# Fellowship Support Program

## Early Assessment of Safety and Learning Pack (EASL)

RACGP

# Introduction

The first two weeks are key to setting up the relationship between Registrars, their Supervisor and Practices. Registrars come from diverse backgrounds, and some may be unfamiliar with working in Australian general practice. If the registrar has already been working in a practice prior to FSP commencement, they may still benefit from revisiting practice systems and resources and considering how the FSP activities will be conducted in practice.

An early assessment for safety and learning (EASL) ensures that the supervision registrars receive is matched to their learning needs. Over the first two weeks of the program, registrars and supervisors must complete the following activities:

1. **This EASL pack**. This contains key documentation and guidelines on:

   a. In-practice Orientation

   b. Orientation checklist

   c. Call for help list.

   d. Clinical Supervision Plan

   e. Develop a Teaching Plan

   The registrar and supervisor need to go through this pack together and complete all the forms. Once complete, please upload a copy of this EASL Pack to the Documentation section of the registrar's FSP Portal.

2. **MCQ:** This is an online applied knowledge multiple-choice question (MCQ). The registrar will complete a questionnaire and the results will be available for the supervisor to review in the FSP portal, under the Documentation section. Registrars and supervisors are able to view these results.

3. **Clinical case analysis (CCA)** two cases to be uploaded by the registrar to the FSP Portal, that the supervisor will need to review and assess. They will appear under the Assessments and Forms section of the portal as CCA entries.

4. **Direct observations** of the registrar's consultations (four cases) as assessed by supervisor. The supervisor needs to assess four consultations in total and provide feedback via the FSP Portal (mini-CEX).

# The EASL – a practical approach

The EASL occurs in the first two weeks of the FSP. One (1) hour per day has been allocated for EASL activities. It is recommended that EASL activities be planned at the start of each day. An example approach is as follows:

| | |
|---|---|
| Day 1 | • Orientation, case review, observation of supervisor consulting. |
| Day 2 | • Review of call for help check-list, supervision approaches (when, who and how to call), case review. |
| Day 3 | • Direct Observation (Mini-CEx), case review |
| Day 4 | • CCA, case review |
| Day 5 | • Direct Observation (Mini-CEx), case review |
| Day 6 | • Direct Observation (Mini-CEx), case review |
| Day 7 | • CCA, case review |
| Day 8 | • Direct Observation (Mini-CEx), case review |
| Day 9 | • Review Learning Plan and MCQ, develop supervision and teaching plan, case review. |
| Day 10 | • Discuss EASL outcomes, case review |

# In-practice orientation

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 several 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. Coming from hospitals, they will need to learn about billing, prescribing, medical software, and referrals as examples. If the registrar has already been working in a practice prior to FSP commencement, they may still benefit from revisiting practice systems and resources and considering how the FSP activities will be conducted in practice.

Orientation for a Term 1 registrar should occur on program commencement, ideally on Day 1, and can be during time allocated for the Early Assessment of Safety and Learning (EASL), I.e., in consultation free time. After that, the supervisor will ideally be able to be observed by the registrar, observe the registrar, or review all registrar consultations for as long as needed to confirm the registrar's readiness to practice without routine review of every consultation.

A registrar in later terms will need a much less comprehensive orientation and will likely be allowed to commence practice without review of all consultations.

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 edit the document for their context.

Not everything can be covered initially, particularly if the registrar has not worked in general practice before – 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 while consulting. For example, chronic disease management MBS items, WorkCover, and advanced computer functions. Some may become the subject of dedicated teaching sessions.

The registrar will have an out-of-practice orientation at the start of the term. Topics at orientation sessions 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 in a new practice.

- 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, the supervisor should observe a number of these consultations. It is then recommended that all registrar consultations should be routinely reviewed until the supervisor is confident that their registrar is competent to manage patient care independently.

## Explaining how supervision and teaching will happen

The orientation of the registrar also involves giving clear information and discussing how supervision and teaching will happen.

This includes:

- Initial level of supervision
    - This could range from you sitting in with every consultation, to discussing every case before the patient leaves, to debriefing all patients seen at the end of the day, through to calling for help only when the registrar feels it is needed.
- How and when to ask for help during the day once routine review of all cases is not required
    - Who is available to be called? How and when do they want to be contacted.
    - Ideally the outcome of this discussion is documented in a supervision plan. A guide to developing a supervision plan that includes a template is available later in this pack.
- The arrangements for back-up supervision if the usual supervisor/s are non-contactable.
    - This includes after-hours back up
- Early discussion of learning needs and plan to address them

- Formal, scheduled teaching (if applicable) – 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.
- Opportunistic teaching from questions or cases
- How assessments will happen including direct observation and clinical case analysis
- Feedback – what it looks like and how it happens
    - Encourage the registrar to seek it. 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 *supervision plan* and *a teaching plan.*

# 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 | Primary 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 | |
| | 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 | |
| | **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 | |

| | | |
|---|---|---|
| | 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 | |
| | Co-consult - registrar does documentation in medical software, referrals and prescriptions, whilst supervisor conducts the consultation with patient. | |
| | Supervisor observes the registrar consult | |

# Call for help list.

## When should I call for help?

GP registrars are expected to seek help from their supervisor for patient's they are not competent or confident to manage alone. In your first term of general practice there will be a period where all registrar consultations are reviewed by a supervisor. Beyond this, it will be up to the registrar, with guidance from the supervisor, to determine when to call for help.

As each registrar has a unique training background and set of clinical experiences it isn't possible to create a standardised list of clinical situations when help should be sought by all registrars. Instead, an individualised plan is required for each registrar. This document is intended to guide a conversation between the registrar and supervisor about when supervision will be needed.

The 'call for help' list was developed through research with registrars and experienced supervisors and medical educators. Some of the problems on the list are present because a registrar is unlikely to have encountered them before. Other problems on the list are high-risk for all GPs and even an experienced GP might seek help from a colleague. Finally, some problems are on the list because, although a registrar may have encountered them during hospital training, management in general practice is different. For example, troponin levels are routinely used for chest pain presentations in hospital but are unlikely to be used in mainstream general practice.

Items may need to be added to the list because the registrar has identified an area where they will need help or because their practice may have a special interest or serve a particular patient demographic not covered in the list. The list doesn't include every clinical situation when help will be needed, and the registrar should feel free to call for any problem when they perceive they need assistance. Over time, the registrar will work with their supervisor to know which problems need to be discussed during a consultation and which can be left to discuss at a later opportunity.

In addition to the list of specific clinical problems to trigger a call for help there is also a list of 'uncertainty flags', a list of 'new and challenging consults', and a list of 'professional and legal scenarios' These lists should be self-explanatory.

## How to use this document

The registrar should read through and become familiar with the list of 'uncertainty flags.' These are broad markers of uncertainty that indicate the registrar should seek assistance. The 'new and challenging consults' and 'professional and legal scenarios' are specific circumstances where, particularly the first time they are encountered, and the supervisor is likely to want to be consulted.

The remaining items on the 'call for help' list are clinical problems. For each of the items on the list of clinical problems the registrar should complete an assessment of their confidence to manage the problem. The registrar should bring their completed list for use in a discussion with the supervisor about when they are likely to need to call for help.

Keep the list handy during the term. Some registrars who have felt reluctant to call for help have found it reassuring to see the breadth of circumstances where help is expected to be obtained.

### Uncertainty flags

- Considering sending patient to Emergency Department
- A patient you are unsure about sending home
- Third presentation for the same issue without a clear diagnosis or plan
- If you think you have made an error
- If you think there is going to be a complaint (disgruntled or dissatisfied patient or relative)
- When you are unsure who to refer to
- Abnormal Pathology or imaging results that you don't understand
- Prescribing medications you are unfamiliar with
- 'Heart sink' patients: i.e. patients you are finding overwhelming

- When a patient attend asking you for a ‘second opinion’

## New or challenging consultations

- Nursing home visits
- Home visits
- Issues of cultural safety particularly for an Aboriginal and/or Torres Strait Islander patient
- Procedures being done for the first time in the clinic (excisions, implants, joint injections)
- Making a new major diagnosis (cancer, diabetes, IHD) and starting management
- Breaking bad news to patient (cancer, HIV, adverse pregnancy outcome)
- Pre-operative assessment of fitness for anaesthetic

## Professional or legal

- Certifying competency to sign a will or other legal documents
- Workers' compensation consultations
- Driving assessment
- Consultations involving determining whether someone is a 'mature minor'
- Commencing a drug of dependence (S8) other than for palliative care
- Repeat drug of dependence (S8) prescriptions

Reference: Ingham G, Plastow K, Kippen R, White N. A 'call for help' list for Australian general practice registrars. Aust J Gen Pract. 2020;49(5):280-7.

# Call for help list

Practice name

Registrar name

Date of plan

Primary supervisor name

Stage of training

| Clinical Problem | Your confidence to manage independently in general practice | | |
|---|---|---|---|
| | Not at all | Somewhat | Confident |
| **Emergency medicine/Acute presentations** | | | |
| Acute significant systemic symptoms: collapse, rigors. | | | |
| Extreme abnormalities of vital signs | | | |
| Acute onset of shortness of breath | | | |
| Severe abdominal pain | | | |
| Chest pain | | | |
| Severe headache that is new or sudden onset or associated with vision change or meningism | | | |
| Concussion/post head trauma | | | |
| Trauma with high risk of injury e.g. high speed or rollover MVA | | | |
| Post collapse, possible seizure | | | |
| Acute eye - unilateral red, painful, vision loss, or periorbital swelling | | | |
| Sudden loss of hearing not due to wax | | | |
| Fracture | | | |
| Nerve, tendon or serious muscular injury | | | |
| Acute red swollen joint | | | |
| **Possible malignancy** | | | |
| New bowel symptoms in a patient over 50 years of age | | | |
| Painless haematuria | | | |
| Lymph node enlargement without simple explanation | | | |
| Unexplained weight loss | | | |
| PR bleeding | | | |
| Testicular lump | | | |

| Clinical Problem | Your confidence to manage independently in general practice | | |
|---|---|---|---|
| | Not at all | Somewhat | Confident |
| A new or enlarging lump | | | |
| Iron deficiency | | | |
| Skin lesions you are unsure of diagnosis and whether to excise | | | |
| Breast lump | | | |
| Persistent cough | | | |
| **Mental health** | | | |
| Acutely suicidal patient | | | |
| Acute psychosis | | | |
| **Paediatrics** | | | |
| All neonates | | | |
| 6-week baby check | | | |
| Australian immunisation schedule immunisations (including catch ups) | | | |
| Unwell child under 2 years of age | | | |
| Failure to thrive under 12 months of age | | | |
| Developmental delay | | | |
| Child and adolescent mental health consultations | | | |
| Child abuse or unexplained injury | | | |
| Eating disorder | | | |
| **Women's health** | | | |
| Antenatal consultations | | | |
| Irregular vaginal bleeding | | | |
| Post-menopausal bleeding | | | |
| Postnatal depression | | | |
| Cervical screening | | | |
| **Aged and palliative care** | | | |
| Dementia or delirium (acute cognitive decline) | | | |
| Deciding whether to start or stop anticoagulation in elderly | | | |
| Palliative care | | | |
| Elderly patient not coping at home | | | |
| Elderly patient with multi-morbidity recently discharged from hospital | | | |
| **General medicine** | | | |
| Poorly controlled diabetes | | | |
| Pyrexia of unknown origin | | | |
| New neurological symptoms or signs | | | |

| Clinical Problem | Your confidence to manage independently in general practice | | |
|---|---|---|---|
| | Not at all | Somewhat | Confident |
| Severe exacerbation of asthma or COPD | | | |
| Rash you are unfamiliar with | | | |
| Domestic (intimate partner) violence | | | |
| **Dependence/Addiction/Pain management** | | | |
| Chronic pain management | | | |
| Managing alcohol/drug dependence | | | |
| **Sexual health** | | | |
| Patient requesting STI screen | | | |
| Travel Medicine | | | |
| Pre-travel consultations | | | |
| Unwell returned travellers or international visitors | | | |

# Clinical Supervision Plan

## Introduction

Ensuring quality care and safety for the registrar's patients is primarily the responsibility of the training practice. The practice is also responsible for the registrar's safety as they consult. The RACGP vocational training standards require the level of registrar supervision to be matched to the registrar's level of competence. A clinical supervision plan describes how your practice intends to achieve this. It is an important document for the registrar, and for all members of your practice supervision team.

A new clinical supervision plan needs to be developed for every registrar term as registrar competencies are different for each registrar, registrar competency changes over time, and practice circumstances may change from term to term.

A clinical supervision plan addresses three things: 1) when to call for help; 2) who to call for help; and, 3) how to call for help. In this document we will outline the issues to consider in addressing each of these and recommend how the plan should be reviewed. We then provide a template for you to complete with your registrar.

## When to call for help

Until you are aware of your registrar's abilities and are confident that they will call for help when they should, it is likely that all their consultations will need review. You may achieve this by any of the following means: sitting-in and observing while they are consulting; reviewing each registrar consultation at its completion in person or by phone before the patient leaves; or scheduling time to discuss and review all of the consultations at the end of the session or day.

Once you are confident that routine review of all consultations is no longer necessary some guidance will need to be given to your registrar about when a call for supervision is required. To help inform this discussion your registrar has been provided with the 'call for help' list – a document that lists problems that registrars and supervisors have considered likely to warrant a call for help. Your registrar should complete a self-assessment of their confidence to manage the clinical problems on the list. This self-assessment, combined with any other available assessments and your knowledge of your registrar's previous experience should inform a conversation about when they should call for help.

You may wish to continue to use the 'call for help' list as a checklist, ticking off each scenario as you determine it can be safely managed, but the expectation is that most practices will just use the list as a 'conversation starter.'

## Who to call for help

A registrar must know who to call for help. There is not one correct way of allocating responsibility for supervision. Some practices have the registrar always calling the same supervisor, others operate on a supervisory on-call roster. Some practices identify doctors to be called for specific clinical problems (skin expert, women's health etc). Whatever method is chosen, it should be documented and clearly communicated to everyone involved.

Once there is no longer review of every consultation, the most crucial factor for effective supervision is that the supervisor is 'approachable and available.' It is important that the supervisor of first contact allows time in their appointment schedule for the predictable interruptions, particularly early in the placement. A backup plan needs to be recorded for when the first-call supervisor is unable to assist or unable to assist immediately. This avoids jeopardizing patient safety when a registrar cannot obtain the help they need and ensures efficient operation of your practice.

## How to call for help

How to call for help will also differ between practices, so, needs to be documented for your practice. Most supervisors will prefer a phone call, but others will use instant messaging systems or a knock on the door.

Your registrar may need some guidance about how to explain their call for help to their patient. As we don't want to requesting a 'second opinion.'

It is also worth spending some time educating your registrar about how you would like requests for help to be communicated to you. For example, you may instruct your registrar to first identify whether they are going to need advice without you seeing the patient or if they need you to come into their room, and the degree of urgency involved. Once this is established the next steps can be negotiated.

## Reviewing the clinical supervision plan

It is important to regularly review the clinical supervision plan. It will likely need to change as your registrar progresses through the term or if practice circumstances change. It is also important that you periodically audit a sample of the registrar's records to detect if a registrar is failing to call you when they should. This can occur for several reasons including:

- a registrar embarrassed to reveal what they do not know
- a registrar feeling their interruption would be unwelcome or a major inconvenience
- a registrar perceiving that the supervisor does not have the required expertise
- a registrar not recognising when they needed help. The so-called 'unknown unknowns' we all have.

The most used strategy for auditing registrar consultations is Random Chart Audit which involves reviewing with the registrar a sample of recent records and is usually conducted during a scheduled teaching session. Alternative options to chart audit include reviews of specialist referrals or an 'inbox audit' of pathology and imaging results. Both these strategies may detect circumstances where a registrar inappropriately referred rather than seeking help from their supervisor.

# Clinical supervision plan

*A supervisor should complete this document with their registrar following the orientation period in each term. The supervisor first needs to be satisfied that the registrar does not require review of all of their consultations. The plan will need reviewing and revising as the registrar progresses.*

Registrar name

Date of plan

Primary supervisor name

Stage of training

Other members of the supervisory team

| | Name | Role |
|---|---|---|
| Other accredited supervisors | | |
| Allied health staff | | |
| Admin and reception staff | | |

## When is the registrar expected to call for help?

Document the particular presentations or circumstances when you expect the registrar to call for help. Are there situations where help can be sought at the end of the session rather than at the time of the consultation? The registrar should be encouraged to call for help whenever they feel unable to adequately meet the patient's need.

## Who is to be called for help?

Record the current arrangements for who the registrar should call during each session and document what should happen when the first-call doctor is not available. This may include arrangements for after-hours and hospital on-call back up. If there are multiple supervisors, you may wish to use a supervision roster, like the example below.

## Supervision roster

| Days | AM | PM | After hours |
|---|---|---|---|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

## How should a call for help be made?

Via phone, knock on door, IT messaging? Consider how will it be explained to the patient and how the request for help should be articulated.

# In-practice teaching and teaching plan

## Teaching time

The registrar's primary supervisor is responsible for ensuring that the registrar receives their mandated minimum teaching time, whether from them or another member of the supervisory team.

Teaching time includes both formal and informal teaching activities, and the amount of time required depends on the registrar's stage of training.

### Minimum teaching times for each full-time registrar

| GP term | Included scheduled and uninterrupted time |
|---|---|
| **GPT1/GPT2** | 1 hour per fortnight or 30 minutes/week |
| **GPT3/GPT4** | 1 hour per month |

For part-time registrars, the expected teaching times are the same as for full-time registrars.

# Scheduled and uninterrupted formal teaching sessions

Most of the scheduled sessions should be one-on-one teaching that addresses your registrar's individual learning needs, for example, observation of consultations, review of medical records, feedback, assessment, and critical incident review.

Teaching sessions should ideally be scheduled in the first hour of a consulting session or before consulting starts in the morning. Scheduling teaching sessions at lunchtime or at the end of the day is not ideal as these times are prone to interruptions or participants running late.

Not all scheduled teaching sessions need to be delivered by the supervisor. For example, a registrar with learning needs in the initial management of diabetes might sit in with a diabetes educator for an initial consultation with a patient recently diagnosed with diabetes.

How each training site coordinates the provision of teaching will reflect the number and type of learners and educators at the site. A teaching plan includes: a calendar of scheduled teaching activities; required assessment activities, and activities planned to address an identified learning need. It also provides the means to record completed teaching activities.

# In-practice teaching activities

General practice training in Australia follows an apprenticeship model with a registrar learning 'on the job'. In this context, a supervisor's prime teaching role is to enhance and deepen the learning that occurs through clinical work.

The teaching you provide will be mainly directed by the individual learning needs of your registrar.

The following teaching methods are used to enhance workplace-based learning.

### Direct observation

There is no better way for you to teach consultation and communication skills than by directly observing their interactions with patients. Direct observation, or 'sitting in', is known to be acceptable to the patient, as well as highly regarded as a learning experience by learners. Sitting in on consultations early and often in the training term is strongly encouraged.

### Problem case discussion

This teaching method tends to be the predominant method used, especially early in general practice training. Your registrar brings a 'problem case' to discuss with you. This provides an opportunity to teach core knowledge, as well as to improve clinical reasoning skills and management of uncertainty.

### Random case analysis

In random case analysis (RCA), a supervisor selects a recent registrar record for discussion. Unlike problem case discussion, where the registrar chooses a patient to discuss, a 'random' selection method allows identification and exploration of areas in which the registrar either doesn't recognise they have a clinical knowledge gap ('unconscious incompetence') or doesn't wish to reveal ('conscious incompetence') they have a knowledge gap. As a result, RCA has educational utility for all stages of learners, and across all levels of competence. Although RCA can be used to explore all domains of general practice, it is a particularly effective method for exploring a registrar's clinical reasoning and record-keeping skills.

### Inbox review

Reviewing test results by going through a registrar's email inbox is an effective way of monitoring rational test ordering and provides a lead-in to a broader case discussion. Inbox review is valuable for exploring how a registrar is managing uncertainty and their understanding of the appropriate use of screening tests.

### Teaching topics

There is no requirement to provide specific topic tutorials as part of in-practice teaching. However, if it meets the registrar's learning needs, discussion of a topic may be appropriate. There are many helpful resources for teaching a topic, including:

- the 2022 RACGP curriculum and syllabus for Australian general practice that is designed for use by registrars and educators and can be a useful resource for a supervisor's teaching. It supports your role as a 'meaning maker' – helping with the application of knowledge rather than being a transmitter of knowledge. There are 42 units covering important general practice clinical presentations and patient populations. Each one includes a case consultation example and learning strategies that are specifically designed for use with supervisors. None of these are mandatory to use in practice but may complement the registrar's work-based learning. A suggested order for covering the syllabus is included in the education calendar however the units can be covered as determined by the registrar's learning needs.
- GPSA has teaching plans that cover a wide range of clinical presentations.

Registrars are also provided with out-of-practice educational activities during their training. Being aware of the content of these activities may help inform the in-practice teaching plan.

## Informal teaching activities

Educational supervision (i.e., in-practice teaching sessions) can also include:

- orientation to the practice
- opportunistic and planned case discussions during and at the end of the day
- group teaching sessions with other registrars and students
- procedural skills education
- cultural education
- provision of feedback
- completion of assessments
- evaluation of teaching.

# Teaching plan

This document is for use between the primary supervisor and the registrar. It should be made available to all members of the supervision team. The teaching plan is completed by the primary supervisory and documents when teaching will occur and any intended activities during the teaching session. It is not the same as a learning plan which might be completed by a registrar to record their learning needs and how they plan to address these. The registrar should complete their learning plan in the FSP portal.

Dedicated teaching time should be scheduled for a time that is not likely to be interrupted or subject to the participants running late. Try to avoid lunchtimes and end of the day. First thing in the morning or the start of a session will work better.

| Practice name | Registrar name | Primary supervisor |
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## Teaching session schedule

When and where is the dedicated teaching time routinely scheduled, and who will be delivering this teaching.

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Practices, particularly those with multiple supervisors, may find it useful to keep a calendar or chart to display activities each week. This will also act as a prompt to plan at least a week ahead. Required assessment activities can be scheduled well ahead of time. Either use the document below or create your own in-practice teaching plan document.

## Teaching activity schedule

| Week | Date | Time | Activity/content | By whom |
|---|---|---|---|---|
| 1 | | | *E.g. Orientation plan*<br>*Consultation observation for early safety assessment* | |
| 2 | | | E.g. Finalise Early Assessment of Safety and Learning | |
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| 26 | | | *E.g. End of term assessment* | |