Contents

Definition of general practice

General practice is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity. It is a clinical specialty oriented to primary health care. It is a first-level service that involves improving, maintaining, restoring and coordinating people's health. It focuses on patients' needs and enhancing links between local communities and other health and non-health agencies.

General practice:

- is personal, family and community oriented, comprehensive primary care that continues over time, is anticipatory as well as responsive
- is not limited by the age, gender, ethnicity, religion or social circumstances of the patient, nor by their physical or mental states
- is normally the point of first contact within the health system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, gender, culture or any other characteristic of the person concerned
- makes e icient use of health care resources through coordination of care, working with other health professionals also in a primary health setting, managing the interface with other specialties, and taking an advocacy role for the patient when needed
- develops a person-centred approach, oriented to the individu

Introduction

The Royal New Zealand College of General Practitioners (the College) provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice in New Zealand. Fellowship of the College is the recognised qualification leading to vocational registration in the scope of general practice.

Candidates for Fellowship of the College are assessed via a Fellowship assessment visit. This document details the standards used in the Fellowship assessment process. It also provides guidance and information for candidates who are about to undergo a Fellowship assessment visit.

Process

The pathways to Fellowship of the College are outlined in the College Fellowship Regulations, available on the College website. Candidates are eligible for a Fellowship assessment visit once they have completed the requirements of the relevant Fellowship pathway and met the requirements outlined in section 4.1 of the Fellowship Regulations.

The purpose of the Fellowship assessment visit is to examine the candidate's actual practice to ensure that it is safe, competent and meets the standards for Fellowship of the College.

In the Fellowship assessment process, candidates are assessed by a visiting assessor against the standards that are set out in this booklet. All indicators listed are essential and must be met in order for the candidate to gain Fellowship of the College.

In addition to evidence collected during the visit, the assessor has available to them other education programme materials, activities and assessments that relate to the candidate. This includes medical educator reports, patient and colleague feedback survey results, audits, and examination results.

Fellowship assessors and censors

Fellowship assessors and censors are senior members of the College who are experienced and respected general practitioners, known to have high standards of practice. They are required to be vocationally registered in general practice and to hold a current practising certificate. They are required to participate in ongoing assessment-related professional development activities.

Assessors are contracted by the College to undertake assessment visits and to write a Fellowship assessment visit report for the candidate that they visit.

The role of the censors is to examine each Fellowship assessment visit report provided by the Fellowship assessors and all other available information regarding the candidate's performance

The assessment visit

The Fellowship assessment visit must take place in a general practice or other practice environment that can meet the criteria for a general practice as listed in the definition of general practice (see above). The candidate must have worked in the practice for at least three months (full-time equivalent) in the past nine months.

Indicative time allocation

The Fellowship visit is likely to take between four and five hours. The approximate time required for each component of the visit is as follows, but these times may vary depending on the specific circumstances of the visit:

- Introduction: Up to 30 minutes
- Sitting in on consultations: Up to 150 minutes
- Review of medical records: Up to 30 minutes
- Discussion with the candidate: Up to 60 minutes
- A check and discussion about the premises, equipment and the practice organisation: Up to 30 minutes

The order in which the activities occur will be decided between the candidate and the assessor before or during the visit.

Preparation for the visit

There are a number of things you need to do to prepare for your visit:

Make sure that the practice manager and sta know that there is to be a visit, what it entails and how important it is to your qualifications. Reception sta will need to greet the assessor on arrival and will need to be able to answer any patient questions that maybe asked. The practice nurse may be needed to help explain systems that are delegated to her that you may not be familiar with.

The consulting room must be ready for the observation of consultations. Ensure that the room is clean and tidy, and that there is a chair with room for the assessor to sit with minimal interference to your consultations.

Notices must be put up in the practice informing patients that there is an assessment visit taking place. Also ensure that patients are provided with, and complete, the necessary consent forms to allow an observer. If a patient does not wish an observer to be present, the visitor will usually take this time to complete other aspects of the visit.

You need to ensure that the practice complies with all legal obligations. These are outlined in the Foundation Standard.

You must have made arrangements to ensure the privacy of your patients during physical examinations and the privacy of your computer notes, by ensuring the only visible notes are those of the patient in the room and by using a computer screensaver and adequate password protection.

You should have a set of consultations booked for the assessor to observe (see ‘Consultation observation’, p.5). These should not be patients selected by you and should reflect your normal booking practices.

You will need to ensure that there is a computer terminal available for the assessor to view your clinical records and referral letters, bearing in mind that this may be required during any consultation where your patient does not wish to have an observer present. If your practice uses

Evidence available to the assessor and censor

The evidence portfolio that is available to the assessor and censors encompasses all learning activities and assessments submitted over the course of the GPEP programme. This includes the RNZCGP clinical record review checklist, Colleague Feedback Survey results, Patient Survey results, examination results and in-practice visit reports. This evidence may be consulted by the assessor in their assessment of any indicator, or by the censors in assessment of overall performance.

The outcome of the visit

The assessor will provide a report on the visit to the College. This report is considered by two College censors, along with other evidence of the candidate's performance in the training programme. The censors will then make a recommendation to the College's censor in chief, which the censor in chief will consider in deciding the visit outcome.

If the censor in chief sees fit, they may request additional information and otherwise investigate further before making their decision on the outcome.

If the two censors cannot agree on what recommendation to make in a particular case, the censor in chief may consult Fellowship assessors and censors as a group regarding the issue or issues giving rise to the di erence of opinion between the censors, before making their decision on the outcome. Alternatively, the censor in chief may decide not to do this, and instead make a decision on the outcome a er considering the information available to the censors, and their views.

In any such consultation, the information available to the censors and censor in chief (including the assessor's report) will be available to the Fellowship assessors and censors attending the meeting. The assessor who carried out the relevant assessment visit will present their report to the group, focusing on the particular matter or matters at issue. Both censors will then provide their views, and the censor in chief may provide their preliminary view. Following that, there will be a group discussion, in which the assessor who carried out the relevant assessment visit, the censors involved in the assessment, and the censor in chief, may participate. The views expressed during that discussion will be taken into account by the censor in chief in making their decision.

Please be aware that it may take up to eight weeks for a decision to be made on the outcome of a visit. The censor in chief's decision is final, and there is no appeal process following this decision; however, if you believe the process has been unfair, you can lodge an appeal against the process using this form.

Note that the assessor does not make the decision on visit outcomes. Candidates should not contact the assessor about the visit outcome

There are three possible outcomes from the visit:

1.

c. Competence concerns

Section 34(1) of the Health Practitioners Competence Assurance Act 2003 relates to notification that practice below the required standard of competence. If a health practitioner (health practitioner A) has reason to believe that another health practitioner (health practitioner B) may pose a risk of harm to the public by practising below the required standard of competence, health practitioner A may give the Registrar of the authority that health practitioner B is registered with, written notice of the reasons on which that belief is based.

If the assessor is concerned that the candidate poses a risk of harm to the public by practising below the required standard of competence, the assessor will discuss their concerns with the censor in chief so that the College-appointed representative is kept informed. Following that discussion, the assessor who has highlighted the concerns may report these concerns to the Registrar of the Medical Council (Health Practitioners Competence Assurance Act 2003, section 32(1)). The Medical Council will instigate its own review process.

Indicator 3 and 4: Medical records

Indicator 3: Medical records meet requirements to describe and support the management of health care provided

The candidate's medical records meet the standard required for general practice.

3.1 Patient records are electronic, secure and traceable.

3.2 The patient's record contains su icient basic demographic information, including ethnicity, to identify them and meet national enrolment requirements.

3.3 The patient's record is objective (non-judgmental), and contemporary, and appropriate sources are identified.

3.4 Clinical notes can be understood by someone who does not regularly work at the practice.

3.5 Important medical warnings (or the absence of any) are displayed on all patient records.

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Evidence

- RNZCGP Clinical Record Review self-audit checklist
- A spot check and review of records by the assessor
- Patient portal notes (if used).

Guidelines

The RNZCGP Medical Record Review self-audit tool is provided in Appendix C. Instructions are provided on the tool itself. You are required to conduct a random audit on 10 patient records and to complete the Report and Plan template. This should be provided to the College before the visit.

During the visit, the assessor will request to see your patient records, including the day's records for the patients that you see under observation.

If your practice is using a patient portal and consultation notes are availablhltualText 0.1719 752.200ultation no hi.fYo d1R

Indicator 7: Practice systems and facilities

Indicator 9: Availability and accessibility

Indicator 9: Patients can obtain care and advice that is appropriate to their needs	
The candidate:	
9.1	ensures that patients are informed about the costs of a standard consultation and any variation in costs for non-standard consultations and treatment
9.2	can provide patients with the indicative costs of referred services if these are in the private sector
9.3	ensures that the time they allocate to the patient is enough to give them good quality care
9.4	can describe how patients with urgent medical problems are identified, triaged and managed in a timely and appropriate manner
9.5	can explain how they fulfil their responsibility to ensure patients have adequate a er-hours care and how patients are told about this care
9.6	will visit homes, rest homes and hospitals when it is necessary and appropriate
9.7	can describe how they address barriers to health care access for M ori.

Evidence

- Practice observation
- Consultation observation
- Patient Feedback Survey results (available in the candidate's portfolio)
- Discussion.

Guidelines

Patients need to be informed about the costs of consultations and additional treatments and should be given indicative costs and options for special investigations or specialist consultations. Much of this information may be provided in a poster at the reception desk showing the costs of practice services. If the management plan that you propose has additional cost implications, these should be discussed in the consultation.

The suggested average time for a consultation is not less than 10 minutes, and consultations that meet the expected standards are likely to average 15 minutes. It is important that the assessor gets to view what you do on a usual day. The assessor will verify this in their review of your records and make a judgment as to whether your practice on the day is representative of your usual practice.

You need to be aware of the practice triage system and your role in this system. You must have a current ACLS certificate (to be awarded Fellowship, this needs to be assessed and at a minimum at the level of the CORE Immediate course) and must know the location of the closest defibrillator (this should ideally not be more than five minutes away).

Fulfilling your obligations for the follow-up and safety of patients for whom you are providing care means that you must ensure they have a clear understanding of what they are to do when you are not available. This requires that:

- you ensure 24-hour care is available
- you inform your patients of your a er-hours care arrangements
- you provide any information necessary for the safe hand-over of care
- you are prepared to visit patients under your care who cannot reasonably access your practice
- you have in place means to assure your safety if this is necessary for the visit.

Indicator 10: Respect for the rights and needs of patients

Indicator 12: Scholarship and professional development

Indicator 12: The candidate can show they consider and apply the most up-to-date evidence in their patient care
The candidate: 12.1 understands current clinical practice guidelines and clinical information sources, and can demonstrate that they use them 12.2 makes provision for professional development and takes responsibility for maintaining their competence 12.3 understands how colonisation, racism, migration and other cultural factors a ect equitable health outcomes; identifies potential inequities by using relevant marginalisation data and uses the findings to address inequities.

Evidence

- Consultation observation
- Practice observation
- Professional development plans (available in the candidate's portfolio)
- Audits of medical practice (available in the candidate's portfolio)
- Discussion.

Guidelines

During the practice visit, the assessor will be looking for evidence that information regarding current clinical practice guidelines (including local, regional or national guidelines as appropriate) and referral pathways is available and is used.

The assessor will want to know how you ensure that your knowledge remains current and you maintain your competence. Evidence will include your membership of a peer group and your record of continuing medical education. The assessor will also evaluate the medical, surgical and general practice reference material immediately available to you, whether in written or electronic form.

Indicator 13: Health and wellbeing

Indicator 13: The candidate is fit for work and has mechanisms for self-management and self-care
The candidate: 13.1 makes provision to maintain their own health and work–life balance 13.2 has considered factors that a ect their performance and has arrangements in place to manage these.

Evidence

- Colleague feedback results
- Discussion
- Candidate presentation.

Guidelines

The assessor will want to discuss the arrangements you make for self-care and for a good work–life balance.

You are expected to have your own GP, and you should not prescribe for or treat your family members, except in extenuating circumstances. The assessor may touch on how you recognise and deal with stress, the support mechanisms you have in place, and any strategies you have for building resilience.

You should acquaint the assessor with any current issues for your health, family or circumstances that may impact on your performance. Please inform the College prior to your visit if you have any outstanding disciplinary or legal actions against you. These are not necessarily a barrier to Fellowship, but a failure to disclose could be.

The Health Practitioners Competence Assurance Act 2003 Section 45 makes it mandatory for a medical practitioner who has reason to believe that another medical practitioner is not fit to practice medicine because of some mental or physical condition to give notice to the Registrar of the Medical Council of New Zealand of such belief.

Required equipment and medicines checklist

All medical equipment, resources and medicines must be suitable for supporting comprehensive primary care, resuscitation and any additional procedures o ered. All essential medical equipment, resources and medicines must be available when needed, and members of the practice team must know how to use the equipment. Equipment must be calibrated, in working order, and servicing expiry dates must be current.

NOTE: You will receive a fillable version of this form in your Fellowship assessment pack.

All basic equipment is required and available within the practice including:
☐ Auriscope
☐ Blood glucose test strips/glucometer
☐ Blood taking equipment
☐ Cervical smear equipment
☐ [redacted]mera or other secure method of taking photos (e.g. smartphone app)

Criteria for assessing consultations

Establishing and maintaining a therapeutic patient–doctor relationship	Defining the problems and reasons for patient's attendance	Performing an appropriate examination	Providing appropriate management	Clinical thinking, organisation and professionalism
3 A therapeutic relationship is established. Limited expression of concerns and feelings by the patient, and limited exploration of them by the candidate. Mostly patient centred. Demonstrates sound levels of cultural sensitivity and competence. Evidence of cultural safety is also demonstrated but limited skill set or application. Attempts whaka-whanaungatanga.	3 The candidate defines the presenting and other major problems, verifies them with the patient and safely prioritises them. Associated problems or preventative care opportunities are missed. Demonstrates culturally safe consultation and attempts to integrate aspects of a M ori model of health.	3 The candidate's examination is limited to major/life-threatening problems only and excludes patient's associated concerns. Consent is obtained. Some demonstration of cultural competency.	3 The candidate negotiates a sound management plan for the major problem(s), with agreement of the patient. Management of associated problems not addressed. Demonstrates cultural competency and incorporates aspects of M ori models of health into the management plan.	3 The candidate could improve their clinical thinking, organisation, or professional behaviour, but the concerns are not significant. Culturally competent; some understanding of health inequity.
4 A therapeutic relationship is clearly established. The patient openly expresses their concerns and feelings. Some weaknesses noted in verifying patients concerns. Patient centred. Demonstrates sound cultural safety skills. Utilises whaka-whanaungatanga e ectively.	4 (en-US)/MCID 1790>>BDC 0 -1.811 TD [(C)10 (ultur)24 (ally)]TJ EMC0 788 >>BDC 0 -1.222 TD [(srPnr)2 Utilises whak- apeutic cl187elyMCSI ti PLang /P o rlealyes5C7778 >>BDC T* [(cle)14 (arly es)2087322 TDm 8C /PnMCID 17rclearly es clearly eso crPnr apeutic cl185522 TDm 8C /P <</Lang Utilises whakely</LDn-D 1/P <(alSUS)/MCID Utilises whak Utilises whak(C US)/MCID Utilises whak Utilises whakaP <</Laee >>B-U<<//LangLang (e(e >>B [(C)10 <</Lae 1790 >>BDC T* [(Utilises wh Utilises whakUtilises whakelytMo <</Laough Utilises whako inCa crPnro7.s(en)1ofcl190022 TDm 8C /P <</Lanmpe(C)10777 >>B(t manne)257/Lan i21 (c Utilises wh-0.0(alTw ak)10.18365.3858lytMo <</LaouuofcP <lti211_0 1 Tf 9 0 0 9 160.189622 TDm 8C /Pap2			

Instructions

Parts 1 and 2 of the checklist require a random audit of 10 patient records. Applications that generate lists of random numbers are available online. However, the easiest way to generate a random sample is to select consecutive patient appointments, beginning at a random time on a randomly selected day.

All records should be electronic and have an entry in the past 12 months. The review should not focus on a single consultation but rather on a series of the most recent consultations for a particular record.

Part 1 can be completed by practice administration sta . Part 2 must be completed by the clinician whose notes are being audited.

Parts 1 and 2

- Randomly select 10 patient clinical records.
- Complete the Part 1 or Part 2 template attached by marking the boxes in the columns numbered 1 to 10 for each of the records reviewed as follows:
  - Y present and adequate
  - IN present but inadequate
  - N not present
  - NA not applicable/necessary in this case
-

Checklist prior to practice visit

Consultations

- [ ] Have you a notice in place and will each patient receive and sign a form demonstrating their consent to the visitor sitting in?
- [ ] Have you printed two copies of the Fellowship Assessment Declaration of Confidentiality form to be signed by the assessor during the visit?
- [ ] Have you allowed for observation of at least eight consultations and su icient debriefing time?
- [ ] Will this be a range of usual general practice consultations (avoiding special interest or alternative medicine consultations)?
- [ ] Have you established a habit of cleansing your hands (water or alcohol) before touching a baby and a er a patient examination where there is a risk of contamination?
- [ ] Have you organised a computer terminal (and paper files if necessary) to be available for the records check?
- [ ] Do you have a reliable system in place for management of routine test results?
- [ ] Can you show that you have ready access to reference advice and guidelines?
- [ ] Can you demonstrate the way you provide your patients with clinical information to supplement your consultations?
- [ ] Can you describe the way you ensure adequate safety-netting, including follow-up, a er-hours care home visits and transfer of care as necessary?

Practice systems

- [ ] Are you familiar with practice surface and instrument cleaning procedures?
- [ ] Can you demonstrate how you ensure sterilising procedures work as intended?
- [ ] Are instruments for invasive procedures stored in sterile packs with sterilisation indicators?
- [ ] Can you demonstrate that all biological waste is stored safely and disposed of in compliance with local regulations?
- [ ] Are sharps kept out of reach of children and discarded safely?
- [ ] Do you discard all single-use instruments (ear pieces, tongue blades, specula etc.) a er single use?
- [ ] Can you verify cold-chain compliance by way of a current Immunisation Accreditation Certificate? (Minimum requirements include protection in transport, a dedicated fridge, daily temperature readings and computer printout from a temperature logging device.)
- [ ] Are controlled drugs stored in a metal or concrete safe securely fixed to the building with the key securely stored?
- [ ] Can you demonstrate the practice procedures for controlled access to restricted drugs?
- [ ] Have you a knowledgeable nurse available on the day to help explain any of the above systems that you might not be familiar with?
- [ ] Can you demonstrate how your patients know about and receive 24-hour cover and how they are informed of the care they receive a er hours?
- [ ] Can you describe the practice triage system for urgent medical problems?
- [ ] Can you demonstrate that there is a complaints procedure and that you know the procedure and timelines as per Health Consumer Right 10?
- [ ] Do you have a reliable patient recall system?
- [ ] Can you demonstrate how abnormal test results are followed up?
- [ ] Do you have access to mobile emergency equipment?