

AUSTRALASIAN FACULTY OF MUSCULOSKELETAL MEDICINE

CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMME

For

New Zealand

Fellows of the Australasian Faculty of Musculoskeletal Medicine

(2014 - 15)



AFMM CPD IMPLEMENTATION SCHEDULE.
PER 3 YEAR CYCLE (300 points/cycle @ 100 points/year)

DOMAIN	FUNCTION	POINTS	PERFORMANCE
AUDIT OF MEDICAL PRACTICE (min 1 audit/yr) (max 40 pts/yr)	<i>The Audit</i>	Up to 40	submission of audit summary
	<i>Practice Visit Audit (First Pass)</i>	15	
	<i>Practice Visit Audit (Second Pass)</i>	10	
PEER REVIEW (min 10hrs/yr) (max 40 pts/year)	<i>case presentation at peer review meeting</i>	2/hr	Notification in Annual CPD Report
	<i>Peer review of Charts</i>	2/hr	
	<i>Practice Visit</i>	10	
CME (min 20hrs/yr) (max 40 pts/year)	<i>conducting a problem-oriented literature search(Medline or similar)</i>	2/hr	Notification in Annual CPD Report
	<i>active membership of a journal club</i>	2/hr	
	<i>attending an accredited scientific meeting</i>	2/hr	
	<i>attending an accredited educational course / workshop</i>	2/hr	
	<i>attending a non-accredited scientific meeting</i>	1/hr	
	<i>accreditation in a particular skill or area of practice</i>	40	
TEACHING AND RESEARCH (min 20hrs/yr) (max 20 pts /year)	<i>preparing a critically appraised topic(CAT)</i>	10	Notification in Annual CPD Report
	<i>writing an appraisal of a scientific article</i>	5	
	<i>preparing a literature review</i>	20	
	<i>other material contribution to education and research e.g. Masters in Pain Medicine.</i>	1/hour up to 20/year	
	<i>speaking at an accredited national meeting</i>	10	
	<i>teaching or examining at an accredited educational course</i>	2 /hour up to 15/year	
	<i>acting as a mentor or preceptor to trainees</i>	up to 15/year	
	<i>undertaking an evidence-based scientific study</i>	20	
	<i>publication of a scientific paper</i>	20	
	<i>publication of book chapter</i>	30	
	<i>material contribution to accredited publication</i>	10	
	<i>editing a relevant publication</i>	20	
	<i>membership of an accredited educational committee</i>	1/hr (max 20)	
PROFESSIONAL ACTIVITIES (max 5 pts/year)	<i>musculoskeletal- related committee activities</i>	1/hr (max 5/yr)	
COMPULSORY ACTIVITY	<i>certificate in cultural competence</i>	10 pts (every 3 yrs)	Certificate of Attendance
COMPULSORY ACTIVITY	<i>Certificate in CPR (ACLS Level 5) Certificate in CPR (ACLS Level 6 or 7)</i>	10 pts 30 pts (every 3 yrs)	Certificate

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Preamble

Programmes instituted by legitimate medical groups for what are variously called Quality Assurance (QA), Continuing Medical Education (CME), Maintenance of Professional Standards (MOPS), Continuing Professional Development (CPD), and Recertification serve two complementary purposes:

1. They encourage individual participants to maintain and upgrade the special knowledge and skills they have acquired as members of the group.
2. They provide the means by which the corporate body can encourage its members to uphold the group's purported expertise and competence, by demonstrating appreciation of contemporary knowledge and standards of practice, and hence to maintain the professional reputation of the group as a whole.

The practical expression of a medical group's expertise and competence is its effectiveness, or net rate of successful outcomes. The net rate is the total rate of successful outcomes achieved by individual members of the group, discounted by the rate of unsuccessful outcomes (adverse events).

Increasing positive outcomes requires assessment of effectiveness using audit. Reducing the risk of negative outcomes involves identifying our individual and group weaknesses. Traditionally, there is little evidence that CPD has achieved that - particularly activities such as attending CME or self audit. Looking to the future, review by peers is becoming paramount. This has started with the Practice Visits, which are now mandatory for AFMM members.

The AFMM considers that the principle concern of medical practice is the quality of care provided to patients, whose needs the system is designed to serve. That quality of care is the "quality" which any "CPD" program sets out to "assure". The AFMM regards all components of the programme, including Clinical Audit, Peer Review, CME and Teaching and Research, as means by which the end of CPD can be achieved.

CPD aims to examine the following domains of medical practice (MCNZ "*CPD & Recertification*") –

- Medical Care** (Diagnostic and management skills)
- Communication** (with patients and families, colleagues, record-keeping)
- Collaboration** (Teamwork)
- Management** (personal, within systems, use of time and resources)
- Scholarship** (lifelong learning, teaching, research, critical appraisal)
- Professionalism** (honesty, integrity, probity, respect for patients, cultural competence, moral reasoning & ethical practice, respect for colleagues, advocacy for patients, commitment to continuous improvement in the healthcare system, collaboration with other healthcare stakeholders).

As part of quality improvement, the CPD programme is subject to annual review by the CPD committee in an attempt to improve its accuracy in assessing and raising the competence of individual Doctors and the Faculty group as a whole. This enables the AFMM to progress towards its primary purpose of promoting the science of, and education in, musculoskeletal medicine, disseminating scientific knowledge of the functions and disorders of the musculoskeletal system, and to promoting scientifically supported methods of treatment of musculoskeletal disorders, and the abolition of methods of treatment not supported by scientific evidence.

This programme is also available to non-AFMM members who must also satisfy its requirements if they wish to be certified as participating in a quality assurance programme in the vocational scope of musculoskeletal medicine.

In producing this CPD document, we acknowledge the support of the Medical Council of New Zealand (MCNZ) and the Royal New Zealand College of General Practitioners (RNZCGP) in particular for generously allowing us to reproduce material sourced from them.

Your Responsibility

It is your responsibility to annually notify the Faculty (through the Administrator) of your commitment to the Reaccreditation programme for the coming year, and to fulfil the requirements of the Reaccreditation programme in a timely manner and report the results in the form laid out in this document. Generally, your first port of call should be to the AFMM Administrator (admin@afmm.com.au).

Privacy

The Faculty commits to providing a quality CPD programme and will endeavour to provide opportunity for Audit, Peer Review, and Continuing Medical Education (CME). The Faculty is committed to your privacy and will not normally release any information unless it pertains directly to your annual recertification with the Medical Councils of Australia or New Zealand, or if there is serious concern about any aspects of your fitness to practice.

The Programme

The essential element of the programme is that it is explicitly performance-based. Evidence of performance in each of the following four domains plus two compulsory activities is to be expressed in terms of a points system:

- AUDIT OF MEDICAL PRACTICE
- PEER REVIEW
- CONTINUING MEDICAL EDUCATION
- TEACHING AND RESEARCH
- CULTURAL COMPETENCE
- ADVANCED CARDIAC LIFE SUPPORT

The points system is outlined in the AFMM CPD Implementation Summary.

Quality is expressed as the rate of successful outcomes (effectiveness) which constitutes direct evidence of expertise and competence (measured by clinical audit and peer review), added to the indirect evidence provided by involvement in CME, and teaching and research activities.

The CPD programme involves a three-year triennium. There are minimal requirements listed for each year, and for the triennium.

The AFMM CPD year runs from 1st April in each year and terminates on 31st March of the following year.

Audit of Medical Practice (Continuous Quality Improvement)

“This is the process used to assess, evaluate and improve the care of patients in a systematic way to enhance health, by objectively measuring performance against standards and, when the actual performance does not meet the standard, making recommendations for change. (This may include altering the standards if they are found to be inappropriate). The process, which may be multidisciplinary, involves a cycle of continuous improvement of care, based on explicit and measurable indicators of quality. It has a statistical basis.” (MCNZ)

The Faculty require each Doctor to perform one audit per year, with a maximum 40 points per annum. The same audit can only be formed twice within a triennium (ie first and second pass) and a different audit in one of the other three years.

The first audit is called the “first pass”, and following alterations to the service provision or treatment, a second pass audit should be performed to measure any changes against the first.

An audit as part of the Regular Practice Review (RPR) must be conducted at least once every two years. For the RPR, points awarded are -

- 15 First Pass for Host Practitioner
- 10 Second Pass for Host Practitioner in one triennium

An audit will be rated at 2 points per hour with a maximum of 40 points per year able to be claimed, and there is no carry over to the next year. The points are awarded in the year in which the audit is completed. The audit report should include the details listed in the section “Non-endorsed Audits” below.

Audits can be provided by –

- The AFMM (Faculty) (including the compulsory Audit (AFMM Practice Visit Check List) as part of the RPR)
- External organizations
- Self designed

The latter two need to be endorsed by the Faculty CPD committee prior to being carried out.

Examples of audit include –

- External audit of procedures (not of the service)
- Comparing the processes or outcomes of care for a service with what is judged to be the best practice in the particular domain
- Analysis of patient outcomes (Effectiveness audit). This involves the recording of data for audit that is collected in the normal course of clinical practice, rather than as an additional task, and may include the use of the AFMM tool, the Recovergram, which was described in the Journal, *Australasian Musculoskeletal Medicine* 5(2)24-28 Nov 2000. This audit should include at least 50 patients and whilst the evidence produced is only of Level III quality, it is of immense practical significance.
- Faculty audit of outcomes with information on where individuals fit within the group as a whole
- Audit of an individual’s performance in an area of practice against his or her peers
- Audits of special aspects of practice (such as rates or outcome of spinal injections)
- Taking an aspect of practice and comparing an individual person to national standards

The biannual regular practice review (RPR) includes an audit of practice facilities which is completed by the Doctor prior to the practice visit by a peer(s). This is a compulsory requirement for once every two years.

Resources include –

1. NZAMSM document on Audit for Accreditation 2004

2. Ministry of Health publication “Towards Clinical Excellent – An Introduction to Clinical Audit, Peer Review, and other Clinical Practice Improvement Activities” (April 2002) (Available from www.moh.govt.nz)

Non-endorsed Audits

Prior to embarking on Audits which are not already endorsed by the Faculty (such as those designed by you or external organisations), you must seek endorsement from the CPD committee by emailing the Administrator with the following details –

1. Title of Audit
2. What Element of Practice Performance are you going to measure?
3. What indicators will you use?
4. What standards of performance do you want to achieve?
5. What resources are you using for those standards?
6. Data to be collected.
7. How will the progress of change be monitored?
8. When is a second cycle planned?

Peer Review

“This is an evaluation of the performance of individuals or groups of practitioners by members of the same profession or team. It may be formal or informal and can include any occasion in which practitioners are in learning situations about their own practice with other colleagues” (MCNZ).

Formal peer review is an activity where peer(s) systematically review aspects of a doctor's work and give guidance, feedback, and a critique of the doctor's performance.

The Faculty requires the Doctor to be involved in a minimum of 10 hour's peer review per year, to a maximum of 40 points per annum.

Examples of Peer Review include –

- Practice Visit component of the Regular Practice Review (mandatory alternate years)
- Presentation of cases to meetings (such as Peer Review meetings, Retreats)
- Peer review of cases
- Review of charts
- 360° (community) appraisals and feedback
- Critique of a video review of consultations by peer(s)
- Peer review groups (currently Auckland, Christchurch, and tele-conference)
- Inter-departmental meetings reviewing clinical cases or outcomes

Regular Practice Review (RPR)

There is recognition that many of the traditional self directed tools used for Reaccreditation of Practitioners for recertification have not been shown to identify areas of weakness. On the other hand, peer review can assist doctors in planning CPD and improving their clinical practice. In addition, the Faculty recognises the wide geographic spread of its members. As a result, the Faculty now requires all Doctors certifying through it to undergo a mandatory RPR every second year. The RPR includes the following components –

1. Audit of practice facility by the host Doctor using the AFMM Practice Audit Check List provided by the Faculty (Appendix 2).
2. Practice visit by a colleague in the role of Assessor. (In the case of Teaching practices, or where a visit has been directed by the Censor-in-Chief due to concerns raised about a Doctor's performance, there will be two assessors visiting and they will also independently complete the Audit Check List. The practice visit will include observation of consultations and the visiting Assessor(s) will use the observation tools used by the RNZCGP (and kindly approved by the RNZCGP for AFMM use).
3. Reports by both the Host Doctor and Assessor(s) following the practice visit.

In the annual report, the RPR can be claimed for 15 points for the first pass in the Audit section, 10 points for the second pass, and both the Host and the Visiting Assessor(s) can claim 10 points for Peer Review after filing of reports by both parties.

Collegial relationships

Doctors who work in a general scope are required by the Medical Council to establish a collegial relationship with a doctor who is registered in the same or closely related vocational scope to which they are working. There are guidelines for this on the MCNZ website and a contract should be signed between the supervised Doctor and the supervisor. The onus is on the two parties to fulfil the MCNZ requirements which may be audited at any time. Credits can be claimed under Peer Review. As a Branch Advisory Body, the AFMM and NZAMM are responsible for this. Affected Doctors should consult the MCNZ website at –

<http://www.mcnz.org.nz/maintain-registration/recertification-and-professional-development/collegial-relationships/>

Continuing Medical Education

CME activities are important as the main methods used by most clinicians to maintain and upgrade their medical education. CME is the traditional yardstick used by many medical groups to monitor members' professional knowledge though mere attendance does not necessarily follow through to improvement of clinical outcomes.

The CME domain includes all activities in which individuals engage to gain access to new information, such as searching the literature, attending scientific meetings and educational courses, participating in informal workshops and seminars, and gaining accreditation in particular aspects of practice. These activities are evaluated in terms of the quality and quantity of information and awarded points accordingly in the programme.

Doctors recertifying must attend a minimum 20 hours of CME per year, and can claim a maximum of 40 points per year. Faculty-accredited CME is scored at 2 points per hour, whereas non-accredited CME is scored at 1 point per hour. If you think a particular course or meeting should be accredited, forward a copy of the programme or web-link to the Administrator for consideration by the CPD committee. The committee will publicise by email or on the AFMM website which providers of education are accredited. The final decision on whether any particular CME is considered relevant to musculoskeletal practice lies with the CPD committee.

For CME not organised by the Faculty, keep copies of all attendance certificates until your triennium is completed. These may be required at any stage by the CPD committee. Do not forward them each year with your annual CPD return.

Teaching and Research

This domain encourages re-accrediting members of the AFMM to establish and maintain the highest standards of scientific learning and practical skill in the discipline of musculoskeletal medicine.

Such contributions include development and revision of sections of the AFMM's Syllabus, preparation of the AFMM's evidence-based clinical practice guidelines and procedural protocols, and preparing critically appraised topics. Other practical ways of acquitting member's responsibilities in this area include teaching in formal educational programs, speaking at scientific meetings, undertaking research, publishing scientific literature, and serving on educational committees and working parties. These functions are allocated points in the CPD program as per the AFMM CPD Implementation Schedule.

Professional Activities

Whilst the Faculty is dependent on its members giving their time and expertise to the Council and its various committees, this cannot be considered part of CPD. On the other hand, it is recognised that participation in these group activities frequently includes discussion on clinical and peer review matters, and this has been recognised by a small credit for such activity.

Compulsory Activities

Within each triennium, it is compulsory to participate in cultural competence training, and advanced cardiac life support.

Cultural Competence

We live in a multi-cultural society with special recognition of the place of Tangata Whenua. Good medical outcomes depend on communication as well as medical expertise. The Faculty require each Doctor to participate in at least one workshop on cultural competence every triennium. A workshop should be at least one half day long, and will be rated 10 points for the purpose of the CPD return. The AFMM undertakes to provide at least one cultural competence workshop every three years. All teaching and re-accreditation programmes should integrate cultural issues.

Advanced Cardiac Life Support

Apart from being required to be competent in dealing with life support situations in public, Faculty members are involved in hands-on treatment of patients, sometimes using invasive techniques. Recognising this, it is a requirement that members successfully complete an advanced cardiac life support course. The minimal acceptable standard is NZ Resuscitation Council level 5 which should be at least ½ day long and attracts 10 points on the CPD return. The CPD committee strongly recommends that accrediting Doctors do a NZ Resuscitation Council level 6 or 7 course at least once every triennium. These constitute a full day course, pre-course study, and attract 30 points on the CPD return.

Precision Spinal Injections

At the October 2010 Retreat in Christchurch, the following requirements for AFMM accreditation and reaccreditation were agreed –

- i) Initial Introductory Course (AFMM or ISIS)
- ii) Apprenticeship thereafter with an experienced needler
- iii) Annual re-accreditation
 - a. Annual summary of procedures done
 - b. Annual report of complications and any incidents including near-miss events
 - c. Annual visit by another needling practitioner similar to the existing Practice Visit.

As an interim measure, Accrediting Doctors involved in Precision Spinal Injections should have kept a log of procedures and provide a summary of the range and number of procedures performed including the number of cases (Appendix 6), and, at the same time, report on any incidents that have occurred during the year (including near-misses). 15 points can be claimed under the Audit section of the CPD. A further 15 points can be claimed under Audit for the practice visit.

Implementation

The programme is designed for ease of participation and to facilitate efficiency of administration. It uses functions that are part of normal practice. It encourages individual members to contribute to the AFMM's objectives, to express their professional knowledge and skills, and to produce evidence of their performance.

The implementation schedule for activities contributing to each of the four domains is attached. Any other activities considered useful for addressing the stated objectives may be submitted to the CPD committee for possible inclusion in the programme.

The requirement for reaccreditation is for each member to gain a total of at least 300 points in each triennium. There is also the requirement to obtain a minimal number of points of 100 per year as per the AFMM Implementation Schedule table. These requirements may be modified in special circumstances, at the discretion of the CPD Committee.

Points are generally awarded at 2 points per 1 hour of work. It is expected that at least 50 hours of work annually will be required for CPD.

All external and self-designed audits must be discussed with the CPD Committee before starting any audit. Faculty promoted audits are already endorsed.

Each year, after completion of the Audit, CME, contribution to the AFMM's education and research activities and Peer Review activities, a member will complete the AFMM Annual CPD Report *in electronic format* and forward them to the Faculty Administrator. This sheet and the Clinical Audit results will convey a summary of the CPD information necessary for the purpose of re-accreditation. Do not send in all your attendance certificates unless requested.

The 'Update' in 'Cultural Competence' and CPR / Resuscitation are only required once every cycle (3 years).

The 'CPD' year runs from 1st April to 31st March. The AFMM Annual CPD Report, including audit summary, should be forwarded to the Faculty Administrator. Copies of Cultural Competence, and Advanced Cardiac Life Support certificates should also be forwarded in the years in which they have been completed.

Random Audit

There will also be a random audit each year of 3 Doctors who will be asked to send in their original documentation verifying what activities they have been involved in. Do not send this material in unless it is requested. You would not have to verify that you have attended official AFMM meetings as a register of attendees is kept for these.

Non-performance

Successful completion of the 3 yearly cycle is vital to maintain the AFMM Fellowship and to maintain Vocational Registration with the Medical Council of New Zealand. Failure to complete the 3 yearly cycle means that the Faculty cannot certify to the Medical Council of New Zealand that you are fulfilling its reaccreditation requirements. In this situation, the CPD committee will design an individualised restoration programme so that the participant can regain vocational registration. At any stage, if there are serious concerns raised about a participant's fitness to practice, the Censor-in-Chief will be notified.

Extenuating Circumstances

If at any stage, personal or professional circumstances make it difficult for you to fulfil your reaccreditation requirements, please convey this to the Faculty Administrator.

Calendar

The timeline for 2014-15 is –

2013

December You will be sent the recertification process for the forthcoming year and will be asked whether you wish to be part of this.

2014

January 31 Deadline for responding to the Email of December with your intentions for the coming year.

March 31 Those who haven't returned their reports for the year 2013-14 will get a reminder.

June 1 Late-processing fee of \$200 will now apply

July 1 Those who haven't sent in their Recertification material will be vulnerable to Medical Council of New Zealand audits.

AFMM CPD Committee.

December 2013.

AFMM CPD IMPLEMENTATION SCHEDULE.
PER 3 YEAR CYCLE (300 points/cycle @ 100 points/year)

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AUDIT OF MEDICAL PRACTICE (min 1 audit/yr) (max 40 pts/yr)	<i>The Audit</i>	Up to 40	submission of audit summary
	<i>Practice Visit Audit (First Pass)</i>	15	
	<i>Practice Visit Audit (Second Pass)</i>	10	
PEER REVIEW (min 10hrs/yr) (max 40 pts/year)	<i>case presentation at peer review meeting</i>	2/hr	Notification in Annual CPD Report
	<i>Peer review of Charts</i>	2/hr	
	<i>Practice Visit</i>	10	
CME (min 20hrs/yr) (max 40 pts/year)	<i>conducting a problem-oriented literature search(Medline or similar)</i>	2/hr	Notification in Annual CPD Report
	<i>active membership of a journal club</i>	2/hr	
	<i>attending an accredited scientific meeting</i>	2/hr	
	<i>attending an accredited educational course / workshop</i>	2/hr	
	<i>attending a non-accredited scientific meeting</i>	1/hr	
	<i>accreditation in a particular skill or area of practice</i>	40	
TEACHING AND RESEARCH (min 20hrs/yr) (max 20 pts /year)	<i>preparing a critically appraised topic(CAT)</i>	10	Notification in Annual CPD Report
	<i>writing an appraisal of a scientific article</i>	5	
	<i>preparing a literature review</i>	20	
	<i>other material contribution to education and research e.g. Masters in Pain Medicine.</i>	1/hour up to 20/year	
	<i>speaking at an accredited national meeting</i>	10	
	<i>teaching or examining at an accredited educational course</i>	2 /hour up to 15/year	
	<i>acting as a mentor or preceptor to trainees</i>	up to 15/year	
	<i>undertaking an evidence-based scientific study</i>	20	
	<i>publication of a scientific paper</i>	20	
	<i>publication of book chapter</i>	30	
	<i>material contribution to accredited publication</i>	10	
	<i>editing a relevant publication</i>	20	
	<i>membership of an accredited educational committee</i>	1/hr (max 20)	
PROFESSIONAL ACTIVITIES (max 5 pts/year)	<i>musculoskeletal- related committee activities</i>	1/hr (max 5/yr)	
COMPULSORY ACTIVITY	<i>certificate in cultural competence</i>	10 pts (every 3 yrs)	Certificate of Attendance
COMPULSORY ACTIVITY	<i>Certificate in CPR (ACLS Level 5) Certificate in CPR (ACLS Level 6 or 7)</i>	10 pts 30 pts (every 3 yrs)	Certificate

Notes on the Implementation Schedule:

1. *Functions implying production of a document are deemed to have been performed when the document is submitted for publication.*
2. *Accredited meetings and courses include those pertinent to topics in the AFMM's syllabus and accredited by the CPD Committee.*
3. *In the CME domain, most functions are rated on the basis of time involved; at 2 points per hour. A maximum of 15 points applies to most of those functions, to encourage diversity of CME activity.*
4. *Undergoing training to the level deemed satisfactory for accreditation in a particular skill or area of practice described in the Faculty's Accreditation Program will gain a Fellow 40 points in the CME domain.*
5. *CME points cannot be carried over into another year except in exceptional circumstances at the discretion of the CPD Committee.*
6. *In the Teaching and Research domain, a maximum of 20 points per year may be claimed for any particular function.*
7. *Material contributions to education and research will be rated according to the time and effort involved in their preparation. For example, writing a new chapter for one of the AFMM's evidence-based guidelines will be rated as worth 20 points; re-writing and updating a chapter already in existence as 10; and re-writing a section of the AFMM Syllabus, amending the references to acknowledge newly-published literature, as 10 points.*
8. *The criterion by which speaking engagements will be recognised is the issuing of a published brochure or programme for the meeting.*
9. *Attendance every 3 years at a CPR Course to update CPR skills (Level 5 minimum, Level 6 or 7 Recommended) and 'Cultural Competence' is mandatory.*

Website Resources

All of the stationery listed in this document can be downloaded from the AFMM website .



AFMM ANNUAL CONTINUING PROFESSIONAL DEVELOPMENT REPORT

(1st April 2014 - 31st March 2015)

Name: _____

DOMAIN	FUNCTION				POINTS	TOTAL
Audit (QA)						
Total Audit	Date	Topic			Hours	Points C/F
(example)	1-Jun-10	AFMM RPR Audit - 1st Pass				15
Total QA (Audit) (Minimum 1 audit per yer, Maximum 40 points subtotaled for year)						
PEER REVIEW						
	Date	Topic	Name of Individual / Group	Venue	Hours	Points Subtotal
(example)	1-May-10	Case Presentations	AFMM Retreat	Orewa Surf Club	0:30	1
Total Peer Review (Minimum 10 hours per year, Maximum 40 points subtotaled for year)						
CME						
	Date	Topic	Presenter	Venue	Hours	Points Subtotal
AFMM & Endorsed (2 points / hour):						
(example)	1-May-10	Ankle Update	Homer Simpson	AFMM Retreat, Orewa	2	4
Non-Endorsed (1 point / hour):						
Total CME (Minimum 20 hours per year, Maximum 40 points subtotaled for year)						
TEACHING & RESEARCH						
	Date	Topic	Audience	Venue	Hours	Points Subtotal
Total Teaching & Research (Minimum 20 hours per year, Maximum 20 points subtotaled for year)						
PROFESSIONAL ACTIVITIES (max 5/year)						
	Date	Council / Committee		Venue	Hours	Points
Total Professional Activities (For discussion about clinical matters or peer review. Maximum 5 points subtotaled for year)						
SUBTOTAL FOR CURRENT YEAR						0
COMPULSORY ACTIVITY						
	Date	Topic	Presenter	Venue	Hours	Points
Cultural Competence						
ACLS (Min level 5)						
ACLS (Recommended level 6-7)						
TOTAL ALL CLASSES						0

Please attach copies of CPR Certificate and Cultural Competency Certificate (if done this year)
I participate in musculoskeletal medicine for at least 10 half days per annum.
This is a true account of my activities toward the Continuing Development Programme

Signature:

Date:

Appendix 1

Regular Practice Review (RPR)

Practice Audit & Visit

The purpose of Continuing Professional Development is for continued improvement of the practice standards of the individual Doctor and the group as a whole. The Medical Council of New Zealand has recognised the limitations in the current CPD programmes. They have promoted discussion recently on the use of practice visits for audit and peer review. The aim is to perform a supportive and collegial review of a Doctor's practice, which should be beneficial for both the host and the visitor(s). Practice visits have been found to be a useful tool by the RANZCOG, RNZCGP, RACP, ANZCAanaeth, and the NZ Dermatology Society.

In 2009, the CPD committee, after consultation decided that the practice visit should be compulsory at least once in every triennium for Doctors certifying through the NZAMSM and AFMM, but can be performed annually. The process does not however have to be arduous. The Obstetricians have a two-day practice visit by two colleagues. We have split the process into a self directed practice audit followed by a practice visit which shall be of at least four hours duration, and include at least three hours of observed consultation.

This process is for a practice visit and assessment of the consulting process. It is not designed for re-accreditation of spinal injections.

Unless there are significant deficiencies discovered, the aim is not to pass or fail the Practitioner to be visited, but the Faculty may pool information in an anonymous manner for comparison of the Practitioner with the results of their broader peer group. The arbitrary scoring on the audit sheet is to facilitate the comparisons, rather than representing a "pass" rate. If for example, the average score of the cohort is low in any particular grouping, the Faculty will have to consider the necessity for further intervention.

The points for the process are –

AFMM Practice Visit Check List (scored in Clinical Audit domain)

- 15 First Pass for Host Practitioner
- 10 Second Pass for Host Practitioner in one triennium

Practice Visit (scored in Peer Review domain)

- 10 Host Practitioner
- 10 Visiting Practitioner

Mechanism

1. The doctor who is being assessed contacts the Faculty administrator.
2. The host doctor completes an AFMM Practice Visit Check List and sends this to the administrator.
3. The Faculty administrator appoints a visiting Doctor, who phones the Host Doctor and arranges a suitable time for the visit. The administrator provides a copy of the completed AFMM Practice Visit Check List to the Host Doctor.
4. The visiting Doctor reviews the practice using the audit sheet as a template, and also the video analysis sheet as a template for the consultations.
5. **It is recommended that at least 3 hours of consultations (mixed new and follow-up patients) should be observed, with another 1 hour allowed for discussion afterward.**
6. The visiting Doctor returns the audit sheets and a written report to the Faculty Administrator.
7. The host Doctor provides a report to the Faculty Administrator.
8. The Faculty Administrator combines the data into a pooled database and when there are sufficient numbers of audits and visits, provides a comparison to each



AFMM Practice Visit Check List

Doctor:

Site:

Date:

(Circle correct) Score Comments

A. Availability and Accessibility

A1. Car Park for Disabled within 50 metres of Building	Yes	No	/2	
A2. Wheelchair Access to Building	Yes	No	/2	
A3. Timely triage assessment of referrals	Yes	No	/2	
A4. Signage (score 1 ea for Practice Entry, Toilet)	Yes	No	/2	
A5. Fire Emergency Signage & Evacuation Plan	Yes	No	/2	
Total	10			

B. Practice Facilities

B1. Clean Environment – regular & effective cleaning system of surfaces, floors, basins, toilet areas clean and deodorised	Yes	No	/3	
B2. Reusable equipment is decontaminated and sterilised	Yes	No	/2	
B3. Instruments stored in a manner to maintain sterility	Yes	No	/2	
B4. Hand Washing Facilities in each consultation room	Yes	No	/3	
B5. Sharps disposable in each consultation room	Yes	No	/3	
B6. Secure Controlled drug storage	Yes	No	/2	
Total	15			

C. Practice Equipment

C1. Hydraulic Plinth in consultation room	Yes	No	/2	
C2. Reflex Hammers	Yes	No	/2	
C3. Equipment for Sharp Sensation	Yes	No	/2	
C4. Gloves	Yes	No	/2	
C5. Ophthalmoscope	Yes	No	/2	
C6. Thermometer	Yes	No	/1	
C7. X-ray Viewing Box	Yes	No	/2	
C8. Ambubag	Yes	No	/2	
C9. IV Equipment (for infusion)	Yes	No	/2	
C10. Airways	Yes	No	/2	
C11. Oxygen	Yes	No	/1	
C12. Defibrillator	Yes	No	/2	
C13. IV Adrenaline	Yes	No	/3	
C14. IV Corticosteroid	Yes	No	/1	
C15. Method for checking drug expiry dates	Yes	No	/2	
C16. Emergency Protocol for Staff	Yes	No	/2	
Total	30			

D. Respect for the Rights and Needs of Patients

D1. Sound-proofed room	Yes	No	/2	
D2. Good lighting	Yes	No	/1	
D3. Change area for patient with privacy	Yes	No	/2	
D4. Patients are made aware of their right to a chaperone	Yes	No	/2	
D5. Code of Health & Disability Poster & Leaflets Visible	Yes	No	/1	
D6. Confidentiality of Records – security of medical records (Passwords for computers, locked storage of paper records)	Yes	No	/2	
D7. Confidential waste paper shredded	Yes	No	/1	
D8. Telephone conversations are private	Yes	No	/2	
D9. The practice has a complaints procedure	Yes	No	/2	
Total	15			

E. Records

E1. Paper Records				
E2. Computer Records				
E3. Computer Record Style - Specialised Software / General eg (MS Office)	Spec	Gen		Name:

E4. Recall system for investigations, follow-up abn results			/3	
E5. Searchable function for audit			/2	
E4. Demographic Data recorded of name, NHI, phone numbers, etc			/3	
E5. Records kept for 10 years			/2	
	Total	10		

F. Communication

F1. Length of first consultation for complex problem (mins)		Mins		30 mins = 1 45-60 2
F2. Length of first consultation for simple problem (mins)		Mins		15-30mins=1.30+mins=2
F3. Length of follow-up appointment (mins)		Mins		10-20mins=1.20 30mins=2
F4. Patient Consent Procedure	Yes	No		Spinal interventions only =1, Clinic Injections 2
F5. Written information available for patients (maximum 2 each indicator)	Yes	No		Some=1, Lots = 2
	Total	10		

G. Integration of Care

G1. Network of other health care providers (Practitioner to describe)	Yes	No	/3	Orth / Physician / PT / Osteo / Chiro
G2. Referral to other providers where limits of ability reached	Yes	No	/3	Evidence of Referral = 3
G3. Referral letters contain all necessary information	Yes	No	/4	Demographic=1, Add phone numbers+1, Add allergies+1, Other med conditions +1
	Total	10		

TOTAL SCORE (for Standard Practice Audit)

Max 100

H. Training Practice – Additional Points to Assess for Training Practices

H1. Adequate Space in Host Trainer's Consultation Room for Trainee to Observe	Yes	No	/4	
H2. Spare consultation room for Trainee to See Patients	Yes	No	/4	
H3. Practice Equipment (Items C1-C8) available to Trainee	Yes	No	/2	
H4. Mechanism for patients to be informed of trainee present in the practice	Yes	No	/2	
H5. Procedure for securing consent of patients to see the Trainee	Yes	No	/2	
H6. Computer Terminal Available to Trainee	Yes	No	/3	
H7. Time put aside each day for case case discussion/review for trainee.	Yes	No	/3	

TOTAL SCORE FOR TRAINING PRACTICE

Total 20

Assessors Notes:

Practice Suitable for Registrars to Observe

Yes No

Practice Suitable for Registrars to Consult

Yes No

Acknowledgements:

RNZCGP Fellowship Assessment Visit Information Booklet for Candidates

Medical Council of NZ Consultation on the proposed use of practice visits (periodic assessment of performance) as part of continuing professional development,



Continuing Professional Development

Practice Visit Assessor(s) Report

Host Doctor:

Site:

Date:

Visiting Doctor:

2nd Visiting Doctor:

(If there is more than one visiting Assessor, each should complete an assessment report)

1, Did you receive a copy of the Host Doctor's Practice Audit sheet for review during the visit? Y / N

2. Consultations observed :

Consultation	New / FU	Duration (mins)	RNZCGP Fellowship Assessment consultation observation tool				Overall Performance
			Therapeutic Relationship	Identifying Problems	Appropriate Examination	Appropriate Management	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total Scores							
Ave Scores							

3. Where there any barriers identifying to undertaking the Practice Visit (eg access, accomodation, travel, attitudes)?:

4. Overall positive comments regarding the Practice Visit:

5. Overall, are there any negative comments you have about the Practice Visit?

6. Has this been a useful peer review activity for you? Please explain:

7. Any other comments:

Signed: _____

Date: _____

Appendix II: Criteria for Assessing Consultations

Establishing and maintaining a therapeutic patient/ doctor relationship	Defining the problems and reasons for patient's attendance	Performing an appropriate examination	Providing appropriate management	The overall performance – the integration of consulting and professional skills
0 Damaging aspects to the relationship with the patient including concerns about cultural competence.	0 Life threatening problems appear to have been missed.	0 Absent or very inadequate examination for the major problems; safety concerns. Patient consent to examination not established.	0 A dangerous management plan including dangerous omissions. Effect of cultural differences not considered.	0 Unethical or dishonest behaviour or other serious concern re candidate behaviour. (Append explanation)
1 The patient is not being heard. Responds to immediate reason for consultation but misses obvious patient cues. Not patient centred.	1 Presenting complaint poorly identified or other major problem(s) may have been missed.	1 Poor examination technique, patient consent to examination not established.	1 Unclear, or poorly justified management for major problem(s) with potential safety risks. Effect of cultural differences not considered.	1 Standard not adequate for Fellowship. Major deficiencies in skills or poor organisation and integration of consulting skills. (Explain) Requires further training.
2 Patient heard but not at ease. Responds to obvious cues but not exploring concerns or feelings of the patient. Not patient centred.	2 Presenting and other major problems probably identified but without verification with patient. Prioritisation unclear.	2 Examination not adequate for the major problems, patient consent to examination uncertain.	2 Safe management for the major problem(s), doubt remains about the patient's agreement to the management and/or the impact of cultural differences.	2 Standard not adequate for Fellowship. Deficiencies in organisation and consulting skills. (Detail these) Requires feedback and then further assessment.
3 A therapeutic relationship is established. Limited expression of patient concerns and feelings. Exploration limited. Mostly patient centred.	3 Presenting and major problems defined, verified with patient, and safely prioritised. Associated problems or preventive care opportunities missed.	3 Adequate examination for the major/life threatening problems, patient consent to examination established, no examination for associated problems.	3 Sound management for the major problem(s), with agreement of the patient. Management of associated problems ignored. Cultural differences factored in.	3 Adequate standard of performance for College Fellowship but organisational and/or consulting deficiencies which could be improved. (Detail the deficiencies)
4 Therapeutic relationship clearly established. Open expression of concerns and feelings. Some weaknesses noted. Patient centred.	4 Most major and associated problems identified, verified with patient and safely prioritised. Preventive care issues may have been missed.	4 Adequate examination for most problems with clear consent of the patient, but some omissions from the ideal examination.	4 Clear and sound management plan for most problems, including all major problems, clear patient agreement. Minor omissions in plan.	4 Clearly suitable for College Fellowship. Practising mostly to a high standard. Minor deficiencies noted.
5 Strong therapeutic relationship clearly established. Mastery of relationship skills to a high level. Clearly patient centred.	5 All relevant problems, concerns and preventive care opportunities clearly identified, verified with patient and safely prioritised.	5 Examination clearly adequate for all problems, with clear consent and full co-operation of the person with authority to provide consent.	5 Clear, sound and comprehensive management plan with clear patient agreement, addressing all problems with no significant omissions.	5 Clearly suitable for Fellowship. Practising to a consistently high standard. No deficiencies noted.
OVERALL RATING	OVERALL RATING	OVERALL RATING	OVERALL RATING	OVERALL RATING



Continuing Professional Development

Practice Visit Host Report

Host Doctor: _____

Site: _____

Date: _____

Who were your Assessors?:

1. Did you request a practice visit or was it by direction of the Faculty?	Self / Faculty Directed
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2. Did you complete a practice audit prior to the assessment?	Y / N
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3. What comments do you have on the Practice Visit Process? You may like to comment on the attitudes of the AFMM Administration, the attitudes of the Assessors, the actual practice visit, changes in consultation dynamics, negative and positive aspects of the practice visit:
--

Signed: _____

Date: _____



AFMM INTERVENTIONAL PAIN PROCEDURE SUMMARY			
(1st April 2014 - 31st March 2015)			
Name:			
		Patient Numbers	Number of Procedures
Cervical	Atlanto-occipital Joint Intra-articular Injections		
	Lateral Atlanto-Axial Joint Intra-articular Injections		
	Third Occipital Nerve Blocks		
	Medial Branch Blocks		
	Zygapophyseal Joint Intra-articular Injections		
	Transforaminal Injection		
	Intra-laminar Epidural		
	RF TON Neurotomy		
	RF Cervical MBB		
	Other Cervical Procedures (List):		
Thoracic	Medial Branch Blocks		
	Zygapophyseal Joint Intra-articular Injections		
	Costo-vertebral Joint Intra-articular Injections		
	Costo-transverse Joint Intra-articular Injections		
	Transforaminal Injection		
	Intra-laminar Epidural		
	RF Neurotomy		
	Other Thoracic Procedures (List):		
Lumbar	Medial Branch Blocks		
	Zygapophyseal Joint Intra-articular Injections		
	Transforaminal Injections		
	Intra-laminar Epidural		
	Caudal Epidural (under Fluoroscopy)		
	RF Neurotomy		
	Other Lumbar Procedures (List):		
Sacro-iliac Joint	Intra-articular Injections		
	RF Neurotomy		
Anterior Chest	List:		
Peripheral Joint	List:		
Sympathetic Nerve Blocks	List:		
Peripheral Nerve Blocks	List:		
Any adverse complications of Procedures (List events):			
Explanation	Patient Numbers refers to theatre slots, eg if you perform the same procedure on the same patient twice during the year, list patient number as 2.		
	Number of Procedures refers to separate procedures, eg count each level of MBB.		