A well-planned, comprehensive orientation to the practice and the local environment is an essential task for the supervisory team to undertake.

Firstly, it helps ensure the safety of the registrar, the practice, and the community. This extends beyond physical safety to include cultural safety.

There are a number of other important benefits:

* registrars report that a good orientation at the start of a placement reduces their anxiety significantly. It can increase a sense of inclusiveness and improve confidence
* minimising later misunderstandings with clear statements of expectations
* avoiding frequent interruptions in the first few weeks for basic questions
* reducing billing and admin mistakes or omissions.

Registrars starting their first practice placement will be unfamiliar with most of the systems and processes of general practice. For example, coming from hospitals they will need to learn about billing, prescribing, general practice software and referrals.

Orientation for a Term 1 registrar should make up at least the first two days of their training term. They should not be consulting patients for at least the first day. The supervisor will need consultation free time during the first day to assist in orientation. The supervisor will ideally be able to be observed by the registrar to introduce the format and operation of a general practice consultation.

When the term 1 registrar commences consulting, a supervisor must determine whether the registrar is capable of consulting safely without review of every patient encounter. To make this determination, a supervisor considers whether the registrar has the clinical knowledge, skills, and attitudes to assess common general practice presentations and insight into the limits of their competency and if they will access help when required. To help the supervisor obtain information relevant to this decision, the RACGP has developed an ‘[*Early Assessment for Safety and Learning’*](chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/www.racgp.org.au/FSDEDEV/media/documents/PLT/Early-Assessment-for-Safety-and-Learning_Supervisor-Guide.pdf) that includes daily case discussion of a selection of the registrar’s notes and the observation of at least 4 consultations. This assessment also informs the development of a [‘*Clinical Supervision Plan’*](https://gplearning.racgp.org.au/Content/2022/SupPD/Clinical%20supervision%20plan_Full.dotx)that clearly outlines the who, when, and how of calling for help The *‘Early Assessment for Safety and Learning*’ and the *‘Clinical Supervision Plan’* must be completed in the first 4 weeks of term 1.

A registrar in later terms will need a much less comprehensive orientation and will already have been assessed as being safe to consult without review of all consultations. They will still require time to become familiar with the practice and a ‘*Clinical Supervision Plan*’ relevant to their knowledge and skills and the practice context will need to be developed. A minimum of half a day is recommended.

The orientation checklist below is available to the registrar, supervisor, and practice manager. It is designed for orientation to the first GP term. The registrar will be responsible for making sure all items are addressed. It is also appropriate for use in later terms although not all the items may need to be covered. Practices are encouraged to download a Word copy of the document and insert their letterhead and modify the document for their context.

Not everything can be covered in the first few days – there is too much information to retain. Many processes will be learnt over the next few weeks, often when they are encountered for the first time in the course of consulting. For example, chronic disease management MBS items, WorkCover, advanced computer functions. Some may become the subject of the dedicated teaching sessions.

The registrar will have one or two days of out-of-practice orientation at the start of the first term. Topics at regional orientation workshops will depend on the region, however all registrars have access to online modules that include topics such as starting in general practice, billing, prescribing, medicolegal aspects of practice, communication and consultation skills, emergencies in practice and clinical reasoning.

Much of what a registrar needs to learn about starting in general practice is more appropriately learned in the workplace.

A good orientation takes time and organisation. Much of it can be done by the practice manager but the supervisor must be involved with teaching how to use the clinical software and in discussions about teaching and supervision.

Before a Term 1 registrar sees their first patient

The following must be covered before a Term 1 registrar sees their first patient

* Meet the people immediately involved - nurse, practice manager, front desk staff, any supervisors
* Who, how and when to call for help (see below)
* Processes and systems
* Computer. At a minimum, the registrar should learn how to record progress notes, write prescriptions, order investigations, write referrals, check results, and know how to access online resources (eTG etc)
* Billing. The registrar needs to know how billing works in the practice. The common item numbers used and how to communicate them to the billing staff. The registrar should understand bulk billing and private billing. It is also very important that registrars are clear on how to bill for follow-up appointments. Concern about charging patients is a known impediment to registrars organising follow-up visits.
* Appointments
* Fire/evacuation
* Personal safety
* Commonly used equipment and supplies
* Emergency equipment and drugs
* Tour of the building
* List of recommended local referral options including pathology, imaging, other specialists, allied health practitioners, community health and social support agencies.
* Sitting in with the supervisor

This is an important orientation activity. It is an effective way for the registrar to learn:

* Consulting skills especially language and phrasing; managing time; controlling the consultation; safety netting; using follow up.
* Computer use. Ideally the registrar uses the computer to print scripts, order tests, look up results, and record notes while the supervisor consults

Sitting in for at least one session is recommended. It is worth allowing some space in the bookings for the supervisor to spend time teaching the registrar after each consultation.

Once the registrar has started seeing their own patients, as part of the ‘Early Assessment for Safety and Learning’ the supervisor is required to sit in and observe at least 4 registrar consultations. Time should also be set aside each day for daily case review of a selection of registrar cases. This daily case review continues until the supervisor determines it is no longer necessary and the *‘Clinical Supervision Plan’* is finalised.

Explaining how supervision and teaching will happen

Orientation of the registrar involves giving clear information and discussing how supervision and teaching will happen.

This includes:

* An initial daily review of a selection of registrar cases and direct observation of at least 4 registrar consultations.
* The ‘*Clinical Supervision Plan’* for once the registrar is determined safe to consult without review of every consultation
* Who is available to be called? How and when do they want to be contacted?
* This includes after-hours back up
* The arrangements for back-up supervision if the usual supervisor/s are non-contactable.
* A plan for alternative supervision for any planned leave by the primary supervisor
* The outcome of this discussion is documented in a supervision plan. A guide to developing the *‘Clinical Supervision Plan*’ that includes a template is available [here](https://gplearning.racgp.org.au/Content/2022/SupPD/Clinical%20supervision%20plan_Full.dotx).
* Early discussion of learning needs and plan to address them
* Formal, scheduled teaching applicable for GPT1-3 terms – how and when it will happen.
* It is best scheduled for a time in the day least prone to interruptions or running late (ideally not at lunchtime or at the end of the day). Planning the teaching, at least one week ahead
* Encourage registrar to keep a list of non-urgent cases and questions to be discussed in teaching sessions
* Opportunistic teaching from questions or cases
* Are there times outside of teaching sessions when this can occur
* How assessments will happen including direct observation for EASL and mid and end-of-term assessments
* Feedback – what it looks like and how it happens
* Encourage the registrar to seek it. Find out about the registrar's previous experiences and preferences – there are significant cultural variations in how feedback is expected to occur discuss trust and safety. Also, express your openness to receive feedback from the registrar.

All supervised doctors should be made aware that it is an expectation that they seek advice as much as they require. This may involve reassuring them of your willingness and availability to help.

These arrangements should be discussed with everyone in the supervision team and relevant aspects communicated with the whole practice.

This should ideally be formalised in a [clinical supervision plan](https://gplearning.racgp.org.au/Content/2022/SupPD/Clinical%20supervision%20plan_Full.dotx) and a [teaching plan](https://gplearning.racgp.org.au/Content/2022/SupPD/In%20practice%20teaching%20and%20teaching%20plan_Full.dotx).

Orientation checklist

Supervisors and practice managers can use this orientation checklist to plan and conduct a comprehensive orientation for a new registrar. This list can be adapted to suit each practice. Please add or delete items as required.

**Registrars are responsible for ensuring that the relevant items are addressed**, ideally by the end of the second week of the term. The orientation can be provided by one or more appropriate practice members. The supervisor needs to have the discussion about supervision, teaching and learning. Use of the computer for clinical purposes should be taught by a medical team member.

Who is responsible for each task varies from practice to practice. Use the left-hand column to assign responsibility.

|  |  |  |
| --- | --- | --- |
| Practice name | Registrar name | Designated supervisor |
|  |  |  |

| Person responsible | Orientation checklist | Complete |
| --- | --- | --- |
|  | **Introduction to the staff and their roles** |  |
|  | Doctors including their interests and expertise |  |
|  | Practice nurses and their roles |  |
|  | Practice manager |  |
|  | Admin staff |  |
|  | Allied health |  |
|  | Cultural educator |  |
|  | Overall practice philosophy |  |
|  | Practice information document and practice history |  |
|  | Practice meetings – formal and informal |  |
|  | **Work health and safety processes** |  |
|  | Duress response |  |
|  | Injury incl. needle stick |  |
|  | Infection control |  |
|  | Fire/evacuation |  |
|  | **Rooms and equipment** |  |
|  | Tour of the premises |  |
|  | Commonly used medical equipment and supplies |  |
|  | Emergency equipment and drugs, including location of defibrillator, fire extinguisher |  |
|  | Phone system, email faxes |  |
|  | **Computer use (best done by supervisor or another doctor)** |  |
|  | Medical records and software demonstration |  |
|  | Prescriptions |  |
|  | Test ordering |  |
|  | Referrals |  |
|  | Test results or correspondence checking processes |  |
|  | Recalls and reminders |  |
|  | Documents |  |
|  | Billing software |  |
|  | Appointments and waiting room |  |
|  | Educational resources e.g., eTG’s, HealthPathways |  |
|  | Telehealth processes |  |
|  | **Provision of useful written information** |  |
|  | Common MBS items |  |
|  | List of practitioners commonly referred to – specialist, mental health, allied health, community health |  |
|  | **Practice administration** |  |
|  | AHPRA registration, medical indemnity |  |
|  | Update National Health Services Directory (NHSD) with registrar’s details |  |
|  | Notify local radiology and pathology providers of registrar’s details |  |
|  | Pay and employment paperwork |  |
|  | Rostering including release for out of practice education |  |
|  | Leave |  |
|  | Patient bookings |  |
|  | How billing works – especially bulk billing vs private, billing for follow up visits |  |
|  | Reports, forms |  |
|  | **Professional issues** |  |
|  | Informed consent (which also includes financial informed consent) |  |
|  | Dress, punctuality, personal communication and behaviour |  |
|  | Confidentiality and privacy |  |
|  | Practice policies |  |
|  | S8 prescribing |  |
|  | Complaints and critical incidents |  |
|  | Social media |  |
|  | Safe administration of immunisations and medications in the practice |  |
|  | **The local community** |  |
|  | Aboriginal and Torres Strait Islander population, other cultural groups, organisations, and services |  |
|  | Key people in the community |  |
|  | Other health providers including pharmacy services |  |
|  | Local specific health needs |  |
|  | Social support services and facilities |  |
|  | Recreation, sporting, cultural opportunities |  |
|  | Consider a tour of the local area |  |
|  | **Local hospital orientation** |  |
|  | **Aged care facility orientation** |  |
|  | **Supervisor meeting to discuss:** |  |
|  | How supervision happens |  |
|  | * Who to call including when primary supervisor unavailable, after hours. Provision of supervision roster. |  |
|  | * When to call – in what circumstances. Clear reassurance and encouragement that asking for help is welcome. Clear message of availability and approachability |  |
|  | * Discussion of call for help list.\ |  |
|  | * How to call – phone call, messaging |  |
|  | How teaching happens |  |
|  | * Dedicated, protected time each week |  |
|  | * What teaching will look like – types of case discussion, direct observation, procedural teaching, topics |  |
|  | * Informal teaching whenever the opportunity arises |  |
|  | * Who may be involved in teaching |  |
|  | * Planning teaching based on identified needs |  |
|  | How assessments and reporting happen |  |
|  | * Giving feedback – how and when. Openness to feedback both ways |  |
|  | Discussion of registrar’s background |  |
|  | * In medicine |  |
|  | * Outside medicine |  |
|  | Discussion of learning needs |  |
|  | Handover when registrar away (results, follow-up) |  |
|  | **Consultation observation** |  |
|  | Registrar observes the supervisor consulting for at least one session |  |
|  | Co-consult - registrar does documentation in medical software, referrals and prescriptions, whilst supervisor conducts the consultation with patient. |  |
|  | Supervisor observes the registrar consult |  |