Prepare for Part D (Medical Records) Practice Assessment Exit Exam

7 March 2025

In the following pages:

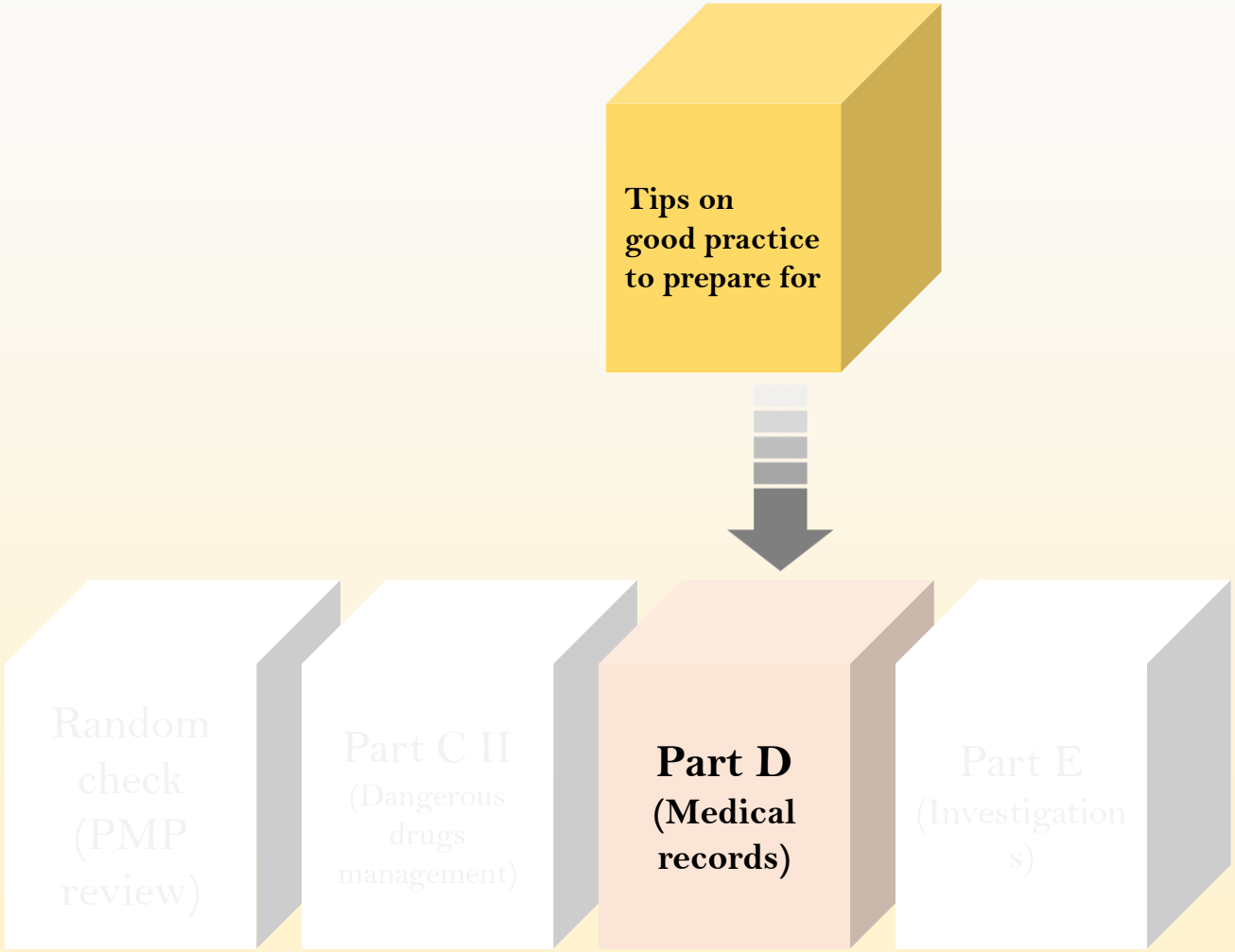
Candidate needs to prepare

Tips on good practice for Candidate

Examiner will assess

Consensus / recommendation in marking

Today


Tips on good practice to prepare for
Random check (PMP review)
Part C II (Dangerous drugs management)
Part D (Medical records)
Part E (Investigations)

The format of Part D , PA is under review

The assessment method of ‘Basic Information’ is under review.

The cases collection requirement of ‘Consultation Notes’ is under review.

More update on the requirements on Part D (Medical Records) will be available in the next workshop: Preparatory Workshop in April 2025 (tentative)

The medical records required for Part D (i)

The content of each medical record should include:

i. Basic information

ii. Consultation notes

The medical records required for Part D (ii)

Documentation of basic information

- Familiarize and able to explain to others on **your clinic's system** (Computer / paper-based)

Basic information

On following areas

as appropriate and as applicable

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

The medical records required for Part D (iii)

Basic Information: use of templates

e.g. BP/P, Weight / Height / BMI may be in the consultation records

The format

- Not compulsory to have all the basic information on a single electronic / paper template
- Recommend to use the usual electronic / paper medical record system at the Candidate's clinic
- NOT RECOMMEND to create a distinct template for the sake of fulfilling all the listed items of the rating form

e.g. if the electronic medical record system cannot support diagram use / generate genogram, then no genogram is acceptable

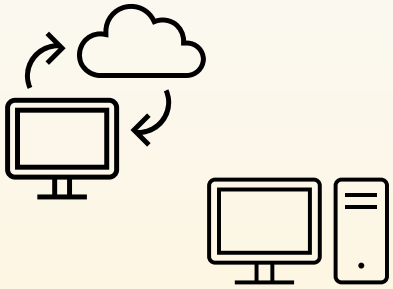
The content

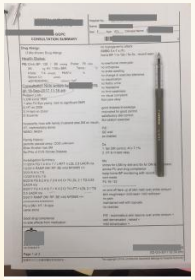
- As appropriate and as applicable
- Not mandatory to have full documentation on all the areas / fill in all the blanks on the template in every medical record
- Should have significant 'negatives' e.g. Allergy: nil known
- Inappropriate 'blanks' on the template/ table may be regard as missing information

The medical records required for Part D (iv)

Consultation Notes required for PA Part D: **paper based**

Your Clinic's Medical Record system





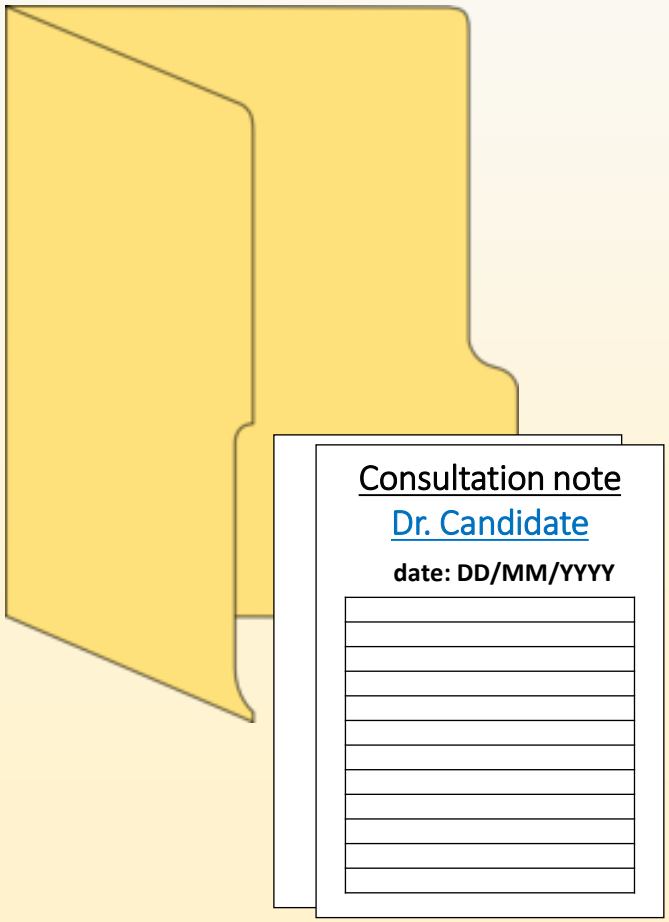
Print-out

Consultation notes

Handwritten records

Readily available upon Exit Examiners' request

The medical records required for Part D (v)



Consultation notes

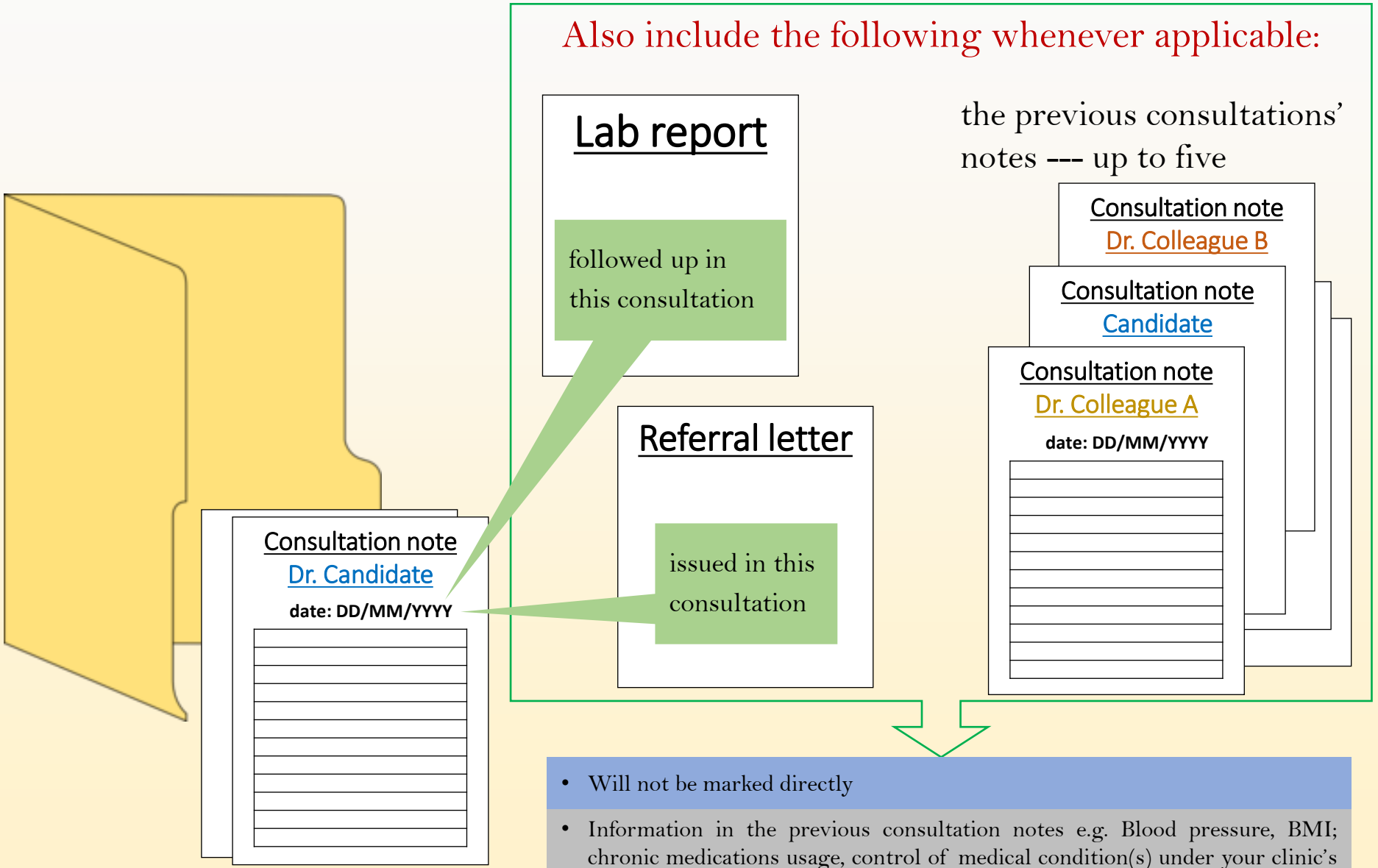
On following areas

as appropriate and as applicable

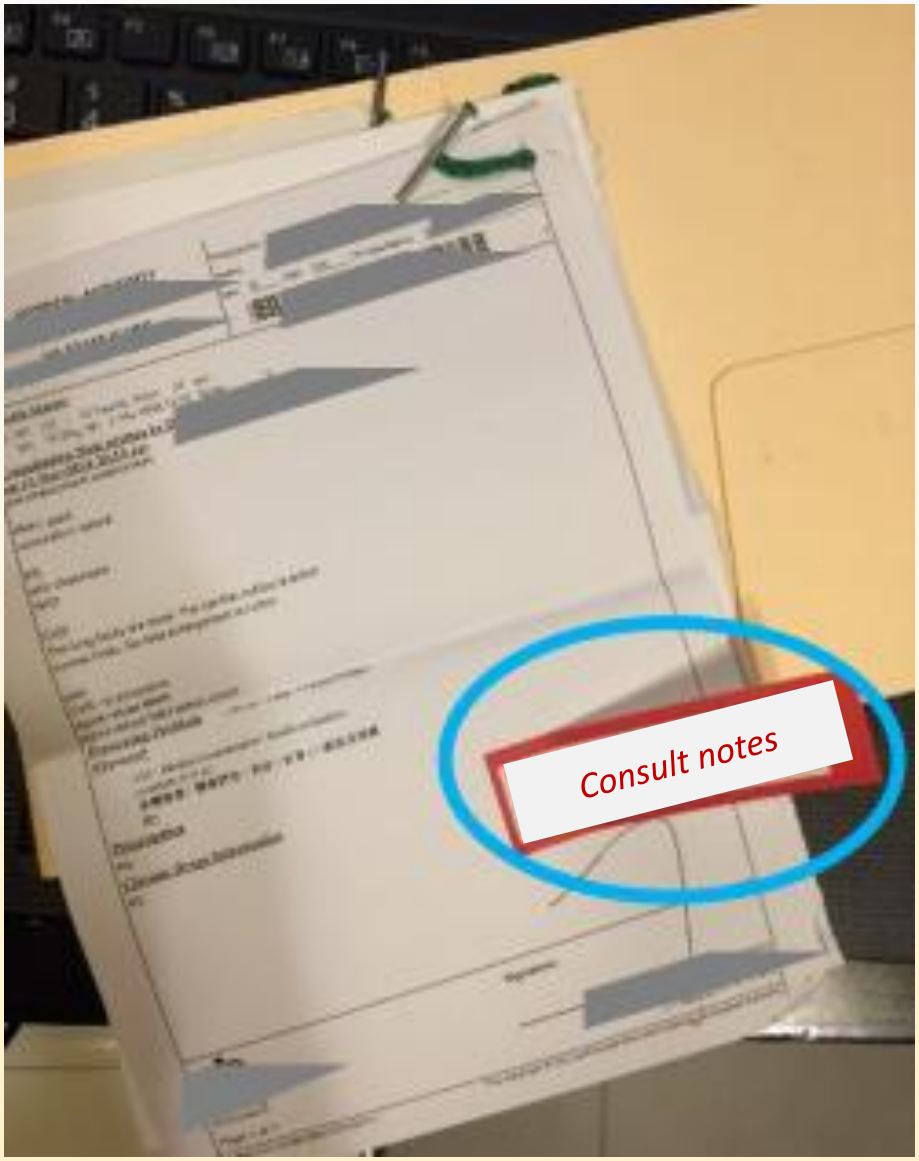
- Main reason(s) of consultation
- Clinical findings
- Diagnosis / working diagnosis
- Management
- Anticipatory care advice

Please note:
- **As appropriate and as applicable**
- **Not mandatory in every consultation**

The medical records required for Part D (vi)



The medical records required for Part D (vii)

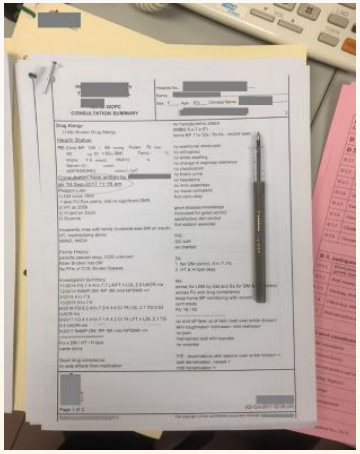


You can use paper flags so that the Examiners can easily identify the notes to be marked in PA

Areas to be assessed

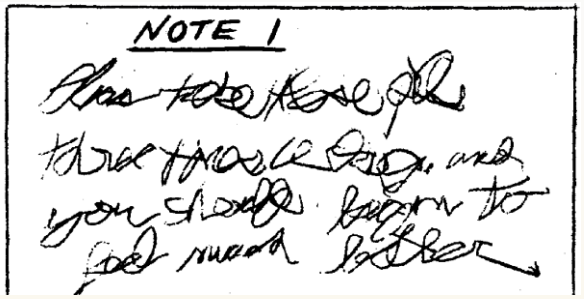
- Legibility
- Basic information
- Consultation notes

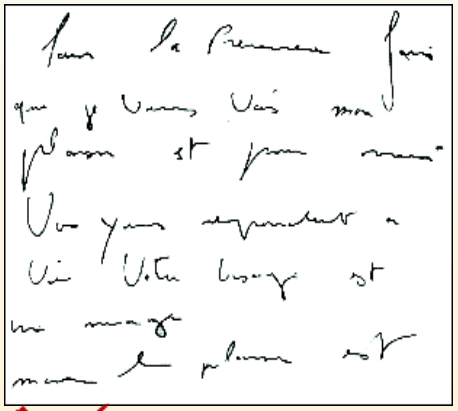
Legibility



C/O:
RN 3/7
ST
Not much cough
No fever
……
P/E:
GC sat
Normal hydration
ENT: red throat, no pus
Chest clear, AE good bilat.
….;

legible→
Assessor proceed to mark the record





Illegible →
the whole case will not be marked

Legibility

AR
Allergic Rhinitis?
Aortic Regurgitation?

PHx
Past history?
Present history?

Use abbreviations sensibly

- Understood by local primary care doctor
- Avoid those easily causing confusion
- Can prepare a 'reference list of abbreviations' for Assessor
- On the other hand, unnecessary to convert all commonly used abbreviations to full forms; e.g.
  - Hx → History
  - C/O → Complaint of
  - P/E → Physical Examination
  - Ix → Investigation
  - CT → computerized tomography
  - US / USG → ultrasound scan / ultrasonogram
  - DEXA / DXA → dual-energy x-ray absorptiometry
  - Urine R/M …
  - LUTS …
  - BPH …

Basic information

The assessment method of 'Basic Information' is under review
More update on the requirements on Part D will be available in the next workshop: Preparatory Workshop in April 2025 (tentative)

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

refers to the regular medications from the Candidate's clinic

Genogram: not mandatory in every case

Consultation notes

'Long consultation notes'

- Keep the consultation notes at appropriate length and easy to read
  - Clauses , short sentences , appropriate abbreviations
  - Appropriate spacings between clusters of information
  - Not necessary for using full sentences, full paragraphs

- Lengthy consultation notes in Part D, E:
  - The highest mark will be 'just pass' only in the respective sections (D3, E2, E4).
  - They are at risk of falling into 'fail' (e.g. 6 or below) if the content has discrepant, inaccurate information.

Consultation notes

Main reason(s) of consultation

- State **clearly in the initial part** of the consultation notes; e.g.
  - *FU DM, HT, hypothyroidism*
  - *C/O: runny nose 2/7*
- **Avoid preceded by irrelevant past information**; **the main reason(s) of the consultation** may sink into the paragraphs of notes causing confusion / misunderstanding
- Keep any **'introductory information'** e.g. significant past / current medical information **concise and relevant**

Consultation notes

Clinical findings

- **Group the findings** under headings e.g. history, physical exam, diagnosis / impression, management, anticipatory care (AA) etc.

C/O
Runny nose 1/7
Watery,
Mild ST,
Not much cough
No fever
TOCC –ve
…….
PE:
GC sat
Temp: ….
Hydration N
…….
Mx:
…….

FU DM , HT
Good compliance to Rx
Tolerated
No hypoglycemia
Diet: usual care; but avoiding sweety fatty foods
Ex: nil regularly
…….
PE:
GC sat
BP
Hstix 2hr pp …….
Mx:
… …. …
AA:
Discussed DEXA , patient not keen at present
…..

Consultation notes

Clinical findings

- Unnecessary to document everything
- Record **relevant positive** findings
  - Adequate positive findings that connecting the reason(s) of consultation to the diagnosis / working diagnosis
  - Explicit documentation is unnecessary
  - Likely will FAIL if the documentation consist of a comprehensive functional inquiry
- Record **significant negative** findings
  - Red flags 
  - Likely will FAIL if the documentation consist of a long chain of negative findings

- **Pediatric developmental documentation:**
  - Developmental milestones documentation in consultation notes is not necessary, especially in straightforward / simple cases e.g. URTI.
  - Instead, documentation on the kids' activities of daily living, social interactions (with parents / other kids / school) are more appropriate.

Consultation notes

Clinical findings

- **Follow up significant issue(s) raised in previous visits as appropriate**
  e.g. overweight, smoking, elevated blood pressure

- **ICE** (idea / concern / expectation) ,
  Elaborated psycho-social history:
  - may not be necessary in straightforward episodic physical / chronic follow up cases
  - important in certain situations e.g.
    - Psychological condition; e.g. insomnia, depression follow up
    - Diagnostic or management challenge e.g.
      - occurrence of a potentially sinister condition (e.g. suspected malignancy)
      - suboptimal chronic disease control
      - distressed patient / relatives
    - Volunteered by the patient / relatives

Consultation notes

Diagnosis / working diagnosis

- **Stated** in the consultation note

- For straightforward episodic / regular follow up cases: state the diagnosis usually sufficient
- Status of control in chronic disease e.g.
  - *HT, stable*
  - *DM suboptimal control*
  - *lipids on statin, at target (< 2.6)*
- 'Triple diagnosis': psycho-social status as appropriate; e.g.
  - *Dementia, care-taker (wife) stress*
  - *Depression, recently employed*
- In case cannot arrive at a diagnosis, give differential diagnoses (ddx) / working diagnosis / clinical impression:
  - *Dizziness; ddx: BPPV, vestibulitis*
  - *Weight loss: bowel pathology?, hyperthyroid*
  - *LUTS: BPH, Co-existing UTI?*

Exhaustive list of ddxs is not necessary

Consultation notes

Management

- Drug use or/ and non-pharmacological measures:
- Injudicious use of drugs e.g. inappropriate use of steroids, hypnotics, will be penalized

RAPRIOP

- Unnecessary to document full RAPRIOP in simple or uncomplicated cases

If follow up is required:

- 'Planned': the interval should be appropriate to the nature of problem(s) to be reviewed
- 'FU p.r.n.', 'open FU': give appropriate safety net advice e.g.

  seek medical attention if

  the tongue ulcer not improve in the next 2 weeks

  rash / vesicles occur on the painful area

Consultation notes

Management

Referral

- Keep the referral letter concise; avoid just copy and paste the whole consultation notes
- If the referral is considered high priority / urgent basis, consider:
  - Safety net advice such as *contact clinic if no Breast Clinic appt. within 2 weeks*
  - contact the patient to confirm a timely appointment is given

- **Arranging follow up of patients who were just referred to specialist for suspected malignancy:**
  - If appropriate safety net advice was given at the time of referral, open follow up or prn FU is appropriate.
  - Routine follow up to review the specialist's appointment or the patient's condition: mostly unnecessary, not a good standard to pursuit

Consultation notes

Anticipatory care advice

- Anticipatory care advice (AA) is contemplated in:
  - straightforward episodic encounter,
  - stable regular follow up chronic medical condition
- AA may not be essential in certain situations, e.g. prolonged consultations due to
  - Patient raised multiple issues
  - Presence of sophisticated psycho-social issues
  - Diagnostic difficulties
  - Management difficulties
- One AA advice in one consultation should be sufficient
- Age and gender appropriate
- Document patient's response to the AA, e.g.
  - *Discussed bone density & DEXA; patient not keen, cost concern*
  - *Flu-shot today at clinic*
  - *PAP smear: due next year in FPA*

Examiner marks all the eligible medical records;

Then give a global mark

- Comprehensiveness: unnecessary for “Pass”
- No major omission e.g. on red flags
- Can have tolerable omissions e.g. on some symptoms or signs; certain ddx or Mx actions
- A bit over-documented or a bit lengthy can be tolerated

Part D (Medical Records)

D3. Consultation notes score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details, with a relevant past medical / social history of an appropriate length**
8	
7.5	**Accurate and legible with sufficient details, with a relevant past medical / social history**
7	
6.5	**Accurate and legible with adequate information for realizing the whole consultations without major omissions**
6	
5.5	**Legible for the consultations but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded**
4	

Some observations, comments and recommendations from previous PA (Part D Medical Records)

Overall performance on D2 (Basic information): area(s) need attention / improvement
• Insufficient positive / significant negative information
• Inaccurate / inconsistent with other part(s) of the record
• Information not updated
• Documentation: length not appropriate OR unclear
• Others:

Overall performance on D3 (Consultation notes): area(s) need attention / improvement
• Main reason(s) of consultation unclear
• Insufficient documentation of clinical findings
• Diagnosis/ Working diagnosis unclear
• Suboptimal management
• Lack of / inappropriate anticipatory care advice
• Documentation: length not appropriate OR unclear
• Others:

Part D (Medical Records)
General

issue noted:	Comments / recommendations
Submitted duplicate cases in the case-log	• To be avoided • In Exit Exam: risk of penalty & disqualifications

Part D (Medical Records)
Documentation: length not appropriate OR unclear

issue noted:	Comments / recommendations
Long consultation notes, even simple URTI , document almost each wording or standard wording from textbook, which is not necessary	
Annual blood result documentation only need the most updated one, candidate also put down those few years ago.	

Part D (Medical Records), D2 (Basic Information)
Insufficient positive / signifiant negative information

issue noted:	Comments / recommendations
"Other allergy" section left blank on the basic information templates	• Enter 'nil' , 'nil known'
Genogram: there was no age and health information for those alive; although age and cause of death of the deceased family members are recorded	• In case of time constraint, focus on information of closely blood-related, spouse, living together (i.e. members surrounding the patient). Put down the significant positives, 'in good health', etc.
No immunization record for child cases	

Part D (Medical Records), D2 (Basic Information)
Inaccurate / inconsistent with other part(s) of the record

issue noted:	Comments / recommendations
Housewife; given sick leave for IOD	
Notes mentioned that patient lives with husband, but marital status being 'unknown' in the basic information of the record	
In the basic information: ' X ' for contraception on one page, but mentioned condom on another page.	

Part D (Medical Records), D2 (Basic Information)
Information not updated

issue noted:	Comments / recommendations
Wife passed away → reason?	
Mother passed away → reason?	

Part D (Medical Records), D3 (Consultation notes)
Main reason(s) of consultation unclear

issue noted:	Comments / recommendations

Part D (Medical Records), D3 (Consultation notes)
Insufficient documentation of clinical findings

issue noted:	Comments / recommendations
ENT referral made; but not a single word on ENT symptoms found in the record	
Topical urea cream prescribed; indication not found in record	
Patient has ECG; routine care? or ordered for any symptoms? Not documented in history and the referral letter.	
eGFR is more relevant thant Creatinine level in monitoring of renal function	
ddx costochondritis but not mentioned any local chest tenderness	
ddx anorexia nervosa but no related symptoms documented	

Part D (Medical Records), D3 (Consultation notes)
Insufficient documentation of clinical findings

issue noted:	Comments / recommendations
Dizziness for 3 month on and off, genogram: husband mental health issues; 2 children need to take care of. Need to explore psychological aspect	
Dx cataract but visual blurring last 10 mins each time, not typical symptoms of cataract. Other causes e.g. dry eyes? Can test red reflex in PE	
Known depression FU PSY. Dx acute stress disorder without any traumatic event encountered. Did not assess suicidal risk.	
Hx of fever / stomach pain → Dx mesenteric adenitis. Location of pain not typical. The Dx can only be made after imaging	

Part D (Medical Records), D3 (Consultation notes)
Diagnosis/ Working diagnosis unclear

issue noted:	Comments / recommendations
• Case A - Syncope 2nd time with few months should need further work up rather than just treatment GI symptoms. DDx may include TIA epilepsy • Case B – sub-mandibular mass may need further work up. e.g. sputum culture, imaging • Overall impression: little attempt to arrive provision dx / ddx; problems are then mostly referred out. Can discuss more with patient and suggest more for options	
Can consider other DDx in kids with prolonged cough e.g. allergic rhinitis; not followed up	
Diagnosed 'post-herpetic neuralgia for persisted pain ~ 1/52 after the onset of rash	
Central chest pain for few weeks; CXR few months ago NAD, ECG no acute changes, dx atypical chest pain without further workup. Symptoms at night and patient on NSAID recently → GERD?	

Part D (Medical Records), D3 (Consultation notes)
Suboptimal management

issue noted:	Comments / recommendations
Tramadol and pholcodine; both opioid types, risk of respiratory suppression	
F/61 FU for neck pain, numbness UL The consultation notes (done in 9/17) typed: MRI neck (9/17): C3/4; C4/5; C5/6; C6/7 mild spinal stenosis with compressing cord…C3/4 mild increase T2 intensity suggestive of early compressive myelopathy. Ortho pending 12/ 2018 -- should attempt to advance the orthopedic appointment Mx: Referred to Physiotherapy -- potential unsafe Mx	
HT newly on drug; no regular FU was arranged, instead advised patient to self book IVAS. Also there is a DM RAMP podiatrist appointment for patient in the record, it is not sure if patient in having DM or not.	
Why 10-year-old child epistaxis given neomycin cream?	
Fasting Hstix 8.3 – 10.4, A1c 8.5%, hx too brief, better to have more hx on lifestyle and any symptoms of poor DM control. Mx just stepped up metformin from 500 mg BD to 750 mg BD, not likely to bring significant improvement	

Part D (Medical Records), D3 (Consultation notes)
Suboptimal management

issue noted:	Comments / recommendations
LDL 3.4, CKD, should switch (treatment) for LDL target < 2.6	
On Hytrin 6 mg , can warn side effects on Mx	
M46, BP 162/84, BP not rechecked. No recommendation for FU high BP. BP also high in the last consultation in March 2023.	
F/87, PR bleed, change of bowel habit, weight loss, only refer patient to surgeon, did not consider other ddx such as bld test / CXR / urine test	
CVS risk 14.4%, LDL 3.0, commented 'suboptimal control' and increased Crestor dose. Aim LDL < 3.4 sufficient if medium CVS risks.	
Hytrin increase from 1 mg to 5 mg daily: too aggressive, may trigger postural hypotension	

Part D (Medical Records), D3 (Consultation notes)
Lack of / inappropriate anticipatory care advice

issue noted:	Comments / recommendations

Enquiry

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