#MentorRCA Top Tips for the RCA | Dr Nigel Giam | Lead GP TPD | Accredited RCA Trainer

13 Consultations - 12 mins each to reflect all the RCA |CSA competences over depth, breadth and sufficiently challenging to reflect the CSA and curriculum coverage.

What works in your favour?
1. Consultations can be recorded onto external digital devices - so get going - they can be uploaded to the RCGP/14 Fish secure server once you have decided which to submit
2. Don't bother recording consultations where there are several agendas to be met
3. Urgent care clinics can be good - one problem, time limited
4. Avoid follow ups with your own patients - they won't hit the criteria
5. Chronic disease cases: look for the acute deterioration upon chronic problem
6. Need to objectively show you are meeting the criteria as you consult
: have the Mentor RCA Marksheet to hand
7. Be stringent in how you mark your consultations
8. Prioritise the Mandatory Criteria | Cases
9. Avoid Low Challenge Cases

Consent:
- As part of my training here at the practice, I am recording my consultations during this clinic. This is solely for training and assessment purposes - Is that ok with you?
- If at any time during the consultation, or at the end you are not happy with the recording, please let me know and it will be deleted
- Please may I confirm your DOB?

So I have produced this guide for the new RCA to help using my experience as a previous RCGP Examiner for both the old videos and the also the CSA:
So lots of queries about how good is good enough?
What exactly is being looked for?
How subjective/objective is the assessment?

This is indeed a different challenge and appreciate it can be disheartening when you have done a whole clinic of recordings and not one is up to scratch. Unfortunately you cannot anticipate when the perfect patient might present but you can control the consultation to demonstrate the behavioural competences if you have the right strategy.

Remember ALWAYS to have the RCA MARKING criteria in front of you.
Use my RCA|CSA Mantras to help you focus.

You need to EXPLICITLY demonstrate the RCA criteria and there are certain phrases/statements which can be used in context to keep yourself close to the criteria and objectively close to the marks.

The video is much more objective than the CSA - it is recorded!
In the old days (yes I am a dinosaur!), 2 examiners watched the video to triangulate.
There are not many of us who trained in the old, examined for it and then moved with the new.

Let's crack on!

The criteria which GPSTs always fall down most on are the GLOBALS : 1 | 2 | 4

Competency 1 - disorganised and unstructured

- ensure that your submission has a natural flow – start with a strong start to the STORY, before you move towards SYMPTOM/SYSTEM
- strong start requires a strong finish from A to B

Competency 2 - does not recognise the issues/priorities/dilemma

- if there is a DILEMMA e.g. antibiotic request, then actually verbalise this word and consider what the dilemma is e.g. RISK vs BENEFIT / Budgetary Governance

Competency 3 – TIME MANAGEMENT

- 12 mins is what has been stipulated, if your video runs over and you have not demonstrated the criteria at that point, then it will not fit the bill

Competency 4 – Poor Choice of Consultation

- Ensure the case chosen demonstrates both sufficient clinical challenge and angle which will be encompassed by the complicating factors of the case – click here

DATA GATHERING

Need to elicit adequate amounts of new information to demonstrate competence

Competency 4 – Abnormal findings and their implications

- This is about risk management. You need to be shown to be taking a good focussed history around red flags of the SYSTEM in context to be able to commit to risk and a working diagnosis. Ensure you SIGNPOST questions if they might appear out of context.
- Ensure that you use the information already available to you in the patient's notes and verbalise this as necessary in context during the consultation
- As highlighted, you need to be eliciting new information to demonstrate competence therefore follow ups should be avoided

Competency 5 – physical/mental examination is appropriate and in context

This is challenging with remote consultations – think about what you can do, rather than what you can't do!

- Can I ask you to take your temperature now if you have a thermometer in your home?
- Do you know how to take your pulse - explain and ask the patient to take it over 15-20 seconds
- Respiratory rate : also ask patient if there is any wheeze, breathlessness, how it is affecting their daily life, can ask objective exercise tolerance in terms of steps in house before getting breathless, kitchen to bathroom etc.
- Do you have a peak flow meter at home?
- Do you have a BP machine at home? Can I ask you to take it out and measure it now?

- Abdo pain: Can you stand upright? Does getting out of bed or bending over exacerbate it? Deep breaths exacerbate pain? If they can lie flat and ask getting the patient to palpate where it is tender – acute tenderness, guarding.

- Try to describe lump in terms of size, e.g. comparable with food like pea size, rice grain or ask the patient to estimate size in mm and ask the patient to examine themselves and describe the texture of the lump - soft, hard vs spongy like a cyst. Smooth vs Craggy etc

Competency 6 – making an appropriate working diagnosis / differentials

- you have to make a commitment – firstly to risk and if a patient asks you what you think is going on, then commit sensitively to your working diagnosis
- you can't sit on the fence e.g. 'I have no idea what is going on, let's get some blood tests and I will see you in 2 weeks'
-

CLINICAL MANAGEMENT SKILLS

Competency 7 – does not develop a management plan that is appropriate/ in line with current best practice

- **Remember that clinical examination is not part of clinical management**
- **Clinical management only commences when you start attending/committing to risk AND when you consider management in accordance with your differentials**
- If you do prescribe then you must specify exactly what you are prescribing In terms of the medication, dose and duration.
- If you undertake a blood test, be clear what it is you are trying to confirm or exclude – we don't need to hear FBC, U+E etc. So for example if you investigate a change in bowel habit, with a PR bleed then you can say "There are some blood tests I would like to undertake to ensure you are not anaemic given the bleeding you have experienced. "

Competency 8 – appropriate use of resources / budgetary governance

- ensure you don't refer / prescribe unnecessarily
- conversely if a patient does require a referral, then how urgent is this?

Competency 9 – follow up and safety netting

Ensure your safety net is complete and verbalised explicitly

How do you know you are right?
How do you know you are wrong?
What would the patient/you do at that point?

for example:
1. So with the antibiotic, I would expect you to start feeling better after 48 hours or so
2. However if you start feeling worse and develop any of the following symptoms ….
3. Please could you get back in touch with the practice or out of hours if the practice is closed

We don't need to schedule a routine follow up but if things are much the same after you have finished the course of antibiotic then do let me know.

Competency 10 – management of risk / awareness of relative risks of different options

- this is about risk management in the context of the relative benefits / risks of any proposed option
- is your management reactive as opposed to defensive to the level of risk you are clinically committing to
- and remember you are managing people as opposed to diagnoses

Competency 11 – health promotion at opportune times

- best demonstrated with a chronic disease type case or when there may have been a stress reaction
- don't become paternalistic with your health promotion in the first half of the consultation
- health promotion is best done as part of your clinical management in the 2nd half

INTERPERSONAL SKILLS

Competency 12 – rapport / awareness / not understanding a patient's health understanding - 'ICE' in context

Don't force 'ICE' - if it is given to you naturally then you should clearly acknowledge it verbally and use it to refocus your line of questioning

e.g. "You mentioned you were worried your cough may be due to cancer. I can see you are concerned, we will keep an open mind and I will ask some questions to try to find out what might be going on"

If 'ICE is not given, then ensure you ask it in context

e.g : "You mentioned you have not been able to work with the cough. Had you any particular thoughts as to what might be causing it?"

e.g. "You mentioned you were concerned about cancer, when you made the appointment today had you any thoughts as to how we might best address your concern?"

Also remember that your actions will have reactions, if a patient is shocked by what you have said, for example around a potentially serious diagnosis, acknowledge that emotion, empathise and energise. (A E E). Think about your tone, timing and pacing.

Competency 13 – poor active listening skills and use of cues. Consulting appears formulaic.

MAKE SURE THE EXAMINER CAN SEE YOU AND MORE IMPORTANTLY HEAR YOU ACKNOWLEDGE AND RESPOND TO CUES.

e.g. "You mentioned you have been quite worried about the cough. Could you tell me more? Did you have a particular concern you wanted me to address?"

Competency 14 - not placing the complaint in context within a psycho social perspective

Remember you are managing people not just symptoms and diagnoses

e.g. "The cough seems to be bothering you. Can I ask has it stopped you from doing your usual activities. For example has it interfered with work?"

This is NOT about saying who lives with you at home, do you work, do you smoke/ drink etc…

Competency 15 – shared management, working in partnership with the patient

There is a difference between being patient centred and being patient driven. This competency is not simply about saying : "Here are the options, what would you like to do?"

In addition, don't simply say "Are you happy with the plan?"- the patient will not necessarily challenge your decision if they are unhappy or they may well do in a confrontational way if they are really unhappy and feel they have not been listened to.

It is much more about readdressing patient agendas, agreeing/negotiating a shared management plan which is reactive and appropriate, as opposed to defensive and risk averse.

e.g. "I appreciate that when we started the consultation you were keen for an antibiotic and I do appreciate where you are coming from. The dilemma of giving an antibiotic immediately when it is not needed is that you may well experience unnecessary side effects, and in the long term antibiotic resistance which is a dangerous side effect. An alternative option might be to delay the antibiotic for the next few days to see if your symptoms settle with conservative measures. In that way the antibiotic is still there if you really need it, but if you don't this will be beneficial for you also. Can I ask what you are thoughts are with regards to that as an option moving forward?"

or

"I have some thoughts as to how we can move forward and would like to share these with you, but can I ask had you any particular thoughts yourself coming in today as to what you would like with regards moving forward with your problem?

: Competency 16 – does not use language and/or explanantions that are relevant / understandable the patient

- don't ASSUME the patient is on the same wavelength as you
- check their understanding if your explanations don't seem to register
- keep it SIMPLE and TALK WITH NOT AT YOUR PATIENTS

Recommended Resources:

Dr Nigel Giam – Top Tips To Passing The CSA

All articles can be downloaded from the website

www.mentormeducation.com under resources

Podcasts on YouTube MentorMRCGPCSA

Example Mentor RCA Video Consults

including Remote Consultations | Interviews with successful ST3 in the RCA

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