# Skills Assessment

# Trainer & Assessor Marking Guide

## Criteria

### Unit code, name and release number

BSBMED303 – Maintain patient records (2)

### Qualification/Course code, name and release number

BSB31115 - Certificate III in Business Administration (Medical) (2)

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## Assessment instructions

Table 1 Assessment instructions

| Assessment details | Instructions |
| --- | --- |
| **Instructions for the trainer and assessor** | This is a skill based assessment and will be assessing the student on their ability to demonstrate skills required in the unit.  This assessment is in 3 parts:   1. Practical 2. Assessment Checklist 3. Assessment Feedback (not included in Marking Guide)   Model answers, sample responses or a criteria for each task or activity is provided below. Use these to support your judgement when determining a satisfactory result.  The student’s response to each question must contain the information indicated in this marking guide in order for their response to be correct. However, if a student provides information other than indicated below, and in the professional opinion of the assessor it is appropriate and meets the intent of the question, it may be considered correct.  Complete the Assessment Checklist for each task and activity and the Assessment Feedback to the student. Ensure you have taken a copy of the assessment prior to it being returned to the student.  The Assessment Feedback page must be signed by both the student and the assessor so the student displays that they have received, understood and accepted the feedback. Ensure the students name appears on the bottom of each page of the submitted assessment. |
| **About this marking guide** | The student’s response to each task or activity must contain the criteria indicated in this marking guide in order for their response to be correct.  All tasks and activities must be completed correctly in order to satisfactorily complete this assessment event.  Assessors will need to make a judgement call as to whether each response meets the criteria based upon the:   * Rules of Evidence:   + Validity – does the answer address the skill required and does the evidence reflect the four dimensions of competency?   + Sufficiency – is the task or activity sufficient in terms of length and depth?   + Currency – has the work been done so recently as to be current?   + Authenticity – is this work the student’s own authentic work? * Principles of Assessment   + Fairness – individual student’s needs are considered in the assessment process   + Flexibility – assessment is flexible to the individual student   + Validity – any assessment decision is justified, based on the evidence of performance of the student   + Reliability – evidence presented for assessment is consistently interpreted and assessment results are comparable irrespective of the assessor conducting the assessment * Dimensions of competency   + Task skills   + Task Management Skills   + Contingency Planning Skills   + Job Role Environment Skills |
| **Student must provide** | Pen, class notes, USB storage device or access to Cloud storage if submitted electronically. |
| **Assessor must provide** | Computer with access to Pracsoft and MedicalDirector Clinical.  The following files located in BSBMED303\_AE\_SR1 folder (in the Learning Bank):   * Patient registration forms:   Henry Watland and  Sam Best   * Transfer of Medical Records form: Anna Andrews * The Surgery’s Policy and Procedures Manual   *These may be hard copy (or made available for students online or on classroom shared drive).*  and   * Outgoing Mail Tray |
| **Due date/time allowed/venue** | Refer to Unit Assessment Guide for due date  The estimated time for a student to complete this assessment is 2½ hours. However there is no time limit for students to complete this assessment. This assessment must be done in class. |

## Part 1: Practical

To complete this part of the assessment, you will be required to participate in practical tasks using an existing patient records management system.

Your printed evidence and written responses will be used as part of the overall evidence requirements of the unit.

You should refer to the list of criteria in the Assessment Checklist to understand what you need to demonstrate in this section of the assessment. This Checklist outlines the assessment criteria used to assess your performance.

Once completed you will need to submit this assessment and all screenshots/printouts for marking.

***As you progress through each task, screenshot each Pracsoft and MedicalDirector Clinical screen as evidence of the completed task and paste into a Word document. Ensure you clearly indicate the task number before each screenshot and include your name and unit name in the document footer.***

***On completion of the assessment, submit all screenshots to your assessor with this assessment paper (and any other prints specified in the assessment task).***

**Scenario**

In your new role as medical receptionist at The Surgery, you are required to create, access, store and maintain accurate patient records according to The Surgery’s policies and procedures and legislative requirements using Pracsoft and MedicalDirector Clinical.

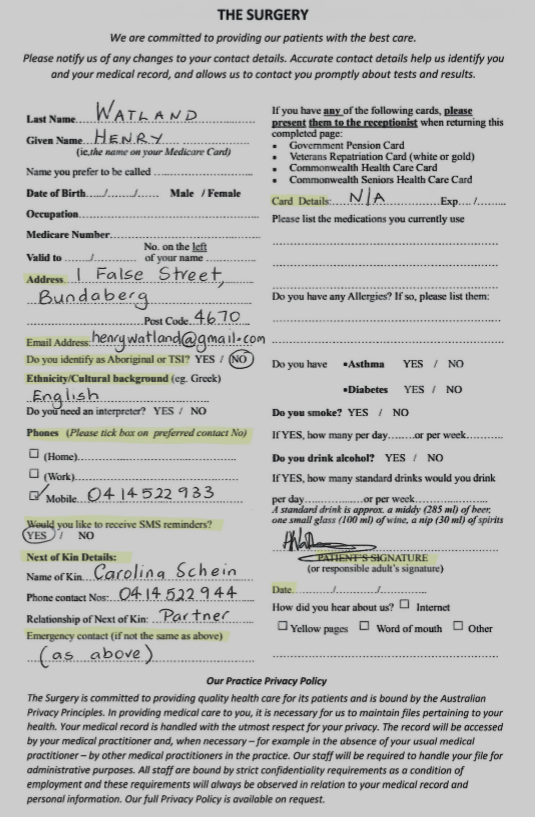
***Note: Your assessor will supply access to all documents to be scanned/imported into the patient records system.***

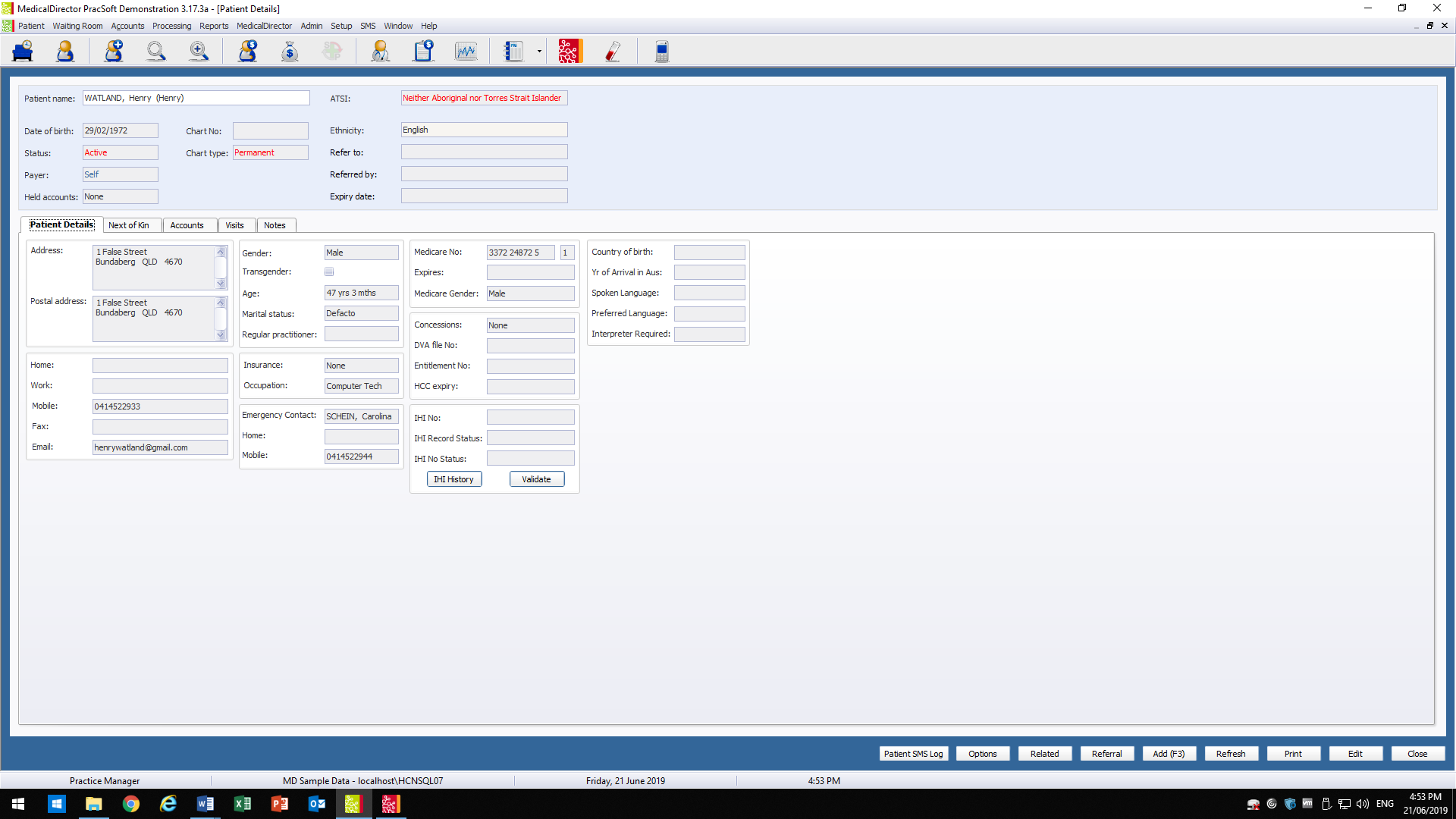
**Task 1: Create, access, store and maintain accurate patient records**

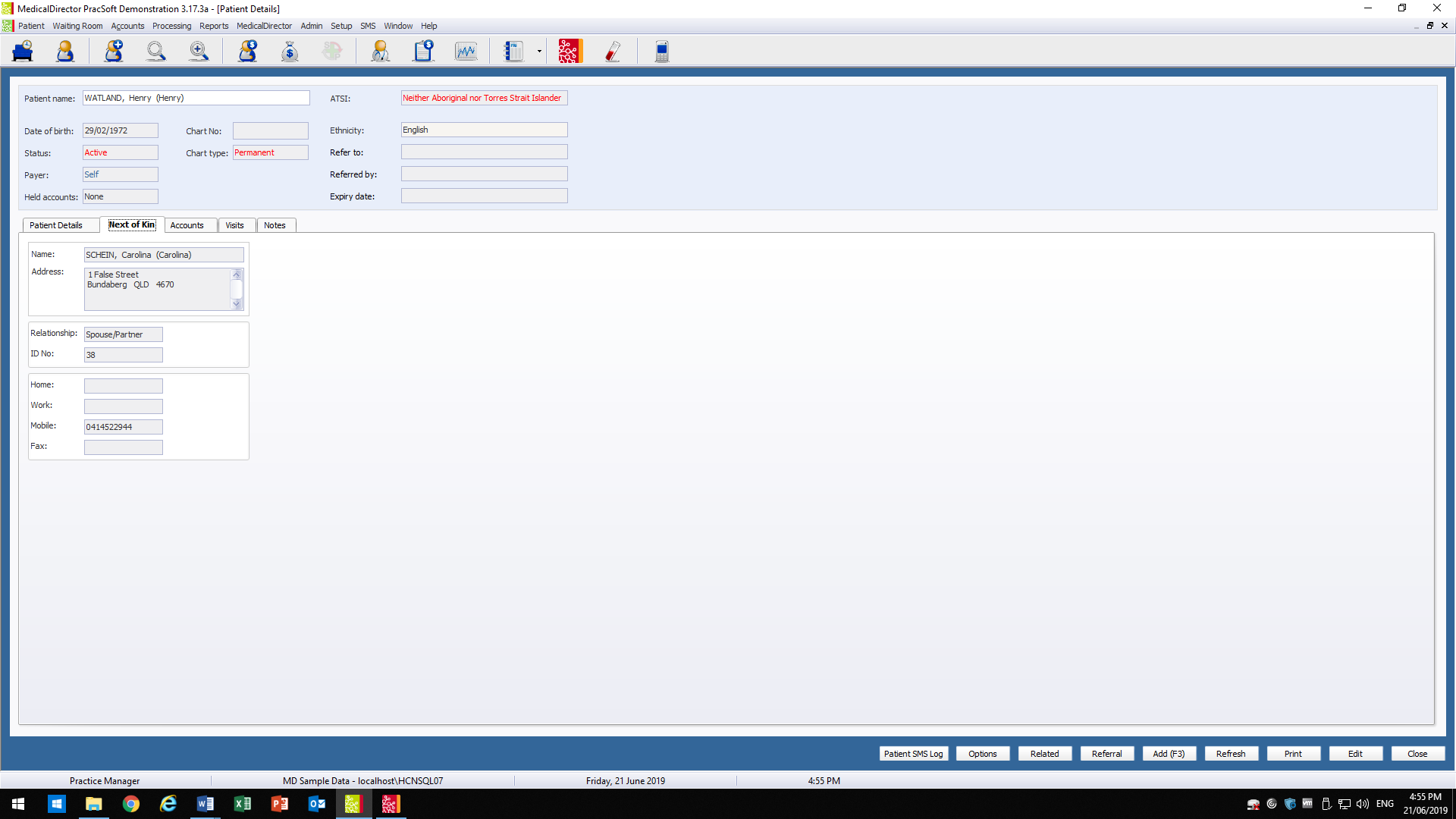
Henry Watland has just arrived for his appointment with Dr AP and advised you he would like his address details updated.

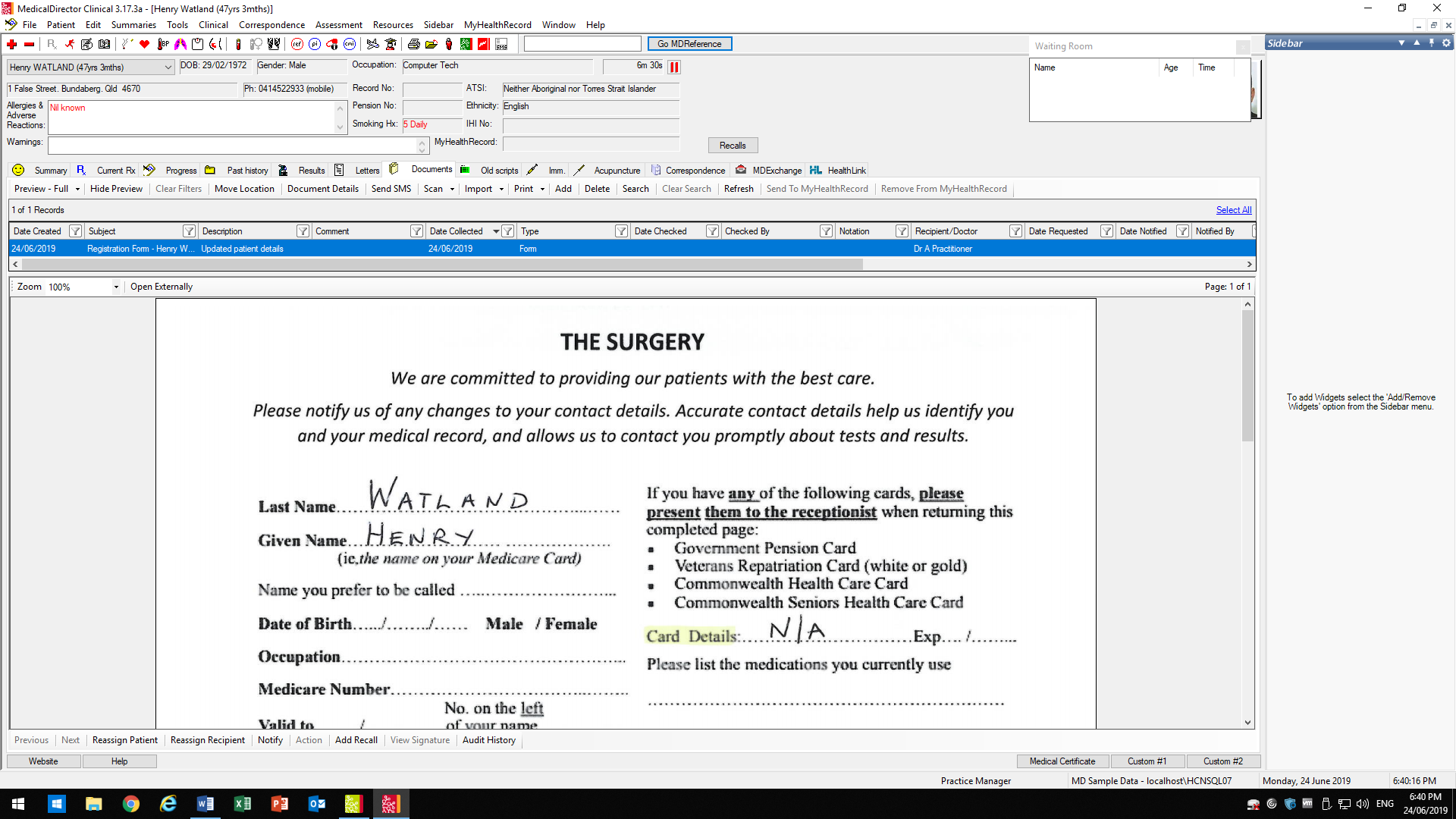
1. On accessing Henry’s patient record, you notice his record does not comply with practice policy as important contact information is missing. To maintain his privacy in the waiting room, you request Henry completes the highlighted areas on the patient registration form *(see below).*
2. Update Henry’s patient record and save changes (to store record).

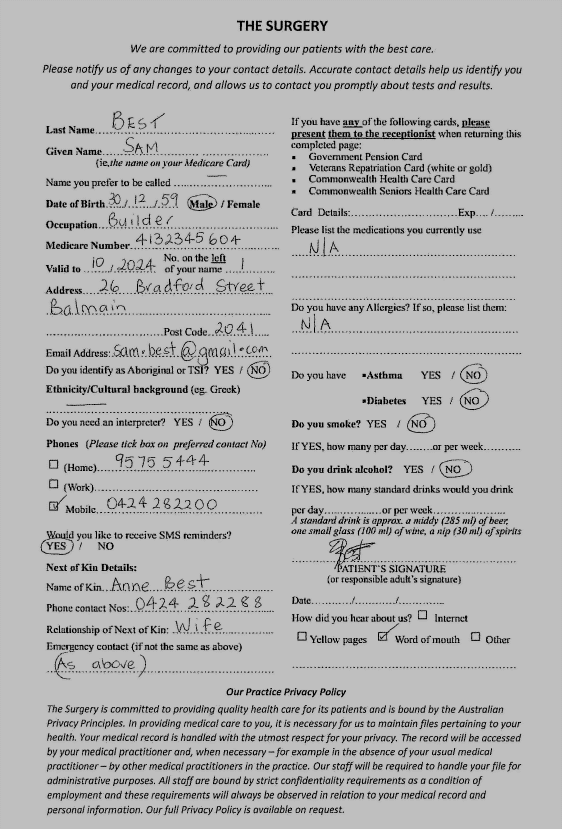
*Screenshot Henry’s updated Patient Details (Patient Details tab and Next of Kin tab), paste into a new Word document and save as:* ***BSBMED303\_SShots***

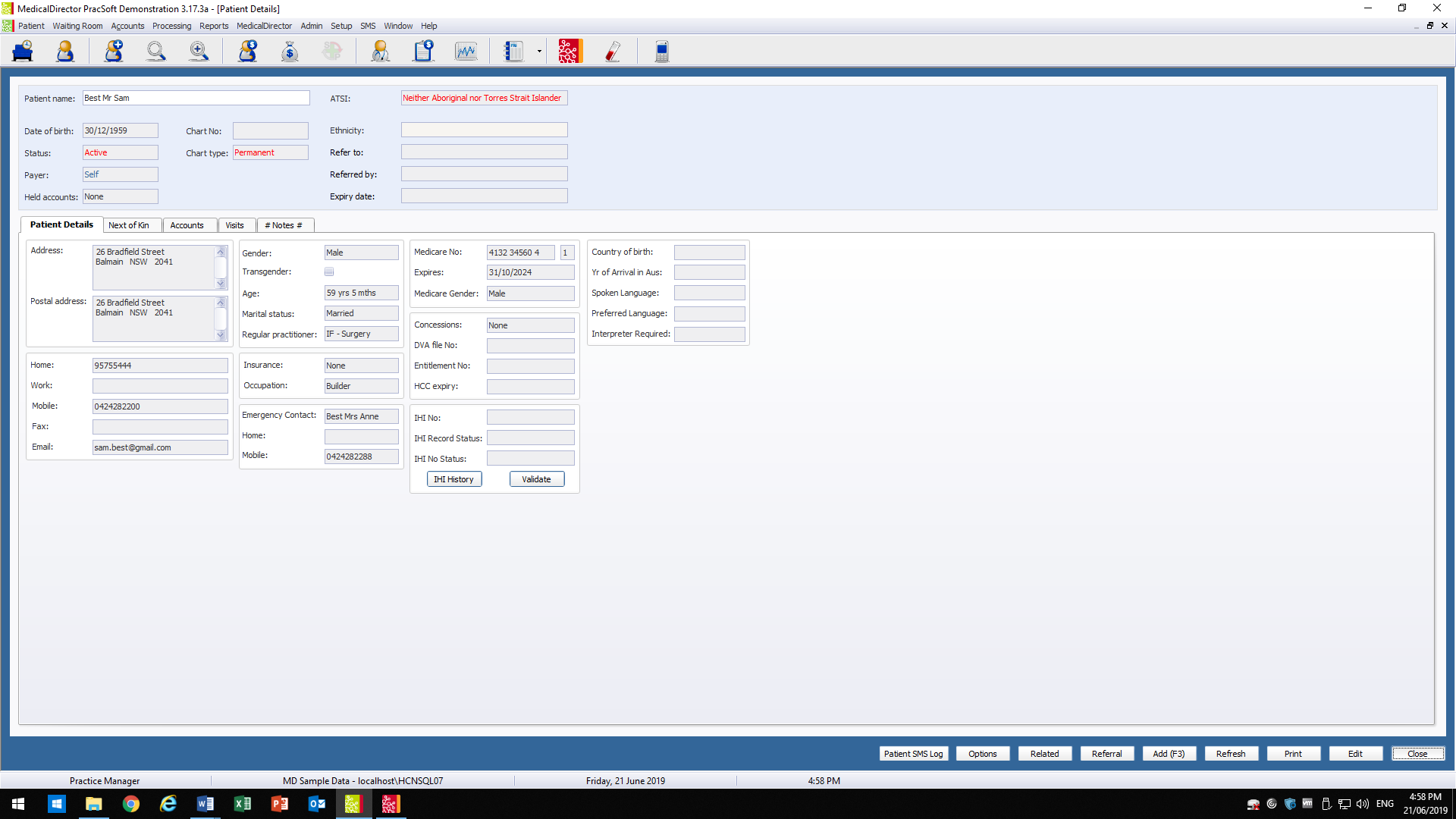
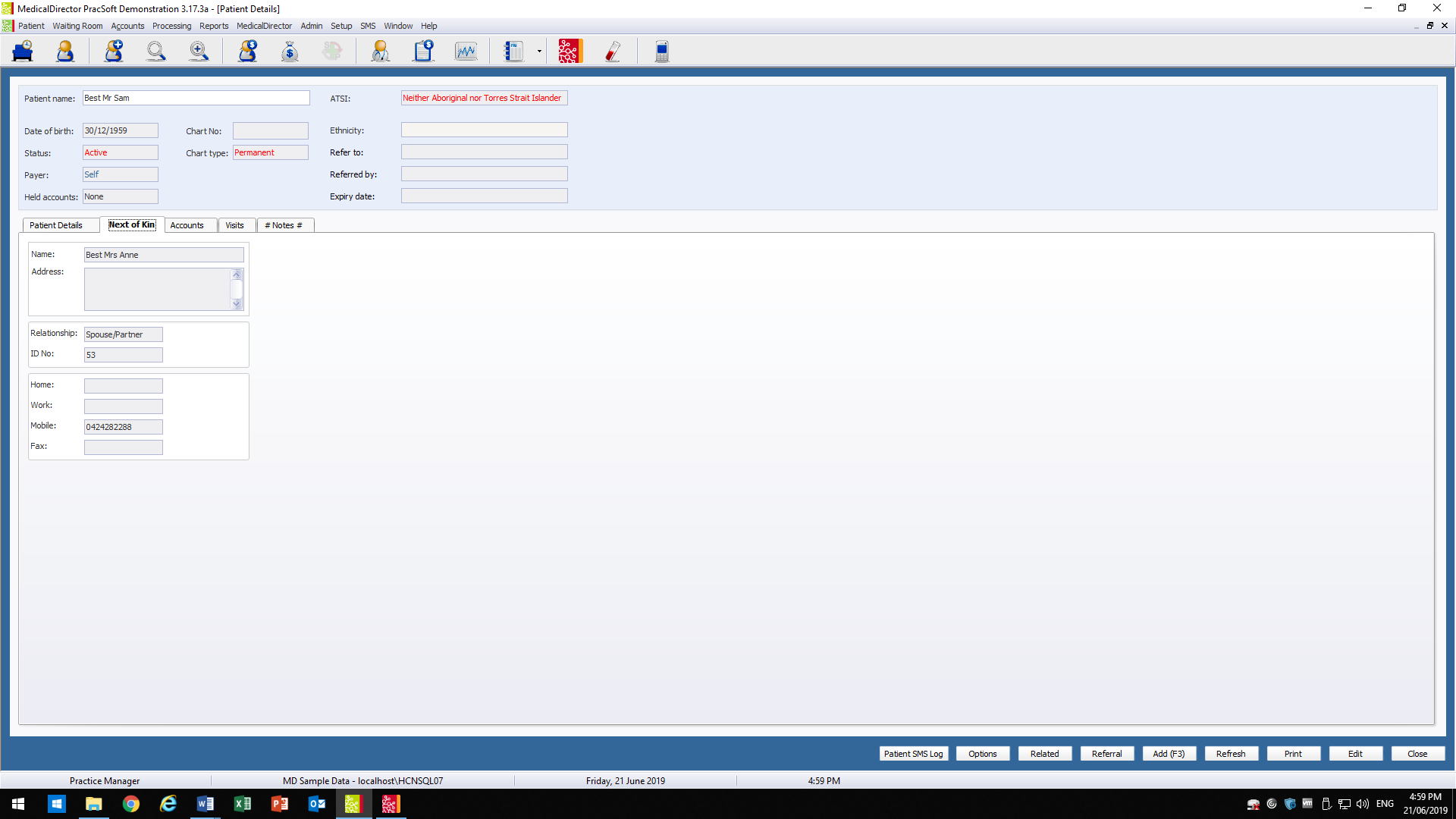


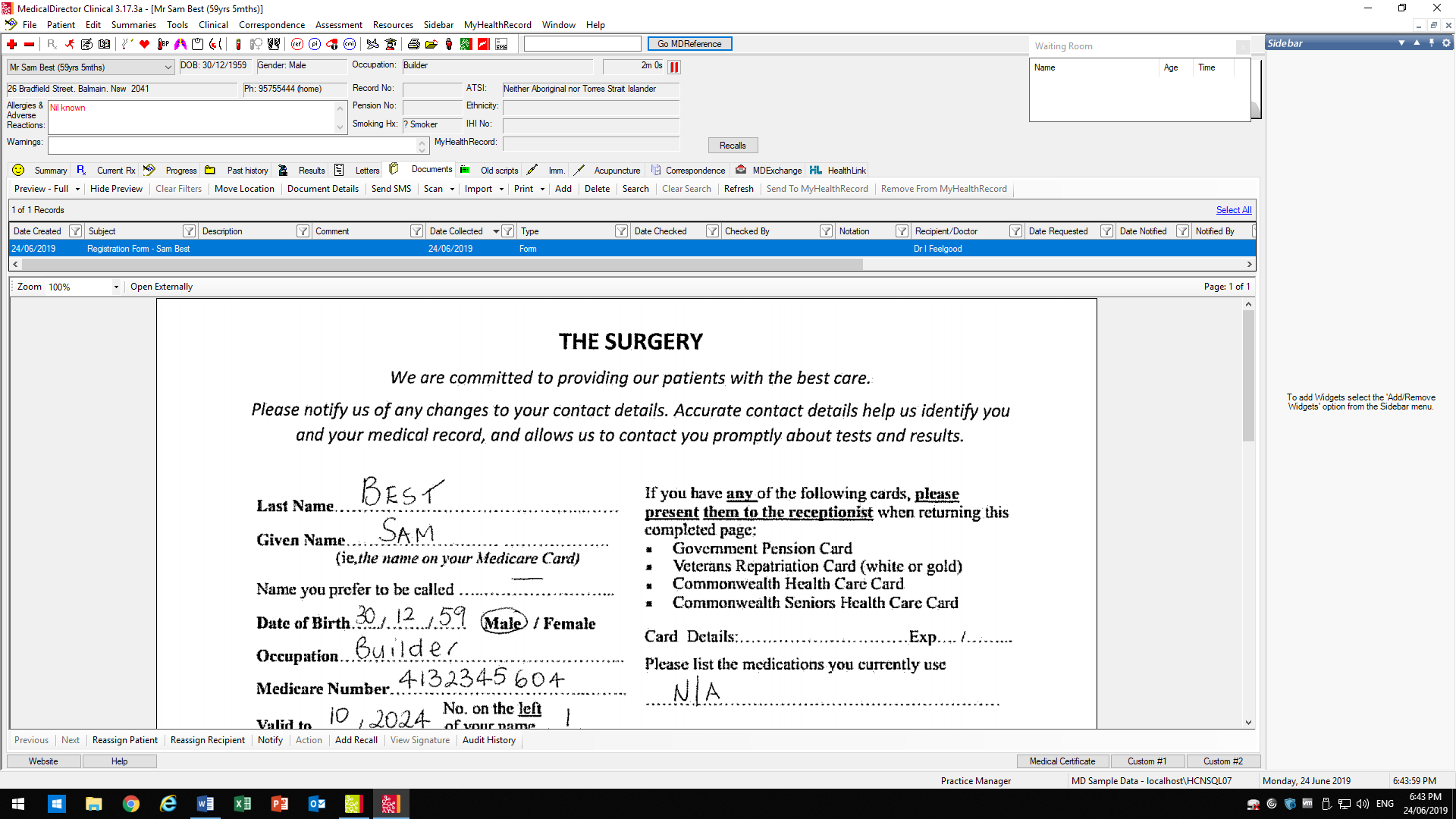




1. Scan/Import the completed patient registration form into MedicalDirector Clinical following practice policy *(and screenshot image showing capture of imported registration form and paste into your Word document and save).*
2. Create the new patient record for **Sam Best** (for his appointment with **Dr IF).** Save and store Sam’s details following The Surgery’s new patient procedure.

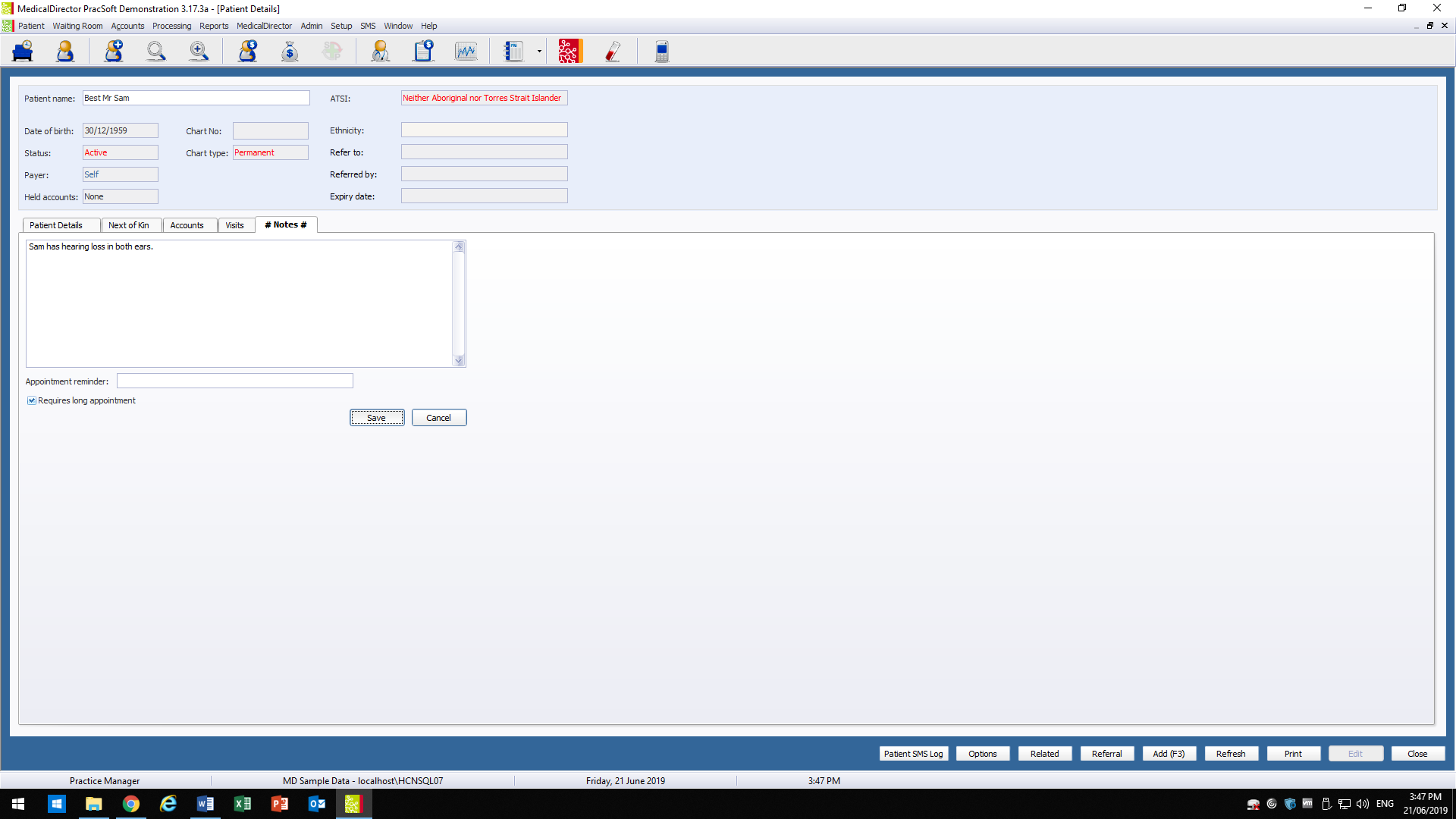
*Screenshot Sam’s Patient Details screen (Patient Details tab and Next of Kin tab) and MedicalDirector Clinical screen showing capture of Sam’s imported patient registration form into your Word document and save.*





1. Following Sam’s appointment, Dr IF requests you record a note in Sam’s patient record to assist reception staff with scheduling future appointments for Sam:

|  |  |
| --- | --- |
| Notes | Sam has hearing loss in both ears  *and*  Requires long appointments |

1. Save (to store) changes to Sam’s patient record *(and screenshot Notes window into your Word document and save).*

**Task 2: Maintain Patient Records**

The Practice Manager has requested you complete the tasks below and archive each patient’s record following The Surgery’s policy and procedures:

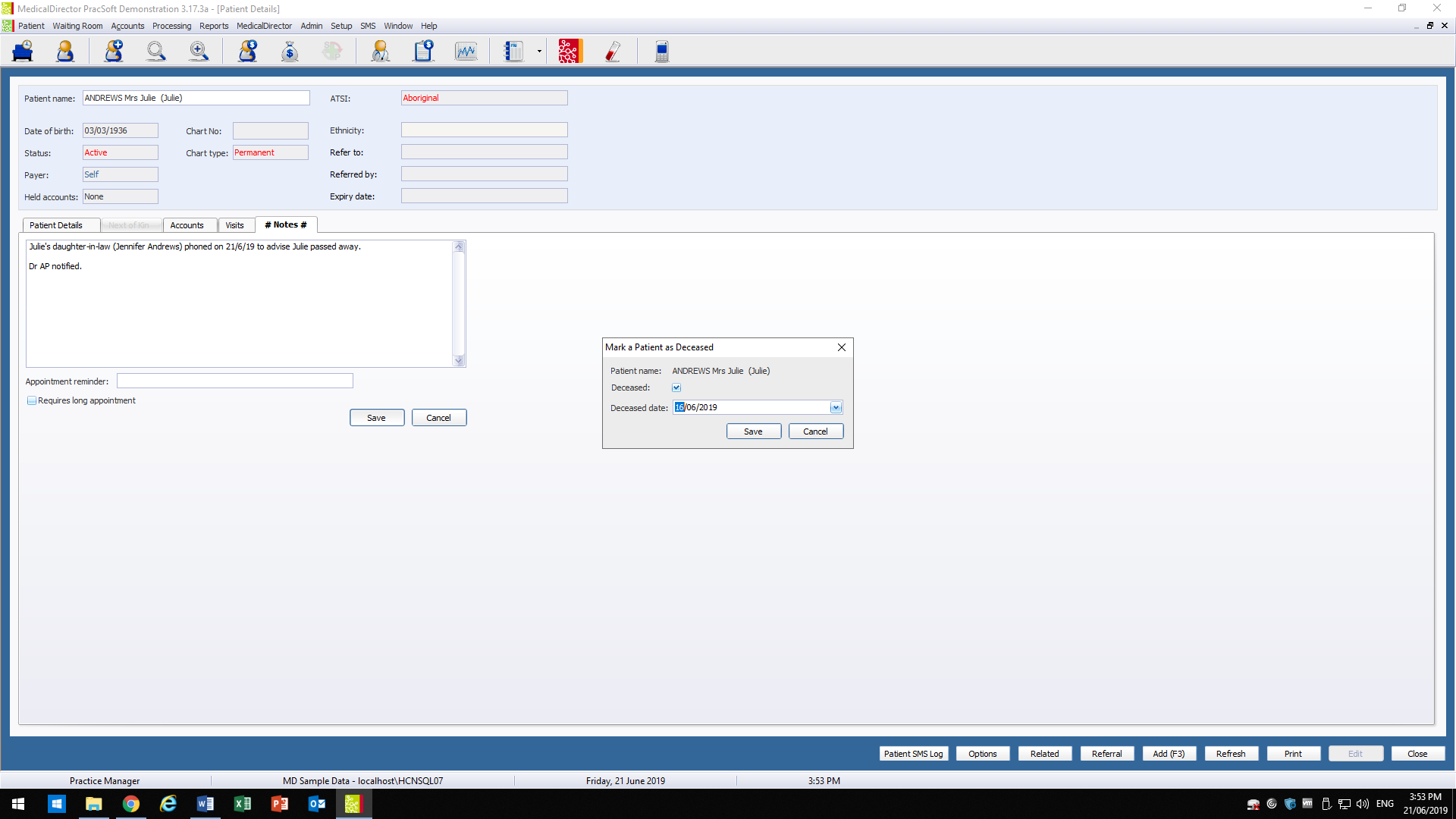
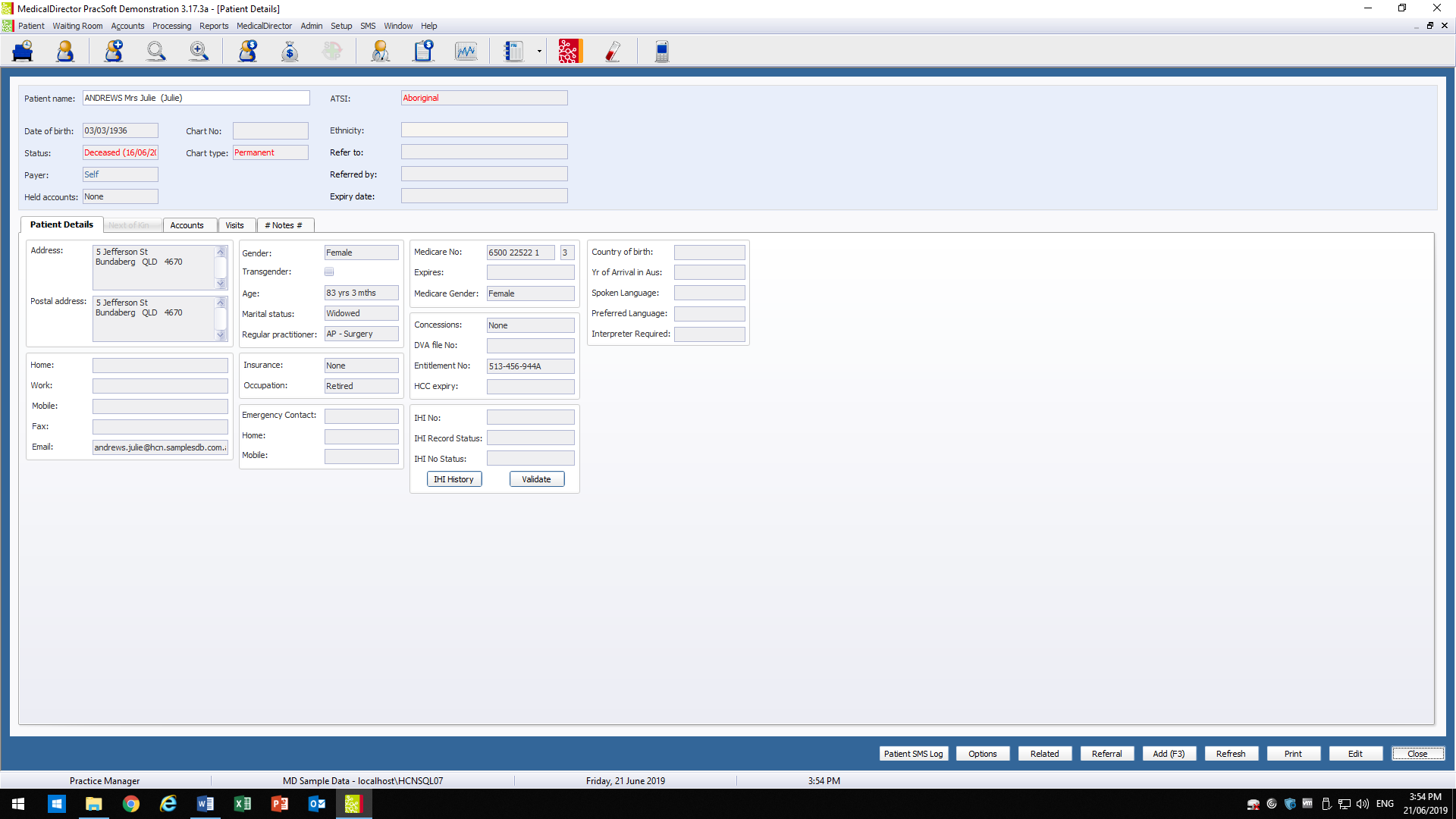
1. Record, save (to store) a patient note in Julie Andrews patient record based on the following information:

*Julie’s daughter-in-law (Jennifer Andrews) phoned today to advise Julie passed away last Thursday.*

*Dr AP has been notified.*

1. Mark Julie’s patient record as deceased and save (to store).

*Screenshot Julie’s Patient Details screen showing Notes/Deceased status and paste into your Word document and save.*

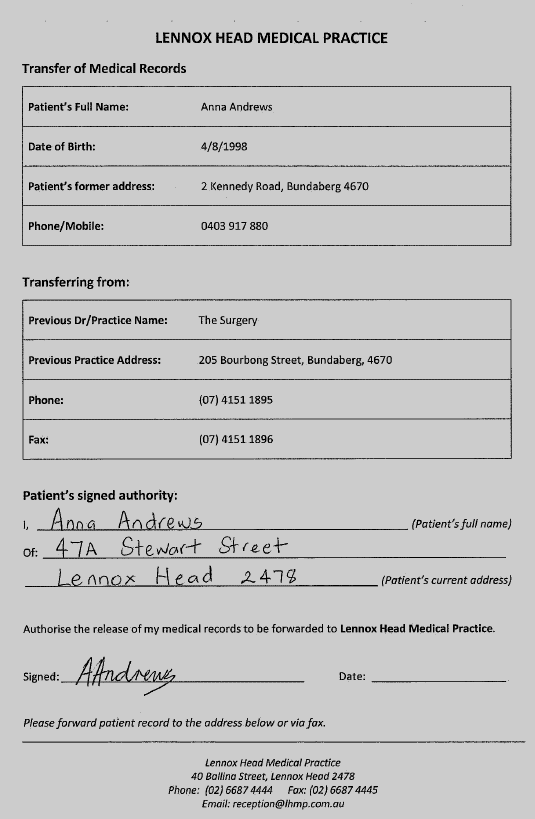


***Print the checklist you created in Assessment 2*** *(Transfer Patient Records to another Medical Practice)* and use the checklist to assist you with administering and recording a transfer for Anna Andrews:

1. The following steps have already been completed/confirmed by the Practice Manager. ***Tick them as “done” on the checklist:***

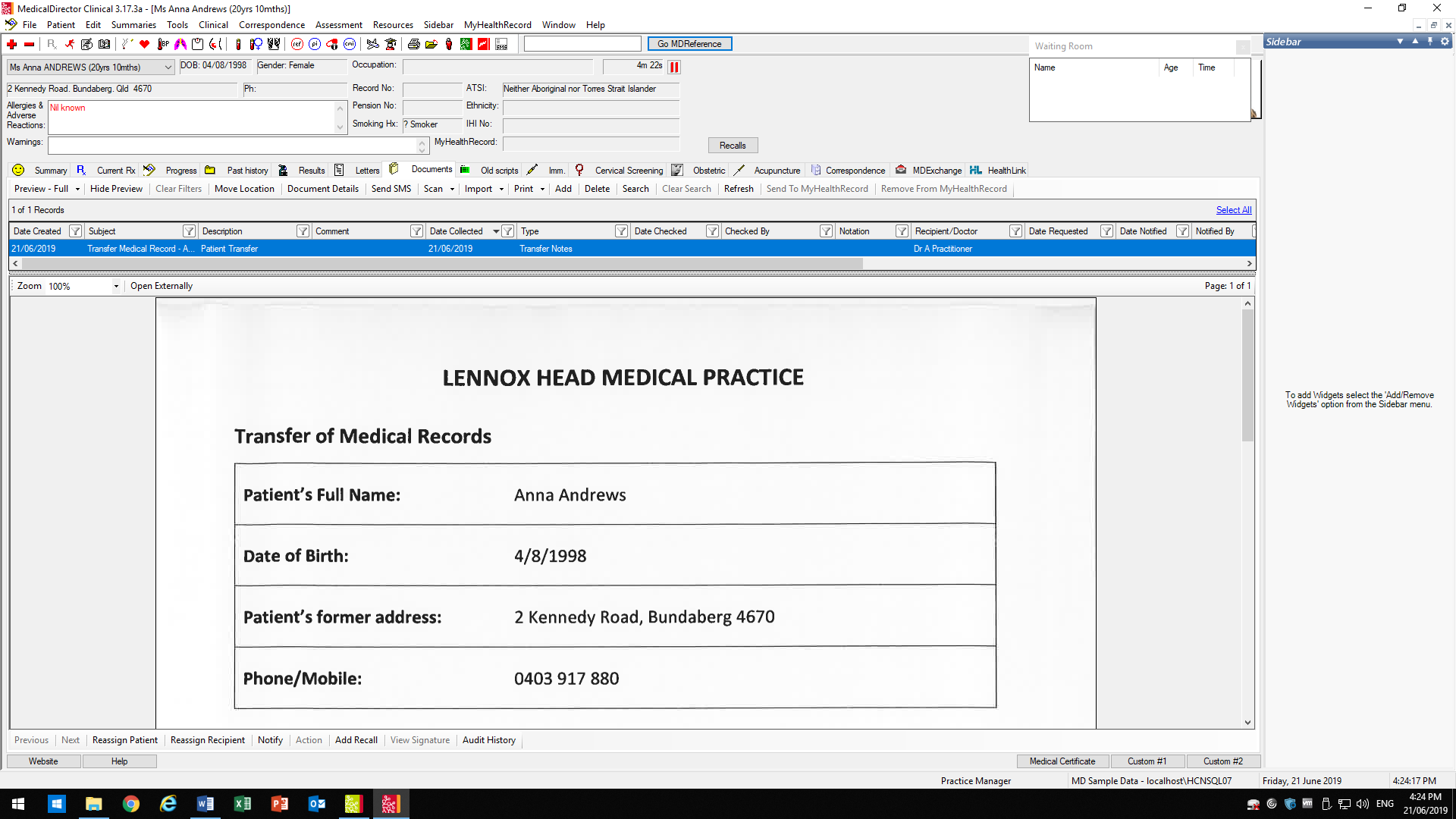
* Patient advised of transfer fee and fee paid
* Treating doctor has authorised the transfer and confirmed a Full Summary is to be released.

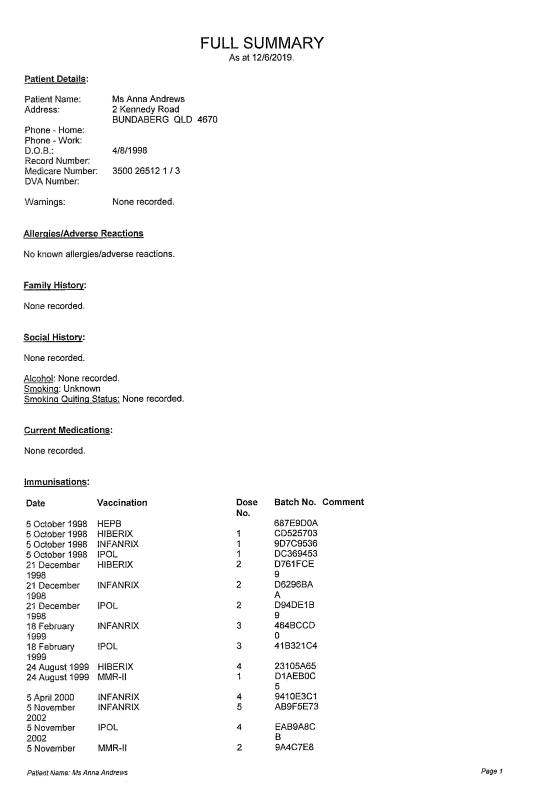
1. Finalise Anna’s transfer (*refer to Transfer of Medical Records request below)* and ***tick off and initial each step to indicate your role in Anna’s transfer:***

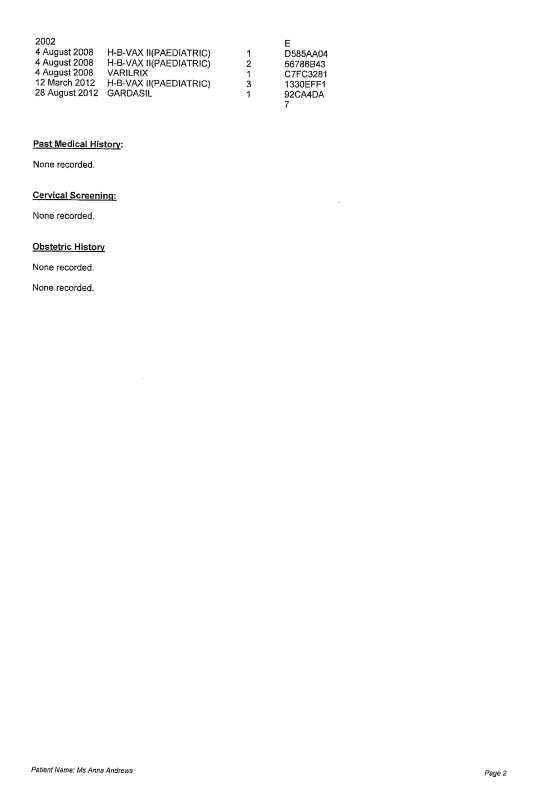


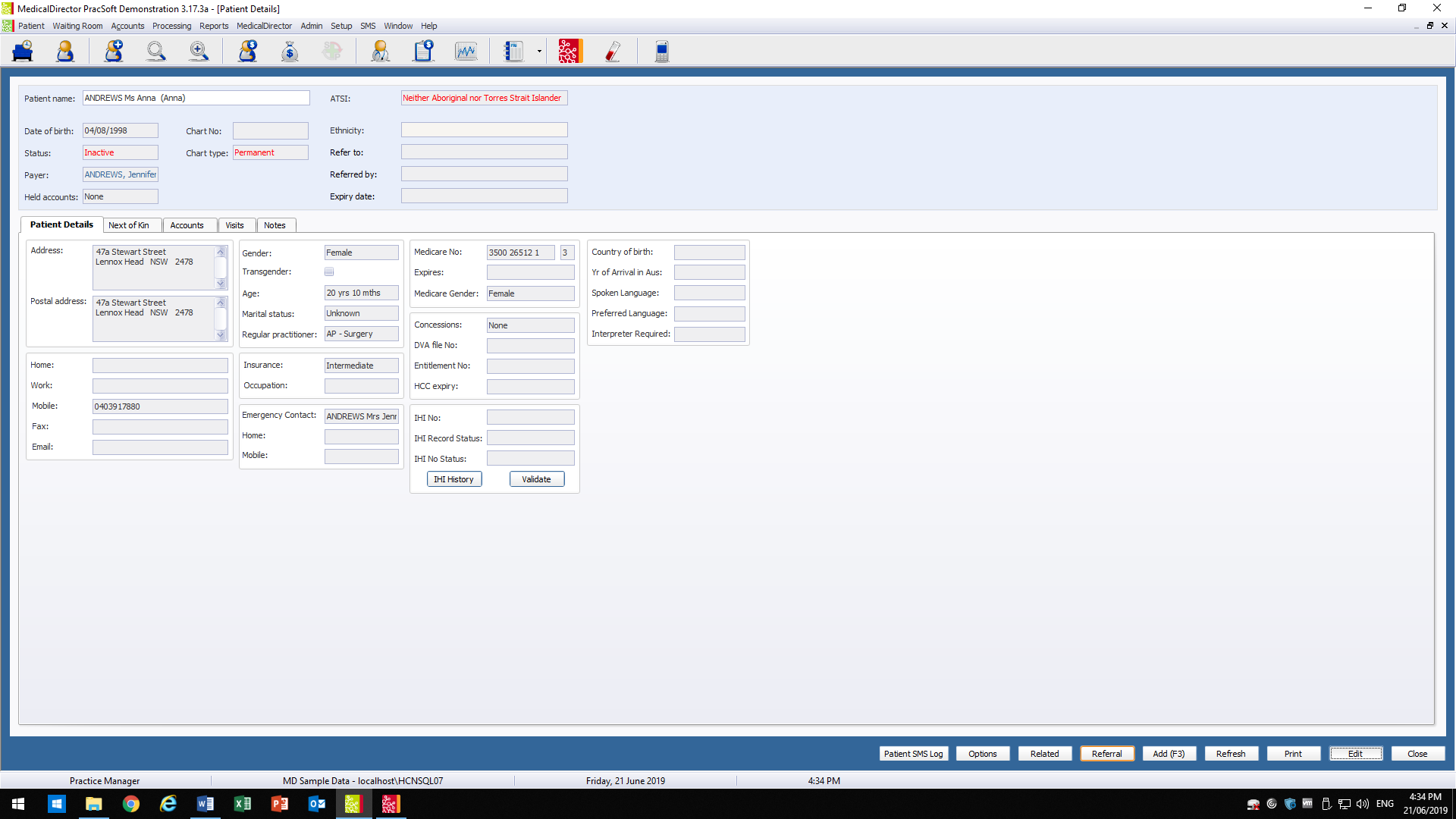
*Screenshot MedicalDirector Clinical screen showing capture of Anna’s imported transfer form and Anna’s inactive status (and updated address/phone details) and paste into your Word document and save.*

**Also submit: printout of Anna’s Full Summary *(with transfer of Medical Records form attached)* and completed checklist.**









1. Update the Transfer Patient Records Register on the next page.

***TRANSFER PATIENT RECORDS REGISTER***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of request | Full name of patient | Date of birth | Transfer fee paid | | Patient’s clinical record printed, request form scanned and patient status updated | | Details of practice requesting transfer | Registered Post barcode and date posted | | |
| **Initials of staff member** | | **Initials of staff member** | | **Initials of staff member** | | |
| 24/6/19 | Alan Smith | 28/11/69 | ✓ | RR | ✓ | RR | Coffs Family Practice  48 Gordon Street  Coffs Harbour  Telephone: (02) 652 6869 | 08123456795 | 26/6/19 | PM |
| **DATE ON TRANSFER REQUEST FORM** | Anna Andrews | **4/8/1998** | ✓ | PM | **✓** | **Student initials** | **Lennox Head Medical Practice**  **40 Ballina Street**  **Lennox Head**  **Telephone: (02) 6687 4444** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

**Monitor and review own role**

**Task 3: Monitor and review own role**

The Practice Manager has scheduled a meeting with you to discuss your progress and development in your new role as receptionist. In preparation for your meeting they have asked you to reflect on your induction and training period and prepare responses to the following:

1. Identify and explain at least two improvements to your own work practices based on the patient recordkeeping tasks you have completed in this assessment. Make notes in the box below and then discuss your ideas with the Practice Manager. Your assessor will observe the discussion and record their observations in Part 2 below.

|  |
| --- |
| IDENTIFY IMPROVEMENTS TO OWN WORK PRACTICES |
| Student responses will vary but may include the following improvements:  Multitasking, prioritising, meeting deadlines and improved workflow, following procedures and sequencing workload, asking questions and clarifying procedures if unsure, more proficiency with patient recordkeeping software, accurate data entry, quicker scanning/importing of documents.  Recommendations for improvements to procedures and processes may include:   * Entering new patient records * Scanning/Importing documents into patient records * Checking currency and accuracy of patient details * Archiving patient records * Transfer of patient records |

## Part 2: Observation Checklist

The Observation Checklist will be used by you to mark the students’ performance. Use this Checklist to understand what skills the student is required to demonstrate in this section of the assessment. This Checklist outlines the Performance Criteria, Performance Evidence and Assessment Conditions you will be marking the student on. All the criteria must be met. The student’s demonstration will be used as part of the overall evidence requirements of the unit. You may ask questions while the demonstration is taking place or if appropriate directly after the task/activity has been completed.

| Task/ Step # | Instructions | S | U/S | Assessor Comments (Describe the student’s ability in demonstrating the required skills and knowledge) |
| --- | --- | --- | --- | --- |
| 1 | *Student used questioning skills in the discussion* |  |  | *Date of Observation:*  *Assessors are to record their observations in sufficient detail to demonstrate their judgement of the student’s performance against the criteria required.*  *Student uses questioning techniques such as open questions, repetition or specific examples to clarify or understand information* |
| 2 | *Student used active listening skills in the discussion* |  |  | *Student uses active listening skills such as paraphrasing, or summarising key points* |
| 3 | *Identified areas for improvement to record keeping* |  |  | *Student responses will vary but may include:*  Recommendations for improvements to procedures and processes may include:   * Entering new patient records * Scanning/Importing documents into patient records * Checking currency and accuracy of patient details * Archiving patient records * Transfer of patient records |
| 4 | *Discussed solutions (at least 1) for solving the identified problem* |  |  | *Student responses will vary. Sample response below:*  *To simplify the creation of medical records we could use a tablet device to get the patient to complete their details online and save those details straight into Pracsoft. This means that we don’t have to read the patients’ handwriting, we don’t have to scan their record in and don’t need to shred it. This could save both time and resources (paper).* |