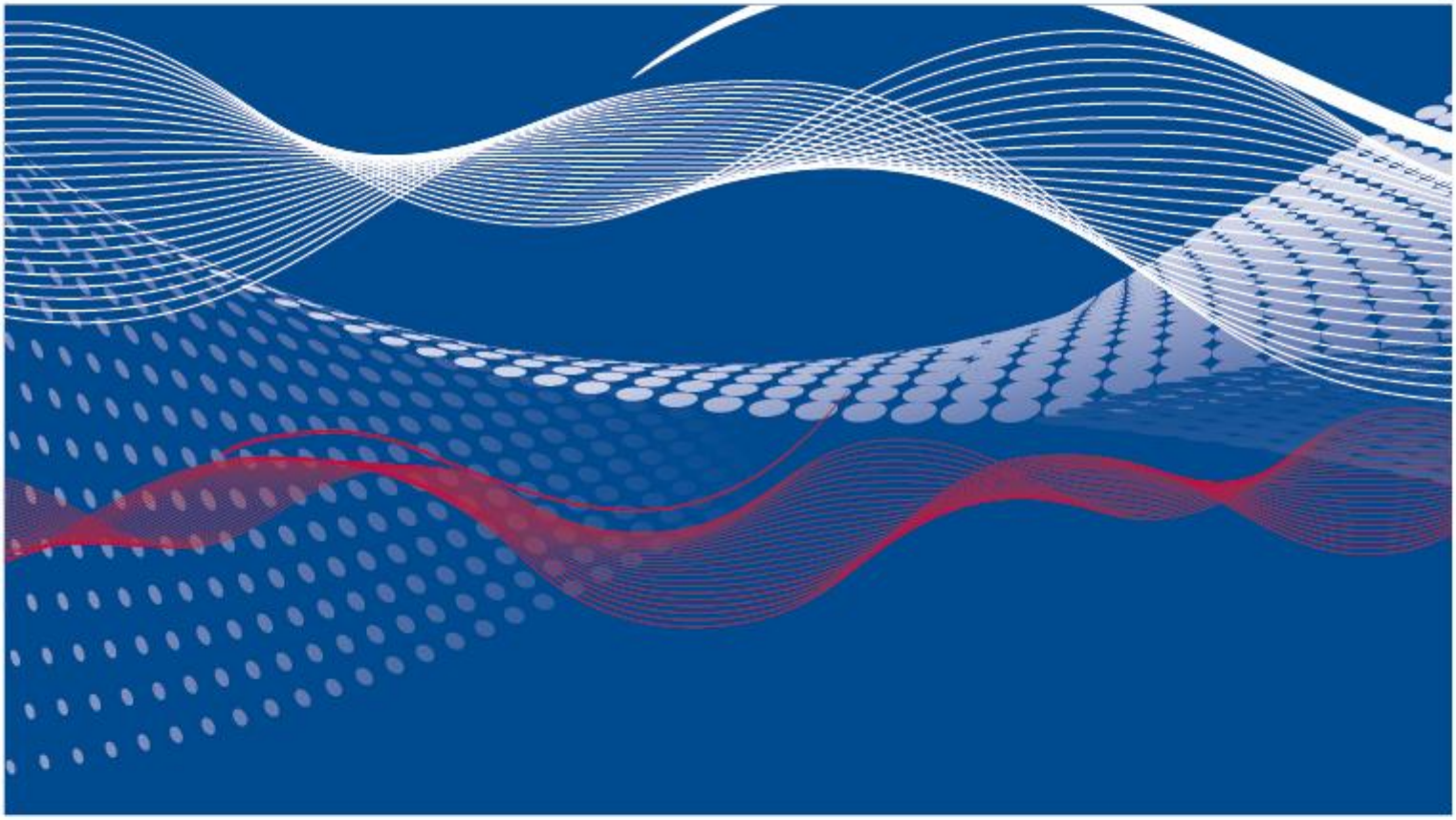
AGPT
LEARNING IN GENERAL PRACTICE

PGPPP (Practice) Guidelines

for the supervision and training of doctors in the Prevocational General Practice Placements Program



General Practice Education and Training Limited

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Incorporating the Australian General Practice Training and Prevocational General Practice Placement programs

Contents

PGPPP (Practice) Guidelines
for the supervision and training of doctors in the Prevocational General Practice Placements Program

Purpose of these practice guidelines

These guidelines have been developed in consultation with key stakeholders to:

- Outline common issues with managing PGPPP learners in the general practice setting;
- Describe GPET's expectations of supervisors undertaking supervision of PGPPP doctors at different levels of training and expertise;
- Describe common approaches to practical issues in the GP setting, such as structuring the learning environment and providing supervision for learners at different levels of training within the practice; and
- Provide some practical tools and resources for use by supervisors of PGPPP doctors.

These guidelines include:

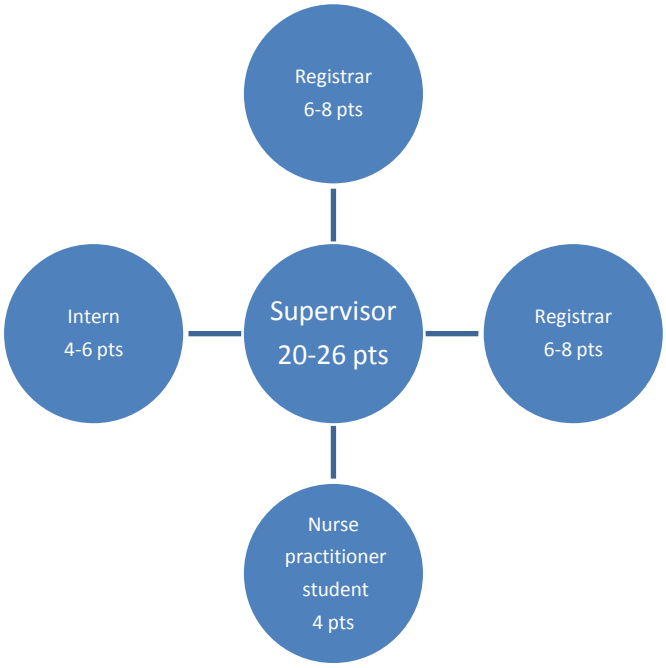
- Structuring the teaching and learning environment in the general practice setting;
- Providing supervision that meets the developing expertise of the junior doctor - the four stage model of supervision and support;
- Managing supervision in other contexts e.g., after hours, home visits, nursing home attendance etc;
- Formal teaching requirements and the junior doctor curriculum;
- Assessment of performance in PGPPP; and
- Resources for supervisors.

Structuring the teaching and learning environment in the GP setting

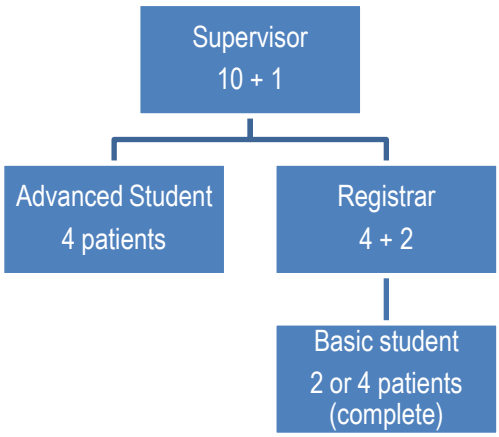
There are many models of structuring practices for multi-learner interactions. These include:

1. The single-learner practice, where the junior doctor has their own room and own patient list for each session. Supervisors are available to observe, debrief or discuss patients and have their own clinical lists.
2. The multi-learner practice, where the supervisor oversees several learners. Professor Dawn DeWitt[1] describes a number of potential structures that may meet the needs of the multi-learner practice. These include the following:

    a. The wheel and spoke model



    b. A vertically-integrated model



3. Of course, different practices will organise models differently depending on the number of supervisors, the roles these supervisors take, the number and seniority of learners, and the availability of infrastructure.

Providing supervision that meets the developing expertise of the junior doctor: the four stage model of supervision and support

These guidelines are based on a stepped process of developing competence and changing supervision techniques. In order for this process to work effectively, there must be opportunities for the supervisor to assess the junior doctor's developing competence, and allow the junior doctor to increase their clinical responsibilities appropriately. This sort of stepped process relies on opportunities leading up to independent practice coupled with structures and strategies to ensure patient safety.

It is expected that in the early stages of the interaction, supervisors will spend some time observing the junior doctor, and having the junior doctor observe them. In order for this to be an effective learning interaction, it is important to incorporate expectations and opportunities to assess competence within this process.

DeWitt describes a model of priming the junior doctor to focus on a particular issue, procedure or examination when observing or being observed, and then debriefing and feedback at the conclusion of each consultation. Obviously, this model is intensive and will not be necessary for long periods of time in a more senior or competent junior doctor.

These stages will vary in length, depending on the seniority and competence level of the learner. They are based on the RIME model[2]: which uses a tool for assessing competence with developing expertise.

The following guidelines outline the stages of training a PGPPP doctor is expected to undertake.

The four stages are:

1. **Reporting**

   Junior doctors at this level reliably gather, organise and communicate information. Competent reporting includes the ability to:

   a. Provide complete and concise data.

   b. Organise presentations and notes.

   c. Use databases appropriately.

   d. Perform a confident, focused physical examination.

2. **Interpreting**

   Junior doctors can successfully take ownership of the creation and justification of diagnostic hypotheses. Competent interpreting includes the ability to:

   a. Consistently generate a good differential diagnosis including conditions 'most likely' and those that must not be missed.

   b. Justify/demonstrate clinical reasoning.

3. **Managing**

   Junior doctors who can successfully take responsibility for negotiating all aspects of patient care. Competent managing includes the ability to:

   a. Consistently order appropriate tests and therapy.

   b. Incorporate outside reading.

4. **Educating**

   Educators take responsibility for other learners. Competent educating includes the ability to:

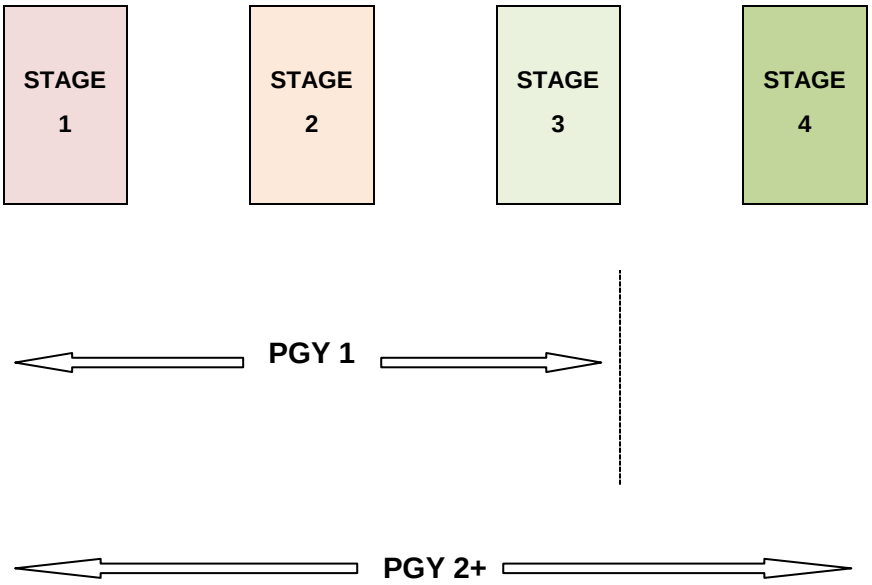
   a. Practice evidence-based medicine independently using primary and secondary sources.

   b. Summarise information for colleagues.

   c. Teach more junior learners something.

Of course, these stages overlap, and are dependent on the complexity of the patients, and the specific experiences of the doctor. However, the four stages do provide a useful framework to help determine when a junior doctor is able to move to a more independent stage of learning.

The following staged model of supervision (see diagram below) utilises the RIME framework to describe four stages of supervision, beginning at Stage 1, where the PGPPP doctor observes and is observed undertaking consultations, to stage 4 where a PGPPP doctor is seeking advice as needed, but is consulting independently at times.



It is expected that PGPPP doctors will move through the stages as their competence and confidence develops. However, not all PGPPP doctors will reach stage 4. For instance, it is suggested that PGY1 doctors should not progress beyond the stage of supervision outlined in stage 3.

At all times and at all stages, the supervisor takes direct and principal responsibility for the care well-being of individual patients.

STAGE ONE - ORIENTATION AND OBSERVED CONSULTATIONS

'Reporter' and developing 'interpreter' roles

Introduction to stage-one training

During stage one, sufficient time is taken to ensure the PGPPP doctor is oriented to the program and community-based practice, and becomes familiar with structures and systems of care. The need to practice safely is introduced and reinforced throughout stage one and beyond.

The 'desired outcomes' (see page 8) should be used as a guide to the activities that need to be undertaken by the PGPPP doctor during stage one.

Throughout stage one, the PGPPP doctor's supervisor takes direct and principal responsibility for individual patients.

Who participates	All PGPPP doctors are expected to undertake and satisfactorily complete stage one.
Patient load	Two patients per hour including discussion and feedback on consultation.
Patient profile	As required for observation purposes – various presentations/all levels of complexity, both genders; all ages.
Supervision	During stage one, the PGPPP doctor is not left unsupervised at any time during patient consultations.

Orientation of a junior doctor to a PGPPP placement

Orientation is essential for all junior doctors undertaking a PGPPP placement.

It is expected that all PGPPP doctors will be orientated to the program and to general practice[1].

The responsibility for orientation is a shared one between the program provider, the training practice and the junior doctor's principal supervisor.

The PGPPP doctor should be orientated to the:

- program by the program provider;
- practice or post by the supervisor and staff;
- safe practice guidelines/alerts (see schedule) by the supervisor; and
- general practice business model by the supervisor and practice staff.

Observed consultations

During stage one, the main activity for the PGPPP doctor is to observe a range of patient consultations within the context of general practice and to be observed undertaking a variety of consultation tasks. The focus is on the skills of consulting in the general practice setting.

The practice is encouraged to structure this activity to provide a range of consultation opportunities to enable the PGPPP doctor to observe their supervisor (and others) undertaking consultations in the general practice setting. This opportunity should also be used to establish a "learning profile" of the junior doctor, with details of any areas of concern,

[1] Throughout this guide, the term 'general practice' includes a reference to 'rural and remote medicine' in a primary health context.

and a list of negotiated learning opportunities. This should also include a list of consultations and situations for which the junior doctor will be required to consult with their supervisor, regardless of their perceived competence. This includes “high-risk” consultations, as well as consultations in which the junior doctor lacks prior experience. Observations should be structured to include a task (i.e., what to observe) as well as an opportunity to debrief.

During stage one; PGPPP doctors are also encouraged to undertake various other supervised observations and visits.

Suggested observation tasks (*within the context* of general practice):

- Other supervising GPs in the practice
- Registrars
- Practice nurse
- Practice manager
- Allied health professionals

Suggested visits (*within the context* of general practice):

- Aged care facilities/hospital
- Home visits
- After hours clinics
- Chemist (dispensing)
- Allied health

The general practice as a business

In discussing the general practice business model and how a general practice operates, practices should ensure PGPPP doctors gain an understanding of the following:

- General practice is often a private practice
- Medicare (via Medicare on-line courses + practice protocol)
- PBS (via on-line courses + practice protocol)
- Private billings (practice protocol, bulk billing arrangements)
- Medical Director or its equivalent
- Patient files (consents/alerts/notes/confidentiality)
- After hours and on-call arrangements
- Processes for arranging investigations, admissions and referrals
- Recall and reminder systems
- Safety and security of other practice staff and patients
- Personal safety and security
- Safe practice

This activity can be restructured for PGPPP undertaking their placement in a rural and remote training post.

PGPPP doctors should also be shown how to accesses resources including:

- College websites (Curricula, Standards, online learning opportunities and relevant education resources)
- Appropriate texts (e.g., Murtagh)
- MIMs or other prescribing resources
- Practice guidelines (hard copy or internet-based)
- AGPT website
- Other practice-related resources

Study resources available for stage one:

- As may be provided by the practices and program providers for stage one.

Content:

The PGPPP doctor becomes familiar with:

1. Common presentations in the community setting.
2. Structures and systems for managing acute, chronic and preventive care in the community setting.
3. The structure and function of a GP consultation.
4. The general practice as a business.
5. Safe practice.

Context:

The PGPPP doctor becomes familiar with:

1. The roles and responsibilities of the various members of the community care team, and can describe their role within the team.
2. Resources available to the GP when addressing learning needs in practice.
3. Day-to-day practice management processes as they apply to the GP.
4. Managing risk in the general practice context.

Competency:

At the completion of stage one, the supervisor is satisfied the junior doctor:

1. Has satisfactorily completed stage one; and
2. Has acquired sufficient knowledge and competency to safely move to stage two.

Desired Outcome:

At the completion of stage one, the junior doctor is able to:

1. Outline the roles and responsibilities of each member of the health care team.
2. Describe the common administrative processes in the GP setting (eg billing, ordering investigations, recall and reminder systems, referrals).
3. Describe the diagnosis and management of common GP presentations.
4. Describe the typical behaviours of a doctor practising safely in the context of general practice.
5. Safely move to stage two.

STAGE TWO – WAVE CONSULTATIONS

'Interpreter and developing 'manager' roles

Introduction to stage-two training

During stage two, the PGPPP doctor is able to practice elements of the consultation in a safe environment with regular feedback and support from their supervisor.

The 'desired outcomes' (see page 11) should be used as a guide to the activities that need to be undertaken by the PGPPP doctor during stage two.

Throughout stage two, the PGPPP doctor's supervisor takes direct and principal responsibility for individual patients.

Who participates	All PGPPP doctors are expected to undertake and satisfactorily complete stage two.
Patient load	Two patients per hour including discussion and feedback on consultation.
Patient profile	A variety of consultations, various presentations, both genders; all ages. Patients with a higher complexity may require additional support
Supervision	During stage two, the PGPPP doctor and the supervisor undertake patient consultations consecutively

Wave consultations

This model of training involves the supervisor and the PGPPP doctor undertaking patient consultations consecutively. The supervisor reviews each of the PGPPP doctor's patients while the patient is still present. DeWitt gives an example of how this might work in practice using the following model

Time	supervisor (12)	Learner (3)
9:00	See pt 1	**Prep pt 3**
9:15	See pt 2	**See pt 3**
9:30	See pt 3	**Present pt 3**
9:45	See pt 4	**Complete pt 3**
10:00	See pt 5	**Prep pt 7**
10:15	See pt 6	**See pt 7**
10:30	See pt 7	**Present pt 7**

It is the responsibility of the supervisor to manage the wave consultations in accordance with the competency and confidence levels of the junior doctor.

Supervisor feedback (given at the conclusion of **EACH** patient consultation) is an essential component of the wave consultation model and should focus on improving the PGPPP doctor's:

1. Knowledge
2. Consultation skills
3. Confidence and competency levels

It is expected that the PGPPP doctor will increase their independence as their level of clinical performance improves with training and experience.

While it is difficult to 'stream' patients in the general practice setting, patients with complex and serious issues should be reviewed more closely when the PGPPP doctor and supervisor are engaged in wave consultations. Certain patients may be 'tagged' by the supervisor to only see more senior members of the practice team.

PGPPP doctor training responsibilities

Throughout stage-two training, PGPPP doctors should be:

1. Actively learning by undertaking consultations, asking questions and seeking guidance.
2. Practising safely.
3. Using patient files/records to inform consultations.
4. Completing patient medical records (electronic and hard copy).
5. Using available e-data bases as part of the consultation process.
6. Organising investigations and referrals.
7. Writing prescriptions.
8. Adopting responsibility for recall and reminders.
9. Determining level of consultation for billing purposes.

Content:

The PGPPP doctor should be able to:

1. Manage common consultations under supervision.
2. Utilise structures and systems for managing acute, chronic and preventive care in the community setting with the support of the supervisor.
3. Conduct an effective GP consultation.

Context:

The PGPPP doctor should be able to:

1. Utilise the various members of the health care team and describe their roles and responsibilities to patients.
2. Locate relevant guidelines and learning resources to assist in decision making.
3. Demonstrate appropriate billing and prescribing practices for simple consultations.
4. Seek advice for complex consultations.

Competency:

At the completion of stage two, the supervisor is satisfied that the junior doctor is sufficiently competent to safely move to stage three.

Desired Outcomes:

At the completion of stage two, the junior doctor is able to:

1. Consult the members of the health care team appropriately to ensure quality care of patients in the GP setting.
2. Utilise common administrative processes in the GP setting (e.g., billing, ordering investigations, recall and reminder systems, referrals).
3. Demonstrate diagnosis and management of common GP presentations under supervision.
4. Safely move to stage three.

STAGE THREE – REVIEWED CONSULTATIONS

'Interpreter' and developing 'manager' roles

Introduction to stage-three training

During stage three training, the PGPPP doctor is able to practice with feedback following each independent unobserved consultation. There is the option of reverting to observed or a 'shared consultation' model when additional support is required.

All patient consultations are reviewed (see below) as part of a risk management strategy to enable the supervisor to review the PGPPP doctor's management strategies.

The 'desired outcomes' (see page 14) could be used as a guide to the activities that might reasonably be undertaken by the PGPPP doctor during stage three.

Who participates	All PGPPP doctors who can reasonably be expected to undertake and satisfactorily complete stage three training. Satisfactory completion of stage two training is a prerequisite to stage three training.
Patient load	Three patients per hour including discussion and feedback on consultation.
Patient profile	Preferably screened presentations with known patient history - both genders; all ages.
Supervision	Under stage three training, the supervisor takes direct and principal responsibility for individual patients.

Reviewed consultations occur when a supervisor reviews the management of a patient after decision-making has already occurred. This may include reviewing the medical records of patients at the conclusion of a session and discussing each case with the junior doctor – *see additional notes below on 'what needs to be reviewed'.*

Reviewed consultations should only be used when the supervisor is confident that the junior doctor can identify the need for additional support and seek assistance appropriately. Reception or booking staff should attempt to direct complex patients to the more senior doctors in the practice.

Stage-three training must be managed within a set of well-defined boundaries, which are understood and agreed to by the junior doctor and the supervisor. These boundaries will need to be discussed and might, for instance, be informed by specifically articulating a certain range of consultations that constitute 'high risk' situations, requiring additional support and immediate assistance.

Such consultations might include, for example

- All pregnant patients (existing or new).
- Patient requiring immunisation (especially those considered to be 'high risk').
- The neonate-patient.
- Adolescent patients displaying any signs of depression.
- Other presentations deemed appropriate to the performance levels of the junior doctor.

Allowing junior doctors to proceed with stage-three training is on the strict understanding that wave or shared consultations are always an option and should occur where the supervisor, practice staff or junior doctor identify a likely need for additional support.

Under the reviewed consultation model of training and supervision, all patient consultations are to be regularly reviewed, and this needs to be done as part of the practice's junior doctor risk management strategy.

What needs to be reviewed?

Reviewed consultation reviews should focus on the junior doctor's patient management strategies. This would generally include a considered review of any investigations, referrals, prescriptions or recall arrangements made (or not made) with patients. Questions should be used to determine the reasons behind the junior doctor's decisions.

In reviewing a junior doctor's patient management strategy, it is also crucial that supervisors undertake a review of the junior doctor's consultation notes and/or entries made in the patient's medical records.

PGPPP doctor training responsibilities

Throughout stage-three training, PGPPP doctors should be:

1. Actively learning through the wave consultation model of training.
2. Identifying situations where additional assistance or support *might* be needed.
3. Developing personal strategies for safe practice.
4. Using patient files/records to inform consultations.
5. Completing patient medical records (electronic and hard copy).
6. Using available e-data bases as part of the consultation process.
7. Considering and organising investigations and referrals.
8. Writing prescriptions.
9. Adopting responsibility for recall and reminders.
10. Determining levels of consultation for billing purposes.
11. Actively participating in the consultation review process.

Content:

The PGPPP doctor should be able to:

1. Manage common consultations.
2. Utilise structures and systems for managing acute, chronic and preventive care in the community setting asking for support and advice where appropriate.
3. Conduct a GP consultation.

Context:

The PGPPP doctor should be able to:

1. Utilise the various members of the health care team and describe their roles and responsibilities within the practice.
2. Utilise relevant guidelines and learning resources to aid decision-making in a clinical context
3. Demonstrate appropriate billing and prescribing practices for simple consultations, and seek advice for complex consultations.
4. If they are PGY 2 or above, safely move to stage four.

Competency:

At the completion of stage three, the supervisor is satisfied that the junior doctor is sufficiently competent to safely move to stage four.

Desired Outcome:

At the completion of stage three, the junior doctor is able to:

1. Share the care of patients appropriately to ensure quality care of patients in the GP setting.
2. Utilise common administrative processes in the GP setting (e.g., billing, ordering investigations, recall and reminder systems, referrals).
3. Demonstrate diagnosis and management of common GP presentations.

STAGE FOUR – INDEPENDENT CONSULTATIONS (PGY 2 + doctors)

Introduction to stage-four training

During stage-four training, the PGPPP doctor is able to practice independently, but with the option of reverting to an increased level of supervision (as required) to review the junior doctor's patient-management strategies.

The 'desired outcomes' (see page 17) should be used as a guide to the activities that need to be undertaken by the junior doctor (PGY 2 +) during stage four training.

Who participates	PGPPP 2 + doctors can undertake stage four training after satisfactory completion of at least stage one and two training. Stage three training for PGY 2 + doctors is a decision for the practice.
Patient load	Three patients per hour (including any selected consultations for review and feedback)
Patient profile	Varied multiple presentations (all ages, both genders) with or without known patient history – new or existing patients.
Supervision	Throughout stage four the supervisor and the junior doctor share responsibility for individual patients.

Independent consultations

Where a PGY 2 + doctor enters stage-four training, the doctor is permitted to undertake an agreed range of 'independent' consultations in an environment where the supervisor is 'on call' for the doctor, and will only review the management of a certain type or number of patient consultations. This may include seeing a particular patient at the end of a consultation (particularly for less experienced PGY 2 + doctors), or reviewing the medical records of a particular group of patients sometime shortly after the consult.

Independent consultations should only be used when the supervisor is confident that the junior doctor can identify the need for additional support and seek assistance appropriately.

Stage-four training (like stage three) must be managed within a set of well-defined boundaries, which are understood and agreed to by the junior doctor and the supervisor. These boundaries will need to be discussed and might, for instance be informed by specifically articulating a certain range of consultations that constitute high risk situations, requiring additional support and immediate assistance.

Such consultations might include, for example:

- All pregnant patients (existing or new).
- Patients requiring immunisation (especially those considered to be 'high risk').
- The neonate-patient.
- Adolescent patients displaying any signs of depression.

Allowing junior doctors to proceed with stage-four training is on the strict understanding that wave consultations are to occur where the supervisor, practice staff or junior doctor identifies a likely need for additional support.

PGPPP doctor training responsibilities

Throughout stage-four training, PGPPP doctors should be:

1. Actively learning by undertaking consultations, raising issues and seeking guidance.
2. Practising safely.

3. Using patient files/records to inform consultations.
4. Completing patient medical records (electronic and hard copy).
5. Using available e-data bases as part of the consultation process.
6. Organising investigations and referrals.
7. Writing prescriptions.
8. Adopting responsibility for recall and reminders.
9. Determining level of consultation for billing purposes.

Content:

The PGPPP doctor should be able to:

1. Manage most consultations and seeks advice appropriately when necessary.
2. Utilise structures and systems for managing acute, chronic and preventive care in the community setting asking for support and advice where appropriate.
3. Conduct a more complex GP consultation e.g., a consultation that manages several problems, or addresses a complex issue.

Context:

The PGPPP doctor should be able to:

1. Work effectively in a team care environment.
2. Utilise relevant guidelines and learning resources to aid decision-making in a clinical context.
3. Demonstrate appropriate billing and prescribing practices.

Competency:

At the completion of stage four, the supervisor is satisfied that the junior doctor is sufficiently competent to practice safely (under supervision) in the GP context.

Desired Outcome:

At the completion of stage four, the junior doctor is able to:

1. Share the care of patients appropriately to ensure quality care of patients in the GP setting.
2. Utilise common administrative processes in the GP setting (e.g., billing, ordering investigations, recall and reminder systems, referrals).
3. Demonstrate diagnosis and management of common GP presentations.
4. Manage chronic care consultations (e.g., diabetes cycle of care).
5. Perform a range of office-based procedures.
6. Manage common consultations under supervision.
7. Utilise structures and systems for managing acute, chronic and preventive care in the community setting with the support of the supervisor.
8. Conduct an effective GP consultation.

Managing supervision in other contexts eg after hours, home visits, nursing home attendance

It is important that the PGPPP doctor is able to participate in the breadth of clinical experience undertaken by the GP, and this includes experiencing different contexts of care.

This also means that supervisory guidelines will have to incorporate safe processes for the PGPPP doctor working in different locations, such as aged care facilities, the local hospital and home visits.

At all times, the supervisor takes direct and principal responsibility for the care of individual patients. This means that structures and systems must be in place for the PGPPP doctor undertaking these consultations. As the PGPPP doctor moves beyond stage 2, it is appropriate for them to undertake consultations without direct and immediate feedback from their supervisor. However, the supervisor should be accessible by phone or personally at all times to ensure patient safety is addressed. Part of this responsibility may be delegated to an appropriate person who is not the nominated supervisor. An example may be a diabetic clinic in the local hospital which is run by a diabetes nurse, where the PGPPP doctor provides medical services.

To assist in developing an appropriate structure for supervision on an individual basis, a sample supervisory learning plan is attached (see Appendix 1). This plan includes a negotiated list of high risk, moderate risk and low risk scenarios that are locally appropriate, and details the appropriate level of supervision to be provided. This document may assist supervisors to manage the delicate balance of allowing PGPPP doctors sufficient autonomy to learn whilst still maintaining a safe and supported environment for the junior doctor and their patients.

Formal teaching requirements and the junior doctor curriculum

Formal teaching requirements will differ according to the training programs initiated by the feeder hospital, and also the availability of resources and prior experience of the PGPPP doctor.

Formal teaching may include:

- Tutorials by the supervisor, which may include multi-level learners or multidisciplinary learners;
- Educational event provided by the local regional training provider of GP education and training;
- Divisional educational activities;
- On-line activities available through the RACGP's GP learning portal or ACRRM's RRMEO; and/or
- Peer tutorials at the feeder hospital or through local GP networks.

It is expected that the PGPPP doctor will receive at least an hour a week of formal education. The curriculum addressed by these educational sessions will be negotiated locally, but will include reference to:

- The RACGP curriculum for pre-vocational training;
- The ACRRM curriculum;
- The Australian Curriculum Framework for Junior Doctors; and/or
- The Learning Plan of the PGPPP doctor.

The outline of the teaching sessions will be negotiated by:

- The PGPPP doctor;
- The Supervisor; and
- The PGPPP provider

Assessment of performance in PGPPP

Assessment of performance of the PGPPP doctor will include:

- Formative feedback for the PGPPP doctor;
- Formative assessments to determine appropriate levels of supervision; and
- Feedback to the hospital managing the PGPPP doctor at the time.

There should be structures and systems in place to ensure the underperforming PGPPP doctor can access additional educational and supervision resources to address their training needs.

REFERENCES

1. DeWitt, D., *Incorporating medical students into your practice.* Aust Fam Physician 2006. **35**: p. 24-6.
2. DeWitt, D., et al., *Pilot study of a "RIME"-based tool for giving feedback in a multispecialty longitudinal clerkship*
3. Medical Education, 2008. **42**: p. 1205-1209.

Resources for supervisors

To be developed

Appendix 1: A sample supervisor learning plan

PGPPP doctor's name: Dr John Average

Supervisor's name and contact details (including an emergency after-hours number and alternative contact if on-call responsibilities are undertaken)

Identified areas of expertise:

- Past experience as a physiotherapist.
- Completed a term in paediatrics.
- Has undertaken a junior registrar position in accident and emergency.

Identified areas that need improvement:

- Has not yet undertaken a term in women's health or obstetrics.
- Has no experience in palliative or end-of-life care.
- Doesn't feel confident in acute cardiology.
- Chronic disease management.

Low risk scenarios: Daily consultations where John feels confident of his management approach eg URTIs in children Most nursing home visits Acute sporting injuries and minor trauma	**Strategies:** stage 3 approach, reviewing each patient at the end of the session. Requesting assistance "on the spot" as needed	**How to access support** Phone supervisor Phone advanced registrar for low risk questions Notify supervisor by messaging Seek nursing support as needed Use Therapeutic Guidelines Consult Murtagh
Moderate risk scenarios: Where John feels unsure of his approach or in the following scenarios Chronic disease consultations, especially care planning Mental health consultations Children who require medication (eg otitis media, moderate croup) Antenatal care	**Strategies:** Stage 2 approach, reviewing the patient before they leave the consulting room	**How to access support** Phone/message supervisor and ask him to review this patient
High risk scenarios: Where the patient is at high risk Any consultation where the diagnosis is unclear and the patient is unwell Any seriously ill child Any immunisation (prior to giving the vaccine) Any neonate Any patient who expresses suicidality Any patient where you feel unsafe or worried	**Strategies:** Stage1 approach, reviewing the patient together	**How to access support** Phone/message supervisor and ask him to review this patient. Remember to request immediate review if the patient is very unwell.