The Hong Kong College of Family Physicians

香港家庭醫學學院

Practice visit:

Medical Record Review including

Investigation (PERMIx Report ____)

Trainee	
Practice name & address	(Working in the practice since_____/_____)

Supervisor/ Assessor		
Period Assessed	1st assessment: week from	2nd Assessment: week from
Date of assessment		
Signature		

Introduction

Medical Record and Investigation Review is part of the Practice Visit during the training period. Reviewing this through random sampling can help trainees to maintain the standard through daily practice.

Assessors should be Trainee's Clinical Supervisor in higher training or a cross cluster supervisors or PA examiner if necessary.

Process:

1. Trainee's record OVERALL framework should have **layout appropriate** for input, easy retrieval and alert on significant findings as needed and relevant to Family Medicine Practice.
2. It will be done **every 3 monthly**.
3. Can choose consultation in different clinic or session that trainee is working.
4. Assessors/Supervisors will choose **any 1 week** for assessment during the period. During the week, trainee needs to work for at least **4 normal working days.**
5. Trainee will be informed of the week of random sampling. Trainee needs to
    a. Prepare related **Consecutive consultation log** as instructed by supervisors.
    b. **Put *on cases with** Anticipatory Care done for that visit
    c. **FOR WALK IN Pt, Put ##on cases with** Investigation *(exclude POCT)* ordered for that visit
6. Assessors need to:
    a. Randomly select at least 5 medical records from the case log to mark every 3 monthly *(Assessment 1: Case 1-5, Assessment 2: Case 6-10)*
    b. Use the PERMIx Assessment Form
    c. Assessors are advised to choose more for random checking if needed especially as part of the education process
    d. Give feedback (with documentation) to the Trainee *after each assessment*
    e. For every 3-6 monthly, a consolidated report will be compiled according to the PERMIx Formative Assessment schedule
    f. Need to include at least 1 records (out of 5 records) with investigations for assessment
7. Trainee need to return the SCAN copy of the completed and signed assessment form to BVTS secretariat.

    Trainee need to keep related consultation log for College's checking until completion of training.

PERMIx Assessment Form

Record type Assessed: ☐ Electronic ☐Hard copy ☐Both

Overall Format Appropriate to FM Practice ☐Yes ☐No, DO NOT PROCEED if No

Assessment 1: Case 1 to _____; Assessment 2: Case _____ to _____

Assessment 1 or 2 (pls input)															
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Pls input Serial No (Refer to Appendix 2)															
0. Legibility															
i. Allergy / Adverse drug reactions															
ii. Basic Information (As appropriate)															
	Can include Current medication list, Problem list (Current / Past health), Family history of significant illness, Genogram, Social history, occupation, basic parameters like Blood pressure/BMI, Growth chart, immunization status, tobacco and alcohol use as appropriate														
Grade (please ✓ one)															
A															
C															
E															
N															
iii. Consultation notes ***(for presenting problem)*** **(Pls input Serial No)**															
History															
Physical Examination															
Diagnosis/Working diagnosis/Problem List															
Management															
Investigation (if av)															
Anticipatory care advice as appropriate (if av)															
Grade (please ✓ one)															

A	
C	
E	
N	

Overall performance: Clear, update, precise, consistent and concise	
Grade (please circle one)	
A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that may have impact on patient care
N	Illegible or Major Wrong information which significantly affect patient management or medical communication

Feedback:

i. Basic Information

Assessment 1:

Assessment 2:

ii. Consultation notes including Investigation, Anticipatory Care

Assessment 1:

Assessment 2:

Overall / other comments:

Please tick the area(s) need attention / improvement according to the overall performance:

Overall performance on Basic Information: area(s) need attention / improvement	Assessment 1 If applicable, please ✓; higher priority ✓✓, etc.	Assessment 2: If applicable, please ✓; higher priority ✓✓, etc.
• Information not updated		
• Inaccurate / inconsistent with other part(s) of the record		
• Documentation: unclear		
• Documentation: length not appropriate		
• Others:		

Overall performance on Consultation Notes: area(s) need attention / improvement	Assessment 1 If applicable, please ✓; higher priority ✓✓, etc.	Assessment 2 If applicable, please ✓; higher priority ✓✓
• History documented: unclear		
• Physical Findings: unclear		
• Diagnosis/ Working diagnosis/Problem list unclear, inaccurate or inconsistent		
• Management plan: unclear (esp for subsequent followed through)		
• Anticipatory care advice: not appropriate		
• Investigation not documented clearly for follow through		
• Documentation: length not appropriate OR unclear		
• Others:		

Assessor please sign on the front page

--- end ---

Appendix 1

Consecutive Case Log sheet (for 1 week): use same format as practice

(pls keep copy in practice by trainee and discard after completion of Higher training)

Appendix 2 (Updated)

Below pls input the Selected Case log details retrospectively

Serial no.	Patient record number	Patient initials	sex	age	Key diagnosis	Date of the consultation
P1						
P2						
P3						