbody>
</table>

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^8^ Health Records Act 2001 (Vic) Act no. 2/2001 Schedule 1, Section 19 The Health Privacy Principles

http://www.legislation.vic.gov.au/domin0/web_notes/dms/pubstatbook.nsf/1932b66241ecf1b7ca256e920000c238e-a57a01dded389fbc2a56e5b002134gFIL.E01-902e.pdf
Before the Visit

To maximise the value of the ECTV, consider the following:

- Make contact with the registrar prior to the visit to clarify the format of the day
- Reinforce with the registrar that the session is a learning opportunity. Greater value will be obtained from observing consultations with patients they find challenging
- Discuss with the practice, where possible, to minimise interruptions during the ECTV and not squeeze in extra patients
- You should pre-arrange a time with the supervisor to discuss the registrar’s progress.

On arrival

Arrive on time! Identify yourself to the reception staff.

For the session to progress well the registrar needs to feel that they are in a safe learning environment. If you have not met the registrar previously, spend the first 15 minutes finding out about them and sharing your own background in order to establish a relationship. Acknowledge that being observed is a difficult experience for all of us.

Remind the registrar that the purpose of the visit is for reflection and education. It is not intended that they work too hard during the session. Check that only three patients have been booked in so there is enough time for feedback and assessment and the RCA review of medical records.

Ask the registrar how their training is progressing. Sometimes an ECTV is the first time the registrar has had contact with the RTP since starting at the practice. If the registrar has issues with the practice, offer to take them up with the RTP after the visit. Avoid trying to solve or mediate issues with the practice during the visit. Remember you are only hearing one side of the story. Explain that the purpose of the visit is to assess consultations rather than solve training or practice issues and these can and will be dealt with through other mechanisms.

Ask if the registrar would like you to focus on any particular issue with their consulting style during the visit. For example, often registrars identify time management as something they want to improve. You can then provide feedback in each consultation regarding time management.

Ground Rules for Direct Observation of Consultations

Generally observed consultations are best if you can try and be a “fly on the wall”.

Clarify with the registrar that the intent is for you to be an observer only. The registrar should ask for your assistance only when they would have asked their supervisor to assist. You can insist that the registrar still contact their supervisor, but you will endear yourself more to the practice by allowing them a session free of registrar responsibility!
You should intervene in a consultation any time you have concerns for patient safety. Even then, unless the concern is immediate it may be possible to raise concerns after the patient has left. The registrar can make contact with the patient after your concerns have been considered. This avoids undermining the relationship between the registrar and the patient.

Look at the layout of the registrar’s room. The best position for the observer is equidistant from both registrar and patient and as far away as possible from both. If the room shape does not allow you to be distant from the patient, try and sit as far as possible away from the patient’s field of vision. After the introductions it is best to avoid looking directly at the patient. If the patient does catch your eye direct the patient non-verbally back to the registrar. If asked, explain your presence as part of an education program for doctors. Sometimes you may be considered by the patient to be a medical student, but this tends to happen less as you age!

Before the consultation determine if the patient is a new patient. If it is a review patient find out what the registrar already knows about the patient.

When calling the patient into the room, the registrar should double-check that the patient is aware another doctor is present before they enter the room. The patient should already know that you are present, but checking outside the room provides a last minute failsafe to enable the patient to refuse rather being presented with a fait accompli.

At the end of the consultation the registrar can write any further notes on the consultation whilst you gather your thoughts for feedback. Use Section 2 of the ARCADO ECTV Formative Assessment Report to record brief details of the consultation and collect your feedback thoughts (Appendix 7.10). This information will be useful in the formative assessment later in the visit. It is not expected that you provide a detailed description of the consultations as the RTP is more interested in your assessment rather than the content of the consultation.

Feedback should be given individually about each consultation. If there are patients waiting to be seen, feedback may be delayed until the waiting room is clear.

When reviewing the first consultation and providing feedback start by acknowledging the discomfort we all feel on being observed. Clarify any information that was not evident to you in the observed consultation. For example, what were the examination findings?

It is particularly important that early in your relationship with the registrar the feedback is balanced. There is always a temptation to jump to what you may see as the issue, but this should be avoided until your relationship is more established and the registrar is less threatened by such a direct approach. Critical or “negative” feedback is much more likely to be effective in a safe learning environment. It needs to be balanced with what has been done well. This is the basis of ‘Pendleton’s rules’ of feedback.⁹

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Ask the registrar to consider what was done well first. Often the things that are done well are things we take for granted such as listening to the patient, using open questions, examining appropriately. Acknowledging what was done well first not only reinforces good practice, but balances feedback so it is safe. Even when you ask the registrar what they have done well they will still often launch into what went “less well”.

Once a supportive and safe relationship with a registrar is established, it is possible to progress beyond Pendleton’s rules. It is still important to keep feedback balanced and responsive to the registrar’s needs. One method is to commence the feedback by asking the registrar how they thought the consultation went or to identify issues that they would like feedback about. This tends to lead directly to addressing the registrar’s concerns.

You will notice that often registrars will be keener to discuss clinical concerns than communication skills issues.

Feedback should always be about observed behaviour rather than the person. It is easier to change our behaviour than ourselves. For example, rather than saying that a registrar is a “loud-mouth” it is better to observe that you noticed that they interrupted the patient before they finished their opening line and didn’t check the patient’s understanding of the planned management. This is also an example of feedback being specific – another important feature of good feedback.

Use questioning to explore the registrar’s approach to the consultation and clinical reasoning in the observed consultation:

- What were you thinking at this time?
- What other investigations did you consider?
- What do you think the patient expected?
- What were you concerned not to miss?
- Did the patient understand?

**Ground Rules for Random Case Analysis**

To conduct RCA, ask the registrar to open up the appointment book to a session within the previous week and select and read records from that session. It is important that the reviewed records are selected by you, the visitor, and not by the registrar. Uncover what the registrar knows of the patient prior to the consultation and ask the registrar what they recall of the selected consultation. If a record is relatively straightforward and does not appear to contain new learning opportunities, use your judgement and progress to another record. It is not essential that every record or case is considered in detail.

The brief guide to RCA (Appendix 7.8 for ACRRM and 7.9 for RACGP) provides a framework of questions that can be used to explore across all domains of general practice. It is possible to explore the registrar’s clinical reasoning in greater detail by asking one or more of the “what if” questions. What if the problem, person, doctor or system was different? Select a number of questions appropriate to the case. The visitor, though, needs to be mindful of avoiding leaving the registrar feeling that they have been cross-examined.
The number of records reviewed will vary depending upon the time available after the consultation observation component is complete and the complexity of the records reviewed.

Record *brief* details about each RCA into Section 2 of the worksheet of the ARCADO ECTV Formative Assessment Report (Appendix 7.10). It is not expected that you provide a detailed description of the records reviewed.

Feedback about random case analysis tends to be embedded in the discussion about the case review. At the end of the review it may be useful to ask “are there any outstanding issues for you in this case that you would like me to discuss with you?”

**Formative Assessment**

Formative assessment at the end of the visit includes:

- a summation of the feedback
- planned learning activities to address identified learning needs
- an overall assessment of the registrar compared to the level of training.

The ARCADO ECTV Formative Assessment Report will help guide you through this process (Appendix 7.10). Some educators provide the written report to the registrar on the day, and others complete it following the visit, and upload it onto the RTPs online learning platform. The written report needs to be finalised within one week of the ECTV for the RTP to upload onto the registrar’s electronic training portfolio. The registrar should not discover any surprises when they read their report. Remember the purpose of formative assessment is to provide assessment for learning rather than assessment of learning.

Briefly review the section 2 of the ARCDAO ECTV Report that will contain brief details that you have already recorded regarding each consultation or record reviewed. Progress to sections 3 and 4 of the report to enable to you to provide summarised feedback, help the registrar plan learning to address learning needs identified and provide an overall assessment of the registrar compared to the standard at their stage of training. There are five areas that are assessed. They are history taking, examination, problem definition and management, explanation and planning, organisational and ethical. Although they are largely self-explanatory, there are reminders for you regarding issues to be considered under each heading. It is possible that you may not be able to make a comment in some of the five areas.

You are asked to provide comments rather than a score in each area. This is because the ARCADO ECTV is an opportunity for a dialogue about performance and suggestions for change, rather than having a focus on pass or fail. It may be helpful to ask the registrar for their self-assessment in each of these areas. Alternatively provide specific examples of behaviour from observed consultations or cases reviewed to back up your comments and suggestions for change. Check if the registrar agrees.

The next component of the report asks you to suggest to the registrar what they should keep doing, do more of or try doing, do less of, and stop doing. This has been designed to encourage descriptive, specific and balanced feedback rather than just a score. This will help provide the registrar with direction to improve. This is the purpose of formative assessment.
When the formative assessment session goes well, it functions as a "brainstorming" session of ideas for the registrar’s learning plan. Encourage the registrar to record agreed suggestions for change in their learning plan. This will facilitate follow up with their supervisor during subsequent teaching sessions or when a visitor next attends.

Finally you are asked to provide a single global assessment of whether the registrar is at the standard expected for their current stage of training. Interestingly and counter-intuitively, global assessments have been found to be a more reliable assessment than checklists of individual competencies.

If a registrar is thought to be performing below the standard then a more detailed assessment will be conducted to determine if your impression is correct. The ARCADO ECTV is not being used as a hurdle assessment tool. It should be considered a screening tool or low-stakes assessment tool. The prime purpose is to facilitate learning rather than to determine registrar progression. Please note that the standard is the current stage of training rather than the end of training.

**Viewing the Registrar’s Learning Plan**

The registrar’s learning plan is intended to be a living document and the ARCADO ECTV is an ideal time for a brief review of the learning plan.

Review the registrar’s current learning plan in their online portfolio. New learning plan items can be added and you can discuss with the registrar how the learning needs can be met and demonstrated. There may be learning plan items present that have been demonstrated to be complete during the visit. If possible check in with the supervisor and discuss any issues raised or additions to the registrar’s learning plan.

**Meeting the Supervisor**

Before leaving the practice meet with the supervisor. Outline the outcomes of the visit to the supervisor including the assessment and learning needs identified. Check if the supervisor has any particular concerns regarding the registrar.

**The Paperwork**

If the ARCADO ECTV Formative Assessment Report was not completed at the time of the visit it should be uploaded or forwarded to the RTP within one week after the visit.

If you had concerns regarding the registrar’s competence for their current level of training in addition to making comments on the report please contact the RTP.
7.2 Guide for the practice manager and supervisor

What is an ECTV?

An ARCADO External Clinical Teaching Visit (ECTV) consists of observation of a GP registrar’s consultations and a review and discussion of their recent medical records by a visiting medical educator or a GP supervisor from another training practice. The ARCADO ECTV provides a teaching and learning experience that focuses both on consultation skills and clinical reasoning. Most registrars have five ECTVs during their training.

Formative Assessment

In the Australian General Practice Training Program summative assessment is conducted by the RACGP and ACRRM towards the end of training. This is assessment of learning. Formative assessment is assessment during training and is conducted by the RTPs. Formative assessment is assessment for learning rather than assessment of learning. It is primarily about providing feedback to the registrar and suggestions for improvement.

An assessment can be a hurdle that must be overcome before a learner can progress to the next level. Formative assessment in an ECTV is not a hurdle assessment. Although there is a judgement of how the registrar is progressing compared to the expected standard, the intent is to use information gained from the assessment to assist and guide learning, rather than to impede progress.

A registrar is not prevented from progressing to the next stage of training based upon a single ECTV formative assessment. If concerns are raised about a registrar’s competence for their current stage of training a more detailed assessment would be required.

Structure of ARCADO ECTV

The ARCADO ECTV is conducted over a 3 hour session during which a minimum of three consultations are observed. Ample time should be allowed for discussion and feedback about the consultation with the remainder of the time used to conduct random case analysis and to complete the formative assessment feedback.

Example format for an ARCADO ECTV

15 minutes Registrar and visitor discussion (no patients to be booked)
30 minutes Consultation patient one and feedback
30 minutes Consultation patient two and feedback
30 minutes Consultation patient three and feedback
45 minutes Review of medical records (Random Case Analysis)
20 minutes Complete assessment and update learning plan
10 minutes Feedback with supervisor
If there are inadequate numbers of consultations observed, the ARCADO ECTV may need to be repeated. While it is the registrar’s responsibility to ensure they have enough patients booked in, the practice should do all they can to assist.

**Handy Hints for the Practice**

- The practice should ensure that patients are advised when they make a booking during the ARCADO ECTV session that an observer will be present in order to minimize the risk of them refusing to be observed on the day.
- Generally Pap smear appointments, removal of suture appointments and immunisation appointments should be avoided as they are unlikely to provide significant learning opportunities.
- The practice should not squeeze in extra patients during the ARCADO ECTV sessions.
- The practice should, where possible, minimize interruptions during the ARCADO ECTV.

**Patient consent and privacy**

All patients being observed must provide consent.

Ideally this occurs three times:

- Verbally, when the patient rings to make the appointment;
- In writing, on arriving for the appointment and
- Verbally, when the registrar calls the patient into the room.

A sample consent form is available in Appendix 7.7 of this guide.

Consent for review of medical records is covered under relevant state legislation. For example, the Health Records Act 2001 (Vic) (HRA) in Victoria states “the use or disclosure (is) for the purpose of…… monitoring, improvement or evaluation of health services; or training provided by a health service provider to employees or persons working with the organisation…. and (when) it is impracticable for the organisation to seek the individual's consent to the use or disclosure”.

Practices or hospitals should advise patients in their “collection statement” that records may be reviewed by a third party as part of training. We have provided an example phrase in Appendix 7.6 of this document. Practices or hospitals should consider displaying a poster explaining the nature of a training practice. Example text for a poster is provided in Appendix 7.5.

Records of the consultation details by the visitor are de-identified by using patient initials and age. Visitors have been advised that you may request that they sign a confidentiality agreement. An example visitor confidentiality statement is provided in Appendix 7.4.

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Feedback and Formative Assessment

Feedback is provided to the registrar after each consultation and the formative assessment is discussed prior to the visitor leaving. If the assessment report is not formally completed at the time it will be completed within one week after the visit.

The completed ARCADO ECTV Formative Assessment Report will be available for the supervisor to view on the online learning platform. The registrar’s learning plan may also have been updated with new learning needs and activities. The supervisor can discuss the report and any new learning activities at the next teaching session.

If there are particular aspects you would like the visitor to consider it is best to make contact prior to the day of the ARCADO ECTV visit. The visitor will check in with the supervisor before leaving the practice. Please make sure the supervisor has time available for this meeting.

The ARCADO ECTV is not on its own an assessment to determine if the registrar is suitable to continue in training. If a supervisor has significant concerns about a registrar they should be discussed with the Regional Training Provider.
Appendix 7.3

ARCADO – Adding Random Case Analysis (RCA) to Direct Observation (DO) in the External Clinical Teaching Visit (ECTV)

7.3 Guide for the Registrar

What is an ARCADO ECTV?

An ARCADO External Clinical Teaching Visit (ECTV) consists of observation of a GP registrar’s consultations and a review of their recent medical records by a visiting medical educator or a GP supervisor from another training practice. The ECTV provides a teaching and learning experience focusing on both consultation and clinical reasoning. Most registrars have five ECTVs during their training.

Formative Assessment

In the Australian General Practice Training Program summative assessment is conducted by the RACGP and ACRRM towards the end of training. This is assessment of learning. Formative assessment is assessment during training and is conducted by the RTPs. Formative assessment is assessment for learning rather than assessment of learning. It is primarily about providing feedback to the registrar and suggestions for improvement.

An assessment can be a hurdle that must be overcome before a learner can progress to the next level. Formative assessment in an ECTV is not a hurdle assessment. Although there is a judgement of how the registrar is progressing compared to the expected standard, the intent is to use information gained from the assessment to assist and guide learning, rather than to impede progress.

A registrar is not prevented from progressing to the next stage of training based upon a single ECTV formative assessment. If concerns are raised about a registrar’s competence for their current stage of training a more detailed assessment would be required.

Structure of ARCADO ECTV

The ARCADO ECTV is conducted over a 3 hour session during which a minimum of three consultations are observed. Ample time should be allowed for discussion and feedback about the consultation with the remainder of the time needed to conduct random case analysis and to complete the formative assessment feedback.

Suggested ECTV scheduling:

15 minutes Registrar and visitor discussion (no patients to be booked)
30 minutes Consultation patient one and feedback
30 minutes Consultation patient two and feedback
30 minutes Consultation patient three and feedback
45 minutes Review of medical records (Random Case Analysis)
20 minutes Complete assessment and update learning plan
10 minutes Feedback with supervisor
If there are inadequate numbers of consultations observed, the ECTV may need to be repeated. Make sure you have enough consultations booked in. This is your responsibility. If you have concerns about the number or type of patients discuss this with your practice manager.

**Handy Hints**

To maximise the value of the ECTV, consider the following:

- Ensure practice staff advise patients when they book that there will be an observer present, in order to minimise the risk of patients refusing to be observed when they attend.
- Request practice staff to avoid booking Pap smear, removal of suture and immunisation appointments as these are unlikely to provide significant learning opportunities.
- Request practice staff to avoid “squeezing” in extra patients during ECTV sessions.
- Request practice staff to, where possible, minimise interruptions during the ECTV.

**Patient consent**

All patients being observed must provide consent. Ideally this occurs three times:

- Verbally, when the patient rings to make the appointment;
- In writing, on arriving for the appointment and;
- Verbally, when the registrar calls the patient into the room.

A sample consent form is available in Appendix 7.7 of this guide.

**Ground Rules for Observed Consultations**

When calling the patient into the room you should double-check that the patient is aware another doctor is present *before* they enter the room. The patient is introduced to the visiting doctor and if necessary it should be clarified that the visiting doctor will not be taking part in the consultation. The consultation is then conducted as though the visitor was not there. The extra time booked for the consultation is to ensure there is adequate time for feedback at the end of the consultation rather than for you to demonstrate how thorough you can be.

The visitor will generally avoid being involved in the consultation unless you ask or unless there are issues of patient safety. Some visitors will prefer you to contact your GP supervisor as normal if you need help but most will assist you with answers to questions. Try not to ask questions of the visitor just because they are there. Questions and feedback are best left until after the patient has left the room.

**Ground Rules for Random Case Analysis**

A selection of records will be obtained by reviewing consecutive records from a recent consulting session chosen at random by the visitor. A recent session is chosen as it is easier for you to recall the circumstances and the thinking behind decisions you made in the consultation. This makes it more useful for discussion.
You will be asked what you knew about the patient prior to the consultation and the notes will be used to trigger a discussion about the case. You will not just be asked about the clinical decisions made. The visitor may pose hypothetical questions based on the case to help explore your knowledge and understanding in greater detail.

It is not essential that every record or case is considered in detail as some may be straightforward and not require further discussion.

Feedback and Formative Assessment

After each consultation and record reviewed you will be given feedback. Approach feedback as a learning opportunity.

Often there will be a particular issue that you would like feedback upon:

- Was the diagnosis correct?
- Did you think the patient was satisfied?
- What is likely to happen next?
- Was my examination appropriate?

Make sure you ask the question you want answered!

At the conclusion of the visit, the visitor will provide you with feedback upon the sum of your consultations and random case analysis using the ARCADO ECTV Formative Assessment Report (Appendix 7.10). The report may be finalised at this time or completed and recorded on the online learning platform for you to access later. It is most important that it is discussed prior to the conclusion of the visit.

This is an opportunity to discover how you are progressing compared to the expected standard and receive suggestions for improvement.

You will notice the ARCADO ECTV Formative Assessment Report has space for comments and suggestions. When the feedback session goes well it functions as a “brainstorming” session of ideas for your learning plan.

Learning Plan Review

The visitor will review your learning plan at the conclusion of the visit. It may be that some learning plan items have been observed to have been completed during the visit. These learning plan items can then be archived.

New learning plan needs identified during the visit should be recorded whilst the visitor is still present. Discuss how you will meet these learning needs.

Visitor Meets the Supervisor

At the conclusion of the visit, the visitor will meet with your supervisor to discuss the outcome of the visit in particular any learning plan items that the supervisor can help address.
7.4 Example Confidentiality Agreement between Practices and Visitors

To maintain the confidentiality and privacy of the information that this practice retains and to ensure compliance with legal obligations, the (Name of Practice) requires all visitors, who have access to information that discloses patient health and the practices’ business, to sign this Confidentiality Agreement.

This Confidentiality Agreement is between:

(Visitor Name)

and

(Name of Practice)

I understand that in performing the responsibilities of my role at the (Name of Practice), I will have access to confidential information relating to patient health and the practice’s business.

I agree that I will not disclose any confidential information to any person not authorised to receive such confidential information.

I undertake not to access, use, disclose, copy, reproduce or retain confidential information for any purposes other than patient care.

I have read and understood the practice’s privacy policy and agree to abide by the procedures used by this practice in ensuring there are no breaches of privacy.

Visitor’s Name:

Visitor’s Signature:

Date:

Practice Representative Name:

Practice Representative Signature:

Date:
7.5 Example practice poster

Accredited Teaching Practice

(Name of Practice) is an accredited teaching practice with (RTP) and (include Universities if relevant for medical, nursing, allied health students).

We employ GP registrars. They are fully qualified doctors undertaking specialist General Practice Training.

Medical, nursing and allied health students are also taught within this practice.

As part of our commitment to quality improvement (Name of Practice) we may use your medical records for:

- Visiting teachers and accreditation surveyors for the purposes of teaching and accreditation of the practice
- Research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

If you would like to request not to have your records accessed for quality improvement purposes, please let reception staff know and have your record marked as not for review.
Appendix 7.6

7.6 Example Practice Information Collection Statement

(Name of Practice) requires your consent to collect personal information about you.

Please read this information and sign where indicated.

(Name of Practice) collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be pro-active in your health care needs.

This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare Australia
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals
- Disclosure to other doctors including locums and to allied health workers and nurses who work in the practice
- Disclosure to visiting teachers and accreditation surveyors for the purposes of teaching and accreditation of the practice
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld.

I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.

Patient Signature........................................................................................................

Date..............................................................................
Appendix 7.7

7.7 Example patient consent form for direct observation by visitor

Dear Patient,

Direct observation by GP Supervisor/Medical Educator

Today Dr ___________________________ has Dr _________________ with him/her. Dr ___________________________ is present to observe and discuss aspects of General Practice with Dr _________________ as part of ongoing professional development.

Dr ___________________________ will not participate directly in the consultation. The content of the consultation will remain confidential. If you would prefer not to have another doctor present for all or any part of the consultation, please let the receptionist or your doctor know.

Please tick one of the following statements:

☐ I consent to have Dr ___________________________ present during my consultation

☐ I decline to have Dr ___________________________ present during my consultation

Signed: ___________________________

Date: ……. / ……. / ……. 
7.8 Brief Guide to Random Case Analysis (ACRRM)\textsuperscript{11}

**Clarify**

- Read the notes and relevant components of the record
- Ask the registrar what they recall of the consultation
- Uncover what the registrar knew of the patient prior to the consultation.

**Explore**

- Ask questions using the ACRRM Domains and “what if?” questions.

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**Assess**

- Provide assessment and feedback to the registrar in the seven domains
- Reinforce what is being done well and provide suggestions for improvement
- Assist the registrar in the development of a learning plan to address learning needs identified.

**Exploring ACRRM Domains**

Below are some questions that can be used to explore the case in greater detail by referencing the ACRRM Domains of General Practice.

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Domain 1: Provide medical care in the ambulatory and community setting

Themes: Patient-centred clinical assessment, clinical reasoning, clinical management

- What was the patient’s agenda?
- Do you think the patient was concerned about anything in particular?
- What do you think the patient expected or wanted the outcome to be?
- Do you feel you reached common ground with the patient?
- What was the focus of your physical examination?
- What diagnosis or problem definition did you make about this presentation?
- What is your understanding of this condition or problem and how it presents and should be managed?
- What other diagnoses or possibilities did you consider?
- Are there important problems or diagnoses not to be missed?
- Did you feel comfortable with the decision you made?
- Can you tell me why you made the decision you did in this case?
- Is there evidence or guideline relevant to the decision you made?
- Why did you refer, investigate or prescribe as you did?
- Did you consider involving other members of the primary health care team?
- What follow up was arranged and why?
- Were the follow up instructions clear and was there safety-netting?
- Did you provide any written or other resources to aid patient understanding?

Domain 2: Provide care in the hospital setting

Themes: Medical care of admitted patients, medical leadership in a hospital team, health care quality and safety

- Why did you admit this patient?
- Why did you investigate or manage as you did?
- Were relevant checklists and management pathways implemented? If not, why?
- How did you monitor progress?
- Do the notes adequately communicate your management plan and review?
- Are the medication and fluid management charts clear?
- How else did you communicate with the health care team?
- Was there clinical handover?
- What was your involvement in discharge planning?
- Were there any near misses or adverse events and how did you respond to them?
Domain 3: Respond to medical emergencies

Themes: Initial assessment and triage, emergency medical intervention, communication and planning

• What was your initial assessment and triage decision?
• How did you stabilise this patient?
• What was your primary and secondary care management?
• Were there difficulties with any emergency procedures that you performed?
• How did you choose and use resources?
• Were there any lessons to be learned from this emergency?

Domain 4: Apply a population health approach

Themes: Community health assessment, population-level health intervention, evaluation of health care, collaboration with agencies

• What are the appropriate evidence-based screening investigations for this patient?
• Does this presentation add to your understanding of the health needs in this community?
• Are there other ways you could achieve health outcomes in this community?
• Was there a requirement for statutory notification of health conditions?

Domain 5: Address the health care needs of culturally diverse and disadvantaged groups

Themes: Differing epidemiology, cultural safety and respect, working with groups to improve health outcomes

• Is this a common presentation in this age/gender/ethnic or cultural group?
• What impact does this have on the patient’s family/community?
• How does the patient’s cultural background impact upon their presentation and management?
• What steps did you take to ensure cultural safety in this case?
• How did you use interpreters or key community contacts?
Domain 6: Practise medicine within an ethical, intellectual and professional framework

Themes: Ethical practice, professional obligations, intellectual engagement including teaching and research

- Were there any issues related to consent or confidentiality?
- Were there concerns about patient-doctor boundaries?
- Are your notes clear?
- Do your notes contain enough information for another to continue care?
- Does your referral letter contain a clear request and adequate information?
- If you used others in the primary health team how did you communicate with them?
- Did you review or use recall or reminders in this case?
- Was time used efficiently in this consultation?
- What item number did you bill and do your notes justify the billing?
- Were the certificates provided accurate and ethical?

Domain 7: Practise medicine in the rural and remote context

Themes: Resourcefulness, flexibility, teamwork and technology, responsiveness to context

- How did/would a remote location impact upon this consultation?
- How did you weigh up the balance of potential benefits, harms and costs in referring this patient to a distant service?
- Are there telehealth options to enable you to access specialised care for this patient?
Appendix 7.9

7.9 Brief Guide to Random Case Analysis (RACGP)\textsuperscript{12}

Clarify

- Read the notes and relevant components of the record
- Ask the Registrar what they recall of the consultation
- Uncover what the Registrar knew of the patient prior to the consultation.

Explore

- Ask questions using the RACGP Domains and “what if?” questions.

Assess

- Provide assessment and feedback to the Registrar in the five domains
- Reinforce what is being done well and provide suggestions for improvement

Assist the Registrar in the development of a learning plan to address learning needs identified.

Exploring RACGP Domains

Below are some questions that can be used to explore the case in greater detail by referencing the RACGP Domains of General Practice.

Domain 1: Communication Skills and the Doctor-Patient Relationship Questions

- What was the patient’s agenda?
- Do you think the patient was concerned about anything in particular?
- What do you think the patient expected or wanted the outcome to be?
- Do you feel you reached common ground with the patient?
- Did you provide any written or other resources to aid patient understanding?

Domain 2: Applied Professional Knowledge and Skills Questions

- What diagnosis or problem definition did you make about this presentation?
- What is your understanding of this condition or problem and how it presents and should be managed?
- What other diagnoses or possibilities did you consider?
- What is your understanding of them?
- Are there important problems or diagnoses not to be missed?
- Did you feel comfortable with the decision you made?
- Can you tell me why you made the decision you did in this case?
- Is there evidence or guideline relevant to the decision you made?
- Why did you refer, investigate or prescribe as you did?
- Did you consider involving other members of the primary health care team?
- What follow up was arranged and why?
- Were the follow up instructions clear and was there safety-netting?

Domain 3: Population Health and the Context of General Practice Questions

- Is this a common presentation in this age/gender/ethnic or cultural group?
- What are the appropriate screening investigations according to the RACGP red book guidelines for this patient?
- What impact does this have on the patient’s family/workplace?
- How does the patient’s cultural background impact upon their presentation and management?
Domain 4: Professional and Ethical Role Questions

- Were there any issues related to consent or confidentiality?
- Were there concerns about patient-doctor boundaries?

Domain 5: Organisational and Legal Questions

- Are your notes clear?
- Do your notes contain enough information for another to continue care?
- Does your referral letter contain a clear request and adequate information?
- If you used others in the primary health team how did you communicate with them?
- Did you review or use recall or reminders in this case?
- Was time used efficiently in this consultation?
- What item number did you bill and do your notes justify the billing?
## 7.10 ARCADO ECTV Report

<table>
<thead>
<tr>
<th>Registrar Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Term:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Visitors Name:</td>
<td></td>
</tr>
<tr>
<td>Supervisor Name:</td>
<td></td>
</tr>
<tr>
<td>Practice:</td>
<td></td>
</tr>
</tbody>
</table>

### Section 1 – Pre-assessment meeting

Any comments from discussion with registrar prior to seeing first patient?

### Section 2 – Brief Details of Cases

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Consult Observation</th>
<th>Random Case Analysis</th>
<th>Complexity: high</th>
<th>med</th>
<th>low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Details (age, gender, reason for visit):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points noted in this case:</td>
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<td></td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Brief Details (age, gender, reason for visit):</td>
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<table>
<thead>
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<th>Consult Observation</th>
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</thead>
<tbody>
<tr>
<td>Brief Details (age, gender, reason for visit):</td>
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<td></td>
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<tr>
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<td>Case</td>
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<td>med</td>
<td>low</td>
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<tr>
<td>Case 4</td>
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<td>Case 5</td>
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<td>Case 8</td>
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<tr>
<td>Case 9</td>
<td></td>
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</tr>
</tbody>
</table>

Brief Details (age, gender, reason for visit):

Points noted in this case:
### Case 10

#### Consult Observation

Complexity: high [ ] med [ ] low [ ]

Brief Details (age, gender, reason for visit):

Points noted in this case:

### Section 3 – Formative Assessment And Feedback Sheet

*This assessment must be discussed with the Registrar at the conclusion of the visit and represents a summary of what was observed and the feedback given during the visit*

**Communication skills – History taking**
In follow up or review appointments the registrar clarifies the reason for the visit and obtains relevant information to assess the patient’s progress.

Comments:

**Clinical Skills – Examination**
Focused examination with correct interpretation of findings.

Comments:

**Clinical Skills – Clinical Reasoning and Problem Definition**
Considers relevant diagnoses. Appropriate reasoning to establish diagnosis or formulation. Rational use of investigations.

Comments:

**Clinical Skills – Management**
Considers relevant management options including ‘wait and see’. Rational use of prescriptions and referrals. Uses accepted guidelines. Uses motivational interviewing techniques.

Comments:
<table>
<thead>
<tr>
<th>Communication skills – Explanation and Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiates management with the patient. Works within the patient’s “illness framework” when possible. Structures explanations well. Avoids jargon and checks patient understanding. Uses drawings and handouts. Arranges follow up and explains reasons for earlier or more urgent review.</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Context of the consultation</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates an understanding of and respect for the patient’s background and the environment – age, gender, cultural, religious, socio-economic. Uses local resources and understands rural context of presentations and management. Institutes appropriate population health or screening interventions.</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional and Ethical and Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaves professionally and acts in the patient’s best interest. Demonstrates awareness of relevant regulatory and legal frameworks for certificates, prescribing and billing.</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisational and Medical Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritises, is timely. Utilises the practice team. Medical record is of adequate quality to enable another practitioner to continue care. Up to date history summaries are maintained. Appropriate use of recalls and IT/IM systems</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
<tr>
<td>Formative Assessment And Feedback Summary</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Keep doing:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Do more of:</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>Do less:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Stop doing:</strong></td>
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<tr>
<td></td>
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</tbody>
</table>
### Section 4 – Overall Assessment and Report

#### Overall Assessment

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Registrar at the expected standard for his/her current stage of training?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment required if “No” or “Unsure:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Review of Learning Plan Completed?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The visitor must review the registrar’s learning plan. New learning needs identified by the visit should be added. Existing learning needs that have been demonstrated to be completed during the visit should be archived.</td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>

#### Discussion with Supervisor Completed?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The visitor should discuss the supervisor the outcome of the visit and check to see if the supervisor has any concerns</td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>

### Section 5 – ECTV Visitor Authorisation

| ECTV Visitors Name: |
| Signature: |
| Date: |
Appendix 7.11

7.11 Example of a completed ARCADO ECTV report

<table>
<thead>
<tr>
<th>Registrar Name:</th>
<th>Dr A Registrar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term:</td>
<td>GPT1</td>
</tr>
<tr>
<td>Date:</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>Visitors Name:</td>
<td>Dr BC Educator</td>
</tr>
<tr>
<td>Supervisor Name:</td>
<td>Dr DE Supervisor</td>
</tr>
<tr>
<td>Practice:</td>
<td>Group Practice</td>
</tr>
</tbody>
</table>

**Section 1 – Pre-assessment meeting**

Any comments from discussion with registrar prior to seeing first patient?

Enjoying working in this practice. Good supervision and support. Has been working at 2 appointments an hour but will be increasing to 3 appointments per hour.

**Section 2 – Brief Details of Cases**

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Consult Observation</th>
<th>Complexity: high □ med □ low □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis</td>
<td></td>
</tr>
</tbody>
</table>

**Brief Details (age, gender, reason for visit):** AB, a 72 yo female, presented with frequency but neg MSU. Also chronic pain wanting to cease Norspan patch due to constipation

**Points noted in this case:** Good use of non-medical language. Good engagement with patient and clear explanations. Appropriate urologist referral. Unsure of other opiate options

<table>
<thead>
<tr>
<th>Case 2</th>
<th>Consult Observation</th>
<th>Complexity: high □ med □ low □</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis</td>
<td></td>
</tr>
</tbody>
</table>

**Brief Details (age, gender, reason for visit):** CD, 55 yo female, post hysterectomy wound review

**Points noted in this case:** Appropriate history and physical examination including opportunistic BP. Clarified follow up vault smear requirements.

<table>
<thead>
<tr>
<th>Case 3</th>
<th>Consult Observation</th>
<th>Complexity: high □ med □ low □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis</td>
<td></td>
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</tbody>
</table>

**Brief Details (age, gender, reason for visit):** EF, 15 yo female, presents with mother. 2/52 history of stomach pains, intermittent brief stabbing chest pains mainly at night and around midnight, and hot flushes. First sexually active aged 13, current boyfriend, never had STI check. Not on contraception. Limited exam of chest and abdo with appropriate care and consent. Ordered Preg test fbe, llft, tft, urine pcr for chlamydia

**Points noted in this case:** Tended to converse mostly with mother. Failed to/unsure how to ask mother to sit outside – good idea even though EF said it was OK for mum to be present. Should ask age of partner and wasn’t aware of legal child protection implications. Preg test and chlamydia screening appropriate as per “Red Book”. Early contraception discussion and countering misunderstanding. Didn’t discuss safe sex with mother present. Didn’t identify anxiety as the main differential and hence fbe tft, llft ordered. Clear follow up plan for contraception appointment
<table>
<thead>
<tr>
<th>Case 4</th>
<th>Consult Observation</th>
<th>Complexity: high ☐</th>
<th>med ☒</th>
<th>low ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis ☒</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Brief Details (age, gender, reason for visit):** GH, 39 yo male, had 5-6/52 left knee pain. Past arthroscopy findings not known. Knee exam NAD. Panadol and voltaren, Xray

**Points noted in this case:** working diagnosis was worsening OA knee
- Meniscal injury not really considered
- Unaware of GP indications for MRI knee
- Good documentation of history but not of exam. Able to conduct full knee exam?
- Patient since returned with normal Xray and referred appropriately

<table>
<thead>
<tr>
<th>Case 5</th>
<th>Consult Observation</th>
<th>Complexity: high ☐</th>
<th>med ☒</th>
<th>low ☒</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis ☒</td>
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<td></td>
</tr>
</tbody>
</table>

**Brief Details (age, gender, reason for visit):** IJ 29yo female with sudden onset atypical chest pain. Family history of IHD, no other significant risk factors.

**Points noted in this case:** Clearly documented, good understanding of problem and need for reassurance. BP taken and cardiac exam recorded. Did baseline ECG – read this himself. Believes reassured effectively. Is “baseline ECG” indicated?

<table>
<thead>
<tr>
<th>Case 6</th>
<th>Consult Observation</th>
<th>Complexity: high ☐</th>
<th>med ☒</th>
<th>low ☒</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Random Case Analysis ☒</td>
<td></td>
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</table>

**Brief Details (age, gender, reason for visit):** KL a 31yo male. Presented for script for SSRI for depression 3 months post commencement. During consult checked symptoms of depression but not SSRI side effects. Insomnia (from SSRI?) sleep hygiene discussed. Checked patient understanding of depression and ongoing management

**Points noted in this case:** Appropriate review of medication management of depression except considering SSRI side effects. Aware of use of mental health plans for psychologist referrals but patient didn’t want this. We discussed GP role in treating depression including brief counselling, encouraging exercise, work/life balance – has not felt comfortable with this to date. Also patient resources handouts such as “Beyond Blue” could be used.
### Communication skills – History taking


In follow up or review appointments the registrar clarifies the reason for the visit and obtains relevant information to assess the patient’s progress.

**Comments:** Good history taking skills. Uses open questions, lets patients tell their stories before asking questions. Didn’t pick up non-verbal cues regarding patient concerns/anxiety in adolescent. Needs to consider asking parents to sit outside during consults with adolescents.

---

### Clinical Skills – Examination

Focused examination with correct interpretation of findings.

**Comments:** Examinations were appropriate but limited assessment of examination skills in this ECTV. Knee joint examination in RCA described as normal but not observed and GPR unaware of meniscal provocation tests.

---

### Clinical Skills – Clinical Reasoning and Problem Definition

Considers relevant diagnoses. Appropriate reasoning to establish diagnosis or formulation. Rational use of investigations.

**Comments:** Problem definition generally consistent with GPT1. Eg not aware meniscal injuries more common in young patient with knee pain, didn’t consider anxiety as main differential in adolescent with chest pain and hot flushes. Investigations reflected this clinical reasoning but were otherwise not inappropriate.

---

### Clinical Skills – Management

Considers relevant management options including ‘wait and see’. Rational use of prescriptions and referrals. Uses accepted guidelines. Uses motivational interviewing techniques.

**Comments:** Well-structured management plans were demonstrated today. Would benefit by providing more written plans/resources for patients.

---

### Communication skills – Explanation and Planning

Negotiates management with the patient. Works within the patient’s “illness framework” when possible. Structures explanations well. Avoids jargon and checks patient understanding. Uses drawings and handouts. Arranges follow up and explains reasons for earlier or more urgent review.

**Comments:** Uses good non-medical English. Negotiates well and good follow up observed.
### Context of the Consultation

Demonstrates an understanding of and respect for the patient's background and the environment – age, gender, cultural, religious, socio-economic. Uses local resources and understands rural context of presentations and management. Institutes appropriate population health or screening interventions.

**Comments:** Dr Registrar was always respectful and appropriate and courteous – eg careful exam of 15yo girl's chest and abdo by male GPR. No cross-cultural patients in this ECTV. Population screening limited assessment in this ECTV other than chlamydia screen in 15yo and BP check in 55yo. Consistent with GPT1 standard.

### Professional and Ethical and Legal

Behaves professionally and acts in the patient's best interest. Demonstrates awareness of relevant regulatory and legal frameworks for certificates, prescribing and billing.

**Comments:** Professional behaviour. Unaware of child protection and age of consent issues. No certificates observed.

### Organisational and Medical Records

Prioritises, is timely. Utilises the practice team. Medical record is of adequate quality to enable another practitioner to continue care. Up to date history summaries are maintained. Appropriate use of recalls and IT/IM systems.

**Comments:** Good use of medical software. Good observed interactions with reception staff. Medical records were thorough and appropriate.
Formative Assessment And Feedback Summary

**Keep doing:**
- Permit patients to give the presenting complaint without interruption
- Negotiating management with the patient and providing clear follow up arrangements
- Reflecting on your consultations and identifying learning opportunities

**Do more of:**
- Provide more written handouts (e.g. Beyond Blue for anxiety)
- Uncovering patient’s agenda by acknowledging non-verbal cues.

**Do less:**
- Ordering tests when you are unsure. Unless clear ‘red flags’ it may be wiser to seek an opinion from your supervisor or ‘wait and see’

**Stop doing:**
- Talking mostly to the parent in consultations with teenagers.

---

### Section 4 – Overall Assessment and Report

<table>
<thead>
<tr>
<th>Overall Assessment</th>
<th>Yes ☒ No ☐ Unsure ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Registrar at the expected standard for his/her current stage of training?</td>
<td></td>
</tr>
</tbody>
</table>

**Comment required if “No” or “Unsure:”**
- Dr Registrar is easily at the GPT1 standard. Has a good basis of patient-centred consultations and the issues found with clinical reasoning and management are expected at this stage.

<table>
<thead>
<tr>
<th>Review of Learning Plan Completed?</th>
<th>Yes ☒ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>The visitor must review the registrars learning plan. New learning needs identified by the visit should be added. Existing learning needs that have been demonstrated to be completed during the visit should be archived.</td>
<td></td>
</tr>
</tbody>
</table>

**Comment:**
- Learning plan reviewed and satisfactory. Added learning needs re opiate choices, knee exam and age of consent/child protection.

<table>
<thead>
<tr>
<th>Discussion with Supervisor Completed?</th>
<th>Yes ☒ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>The visitor should discuss the supervisor the outcome of the visit and check to see if the supervisor has any concerns</td>
<td></td>
</tr>
</tbody>
</table>

**Comment:**
- Discussed with supervisor who reports the clinic is very happy with Dr Registrar’s progress. Supervisor will follow up on learning issues identified

---

### Section 5 – ECTV Visitor Authorisation

<table>
<thead>
<tr>
<th>ECTV Visitors Name:</th>
<th>Dr BC Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>![Signature]</td>
</tr>
<tr>
<td>Date:</td>
<td>1/1/2016</td>
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</tbody>
</table>