RNZCUC
ROYAL NEW ZEALAND COLLEGE OF URGENT CARE

RECERTIFICATION GUIDELINES – 2014

SECTION 1 - RECERTIFICATION OVERVIEW

Recertification in urgent care is a three year cycle which aims to identify areas for improvement in Fellows' practice, and to monitor and improve standards within the branch.

It is a requirement for ongoing registration in the branch of urgent care.

CLINICAL TIME REQUIREMENT

The minimum requirement for recertification is 1152 hours per 3 year recertification cycle.

RECOGNITION OF ALTERNATIVE CLINICAL EXPERIENCE FOR REACCREDITATION

(from http://cucp.org.nz/fellows.aspx - check for updates)

Some vocationally registered urgent care physicians provide services from a facility that does not quite meet the approved facility criteria. An example would be doctors practising in the armed forces. RNZCUC feels that it is in the best interests of the public that such physicians be able to maintain vocational registration in urgent care.

Accordingly, up to half such work (four hours per week) can be counted towards urgent care reaccreditation, subject to the following conditions:

1) A biennial log of one week's consecutive patients and diagnoses be kept.
2) That information on hours of xray and accessibility to x-ray be provided.
3) That there is no other vocational branch that provides training and recertification that more closely addresses the services provided.
4) Approval by the Medical Council.

CONTINUING PROFESSIONAL DEVELOPMENT

The MCNZ requires 50 hours per annum of continuing professional development activities.

RNZCUC's CPD programme is a points-based system based on MCNZ guidelines (see http://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Continuing-Professional-Development.pdf)

There are five compulsory CPD activities, of which three are points based, where one point is given per hour, to prescribed maxima.

1. Professional development plan ('PDP')
2. Annual resuscitation course
3. Continuing medical education (points)
4. Audit (points)
5. Peer review (points)

A minimum of 120 hours per cycle is required from the points-based activities above. Combined with the resuscitation and professional development plan requirements, this exceeds MCNZ's CPD requirement of 50 hours per annum.

PROFESSIONAL DEVELOPMENT PLAN

The Professional Development Plan ('PDP') is a means by which urgent care physicians can reflect on areas of their clinical practice which they wish to strengthen or address possible weaknesses.

RNZCUC requires **one PDP per three year cycle**, updated and reviewed annually, and comprehensively reviewed at the end of the cycle.

A PDP may take into account

- Need to update clinical knowledge and skills.
- The requirement of ED / Clinic.
- Personal ambition and goal.
- Areas a Fellow would like to follow up on.
- Issues arising from a patient cases.
- Outcome of audits.
- Patient feedback, complaints or incident reports.
- Areas of practice in which a Fellow feels uncomfortable.

Name_____ Date_____

Area for development	Development goals	Action	Year 1 outcome/ review	Year 2 outcome/ review	Year 3 outcome/ review
Ophthalmology	Improve understanding of eye cases. I feel uncomfortable with eye terminology and eye case assessment and management beyond simple cases. Weakness noted in my UCPEX exam. Become more skilled in using a slit lamp	Eye clinic attendance.	Attended two private clinics. Good teaching but few urgent care cases Used S/L in review of 15 Clinic cases. More comfortable using S/L in my facility – identified flare and cells. Understand importance of VA and proper technique – lighting, distance and encouraging the patient to keep trying until they guess wrong.	Attended three hospital Eye A&E. sessions. Felt unwelcome sometimes – depended who was on. Difficult to get permission to attend on one occasion. Now comfortable with S/L use and eye terminology and case management	
Communication	Improve score in patient satisfaction survey audit – currently 1-2 SD below the norm. One HDC complaint last year.	Attended MPS risk management seminars Attend RNZCUC UCC communications day	Attended 'Mastering adverse outcomes" and UCC Communications day. Repeat PSS scores now within normal range	Attended 'Mastering difficult interactions with patients' and 'Mastering professional interactions'	Attended 'Mastering shared decision making' Repeat PSS audit scores above average
Orthopaedics	Improve understanding of minor fracture and orthopaedic case management, with a view to running a regular fracture clinic in my Clinic.	Attend twenty of my facility's orthopaedic clinics; have the visiting orthopaedic surgeon review my examination techniques, xray interpretation and proposed case management.	Attended twelve clinics. Teaching felt worthwhile but difficult to assess how successful.	Attended ten further clinics. Ran a trial fracture clinic and attended ortho clinics where my fracture clinic patients were seen for review – no problems.	Running regular fracture clinics for my Clinic; good working relationship with visiting ortho surgeon and no clinical or management problems apparent to date in my fracture clinic patients.

Overall PDP review – end of year 3

Weaknesses in ophthalmology and communications seem to have been successfully addressed. Note difficulty in getting good eye case teaching in my area – can RNZCUC help? Orthopaedic knowledge strengthened and fracture clinics appear to be running successfully. Consider tailored patient satisfaction survey for fracture clinic, addressing my performance and their satisfaction with the service.

Continue to monitor communications scores.

RESUSCITATION COURSES

OVERALL REQUIREMENT

Attend a course each year that meets the minimum requirements below.

RNZCUC strongly recommends one eight hour course per cycle, and that Fellows substitute one of the four hour courses for an alternative resuscitation course as their particular practice might require – e.g. APLS for Fellows who work in a paediatric emergency department.

MINIMUM REQUIREMENTS FOR CPR COURSE

1. Generally a minimum four hour duration.

2. CPR (updated guidelines on latest accepted practice)

- CPR adults
- CPR paediatrics

3. Defibrillation (adults and paediatric):

- Safe Use of a manual defibrillator
- Safe Use of a automated defibrillator

4. Management of airways (adults and paediatric)

- CPR (adults and paediatric)
- Endotracheal Intubation
- Alternatives to endotracheal intubation – laryngeal mask airways
- Airway adjunctive equipment

5. Emergency cardiac resuscitation drugs (practical use of in adults and paediatrics)

- Update and overview

6. Practical management of common emergency scenarios (adults and paediatric):

- Cardio-respiratory arrest
- Collapse/syncope
- AMI
- Anaphylaxis
- Identification of common & life-threatening ECG abnormalities

OTHER RESUSCITATION COURSES

The courses listed below or similar are accepted as an alternative to ACLS for one year of the three year cycle.

ATLS (Advanced Trauma Life Support)
APLS (Advanced Paediatric Life Support)
EMST (Early Management of Severe Trauma)
ELS (Emergency Life Support)
EMSB (Emergency Management of Severe Burns)
PALS (Paediatric Advanced Life Support)

CME, AUDIT AND PEER REVIEW – SUMMARY OF POINTS REQUIRED

	Min number/cycle	**Min pts/cycle**
Peer review groups	12	24
Other peer review	n/a	6
Clinical audit	3	30
Continuing medical education	n/a	60
Total		**120**

CME POINTS

"This includes:
— attendance at relevant educational conferences, courses and workshops
— self-directed learning programmes and learning diaries
— assessments designed to identify learning needs in areas such as procedural skills, diagnostic skills or knowledge
— journal reading.

CPD may also include:
— examining candidates for College examinations
— supervising or mentoring others
— teaching
— publication in medical journals and texts
— research
— committee meetings with an educational content, such as guideline development
— giving expert advice on clinical matters
— presentations to scientific meetings
— working as an assessor or reviewer for the Council."
- Excerpt from MCNZ guidelines

Item	**Maximum per item**	**Maximum per cycle**
Educational conferences, courses and workshops.	6 per day	20
Self-directed learning programmes and learning diaries, including studying HDC opinions, on-line CME such as www.emedicine.com , Premec case studies, and other RNZCUC-approved providers.		20
Self-directed learning programmes and learning diaries		20
Learning needs assessments		10
Journal or text reading	1 per article / chapter	10
Examining candidates for RNZCUC or other UC-related examinations	5 per exam	20
Supervising or mentoring		20
Teaching		20
Publication in medical journals and texts	30	30
Urgent care research	30	30
Committee meetings with an educational content, e.g. guideline development	5 per meeting	20
Giving expert advice on clinical matters		10
Presentations to scientific meetings		20
Working as an urgent care assessor or reviewer for Council, RNZCUC or other Council-recognised or statutory body.	5 per case	20
Clinical audit development or review.		20
Formal examinations relevant to urgent care.	5 per exam	20

CME NOTES

Note: In all cases, hours / points claimed must be for content that is directly related to urgent care.

EDUCATIONAL CONFERENCES, COURSES AND WORKSHOPS:

Automatically approved courses are:-

- Urgent Care Course components (e.g. communications day, as a refresher)
- Goodfellow Unit courses
- Clinic CME Courses
- Hospital CME Programmes
- The urgent care content of approved conferences.

SELF-DIRECTED LEARNING PROGRAMMES AND LEARNING DIARIES

'Learning diaries' includes reflection on your practice by keeping a journal of selected cases with your thoughts on the cases and how management could have been improved.
RNZCUC approved online providers include www.emedicine.com and http://www.emchattanooga.com/emergency-medicine-podcasts ; please let RNZCUC know if you would like another provider to be considered.

LEARNING NEEDS ASSESSMENTS

Assessments of your practice by you, or by others but with your participation, designed to identify learning needs in areas such as procedural skills, diagnostic skills or knowledge.

JOURNAL OR TEXT READING

Includes reading for personal development as well as reading as part of preparation for presentations to peers or for teaching.

PUBLICATION IN MEDICAL JOURNALS OR TEXTS

Includes:

- Preparation of a paper on a subject relevant to urgent care for publication in a recognised medical journal.
- Review of an individual paper, journal issue or recent text for colleagues such as at a journal club or peer review group.

CLINICAL AND COMMITTEE MEETINGS

This includes clinical and committee meeting time relevant to urgent care and having an educational content, such as developing management guidelines or educational policy in urgent care.

CLINICAL AUDIT DEVELOPMENT OR REVIEW

Includes preparation or review of a clinical audit such as a formal audit for RNZCUC or for the Medical Council of New Zealand.

PERFORMANCE APPRAISAL

Provision of oversight is as defined by the Medical Council of New Zealand.

FORMAL EXAMINATIONS

Examinations currently recognised by RNZCUC include:-

- PG Diploma in Health Sciences, specialisation in Community Emergency Medicine (Auckland University).
- Diploma of Sports Medicine
- Any other RNZCUC-approved examinations or diplomas.
- Examinations in an overlapping branch (scope)

Study may be recognised separately – see above, e.g. 'Journal or text reading'.

ADDITIONAL ACTIVITIES

For approval of an urgent care CME activity not covered above, write to the Professional Standards Committee.

RNZCUC AUDIT OF CME

Keep CME certificates and records of peer group meetings and other recertification activities.

RNZCUC audits 10% of all logbooks.

PEER REVIEW

	Min number/cycle	Min pts/cycle
Peer review groups	12	24
Other peer review	n/a	6

RNZCUC views peer review groups as an important part of recertification and has set minimum peer review GROUP requirements.

'Peer review' is therefore divided into 'peer review group' and 'other peer review' categories.

A small number of additional peer review activities are also required. Most urgent care doctors should meet this requirement in the course of their normal practice, e.g. case discussions with other doctors.

Peer review points apply for **interactive hours only** – not preparation.
The following comments apply to both the 'peer review meeting' and 'other peer review' categories. Activities that could qualify as 'peer review groups' are in bold.

"This [peer review] is evaluation of the performance of individuals or groups of doctors by members of the same profession or team. It may be ***formal or informal*** *and can include* ***any time when doctors are learning about their practice with colleagues.***
Peer review can also occur in multidisciplinary teams when team members, including other health professionals, give feedback. In formal peer review, peer(s) systematically review aspects of your work, for example, the first six cases seen, or a presentation on a given topic.
Peer review normally includes feedback, guidance and a critique of your performance.
Peer review must take place in an environment conducive to:
— the confidentiality of the patients being discussed
— the privacy of the doctors whose work is being reviewed
— mutual learning
— professional support and collegiality.
Examples of peer review:
— joint review of cases
— review of charts
— practice visits to review a doctor's performance
— 360° appraisals and feedback
— critique of a video review of consultations
— discussion groups
— inter-departmental meetings, which may review cases and interpretations of findings
— mortality and morbidity meetings.
For clinicians, peer review does not include:
— practice management
— matters relating to practice premises or systems
— non-clinical research
— non-clinical education
— participation on College or other committees that are not of a clinical nature."
(Excerpted from MCNZ guidelines)

A common example of 'other peer review' in urgent care would be case discussion with colleagues.

PEER REVIEW GROUPS

Peer Review Groups meet regularly to discuss case management and clinical problems, and present reviews of papers, journals and recent texts. These sessions can be used to develop facility guidelines and to ensure compatibility with other practitioners.

RULES GOVERNING PEER REVIEW GROUPS

At least one other member should be a FRNZCUC or urgent care advanced trainee. If you can not find a peer group that has at least one other urgent care physician, please discuss with the Professional Standards Committee convenor. RNZCUC will review the proposed peer group and consider factors such as whether one or more of the group's members practises predominantly in a RNZCUC-recognised urgent care training facility, the qualifications and experience of the group members, and other contact you might have with urgent care practitioners, in the workplace or in other clinical meetings.

RNZCUC accepts video conference based groups (e.g. Skype) but prefers face-to-face meeting.

GETTING THE MOST FROM PEER REVIEW GROUPS

Many doctors report that the best discussions often only eventuate after several meetings, when participants become comfortable with the group and feel free to be frank.

Some keys to facilitating this atmosphere are:

- An attitude that all members of the group are equals (peers).
- No direct criticism or threatening attitudes.
- Keep time limits.
- Encourage participation by all members.
- Encourage and plan for socialization at the end of the meeting.

CLINICAL AUDIT

	Min number/cycle	Min pts/cycle
Clinical audit	3	30

Claim:
10 points / audit for patient notes or patient satisfaction audits
1 point / hr top a max of 10 points / audit for other audits

"This is a process used to assess, evaluate and improve the care of patients in a systematic way to enhance health by objectively measuring your performance against standards and, when your performance does not meet the standard, recommendations for change are made. (This may include changing the standard if it is found to be inappropriate.) Clinical audit may be multidisciplinary. It involves a cycle of continuous improvement of care, based on explicit and measurable indicators of quality.
It has a statistical basis.
Examples of clinical audit include:
— external audit of procedures (not of the service)
— comparing the processes, or outcomes of health or patient care, with best practice in that domain
— analysis of patient outcomes
— audit of departmental outcomes including information on where you fit within the team
— audit of your performance in an area of practice against that of your peers
— taking an aspect of practice such as transfusion rates and comparing your performance to national standards
— formal double reading of scans or slides and assessment of your results against those of the group
— patient satisfaction survey
— check that cervical smear, diabetes, asthma, heart failure, lipid control and other procedures are done to pre-approved standard formats, including reflection on the outcome, plans for change and follow-up audit to check for health gains for that patient or for that group of patients."
(Excerpted from MCNZ guidelines – **note that cervical smear, diabetes audits etc are MCNZ examples only and are generally not suitable for urgent care purposes**.)

AUDIT POINTS TABLE

COMPULSORY (once per 3 year cycle)	**Points per audit**
Patient satisfaction survey – RNZCUC or RNZCGP	10
Clinical notes audit*	10
OPTIONAL	
Referral data	1/hr, maximum 10
Referred patient outcome	1/hr, maximum 10
Fracture xray interpretation	1/hr, maximum 10
Suture outcome	1/hr, maximum 10
Other RNZCUC-approved	1/hr, maximum 10

* May be done every second cycle with RNZCUC approval.

AUDIT NOTES

See appendices for details of approved audits and instructions.

ALTERNATIVE AUDITS

Contact the Professional Standards Committee if you would like approval for an audit not listed above.

If approved, you will be able to claim up to 10 points per audit, to a maximum of one alternative audit during the three year cycle.

They must involve a minimum of ten urgent care patients in an urgent care facility, and can not be facility audits.

COMPETENCE REVIEW

The Professional Standards Committee will occasionally will contact a doctor to arrange a competence review, similar to those the MCNZ conducts. The PSC will only do so when it has grounds to question a doctor's competence. Though a form of audit, competence reviews do not qualify for audit points.

SECTION 2 - LOG BOOK

Report via the following logsheets:

1. Professional development plan
2. Resuscitation log
3. CME log
4. Peer review group log
5. Peer review – other activities log
6. Patient satisfaction survey
7. Clinical notes audit
8. Referral data assessment audit
9. Referred patient outcome audit
10. Fracture x-ray interpretation audit
11. Suturing outcome audit

Please total clinical hours every 12 months and send in to the Professional Standards Committee.

Keep evidence of CME and practical skills hours, rosters and such to verify clinical hours. The PSC will also accept verification of clinical hours by a medical director.

PROFESSIONAL DEVELOPMENT PLAN

Name_____ Date_____

Area for development	Development goals	Action	Year 1 outcome/ review	Year 2 outcome/ review	Year 3 outcome/ review

Overall PDP review – end of year 3

RESUSCITATION COURSE LOG

NAME _____

Date	Course name, duration and provider.

CME LOG

NAME _____

Date	Item	Points

PEER REVIEW GROUP LOG

NAME _____

Date	Item	Points

PEER REVIEW – OTHER ACTIVITIES LOG

NAME _____

Date	Item	Points

AUDIT SUMMARY SHEET

NAME _____

Date	Item	Points

CLINICAL TIME LOGSHEET

NAME _____ From _____ to _____

Dates from / to	Location	Hours

TOTAL OF HOURS _____

Office Use only:

	PDP	Resusc	CME	PRG	PR-O	Audit	Clinical Time	Sign/name	Comments
Year 1									
Year 2									
Year 3									
Cycle									

Commencement date of recertification cycle: _____

Summary of points / hours per annum for the 3 year cycle

1. CME	YEAR 1		YEAR 2		YEAR 3		3 Year TOTAL	
2. PRACTICAL SKILLS	YEAR 1		YEAR 2		YEAR 3		3 Year TOTAL	
3. CLINICAL TIME	1st 12 Months clinical hours total							
	2nd 12 Months clinical hours total							
	3rd 12 Months clinical hours total							
	ACCUMULATING TOTAL OF HOURS WORKED							
4. AUDIT	AUDIT ACTIVITY						DATE COMPLETED	
	Patient satisfaction survey Clinical notes audit Referral data audit Referred patient outcome audit X-ray fracture comparison log Suturing outcome audit Other approved audit							
5. COMMENTS								

APPENDIX ONE - PATIENT SATISFACTION SURVEY

Choose either of the UCPSS or the General Practice Patient Satisfaction Survey.

The PSC compares your result to other doctors' and returns the analysis to you.

A copy of the UCPSS is attached. Copy this and use it if you wish.

A sample GP PSS is also attached. If you wish to use this, please contact the RNZCGP . The RNZCGP charges for this audit. The RNZCUC audit and analysis are free.

RNZCUC PATIENT SATISFACTION SURVEY (UCPSS)

INSTRUCTIONS TO ASSIST RECEPTIONISTS RUNNING THE SURVEY

The purpose of this survey is to give doctors candid feedback as to whether or not patients are satisfied with their consultations.

All RNZCUC doctors are asked to have surveys completed regularly. They are conducted privately and randomly. The doctor will not be shown individual responses and does not know whether or not a patient will be asked to give feedback.

The survey is meant to assess the **DOCTOR** and not the **CLINIC.**

Attached is a sample of the one page survey.

- Please photocopy the survey you have received.
- **A minimum of 50 patients should be surveyed.**
- Patients should be encouraged to fill them out by the receptionist who can inform patients that they will be helping the doctor to assess his or her communication skills.
- This is to be given out to patients by the receptionist once they have been seen by the doctor.
- Please give them out over a period of one week to every third or fourth patient seen by the doctor.
- Note: Some patients may not be able to participate in the survey. Eg. Those who do not speak English, are too young or are too ill. If you identify anyone in these categories, please do not ask them to complete the questionnaire.
- If possible, set up a quiet area in the practice where patients can complete the questionnaire without being interrupted.
- Find a box with a slot in the top for patients to post questionnaires.

INVITING PATIENTS TO TAKE PART IN THE SURVEY

- 50 consecutive patients should be asked to complete the questionnaire.

  It is important that patients are not selected.
- It is suggested that you explain to patients that their doctor is "taking part in the survey to find out what patients think about the doctors communication skills and that other doctors throughout New Zealand are also doing the study".
- Ask the patient to fill out the questionnaire **after the consultation** and discourage patients from taking the questionnaire home. The questionnaire should take about three minutes to complete.
- Let the patients know that the doctor will not see the questionnaire once it is completed and no one will be able to identify their responses.

When completed the survey sheets are to be sent back by the receptions / Practice Manager to:

Brenda Evitt
RNZCUC
110 Lunn Ave, Remuera, Auckland

If you have any questions please call RNZCUC on 09 5277966
or email brenda@rnzcuc.org.nz

Note: If you have more than one doctor undertaking the questionnaire, it is recommended that you manage the survey one at a time. There should be one box per doctor and it is a good idea to name each box to ensure the questionnaires are not collated with those of other doctor.

RNZCUC PATIENT SATISFACTION SURVEY (UCPSS)

This survey is to give doctors feedback as to whether or not patients are satisfied with their consultations. All urgent care doctors are asked to have surveys completed regularly. They are conducted privately and randomly. The doctor is not shown individual responses and does not know whether or not a patient is asked to give feedback.

The survey is meant to assess the **DOCTOR** and not the **CLINIC,** so please try not to let things like the length of wait, other staff or services in the clinic affect your rating.

- Please do not write your name on this survey
- Please complete the survey after you have seen the doctor

Who will see your answers?

The results will be collated at the Royal New Zealand College of Urgent Care and the overall results be will be discussed with the doctor. You will not be identified in the feedback.

Dr _____ **Clinic** _____ **Date**_____

Please tick √ the appropriate box to indicate how you rate the doctor's performance.

		Poor	Fair	Good	Very Good	Excellent
1	**Quality of information - was it what you wanted? Did it seem accurate and up-to-date?**					
2	**Communication - did the doctor give clear information? Was it easy to understand?**					
3	**Doctor's manner - e.g. was he / she courteous, caring, professional?**					
4	**The amount of time given to me for this visit was:**					
5	**What is your overall assessment of the doctor?**					

ADDITIONAL COMMENTS:

RNZCGP PATIENT SATISFACTION SURVEY (DISQ)

This is a RNZCUC-approved alternative to the RNZCUC survey.

The patient satisfaction survey is designed to give the feedback communication skills when consulting compared to other doctors. Contact the RNZCGP if you wish to use this survey. There is a charge.

Contact details:

Royal New Zealand College of General Practitioners
PO Box 10440
WELLINGTON

TEL:	04 496 5999
EMAIL:	katherine.gilligan@rnzcgp.org.nz
COST:	$150 (discounted rate for RNZCUC members)

APPENDIX TWO – NOTEKEEPING AUDIT

INTRODUCTION

Please read carefully

A notekeeping audit is a compulsory part of urgent care accreditation and reaccreditation.

As a minimum, RNZCUC requires trainees to complete a notekeeping audit in the first year of training, and Fellows to complete one every one or two cycles.

Good notekeeping is important and often done poorly.

The underlying clinical practice *may* be sound despite poor notekeeping. Often though, poor notekeeping means poor clinical practice and a failure to think systematically – unsound clinical methods.

If a patient complains about medical treatment, the notes will often decide the case.

Good notes that are well presented in conventional format are easy for other doctors to understand – and communication with other doctors – in urgent care, general practice and hospitals – is a very important part of urgent care.

As at 2014, many doctors are failing this audit, and RNZCUC's impression is that the overall standard of notekeeping is low.

COMPONENTS OF AUDIT

The notekeeping audit checks for the following basic elements:

- History, including presenting complaint, previous medical history, current medications and allergies.
- Examination findings, including basic observations
- Diagnosis
- Plan

In addition, the audit reviewer will comment on any apparent causes for significant clinical concern.

COMMON PROBLEMS

The commonest problem is failure to record a patient's previous medical history and current medications.

This is especially common in apparently fit patients with an incidental presenting complaint, and in children.

Patients may claim to be perfectly well, but on enquiry, are taking medication, for example, for asthma and peptic ulcer disease.

In the case of infants, an additional comment on the pregnancy and delivery is expected as part of the past medical history.

Failure to record allergies is another common audit finding.

NOTEKEEPING TEMPLATE

A facility's notekeeping template can have a big effect of the quality of notekeeping, and so, on the quality of care.

A good template will prompt the doctor and other staff to think systematically.

RNZCUC recommends that all facilities' notekeeping templates, *as a minimum*, have a prominent separate labelled area for each of the following:

- History of presenting complaint
- Previous medical history
- Current medications
- Allergies
- Examination findings
- Basic observations (T/P/BP/R)
- Diagnosis
- Plan

These labelled template areas should have 'front page' prominence, and not, for example, buried in a sub-menu.

Templates vary very widely. One ED, for example, has a labelled area for 'Smoking Cessation', but none for 'Diagnosis'. Another ED has no labelled area for Allergies.

COMMENTS ON THE FACILITY'S NOTEKEEPING SYSTEMS

As part of the notekeeping audit, the audited doctor identifies the facility's system or systems, and comments on how well the notekeeping template meets RNZCUC's standard, and how the template and systems could be improved.

COPING WITH POOR FACILITY NOTEKEEPING SYSTEMS

A poor template and / or poor systems encourage poor notekeeping and poor practice, and vice-versa. RNZCUC encourages urgent care physicians to pass on any concerns they have to RNZCUC and to their facility management.

When a facility's notekeeping template is defective or does not exist, you may be able to create your own using the facility software – for example, a keyboard shortcut that generates:

Previous Medical History:

Medications:

Allergies:

In many facilities, the nurse routinely records elements of history, previous medical history, and basic observations. The responsibility for the medical notes remains with the doctor, and RNZCUC encourages doctors to both check the nurse's history with the patient and acknowledge this in the notes, e.g., 'per above nurse notes, verified.'

In some cases it appears that if the nurse has not recorded the above then nobody does. This pattern will result in a failed audit.

INSTRUCTIONS TO AUDITED DOCTOR

Please read carefully

1) Print off TEN consecutive records of patients presenting **for the first time** for a particular episode.
Be sure to print off **all** clinically relevant notes, for the patient, including nurse triage notes, wherever they are stored in your facility's record management system, including medications, allergies, and PMHX.
2) Anonymise by removing all identifying patient details, but leave clinically relevant fields visible, **including age and sex**.
3) Please note any special or unusual features of the consultation, e.g. resuscitation case, difficult consultation, diagnosis uncertain, errors, or alternative approaches to the problem.
Note: this is for reflection and discussion and is not measured in this audit.
4) Please comment on your facility's notekeeping system or systems:
a) What is the name of the notekeeping system?
What is the software?
If there is a paper component, including nursing notes, who designed them? Nurse, doctor or manager? Are they a standard design or customized?
How could the notekeeping system or template be improved?
b) How well do you think your facility's notekeeping template meets RNZCUC's standard – i.e. is there a space for each of the eight elements tested in this audit?
c) Any other comments on notekeeping or this audit?
5) Send to RNZCUC.

INSTRUCTIONS TO AUDITOR

MARKING

Record a '1' if the record is adequate and a '0' if not.
If an item was not recorded and, you feel, not needed, record a '1', as the record is therefore adequate.
If the trainee says the information is elsewhere on the facility's system, record a '0' and suggest re-doing the audit with all the records. (The audited doctor is asked to supply ALL relevant records from all parts of the facility's record storage system).

ASSESSMENT CRITERIA

Item	Pass / fail criteria	Notes
Previous medical history adequate?	Must be present and adequate	
Medications record adequate?	Must be present and adequate	Includes all current meds, longterm and short term. '0' if only short term meds are mentioned.
Allergies or alerts recorded?	Must be present and adequate	
Baseline recordings adequate?	Case appropriate	e.g. T/P/BP in abdominal pain
Examination findings adequate?	Case appropriate	e.g. neurovascular status of limb in, suspected fracture; SLR in low back pain
Diagnosis recorded?	Must be present and adequate	Using conventional diagnostic terms, e.g. 'contact dermatitis L arm', and not 'rash'
Plan adequate?	Must be present and adequate	

CLINICAL CONCERNS

Record a '0' if you felt uneasy about the patient management, e.g. that important findings were not recorded, or that an important diagnosis may have been overlooked.
Also use the space to record any comments about the management for the doctor's benefit or RNZCUC records, e.g.:
- a pattern of failure to record allergies, or neurovascular status in suspected limb fractures
- suggestion to use keyboard shortcuts to speed entry of mundane negative findings, when the doctor is writing them in full every time, or to provide a template.

APPENDIX THREE - REFERRAL DATA ASSESSMENT AUDIT

This is a self audit of written referrals to colleagues – hospital or community based.

Written referrals should convey relevant information about the patient, the patient's condition and referring doctor.

Instructions:

Collect and keep copies of 20 consecutive written referrals, and summarise them in the attached log. Use anonymous patient identifiers, such as a NHI number or 'Mrs A'.

Tick the box next to each case if the information is present on the referral.

'Information' includes negative findings- e.g. tick the **Meds** box if you have recorded on the referral "on no medications".

DOB:	date of birth
ID:	address and contact details including phone No's
Hx:	patient presenting complaint
OE:	examination findings
Meds:	medication currently taken
All:	any known allergies
Dx:	diagnosis or working diagnosis
NOR:	name of doctor patient referred to.
Sig:	referring doctor signature
Date:	date of referral

Contact: referring doctors contact details

GP: Patients regular GP

Then total the ticks vertically (T1= totals), and transfer them to the summary sheet.

Referral data assessment log **Name: _____**

	Patient identifier	DOB	ID	Hx	Phx	OE	Meds	All	Dx	NOR	Sig	Date	Contact	GP
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
TTL														

DATE COMPLETED _____

APPENDIX FOUR - REFERRED PATIENT OUTCOME AUDIT

This is a self audit designed to assess the outcome of your referrals to colleagues.

INSTRUCTIONS

Collect and keep copies of ten referral/transfer notes.

At the time of referral or transfer, note the name of the receiving doctor. Explain to the receiving doctor about this audit and ask if you can contact him/her again for follow up information.

The following day (or as soon as practicable), contact the receiving doctor and ask a series of 'yes/no' questions.

Ask the receiving doctor (at follow up):

- the hospital diagnosis
- appropriateness of referral
- the appropriateness of the mode of transport
- any comments/observations regarding referral (record these).

Note whether or not you got a copy of the discharge summary.

- Record the answers on the analysis sheet and record the percentage of yes and no responses.
- Summarise and send to the RNZCUC.

RNZCUC will compare your result with others and report back to you.

	1	2	3	4	5	6	7	8	9	10	Total Y's /10
Mode of Transport											n/a
Your Dx											n/a
Hospital Dx											n/a
Suitable mode transport? Y/N											
Record of Dr spoken to? Y/N											
Appropriate referral? Y/N											
Discharge letter / summary? Y/N											
Your dx same as hospital dx? Y/N											

Notes/Comments :

Date audit completed: _____

Name of facility where audit was carried out: _____

Name and signature_____

APPENDIX FIVE - FRACTURE X-RAY INTERPRETATION AUDIT

This self audit compares your x-ray diagnoses of suspected fractures / dislocations (per your clinical notes) with the radiologist's.

For this audit, record one of three outcomes

A) Consistent

The referring doctor's diagnosis of a suspected fracture / dislocation from the x-ray is consistent with the radiologist's report.

B) False positive

The referring doctor reads the x-ray as abnormal (fracture or dislocation but the radiologist reports the x-ray as normal.

C) False negative

The referring doctor reads the x-ray as normal, butthe radiologist reports an abnormality.

For inconsistent reports ('B' or 'C' above), code the type of fracture/dislocation using the attached code table, so that RNZCUC can analyse the most common false positive or false negative diagnoses.

Instructions

Collect and keep copies of twenty consecutive x-ray referrals for suspected fracture / dislocation, along with a copy of the clinical notes (x-ray findings) and the radiologist reports.

Enter data from these onto the attached table along with the code number for the type of fracture / dislocation, if this is a type B or C finding (false positive or false negative).

Then total the results, transfer to the summary sheet, and return to RNZCUC.

RNZCUC will return the results with any comments and recommendations. This audit highlight a need for further training in x-ray diagnosis of fractures and dislocations.

FRACTURE XRAY INTERPRETATION TABLE

Name: _____ DATE COMPLETED: _____

Case number	A - Consistent	B - False Positive	C - False negative	# Read Code
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
Total				

FRACTURE XRAY INTERPRETATION SUMMARY

	A	B	C
Totals			

Type B & C code counts (number of instances)			
Type B		**Type C**	
#Code	**Count**	**#Code**	**Count**

Name _____

Signature: _____

ACC READ CODES FOR FRACTURES AND DISLOCATIONS

Fracture Skull	S030
Fracture Facial Bones	S044
Fracture Thoracic Spine	S102
Fracture Lumbar Spine	S105
Fracture Sacrum	S106
Fracture Coccyx	S108
Fracture Ilium	S10B3
Fracture Acetabulum	S10B4
Fracture Pubis	S10B5
Fracture Rib (closed)	S120
Fracture Clavicle (closed non-displaced)	S20
Fracture Humerus (closed distal)	S224
Fracture Elbow	S224
Fracture Distal Humerus, Supracondylar (closed)	S2241
Fracture Humerus (closed proximal)	S226
Fracture Proximal Radius/Ulna (closed)	S230
Fracture of Proximal Radius/Ulna (open)	S231
Fracture of Shaft of Radius/Ulna (closed)	S232
Fracture of Shaft of Radius/Ulna (open)	S233
Fracture of Distal Radius/Ulna (closed)	S234
Fracture Colles	S2341
Fracture of Distal Radius/Ulna (open)	S235
Dislocation Elbow	S24
Fracture Scaphoid (closed)	S2401
Fracture Carpal Bone	S24z
Fracture of Metacarpal Bone	S25
Fracture Phalanx-Hand	S26
Fracture Hip/Femur	S30
Fracture Tibia/Fibula	S33
Fracture Ankle	S34
Fracture Tarsal Bones/Metatarsals (closed)	S352
Fracture Phalanges (foot closed)	S36
Stress Fracture	S3z2
Dislocation/Subluxation Shoulder	S41
Dislocation Clavicle	S4104
Dislocation Wrist/Metacarpal	S43
Dislocation/Subluxation Finger/Thumb	S44
Dislocation Hip	S45
Dislocation Knee (patella)	S463
Dislocation Knee (not otherwise specified)	S465
Dislocation Phalanges (foot)	S48
Dislocation Tarsal Bones	S4801
Dislocation Metatarsals	S4804
Dislocation Cervical Spine	S490
Dislocation Lumbar Spine	S4920
Dislocation Sacrum	S4942
Fracture Knee	S4F
Dislocation Ankle-	S4G
Dislocation/Subluxation Other	S4J

APPENDIX SIX - SUTURE OUTCOME AUDIT

- Follow five patients whose wounds you suture, and assess the outcome.
- Summarise the results using the table provided and sent to RNZCUC for analysis.
- RNZCUC will compare your result with others and report back to you.

Wound outcome audit	**1**	**2**	**3**	**4**	**5**
Patient identifier					
Date of Suturing					
Tetanus status checked					
Type (SUperficial, DEep,DIirty, CLean)					
Wound site					
Wound length					
Type& no. sutures					
Status at first wound check					
Date for suture removal					
Removed on time Y/N					
Healing appropriately, Y/N					
COMPLICATIONS					
Infection Y/N					
Sutures still in Y/N					
Wound breakdown dehiscence Y/N					
Other					

Date audit completed: _____

Name of facility where audit was carried out: _____

Your name and signature_____