

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.**

Background

Clinical encounters are the core learning activity of general practice training in Australia. However, exposure to different patient demographics and presentations is highly variable between registrars and practices. This has a clear impact on the nature and quality of your training.

The ReCEnT project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations to provide you with a report to enable you to reflect upon your practice. You will record details of **sixty** (60) consecutive consultations on three occasions during your training time. Educational factors related to the encounter will be recorded along with consultation details.

The project has been documenting the content and nature of Australian GP registrars' clinical consultations since 2010. This information is of great value in supporting both your individual learning, as well as informing your education and training program overall. The project also provides a platform for further research and audit activity by GP registrars.

Between 1998 and 2015, the BEACH (Bettering the Evaluation and Care of Health) program, coordinated by the Family Medicine Research Centre at the University of Sydney, collected information on the clinical activity of Australian general practice. In order to make the two sets of data comparable, the ReCEnT Patient Encounter form and instructions have been made as comparable as possible with the equivalent BEACH resources (with permission).

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. As well, do not record consultations as part of a specialised clinic e.g. immunisation, flu-needle clinic, or Women's Health clinic.

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.

NB. 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, but please respond to every relevant question on the form. The more complete your data the better the feedback report for you to reflect upon.

More information than the form allows?

To sensibly limit the time to record data there are some limits imposed on lists of items. You can record up to 4 problems, 12 pathology tests, 8 imaging requests, 8 medications prescribed, 8 medications reduced, and 8 medications ceased. If there are more than these limits, please use your judgement to decide which are the **most important** items 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 keratosis or seborrheic keratosis.

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 and, in some cases, the rationale for doing so. Some elements are self-explanatory and therefore not included below.

Registrar ID

Each registrar has been given a unique numerical code to protect their privacy. It is not displayed on screen. Only your medical educator and supervisor and (if you agree to your data being used for research purposes) the researchers involved in the project will have access to information which might identify you. No information will be reported which allows individuals to be identified.

Encounter number

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

Date

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

Duration of Consultation

The duration of the consultation is an important feature of quality of care in general practice. Longer consultations are associated with a number of quality factors - higher patient satisfaction, opportunistic preventive care, and identification and management of psychosocial problems.

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.

Medicare (MBS) Items

Please record up to four Medicare Benefit Schedule (MBS) item numbers or WorkCover item numbers as appropriate. Only include item numbers for services provided to the patient in your consultation rooms or using telehealth. i.e. do not record home visits or nursing home visits, or where the patient is not involved e.g. case conferences.

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.

Patient demographics

Patient details ^

Age *	Years * <input type="text"/>	Months * <input type="text"/> ⁱ	Gender *	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Non Binary <input type="checkbox"/>
New to practice *	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aboriginal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
New to me *	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Torres Strait Islander	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Non English speaking background	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Consulted in a language other than English	<input type="text"/>		

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

Aboriginal and Torres Strait Islander Australians have a substantially greater burden of illness than their non-Indigenous counterparts. Identifying Indigenous status is an important element of the consultation. If your patient’s record does not identify Indigenous 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.healthinonet.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

Continuity of care is very closely related to patient satisfaction.

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

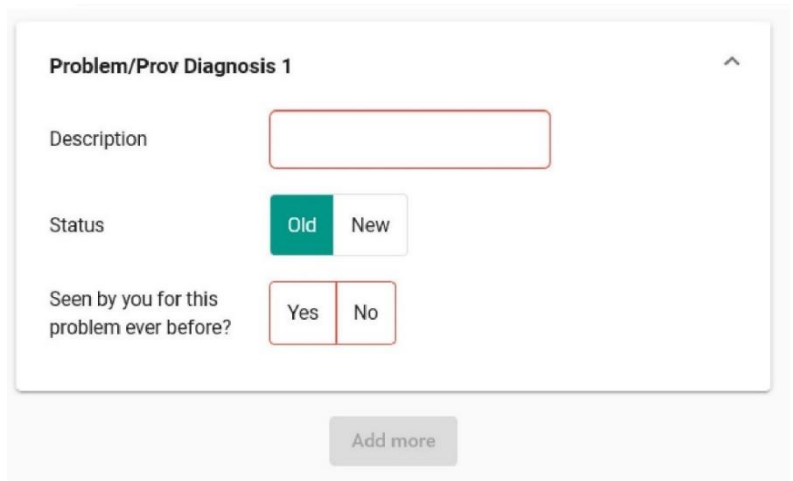
New patient to registrar

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.



Problem/Prov Diagnosis 1

Description

Status Old New

Seen by you for this problem ever before? Yes No

Add more

TIPS

- Use one provisional diagnosis/problem box for each diagnosis/problem.
- Please be as specific as possible with your provisional diagnosis i.e. record at the highest level possible with the information available. 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 - you don't need to list all the patient's known diagnoses.
- 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.
- Again, please 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 treated for that problem by any medical practitioner before.

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

Previously seen for this problem

Continuity of care is an important area of primary care. If you have 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. There are buttons to 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.

Essentially, 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 do in the feedback report you get.

Observations and examinations ^

Observations

Blood pressure	Heart rate	X
Height and/or weight and/or BMI calculation	Temperature	
Oxygen saturations	Respiratory rate	

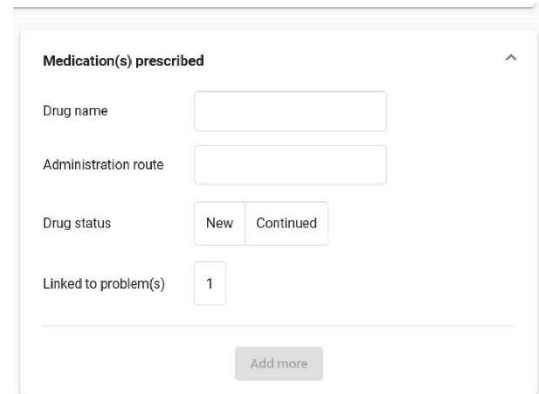
Physical examinations

	For problem(s)				
Ear and/or nose and/or throat	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Respiratory	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Skin and/or hair and/or nails	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Musculoskeletal and/or rheumatological	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
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Baby check (0-12 months)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Gastrointestinal	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Eye	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Pregnancy-related examination	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
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Cardiovascular	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Genital examination	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Breast examination	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Neurological	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Urological	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Mental state examination	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Thyroid	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Haematological	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		
Developmental assessment	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; text-align: center;">1</td> <td style="width: 25px; text-align: center;">2</td> <td style="width: 25px; text-align: center;">3</td> <td style="width: 25px; text-align: center;">4</td> </tr> </table>	1	2	3	4
1	2	3	4		

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.



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. 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.

Problem (s)

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

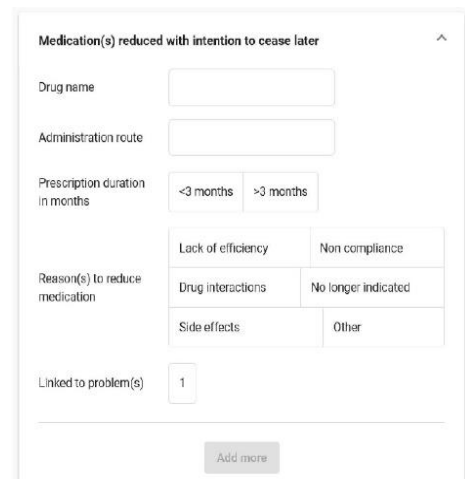
TIPS

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

Medication dose reduced with intention to ceasing later

If you intend to cease a medication in the future but need to commence by reducing the dose as a way of weaning it, then please record that medication here. Also record its route of administration, the associated problem and choose the applicable reason(s) (there may be more than one).

You do not need to record medications where you reduce the dose but do not intend to cease later.



Medications ceased

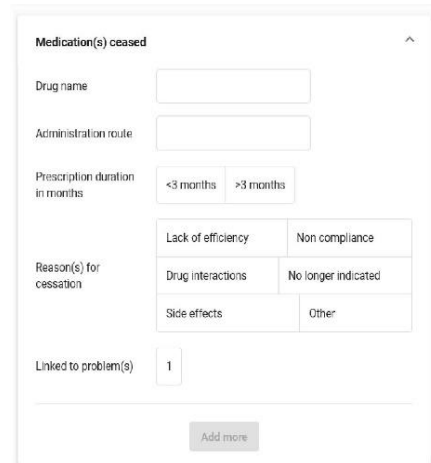
There is an increasing emphasis in GP training on registrars reviewing patients' treatment regimens and ceasing medicines that are no longer indicated. Medicines might also be ceased because of side effects or because of recognition of drug interactions or because the patient no longer wishes to take the medicine (or has already self-ceased the medicine: for ReCEnT purposes we classify both these circumstances as 'non-compliance') or recognition that the drug isn't working (lack of efficacy). Or there may be more than one reason for de-prescribing.

Record when you cease prescribing any medications and click which problem the ceased medication relates to.

Also click the box or boxes (it could be for more than one reason) for whether the drug cessation was for:

- being no longer indicated and/or
- side effects and/or
- drug interactions and/or
- non-compliance and/or
- lack of efficacy

Also click 'Yes' or 'No' (as appropriate) for whether the patient was on the medication for more than three months or not.

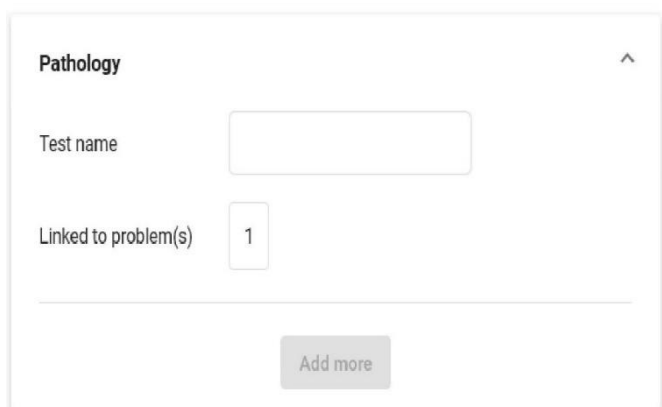


TIPS

- Only record medications that were ceased at this encounter

Pathology

Give details of up to twelve pathology tests ordered at the encounter. Document one test per box. Click the associated problem number(s).



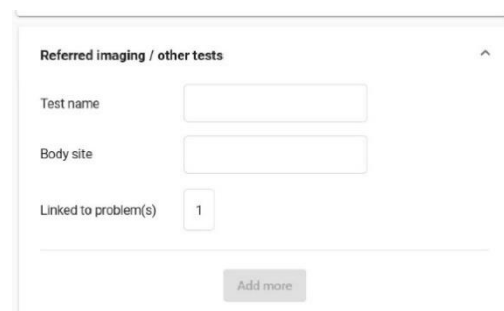
TIPS

- For single tests, write the test name (e.g. HbA1c). If ordering a set of tests such as a FBC or LFT or lipids or TFTs, record them in this grouped form just as you would write it on the request form. You don't need to list each of the individual tests incorporated in the set.
- Do not record urine dip stick tests.
- Link each test to the appropriate problem.

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).



The screenshot shows a form titled "Referred imaging / other tests". It contains three input fields: "Test name", "Body site", and "Linked to problem(s)". The "Linked to problem(s)" field has the number "1" selected. Below the fields is a grey "Add more" button.

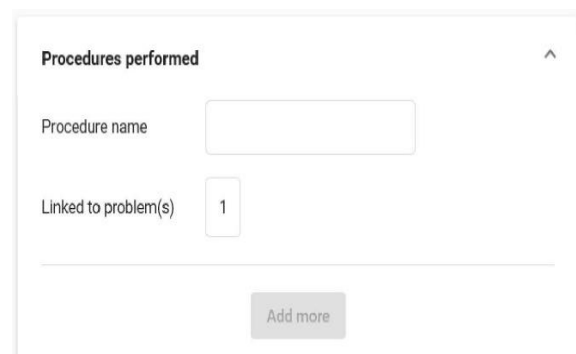
TIPS

- If you referred the patient for an ECG or spirometry (rather than performed it yourself) it should appear as an 'other test'.

Procedures

We are very interested in the opportunities that registrars have for procedural training in the practice setting. The 'Procedures performed by me' box relates to diagnostic and therapeutic procedures that **YOU actually provided** during the encounter.

Include in this section procedures such as pregnancy tests, ECG, spirometry, cervical screening tests, injections, excisions and ear syringing that have been done **in the consultation**. Document one procedure per line. Click the associated problem number(s).



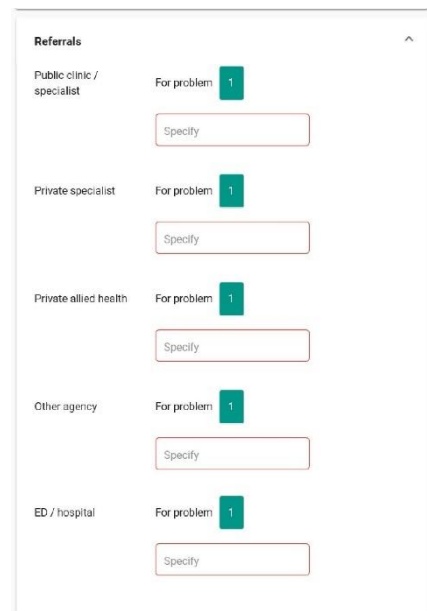
The screenshot shows a form titled "Procedures performed". It contains two input fields: "Procedure name" and "Linked to problem(s)". The "Linked to problem(s)" field has the number "1" selected. Below the fields is a grey "Add more" button.

TIPS

- Do **NOT** include in this section history taking; routine physical examinations e.g. blood pressure checks; routine urinalysis; referrals, imaging, pathology or other tests ordered (there are specific sections for these); or ECG or spirometry that is not included in patient management as part of this consultation. Please write the procedure in this box even if you refer to it in problem/diagnosis. For example, a patient might present for a cervical screening test, and diagnosis might be 'cervical screening test', but you should still record this here if you performed or assisted (you may have assisted a practice nurse or another GP in your practice). Another example is for immunisations. This might be the diagnosis, but you should still write it under procedure if you performed or assisted in the immunisation.

Referrals

Referral to other practitioners is an important aspect of patient management. If you referred the patient, 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.

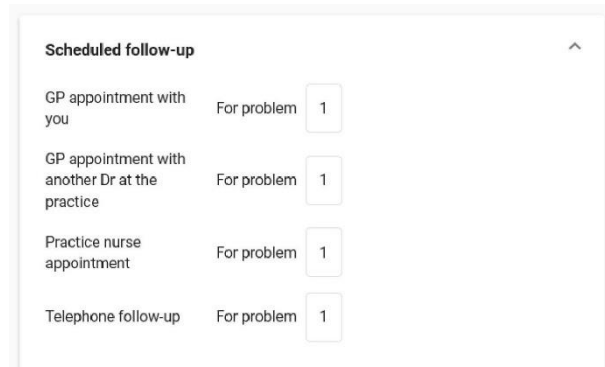


Referral Type	For problem	Specify
Public clinic / specialist	1	
Private specialist	1	
Private allied health	1	
Other agency	1	
ED / hospital	1	

Scheduled follow up

Follow up and safety-netting are core aspects of good clinical practice. For each problem, record the plan for **scheduled** follow up.

- Do **not** record it if you merely tell 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.



Follow-up Type	For problem
GP appointment with you	1
GP appointment with another Dr at the practice	1
Practice nurse appointment	1
Telephone follow-up	1

Educational aspects

There are two educational aspects of the consultation we want to identify - 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.



Generated learning goals

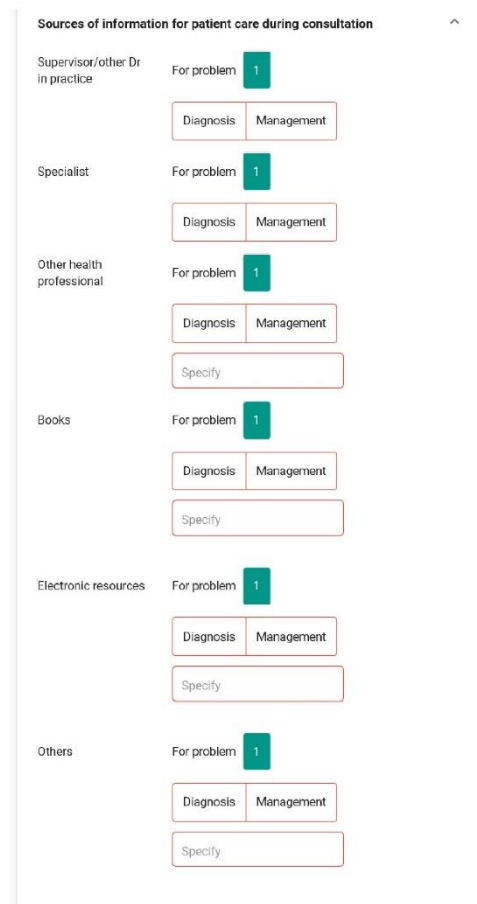
Linked to problem(s)

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.



Sources of information for patient care during consultation

Supervisor/other Dr in practice For problem 1

Specialist For problem 1

Other health professional For problem 1

Books For problem 1

Electronic resources For problem 1

Others For problem 1

Antibiotics Question

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

Antibiotics

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

X

Fatigue amongst patient's symptoms

This question relates to fatigue and long COVID (also known as post COVID-19). Please answer this question any time that fatigue is one of the symptoms your patient presents with, it does not need to be the main symptom.

Fatigue amongst patient's symptoms

How likely do you think long COVID was the cause of the fatigue?

Didn't consider long COVID in differential diagnoses
Very unlikely
Unlikely
Likely
Very likely

Which problem(s) involved fatigue?

1	2	3	4
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Finishing the form

If you have finished entering data, then click 'Submit'.
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, then click 'Reset'.

Reset	Save	Submit
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