ReCEnT: Instructions for completing the 'Encounter Form'

Introduction

These instructions are written to complement the orientation workshop and training on your participation in the ReCEnT project. **It is important to read through these instructions in full prior to commencing data collection**.

General Instructions

Consecutive consultations

Please complete an encounter form for each one of sixty (60) consecutive clinical encounters. There is only one exception to this:
- when you see a patient and ask them to return later that day for review e.g. you see a child with a suspected fracture after a fall, send them off for an X-ray and ask them to return with the films – in this case, please use a single form and complete it as if it was conducted all in one consultation

Forms must be completed during your allocated data collection period. You will be advised when that is.

Please record all consecutive consultations; in particular, do not leave out more complex interactions which might take a little longer to record. Excluding more complex consultations will minimise the breadth of clinical encounters recorded and potentially bias the data returned to you in your ReCEnT feedback report.

Only record consultations conducted in the general practice office setting i.e. DO NOT record consultations conducted in a nursing home, or on a home visit.

Do not record consultations as part of a specialised clinic e.g. immunisation, flu-needle clinic, or Women's Health clinic. While this data may be of epidemiological/research interest, including a number of these 'single purpose clinic' consultations in your data will diminish the reliability/usefulness of your reflective feedback report.

If you work at more than one practice, you will be advised which practice you should complete your ReCEnT encounters at. Please complete all of your sixty (60) consecutive clinical encounters there.

Note: You do NOT need to discuss the project with each patient. You do NOT need the patient's consent. You do NOT need to record anything regarding ReCEnT in the patient's notes.

Complete all questions

Some of the items are mandatory and are indicated by a red asterisk.

Note: while other sections of the form that are not mandatory, it is a requirement that you complete all sections that are relevant to the consultation. This includes for example, adding medications when medications were prescribed, referrals where referrals are made, any pathology ordered etc. The more complete your data the more valid the content of your feedback report for you to reflect upon.

More information than the form allows?

To sensibly limit the time to record data there is a limit of 4 problem statements. If you have seen more than this, please use your judgement to decide which problems are the **most important** to include, remembering this information is intended for you to reflect upon your practice.

Abbreviations/Acronyms

Unless it is a very well established abbreviation or acronym, please write out in full. For example, SCC always means squamous cell carcinoma, but SK could mean solar kerotosis or seborrhoeic kerotosis.
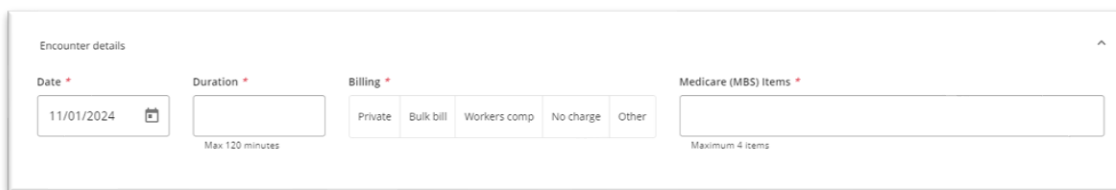
Completing the encounter form

You will be familiar with the format of the encounter form from your ReCEnT project orientation session. The following is a reminder on how to complete each element of the form. Some elements are self-explanatory and therefore not included below.

Encounter number

The encounter number is automatically allocated from 01-60. Please complete a new form for every clinical encounter, regardless of whether you have seen the patient previously in the data collection period.

Encounter details

Date

This is the date of the encounter. It defaults to the current date, but you can override that manually.

Duration of Consultation

Please record the duration of the consultation as accurately as possible to the **nearest minute**. The maximum duration allowed is 120 minutes. If your consultation was longer than that then just enter 120 minutes.

> TIPS
> - Use the electronic timer in your medical record software
> - Avoid rounding up or down to five-minute increments
> - Include the time it takes to write your notes as well as the patient contact time.
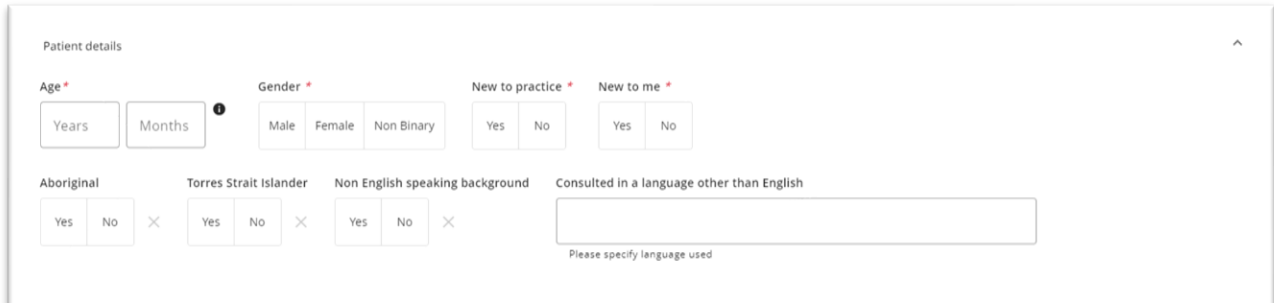
Billing

- **Private**: Click this box if the patient paid a co-payment.
- **Bulk Bill**: Click this box if the visit was bulk billed.
- **Workers Comp**: Click this box if the visit was covered under WorkCover.
- **No Charge**: Click this box if the visit was free to the patient and there was no Medicare billing.
- **Other**: Click this box if the encounter is being paid for by another source e.g. insurance company, overseas patient, work or employment medical.

Medicare (MBS) Items

Please record edicare Benefit Schedule (MBS) or WorkCover item numbers as appropriate. Only include item numbers for services provided to the patient in your consultation rooms or using telehealth.

Note: Home visits, nursing home visits, or consultations where the patient is not involved (e.g. case conferences) should **not be included** as an encounter.

Patient demographics

Age and Gender

Record the age in years only for adults and children 2 years and older. Under 2 years record the age in months only. If under 1 month then the age is 0 years and 0 months.

Gender has 3 possibilities – 'Male', 'Female' and a third category 'Non Binary' which you should use for any patients you are aware of who do not identify as male or female.

Aboriginal and Torres Strait Islander

If your patient's record does not identify Aboriginal or Torres Strait Islander status, please ask the patient 'Do you identify as an Aboriginal or Torres Strait Islander?' and click the boxes as appropriate. The patient may answer 'Yes' to either or both.

For more information on identification of Indigenous status, see the following link
http://www.healthinfonet.ecu.edu.au/health-facts/health-faqs/identification

Non-English Speaking Background (NESB)

To identify NESB status, please ask the patient 'Do you speak a language at home other than English?'. If the patient is from a NESB i.e. primary language spoken at home is NOT English, click the 'Yes' box. Otherwise, click the 'No' box. You will have to directly ask about the language spoken at home to obtain this information.

Consultation where you spoke a language other than English

If **you** spoke a language other than English for part or all of the consultation, then please write the name of the language here. This section is only to be completed when **you** speak the language, it does not include consultations where you use a translator. It does not include consultations where you just speak a greeting in the other language and do not speak that language to do your work as a doctor.

Consultation factors

New patient to practice

If this is the patient's first visit to this practice, click the 'Yes' box. Otherwise, click the 'No' box.
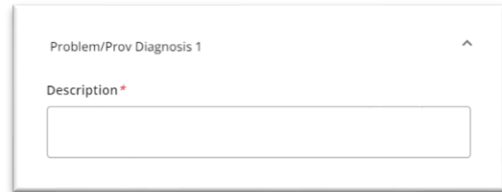
New patient to registrar

If this is the first time you have seen the patient, click the 'Yes' box. Otherwise, click the 'No' box.

Problem/provisional diagnosis

In this box, please write your **single most likely** provisional diagnosis, or if there are a number of separate diagnoses/problems, write them in separate boxes. Record at least one and up to four problems.

Please do not list the differential diagnosis - it does not matter if you are uncertain of the diagnosis and it turns out to be something else later. In particular, please **do not use question marks** e.g. chest pain ?ischaemia, as this makes interpretation very difficult.

> TIPS
> - Use one provisional diagnosis/problem box for each diagnosis/problem.
> - Be as specific as possible for example, for diabetes, differentiate between IDDM/NIDDM etc.
> - In cases where there is no clear provisional diagnosis, it is OK to record:
>   - ill-defined conditions (e.g. 'cough', 'chest problem'),
>   - preventive care (e.g. 'cervical screening test', 'contraception', 'immunisation' or 'checkup'), and
>   - social problems (e.g. 'problems with spouse').
> - Only record problems actually dealt with at this encounter.
> - The order in which you record the problems is not significant.
> - If more than four problems are managed at the consultation, record the four problems that best describe the breadth of the consultation.
> - DO NOT use question marks.

Problem status

Problem status refers to whether the problem is new or old TO THE PATIENT.
Click 'New' if:

- this is a new problem to the patient, or
- this is a new episode of a recurrent problem (e.g. UTI), or
- the patient has not been seen for this problem by any medical practitioner before.

Click 'Old' if the patient has been seen before by ANY medical practitioner for this chronic problem, or for this exacerbation/acute episode of chronic problem, or for this acute problem.

If the problem statement is a 'New' problem, you will be asked an additional question, 'How confident are you in your provisional diagnosis'.

If you have entered a description of symptoms (e.g. 'shortness of breath' or 'upper abdominal pain') as the problem statement, rather than a specific diagnosis, please select 'Very unconfident'.

Previously seen for this problem

If you have personally seen the patient for the problem **at any time** before, please click the box marked 'Yes'. If not, please click the box marked 'No'.

Observations and Examinations

Complete this section regardless of whether the consultation is in person or via telehealth.

Select which observations you recorded, if any, and which systems you undertook targeted examinations for. Select the problem(s) that the examination was associated with.

Any examination you undertake, no matter how limited or targeted is OK to record. Your targeted examination may encompass components of several of the 'traditional' systems examinations. If so, then choose as many of the systems that are relevant. For example, for an URTI problem you may have undertaken parts of both ENT and Respiratory examinations.

Don't understate your work, that way you will have a fair representation of what you have done when you Interpret your feedback report.

Medications prescribed

Record medications when

- a prescription is written at this encounter,
- you recommend that the patient take an 'over the counter' (OTC) medication,
- you administer or supply a medication/vaccine e.g. If 'Immunisation' is the problem managed, please enter drugs administered at this encounter, (e.g. CDT, DTP) or any drug samples you provide.

Problem (s)

- Click the number of the problem for which each medication was prescribed.

Drug name and Route of Administration

- Write the brand or generic name of the medication and its route of administration e.g. Nexium tablets po, or metoclopramide IM. For vaccinations, specify the brand name, e.g. 'HB VAX II', instead of 'hepatitis B vaccine'

Drug status

- If the medication is being used for the management of this problem for the first time then click the 'New' box. If it is a continuation or repeat of previous therapy then click the 'Continued' box.

> TIPS
>
> - Only record medications that were prescribed / advised / supplied at this encounter

Medications deprescribed

Deprescribing includes medications that were ceased, or when reduced with the intention to cease. Record when you deprescribed any medications and click which problem the ceased medication relates to.

Also click < 3 months or ≥ 3 months (as appropriate) for whether the patient was on the medication for more than three months or not.

Pathology

Give details of pathology tests ordered at the encounter. Document one test per box. Click the associated problem number(s).
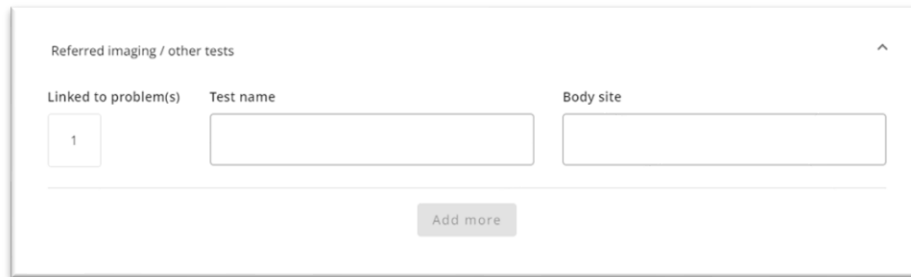
Referred Imaging/other tests
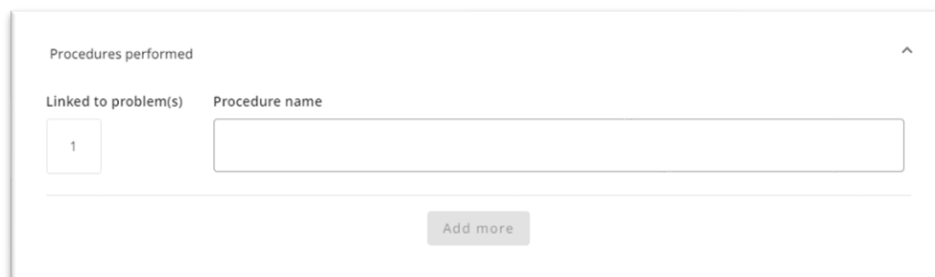
For imaging, write the name of the test (e.g. x-ray, ultrasound) and body site and click the number(s) of the diagnosis/problem which is being investigated.

For other referred tests e.g. nerve conduction studies, allergy testing etc, specify the type of test and click the relevant diagnosis/problem number(s).

Procedures

The 'Procedures performed' box relates to diagnostic and therapeutic procedures that **YOU provided** or assisted
with during the encounter.

Include in this section procedures such as skin excisions, biopsies, wound dressings, ECG, spirometry, cervical
screening tests, injections, and ear syringing that have been done **in the consultation**.

Document one procedure per line. Click the associated problem number(s).

Referrals

If you referred the patient to another practitioner specify to whom and for which problem. For example, if you referred the patient to a private physiotherapist, this would be 'Private Allied Health', write 'physio' and click the number(s) of the problem for which the referral was made.

Scheduled follow up

For each problem, record the plan for **scheduled** follow up.

- Do **not** record 'safety-netting' such as telling the patient to come back if they get worse, or are concerned etc.
- More than 1 option may apply for some problems.
- There is no option available for no planned follow-up. Please only click the problems for which **formal** follow-up is scheduled.

Educational aspects

These are two educational aspects of the consultation that are important for our educational program planning as well as individual registrar feedback - the source(s) of immediate information /assistance accessed during the consultation, and any learning goals developed for review afterwards.

Learning Goals

For the purposes of the ReCEnT project, learning goals are defined as 'expected educational outcomes as a result of the clinical encounter'. This does NOT include information accessed at the time of the consultation (this should be recorded in Sources of Information). Rather, it refers to plans to look up information, or seek advice about any aspect, following the consultation or at some time in the future.

Click the problem(s) related to any learning goals that occurred to you.

Sources of Information

If you sought information or assistance **during the consultation** for either diagnosis or management, please indicate the source and the relevant problem number(s). Be as specific as you can, particularly in relation to electronic resources and clinical guidelines.

More than one option may apply for some problems.

Antibiotics Question

Complete this question only if you prescribed or recommended an antibiotic at this encounter, otherwise leave blank.

Antibiotics prescribed			^
If you prescribed or recommended an antibiotic, was it:			
For immediate use	Provided as a script to be filled later	Arranged for patient to collect script later	✕

Finishing the form

If you have finished entering data, then click 'Submit'(located in bottom right corner of the page).
If you have not finished entering data, then click 'Save' and come back later to finish.
If you wish to clear everything from the form and start again, click 'Reset'.

Reset   Save   **Submit**