GP AUDIT CRITERIA

For Telephone Triage and Face to Face Consultations

Based on the RCGP Urgent and Emergency Care Clinical Audit Toolkit 2010

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The performance of all GP's who work for SELDOC (including agency GP's) is audited every month using the below method and criteria.

Every GP is audited once a month so all GP's are audited at least 12 times per year (providing they work every month in that year).

Two thirds of audits (8 per year) are conducted on GP's face to face consultations, where the doctor's clinical notes from the case is audited.

One third of audits (4 per year) are conducted on GP's telephone consultations where a recording of the call is audited as well as the clinical case notes.

Each GP will receive quarterly feedback regarding their audit score results.

Any GP who scores a red result will receive this feedback immediately (before their quarterly feedback) and asked to improve.

If a GP persists to score red results despite receiving feedback twice, then on the 3rd red result their performance will be audited more closely with an over sample. If this over sample audit demonstrates consistent concerns with their performance, then a Performance Review is held by the Group Medical Director as per the GP Performance Policy. If any single audit score or comment raises significant concerns regarding a doctor's performance, then a Performance Review would be held immediately.

<u>Mark Scheme</u>

Telephone Audits comprise of 15 questions and Face to Face Audits comprise of 14 questions.

For each question a score of two is given if the doctor fully meets all the criteria, one if they partially meet the criteria and zero if they don't meet any of the criteria. Results are entered onto SELDOC's 'Telephone Audit Record Sheet' or 'Face to Face Audit Record Sheet'.

The results are expressed as a percentage (mark/30) for Telephone Audits, and (mark/28) for Face to Face audits.

80% is the accepted pass mark and green, 70-79% is amber and 'requires some improvement' and 69% and below is red, and 'requires improvement'.

Telephone Audit Criteria

Introduction- The doctor clearly introduces themselves by stating their name, position and where they are calling from (e.g. “Hello this is Dr Smith, I am a GP from the GP Out of Hours Service SELDOC).

Confirm Identity- The doctor confirms that they are speaking to the correct patient. If they are speaking to someone else, they ask to speak to the patient (or legal guardian for a child). If that is not possible (establish reason why e.g. patient doesn’t speak English) they establish who the person is that they are speaking to and in what capacity they know the patient (friend, relative, another health care professional). The doctor does not need the patient’s consent to take a history from someone else but would need the patients consent if the doctor was giving any information to the other person (e.g. blood test results).

Reason- The doctor clearly establishes the reason for the call (Presenting Complaint) and takes a detailed HPC (History of Presenting Compliant) including eliciting concerns or health beliefs that the patient (or caller) may have in relation to this.

Emergency- The doctor asks appropriate questions during the History of Presenting Complaint in order to identify or exclude ‘**Red Flags’** and by doing so establishes if this is an emergency or serious situation. This may also include questions regarding relevant Past Medical History, Medications, Allergies and Social History. Questions are phrased in a way that the patient or caller can understand and if an emergency or serious situation is identified the doctor acts accordingly.

Past Medical History- The doctor takes a detailed Past Medical History

Medications- The doctor enquires about the patients regular (repeat) medications and if any medication have been taken for this presenting complaint.

Allergies and Social History- The doctor asks if the patient has any known allergies to any medications and / or any relevant allergies to anything else. The doctor asks about any relevant social history (e.g. immunisations for a child, smoking history for a respiratory complaint or travel history for diarrhoea).

Conclusion- The doctor constructs an appropriate diagnosis or differential diagnosis based on the history and findings to date. Identifies appropriate ‘symptom cluster’ with algorithm use.

Empowering- The doctor displays empowering behaviour by acting on cues/beliefs, involving the patient in decision-making. Use of self-help advice. responds appropriately to requests for information.

Management- The doctor streams/refers the patient appropriately (including ending the call with advice). Referrals are prioritised appropriately

(emergency/urgent/routine). Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified). Decisions are safe.

Prescribing- The doctor prescribes appropriately (or appropriately does not prescribe) following evidence base or recognised good practice. Generics used (unless inappropriate) and formula-based prescribing where possible.

Safety Netting- The doctor clearly states when to return or call back and gives clear safety netting instructions as to what to look out for if a patient doesn't get any better or gets worse and when to seek further medical help.

Rapport- The doctor demonstrates good listening skills, communicates effectively (includes use of English), conducts themselves in a professional manor.

Records- The notes are a well written, accurate reflection of the consultation.

Safeguarding- The doctor identifies any safeguarding concerns (or correctly excludes safeguarding concerns by asking the relevant questions) and acts appropriately by referring to the appropriate service.

Face to Face Audit Criteria

Confirm Identity- Only applicable for children and some adults, if the person giving the history is not the patient the doctor has recorded who the person is and in what capacity they know the patient (e.g. child is with mum, a support worker with a mental health patient, friend of the patient as the patient doesn't speak English, etc.) If it is an adult patient giving the history about themselves then score the doctor full marks for this.

Reason- The doctor clearly establishes the reason for the consultation (Presenting Complaint) and takes a detailed HPC (History of Presenting Compliant) including eliciting concerns or health beliefs that the patient (or carer) may have in relation to this.

Emergency- The doctor documents positive or negative answers to appropriate questions (History of Presenting Complaint) that have been asked to identify or exclude **'Red Flags'** and by doing so establishes if this is an emergency or serious situation. This may include questions regarding relevant Past Medical History, Medications, Allergies and Social History. If an emergency or serious situation is identified the doctor acts accordingly.

Past Medical History- The doctor documents a detailed Past Medical History

Medications- The doctor documents if the patient takes any regular (repeat) medications or documents that the patient doesn't take any regular medications. They also document if any medication has or has not been taken for this presenting complaint.

Allergies and Social History- The doctor documents if the patient has any known allergies to any medications and / or any relevant allergies to anything else. The doctor documents any relevant social history (e.g. immunisations for a child, smoking history for a respiratory complaint or travel history for diarrhoea).

Examination- The doctor records an appropriate and relevant examination of the patient including observations, positive or negative findings linked to the history, and whether a chaperone was offered for any intimate examinations. If an appropriate and relevant examination is not undertaken by the doctor the doctor must record a valid reason why.

Conclusion- The doctor constructs an appropriate diagnosis or differential diagnosis based on the history and examination findings. Identifies appropriate 'symptom cluster' with algorithm use.

Empowering- The doctor displays empowering behaviour by acting on cues/beliefs, involving the patient in decision-making. Use of self-help advice (including patient information leaflets). Responds appropriately to requests for information.

Management- The doctor streams/refers the patient appropriately (including ending the consultation with advice/treatment). Referrals are prioritised appropriately (emergency/urgent/routine). Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified). Decisions are safe.

Prescribing- The doctor prescribes appropriately (or appropriately does not prescribe) following evidence base or recognised good practice. Generics used (unless inappropriate) and formula-based prescribing where possible.

Safety Netting- The doctor clearly documents when to return or call back and gives clear safety netting instructions as to what to look out for if a patient does not get any better or gets worse and when to seek further medical help.

Records- The notes are well written and easy to follow.

Safeguarding- The doctor identifies any safeguarding concerns (or correctly excludes safeguarding concerns by asking the relevant questions) and acts appropriately by referring to the appropriate service.