

# Appendix 4

## B E A C H - BETTERING THE EVALUATION AND CARE OF HEALTH

### NATIONAL MORBIDITY AND TREATMENT STUDY

#### INSTRUCTIONS FOR PARTICIPATING DOCTORS

In your research pack there are three copies of a laminated notice which informs the patients of the study and of their right to refuse to allow inclusion of their unidentified data. Could you ask your reception staff to ensure your patients read the notice. If you have patients who consult with you in another language, please make them aware of their options regarding the study. In the case of indirect encounters, home visits and palliative care, please use your professional discretion in this matter.

Reading these instructions will decrease the variation among practitioners in their recording techniques. The recording forms should be completed during the course of the consultation as it will result in a better description of your activity and there is also some information that needs to be asked of the patient. Patient information questions at the bottom of the form vary and are presented in blocks within the pad, so please read carefully the instructions relating to these questions.

Fill out one form for each of 102 consecutive encounters including both direct (face-to-face) or indirect consultations which result in an action. The recording pad contains 105 forms to allow for recording errors. If a form becomes illegible draw a line through it and continue with the next sheet.

#### **RECORDING FORM ITEMS:**

**DOCID:** Each form has been stamped with your identification number for the purpose of this study. This is only used to keep track of the records in a de-identified manner and to ensure you receive an analysis of your results.

**ENCOUNTER NUMBER:** Each form in your recording pad has already been stamped with a consecutive encounter number 001-105. This is not a patient identification number, so if you see the same patient twice or more during the recording period, you will complete a new form at each of the encounters. No linking of forms is required. The audit is encounter-based, not patient-based.

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#### **ENCOUNTER INFORMATION**

**DATE:** Enter day, month and year of encounter. **BIRTH:** Enter day, month and year of patient's birth. When a patient was born in the 19th century, please specify. **SEX:** Tick box for sex of patient.

**PATIENT STATUS:** If this is the patient's first visit to your practice, tick the NEW box. If the patient has been seen previously at this practice by you or one of your associates tick the OLD box.

**PATIENT POSTCODE:** Enter postcode of patient's home address.

**VETERANS' AFFAIRS:** Tick box for Gold Card status (all illnesses covered) of the patient or White Card status (partial cover) if applicable, irrespective of the source of payment for this consultation.

**HCC STATUS:** If the patient is a Health Care Card holder eg unemployed or pensioner, then tick Yes, otherwise tick No. It is possible for a patient to hold both Veterans' and HCC cards.

NESB: Does the patient come from a Non-English Speaking Background (NESB) i.e. is the primary language spoken at home not English?; or does the patient identify themselves as an Aboriginal or as a Torres Strait Islander? Tick the appropriate boxes.

PATIENT SEEN: These are direct encounters which occur either in the surgery, at home, in a hospital or nursing home. Write Medicare item number or tick the appropriate box for encounters covered by Hospital, State paid, Workers Compensation or those that are not charged. Where there are multiple item numbers involved, record the consultation item, eg 23, as procedures and tests are recorded elsewhere on the form.

PATIENT NOT SEEN: For indirect encounters where the patient is not seen (e.g. telephone consult) but some action is generated (script, referral etc), tick the appropriate boxes. Multiple responses are allowed.

PATIENT REASON FOR ENCOUNTER: At least one and up to three patient reasons for the encounter taking place can be recorded. They are the patient's view of the reasons he/she is consulting you. They can be in terms of symptoms e.g. "*runny nose*", a diagnosis e.g. "*diabetes*", request for service e.g. "*script for BP*", "*referral*". "*Worried about...*", "*follow-up*", "*check-up circulatory*" and "*pap smear*" are more examples of the many possible reasons for the encounter. If the body system is not stated by the patient but is understood between you, please record it.

#### PROBLEM MANAGEMENT INFORMATION

DIAGNOSIS/PROBLEM: At least one and up to four problems can be recorded. For each problem you manage, details are recorded on the problem's status, medications ordered, procedures/other treatment/ counselling carried out and referrals made. In each box, record one diagnosis/problem actually dealt with at that encounter, including ill-defined conditions (e.g. "*cough*"), preventive care (e.g. "*papsmear*" or "*checkup*"), and social problems (e.g. "problems with spouse"). Diagnose at the highest level possible with the information available. The order in which you record the problems is not significant. If there are more than four problems managed at the consultation, record the four problems which best describe the breadth of the consultation.

For each problem:

WORK RELATED: Irrespective of the source of payment for the consultation, if it is likely in your view that the symptom or problem has resulted from work-related activity or workplace exposures, tick the box. Where there is uncertainty but it is more likely than not that the condition is work-related, then the box should be ticked. If there is a pre-existing condition which is thought to have been significantly exacerbated by work activity or workplace exposures, the box should be ticked.

PROBLEM STATUS: Tick NEW if the patient has not been treated for that problem by any medical practitioner before. Tick OLD if the patient has been seen before by ANY medical practitioner for this chronic problem or this episode of an acute problem.

Management:

MEDICATIONS: Record any medication for which a prescription is written at this encounter, or any medication that you administer or recommend the patient to buy "over the counter" (OTC).

For written prescriptions: the **strength** is the quantity and unit of measure, e.g. 100 mg. If the Strength is difficult to measure, as in the case of topical skin creams, leave the Strength box blank. The **regimen** can be recorded in the accepted abbreviations of "bds", "tds", etc. If the drug is to be taken "as required", write PRN. **RPTS:** number of repeats should be recorded. If a medication is an advised OTC then tick the corresponding OTC box otherwise leave blank,

**GP SUPPLY:** tick box if medication is from the practice supplies eg drug sample or vaccine from refrigerator. Otherwise, leave blank.

**DRUG STATUS:** if the medication is being used for the management of this problem for the first time then tick the **NEW** box, otherwise if it is a continuation, or repeat, of previous therapy for this problem then tick the **CONT.** box.

**PROCEDURES, OTHER TREATMENTS, COUNSELLING ETC.:** Record up to two procedures, other treatments or counselling for each problem or leave blank if none was provided.

**NEW REFERRALS/ADMISSIONS:** If a new referral to a specialist or allied health professional is made or a hospital admission arranged for this problem, please specify, eg: dermatologist or hospital emergency etc. Multiple responses are possible.

**TESTS ORDERED/UNDERTAKEN: Pathology:** Please give details of any pathology tests ordered or undertaken and circle the associated problem number(s) next to them. If it is just a single test, write the test name (e.g. *HBA1C*, *pap smear*). If ordering a set of tests such as a FBC, LFT, lipids, thyroid function, record them in this grouped form. You don't need to list each of the individual tests incorporated in (e.g.) LFT. **Imaging:** If any imaging is ordered, specify the **Body site** under the applicable category (e.g. *X-ray chest*, *CT head*). Lateralization is not required. Circle associated problem number(s).

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