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Random Case Analysis in Practice Clinical Meetings

This manual describes how random case analysis (RCA) can be used in practice clinical meetings as a patient safety and quality improvement tool.

In the RACGP CPD Program, RCA can be a self-directed CPD Accredited Activity receiving 40 points. More detail is available www.racgp.org.au/education/professional-development/qi-cpd

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Background

Random case analysis

Random case analysis (RCA) involves the discussion of a selected medical record with a peer. It has been used for education purposes in Australian GP training [1]. A fundamental aspect of RCA is that the selection of the clinical record is by not directed by the clinician having their records reviewed. This 'random' selection makes RCA is useful in identifying blind spots or 'unknown unknowns' in a clinician's skills or knowledge. The use of peer feedback in group sessions has been shown to be a powerful motivator of behaviour change [2]

RCA has been found to be particularly useful in teaching and assessing ***clinical reasoning***. When making diagnostic or management decisions, a GP considers the patient's concerns, medical history, social history, the strength of the evidence for various management options, and the available resources to manage the patient. This complex reasoning task is sometimes referred to as "the art of general practice" or "thinking like a GP thinks." This skill cannot be learned in a textbook. It can be developed through the discussion that occurs during RCA about contextual factors influencing the decision that was made in the case being reviewed.

RCA also has utility in teaching and assessing ***medical record keeping***. The standard for medical notes is that they should be adequate to enable another practitioner to continue patient care [3, 4]. RCA offers an opportunity for practitioners to consider whether the records reviewed meet this standard.

The approach to RCA described in this manual focuses on clinical reasoning and medical record keeping. These skills belong to two of the five RACGP domains of general practice. These are the domains that RCA is best suited to evaluate. RCA can be used to explore knowledge and skills in other domains of general practice such as communication skills, health screening, and professionalism. It is also possible to use each RCA case as a springboard for broader discussions beyond the specific case by asking what if the problem, person, doctor, or system was different? This more extensive use of RCA is outlined in "Random case analysis. A new framework for Australian general practice training" [1].

Quality improvement

Discussions of clinical care can move beyond considering the choices of individual clinicians and consider practice systems. A quality improvement approach involves an ethos of looking to improve rather than finding fault and considering how improvements can be measured. management and consider practice systems. Clinicians coming together to discuss improvements in clinical care is a feature of care in other countries. This quality improvement peer-review strategy is called 'quality circles' [5]. RCA is a method well-suited to generate clinical care discussion in quality circle meetings.

Patient safety

Attempts to improve patient safety often involve looking back at the care provided in cases where errors or patient harm have already been identified. In contrast, RCA examines cases where errors have not yet been identified. Potential threats to patient safety may be uncovered before harm results. RCA in clinical meetings may proactively prevent adverse patient outcomes.

Fulfilling Medical Board requirements for performance review

The Medical Board of Australia has designed a Professional Performance Framework to support doctors to take responsibility for their own performance [6]. The framework requires at least 25% of continuing professional development to consist of performance review. The Medical Board notes the value of peer review and encourages collaboration to promote a positive, respectful culture in medicine. RCA provides a method of achieving performance review in a supportive setting with trusted colleagues.

Providing effective feedback

It is important to acknowledge and reflect on the awkwardness of giving feedback. The conversations are difficult but important. It can be useful to reflect on the reason for the discomfort. In general practice practitioners deal with high levels of uncertainty in many of their consultations and due to the very broad nature of general practice can feel they are "not good enough." The following 4 principles are some strategies for overcoming "not good enough" and making sure the feedback provided is useful and safe.

Learner-centered feedback

Just as consultations in general practice should be patient-centered, feedback should be learner-centered. It is important to address the agenda of the presenting GP before considering the agenda of other group members. What questions does the presenting GP have about the case that they would like answered?

Balanced feedback

Start by acknowledging the difficulty of GP consultations. If possible, commence with feedback that is positive about the decisions made or the clinical records kept. Often these positives appear so obvious that they are not mentioned. For example, the history may be recorded well or the follow up instructions are clear, or the decisions made were consistent with guidelines. It is just as important to support good practice as it is to provide constructive feedback.

Feedback is offered

Feedback is often best offered as a suggestion rather than provided as a correction. For example, by saying, "what do you think about the idea of doing X?" instead of "in this situation I would have done X".

Feedback is specific

Feedback should be specific and not about the person. Rather than providing feedback that, "your test ordering is haphazard", it would be better after asking why the particular test was ordered, to outline what was considered the appropriate investigations to be and why. It is hard to alter being 'haphazard', but it is possible to consider whether specific tests were justifiable and alter practice accordingly.

Receiving authentic feedback

It can also be difficult to obtain feedback, particularly where there is a power imbalance in a relationship or where there are cultural norms at play. For example, a senior GP may have difficulty obtaining authentic feedback from a junior colleague. This can be overcome by the GP seeking feedback expressing doubts and inner questions about their performance. Such honesty invites reciprocal behaviour from more junior doctors that can deepen relationships and educational impact [7].

Preparing for the meeting

Inviting participants

Practitioners should be invited well in advance of the meeting and a reminder sent closer to the date. Although a personal face to face invitation and explanation is best, appendix 1 includes a sample invitation email and an explanation regarding the content of the session and how RCA will be used.

Consider who you would like to invite: doctors only, all clinical staff, or selected clinical staff?

RACGP CPD accreditation

In the 2020 -2022 RACGP triennium it is possible to have RCA in practice clinical meetings accepted as a CPD accredited activity, formerly known as a Category 1 activity. A process to aid achieving accreditation is outlined in Appendix 4.

Legal issues

It is important to consider how best to approach the legal requirements for examining records in your practice using RCA. A useful resource produced by the RACGP is "Privacy and managing health information in general practice"[8]. The advice provided is broad and is not tailored to a specific circumstance and appropriate legal advice still may be required.

The relevant legislation to using health records in RCA clinical meetings includes The Privacy Act 1988 incorporating 13 Australian Privacy Principles (APPs) and health records legislation in Victoria, New South Wales and the Australian Capital Territory. In general, the use of medical records without specific patient consent is permitted for improvement or evaluation of a health service. For example, in the Health Records Act Victoria, access may be permitted where "it is impracticable for the organisation to seek the individual's consent to the use or disclosure." Provisions such as these are the basis for allowing access to medical records during practice accreditation visits. As RCA similarly involves access to clinical records that cannot be accurately predicted prior to the session, accessing records during RCA for the purposes of quality improvement would likely be treated in the same manner as practice accreditation.

Although de-identification of records is recommended wherever possible, this may be difficult, if not impossible, for RCA. Practices should consider whether they should have a privacy notice (also known as a 'collection notice' or 'APP 5 Notice') that includes a description of the use of records in an RCA quality improvement session. An informed patient could then elect to not allow their records to be used in an RCA session. An example of wording to be used in a privacy notice is in Appendix 6.

Selecting the meeting type and date

Determine if you wish the meeting to be face-to-face or to be via web conference. There are advantages and disadvantages and technical issues to be considered with each format that are discussed in the following sections. Selecting a time and date can be harder. If a time cannot be found that suits all participants consider running the meeting on different days and times. Participants have to attend at least 4 hours of random case analysis and participate in the planning and review meetings to be eligible for RACGP CPD points.

Web conference meetings

The use of web conferencing has been accelerated by the COVID-19 pandemic. In addition to infection control advantages, using web conferencing platforms may increase participation and inclusivity, particularly when a practice has many part-time clinicians or operates over more than

one site. Screen-sharing can be used so all participants can easily see the medical record being discussed.

A disadvantage of web-conferencing is group discussion is not as easy and non-verbal cues to a participant's emotional responses may be missed. Participants should have their webcam operational and microphone on mute except when they wish to talk. It is important that participants are familiar with the web conferencing platform being used and are in a private location and using headphones. In larger group meetings, one participant may need to be selected as web conference facilitator to manage interactions such as changing hosts for screen-sharing, muting participants who have background noise, seeking responses by raising of hands, or monitoring group chat.

Face-to-face meetings

In preparing for a face-to-face meeting, make sure there is a way to display clinical records so all in the meeting can read them simultaneously. This is most easily done by using a projector connected to a laptop or computer that can access the clinic's medical software. The records can then be projected onto a wall or screen. As the displaying of the clinical record is vital to the session, it is best to have technical issues well-sorted prior to the meeting. Is the connection to the server fast enough to enable exploration of the record during the meeting? If not connected to the server (using a briefcase version), are the records being displayed the latest records?

The room set up should also be conducive to group discussion – participants should be able to see each other as well as the screen (Diagram 1).

Diagram 1.

An ideal room set-up that enables viewing of records as well as group discussion.

Selecting the presenting GP, group facilitator and scribe

For each meeting a presenting GP needs to be selected. This is the GP who will have their medical records reviewed. For the first meeting it will be wise to select an experienced or senior GP within the practice as the presenting GP. Ideally this GP will be a role-model by being open to feedback and improvement suggestions from the group.

A group facilitator will also need to be selected for each meeting. The group facilitator is the person who will lead the RCA questioning of the medical record and the group discussion that follows. The group facilitator would ideally be competent in running small groups and ensuring the wellbeing of all participants. In larger web conferencing meetings, a separate moderator of the web platform may be required.

A scribe is the person who will record the outcomes of the meeting. Ideally this person will be separate from the group facilitator. The scribe will record any practice systems issues or safety concerns identified where a patient needs to be contacted. They may also be required to record other information to obtain RACGP CPD points or PIP QI payments.

Ideally these roles will rotate among all practitioners in subsequent meetings as everyone becomes familiar and comfortable with the process.

Deciding if RCA sessions will analyse all records or will be a focused review.

RCA is an adaptable process. Although developed to look at *all* clinical records, RCA sessions can be focused on a particular clinical issue. For example, analysing all records involving the care of patients with Depression or all records where an opioid was prescribed. The choice to focus on a particular clinical issue might occur in response to an adverse event in your practice or because significant variance in management amongst clinicians has been identified.

Selecting the records to be reviewed

Prior to the meeting, the group facilitator should decide on the records of the presenting GP that will be reviewed. It is best to review recent notes as it is hard for the presenting GP to recall the thinking behind decisions (clinical reasoning) from consultations more than a few weeks ago. It is important that the presenting GP does not select the records to be discussed. For the first session we recommend the group facilitator progresses through the notes for a single session one after another rather than making a selection of only some records in the session. This avoids giving the impression that the facilitator is selecting records where fault can be found which could lead to defensiveness.

In subsequent meetings, as a supportive culture is established, it may be possible for the group facilitator to exclude notes that the facilitator does not consider valuable to discuss. However, even records of simple consultations may have valuable lessons. What may appear straightforward to the group facilitator may not be clear to other members of the group. In summary, it is important at least at the outset, that the group facilitator selects recent records from a clinical session and progresses sequentially through them.

There will be cases that a presenting practitioner may not want to discuss with the group. There can be many reasons for this, and this decision should at all times be respected by the group and another case chosen in its place.

If your practice has identified that it wishes to focus on a particular area of clinical practice, then this filter can be applied to record selection.

Conducting the RCA meeting

Setting the ground rules

At the start of the meeting, set the ground rules for group discussion. A supportive environment is best for learning. If RCA is done poorly or insensitively it can impact on a doctor's self-worth and negatively on their mental health. The following points are worth raising to help create this culture:

- The presenting GP can at any time advise that they do not wish to discuss a particular case.
- This is a quality improvement and patient safety process and not fault-finding.
- Honest reflection on reasons for decision will happen if participants feel supported and safe.
- The aim is to share the expertise that is within the group and learn from each other. No single person is the expert!
- General practice is a complex discipline and there will be differences of opinion and often no single correct answer. The purpose of discussing cases is to explore the nuances in clinical decisions.
- Different views can be questioned to understand the reasoning behind them, but it is important that different views are respected.
- It is difficult for a doctor to have their clinical decisions reviewed by colleagues. With the benefit of hindsight and the removal of time pressures we can all identify circumstances where a different decision than the one we made would have been wiser.
- Errors will occur to the best clinicians and in the best systems. Doctors are often their own worst critics.

Random case analysis of a clinical record

As outlined previously, the group facilitator selects a record from a recent clinical session of the presenting GP. There are four phases to the review of a clinical record using RCA in the clinical meeting.

1. Clarification
2. Exploration
3. Feedback
4. Safety and Quality Improvement

Clarification. The record is read by the group and the presenting GP clarifies the record and the background to the case. What is the meaning of abbreviations used? What was known about the patient prior to this consult? Does the presenting GP have any further recollections of the case? Before progressing to the next phase, the group facilitator should check if any of the group members needs an issue clarified.

Exploration. The group facilitator leads with some questions about the case to explore the presenting GP's clinical reasoning. Was a diagnosis achieved and what diagnoses were being considered? Why were the management decisions selected in this case? At this point the group members may have further questions about the clinical reasoning in the case. The group facilitator needs to be mindful of avoiding the questioning being an interrogation of the presenting GP. It is possible to extend discussion regarding clinical reasoning by considering the 'what if' questions. What if the problem, patient, system, or doctor was different? How would this have affected decisions? While this is valuable for education of the group, the facilitator should also be mindful if fewer cases are discussed there is less performance review completed.

Feedback. The facilitator asks the presenting GP if there are any issues with the consultation or record that they would like feedback on. These are addressed before any further discussion. The

facilitator asks the group to identify things that were done well. This reinforces the values of the clinical team and what the practice wants to keep doing. After (if appropriate) acknowledging the difficulty of the consultation, ask for suggestions on what might have been done differently and why. The suggestions must be specific. Allow the presenting GP to respond to these suggestions.

Safety and quality improvement. Ask the group whether the medical record is adequate to enable other practitioners to continue the care of the patient. This is the MBS and AMA Code of conduct standard. If the record is not sufficient to enable this, what is missing? What specifically should be in the record? Allow the presenting GP to respond.

Ask the group to consider whether there were any safety issues to be considered for the patient. If there are safety issues, what should be the response? Actions to be taken for patient care should be recorded in the patient history with a note to indicate they were recommended following a review of the patient record in a practice clinical meeting.

What issues (if any) did this record reveal for practice systems? Think about appointment bookings, handover within the practice, reception triage, practice policies. Are there changes to be recommended because of the RCA discussion? The scribe should keep a record of the changes recommended so they can be reported to the relevant management team within your practice.

Continuing and concluding the meeting and CPD cycle

After the four phases are completed, the next medical record is reviewed and so on throughout the clinical meeting. At the conclusion of the meeting, it is important to thank the presenting GP for sharing their clinical records for discussion. The group facilitator or scribe should summarise any actions to be taken following the group discussion about safety and clinical systems improvement. If the session is being completed as an RACGP CPD activity, then the scribe should keep a record of the meeting. At the final meeting, the evaluation and reflective questions should be considered by the group and completed prior to submitting the required documentation to the RACGP.

Glossary of terms

Random Case Analysis is a specific method of case note review where the selection of the clinical record is random and not directed by the clinician having their records reviewed. The case is then discussed to consider the decisions made and the appropriateness of the record.

Presenting GP- the GP whose records are chosen for the RCA.

Group facilitator - walks the presenting GP through the RCA and asks for input from observing clinicians where appropriate.

Scribe – the GP who records the outcomes of the meeting including safety concerns, recommended system changes for the practice, quality measures, RACGP CPD requirements regarding attendance and evaluation and reflection questions.

Web conference facilitator - the person selected to manage interactions such as changing hosts for screen-sharing, muting participants who have background noise, seeking responses by raising of hands, or monitoring group chat

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References

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Appendix 1 - Sample introduction email

Our practice is introducing a new quality improvement and patient safety activity using Random Case Analysis (RCA) and I am inviting you to attend.

I will be applying for RACGP Continuing Professional Development Points as an accredited CPD Activity for 40 points. If you attend the planning meeting and a total of four hours of meetings during the triennium this should entitle you to CPD points.

The first meeting is a planning meeting and will be on ….. At this meeting, we will agree on how we will conduct the meetings and what we hope to achieve. At the subsequent meetings we will undertake RCA which is the review of a random selection of clinical records. We will take turns to have a random selection of records reviewed by our clinical peer group. When the records being reviewed are your records, you will be asked to clarify what occurred during the consultation and any background to the consultation. Other GPs in our practice will then ask questions about the decisions made and what was recorded. The aim is to share expertise and learn from each other.

Our emphasis is not on fault-finding but on improving the quality of our clinical care and record keeping. I expect we will identify issues impacting on safe patient care and we will consider how best to respond to them.

Appendix 2 - Checklist before first session

- For web conferencing, confirmation that all attendees can use the web platform, are using a headphone set, and understand that they must be in a private room with their web camera on.
- For face-to-face meetings, a dry run of the IT has confirmed it is possible to display medical records so all attendees can see them and that the connection speed to the server is adequate to enable exploration of the record.
- If intending to apply for RACGP points, a planning meeting has been conducted to determine program outline and responsibilities for maintaining CPD documentation. This meeting can be incorporated into the start of the first meeting. (see Appendix 4 and Appendix 5)
- Ensured the practice privacy statement (if there is one) includes reference to RCA session (see Appendix 6)
- Facilitator and presenter and scribe selected.
- For a web conference meeting, consider appointing an additional person responsible for managing participants on the conferencing platform. This person will respond to connection issues, muting participants if needed, responding to or instigating text chat as appropriate.
- A time has been selected that is suitable for practitioners to attend.
- For a face-to-face meeting, consider arranging food at the start of the event to encourage prompt commencement of meeting after a meal.
- Payment to encourage attendance has been arranged if appropriate.

Appendix 3 - Quick guide to conducting RCA session

Ground Rules – confidentiality, respect, quality improvement, feedback principles

Confirm Scribe

Document Attendees

For each record

- Clarify - ***what*** happened – What was known about patient? What do the abbreviations mean? What diagnosis was made? What further memories of the case are not in the record?
- Explore –***why*** questions - Why was this diagnosis made? Why was an investigation requested? Why was the management chosen?
- Feedback – Ask first, what issues would the presenting GP like feedback on? Provide this first and before any further feedback from the group that is balanced, offered, and specific.
- Safety and Quality Improvement – is the record adequate for ongoing care? Are there safety issues? Are there practice system issues? Record the outcomes.

At the conclusion of each meeting the scribe should summarise the outcomes of the meeting using the template in Appendix 5. At the final meeting complete evaluation and reflective questions and document the responses prior to submission to the RACGP.

- Thinking about the clinical decisions made including tests ordered, and medications prescribed, was there agreement about the decisions made? If there were differences in approaches, are these reasonable differences as a 'matter of clinical opinion'? Alternatively, are there guidelines or other resources that might resolve these differences?
- Were the reviewed medical records sufficient to enable other practitioners to continue care? How might they be improved?
- Did this activity motivate you to change systems or processes in your practice that would improve patient safety? If so, what were they?
- How can you monitor to see if the change occurs?
- How might the RCA activity be improved next time?

Appendix 4 - Applying for RACGP CPD points

In the 2020 -2022 RACGP triennium it is possible to have RCA in practice clinical meetings accepted as a CPD accredited activity, formerly known as a Category 1 activity. There are four essential steps to be completed:

1. Conduct a planning meeting with all participants.
2. Manage the RCA meetings and complete a report of each meeting.
3. Complete evaluation and reflection questions at the end of the final meeting
4. Online notification of the activity to the RACGP and submit documents.

1. Conduct a planning meeting with all participants.

There must be a minimum of 4 participants and maximum of 12. All participants must attend the planning meeting. *This meeting does not have any time requirement and could potentially be held at the commencement of the first RCA session.*

Introduce RCA as a performance review activity aimed at reviewing clinical decisions including the choice of investigations and medications. It considers the contextual factors (disease, patient, system, doctor) influencing diagnostic and management decisions.

At the planning meeting determine if you wish to conduct a general review of all clinical records or if you wish to focus on a specific clinical issue. If you are focusing on a specific clinical issue, then determine how the clinical records for the relevant clinical issue will be identified and selected.

Agree on your program outline. That is, the date, time, and duration of the meetings and how you will manage the roles of presenting GP, facilitator, and scribe for each meeting. This should also be documented (see Appendix 5 for an example of the documentation required).

Agree on who will maintain the records required to be kept of the activity and who will ultimately notify RACGP to enable allocation of points.

2. Manage the RCA meetings and complete a report on each meeting.

Undertake the cycle of meetings as per the program outline (duration of a meeting at least one hour and a minimum of 4 hours in total are required for each GP).

It is a requirement for RACGP CPD accreditation that the meetings are dynamic and involve active participation of learners. Following this RCA guide will ensure the meetings are conducted in a manner to enable this to happen. All participants should have an opportunity to speak during the sessions and ideally all have a turn at leading the session.

The scribe should complete a record of what was discussed and decided. A template is available in Appendix 5. This summary could be made available to participants who are unable to attend a meeting. This record does not need to be submitted to the RACGP.

3. Complete evaluation and reflection questions at the end of the final meeting.

At the end the final meeting, as a group consider the following evaluation and reflection questions. If there has been a long gap between meetings it will be useful to look at the reports from previous meetings to help answer the questions:

- Thinking about the clinical decisions made including tests ordered, and medications prescribed, was there agreement about the decisions made? If there were differences in approaches, are these reasonable differences as a 'matter of clinical opinion'? Alternatively, are there guidelines or other resources that might resolve these differences?

- Were the reviewed medical records sufficient to enable other practitioners to continue care? How might they be improved?
- Did this activity motivate you to change systems or processes in your practice that would improve patient safety? If so, what were they?
- How can you monitor to see if the change occurs?
- How might the RCA activity be improved next time?

4. Online notification of the activity to the RACGP and submit documents.

At the end of the cycle of meetings go online and record the GP participant section of the application form with details of names of GPs and their RACGP identification number. The GP also uploads supporting material including the program outline and responses to the evaluation and reflection questions.

Appendix 5 – Documentation for CPD points

The following documentation will aid the completion of required activities to be accredited as a CPD Accredited Peer Group Learning Activity.

The educational content of the activity must be a **minimum of 4 hours (excluding planning and review meeting)**

Activity title	Random Case Analysis at *(insert practice name here)*
Review meeting date	*(Insert date of last meeting here)*
Name of facilitator:	*(Insert name of person submitting documentation to RACGP)*

1. Program Outline

Use this table to record the dates of sessions and attendance of sessions. This record will need to be submitted to RACGP to obtain CPD points for attendees.

Session date	Duration (min 1 hr)	List of Attendees and RACGP number

2. RCA Meeting record

Use a copy of this table to record the details of each meeting. This record will be a useful record to share with practice members who did not attend. It will also keep a record of practice system changes recommended during the sessions. This meeting record does not need to be submitted to the RACGP. At the final session all of the meeting records can be reviewed to help answer the reflective questions.

Session date	*Insert session date*
Summary of cases discussed and clinical issues raised	*Record a brief deidentified summary of cases discussed and pertinent clinical issues raised.*
Were the medical records adequate? If not, how might they be improved?	
Were there practice system issues uncovered? If so, how are they going to be addressed? Who is responsible for taking this further?	*Record any practice system issues uncovered and changes recommended.*

3. Final Reflective Questions

Thinking about the clinical decisions made including tests ordered, and medications prescribed, was there agreement about the decisions made? If there were differences in approaches, are these reasonable differences as a 'matter of clinical opinion'? Alternatively, are there guidelines or other resources that might resolve these differences?
Were the reviewed medical records sufficient to enable other practitioners to continue care? How might they be improved?
Did this activity motivate you to change systems or processes in your practice that would improve patient safety? If so, what were they?
How can you monitor to see if the change occurs?
How might the RCA activity be improved next time?

Appendix 6 – Practice privacy notice for RCA

Many practices have a privacy notice (also known as a 'collection notice' or 'APP 5 Notice') that explains to patients how your practice records are stored, accessed and used. If your practice has a privacy notice, it should include a description of the use of records in RCA. An informed patient could then elect to not allow their records to be used in this way.

An example statement is as follows:

> "As part of our commitment to quality improvement (Name of Practice) may use your medical records for discussion about the care provided by our clinical team of doctors, nurses and allied health professionals. The purpose of these discussions is to improve the knowledge and skills of our team and identify practice systems that can be improved for better and safer care.
>
> You can request to not have your records accessed for quality improvement purposes. Please let reception staff know and your record will be marked as not for review."

For further information about practice privacy and health record management the RACGP has a resource "Privacy and managing health information in general practice" and templates for privacy statements available from https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/privacy