

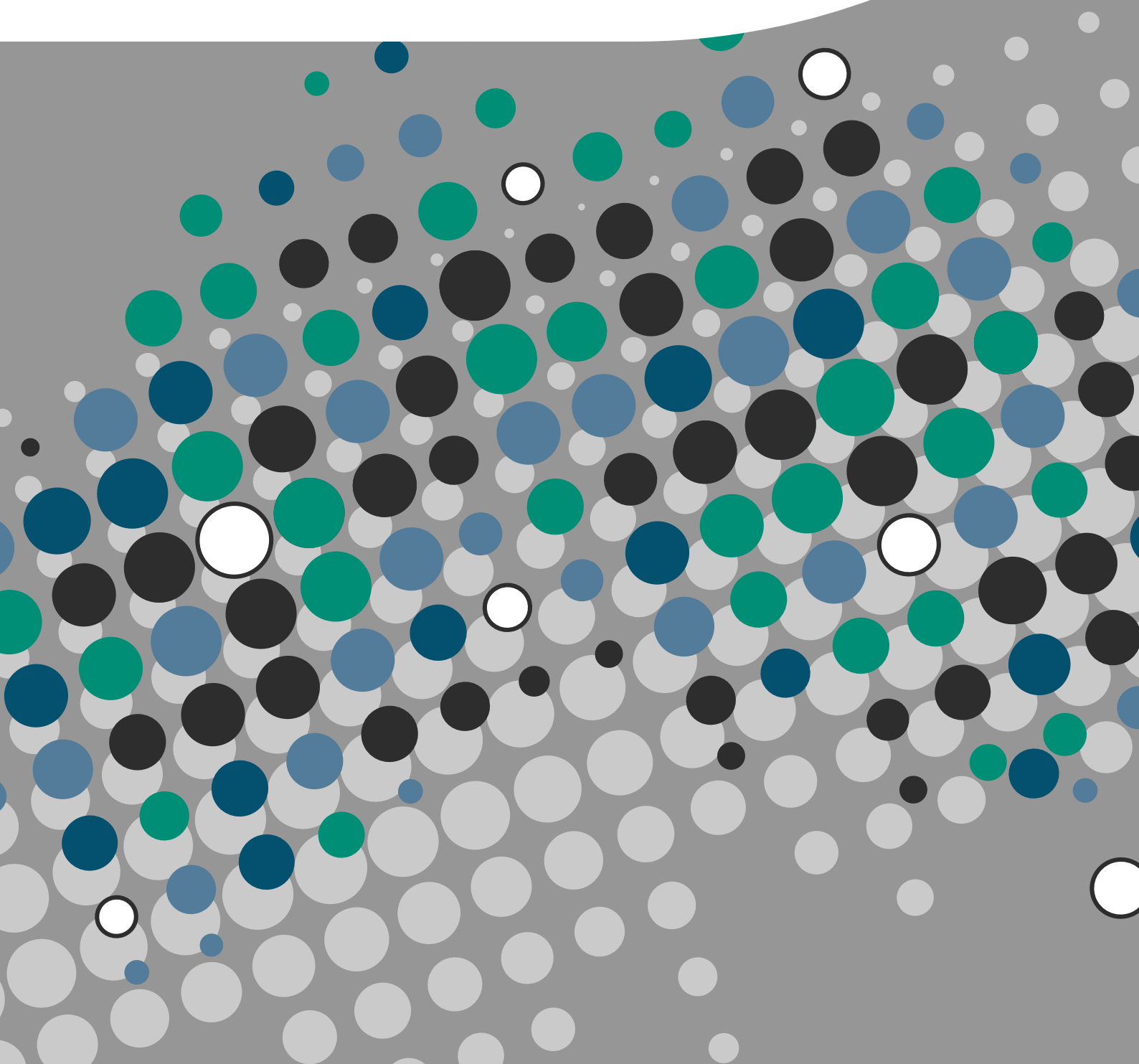


RACGP

Royal Australian College
of General Practitioners

Standards for health services in Australian immigration detention facilities

2nd edition



Standards for health services in Australian immigration detention facilities, 2nd edition

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Introduction to the Standards for health services in Australian immigration detention facilities (2nd edition)

Preamble

The Royal Australian College of General Practitioners (RACGP) supports health professionals, their employer organisations and the Australian Government's Department of Home Affairs to provide high-quality healthcare to people detained in Australian immigration detention facilities.

By being supportive of the development of the *Standards for health services in Australian immigration detention facilities* (2nd edition) (IDF Standards), the RACGP is not condoning or supporting the use of immigration detention. There is a significant body of evidence that demonstrates the adverse mental and physical health impacts of immigration detention, particularly prolonged detention, on people seeking asylum. The impacts of detention can be profound, particularly for the most vulnerable, including children and adolescents, pregnant women, and individuals with previous experiences of torture and trauma. The mental and physical health impacts of detention on children,¹⁻⁶ and prolonged detention on all individuals, are well documented.⁷⁻²⁴ The RACGP acknowledges that, within the constraints of the current legislative framework, there needs to be a quality and safety standard to optimise delivery of healthcare to those detained in immigration detention facilities.

Who are the IDF Standards for?

Quality and safety standards are used in health services across the world as a means of promoting excellence in patient care,²⁵ with accreditation against such standards promoting leadership, enhancing corporate culture and improving clinical performance.²⁶

The RACGP IDF Standards have been written principally for the multidisciplinary teams of health professionals who provide healthcare to people detained in Australian immigration detention facilities.

To ensure safe, quality care for individuals in detention, it is vital for health services to provide initial, continuing, comprehensive, and coordinated medical and allied healthcare. Health services need to:

- provide for individuals, families and communities within immigration detention facilities
- integrate biomedical, psychological, social and environmental factors
- consider a patient's language, culture, beliefs and values in their understanding of health.

In acknowledgement of the recognised physical and mental health impacts of prolonged immigration detention, the Australian Government has a distinct duty of care to provide quality healthcare to those who are detained in immigration detention facilities. The government must ensure that all people in detention are able to access timely and effective primary healthcare, commensurate with the healthcare that would be available to the Australian community, for their condition/s and identified level of vulnerability. These services must be provided in a culturally responsive, trauma-informed framework. Where a health condition cannot be managed within the detention facility, care must be facilitated by referral for external opinions, expertise,

and/or investigation and treatment services.

In this context, the Australian Government and the employers of the health professionals working in immigration detention facilities are important audiences for the IDF Standards.

Current immigration detention context

Since the publication of the first edition of the RACGP *Standards for health services in Australian immigration detention centres* in 2007, the immigration detention context has undergone significant change. Of particular note, over the past 10 years, there have been prolonged periods where large numbers of people seeking asylum have been detained. This cohort has included people who arrived by boat, individuals and families who arrived by plane, as well as those who were living in the Australian community on temporary visas who subsequently applied for protection or received a negative protection legal decision. This includes individuals of all ages from a diverse range of cultural and linguistic backgrounds. Currently, the majority of individuals held in immigration detention are people who have been released from the justice system after serving their sentences, who were not born in Australia, or born in Australia to non-Australian citizens, who have had their visas revoked.

These Standards have been developed to apply to healthcare facilities and professionals providing health services in restrictive immigration detention facilities funded by the Australian Government. In recognition of the changes to immigration detention environments and the populations detained, the IDF Standards have been developed to be readily applied in the future, regardless of legislative changes to detention environments and populations detained.

Challenges within the immigration detention facility environment

Given the inherent vulnerabilities of groups of individuals and families who have had refugee-like experiences and/or been detained within the Australian justice system, health services within immigration detention facilities provide healthcare in a unique and challenging environment.

Some of these challenges include, but are not limited to:

- lack of choice for individuals to select their own healthcare provider
- cultural and linguistic diversity with variable healthy literacy, with the potential for language or cultural differences to create misunderstandings and misinterpretations during consultations
- cultural awareness, which is of paramount importance in these healthcare settings. However, given that 'culture' is complex it is important to acknowledge that many individuals detained in immigration detention facilities might belong to minority groups in their home countries and might have been persecuted for this reason
- the process of detaining individuals, which might erode their trust in the healthcare system and make them hesitant to access care. This hesitancy needs to be recognised in the context of the individual's cultural, religious and sociopolitical background
- detained populations having high levels of post-traumatic stress, including from within their country of origin, their journey and experiences in the criminal justice system and/or immigration detention facilities
- complex health issues (including physical and mental health), related to pre-existing vulnerabilities such as:
 - conditions endemic in their country of origin
 - conditions acquired through their journey
 - possibly limited access to quality healthcare, including vaccination
 - experiences of trauma

- the psychological consequences of living in prolonged uncertainty
- experiences of incarceration prior to coming into immigration detention.

The duration of detention depends on many factors, is often uncertain, and could be brief or prolonged within the current legislative framework. This uncertainty, combined with the experiences of many people prior to being detained, including trauma, contributes to increased vulnerability and risk of physical and mental health problems. The provision of high-quality healthcare in the context of detention can therefore be a challenging undertaking.

An appreciation and understanding of how these complex issues impact an individual's perception of physical and psychological health is important in achieving good-quality healthcare from a whole-person perspective. The RACGP recognises that the people who are detained in these facilities have a critical stake in the IDF Standards, and recognises that they are also an important secondary audience.

Application of the IDF Standards in immigration detention facilities

The risks of not having standards in place for healthcare provision in detention settings are significant.

The IDF Standards have been developed for application across all restrictive immigration detention facilities funded by the Australian Government, where, as a consequence of their detention, the individuals held there are not able to choose to access other external primary care and/or mental health services. The RACGP encourages the application of the IDF Standards in any Australian Government-funded restrictive immigration detention facility with a dedicated health service or facility, including:

- immigration detention centres
- immigration transit accommodation
- alternative places of detention (APOD), if the APOD has onsite health service provision by a contracted provider.

The RACGP holds no responsibility for the contractual arrangements and consequences regarding the accreditation of an immigration detention facility. However, the RACGP strongly recommends that the IDF Standards be contractually applied across all immigration detention facilities to demonstrate how the health services in each facility provide quality, safe and effective care for individuals in detention.

How do the IDF Standards reflect the principles of quality and safety?

The IDF Standards aim to address the quality and safety of the healthcare provided to people detained in Australian immigration detention facilities. The IDF Standards provide setting-specific indicators that, along with the core and quality-improvement modules, form, in essence, the same standards that apply to, and are expected of, general practice healthcare delivered to the Australian community.

There is consistent evidence that shows that accreditation programs improve the process of care provided by healthcare services.²⁷

Safety-related behaviours are affected by informal aspects of an organisation (such as its attitudes to safety),²⁸ and there is a need for indicators of processes and structures that support a safety culture. For example, it is important that infection-control processes are documented in a meaningful way (eg a written policy); however, it is arguably more important that the relevant staff members know and understand the infection-control processes.

Quality in care can be described in terms of the structure, process and outcomes of the health service:

- Structure relates to material resources, facilities, equipment and the range of services provided at the health service.

- Process relates to what is done in giving and receiving care (eg the consultation, ordering tests or prescribing).
- Outcomes relate to the effects of care on patients and communities (eg immunisation coverage rates, diabetes management or cervical screening).²⁹

The IDF Standards do not and cannot address all of the impacts on the health and wellbeing of people detained in Australian immigration detention facilities. A range of issues impacts health and wellbeing (such as prolonged uncertainty, housing, nutrition, physical activity and access to meaningful activities, including education and work-related skill development) that reinforce the importance of high-quality and safe healthcare provided by the health service. These issues are beyond the scope of the IDF Standards and must be prioritised by the organisations contracted to manage the day-to-day operations of immigration detention facilities, including the Australian Government.

Indicators that focus on outcomes and patients

The indicators in the IDF Standards have been written, where appropriate, with a focus on outcomes and patients, instead of prescribed processes or what your health service does.

By focusing on outcomes, health services can develop systems and processes that reflect your preferred ways of working, and choose how you demonstrate meeting the intent of each indicator. Through the accreditation process, you must provide evidence that you meet each indicator, either through inspection or interview. Focusing on outcomes will give your health service greater ownership of your practices and systems, ensuring that your team members are more likely to follow them, not only during accreditation but also before and after.

Development process

The RACGP developed the *Standards for health services in Australian immigration detention facilities* (2nd edition) in consultation with the Department of Home Affairs, staff working in health services at immigration detention facilities, GPs, health service managers, nurses, consumers, technical experts and many other stakeholders.

Modular structure

These Standards have the same modular structure as the RACGP's *Standards for general practices* (5th edition). The IDF Standards have the following three modules:

- core (modified version of the *Standards for general practices* for the immigration detention context)
- quality improvement (QI), modified as per core module
- immigration detention facility, which is specific to immigration detention facility health services.

Indicators throughout both the core and QI modules are the same as the *Standards for general practices* (5th edition). The core and QI modules were developed as a set of standards applicable to all primary care environments in Australia. Some criteria, indicators and explanatory notes have been modified to suit the context of health services in immigration detention facilities. All core and QI indicators have been retained; however, where an indicator might not be relevant to the current immigration detention setting, this has been identified in the explanatory notes. Figure 1 illustrates this modular approach.

Health services seeking accreditation against the IDF Standards must meet the requirements of all three modules: core, QI and immigration detention facility health services.

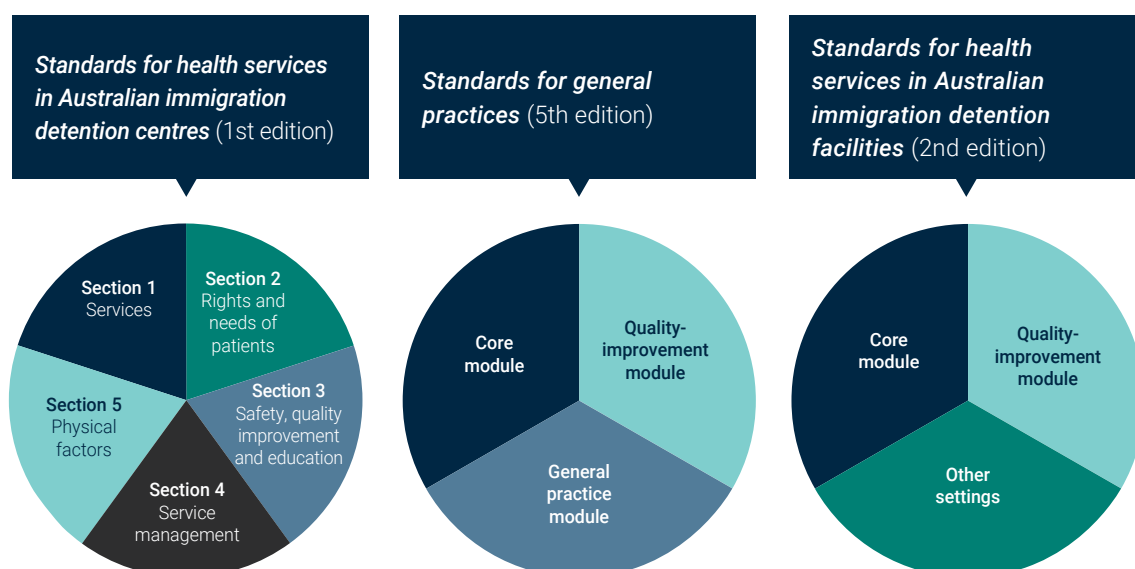


Figure 1. Modular structure of the RACGP Standards

The numbering system works as follows:

- Standards in each module are numbered separately (standards 1–8 in the core module, standards 1–3 in the QI module and standards 1–5 in the immigration detention facility health service module).
- The criteria for each standard have a code indicating the module (C for core, QI for quality improvement and IDF for immigration detention facility health services), followed by sequential numbering that indicates the standard and criterion. For example, C1.1 is the first criterion for the first standard in the core module; C1.2 is the second criterion for the first standard in the core module; IDF1.1 is the first criterion for the first standard in the immigration detention facility health service module).
- Each module starts with Standard 1; therefore, there is Criteria C1.1 and QI1.1 and IDF1.1.
- Each criterion has one or more indicators, labelled alphabetically (A, B, C, etc).

Table 1. Comparison of the Standards

<i>Standards for health services in Australian immigration detention centres (1st edition)</i>	<i>Standards for health services in Australian immigration detention facilities (2nd edition)</i>
Numbering in the 1st edition	Numbering in the 2nd edition
Section 1: Services	Module: Immigration detention facility health service module
Standard 1.1: Access to care	Standard 1: Access to care
Criterion 1.1.1: Scheduling care in opening hours	Criterion IDF1.1: Responsive system for patient care
Indicator: ▶ A There is evidence that our service has a flexible system to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs (document review)	Indicator: ▶ A Our health service provides different consultation types to accommodate patients' needs

Explanatory notes

The explanatory notes for each criterion comprise the following three sections:

- **Why this is important:** This section explains why the indicators are important from a quality and safety perspective.
- **Meeting this criterion:** This section sets out ways that your service can choose to demonstrate that you meet the criterion and/or its indicators.
- **Meeting each indicator:** This section contains a list of any mandatory activities your service must do to meet the indicator, and/or a list of optional ways your health service can choose to meet the indicator.

Mandatory (▶) and aspirational indicators

Indicators marked with a ▶ symbol are mandatory, which means that your health service must demonstrate that you meet this indicator to achieve accreditation against the IDF Standards.

Indicators that are not marked with the mandatory symbol are aspirational. The RACGP encourages you to meet the aspirational indicators, but they are not essential to achieve accreditation.

Use of 'must' and 'could'

In the explanatory notes, the words 'could' and 'must' are used as follows:

- 'Must' is used to indicate that something is mandatory.
- 'Could' is used to indicate that something is optional.

Plain English

Every effort was made to write this edition in plain English to reduce ambiguity and use less technical language than in the previous edition of the IDF Standards.

Reduced citations of federal, state or territory legislation

Legislation has been cited only where it is especially important to a particular aspect of service provision (eg in the core module, [Criterion C6.3: Confidentiality and privacy of health and other information](#)). As federal, state or territory, and local legislation overrides any non-legislative standards, including those in this document, your service is responsible for ensuring that you comply with relevant legislation.

If your service is accredited against the IDF Standards, you will have met some of your legislative responsibilities, but this does not mean that you have automatically met all of them, as the IDF Standards do not address all the relevant state and territory legislation.

Evidence-based standards

The IDF Standards are based on the best-available evidence of how health services can provide safe and quality healthcare to patients.

This evidence is based on two sources:

- Relevant literature.
- Level IV evidence (where studies are not available) – also known as evidence from a panel of experts. To ensure that this level IV evidence is as robust as possible, the IDF Standards have been tested by health services in Australian immigration detention facilities, overseen by an expert committee consisting of GPs, academic GPs and nurses, health service managers and consumer representatives.

Accreditation

For your health service to be accredited against the IDF Standards, you must be formally assessed against the IDF Standards by an accrediting agency approved under the National General Practice Accreditation (NGPA) Scheme (the Scheme), which commenced on 1 January 2017. A list of approved accrediting agencies can be found on the [RACGP website](#). The IDF Standards are not a document within the NGPA Scheme.

The accreditation cycle

The accreditation cycle is three years. This means that if your service achieves accreditation against these IDF Standards, the accreditation is valid for three years from that date. To maintain your accreditation, you must be successfully reassessed for the next accreditation cycle.

The assessment process

Each accreditation agency has surveyors who are trained to conduct assessments. The agency you select will:

- work with your health service to help you prepare for the accreditation process
- appoint a team of surveyors to visit each location where your health service operates and assess your health service against the IDF Standards.

Surveyor teams

Surveyor teams must include at least two surveyors, one of whom must be an appropriately qualified, trained and approved GP surveyor, and the other an appropriately qualified nurse, health service manager or allied health professional with relevant experience in immigration detention facilities.

Surveyor teams can include a third person, such as a non-health practitioner or consumer who has received appropriate training in the IDF Standards.

Fair and independent assessments

Accreditation assessments are based on common sense; the accreditation agencies will not seek to penalise or exclude a health service from accreditation due to technicalities.

The RACGP considers that an independent review of your service that includes two or more surveyors (one GP and one or more non-GP surveyor) will foster genuine collaboration and sharing of expertise among peers.

Requirements for accreditation bodies

The RACGP has developed the following requirements that accrediting agencies and surveyors must meet to assess health services in Australian immigration detention facilities.

By ensuring that bodies have appropriate systems, processes and commitment, and that surveyors have the appropriate skills, qualifications and experience, the accreditation process has the required rigour and level of accountability.

Accreditation agencies

To assess services against the IDF Standards, accrediting agencies must demonstrate to the RACGP:

- an in-depth understanding of:
 - the IDF Standards
 - the nature of health services in Australian immigration detention facilities
 - requirements for training and vocational registration of GPs
- an accreditation assessment framework that includes a requirement to conduct a single onsite assessment once every three years at each location from which a health service operates
- the capacity to efficiently assess health services in immigration detention facilities across Australia
- a governance and advisory structure that includes GPs who have considerable experience in immigration detention facility health services
- a commitment to not refuse an application for accreditation from a health service that meets the RACGP definition of an immigration detention facility health service, regardless of location or size
- a commitment to not financially or otherwise discriminate against a service because of location or size.

Surveyors

All surveyors must:

- demonstrate a good understanding of confidentiality issues relating to health services in immigration detention facilities, personal health information and patient privacy
- meet requirements relating to their previous and recent experience
- complete ongoing surveyor training, as required by the Scheme, to maintain their competence and knowledge of the IDF Standards.

GP surveyors

A survey visit must be completed by a survey team comprising of at least two surveyors, of which one must be a GP who:

- is vocationally registered under the *Health Insurance (Vocational Registration of General Practitioners) Regulations 1989* (Cth)
- holds active medical registration with Australian Health Practitioner Regulation Agency (AHPRA)
- holds Fellowship of the RACGP (FRACGP) or Fellowship of the Australian College of Rural and Remote Medicine (ACRRM) if appointed after 31 October 2017

- has experience in providing care to individuals in immigration detention
- has experience in refugee healthcare
- has at least five years' full-time equivalent experience as a vocationally registered GP
- has either:
 - worked at least two sessions a week for the past two years in face-to-face patient contact in an accredited primary healthcare service, or
 - has worked at least two sessions a week in face-to-face patient contact in an accredited primary healthcare service in the past two years, and
 - satisfies their college's continuing professional development requirements.

Non-GP surveyors

The survey visit's co-surveyor can be a qualified nurse, health service manager, allied health professional, Aboriginal health worker or other health practitioner who:

- completes ongoing surveyor training as required by the NGPA Scheme to maintain their competence and knowledge of the IDF Standards
- has at least five years' full-time equivalent experience
- has either:
 - worked at least 16 hours a week for the past two years in an accredited primary healthcare service, or
 - has worked at least 16 hours a week in an accredited primary healthcare service in the past two years.

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References

1. Dudley M, Steel Z, Mares S, Newman L. Children and young people in immigration detention. *Curr Opin Psychiatry* 2012;25(4):285–92.
2. Lorek A, Ehntholt K, Nesbitt A, et al. The mental and physical health difficulties of children held within a British immigration detention center: A pilot study. *Child Abuse Negl* 2009;33(9):573–85.
3. Kronick R, Rousseau C, Cleveland J. Asylum-seeking children's experiences of detention in Canada: A qualitative study. *Am J Orthopsychiatry* 2015;85(3):287–94.
4. Mace AO, Mulheron S, Jones C, Cherian S. Educational, developmental and psychological outcomes of resettled refugee children in Western Australia: A review of school of special educational needs: medical and mental health input. *J Paediatr Child Health* 2014;50(12):985–92.
5. Mares S, Jureidini J. Psychiatric assessment of children and families in immigration detention: Clinical, administrative and ethical issues. *Aust N Z J Public Health* 2004;28(6):520–26.
6. Steel Z, Momartin S, Bateman C, et al. Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Aust N Z J Public Health* 2004;28(6):527–36.
7. Coffey GJ, Kaplan I, Sampson RC, Tucci M. The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Soc Sci Med* 2010;70(12):2070–79.
8. Deans AK, Boerma CJ, Fordyce J, et al. Use of Royal Darwin Hospital emergency department by immigration detainees in 2011. *Med J Aust* 2013;199(11):776–78.
9. Green JP, Eagar K. The health of people in Australian immigration detention centres. *Med J Aust* 2010;192(2):65–70.
10. Newman L, Proctor N, Dudley M. Seeking asylum in Australia: Immigration detention, human rights and mental health care. *Australas Psychiatry* 2013;21(4):315–20.
11. Porter M, Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *JAMA* 2005;294(5):602–12.
12. Robjant K, Hassan R, Katona C. Mental health implications of detaining asylum seekers: systematic review. *Br J Psychiatry* 2009;194:306–12.
13. Silove D, Steel Z, Watters C. Policies of deterrence and the mental health of asylum seekers. *JAMA* 2000;284(5):604–11.
14. Steel Z, Silove DM. The mental health implications of detaining asylum seekers. *Med J Aust* 2001;175(11–12):596–99.
15. Steel Z, Momartin S, Silove D, Coello M, Aroche J, Tay KW. Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Soc Sci Med* 2011;72(7):1149–56.
16. Steel Z, Silove D, Brooks R, Momartin S, Alzuhairi B, Susljik I. Impact of immigration detention and temporary protection on the mental health of refugees. *Br J Psychiatry* 2006;188:58–64.
17. Sultan A, O'Sullivan K. Psychological disturbances in asylum seekers held in long term detention: A participant-observer account. *Med J Aust* 2001;175(11–12):593–96.
18. Young P, Gordon MS. Mental health screening in immigration detention: A fresh look at Australian government data. *Australas Psychiatry* 2016;24(1):19–22.
19. MacLean SA, Agyeman PO, Walther J, Singer EK, Baranowski KA, Katz CL. Mental health of children held at a United States immigration detention center. *Soc Sci Med* 2019;230:303–08.
20. von Werthern M, Robjant K, Chui Z, et al. The impact of immigration detention on mental health: A systematic review. *BMC Psychiatry* 2018;18(1):382.
21. Van Hout MC, Lungu-Byrne C, Germain J. Migrant health situation when detained in European immigration detention centres: a synthesis of extant qualitative literature. *Int J Prison Health* 2020;16(3):221–36.
22. Passardi S, Hocking DC, Morina N, Sundram S, Alisic E. Moral injury related to immigration detention on Nauru: A qualitative study. *Eur J Psychotraumatol* 2022;13(1):2029042.
23. Cleveland J, Kronick R, Gros H, Rousseau C. Symbolic violence and disempowerment as factors in the adverse impact of immigration detention on adult asylum seekers' mental health. *Int J Public Health* 2018;63(8):1001–08.
24. Essex R, Kalocsányiová E, Young P, McCrone P. Psychological distress in Australian onshore and offshore immigration detention centres from 2014–2018. *J Immigr Minor Health* 2022. Online ahead of print.

25. Greenfield D, Braithwaite J. Health sector accreditation research: A systematic review. *Int J Qual Health Care* 2008;20(3):172–83.
26. Braithwaite J, Greenfield D, Westbrook J, et al. Health service accreditation as a predictor of clinical and organisational performance: A blinded, random, stratified study. *Qual Saf Health Care* 2010; 19(1):14–21.
27. Alkhenizan A, Shaw C. Impact of accreditation on the quality of healthcare services: A systematic review of the literature. *Ann Saudi Med* 2011;31(4): 407–16.
28. Naveh E, Katz-Navon T, Stern Z. Readiness to report medical treatment errors: The effects of safety procedures, safety information, and priority of safety. *Med Care* 2006;44(2):117–23.
29. Donabedian A. The quality of care. How can it be assessed? *JAMA* 1988;260(12):1743–48.

Core module

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Core Standard 1

Communication and patient participation

Our health service provides timely and accurate communications that are patient centred.

Communication with patients includes:

- communication that occurs before the consultation, during the consultation and after the consultation
- verbal and written communication, and the use of interpreters, including sign language interpreters
- communication between the patient and
 - the practitioner
 - the health service team
 - other clinicians in the health service.

Communication must be patient centred. This means that the health service team considers the patient's values, needs and preferences, and gives the patient time to provide input and participate actively in decisions regarding their healthcare.¹ Patients must be provided with the appropriate information they need to manage their condition.

The health service must also consider the communication needs of carers and other relevant parties.

Criterion C1.1: Information about your health service

Indicator

C1.1▶A Our patients can access up-to-date information about the health service.

At a minimum, this information contains:

- our health service's location and how to contact us
- our consulting hours and details of arrangements for care outside of normal opening hours
- our health service's billing principles
- our health service's communication policy, including when and how we communicate with patients
- our health service's policy for managing patient health information (or its principles, and how full details can be obtained from the health service)
- how to provide feedback or make a complaint to the health service
- details on the range of services we provide.

Why this is important

Information about the health service, including the range of services provided, is important to all patients. Individuals in detention might not be aware of a health service within the immigration detention facility if information is not provided in a language understood to them.

Meeting this criterion

The format of the information

You can provide this information in many formats, such as printed information sheets and text on the health service's website. Pictures and simple-language versions help patients who would otherwise be unable to read or understand the information. The health service needs to update this information regularly so that it remains accurate. Ideally, the information is updated as soon as it changes.

Your health service provides care to individuals from a diverse range of ethnicities, cultures and linguistic backgrounds, and needs to provide access to written information in the languages most commonly used by your patients. You could also display the languages spoken by the health service team on an information sheet or poster.

Appointment types

The information you provide to patients about appointment types needs to detail what appointments are available and in what circumstances. Your health service could educate, and communicate with, patients about the process and the benefits of an appointment type before they take part, especially if a patient is unfamiliar with an appointment supported by technology. You could also advise patients of the different durations available for each appointment type.

Meeting each indicator

C1.1▶A Our patients can access up-to-date information about the health service.

You must:

- make health service information available to patients
- update health service information if there are any changes.

You could:

- ensure patients are alerted to the presence and functions of the health service on their arrival at the immigration detention facility
- create and maintain an up-to-date information sheet that contains all the required information in language that is clear and easily understood
- provide alternative ways to make the information available to patients who have low literacy levels (eg provide versions in languages other than English, and versions that include pictures)
- provide brochures to patients on their first encounter, and/or signs in the waiting room, in English and languages other than English, explaining:
 - the health service’s policy regarding its collection, storage, use, and disclosure of personal and health information
 - available services
 - after-hours services
- display a list of names of the health service team members on duty
- provide information to patients about the languages these team members speak when health service team members are bilingual
- make contact details of interpreters available
- alert patients to when their regular practitioner is available at the health service
- provide details about how patients can access an interpreter
- train health service team members so that they can use the interpreter service.

Criterion C1.2: Communications

Indicator

C1.2▶A Our health service manages communications from patients.

Why this is important

Effective communication with patients ensures that:

- patients can contact the health service when they need to
- patients can make appointments and receive other information in a timely fashion
- urgent enquiries are dealt with in a timely and medically appropriate way.

Urgent enquiries must be delivered to the health service immediately. It is important to recognise that written communication (paper or electronic) might not be attended to for some time.

The immigration detention facility needs to inform individuals in detention how they can access your health service, relevant staff or alternative arrangements in the case of an urgent matter.

Meeting this criterion

Your health service must ensure that patients can directly communicate with the health service during normal opening hours.

Communicating by telephone

If your service communicates with patients by telephone, before putting a caller on hold, reception staff must first ask if the matter is an emergency.

When a member of the health service team provides information (such as test results) to a patient by telephone, they must make sure that the patient is correctly identified so that patient confidentiality is not compromised. To do this, at least three patient identifiers (items of information that are accepted for use to identify a patient) must be obtained, such as:

- patient's name (family and given names together are one identifier)
- patient's date of birth
- an individual identification number where it exists (eg immigration detention facility ID number).

Advice regarding communication by telephone is not applicable if individuals in detention do not have access to telephones.

Communicating by written request

Your health service might receive written requests for appointments from patients in the immigration detention facility. These requests could be made by individuals in designated areas and might be passed on to the health service by non-health staff.

Your health service must demonstrate that it can identify and triage patients, including triage for those who need to be seen urgently. Triage following a written request could be based solely on the written information provided by the patient and/or on reviewing the patient's health record. When a written

request is provided in a language not spoken by an available member of the clinical team, translation must take place as soon as possible.

Communicating by electronic means

If you choose to communicate with patients electronically (eg by telehealth, email, secure messaging or text message), you must:

- adhere to the Australian Privacy Principles, the *Privacy Act 1988* and any state-specific laws
- clearly state what content the health service team can and cannot send using electronic communication (eg your health service might require that sensitive information only be communicated in person by a medical practitioner or other appropriate health professional, unless there are exceptional circumstances)
- inform patients that there are risks associated with some methods of electronic communications, and that their privacy and confidentiality might be compromised
- obtain consent from the patient before sending health information to the patient electronically (consent is implied if the patient initiates electronic communication with the health service)
- check that the information is correct and that you are sending it to the correct email address, phone number or person before sending the information
- avoid sending information that promotes products and/or preventive healthcare, because some patients can interpret this as an advertisement.

If you allow patients to contact the health service by email, inform them:

- of how long they can expect to wait for a response
- that they should not use email to contact the health service in an emergency.

Health services need to consider what content is safe and appropriate to send and discuss via electronic messaging and the methods to do so. While developed for a general practice setting, the RACGP's [Using email in general practice – Guiding principles](#) and [Secure communications in general practice – Product list](#) can be applied across various health service settings to improve electronic communications.

The RACGP's [Using email in general practice – Privacy and security matrix](#) shows the risk associated with emailing certain types of information to patients or other healthcare providers, depending on your health service's policies and processes.

Informing the clinical team of communications

All messages from patients, to patients or about patients must be added to, and become part of, the patient's health record, as must any actions taken in response to the message.

Develop procedures for the following:

- how messages are communicated – internal electronic messaging systems are useful for this
- how messages are recorded (eg for privacy reasons, it might be unacceptable to record them on a sticky note)
- how electronic messages are added to patient health records (eg how relevant emails can be copied into the medical software)
- how to ensure that a message is given to the intended person and what to do if the intended recipient is absent
- how to ensure that practitioners can respond to messages in a timely manner.

Communicating with patients with communication needs

If patients (eg patients from culturally and linguistically diverse [CALD] backgrounds or those with a communication impairment) need to use other forms of communication, consider using the services that are available, such as:

- the **National Relay Service** (NRS) for patients who are deaf
- the **Translation and Interpreter Service** (TIS National) for patients from CALD backgrounds.

Communication during a crisis, emergency and disaster

During a crisis, emergency or disaster, the volume of incoming telephone or electronic communication might increase. It is important that your health service, as part of your emergency response plan, develops and maintains a communication policy to appropriately triage and manage communication to patients and clinical team members during this time.

Electronic appointments

If your patients can make appointments electronically:

- select the technology and system that best suit your health service's requirements
- decide which appointments are appropriate for electronic bookings (eg you could offer this option only for routine, non-urgent appointments).

Meeting each indicator

C1.2▶A Our health service manages communications from patients.

You must:

- use three forms of identification for identifying patients when they communicate with the health service
- document in each patient's health record when:
 - team members have attempted to contact the patient or successfully contacted the patient
 - a patient contacts the health service, the reason for the contact, and the advice and information the patient was given.
- translate messages in languages other than English as soon as possible
- demonstrate how members of the health service team attend to and triage written requests
- demonstrate how non-health staff can quickly and safely provide messages from individuals to the health service.

You could:

- have a recorded phone message (which might be an introductory message or 'on hold' message) that tells patients what to do in an emergency (if your health service uses telephone)
- have a policy, procedure or flowchart that shows how to manage messages from patients
- maintain a communication policy to manage and triage incoming communication during a crisis, emergency and disaster
- demonstrate how your patients receive open, timely and appropriate communication about their healthcare during a crisis, emergency or disaster

- document what information and advice the health service team can and cannot give to patients over the phone or electronically
- educate reception staff about which messages need to be transferred to the clinical team
- have an appointment system that includes time for the clinical team to return messages to patients
- have an automatic email response (if your email system allows it) that includes the health service's telephone number and when the sender can expect to receive a reply (if applicable to your communication system)
- establish a process so that patients are advised of the health service's policy for checking, responding to, and sending written communications and/or emails.

Criterion C1.3: Informed patient decisions

Indicator

C1.3▶A Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits and risks.

C1.3▶B Our patients receive information to support the diagnosis, treatment and management of their conditions.

Why is this important

Patients have the right to make informed decisions about their health, medical treatments, referrals and procedures. You have a duty to provide information that the patient can understand, and that is tailored to their individual needs.

Meeting this criterion

Providing appropriate and sufficient information

Practitioners can provide information verbally to patients during a consultation. When explaining proposed investigations, referrals and treatments to patients, deliver the information in an appropriate language and format. This means using simple language, minimising jargon and complicated terms, and using clear diagrams.

When delivering information to a patient, consider:

- the patient's physical, visual and cognitive capacities that might affect their ability to understand the information, make decisions or provide consent
- the most appropriate way to communicate potentially sensitive information (eg about sexually transmissible infections, blood-borne viruses and pregnancy results)
- the patient's cultural and linguistic background (eg you might need to use an interpreter to ensure that the patient understands everything that you have told them)
- the patient's family members who are involved in their care (with the patient's consent when the patient has capacity)
- the patient's level of health literacy, and therefore, their ability to understand the information
- managing the amount of information you give to avoid overwhelming them.

All of these factors must also be considered if you need to give information to a carer.

Further information provided to patients and carers can be paper based or electronic (eg leaflets, brochures and links to reputable websites).

It is appropriate to discuss with patients the option of no treatment. Practitioners can explain the advantages and disadvantages of different treatment approaches in conversation with patients. Unnecessary tests and treatments can be painful and dangerous, carrying a risk of complication that can affect quality of life or, in extreme cases, trigger a life-threatening problem.

Information about interventions

Receiving information about tests and treatments (including medicines and medicine safety) might help patients to make informed decisions about their care. For this reason, practitioners need to:

- check the patient's understanding about the intervention
- check the carer's understanding of the intervention, if the patient has a carer
- offer to discuss any issues about a patient's condition, proposed treatment and medicines that could be confusing
- direct patients to reliable health and medicine electronic resources where they can find further information
- recommend that patients seek further advice about their medicines from a member of the clinical team, pharmacist or prescriber.

Health literacy

Individual health literacy is defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC) as 'the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and healthcare and take appropriate action'.²

Health literacy plays an important role in enabling effective partnerships between practitioners and patients. For partnerships to work, everyone involved needs to be able to give, receive, interpret and act on information, such as treatment options and plans.

Assessing the health literacy of patients and then providing them with information based on that assessment can help increase a patient's awareness and understanding of their diagnosis, condition, treatment options, and the possible risks or side effects of medications or treatments.

Practitioners can build a patient's health literacy by:

- recognising the patient's needs and preferences, and tailoring communication accordingly
- assuming that most people will have difficulty understanding complex health information and concepts
- providing health information in an unrushed manner using terminology that the patient understands
- using multiple forms of communication to confirm that information has been delivered and received effectively
- giving the patient targeted information (eg leaflets) and telling them where they can access further targeted information (eg websites and support groups)
- encouraging the patient, carer and other relevant parties to say if they have difficulty understanding the information
- using proven methods of informing patients about the risks of treatment options.

Support groups

Your health service could support patients' health literacy and informed patient decisions by referring patients to relevant support groups. If doing so, consider a risk assessment or evaluation to determine the appropriateness of referring the patient to an external support group, as complex needs, situations and comorbidities might impact potentially vulnerable members of the support group and might make an independent support group an inappropriate source of support.

Meeting each indicator

C1.3▶A Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits and risks.

You must:

- obtain patient consent for a third party (eg an interpreter) to be present at consultations when the patient needs help understanding their health information
- have a process that ensures that patients understand the information.

You could:

- use diagrams or flip charts in consultations to help explain health matters to patients
- use tools that help the practitioner and patient share the decision-making, and establish a supportive and effective partnership
- provide patients with the information they need to understand and manage their health, such as paper copies of information sheets and names of electronic resources, in a way that is understandable to them.

C1.3▶B Our patients receive information to support the diagnosis, treatment and management of their conditions.

You must:

- document in the patient's health record the treatment options and associated risks and side effects that you have explained and discussed with the patient
- document in the patient's health record the patient's refusal to obtain or follow any clinician's advice.

You could:

- provide patients with information sheets and instructions about relevant health conditions, treatments and medicines in their language
- make available a range of health information sheets that are 1–2 pages long in their language
- have information relating to culturally specific health information in the waiting room and consultation rooms in their language
- display posters containing information about specific diseases, such as hepatitis B and tuberculosis in their language.

Criterion C1.4: Interpreter and other communication services

Indicator

C1.4▶A Our health service endeavours to use a professional interpreter with patients who do not speak the primary language of our health service team.

C1.4▶B Our health service endeavours to employ communication strategies to engage with patients who have difficulty accessing the service due to a communication impairment.

C1.4C Our patients can access resources that are culturally appropriate, translated and/or in plain English.

Why this is important

Patients have a right to understand the information and recommendations they receive from their practitioners.³

Practitioners have a professional obligation to communicate effectively and to understand their patients' health concerns.

Meeting this criterion

Communication with patients who do not speak the primary language of our health service team

Avoid using a family member or friend of the patient as an interpreter because:

- information about the patient's diagnosis might not be translated effectively, which might result in harm to the patient⁴
- it might impose unreasonable responsibility and stress on the selected individuals, particularly if they are young or a very close relative (eg a child)
- it might upset the friendship dynamics and family relationships.⁵

The Australian Government's TIS National assists health services in immigration detention facilities to provide care to patients. More information is available at www.tisnational.gov.au. The Australian Government also funds a free interpreting service for patients who are deaf and use Australian sign language (Auslan). Consider developing a policy that explains how the health service team can communicate with patients who have low or no English proficiency. The policy could include:

- how to identify a patient who requires an interpreter or communication service (eg placing a specific flag in the patient's health record)
- how to use the health service's telephones when using interpreting services (eg setting up a three-way conversation or using speaker phones)
- displaying the national interpreter symbol in the reception area where patients can easily see it (including areas from where patients can communicate with the health service)
- what information (such as the need for an interpreter, the patient's preferred language, gender and cultural sensitivities) is to be recorded in a patient's health record and referral letters
- training the health service team in using interpreters
- documenting in each consultation record whether an interpreter has been used.

Although patients engaging with the health service might appear comfortable with English, they might still benefit from being offered an appropriate interpreting service.

Assessing the health literacy of patients using an interpreter

It is common for patients to have low health literacy levels and find it hard to understand medical concepts or the health system in general. Practitioners might not be aware of this fact, which can create a communication gap between the practitioner and patient.

With the help of interpreters, practitioners need to assess the patients' level of literacy in their own language. Following such a process, health professionals could better understand a patients' health literacy level according to the level of their preferred language. Further details regarding how practitioners can build a patient's health literacy is provided at [Criterion C1.3: Informed patient decisions](#).

Patient refusal of an interpreter

There are potential risks when treating patients who decline to use an interpreter. This is particularly problematic when there is a possibility of a detrimental outcome if specific information is not communicated correctly to the patient.

If a clinician decides that an interpreter is needed, and one is available and offered to, but declined by, the patient, you could manage any associated risks by recording that the patient declined an interpreter in the patient's health record.

Refer to [Criterion C1.3: Informed patient decisions](#) for more information about informed patient decisions.

Refer to [Criterion C2.1: Respectful and culturally appropriate care](#) for more information about respectful and culturally appropriate care.

Communication with patients who have communication impairments

The health service team must consider the needs of patients who need assistance with communication due to hearing, speech or vision impairment, disability or cognitive impairment.

The health service team could consider the following when communicating with a patient with a communication impairment:⁶

- Ask the person about the best way to communicate if you are unsure.
- Speak directly to the patient.
- Confirm whether the detainee is under a guardianship order and how they can be accessed.
- Confirm that you have understood the reason for their visit, their symptoms and other issues, and confirm that the patient has understood the information you have given them.
- Your health service needs to know how to access the NRS for patients who are deaf or have a hearing or speech impairment. More information is available at the [National Relay Service](#).
- Further information about how your health service can communicate with patients who have communication impairments is available at [Communication Rights Australia](#) and at [Novita](#).

Translated and plain-English resources

Consider having a directory of resources, services, electronic tools and websites that will help you provide information in languages other than English.

The [Health Translations directory](#) provides health practitioners with access to translated health information if they are working with CALD communities.

Meeting each indicator

C1.4▶A Our health service endeavours to use a professional interpreter for patients who do not speak the primary language of our health service team.

You must:

- provide evidence that interpreters are used for patients who do not speak the primary language of your health service team
- document in the patient's health record details of any translation services used for that patient
- document in the patient's health record details of any refusal to use an interpreter.

You could:

- have a policy addressing the use of interpreter and communication services
- use appropriately qualified interpreters
- make sure all team members can access a list of contact details for interpreter and other communication services.

C1.4▶B Our health service endeavours to employ communication strategies to engage with patients who have difficulty accessing the service due to a communication impairment.

You must:

- provide evidence that appropriate communication services are used to communicate with patients who have a communication impairment
- enter in the patient's health record details of any communication services used
- document in the patient's health record details of any refusal to use a communication service.

You could:

- educate health service team members so they know how to contact and use services, such as Auslan interpreting services for patients who are hearing impaired
- keep a record of any health service clinical staff who are comfortable communicating in a language other than English and use this list to offer appointments with clinical staff to patients speaking those languages.

C1.4C Our patients can access resources that are culturally appropriate, translated and/or in plain English.

You could:

- maintain a list of electronic resources and services from which patients can access translated resources
- keep information sheets in the common languages of the patient population in the consultation spaces.

Criterion C1.5: Costs associated with care initiated by the health service

Indicators

C1.5▶A Our patients are informed about out-of-pocket costs for healthcare they receive from our health service.

C1.5▶B Our patients are informed that there are potential out-of-pocket costs for referred services.

Why this is important

Providing information in advance about costs that patients will or might incur (including costs in addition to consultation fees) is one way you can help patients make an informed decision about their own healthcare.

Where a service is provided to patients at no cost to them, health service staff must inform the patient and reassure them that costs will not be recouped at a later time.

If the patient indicates, or you otherwise know or suspect, that the costs of a suggested referral or test pose a barrier to the patient, discuss alternatives with them, such as referral to public services.

Meeting this criterion

Costs at your health service

Your health service needs to inform patients of the possible cost of additional treatments or procedures before beginning the treatment or procedure. To make sure that a patient understands these possible costs, consider their communication abilities and needs (eg they might need an interpreter or materials that are in their preferred language or in plain English).

A governing body might absorb the costs for medical treatment in an immigration detention setting, in which case patients must be informed of this.

Your health service could make a document available to patients of any potential costs, or services that do not have any cost to patients.

Costs for referred services

You do not need to know or provide the exact costs of referred and investigative services. Before you make a referral or request for investigation, inform patients that these services could attract an out-of-pocket cost. If exact costs are unknown, your health service could inform the patient about the likely cost of referred services.

Meeting each indicator

C1.5▶A Our patients are informed about out-of-pocket costs for healthcare they receive from our health service.

You must:

- inform patients about out-of-pocket costs for healthcare they receive from your health service.

You could:

- inform patients that they will incur no cost for the healthcare they receive from your health service
- display billing information in waiting areas
- explain the billing policy in person to patients.

C1.5▶B Our patients are informed that there are potential out-of-pocket costs for referred services.

You must:

- let the patient know when you are making a referral or requesting investigations that there might be a cost for the service. You do not need to know the exact cost.

You could:

- provide the contact details of the referred service provider so that the patient can find out about the costs for that service
- develop a contact list of local service providers that you can give patients so that they can find out about costs and select the service provider of their choice
- inform the patient about the likely cost of referred services.

Core Standard 2

Rights and needs of patients

| Our health service respects the rights and needs of patients.

The ACSQHC's *Australian charter of healthcare rights* aims to create a common understanding of the rights of people receiving healthcare. View or download this charter at: www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/review-of-the-charter-of-healthcare-rights-second-edition

The RACGP's [General practice patient charter](#) is aligned with the ACSQHC's *Australian charter of healthcare rights*, and describes the responsibilities of patients.

Criterion C2.1: Respectful and culturally appropriate care

Indicator

C2.1 ► A Our health service, in providing patient healthcare, considers and respects patients' rights, identity, body diversity, beliefs, and their religious and cultural backgrounds.

C2.1 ► B Our patients receive information from the clinical team about the risks resulting from refusing a specific treatment, medicines, advice or procedure.

C2.1 ► C Our health service acknowledges a patient's right to seek other clinical opinions.

C2.1 ► D Our patients in distress are provided with privacy.

C2.1 ► E Our clinical team considers ethical dilemmas.

Why this is important

The ideal patient–practitioner partnership is a collaboration based on mutual respect and mutual responsibility for the patient's health. The clinician's duty of care includes clearly explaining the benefits and potential harm of specific medical treatments and the consequences of not following a recommended management plan.

Understanding what respectful and culturally appropriate care is

Respectful and culturally appropriate care is based on cultural awareness and sensitivity, which begins with learning about other cultures and cultural beliefs. Cultural awareness is defined by the Centre for Cultural Diversity in Ageing as:

An understanding of how a person's culture may inform their values, behaviours, beliefs and basic assumptions [It] recognises that we are all shaped by our cultural background, which influences how we interpret the world around us, perceive ourselves and relate to other people.⁷

Culturally safe policies aim to create an environment that is 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need', where there is 'shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening'.⁸

Patients' rights

Patients have the right to care that considers and respects their identity, body diversity, religion and cultural beliefs; displays an acceptance of diversity; and promotes their dignity, privacy and safety. Respect for a patient means that care is available to anyone without bias or influence of one's own personal beliefs, and extends to recording, storing, using, and disclosing health and other information about them.

You need to understand the demographics and cultural backgrounds of your patient population so that you can provide the most appropriate care. When clinical team members ask patients about their cultural identity and beliefs so as to update the patient's details, it is beneficial to explain that this helps the health service to provide culturally sensitive care.

All members of the health service team need to have interpersonal skills that allow them to successfully interact with patients and colleagues.

Be mindful that when dealing with patients, the health service team must also comply with commonwealth and any relevant state or territory antidiscrimination laws.

Rights to refuse treatment and obtain second opinions

Patients with decision-making capacity have the right to refuse a recommended treatment, medicines, advice or procedure, and have the right to seek clinical opinions from other healthcare providers.

If you refer the patient for a second opinion, you do not need to know or provide the exact costs of the referred services, but before you make a referral, inform patients that these services could attract an out-of-pocket cost.

Patients' responsibility

Patients have a responsibility to be respectful and considerate towards their practitioners and other health service team members.

Ethical dilemmas

Practitioners often need to manage ethical issues and dilemmas in many different primary healthcare situations. These can range from bioethical dilemmas (including end-of-life care and pregnancy termination) to receiving gifts from patients.

Meeting this criterion

Respectful and culturally appropriate care

You could consider factors that might affect the provision of respectful and culturally appropriate care, including:

- the patient's preference for a clinician of a specific gender
- the role of the patient's family
- the impact that the patient's culture has on their health beliefs
- history of traumatic events (eg events associated with forced migration or adverse childhood or life experiences).

Practitioners have a professional obligation to take reasonable care when taking a history from a patient and developing management plans. They must also ensure there is clear and effective communication in the patient–practitioner relationship so that they can effectively manage the patient's healthcare. The patient needs to understand the discussion that takes place and the proposed management and treatment. This might require the use of translating and interpreting services.

If a carer has an ongoing role in the day-to-day care of a patient, it is generally advisable to include the carer in the patient–practitioner relationship with the permission of the patient (if the patient is able to give such consent).

It is also respectful for non-clinical staff to be positive, friendly, attentive, empathetic and helpful.

Managing health inequalities

Understanding local health inequalities, including those within the detention facility, allows your health service to identify opportunities to provide tailored healthcare to specific patients or patient groups. To develop an understanding of your health service population, you can either analyse health service data or use publicly available information.

Refusal of treatment or advice

Patients might refuse a practitioner's recommended course of action, including advice, medicines, procedure, treatment or referral to other care providers. When this happens, the health service might manage any associated risks by documenting in the patient's health record:

- the informed refusal
- the clinical team member's explanation of the risks of not following health advice
- whether the individual has capacity to make an informed choice
- the action taken by the practitioner, health service or patient
- any other relevant information, such as an indication that the patient intends to seek another clinical opinion.

Patients can be counselled by the health service to ensure they are aware of the risks associated with refusing recommended treatment, medicines, advice or procedure.

Second opinions

If the practitioner is aware that the patient wishes to seek another clinical opinion, they could offer to provide a referral to the provider who is to give that opinion. Document in the patient's health record:

- the patient's decision
- the actions taken by the practitioner
- any referrals to other care providers.

You can also encourage patients to notify their practitioner when they decide to follow another healthcare provider's advice so that the practitioner can discuss any potential risks of this decision.

In some immigration detention settings, there are scenarios where it might not be possible to refer a patient for a second opinion. If this is the case, practitioners must explain to the patient the reasons for not being able to refer and document this in the patient's health record.

Deciding to no longer treat a patient

If a practitioner no longer considers that it is appropriate to treat a particular patient, the steps taken to help the patient receive alternative ongoing care need to be recorded in the patient's health record.

Dealing with patients who are distressed

You might develop a plan to help patients, and other relevant people, who are distressed and to ensure that they are treated respectfully. For example, you can provide a private area (such as an unused room in your health service or the staff room) where the person can wait before seeing a practitioner.

Ethical dilemmas

Examples of situations that might create ethical dilemmas in a health service include:

- patient–practitioner relationships (familial relationships, friendships, romantic relationships)
- professional differences
- cultural barriers that might cause patient resistance to certain care
- language barriers that might cause ambiguity or confusion for the patient or practitioner
- emotionally charged clinical situations (eg when a patient has an unwanted pregnancy or terminal illness, has endured torture or trauma, or wishes to discuss end-of-life issues)
- issues around sexual orientation and gender diversity.

You need a system to document situations that present ethical dilemmas and the actions taken. Practitioners could discuss the ethical dilemmas with a colleague or with their medical defence organisation. Documentation of a discussion about an ethical dilemma with a medical defence organisation must be kept separate from the patient's health record, ideally in a separate medico-legal file.

You might also provide ongoing training to help practitioners deal with ethical dilemmas, and encourage the health service team to participate in reflective discussions about situations that present ethical dilemmas.

Where a practitioner is facing an ethical dilemma, the practitioner could also inform the patient that they see an ethical dilemma for themselves, and refer them to another practitioner, if possible.

Healthcare must be provided according to the patient's needs and be informed by best practice, standards, and current guidelines and legislation. The personal beliefs of a practitioner or organisation must not influence the delivery of healthcare.

Meeting each indicator

C2.1 ► A Our health service, in providing patient healthcare, considers and respects patients' rights, identity, body diversity, beliefs, and their religious and cultural backgrounds.

You must:

- demonstrate that you have considered and respect patients' rights, identity, body diversity, beliefs, and religious and cultural backgrounds when providing healthcare.

You could:

- maintain a cultural safety policy for the health service team and patients so that your health service team knows they are required to provide care that is respectful of a person's culture and beliefs, and that is free from discrimination
- provide appropriate training and education so that the health service team knows how to help patients feel culturally safe in the service
- maintain a policy about patients' rights and responsibilities
- maintain a policy about the ceasing of a patient's care
- maintain policies and processes about patient health records
- maintain an antidiscrimination policy
- provide access to cultural awareness and cultural safety training for the health service team, and keep records of the training in the health service's training register
- maintain a policy of acknowledging, recording, and implementing the names and pronouns used by each patient
- demonstrate that patients' assigned sex at birth, variations of sex characteristics (intersex status) and gender are recorded separately in your clinical software
- meet a patient's request for a practitioner they feel comfortable with, if possible
- have separate sections of the waiting room for men and women, if possible and if culturally appropriate for your patient population
- hold meetings for the clinical team to discuss and identify the unique health needs of lesbian, gay, bisexual, transgender, intersex, queer and asexual (LGBTIQ+) patients and those of other gender and sexual diversities
- use a clinical audit tool to identify cultural groups in your population

- display LGBTIQ+ symbols and/or flags
- display organisational cultural protocols within the office, waiting areas and consultation rooms
- provide resources appropriate to the health literacy and cultural needs of your patients.

C2.1 ► B Our patients receive information from the clinical team about the risks resulting from refusing a specific treatment, medicines, advice or procedure.

You must:

- keep appropriate documentation in the patient's health record
- develop a process outlining what the clinical team must do when a patient refuses treatment, medicines, advice or a procedure.

You could:

- establish and follow a process for dealing with suggestions and complaints.

C2.1 ► C Our health service acknowledges a patient's right to seek other clinical opinions.

You must:

- keep documentation of a patient's decision to seek another clinical opinion in the patient's health record
- provide referrals to other healthcare providers when appropriate
- keep appropriate documentation of referrals in the patient's health record.

You could:

- develop a policy or procedure that explains how the clinical team must manage patients seeking another clinical opinion.

C2.1 ► D Our patients in distress are provided with privacy.

You must:

- provide a room or area where patients who are distressed can have privacy.

You could:

- use a spare consulting room to provide privacy for patients who are in distress
- allocate a staff member to check on the welfare of patients in distress.

C2.1 ► E Our clinical team considers ethical dilemmas.

You must:

- document any ethical dilemmas that have been considered, and the outcome or solution.

You could:

- develop a policy or procedure that explains how the clinical team must manage ethical dilemmas
- discuss ethical dilemmas at clinical team meetings
- provide a buddy or mentoring system in which ethical dilemmas can be discussed
- use a clinical intranet or group email to pose common ethical dilemmas and solutions for the clinical team to consider and discuss
- display a notice in the waiting room listing ethical dilemmas that practitioners sometimes encounter, and how they generally deal with them
- include ethical dilemmas as a standing agenda item at team meetings.

Criterion C2.2: Presence of a third party during a consultation

Indicator

C2.2▶A Our health service seeks to obtain the prior consent of a patient when the health service introduces a third party to the consultation.

C2.2▶B Our health service documents in the patient health record when we introduce a third party to the consultation.

Why this is important

Obtaining prior consent for the presence of a third party during a consultation means that the health service is complying with privacy laws and the patient's confidentiality rights.

Documenting the presence of a third party in the patient's health record means that there is an accurate record of who was present during the consultation.

Meeting this criterion

Prior consent to the presence of a third party arranged by the health service

Before the consultation commences, the health service must ask the patient if they consent to having a third party introduced by the health service present during the consultation. Third parties can be immigration detention facility staff, security officers, interpreters, registrars (including GPs in training), chaperones/observers, and medical, allied health or nursing students.

There might be safety and/or security risks to the patient or clinician that require a third party to be present. If the presence of a third party is required for safety and/or security reasons, prior consent is preferred, but is not mandatory. If a third party is required for safety and/or security reasons, this must be discussed with the patient and documented in the patient's health record.

If not for safety and/or security reasons, prior consent for a third party introduced by the health service to be present during the consultation is mandatory. You must document whether the patient has provided prior consent and if they want to proceed with the consultation.

If a patient has previously given consent to have a third party present, you must still check that the consent remains valid at the beginning of each consultation.

If a student, nurse or other health professional is to be present during the consultation (whether they are going to observe, interview or examine), the health service must seek the patient's permission when the patient makes an appointment, or failing that, when the patient arrives at reception.

It is not acceptable to ask permission once a consultation has commenced, as some patients might not feel comfortable refusing consent in the presence of the third party, and therefore agree even if they would prefer not to. Practitioners must record in the consultation notes that the patient has consented to the presence of a third party.

It might be necessary to later identify any third parties that were present during a consultation. For this reason, details of the third party must be recorded so that they can be linked back to the consultation and subsequently identified if required. For example, you could identify the third party by reference to their role (eg nurse, medical student) or initials. Your medical defence organisation can provide advice on how your health service can develop a system for recording the presence of third parties in a consultation.

Chaperones and observers

In an immigration detention setting, there are a number of situations where a practitioner or a patient might wish, or need, to have a chaperone present during a consultation (eg a family member, friend, caseworker, or advocate). The health service must clearly document the presence of a chaperone. If the practitioner requests the presence of a third party for this purpose, they must obtain and document prior consent from the patient. Details of the chaperone must be recorded so that they can be subsequently identified if required. If the patient declines the offer of a chaperone, it is best practice to document this. More information on chaperones and observers, including requirements for your health service, is available in the fact sheet, [The use of chaperones and observers in general practice](#).

Patients not able to provide consent

If a patient is unable to provide consent (eg they have intellectual disability), the health service must obtain consent from a legal guardian or advocate who has been appointed to oversee the interests of the patient, with the exception of emergency situations. This must be recorded in the health record.

Third parties who accompany the patient

When a patient is accompanied to the health service by a third person (such as a family member or carer), it might be appropriate to record the presence of the third party in the consultation notes.

In some circumstances, a patient might give consent to the presence of a third party during a consultation, but it might not always be given freely (eg when a patient is in a violent relationship). The practitioner needs to consider whether it is appropriate for the third party to remain present for the consultation.

Patients escorted to appointments by immigration detention facility staff

The immigration detention facility might deem it necessary for a patient to be escorted by security staff to an appointment at the health service or at an external medical facility. Unless there is a tangible risk to members of the health service team, security staff should not be present during a consultation without the consent of the patient. Staff who have escorted a patient to their appointment must, wherever possible, ensure adequate privacy for the patient and health service staff during the appointment.

Meeting each indicator

C2.2▶A Our health service seeks to obtain the prior consent of a patient when the health service introduces a third party to the consultation.

You must:

- demonstrate that your health service obtains prior consent of a patient when the health service introduces a third party to the consultation
- document in the health record when a third party must be present in a consultation for safety and/or security, but the patient has not provided consent.

You could:

- maintain a policy about the presence of a third party during a consultation that includes details about the specific safety and security reasons your health service could introduce a third party without prior patient consent
- provide information to patients about instances where third parties could be introduced to a consultation without the patient's prior consent
- include information about the third-party policy in the induction manual for the health service team
- place signs in the waiting room when medical or nursing students are at the health service and observing consultations.

C2.2▶B Our health service documents in the patient health record when we introduce a third party to the consultation.

You must:

- document in the health record the presence of a third party arranged by the health service, including sufficient identifying details, and whether prior consent was obtained
- document the identity of a chaperone.

You could:

- maintain a policy about the presence of a third party during a consultation that includes details about the specific safety and security reasons as to why your health service might need the third party to attend the consultation, despite patient consent not having been provided.

Criterion C2.3: Accessibility of services

Indicator

C2.3▶A Our patients with disabilities or impairment can access our services.

Why this is important

To comply with the *Disability Discrimination Act 1992* (amended 2018), you need to ensure that people with disability or impairment can access the health service and its services in ways that maintain their dignity.

Meeting this criterion

Access is important

All patients, including those with disability or impairment, must be able to easily, safely and physically access the health service's premises and services. You can achieve this by:

- providing pathways, hallways, consultation areas and toilets that are wheelchair friendly
- having a wheelchair that patients can use while they are at the health service
- installing appropriate ramps and railings
- using pictures, signs and other sources of information to help patients who have intellectual disability or vision impairment, or who are not fluent in English.

You could improve your health service's non-physical access for patients with disability or impairment by:

- using existing and emerging technology to give patients access to telehealth or videoconferencing consultations
- having practitioners visit an individual's living quarters, where appropriate.

Meeting each indicator

C2.3▶A Our patients with disabilities or impairment can access our services.

You must:

- have physical infrastructure and processes that enable patients with disabilities or impairment to access your services.

You could:

- use pictures or signs to help patients with intellectual disability or visual impairment
- provide a transport service to help patients who cannot otherwise get to the health service
- have software and technology available to assist patients with disability and impairment
- provide visits to living quarters for patients who are unable to access the health service.

Core Standard 3

Health service governance and management

Our health service has integrated governance and management systems that maintain and improve the quality of care provided to patients.

Health service governance relates to the principles, methods and processes that clinicians and health service personnel follow to support patient safety and quality care. It also helps you to set, measure and achieve your social, fiscal, legal and human resources objectives.

The ACSQHC notes that good health service governance is:

- participatory
- consensus oriented
- accountable
- transparent
- responsive
- effective and efficient
- equitable and inclusive
- compliant with all relevant laws.⁹

Good management and leadership fosters a culture that is based on mutual respect. When you have this, the entire health service team will be supported to achieve excellence in all areas of the health service, and participate in just and open discussions about how the health service can improve.

Criterion C3.1: Business operation systems

Indicator

C3.1▶A Our health service plans and sets goals aimed at improving our services.

C3.1B Our health service evaluates its progress towards achieving its goals.

C3.1▶C Our health service has a business risk-management system that identifies, monitors, and mitigates risks in the health service.

C3.1▶D Our health service has a complaints resolution process.

Why this is important

Planning, setting and evaluating business goals

A health service needs to operate successfully within its budget and any constraints of the immigration detention facility to create an environment where quality clinical care can be delivered. To operate successfully, strategic thinking and planning is important. A documented service delivery plan is an effective way of measuring your progress, and increases the likelihood of achieving your health service's objectives. This plan needs to be linked to your strategy and that of the immigration detention facility, and include how it will be implemented.

Having a plan helps the team to work together towards a common goal. It also gives the team the ability to evaluate progress, and assists the health service in achieving consistency and quality in its operations and to conduct continuous quality improvement.

It is the responsibility of your health service to define its governance structures relative to its own requirements, as governance arrangements and structure will vary depending on the size and complexity of each health service. In smaller health services, there might be a merging of governance and management responsibilities. Other health services might be part of a wider corporate group and have either public or private shareholders, and others still might be government bodies or not-for-profit community-based organisations. A clear understanding of ownership and governance arrangements will help you develop appropriate policy and performance frameworks.

Business plans can sit at the contracted provider level and not with the health service itself. Regardless, health services will have input regarding local initiatives to achieve the objectives of a business plan.

Management needs to appropriately communicate business goals and governance structures to staff, including any significant change to your health service's workforce and service delivery.

Business risk management

Managing safety and risk is part of quality assurance, and therefore is a significant part of health service management. Clinical risks need to be managed, but so too do business risks, because if the business fails, the health service will not be able to provide clinical care. A risk-management process helps you to consistently identify, document and manage business risks.

Managing complaints

Patient complaints are a valuable source of information. Open discussions about patients' needs and their concerns about the quality of care will help your health service understand potential problems and identify how you can improve your services.¹⁰

Having a complaints resolution process is separate to actively collecting patient feedback about the service. Refer to [Criterion QI1.2: Patient feedback](#) for more information on patient feedback.

Meeting this criterion

Planning, setting and evaluating business goals

You could develop a strategic plan that documents your health service's direction and objectives. The strategic plan could include:

- the health service's mission, vision, ethics (or code of behaviour) and values
- how you plan to make efficient use of resources, including the level of staffing and skill mix required
- environmental factors
- financial factors
- human resource management, including effective recruitment, selection, appointment, management, retention, separation and support systems.

If you have a smaller health service (eg with fewer than 10 health service staff), you could have an action plan that sets out your goals and progress, instead of a strategic plan.

You can evaluate the health service's progress against its strategy and business goals in a number of ways. For example:

- including it as an agenda item in team meetings
- scheduling strategy planning and evaluation meetings at defined intervals
- reviewing the health service's patient population data and outcomes
- seeking patient feedback
- holding a team planning meeting.

Business risk management

You could develop a business risk-management strategy that identifies, analyses and evaluates risks, and explains how you have managed them.

Risks that might be identified in your health service's business risk-management strategy include:

- poor record keeping
- IT system failures
- inadequate systems for updating patients' details and following up test results
- lack of documentation of the consent process
- workplace health and safety incidents as a result of equipment that is not maintained in accordance with the manufacturer's recommendations
- inadequate number of health service staff working during busy times
- conflicts of interest
- workforce planning
- unexpected sick leave
- emergencies (eg environmental disasters)

- updates to, or breaches of, the IT security system.

Mitigating business risk enables your health service to operate successfully, allowing you to focus on providing quality patient care.

Your health service needs to strongly consider a risk register. It is a good way of identifying and recording potential risks so that you can take action to reduce the likelihood of the risk occurring and the severity of the impact if the risk becomes a reality.

The risk register could also include a risk matrix to help you define the level of each identified risk (eg low, moderate, high, extreme), based on a combination of the:

- likelihood of an event
- severity of its impact if it were to occur
- mitigation/treatments.

If you fail to keep your risk register up to date, your risk-mitigation strategies might not be adequate and new risks might not be identified. This can potentially have adverse impacts on the health service's operations and the quality of healthcare the health service provides.

You could schedule regular risk-management meetings and/or include risk management as a standing agenda item for team meetings so that identified risks are regularly reviewed, updated and minimised.

More information on emergency planning and preparation is located at [Criterion C3.3: Emergency response plan](#).

Managing complaints

You must have a receptive attitude to patient feedback and complaints. If you receive a patient complaint, try to resolve the issue within the health service team. If the health service team cannot resolve the complaint, contact your medical defence organisation for advice on resolving a complaint before any further action is taken.

Develop a system to record, review and manage complaints (including timely response to complaints), and include how you will advise patients of the progress and outcome of their complaint. Consider displaying notices that state that the health service will always try to resolve complaints directly.

Read Section 3 of the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*, which contains advice about managing complaints.

You can take basic actions, such as:

- acknowledging the patient's right to complain
- working with the patient to resolve the issue, where possible
- providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology
- ensuring the complaint does not adversely affect the patient's care (in some cases, it might be advisable to refer the patient to another practitioner)
- complying with laws, policies and procedures relating to complaints.

If the matter cannot be resolved, the patient can contact their state's health complaints commissioner for advice and possible mediation. Health services could ensure patients have access to information about the processes for making a health complaint in their state or territory.

During the complaint process, consider the patient's cultural and/or language needs, particularly if the matter cannot be resolved between the patient and the health service. It might be that the patient could benefit from an interpreter service or a legal representative.

Meeting each indicator

C3.1 ► A Our health service plans and sets goals aimed at improving our services.

You must:

- plan and set business goals
- communicate the business plan and goals to health service staff.

You could:

- write a statement of the health service's ethics and values
- maintain a business strategy
- maintain an action plan.

C3.1B Our health service evaluates its progress towards achieving its goals.

You could:

- maintain progress reports about the business strategy or action plan
- create a strategy for continuous quality improvement
- implement quality-improvement initiatives.

C3.1 ► C Our health service has a business risk-management system that identifies, monitors and mitigates risks in the health service.

You must:

- communicate the business risk-management processes to staff
- maintain a documented risk-management process
- develop procedures to mitigate risks.

You could:

- maintain a risk register
- maintain a log of risks if you are a small health service
- keep a record of meetings where risks have been identified and actions agreed on to manage those risks.

C3.1 ► D Our health service has a complaints resolution process.

You must:

- maintain a complaints resolution process.

You could:

- keep a log or ledger of complaints
- place a suggestion box in the waiting room and regularly review suggestions
- establish and follow a process for dealing with suggestions and complaints.

Criterion C3.2: Accountability and responsibility

Indicator

- C3.2▶A** All members of our health service team understand their role in the health service.
- C3.2▶B** Our health service has performance discussions with each team member.
- C3.2▶C** Our health service inducts new members of the health service team and familiarises them with our systems and processes.
- C3.2▶D** Our health service has at least one team member who has the primary responsibility for leading risk-management systems and processes.
- C3.2▶E** Our health service has at least one team member who coordinates the resolution of complaints.

Why this is important

Roles and responsibilities

Having clear lines of accountability and responsibility is part of good governance. It encourages continuous improvement in safety and patient care.

When specific roles and responsibilities are agreed to and documented (eg in position descriptions):

- the health service can monitor each team member's performance against their role's requirements, and determine whether any support and training are required
- each team member knows who they are reporting to for each duty or responsibility
- each team member knows who is responsible for each aspect of the health service's operations.

Performance monitoring

The objectives of performance monitoring are to:

- assess the performance of an individual
- determine how the health service team would benefit from further training and development.

Induction program

An induction program must be a routine part of employment, so that all new practitioners and other health service team members understand:

- the principles and policies under which the health service operates
- the day-to-day operations of the health service
- workplace health and safety issues
- the processes for maintaining the privacy and confidentiality of patients' health information
- the systems used to identify and manage emergency patients who come to, or contact, the health service.

Critical incident reporting

When a health service provider is contracted or otherwise required to report on the clinical outcomes of your health service and health service team, the report and records of any outcomes must be provided to the requesting stakeholder, as well as the health service. Any stakeholder with a decision-making role in your health service must be aware of critical incidents, as there is a duty of care to ensure these are avoided in the future if found to have occurred.

Any audit conducted on your health service must be reported to your health service's governing body, if it exists. Your health service team must have access to information about their role in respect to audits, reporting lines and relationship with any governing body. You could achieve this by having performance appraisals with team members to ensure they operate within the clinical governance framework.

Environments in immigration detention facilities, particularly where there are individuals who have been detained for prolonged periods, are recognised to be high-risk environments for self-harm and suicide attempts, as well as protest activity. When critical incidents or serious near misses occur that involve the health service provider, it is important to have a robust process to report such incidents and to investigate root causes to identify if processes can be improved to reduce future risk.

To be effective, such investigations need to involve all relevant stakeholders in a collaborative effort to identify processes that could be improved in the future. Critical incidents typically involve a loss of life or significant morbidity. The health service provider typically has a duty of care to identify if the service or any of its staff contributed to the incident, and if so, to report what actions have been taken to minimise future risk of recurrence.

Criterion QI3.1: Managing clinical risks provides detail on managing clinical risks in your health service.

Meeting this criterion

Roles and responsibilities

For each role, you could create a position description that includes the title of the role, and the responsibilities and duties of the person in that role. This can then form the basis of:

- recruiting for the role
- training and development
- setting lines of accountability
- monitoring performance
- managing remuneration
- succession planning.

Each person could sign their position description to indicate that they understand and accept their role and responsibilities. Position descriptions could be reviewed regularly (eg once a year) to keep them up to date and to make sure each person understands their role and responsibilities.

Your health service must appoint one member of the health service team or immigration detention facility staff who has responsibility for risk management, and one person who has responsibility for complaints resolution. The same person could be responsible for both areas. The responsibilities of each role must be documented, and members of the health service team must understand the responsibility of each role and who holds each role.

Performance monitoring

One way that health service managers can monitor a team member's performance is to have regular meetings, where issues can be raised and addressed quickly. This is particularly useful in smaller health services, where informal processes generally work better than formal processes.

If you decide to introduce formal performance discussions (eg every six months), consult with your health service team to ensure that the process is practical and fair. Organisations that spend a substantial amount of time training managers and the health service team about the process are generally more successful at implementing effective performance discussions.

The performance monitoring system could cover:

- setting standards for performance
- assessing performance against the standards
- providing and receiving feedback about performance
- agreeing on actions to further improve performance.

Whether you use formal or informal processes, managers need to document the performance discussions, agreed actions and ongoing development needs. Performance discussions provide the opportunity for a balanced conversation between a manager and the health service team member, and are therefore not meant to be disciplinary in nature. Practitioners in the health service team could choose to have performance discussions with each other, rather than with the health service manager or other health service staff members.

Induction program

You could include the following information in your induction program:

- an overview of your health service's systems and processes
- the local health and cultural environment in which your health service operates (eg if the health service is located in an area that has a high level of illicit drug use, the health service team needs to understand the health service's policy on the management of Schedule 8 medicine prescribing)
- key public health regulations (such as reporting requirements for communicable diseases and child abuse)
- local health and community services, including pathology, hospital and other healthcare providers to which your health service team is likely to refer patients.

Meeting each indicator

C3.2▶A All members of our health service team understand their role in the health service.

You must:

- educate members of the health service team about their role when they start working at the health service
- educate and manage health service team members so that they work within the scope of their role.

You could:

- create position descriptions
- create an organisational chart
- maintain a health service policy document.

C3.2▶B Our health service has performance discussions with each team member.

You must:

- regularly monitor the performance of the health service team.

You could:

- implement a formalised performance-monitoring process
- have regular catch-ups between managers and their health service team members
- establish development goals for members of the health service team.

C3.2▶C Our health service inducts new members of the health service team and familiarises them with our systems and processes.

You must:

- have a system to induct members of the health service team.

You could:

- keep an accurate and up-to-date employment file on each member of the health service team
- maintain a human resources policy and procedure manual
- create templates and checklists for inducting new team members
- maintain a documented induction process.

C3.2▶D Our health service has at least one team member who has the primary responsibility for leading risk-management systems and processes.

You must:

- educate the team member responsible for risk management so that they understand their role.

You could:

- maintain a human resources policy and procedure manual
- create a position description/s that includes the responsibility for risk management.

C3.2▶E Our health service has at least one team member who coordinates the resolution of complaints.

You must:

- maintain a record of how complaints have been managed.

You could:

- maintain a complaints register
- create a position description that includes the responsibility for complaint resolution
- keep minutes or notes of health service meetings that show that patients' complaints have been considered and discussed in those meetings.

Criterion C3.3: Emergency response plan

Indicator

C3.3▶A Our health service has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases or unplanned absences of clinical team members.

Why this is important

In an emergency, especially one such as a pandemic, the demand for healthcare services generally increases,¹¹ so it is crucial that your health service can continue to provide services during this time, if appropriate.

Emergencies might affect the health service or immigration detention facility more broadly. If your health service is prepared for an emergency, you are more likely to provide effective continuity of care for your patients, and to continue operating your service as smoothly as possible.

As unplanned absences of clinical team members can affect the health service's ability to provide quality patient care, your health service could consider succession planning, or encourage health service staff to share their skills and knowledge among the health service team.

Meeting this criterion

In an immigration detention setting, your health service might be included as part of a wider facility's emergency response plan. While your health service might not have complete authority over the development of an emergency response plan, it must review the practicality of any plan in relation to the health service. Your health service can contribute to any wider emergency response plan by providing feedback. The following detail will assist your health service in planning, or contributing to, an emergency response plan.

In an emergency, your health service might experience issues in each of the following areas:

- Patients
 - increased demand for services
 - disruption to the normal health system functioning (eg inability to transfer patients to hospital)
- Infrastructure and systems
 - minor or significant damage to the health service's infrastructure
 - loss of access to vital information
 - loss of access to essential systems, networks and communication
 - reduced capacity or loss of key health service staff
- Supplies and services
 - loss of critical equipment and supplies
 - loss of, or disruption to, power supply
 - loss or contamination of water supply

To help reduce the impact of an emergency, you could complete or participate in appropriate emergency planning and preparation, with frequent reviews to identify and update actions that need attention before, during and after an emergency. These actions might include:

- having a documented emergency response plan
- appointing an emergency management coordinator
- undertaking research to identify key information (eg emergency services, the local geography and previous events that have affected the community or immigration detention facility)
- providing the health service team with education and training that will help them effectively prepare for, and respond to, emergencies
- testing components of the emergency response plan (eg evacuation drills) once a year
- reviewing, monitoring and updating the emergency response plan every three months
- keeping the emergency kit fully stocked.

The emergency response plan could contain:

- information on how to communicate with patients and other services
- contact details of all members of the health service team
- contact details for response agencies and other health services
- details about the health service, such as accounts, service providers (eg insurers, lawyers, providers of telephone, internet and utilities) and insurance policy numbers
- information on how the health service will triage and run clinical sessions during an emergency
- details about where health service staff will work from in the case of an emergency
- information on how the health service can provide telehealth services during an emergency, including the locations from which your health service will facilitate telehealth, as per the above item
- the health service's policy on infection control
- details of equipment needed to manage an emergency
- information on how to manage unplanned absenteeism of multiple health service team members (including succession planning)
- the health service's policy on the management of patients' health information in computer and paper-based systems.

You must also have a recovery plan that details what the health service team could do to re-establish the health service's operations, when appropriate, if your health service needs to close due to an emergency.

Meeting each indicator

C3.3▶A Our health service has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases or unplanned absences of clinical team members.

You must:

- [have an emergency response plan.](#)

You could:

- educate the health service team so that they understand the emergency response plan

- create a position description for a team member responsible for maintaining the emergency response plan
- create and test mock emergency scenarios
- discuss and review emergency processes at team meetings, particularly the health service's evacuation process
- complete succession planning for key health service staff
- encourage health service team members to share their skills and knowledge.

Criterion C3.4: Health service communication and teamwork

Indicators

C3.4▶A Our health service team has the opportunity to discuss administrative matters with the principal practitioners, health service directors, health service and immigration detention facility management, or owners when necessary.

C3.4▶B Our health service encourages involvement and input from all members of the health service team.

C3.4▶C Our clinical team discusses the health service's clinical issues and support systems.

Why this is important

Teamwork

Research in Australia and the USA confirms that effective teamwork helps organisations to successfully implement safety initiatives,¹² and that bullying and harassment can be a significant threat to quality care and patient safety.¹³ Therefore, your health service needs to not only cultivate a just, open and supportive culture that preserves and values individual accountability and integrity, but also needs to foster a whole-of-team approach to quality patient care. For example, regular discussions where all members of the health service team are encouraged to contribute their ideas and observations can help to build a high-performing team and a positive workplace culture that effectively deals with bullying and harassment.

Having clinical guidelines and appropriate support systems that facilitate discussions helps to identify and address clinical issues and deliver consistent and quality care.

Meeting this criterion

Teamwork

The most common way for health services to build teamwork is to schedule regular meetings, where all members of the health service team are encouraged to contribute to discussions. For small health services, this can be an informal discussion at regular intervals, such as at the end of every week.

It is a good idea to document the decisions made at team meetings and the names of those responsible for implementing related actions.

Where relevant, provide all members of the health service team with the opportunity to discuss administrative issues with the health service directors and/or owners when necessary. When the health service owner is not a member of the health service, the health service team could develop systems for discussing administrative matters with the owner. Although these discussions do not necessarily need to occur as a formal meeting, formal meetings are recommended, particularly for medium and large health services.

Good communication between the manager/employer and the health service team will help to create an efficient and productive workplace where there are positive working relationships. This will result in long-term benefits for the health service, the health service team and patients. Meaningful communication must extend to non-health staff who work in the immigration detention facility and have responsibility for patients' accessing healthcare (eg security staff responsible for escorting patients to appointments, staff who deliver messages from patients to the health service).

Good communication between members of the clinical team can be achieved with face-to-face meetings. Communication tools, such as message systems and notice boards, can be used to record clinical issues and ideas. The clinical team must have access to up-to-date resources on a range of clinical issues to improve the treatment of patients and for their own professional development.

Where there is administrative oversight of the health service (eg by a government or contracted organisation), the health service might need to engage with non-health staff who manage its contract.

Meeting each indicator

C3.4▶A Our health service team has the opportunity to discuss administrative matters with the principal practitioners, health service directors, health service and immigration detention facility management, or owners when necessary.

You must:

- develop a process for the health service team to escalate issues
- provide evidence that the health service team has had opportunities to discuss administrative matters.

You could:

- keep a record of meetings
- have daily check-ins between health service staff to discuss and plan care for patients who have appointments that day.

C3.4▶B Our health service encourages involvement and input from all members of the health service team.

You must:

- make the health service team aware of the health service's communication channels they can use to provide input
- develop a process for the health service team to escalate issues.

You could:

- encourage all health service team members to attend team meetings
- keep a record of meetings
- have daily check-ins between health service staff to discuss and plan care for patients who have appointments that day
- inform prospective and current members of the health service team during recruitment interviews and inductions that they are encouraged to provide input and feedback about improving business operations.

C3.4▶C Our clinical team discusses the health service's clinical issues and support systems.

You must:

- make the clinical team aware of the health service's clinical communication processes.

You could:

- keep a record of clinical team meetings
- have daily check-ins between health service staff to discuss and plan care for patients who have appointments that day
- create and document a buddy system
- use the health service's intranet or email to facilitate discussions.

Criterion C3.5: Work health and safety

Indicators

C3.5▶A Our health service supports the safety, health and wellbeing of the health service team.

C3.5▶B Our health service team is encouraged to obtain immunisations recommended by the current edition of the *Australian immunisation handbook*, based on their duties and immunisation status.

Why this is important

Each health service owner/manager is responsible for providing a safe working environment. This includes being genuinely committed to the health, safety and wellbeing of the whole health service team. In Australia, the health service owner/manager is obliged to meet their responsibilities as an employer by adhering to relevant federal and state/territory workplace health and safety laws.

Inappropriate and disruptive behaviour within the health service and clinical team can risk patient safety. Although such behaviour might not be an obvious workplace health and safety or bullying issue, it can undermine both the culture of the setting and clinical care.^{14–16}

You should encourage members of the health service team to be immunised so as to protect the team from being infected with vaccine-preventable infectious diseases and from transmitting such infections to patients. The exact immunisation requirements will depend on the risk of infection based on the health service's location, patient population and each health service team member's duties.

Where catch-up vaccination is appropriate, your health service should offer these to the health service team as quickly as possible to provide protection.

Meeting this criterion

Safety of your health service team

Having an adequate number of health service team members on duty, based on the size of your health service during normal health service hours, contributes to the safety and wellbeing of the health service team. In addition, it means that communication from patients can be promptly attended to, appointments made accurately and according to urgency, and medical emergencies can be managed appropriately.

When operating outside normal opening hours, there are additional factors to consider to protect the safety and security of team members, especially if they are on their own. For example:

- Is there sufficient lighting in the car park?
- Who must be contacted in case of an emergency?
- Is a duress alarm required?
- Are safety cameras needed?

It is important that the layout of the facility complies with workplace health and safety requirements, and that individual desks are configured so that health service team members have the full range of movement required to do their job, and can move without strain or injury. One way to do this is to have a professional conduct an ergonomic assessment of each desk and workspace.

Health and wellbeing of your health service team

You can support the health and wellbeing of the health service team in many ways. For example:

- regular breaks for practitioners during consulting time can reduce fatigue, as well as enhance the quality of patient care. Fatigue and related factors (sometimes called 'human factors') are associated with increased risk of harm to patients
- a plan for re-allocating patient appointments if a practitioner is unexpectedly absent from the health service can reduce the burden on the other practitioners
- making information about support services available to the health service team can help them identify and deal with pressures and stressors. This is particularly important in rural and remote areas and in small health services.

Dealing with violence

Patient aggression and patient-initiated violence in healthcare settings continue to be an issue.

Your risk-management strategy (refer to [Criterion C3.1: Business operation systems](#)) could include patient-initiated violence so that you consider the risk and ways to mitigate the risk. Typically, such strategies include:

- a zero-tolerance policy towards violence
- displaying signs that inform people of your zero-tolerance policy
- installing a duress alarm system that the health service team can use if a patient is threatening or violent, and establishing a response plan in case the alarm is triggered
- setting out clear steps to take when dealing with violence, including contacting security staff if necessary.

A practitioner has the right to discontinue the care of a patient who has behaved in a violent or threatening manner (except in an emergency). This includes the practitioner ending the professional relationship during a consultation or by letter or other means, depending on safety considerations. Keep a record of the process and of any subsequent contact that the patient has with the health service.

Health service team immunisation

Refer to the [Australian immunisation handbook](#) to identify recommended vaccinations for healthcare workers.

Offer and encourage practitioners and other members of the health service team to have:

- immunisations recommended by the current edition of the [Australian immunisation handbook](#)
- testing of their natural immunity to vaccine-preventable disease or immunisation status.

These services can be undertaken by the health service if appropriate, or the health service team member's own GP.

Consider the wellbeing of health service team members who are not immunised if there is an outbreak of disease. For example, during a disease outbreak, you could consider redeploying non-immunised team members to reduce the likelihood of them contracting the disease. This would also help prevent transmission of the disease to patients who cannot be immunised for medical reasons.

The principles of [catch-up vaccination](#) are provided as part of the [Australian immunisation handbook](#).

Meeting each indicator

C3.5▶A Our health service supports the safety, health and wellbeing of the health service team.

You must:

- include work health and safety requirements when inducting new employees.

You could:

- maintain a workplace health and safety policy and procedure
- maintain a policy and procedure manual that includes workplace health and safety requirements
- develop and adhere to appropriate health service staff rosters
- include workplace health and safety as a standing agenda item on team meetings
- maintain an appointment book that shows scheduled breaks
- create appropriate design and layouts for the health service's building, workstations and desks
- provide the health service team with access to support services
- maintain a policy and procedure to support staff during and after critical incidents
- provide regular, on-the-job health-promotion programs, such as preventing and managing health hazards at work and mental health
- provide or support staff to access psychological assistance outside of the workplace
- provide staff with infrastructure to prevent harm, such as duress alarms or radios.

C3.5▶B Our health service team is encouraged to obtain immunisations recommended by the current edition of the *Australian immunisation handbook*, based on their duties and immunisation status.

You must:

- record the natural immunity to vaccine-preventable diseases or immunisation status of health service team members, if known (with their consent)
- encourage staff members to obtain immunisations recommended in the *Australian immunisation handbook*, as appropriate to their duties.

You could:

- offer the health service team testing of their natural immunity to vaccine-preventable disease or immunisation status
- conduct information sessions for the health service team about the advantages and possible side effects of vaccination schemes
- record staff immunisations or refusals in staff members' human resource file.

Criterion C3.6: Research

Indicators

C3.6▶A Our health service ensures that all research has ethics approval.

C3.6▶B Our health service confirms that the appropriate indemnity is in place for the research, based on the level of risk.

C3.6▶C Our health service only transfers identified patient health information to a third party for quality improvement or professional development activities after we have obtained the patient's consent.

If your health service has not conducted any research, this criterion is not applicable.

Why this is important

The National Health and Medical Research Council (NHMRC) has developed the [Australian code for the responsible conduct of research](#) (the Code), which promotes integrity of research and provides guidance about responsible research practices.

When conducting research, you must ensure that the collection, use and disclosure of data comply with privacy laws. Even if your health service is using de-identified patient health information, there are still some situations in which you must obtain informed patient consent.

Human research ethics committees (HRECs) review research proposals to ensure that they are ethically acceptable and in accordance with relevant standards and guidelines. Your HREC will decide on the necessary patient consent requirements for your research project.

There are many HRECs operating in institutions and organisations across Australia. A list of HRECs registered with the NHMRC is available [online](#).

More information about the RACGP's National Research and Evaluation Ethics Committee is available on the [RACGP website](#).

The Code and consent requirements apply to all research situations. For example, they apply even if a member of the health service team is not conducting research themselves, but is contributing to someone else's research.

Meeting this criterion

The NHMRC's Code defines 'research' as follows:

... includes work of direct relevance to the needs of commerce, industry, and to the public and voluntary sectors; scholarship; the invention and generation of ideas, images, performances, artefacts including design, where these lead to new or substantially improved insights; and the use of existing knowledge in experimental development to produce new or substantially improved materials, devices, products and processes, including design and construction.

It excludes routine testing and routine analysis of materials, components and processes such as for the maintenance of national standards, as distinct from the development of new analytical techniques.

It also excludes the development of teaching materials that do not embody original research.

The health service team must be familiar with the NHMRC's Code when participating in research.

In addition, you might wish to develop a policy that includes information about:

- selecting a specific group of patients (eg patients with depression) on whom the research is to be conducted
- the process and documentation of ethics approval
- the use of a specific room in which to conduct the research
- data storage, record keeping and compliance with privacy laws
- relevant training for the health service team
- information provided to patients.

Research indemnity

You must ensure that appropriate insurance is in place to indemnify your health service for research.

If your health service is involved in a clinical trial, your health service will usually be indemnified by the sponsor (eg a drug company), but you need to make sure that the indemnity covers your liabilities. If it does not, you will need to get a separate insurance policy or indemnity.

If the research is not a clinical trial, you must have your own insurance that covers the research.

In all cases, each member of the health service's clinical team needs to ensure that their individual medical indemnity insurance covers their research activities.

Quality-improvement activities, ethics and consent

In general, the purpose of a health service's quality-improvement or clinical audit activities is to improve the delivery of a particular treatment or service. Before transferring health information to a third party, you need to seek specific consent from patients. The RACGP encourages you to include information about quality-improvement activities and clinical audits in the health service's policy that addresses the management of health information. You could seek patient consent by including this information in new patient registration forms and asking patients to indicate if they consent to this use of their health information and to its transfer. You must make patients aware that declining to participate in research will not affect the care they receive at the health service.

Ethics approval is not required for quality-improvement activities where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the health service.

Meeting each indicator

C3.6▶A Our health service ensures that all research has ethics approval.

You must:

- keep evidence of ethics approval for research activities
- maintain records of any research activity that has gone through the ethics approval process
- retain documentation of patients' consent for the required period.

You could:

- maintain a policy about participating in research that complies with the NHMRC guidelines.

C3.6▶B Our health service confirms that the appropriate indemnity is in place for the research, based on the level of risk.

You must:

- maintain records of appropriate indemnity for your health service and GPs based on research activity level of risk.

You could:

- have a process addressing health service communication with external researchers and their risk requirements
- contact your indemnity insurer to confirm you have the appropriate level of cover for the research being undertaken if it is not explicit in your policy.

C3.6▶C Our health service only transfers identified patient health information to a third party for quality-improvement or professional development activities after we have obtained the patient's consent.

You must:

- document in the patient's health record the patient's consent for you to transfer their health information to a third party to conduct quality-improvement activities
- inform patients that declining to participate in research will not affect the care they receive at the health service
- maintain a privacy policy.

You could:

- maintain a policy addressing the management of patients' health information
- seek patient consent for the use and transfer of health information on new patient registration forms.

Core Standard 4

Health-promotion and preventive activities

Our health service provides health-promotion and preventive services that are based on patient need and best-available evidence.

Health promotion is the process of enabling people to improve and increase control over their health. As well as influencing an individual's behaviour, it also encompasses a wide range of social and environmental interventions,¹⁷ such as education programs and changes to laws and policies.

Health promotion is distinct from the education and information that practitioners use to support their diagnosis and choice of treatment.

Health professionals can deliver health promotion and reinforce it in various ways. This could include written materials and education clinics that help people self-manage their chronic diseases.

An immigration detention facility's health service might be an individual's only access to healthcare. It therefore has a crucial role in promoting health, preventing illness and delivering preventive care. Visiting the health service allows patients to be screened for specific diseases, can identify risk factors for disease, and enable discussion of ways in which to achieve a healthy lifestyle.

Preventive healthcare consists of measures taken to prevent diseases (as opposed to treating them),¹⁸ and to detect them in their early and often asymptomatic stages, based on relevant current clinical and other guidelines.

A holistic approach to care encourages a health service to consider and respond to each patient's individual circumstances when providing health promotion, preventive care, early detection and intervention.

For example:

- heritage (eg does the patient identify as being of a particular origin?)
- medical or social conditions (eg was the patient a refugee? Did the patient experience childhood abuse?)
- LGBTIQ+ status (eg is the patient struggling with their status or adjusting to a new status?).

You can also coordinate with other health professionals and agencies to undertake health promotion and achieve preventive care objectives.

Criterion C4.1: Health promotion and preventive care

Indicators

C4.1▶A Our patients receive appropriately tailored information about health promotion, illness prevention and preventive care.

Why this is important

Providing information about health promotion and self-care programs can enable individuals in detention to better understand their health and improve their self-management. Health promotion focuses on:

- prevention and protection, rather than treatment
- populations and individuals
- factors and behaviours that cause illness and injury, rather than the illness and injury itself.¹⁹

Meeting this criterion

Providing a systematic approach to preventive care

Assessing a patient's health risks is an important component of preventive care, part of which is early detection of disease. Screening programs for cervical cancer and bowel cancer are good examples of this.

Adopting a systematic approach to health promotion and preventive care can include:

- conducting patient prevention surveys
- reviewing and understanding the health service's patient population and their healthcare needs
- maintaining a disease register
- establishing a reminder system
- maintaining a directory of local services that offer programs to help patients modify their lifestyle.

A reminder system that helps ensure that patients undergo regular screening and checks must also protect the privacy and confidentiality of each patient's health information.

If you decide to stop using a reminder system, it is good practice to advise patients, so that they can use their own system to ensure that they have regular screenings and checks.

Providing information to patients

Practitioners can provide education about health promotion and preventive care during a consultation. This can be done verbally and by giving patients written and visual information. Patients must be offered interpreters during consultations when necessary, so that they understand the information and care provided. Refer to [Criterion C1.4: Interpreter and other communication services](#) for more information about using interpreters.

You must consider the health literacy of patients; that is, their understanding of information about health and healthcare, how that care affects their lives and how they can use the information you provide to make decisions. In an immigration detention setting, you must account for language barriers (eg limited English proficiency and education levels). By providing information in documents, such as brochures and fact sheets, and on reputable websites, including your own, you will be encouraging patients to select information on health issues that might affect or interest them.

You can also tailor information so that it caters for your patient population.²⁰ For example:

- you can modify or add to the information in documents, such as brochures and pamphlets that you receive from health departments, non-government organisations, health-promotion programs, local community organisations, and support and self-help groups
- you can provide information in other languages and other formats for patients with limited English proficiency (eg in plain English, pictures, videos)
- you can do a health literacy assessment on resources
- you can provide culturally appropriate material.

Managing patient information to support preventive care

When you collect information about a patient's health (eg the patient's family medical history), record the information in the patient's health summary and health record. Keeping a complete health summary that includes the patient's main health issues means you can provide better care and pass on appropriate information when patients seek care from other health professionals.

If the patient's complete family medical history is not readily available, or the information is sensitive and the patient is reluctant to provide it, appropriate respect must be given.

Some information might also be transferred to national state-based registers (eg immunisation data, cervical screening and familial cancer registries) to improve care. If your health service participates in national registers, you need to:

- obtain consent from each patient to have their health information sent to a register
- inform patients that they can opt out of certain registers, but not others (eg HIV infection register)
- remind patients when they need to have another screening (do not rely on patients receiving reminders from these registries).

Meeting each indicator

C4.1 ▶ A Our patients receive appropriately tailored information about health promotion, illness prevention and preventive care.

You must:

- document in the patient's health record discussions or activities relating to preventive health.

You could:

- use preventive health guidelines and resources
- hand out up-to-date pamphlets and brochures
- provide information on the health service's website
- run preventive health activities, such as diabetic education groups and groups to help patients quit smoking
- have a reminder system to prompt patients of screening activities
- promote access to vocational support systems and education programs, particularly school and early childhood education access for appropriately aged children
- conduct information sessions for patients about the advantages and possible side effects of immunisation programs
- maintain processes to ensure accountability for developing strategies to promote mental health, and address early identification and prevention of mental health problems.

Core Standard 5

Clinical management of health issues

Our health service provides care that is relevant to the patient and consistent with best-available evidence.

Australia's current primary healthcare systems base their practices on the best-available evidence. This recognises that, in the absence of properly conducted clinical trials or other evidence of equal or greater reliability, peer group consensus might be an accepted level of evidence and might be the best-available evidence at the time.

It is important that:

- practitioners can exercise clinical autonomy in decisions that affect clinical care
- you provide practitioners with access to up-to-date clinical information, and have appropriate processes in place to support practitioners.

Criterion C5.1: Diagnosis and management of health issues

Indicators

C5.1 ► A Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

C5.1 ► B Our clinical team supports the consistent diagnosis and management of our patients.

Why this is important

Clinical guidelines provide important recommendations for clinical care and must be accessible to practitioners, so that your health service can achieve consistent and tailored healthcare based on patient demographics.

Applying clinical guidelines consistently helps to:

- provide consistency in the diagnosis and management of health issues
- reduce variation of care between clinicians
- provide continuity of care of each patient
- give the patient clear and consistent messages about their health issues and treatment.

In addition, patients value consistency in the quality of treatment and advice given by different practitioners in your health service.

Meeting this criterion

You need to make sure that clinical guidelines are current, based on best-available evidence and are accessible, either electronically or in hard copy. This includes maintaining a current version of the clinical software databases that include drugs guides, medical dictionaries, coding classifications and information about consumer medicine. Some clinical software is automatically updated to the current version.

When clinical teams discuss clinical care, they must refer to and consider the best-available evidence to ensure their clinical care aligns with best practice.

In some instances, 'best practice' might involve doing more than adhering to current clinical guidelines. For example, good communication between members of the clinical team can help to achieve a consistent approach to clinical care. While it is better for the clinical team to have face-to-face meetings, communication tools, such as message systems and notice boards, can be useful to raise and address clinical issues.

Meeting each indicator

C5.1 ► A Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

You must:

- have current, best evidence and accurate clinical guidelines available in electronic and/or hard copy for the health service team to access.

You could:

- have regular team meetings or group emails about clinical topics, and document the topics of discussion and the decisions made
- join local networks, if available, to discuss clinical issues.

C5.1 ► B Our clinical team supports the consistent diagnosis and management of our patients.

You must:

- demonstrate how your clinical team supports the consistent diagnosis and management of our patients.

You could:

- keep records of clinical team meetings when the use of clinical guidelines was discussed
- have clinical team members discuss the care of patients with other team members, while ensuring patient confidentiality
- educate the health service team so that they can find and use resources and guidelines
- keep records that show what evidence-based resources and guidelines the health service team uses
- establish and maintain a system that the health service team uses to pass on messages to other team members (eg a communication book, internal mail or email system).

Criterion C5.2: Clinical autonomy for practitioners

Indicator

C5.2▶A Our clinical team can exercise autonomy, to the full scope of their practice, skills and knowledge, when making decisions that affect clinical care.

Why this is important

Professional autonomy and clinical independence are essential components of high-quality care, as clinically appropriate recommendations are in the patient's best interests.

The intent of this criterion is that, instead of having decisions imposed on them, the practitioner is free (within their scope of practice) to provide what they believe is the best level of care for each individual patient, based on their clinical judgement and current clinical and other guidelines. In an immigration detention setting, a clinician must be able to provide their autonomous opinion and document it, even if an overruling authority does not implement the clinician's decision. Retaining autonomy (and relevant documentation) protects the clinician in instances where a decision is not implemented.

All members of the clinical team must (within the boundaries of their knowledge, skills and competence) comply with the professional and ethical obligations required by law, their relevant professional organisation and the health service. Information about relevant **codes of conduct** is available at AHPRA.

Regular and ongoing professional development helps to maintain a practitioner's clinical knowledge, skills and competence.

Meeting this criterion

Practitioners are free, within the parameters of evidence-based care and their credentials, to determine:

- the appropriate clinical care for each patient
- the specialists and other health professionals to whom they refer patients
- the pathology, diagnostic imaging or other investigations they order
- how and when to schedule follow-up appointments with each patient.

Practitioners must still comply with the policies and procedures of the health service.

Meeting each indicator

C5.2▶A Our clinical team can exercise autonomy, to the full scope of their practice, skills and knowledge, when making decisions that affect clinical care.

You must:

- give practitioners autonomy in relation to:
 - overall clinical care of their patients
 - referrals to other health professionals
 - requesting investigations
 - duration and scheduling of appointments.

You could:

- maintain a policy specifying that practitioners have clinical autonomy to deliver evidence-based care, according to their scope of practice, skills and knowledge.

Criterion C5.3: Clinical handover

Indicator

C5.3▶A Our health service manages the handover of patient care both within the service to other members of the clinical team and to external care providers.

Why this is important

Clinical handover of patient care, to other members of the clinical team and to external care providers, is frequently required in health services. An individual whose health is deteriorating might require immediate medical transfer, either within the immigration detention facility or to an external care provider (eg hospital). Members of the health service team need to manage, or be involved in the management, of such transfers. Transfers from some sites require prior administrative approval from a governing body. Effective communication about the current clinical issues necessitating transfer and potential risks of delays accessing specialised treatment might need to be communicated to initiate and to expedite this process.

Lack of, or inadequate, transfer of care is a major risk to patient safety. It can result in serious adverse patient outcomes, including:

- delayed treatment
- delayed follow up of significant test results
- unnecessary repeats of tests
- medication errors.

It can also result in legal action.

Meeting this criterion

Clinical handover needs to occur whenever there is a transfer of care from one provider to another.

For example, when:

- a practitioner is covering for a fellow practitioner who is on leave or is unexpectedly absent
- a practitioner is covering for a part-time colleague
- a practitioner is handing over care to another health professional, such as a nurse, physiotherapist, podiatrist or psychologist
- a practitioner is referring a patient to a service outside the health service
- there is a shared-care arrangement (eg a team is caring for a patient with mental health problems)
- there is an emergency, such as handover to hospitals or ambulance
- the patient makes a request (eg to upload their health summary to a shared electronic health record).

Whenever clinical handovers occur due to the absence of a regular practitioner, it is good practice to:

- tell the patient who will take over their care
- pass on information about the patient's goals and preferences
- support patients, carers and other relevant parties who will be involved in the clinical handover, according to the wishes of the patient.

Clinical handovers can be completed in person, over the telephone, via video consultation or by conveying written information (eg in hard copy, facsimile, email or end-to-end encryption platforms).

You could consider having a policy to ensure that standard processes are followed during a handover.

The policy could include:

- how to use the progress notes in the patient's health record during a clinical handover
- how to have a secure clinical handover when sharing electronic health records (eg using healthcare identifiers that uniquely identify the individual patient)
- how to give and receive information relating to living quarter visits, after-hours services, hospital discharges and care provided by other healthcare professionals
- how to record the clinical handover in the consultation notes
- how to report near misses and failures in a clinical handover
- the use of a buddy system that enables a buddy to follow up results and correspondence and continue the care of the patient when a colleague is absent.

Meeting each indicator

C5.3 ► A Our health service manages the handover of patient care both within the service to other members of the clinical team and to external care providers.

You must:

- keep copies of referrals to allied health services, other practitioners, specialists and ambulance staff in the patient's health record
- have a process for handover of care in the event of unexpected or expected leave.

You could:

- keep records of any breakdowns in the clinical handover system that were identified and addressed
- use a clinical software program to generate referrals that are automatically populated with a health summary. The referral must be accompanied by a statement written by the practitioner giving the reason for the referral
- have a policy explaining how to conduct internal and external handovers, including to locum practitioners
- have a standard form to be used for ambulance transfers
- conduct face-to-face handovers, unless it is not possible
- maintain service-level agreements with medical deputising services and after-hours cooperative arrangements, clearly setting out the responsibilities of all parties
- have a shared-care arrangement when appropriate
- create and document a buddy system
- use internal messaging or internal email for clinical team members to communicate with each other
- use software, such as patient information and management systems, that enables you to upload a patient's shared health summary/record or event summary to the patient's national shared electronic health record when the patient requests it.

Core Standard 6

Information management

| Our health service has an effective system for managing patient information.

Information management refers to the management, storage and disposal of records (paper and electronic), and the technology used to do this. You are required to comply with the relevant state/territory and federal laws relating to the collection, storage, use, disclosure and disposal of patients' health and personal details.

Criterion C6.1: Patient identification

Indicator

C6.1 ▶ A Our health service uses a minimum of three patient identifiers to correctly identify patients and their clinical information.

Why this is important

Verifying a patient's identity helps to maintain patient safety and confidentiality. Failure to correctly identify a patient can have serious, potentially life-threatening consequences for the patient.

Using three approved patient identifiers reduces the risk of misidentifying patients and ensures that practitioners have the correct patient health record for each consultation. Rand Corporation, a not-for-profit research organisation, provides further information about the importance of **correctly identifying patients**.

Meeting this criterion

Correct patient identification is necessary any time there is any transaction between a patient and the health service, including when:

- a patient makes an appointment
- a patient presents to the health service for their appointment
- you communicate with a patient over the telephone or electronically
- a patient sees more than one practitioner during a visit
- a patient record is accessed
- you collect and manage information (eg scanned documents, X-rays) about a patient.

Patient identifiers are items of information that are accepted for use at your health service to identify a patient. They can include the following:

- patient's name (family and given names together are one identifier)
- patient's date of birth
- an individual identification number where it exists (eg immigration detention facility ID number)
- an identification card with a photo.

Your health service needs to have a method to identify patients. Your health service must respect patients' right to preserve their identity, including nationality, name and family relations. Your health service could implement a policy to identify patients without reference to an identification number (eg boat ID). Any method to identify patients must be decided and used consistently across all aspects of the health service.

Asking for patient identifiers

When asking for patient identifiers, health service team members must ask the patient to state at least three identifiers (eg their full name, date of birth and identification number), while remaining mindful of privacy and confidentiality issues. Health service staff must ask the patient for the information, rather than provide the identifying information and then ask the patient to confirm the information.

A patient could supply government-issued photographic documentation to provide information for your records and to subsequently provide one or more identifiers.

When a patient is well known to the health service team, it might appear unnecessary or illogical to ask for identifiers every time they attend or contact the health service. However, it is common for health services to have patients with identical or similar names, or dates of birth, and to therefore mismatch patients and patient health records. Some health services overcome this by routinely asking patients to verify particulars each time they attend. This also helps the health service to maintain accurate contact details for each patient.

Patients who wish to remain anonymous

Patients have the right to request anonymity and might ask to receive health services anonymously if, for example, sensitive issues arise or they feel they might be at risk, such as in domestic violence situations or difficult relationships. Patient anonymity might not be possible in an immigration detention setting and, if not, this must be communicated to the patient.

Meeting each indicator

C6.1 ► A Our health service uses a minimum of three patient identifiers to correctly identify patients and their clinical information.

You must:

- use a minimum of three patient identifiers to confirm a patient's identity each time they attend or contact the health service.

You could:

- keep a prompt sheet at reception to remind reception staff to ask for approved patient identifiers
- explain to patients the reasons for identifying them at each visit (eg safety reasons, keeping accurate patient details), particularly if you have a small health service or have patients well known to the health service team members
- maintain a policy of acknowledging, recording, and implementing the names and pronouns used by each patient.

Criterion C6.2: Patient health record systems

Indicators

C6.2▶A Our health service has a system to manage our patient health information.

C6.2▶B If our health service is using a hybrid patient health record system, a note of each consultation/interaction is made in each system, and that record includes where the clinical notes are recorded.

Why this is important

Patient health record systems are generally electronic.

Your health service has an active hybrid patient health record system if one or more of your practitioners enter patient information into a paper-based system and one or more uses electronic files.

A fully electronic patient health record system is preferable to a paper-based or hybrid system because clinical notes in an electronic system:

- are more legible
- are more accessible
- reduce duplication
- are safer for both patient and provider
- are more easily protected and backed up, which means your health service is less likely to lose or misplace information as a result of incorrect filing, natural disaster, fire or theft.

In addition, electronic systems can support clinical decision-making (eg alerts can be set for patient allergies, and the patient's detailed medical history, including past and current medications and dosages, can be accessed more easily).

Using an active hybrid patient health record system to record patient health information is discouraged, as it can result in some information being recorded on one system (eg a medicines list on a computer) and some information being recorded on another system (eg past medical history on handwritten notes), or some information not being recorded at all.

Meeting this criterion

Your health service must have a patient health record system that suits the needs of your health service, whether it is an electronic, paper-based or hybrid system.

Using a hybrid patient health record system

If you use a hybrid patient health record system:

- all practitioners in your health service, including locums, must know that the patient health record system is a hybrid
- all practitioners, including locums, who see a patient must know to look at both systems to access all relevant information
- information in both systems must be readily available at all times

- information does not need to be duplicated in both systems, but there must be a clearly visible note in both systems stating that the health service uses a hybrid patient health record system and where information is recorded
- you must be working towards recording at least allergies and medications electronically.

Meeting each indicator

C6.2▶A Our health service has a system to manage our patient health information.

You must:

- use clinical software to manage patient health information
- have all patient health information available and accessible when needed.

You could:

- conduct audits to identify gaps in patient information
- provide relevant education to the health service team when the clinical software is updated.

C6.2▶B If our health service is using a hybrid patient health record system, a note of each consultation/interaction is made in each system, and that record includes where the clinical notes are recorded.

You must:

- keep a record of consultations in both the paper and electronic health record if using a hybrid system
- have all patient health information available and accessible when needed.

You could:

- transition to a completely computerised patient health information system.

Criterion C6.3: Confidentiality and privacy of health and other information

Indicators

- C6.3▶A** Our patients are informed of how our health service manages confidentiality and their personal health information.
- C6.3▶B** Our patients are informed of how they can gain access to their health information we hold.
- C6.3▶C** In response to valid requests, our health service transfers relevant patient health information in a timely, authorised and secure manner.
- C6.3▶D** Only authorised team members can access our patient health records, prescription pads and other official documents.

Why this is important

You must collect personal health information and then safeguard its confidentiality and privacy in accordance with:

- the Australian Privacy Principles contained in the *Privacy Act 1988*
- long-standing legal and ethical confidentiality obligations
- other relevant state or territory laws (that might or might not be health specific).

You are subject to stringent privacy obligations because you provide health services and hold health information. Health information is a subset of personal information. Personal information is, by definition, sensitive; it requires more rigorous protection than non-sensitive information. Personal information can include any information collected to provide a health service, such as a person's:

- religious beliefs
- political opinion
- sexual orientation
- health information (such as a medical or personal opinion) relating to their disability or health status.

Even if there is no name attached to particular details, some details about a person's medical history or other information could identify the person (eg details of an appointment). Therefore, this information is still considered health information and must be protected in accordance with the *Privacy Act 1988*.

If unauthorised people have access to prescription pads and/or other official documents, they can misuse these documents, particularly to gain access to medication that has not been prescribed to them.

Refer to [Criterion IDF5.1: Health service facilities](#) for more information on privacy and patient dignity, including the involvement of non-health staff (eg security staff).

Meeting this criterion

Consider and address:

- all privacy requirements
- how to manage the responsibilities of the health service team

- the risks associated with keeping health records.

This includes reviewing and developing policies about your health service's use of:

- computer systems and IT security
- systems that automatically generate letters or referrals
- email
- file sharing applications.²¹

Real-time audio/visual recording, and duplication and storage of a consultation, including those via telehealth and those conducted remotely, must never occur without the patient's consent. Refer to [Criterion C6.4: Information security](#) for more information.

The RACGP's *Privacy and managing health information in general practice* explains the safeguards and procedures to implement to meet legal and ethical standards relating to privacy and security. While this is a general practice resource, it can be applied to the health service setting in an immigration detention facility. Your medical defence organisation can also provide information and advice about developing relevant strategies.

Privacy policy

Your health service must document a privacy policy that addresses the management of patient health information, and must inform patients of the policy. Your privacy policy must be written in plain English, specify a review date and address certain legal requirements, which include:

- information about collecting health records:
 - the definition of a patient health record
 - the kinds of personal information that the health service collects and holds
 - how and why the health service collects, stores, uses, protects and discloses personal information
 - how patients can communicate with the health service anonymously.
- patients' interactions about their privacy and health information:
 - how patients can access and correct personal information held by the health service
 - how a patient can complain about a breach of the Australian Privacy Principles or of a registered Australian Privacy Principles code, and how the health service will deal with such a complaint.
- disclosure of patients' health information to a third party:
 - obtaining informed patient consent when disclosing health information
 - to whom health information is likely to be disclosed
 - whether health information is likely to be disclosed overseas and, if so, where and how
 - how the health service uses document automation technologies, particularly so that only the relevant medical information is included in referral letters.

Where health services are contracted by a body, such as the Department of Home Affairs, health information collected by the health service might be owned by that body, or might need to be disclosed to it under certain circumstances (eg reporting communicable diseases, or as otherwise legislated). You must provide patients with the detail of your health service's policy for managing their health information, which includes who owns that information. Refer to [Criterion C1.1: Information about your health service](#) for more information on providing information about your health service.

It is important that health information is only disclosed to non-health stakeholders within the immigration detention facility, with the patient's consent to reduce the risk of harm to the individual and/or the public health within the immigration detention facility.

Refer to the [RACGP's privacy policy template](#).

For further information about privacy, visit the [Office of the Australian Information Commissioner website](#).

Your health service must make your privacy policy available to patients. This could be on your website, or health service staff could produce a copy when a patient asks for one. The policy should be available in languages other than English, appropriate to your patient population.

Disclosure of patient health information to a responsible person

The *Privacy Act 1988* permits an organisation to disclose necessary health information to an individual's responsible person (such as a carer), providing:

- it is reasonably necessary, in the context of providing a health service to that individual
- the individual is physically or legally incapable of consenting or communicating that consent.

If a carer is seeking access to a patient's health information, it is a good idea to seek advice from your medical defence organisation before giving the carer access to the information.

Secure transfer of health information

When communicating information about patients to health services and government agencies, always use secure electronic communication.²²

When transferring patient health information to others (eg patients, other health service providers, or in response to third-party requests), follow the processes in the Australian Privacy Principles and all requirements of relevant state or territory laws addressing the transfer of patient health information.

For further advice about what information could be transferred, refer to the [RACGP's Managing external requests for patient information](#).

Contact your insurers if you have any concerns about third-party requests for the transfer of patient health information.

Familiarity with requirements

The health service team must read and understand your privacy policy and understand the need for confidentiality of patient health information. As well as being familiar with the Australian Privacy Principles, team members need to be familiar with the relevant state/territory laws about privacy and health records. For more information about privacy laws in each jurisdiction, visit the [Office of the Australian Information Commissioner website](#).

Appropriate access to patient health records and/or other official documents

Health service staff have a responsibility to use patient information only for its intended purpose and for the benefit of the patients. Access to patient records is given to members of the health service team so that they can perform their roles and provide efficient service to the patients and other team members.

Meeting each indicator

C6.3▶A Our patients are informed of how our health service manages confidentiality and their personal health information.

You must:

- maintain a privacy policy
- demonstrate how your health service informs patients about their rights to privacy and confidentiality in a language they understand
- demonstrate how patients are made aware of who owns their health records.

You could:

- maintain a patient health information management policy.

C6.3 ► B Our patients are informed of how they can gain access to their health information we hold.

You must:

- maintain a privacy policy.

You could:

- educate the health service team about the need for confidentiality and have each member sign a confidentiality agreement, which is stored in their employment file
- maintain a patient health records policy.

C6.3 ► C In response to valid requests, our health service transfers relevant patient health information in a timely, authorised and secure manner.

You must:

- maintain a privacy policy.

You could:

- document in the patient's health record their consent to communicate electronically
- undertake regular privacy training
- protect the patient's privacy when communicating electronically with or about patients by using a secure message system or other method of encryption, unless the patient has provided informed consent to their information being sent without such protection.

C6.3 ► D Only authorised team members can access our patient health records, prescription pads and other official documents.

You must:

- maintain a privacy policy
- demonstrate how your health service informs patients when their health record has been accessed
- demonstrate how patients are made aware of who is authorised to access their records
- securely store all official documents, including prescription forms, administrative records, templates and letterheads.

You could:

- maintain a policy addressing the management of patient health information.

Criterion C6.4: Information security

Indicators

- C6.4▶A** Our health service can identify a person (health service team member or immigration detention facility staff member) who has primary responsibility for the electronic systems and computer security.
- C6.4▶B** Our health service does not store or temporarily leave the personal health information of patients where unauthorised access to that information can occur.
- C6.4▶C** Our health service's clinical software is accessible only via unique individual identification that gives access to information according to the person's level of authorisation.
- C6.4▶D** Our health service has a business continuity and information recovery plan.
- C6.4▶E** Our health service has appropriate procedures for the storage, retention and destruction of records.
- C6.4▶F** Our health service has a policy about the use of email.
- C6.4▶G** Our health service has a policy about the use of social media.

Why this is important

Maintaining the privacy and security of health information held by a health service is a legal obligation. This includes maintaining the security of computers and other devices.

Given health services can use electronic communication to communicate with patients and other health professionals, an email policy will help to protect the security of patient information and the reputation of the health service.

Meeting this criterion

The RACGP's *Information security in general practice* guide contains:

- information about security issues
- recommendations to protect against potential loss of sensitive data
- templates you can use to create policies and procedures relating to information security.

You could refer to this document to help meet the requirements of this criterion.

Remote access

If your health service allows remote access to its systems for clinicians and other users, your health service must document its policies on remote access and use of wireless systems. Refer to the RACGP's *Information security in general practice* for further information on remote access.

Designated health service team member

Your health service must have a designated health service team member who has the primary responsibility for computer security, or where the immigration detention facility staff are responsible for computer security, information on who that responsible person is must be known by the health service team.

These responsibilities must include:

- knowing who and when to call for expert advice
- giving relevant team members the contact details of any external expert the health service has used
- educating the health service team about data security and the need to follow security protocols and policies
- monitoring whether team members are following security protocols and policies.

Keeping health information concealed

Computer screens must be positioned so that only appropriate members of the health service team can see confidential information. Automated privacy protection tools (such as screensavers) must be used to prevent unauthorised access to computers when they are left unattended (eg when a practitioner leaves the consultation room to collect equipment, medication or information).

Mobile phones, tablets, laptops and other portable devices, and the information stored or accessed on them, as well as any files or printed documents, need to be as secure as your health service's desktop computers and network. This is particularly important because they are potentially more accessible to people outside the health service.

You must ensure that information cannot be accessed by unauthorised people, such as other individuals in detention and non-health service staff (eg security staff and cleaners).

Restricting access to clinical software

Health service team members only require access to the information they need to undertake their roles. If you have given different members of the health service team different levels of access to patient health information:

- document who has access to different levels of patient health information data
- make sure that health service team members understand why they must keep their passwords private.

Unique individual identification is important so that health service team members can access the information they need to undertake their roles. Some examples of unique individual identification could include passwords, fingerprint recognition, voice recognition or retinal screening.

Business continuity and information recovery

If your health service uses computers to store patient health information, you must have a business continuity plan to protect information in the event of an adverse incident, such as a system crash or power failure.

The business continuity and information recovery plan needs to include:

- the processes by which all critical information relating to the health service's operations (such as appointments, billing and patient health information) will be frequently backed up
- a schedule of regular tests so that backups are being correctly created and can be accessed and read as expected
- details of the secure offsite location where the backup information is stored
- standard letters of agreement that external IT providers sign to indicate their commitment.

Replacing IT equipment

When IT equipment needs to be replaced or upgraded, refer to the RACGP's *Effective solutions for e-waste in your practice* to ensure that you do not inadvertently lose or transfer key information. Just deleting records does not actually remove the data from a computer system, which means that people might still be able to

recover files that have been deleted, but not removed.

Other equipment, such as photocopiers and fax machines, might have hard drives that contain confidential information that must be properly removed before you dispose of them.

Destroying information

Information created in an immigration detention setting might be owned by the Australian Government, and destruction of such information must comply with Australian Government policies for the destruction of Commonwealth records.

If you are considering destroying clinical records for patients who are no longer patients of the health service, have not been seen for many years or who have outdated results in their records, consult with the immigration detention facility's management or the Department of Home Affairs.

You could also consult with your medical defence organisation to understand your legal requirements regarding records owned by the Australian Government and manage the risks.

For maximum security, the use of a cross-cut shredder is recommended to destroy paper documents containing sensitive material.

If your health service has a policy to destroy these records, you must also have a system that provides timely identification of information that is no longer relevant.

You also need to have processes for the disposal of hard drives and other storage media.

Email and social media policies

If your health service uses email and social media, you must have policies for its use, especially for the use of identifiable medical details and correspondence with patients. The health service team must be familiar with the policies, comply with them and understand the risks associated with using email. The policies could also be made available to patients.

A policy for use of email in the health service might include information about:

- maintaining passwords and keeping them secure
- verifying and updating email addresses
- informing patients of possible risks to their privacy if standard unencrypted email is used
- obtaining patient consent to communicate with them via email.

For further information, refer to the [RACGP's Using email in general practice](#).

If your health service does not use email, have a policy that states this.

Practitioners registered with AHPRA are required to comply with AHPRA's social media policy.

Meeting each indicator

C6.4▶A Our health service can identify a person (health service team member or immigration detention facility staff member) who has primary responsibility for the electronic systems and computer security.

You must:

- have at least one team member who has primary responsibility for the electronic systems and computer security.

You could:

- maintain a policy addressing the management of patient health information
- create a position description outlining the roles and responsibilities relating to computer security.

C6.4►B Our health service does not store or temporarily leave the personal health information of patients where unauthorised people could see or access that information.

You must:

- maintain a privacy policy.

You could:

- maintain a policy addressing the management of patient health information
- have a physical layout that means unauthorised people cannot view patient health information
- use password-protected screensavers
- use a cross-cut shredder and/or have a secure document-shredding agreement with a reputable provider
- wipe all information off hard drives and photocopiers before disposing of them.

C6.4►C Our health service's clinical software is accessible only via unique individual identification that gives access to information according to the person's level of authorisation.

You must:

- maintain the security of the clinical software passwords of each individual health service team member
- maintain a privacy policy.

You could:

- maintain an information technology policy
- give only appropriate access to each role based on position descriptions
- ensure that staff members are trained to log out or lock computers and other devices after each use
- maintain a register of who borrows or takes a laptop or mobile phone
- maintain secure passwords for portable devices
- install current antivirus software on all devices.

C6.4►D Our health service has a business continuity and information recovery plan.

You must:

- operate a server backup log
- maintain up-to-date antivirus protection and hardware/software firewalls
- maintain and test a business continuity plan for information recovery
- maintain a privacy policy
- store backups offsite in a secure location.

You could:

- maintain a policy for the management of patient health information
- undertake regular privacy training.

C6.4▶E Our health service has appropriate procedures for the storage, retention and destruction of records.

You must:

- maintain and test a business continuity plan for information recovery
- maintain a privacy policy.

You could:

- maintain a policy for the management of patient health information
- maintain an information technology policy
- undertake regular privacy training.

C6.4▶F Our health service has a policy about the use of email.

You must:

- maintain an email policy.

You could:

- put your email policy on your website
- have an automated response to patient emails that advises them of when they are likely to receive a response.

C6.4▶G Our health service has a policy about the use of social media.

You must:

- maintain a social media policy.

You could:

- put your social media policy on your website.

Core Standard 7

Content of patient health records

Our patient health records contain an accurate and comprehensive record of all interactions with our patients.

Maintaining accurate and comprehensive patient health records is crucial in providing patients with continuity of high-quality and safe care.

The patient health record is information held about a patient, whether in paper or electronic form.

Criterion C7.1: Content of patient health records

Indicators

C7.1▶A Our health service has an individual patient health record for each patient that contains all health information held by our health service about that patient.

C7.1▶B Our active patient health records contain, for each active patient, their identification details, contact details and demographic information.

C7.1▶C Our health service can demonstrate that timely access to next-of-kin information and emergency contact information is available for each active patient.

C7.1▶D Our patient health records include records of consultations and clinical-related communications.

C7.1▶E Our patient health records show that matters raised in previous consultations are followed up.

C7.1▶F Our health service routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.

C7.1G Our health service routinely records the cultural backgrounds of our patients in their patient health record.

C7.1▶H Our patient health records contain, for each active patient, lifestyle risk factors.

Where Aboriginal and Torres Strait Islander peoples are not in detention, Indicator C7.1▶F and its accompanying explanatory notes (ie mandatory requirements) do not apply to health services in Australian immigration detention facilities.

Why this is important

Complete patient health records improve patient safety and wellbeing, as they support clinical decision-making. For example, a complete patient health record assists your clinical team to easily access information on a patient's allergies or the patient's medical history.

Consultation notes and patient health records are also a way of managing risks. Medical defence organisations have identified that failure to follow up matters that patients have previously raised poses a considerable risk to health services and practitioners.

Meeting this criterion

Content of patient health records

Patient health records must be updated as soon as practicable during or after consultations and living quarter visits. The record must identify the person in the clinical team making the entry.

All patient health records, including scans of external reports, must be legible so that another practitioner could take over the care of the patient.

Consultation notes must contain the following information:

- date of consultation
- who conducted the consultation (eg by initials in the notes or by audit trail in an electronic record)

- method of communication (eg face to face, email, telephone or other electronic means)
- whether an interpreter was used
- patient's reason for consultation
- relevant clinical findings including history, examinations and investigations
- allergies
- diagnosis (if appropriate)
- recommended management plan and, where appropriate, expected process of review
- any medicines prescribed for the patient (including the name, strength, directions for use, dose, frequency, number of repeats and date on which the patient started/ceased/changed the medication)
- patient consent for the presence of a third party brought in by the health service (eg a medical student)
- record of patient emails (if applicable).

When available, use consistent coding of diagnoses. Choose the most appropriate diagnosis from a recognised clinical terminology (one of these is supplied with every electronic clinical record package) in the consultation notes so that continuous improvement of clinical care and patient outcomes can be achieved.

Other information might be included in the patient health record, such as:

- any referrals to other healthcare providers or health services
- medicines the patient takes that were not prescribed or advised by the health service
- complementary and over-the-counter medicines (because many people now take complementary and over-the-counter medicines that might react adversely with conventional medicines, you could document the patient's use of these as you would other medicines, whether prescribed by a member of the clinical team or reported by the patient)
- any relevant preventive care information collected, such as currency of immunisations, blood pressure, waist measurement, height and weight (body mass index)
- an advanced care plan
- the presence of a third party brought in by the patient (eg carer)
- any special advice or other instructions given to the patient.

System to store patient health information

You need to have an effective system to store patients' health information in a dedicated patient health record. In addition to containing clinical information, the patient health record might also contain other relevant information, such as details of personal injury insurance claims.

Patient health records in clinical software

Consider updating medical software when practicable. This will mean that older files will remain compatible with later versions of the software, and that you will be able to run the software on modern hardware and operating systems.

You might consider retaining older hardware and operating systems so that you can store and retrieve older records.

Collecting information from patients

Patient privacy is critical when collecting information that forms part of a patient health record, including all demographic and health information.

You can collect information from a new patient using a generic form, on paper or electronically, or by privately interviewing patients before the first consultation. You must ensure patients can provide information privately. If clarification of any patient details is needed, ensure you do so in a private space, preferably away from any waiting areas. Consider the sensitivity of details being collected or clarified, and determine whether a member of clinical team is best suited to ask the patient for that information (eg in a private consultation room). Refer to [Criterion C6.3: Confidentiality and privacy of health and other information](#) for more information.

You must have a system that ensures that patient information is updated regularly so that it remains accurate.

You need a patient identification process to ensure that the right patient is matched to the right record and is therefore receiving the right treatment. Refer to [Criterion C6.1: Patient identification](#) for more information about patient identification.

Patient details need to be as complete as possible. A patient or their emergency contact might not have access to telephone, but your health service could still record their locations or other ways to access them when needed. If the patient's contact, next of kin, or emergency contact information is held by another agency (eg the Department of Home Affairs), you must demonstrate that timely access to that information is available for each active patient when needed.

You must document if a patient refuses to provide their identification details, contact details, demographic, next of kin or emergency contact information.

Collecting information about sex, gender, variations of sex characteristics and sexual orientation

Data-collection methods often do not distinguish between an individual's identity and the labels other people might use about them. For example, people who are classified as 'transgender' by others might self-identify as women or men. Someone who was assigned 'male' at birth and whose documents list sex as 'male' might select 'woman' as her gender, 'female' as her sex on a form, 'her/she' as her pronouns and not identify as 'transgender'.

Missing or misrepresented information in a patient's health record can have substantial implications for clinical care delivery. For example, a male patient whose assigned sex at birth is 'female' still requires screening for female disease risk factors. If a patient's assigned sex at birth and gender are conflated and inaccurately recorded, appropriate treatments might not be offered. Your health service needs to explain the reason for collecting this information to patients, so they know data are being confidentially collected for their own health outcomes, not for discriminatory or prejudicial purposes.

Likewise, information about gender can be interrelated to various aspects of the patient's health (eg expression and experience of mental health), so it is important that this information is collected independently of assigned sex at birth.

There is no singular experience or identity for people born with variations of sex characteristics (intersex). When your health service seeks to obtain information about variations of sex characteristics, you need to ask patients a separate question from those asking about assigned sex at birth and gender. When asking about a patient's sex, do not include 'intersex' or 'born with a variation of sex characteristics' alongside the options 'male' and 'female'. Doing so might be perceived as offensive or inaccurate when the patient identifies as male or female. A patient born with a variation of sex characteristics might identify as both intersex and male or female, so conflating sex and variations of sex characteristics in a single question might be perceived as offensive or inaccurate.

For the best health outcomes, ask for and record details about a patient's sex, gender, variations of sex characteristics and sexual orientation separately. Your health service could do the following to improve the accuracy of responses when collecting this information from patients:

- Clearly explain why questions are being asked and how answers will be used.
- Use forms that allow patients an option from multiple fields.
- Ask patients what pronouns they use, then document and use this information (eg in referral letters).
- Ask questions that distinguish between identity (ie male/female) and descriptors of behaviour, attraction and experience (ie ask who your patient's sexual partners are).

For more information, refer to the RACGP's *Standards for general practices (5th edition) fact sheet: Collecting and recording information about patient sex, gender, variations of sex characteristics and sexual orientation*.

Collecting information over time

Patient information is gathered over more than one consultation. It is important that clinically significant, separate events in a patient's life and the care provided are recorded and managed so that the information is readily accessible.

One way of doing this is to regularly update each patient's health summary so that all relevant information is easy to find in one central location.

Clinically significant information might include the patient's health needs and goals, preventive health activities, medical conditions and their preferences and cultural values. Having this information improves the practitioner's ability to provide care that is tailored to the patient's needs and circumstances.

Retaining health records of active and inactive patients

Health records created in immigration detention facilities are the property of the Australian Government. Your health service must keep and securely store and dispose of health records of active and inactive patients in accordance with legal obligations imposed by the *Privacy Act 1988* and the Australian Privacy Principles. Inactive records are returned in full to the Australian Government as per the *Archives Act 1983*.

An inactive patient is generally defined as a patient who has attended the health service fewer than two times in the past two years.

You must retain health records of inactive patients in accordance with relevant national, state or territory laws, as well as those governing the information created in an immigration detention facility (eg policies for the destruction of Australian Government records). You might want to consult your contracting organisation or medical defence organisation to understand the health service's requirements for inactive patient records owned by the Australian Government.

Lifestyle risk factors

Lifestyle risk factors, such as smoking, nutrition, alcohol, drug use (eg recreational, intravenous) and lack of physical activity, are associated with many diseases. Record these risk factors in the patient health record and review management plans at defined intervals. Some risk factors are unique to immigration detention; for example, the period of confinement, seclusion, exposure to violence, trauma and mode of arrival.

Routinely measure and record each patient's height, weight and blood pressure at defined intervals. This will help you to identify significant or unexplained weight loss or gain that might indicate a disease, and/or to assess a child's growth and development. The practitioner must know which health checks need to occur at what intervals, in accordance with best practice.²³

Meeting each indicator

C7.1▶A Our health service has an individual patient health record for each patient that contains all health information held by our health service about that patient.

You must:

- maintain individual health records for each patient that include all required information.

You could:

- maintain a policy addressing the management of patient health information
- ensure handwritten records are legible
- ensure new patient forms ask for all required information
- cover policies and processes relating to patient health records during staff inductions.

C7.1▶B Our active patient health records contain, for each active patient, their identification details, contact details and demographic information.

You must:

- include, for each active patient, all of the required information listed in the indicator.

You could:

- maintain a policy addressing the management of patient health information
- use a new patient form that asks for all required information.

C7.1▶C Our health service can demonstrate that timely access to next-of-kin and emergency contact information is available for each active patient.

You must:

- demonstrate that timely access to next-of-kin information and emergency contact information is available for each active patient if it is needed.

You could:

- maintain a policy addressing the management of patient health information, including what information can be held by your health service
- maintain a policy addressing access to patient health information that is held by another agency (eg the Department of Home Affairs).

C7.1▶D Our patient health records include records of consultations and clinical-related communications.

You must:

- ensure consultation notes include all mandatory elements
- include a record of all clinical-related communications (including emails, if applicable) in the patient's health record.

You could:

- maintain a policy addressing the management of patient health information
- check documents that are scanned into electronic health records are clear and can be easily read, and make appropriate notes if anything is unclear or illegible.

C7.1▶E Our patient health records show that matters raised in previous consultations are followed up.

You must:

- document matters that have been followed up in the patient health record.

You could:

- maintain a policy addressing the management of patient health information
- use flags in the consultation notes to mark issues that need to be followed up.

C7.1▶F Our health service routinely records the Aboriginal and/or Torres Strait Islander status of our patients in their patient health record.

You must:

- document the patient's Aboriginal and/or Torres Strait Islander status in patient health records.

You could:

- maintain a policy addressing the management of patient health information.

C7.1G Our health service routinely records the cultural backgrounds of our patients in their patient health record.

You could:

- maintain a policy addressing the management of patient health information
- ask patients about their cultural background during a consultation, and record this information in your clinical software (in a specific field or in general notes)
- ask patients about their cultural background in your new patient form, and enter this information into your clinical software system (in a specific field or in general notes).

C7.1▶H Our patient health records contain, for each active patient, lifestyle risk factors.

You must:

- document information relating to lifestyle risk factors such as height, weight and blood pressure in the patient health record.

You could:

- maintain a policy addressing management of patient health information.

Core Standard 8

Education and training of non-clinical staff

| Our non-clinical staff are appropriately qualified and trained to perform their role.

This standard focuses on the systems that your health service uses to ensure that non-clinical members of the health service team receive continuing education and training that is appropriate for their role.

Criterion C8.1: Education and training of non-clinical staff

Indicators

C8.1 ▶ A Our non-clinical health service staff complete training appropriate to their role and our patient population.

C8.1 ▶ B Our non-clinical health service staff complete CPR training at least every three years.

Why this is important

Health service administrative staff have a vital role in the provision of safe and quality care, and therefore require training appropriate to their role.

A health service that supports education and training of non-clinical health service staff fosters continuous improvement and risk management.

Meeting this criterion

Training relevant to the role

Training might cover areas, such as:

- your health service's procedures
- use of technology (hardware, systems and software)
- first aid
- medical terminology
- medical reception
- cross-cultural safety
- communicating with patients with communication needs (eg patients from CALD backgrounds, or those with a communication impairment)
- safe operation of specific equipment
- managing access to medical appointments
- providing emergency first aid/care to individuals when there are no health professionals available.

Practitioners or other members of the health service team can deliver inhouse or 'on-the-job' training in health service-specific areas, such as:

- using the patient health record system
- making appointments
- recognising medical emergencies when patients present in reception
- confidentiality requirements
- the health service's policies and procedures.

CPR

CPR training for your health service administrative staff can be conducted by an accredited training provider, or by members of the clinical team, if appropriate. These clinical team members must have a current CPR instructor's certificate that complies with Australian Resuscitation Council (ARC) guidelines on instructor competencies.

The ARC requires that CPR trainees physically demonstrate their skills at the completion of the CPR course. CPR training that is completed solely online does not meet this requirement.

Your health service needs to ensure that outside of normal hours of health service operation, emergency resuscitation or other interventions to stabilise patients are available if needed.

Meeting each indicator

C8.1 ► A Our non-clinical health service staff complete training appropriate to their role and our patient population.

You must:

- provide evidence that non-clinical staff are provided with relevant training.

You could:

- record each employee's qualifications in employment files
- specify required qualifications in job descriptions for each non-clinical role in the health service team
- demonstrate how non-clinical health service staff are trained to facilitate the use of interpreters
- demonstrate that health service team members seek to provide a culturally safe experience for their patients (refer to [Criterion C2.1: Respectful and culturally appropriate care](#) for more information)
- demonstrate how staff have access to cultural awareness education and ongoing cultural upskilling
- demonstrate how non-clinical health service staff are trained to work with interpreters
- demonstrate that health service team members have cultural awareness and seek to provide a culturally safe environment for their patients (refer to [Criterion C2.1: Respectful and culturally appropriate care](#) for more information)
- keep training logs that record training that non-clinical team members have completed
- keep a training calendar listing opportunities for professional development and training that has been completed
- conduct annual performance reviews that identify learning and development goals
- store documents that record training needs and training completed
- demonstrate that non-clinical staff have undertaken infection prevention and control training appropriate to their role
- demonstrate that non-clinical staff know who is responsible for infection prevention and control at your health service.

C8.1 ► B Our non-clinical health service staff complete CPR training at least every three years.

You must:

- provide evidence that non-clinical health service staff complete CPR training every three years.

You could:

- keep training logs that record training that non-clinical health service team members have completed, including CPR training
- keep a training calendar listing opportunities for professional development and training completed
- plan annual performance reviews
- store documents that record training needs and training completed.

References

1. Epstein RM, Franks P, Fiscella K, et al. Measuring patient-centered communication in patient-physician consultations: Theoretical and practical issues. *Soc Sci Med* 2005;61(7):1516–28.
2. Australian Commission on Safety and Quality in Health Care. National statement on health literacy: Taking action to improve safety and quality. Sydney, NSW: ACSQHC, 2014.
3. National Health and Medical Research Council. General guidelines for medical practitioners on providing information to patients. Canberra, ACT: NHMRC, 2004.
4. Queensland Health Interpreter Service. Frequently asked questions. Brisbane, Qld: Queensland Health, 2012. Available at www.health.qld.gov.au/multicultural/interpreters/qhis_faq [Accessed 7 August 2022].
5. Mohr JJ, Batalden PB. Improving safety on the front lines: The role of clinical microsystems. *Qual Saf Health Care* 2002;11(1):45–50.
6. Department of Human Services. Communication with people with disabilities. Melbourne, Vic: DHS, 2011. Available at www.dhs.vic.gov.au/for-business-and-community/community-involvement/people-with-a-disability-in-the-community/communicate-and-consult-with-people-with-a-disability/communication-with-people-with-disabilities [Accessed 7 August 2022].
7. Centre for Cultural Diversity in Ageing. Cultural awareness. Glenferrie South, Vic: Centre for Cultural Diversity in Ageing, 2015. Available at www.culturaldiversity.com.au [Accessed 7 August 2022].
8. Williams R. Cultural safety – What does it mean for our work practice? *Aust N Z J Public Health* 1999;23(2):213–14.
9. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney, NSW: ACSQHC, 2012.
10. Australian Council for Safety and Quality in Health Care. Better practice guidelines on complaints management for health care services. Canberra, ACT: Australian Council for Safety and Quality in Health Care, 2004.
11. Department of Health. History of pandemics. Canberra, ACT: DoH, 2011. Available at www.health.gov.au/internet/main/publishing.nsf/Content/about-pandemic-history [Accessed 7 August 2022].
12. Starfield B, Chang HY, Lemke KW, Weiner JP. Ambulatory specialist use by nonhospitalized patients in US health plans: Correlates and consequences. *J Ambul Care Manage* 2009;32(3):216–25.
13. Longo J, Hain D. Bullying: A hidden threat to patient safety. *Nephrol Nurs J* 2014;41(2):193.
14. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: A national study of healthcare complaints in Australia. *BMJ Qual Saf* 2013;22(7):532–40.
15. Pearson CM, Porath CL. On the nature, consequences and remedies of workplace incivility: No time for ‘nice’? Think again. *Acad Manag Perspect* 2005;19(1):7–18.
16. Rosenstein AH, O’Daniel M. A survey of the impact of disruptive behaviors and communication defects on patient safety. *Jt Comm J Qual Patient Saf* 2008;34(8):464–71.
17. World Health Organization. Health promotion. Geneva: WHO, 2017. Available at www.who.int/health-topics/health-promotion#tab=tab_1 [Accessed 7 August 2022].
18. Katz DL, Ali A. Preventive medicine, integrative medicine and the health of the public. Commissioned for the IOM summit on integrative medicine and the health of the public. Washington DC, WA, 2009.
19. Australian Institute of Health and Welfare. Public health expenditure in Australia 2008–09. Health and welfare expenditure series no. 43. Cat. no. HWE 52. Canberra, ACT: AIHW, 2011.
20. Edgar T, Volkman JE. Using communication theory for health promotion: Practical guidance on message design and strategy. *Health Promot Pract* 2012;13(5):587–90.
21. Browne P, Jammal W. How to manage your medicolegal risk. *Medical Observer*, 2015. Available at www.medicalobserver.com.au/professional-news/how-to-manage-your-medico-legal-risk [Accessed 7 August 2022].
22. The Royal Australian College of General Practitioners. RACGP position statement: The use of secure electronic communication within the healthcare system. East Melbourne, Vic: RACGP, 2016. Available at <https://www.racgp.org.au/FSDDEV/media/documents/Running%20a%20practice/Technology/RACGP-Position-Statement-Safe-and-effective-electronic-transfer-of-information-May-2021.pdf> [Accessed 7 August 2022].
23. Department of Health. MBS health assessments items 701, 703, 705, 707 and 715. Canberra: DoH, 2016. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_general_factsheet [Accessed 7 August 2022].

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QI Standard 1

Quality improvement

Our health service undertakes quality-improvement activities to support the quality of care provided to our patients.

The Standards encourage quality improvement and enable services to identify opportunities to make changes that will improve patient safety and care. You can identify and base these changes on:

- regular reviews of your health service's governance, internal systems and clinical care
- analysis of your health service's information and data collected (eg by seeking feedback from patients and team members, and conducting audits of clinical data).

All members of your health service team need to have opportunities to contribute to your health service's quality-improvement activities.

Criterion QI1.1: Quality-improvement activities

Indicators

QI1.1▶A Our health service has at least one team member who has the primary responsibility for leading our quality-improvement systems and processes.

QI1.1▶B Our health service team shares information internally about quality improvement and patient safety.

QI1.1▶C Our health service seeks feedback from the team about our quality-improvement systems and the performance of these systems.

QI1.1▶D Our health service team can describe areas of our health service that we have improved in the past three years.

Why this is important

Making quality improvements to your health service's structures, systems and clinical care leads to improvements in patient safety and care, particularly when the improvements are based on your health service's information and data.

It is essential that the health service team members are actively involved in your health service's safety and quality systems so they understand why the improvements need to be made, and can help to implement them.

Meeting this criterion

Roles and responsibilities

Having at least one team member responsible for leading quality improvement in your health service establishes clear lines of accountability. The responsibilities of this role must be agreed to and documented (eg in a position description).

Even if the quality-improvement functions in your health service are managed centrally outside of the health service, these functions need to be implemented locally at your health service location. As such, your health service must have at least one team member who has the primary responsibility for leading quality-improvement systems and processes at the health service.

At locations where transient staff are prevalent, it is important to document quality-improvement systems and processes to retain the knowledge of these processes.

Engaging the health service team

Quality improvement relates to many areas of an immigration detention facility's health service, so the collaborative effort of the entire health service team is necessary if you are to achieve improvements in the quality of care and patient safety.

You could improve engagement by establishing a quality-improvement team made up of members from all parts of your health service team (eg doctors, nurses and administrative staff).

Actively participating in quality improvement gives all members of your health service team an opportunity to come together to share information and consider how the health service can improve.

To improve engagement and obtain feedback from the health service team about quality-improvement initiatives and performance, you could:

- include quality improvement as a standing agenda item at team meetings
- provide notice boards or suggestion boxes for the team to contribute their ideas
- keep the team up to date with any system or process changes
- create short surveys to get the team's thoughts on initiatives.

Quality-improvement activities

Activities to improve your health service can involve examining the health service's structures, systems and clinical care. Relevant patient and health service data can help you identify where quality improvements can be made (eg patient access, management of chronic disease, preventive health).

Quality-improvement activities can include:

- changes to the day-to-day operations of the health service, such as:
 - scheduling of appointments
 - normal opening hours
 - record-keeping practices
 - how patient complaints are handled
 - systems and processes.
- responding to feedback or complaints from patients, carers or other relevant parties
- responding to feedback from members of the health service team
- auditing clinical databases
- analysing near misses and errors
- clinical improvement activities, such as:
 - improving vaccination rates
 - recording smoking status
 - using the model for improvement for change
 - setting specific, measurable, achievable, relevant, and time-bound goals.

Quality-improvement plans

Your health service could maintain a quality-improvement plan and a register of quality-improvement activities showing which have been undertaken, and their outcomes.

Using a quality-improvement plan and register means you can:

- track quality-improvement efforts
- identify whether improvements were made or other efforts are required to address the quality issue
- reduce duplication of effort and time
- evaluate the plan and effect of the activities conducted
- provide a learning tool for members of the health service team who want to be involved in improvement activities.

Meeting each indicator

QI1.1▶A Our health service has at least one team member who has the primary responsibility for leading our quality-improvement systems and processes.

You must:

- educate the team member with primary responsibility for quality-improvement activities in the health service about their role.

You could:

- document the responsibilities of this role in the position description
- develop a quality-improvement team made up of members of clinical and administrative staff.

QI1.1▶B Our health service team shares information internally about quality improvement and patient safety.

You must:

- have a system to identify quality-improvement activities.

You could:

- allocate time in each team meeting to discuss quality-improvement systems with your health service team
- keep a record of planning meetings where quality-improvement activities are discussed.

QI1.1▶C Our health service seeks feedback from the team about our quality-improvement systems and the performance of these systems.

You must:

- keep a record of feedback from the health service team about quality-improvement systems.

You could:

- have notice boards or suggestion boxes the team can use to contribute their ideas
- create short surveys for the team to complete that are incorporated into a quality-improvement plan.

QI1.1▶D Our health service team can describe areas of our health service that we have improved in the past three years.

You must:

- keep records of quality improvements made to the health service or health service systems in response to feedback, complaints or audits.

You could:

- keep minutes of meetings where improvements to the health service are discussed
- have a system for developing, mandating, implementing and reviewing policies and procedures
- include quality improvement as a standing agenda item at team meetings.

Criterion QI1.2: Patient feedback

Indicators

QI1.2▶ A Our health service collects feedback from patients, carers and other relevant parties in accordance with the RACGP's *Patient feedback guide*.

QI1.2▶ B Our health service analyses, considers and responds to feedback.

QI1.2▶ C Our health service informs patients, carers and other relevant parties about how we have responded to feedback and used feedback to improve quality.

Why this is important

Collecting and responding to feedback about patients' experiences has been shown to improve:

- clinical effectiveness and patient safety
- adherence to recommended medication and treatments
- preventive care, such as the use of screening services and immunisations.¹

Patients appreciate knowing that their feedback is taken seriously and acted on where possible.

Meeting this criterion

You must collect feedback from patients, consider the feedback and use it to improve the quality of your care.

Where possible, encourage patients, carers and other relevant parties to raise any concerns with the health service team directly. In response, your health service needs to attempt to resolve these concerns within the health service.

Patient feedback focuses on the whole patient experience with your health service. While complaints might be a part of patient feedback, they are no more important within this criterion than other aspects of the patient's experience. Information on managing a complaints resolution process is available at [Criterion C3.1: Business operation systems](#).

Collecting feedback

You can collect feedback using any method that meets the requirements of the RACGP's *Patient feedback guide*. When deciding how you want to collect feedback from your patients, consider the following:

- the kind of information you are seeking: broad, specific or in depth
- the time required to conduct patient feedback and analyse the results
- the demographics of your patients, including their education level and the range of languages they speak.

You can use any of the following methods to collect patient feedback:

- an RACGP-approved questionnaire developed by a commercial company
- a questionnaire developed in accordance with the RACGP's *Patient feedback guide*
- a focus group developed in accordance with the RACGP's *Patient feedback guide*
- interviews developed in accordance with the RACGP's *Patient feedback guide*

- a specific method that your health service decides on that meets the requirements of the RACGP's *Patient feedback guide* and is approved by the RACGP.

The RACGP's *Patient feedback guide* provides more detail on how to collect, analyse and use feedback from your patients.

You can choose to collect patients' feedback about their experience of accessing healthcare at your health service, either at one period during the three-year accreditation cycle or on an ongoing basis throughout the three years.

Collecting feedback all at once

If you choose to collect feedback all at once, this must be undertaken at least once every three years.

Collecting feedback on an ongoing basis

If you choose to seek feedback from patients on an ongoing basis over a three-year period instead of collecting it all at once, you could:

- have short questionnaires focusing on specific areas of interest (eg a new service, a change to the waiting areas), which patients could complete on paper or electronically (eg tablet or computer)
- hold patient forums and information days
- have an electronic tablet at the entrance to the health service so randomly selected patients could quickly rate an aspect of their visit to your health service (eg give it a score out of five).

If you choose to collect patient feedback on an ongoing basis, you need to ensure that the overall process still meets the requirements of the RACGP's *Patient feedback guide*.

The RACGP's *Patient feedback guide* provides more detail about how to collect patient feedback on an ongoing basis.

Collecting carers and other relevant parties' feedback on their experience

Your health service could collect feedback from carers and other relevant parties on their experience at or with your health service. These activities would be in addition to your patient feedback requirements. For example, you could offer carers and other relevant parties feedback forms or encourage them to use a suggestion box at reception.

Using feedback

Regardless of the method you use to collect patient feedback, you must analyse the feedback you receive and use it to improve the quality of your care.

Some of the suggestions made by patients will not be practical or feasible for your health service, so it is up to you to decide what feedback will be used and to prioritise activities based on the feedback.

After collecting and analysing patient feedback, identify key issues and decide on a quality-improvement plan. To do this, you could:

- convene a team meeting dedicated to this activity
- seek team members' opinions on the priority of the activities that will address patient feedback
- send each team member a summary of the feedback and ask them for their thoughts on what quality-improvement activities could be implemented
- consider which feedback aligns with the health service's strategic objectives.

Because patients value knowing that their feedback has been respectfully considered and implemented where possible, inform patients of the quality-improvement activities that you are planning to implement and those you have implemented. For example, you could display posters in the waiting area, include relevant information on your website and in your newsletter, and send letters to patients. If you have received a lot of feedback relating to something that is not feasible, you could tell patients why this suggestion is not viable for your health service.

Meeting each indicator

QI1.2▶A Our health service collects feedback from patients, carers and other relevant parties in accordance with the RACGP's *Patient feedback guide*.

You must:

- collect feedback from your patients in line with the requirements of the RACGP's *Patient feedback guide*.

You could:

- use the RACGP's *Patient feedback guide* to develop your own patient feedback process
- use a commercially available questionnaire that is approved by the RACGP
- conduct face-to-face patient feedback sessions, such as focus groups or interviews
- seek feedback from patients about specific areas of the health service.

QI1.2▶B Our health service analyses, considers and responds to feedback.

You must:

- keep records that show that you considered and discussed issues raised by patients, and have made improvements in response to their feedback.

You could:

- discuss patient feedback responses at team meetings
- create specific action plans to address issues raised by patients
- share the results and outcome reports about activities that were based on patient feedback with the health service team
- incorporate improvements into relevant policies and procedures.

QI1.2▶C Our health service informs patients, carers and other relevant parties about how we have responded to feedback and used feedback to improve quality.

You must:

- inform patients about how the health service has responded to feedback received.

You could:

- advise patients about how the health service has responded to patient feedback via health service newsletters, and in notices in waiting rooms.

Criterion Q11.3: Improving clinical care

Indicators

Q11.3A Our health service team uses a nationally recognised medical vocabulary for coding.

Q11.3▶ B Our health service uses relevant patient and health service data to improve clinical practice (eg chronic disease management, preventive health).

Why this is important

Using a nationally recognised medical vocabulary helps you to collect structured data that can be used to review clinical practices to improve quality and safety.

Collecting structured clinical data can help improve patient care because it can be used when:

- carrying out quality-improvement activities, such as audits and plan, do, study, act (PDSA) cycles
- implementing processes that identify patients with particular medical conditions (eg registers for chronic diseases, such as diabetes).

Meeting this criterion

Standardised clinical terminology

Using a nationally recognised medical vocabulary means that:

- key details of a consultation (eg why a patient attends the health service, the problems managed during a consultation, referrals and requested investigation) are recorded in a standardised way
- data can be retrieved for auditing, quality improvement and continuity of care
- analysis of your health service's data is more accurate and reliable
- there will be less ambiguity, which is sometimes the case when free text descriptions are used in a patient's health record.

Nationally recognised medical vocabularies, such as the World Health Organization's International Classification of Primary Care (ICPC) and SNOMED CT, help to ensure that data is recorded consistently and can be used for multiple purposes, such as chronic disease registers and population health research.

Most clinical software systems in Australia use a recognised medical vocabulary (eg DOCLE, PYEFINCH, SNOMED CT, ICPC and ICPC2+).

If you are using a software system that does not use a nationally recognised medical vocabulary, you might consider how you could include one in your patient health records.

You do not necessarily need to re-code existing information previously recorded as free text, particularly if there are important details in a patient's medical history that are difficult to formally code, but adding some standardised vocabulary might be useful.

You could also develop a policy and process to implement a recognised medical vocabulary to ensure consistency in newly created records and when updating records.

Improving clinical practice

Quality improvement is an essential part of routine care that involves making changes that will increase quality and safety for patients.

Quality-improvement activities can include activities specifically designed to improve clinical care or the health of the entire health service population, such as changes to:

- rates of immunisation
- how the health service cares for patients who have experienced torture and trauma
- how the health service cares for patients with chronic pain syndromes, diabetes or hypertension
- systems used to identify risk factors for illnesses that are particularly prevalent in the health service's local community/immigration detention facility (eg blood-borne virus) and countries of origin relevant to patient population
- antibiotic prescribing to improve clinical care and/or the health of the entire health service population.

Improving clinical practice through clinical audits

You can undertake a clinical audit to improve your clinical practice. A clinical audit is a planned medical education activity designed to help practitioners systematically review aspects of their own clinical performance against defined best practice guidelines. The two main clinical audit components are:

- an evaluation of the care that a health service and its individual practitioners provide
- a quality-improvement process.

Research indicates that the process of audit and feedback is widely used to improve professional practice. The process of audit and feedback can be used on its own or as part of multifaceted quality-improvement intervention, and can often lead to small but potentially important improvements in practice.²

Improving clinical practice through PDSA cycles

You could also choose to complete a PDSA cycle to improve your clinical practice. PDSA cycles encourage the individual practitioner or the health service team to implement a planned improvement by breaking it down into small, manageable stages. The PDSA stages are completed one at a time, and small changes achieved at each stage are tested to make sure that improvement has occurred without wasted effort before moving to the next stage.

PDSA cycles emphasise starting on a small scale and reflecting and building on the learning that occurs during each stage. PDSA cycles can be used to quickly and easily test suggested improvements that are based on existing ideas and research, or to implement practical ideas that have been proven to work elsewhere.

It is a cyclical model because the benefit you planned is not always achieved after one PDSA cycle. Therefore, the initial PDSA can be refined and the cycle repeated as many times as necessary to reach the desired benefit.

A PDSA cycle can be undertaken by an individual practitioner, a group of health professionals and/or a multidisciplinary team. Common targets of PDSA cycles include:

- medication refills
- adult immunisations
- diabetes or hypertension screening and care

- no-show rates
- results reporting.

Further information on clinical audits is available on the RACGP [CPD 2020–22 Triennium website](#).

Other sources of information

To improve the targeting and use of your prevention activities (eg smoking cessation, weight management), you might wish to collect data from other sources, such as:

- your clinical software or paper-based systems about, for example, smoking status
- your diabetes register
- pathology services that provide, for example, diabetes screening and cervical screening
- data reports that you can use as benchmarks to identify gaps, areas and opportunities for improvement to assist in health service planning. You can access these reports by participating in quality-improvement programs that are provided by regional healthcare coordination organisations.

Meeting each indicator

QI1.3A Our health service team uses a nationally recognised medical vocabulary for coding.

You could:

- use patient management software to code patient health information
- keep clinical data and reports, such as rates of childhood vaccinations, completed adult health checks and updated risk factors.

QI1.3►B Our health service uses relevant patient and health service data to improve clinical practice (eg chronic disease management, preventive health).

You must:

- **show evidence that you have conducted a quality-improvement activity, such as a PDSA cycle or clinical audit, at least once every three years.**

You could:

- use coded patient health information to audit patient health records and compare clinical practice
- maintain a continuous improvement register
- maintain a clinical audit based on a quality-improvement plan completed by the health service team
- participate in an audit on antibiotic prescribing.

QI Standard 2

Clinical indicators

Our health service records and uses patient data to support quality-improvement activities.

Having accurate and up-to-date information about patients helps your health service provide safe, high-quality care, and ensures that other healthcare providers to whom you refer a patient also provide a suitable standard of care.

Health summaries reduce the risk of inappropriate management, including medicine interactions and adverse side effects (particularly when allergies are recorded).

Having accurate and up-to-date information on medicines means that you can achieve best practice prescribing.

Criterion QI2.1: Health summaries

Indicators

QI2.1 ► A Our active patient health records contain a record of each patient's known allergies.

QI2.1 ► B Each active patient health record has the patient's current health summary that includes, where relevant:

- adverse drug reactions
- current medicines list
- current health problems
- past health history
- immunisations
- family history
- health risk factors (eg smoking, nutrition, alcohol, physical activity)
- social history, including cultural background
- preferred language and interpreter requirements.

QI2.1C Our active patient health records contain, where relevant, a record of each patient's:

- assigned sex at birth
- variations of sex characteristics
- gender.

Why this is important

Maintaining clear and accurate patient health records is essential if your health service is to provide high-quality care.⁹ A good health summary helps practitioners, locums, medical practitioners in training and students to obtain an overview of all components of the patient's care so as to continue to provide safe and effective care.

Health summaries:

- reduce the risk of inappropriate management, including medicine interactions and side effects (particularly when allergies are recorded)
- provide an overview of social circumstances and family history that is vital to holistic care
- highlight lifestyle and risk factors (eg smoking, nutrition, alcohol, physical activity) that can help practitioners to promote healthy lifestyles
- highlight risk factors associated with chromosomal, gonadal and/or anatomical characteristics (particularly when a patient's gender identity and assigned sex at birth are different, or a patient advises they have innate variations of sex characteristics)
- help prevent disease by tracking immunisation and other preventive measures.

Meeting this criterion

A patient's health summary must give a practitioner sufficient information to enable them to safely and effectively provide care for the patient.

The RACGP encourages you to work towards all of your active records containing a current health summary, including a record of known allergies. However, to satisfy this criterion, your health service must have a:

- record of known allergies for at least 90% of your active patient health records
- current health summary for at least 75% of your active patient health records.

If a patient has no known allergies, a practitioner must verify this with the patient and then record 'no known allergies' in the patient's health record. If your health service uses a hybrid health record system, you must record the patient's allergy status in whichever system is used for prescribing.

You could also record:

- patients' assigned sex at birth, variations of sex characteristics (intersex) and gender separately
- aspects of a patient's social history if this might increase their risk of health issues. For example, you might record a patient's refugee status, where they live (eg urban, rural, remote), and information about their sexual partners and/or activity
- factors and events associated with immigration detention that can affect the patient's physical and mental health, including appeal and litigation outcomes, or movement between immigration detention facilities
- recent important events in a patient's life that could affect the patient's preferences, values and care they require (eg changes in accommodation, carer arrangements, family structure, and employment).

It is good practice to ask patients if they are taking any medicines not prescribed by the health service or if they are using complementary therapies, and to record this information in their patient health record.

Meeting each indicator

QI2.1 ► A Our active patient health records contain a record of each patient's known allergies.

You must:

- include records of known allergies in active patient health records
- record allergies for at least 90% of your active patient health records.

You could:

- keep records of when GPs ask patients about allergies.

QI2.1 ► B Each active patient health record has the patient's current health summary. Refer to indicators in **Criterion QI2.1: Health summaries**.

You must:

- keep a current health summary in each active patient's health record.

You could:

- conduct a regular audit of patient health records.

QI2.1C Our active patient health records contain, where relevant, a record of each patient's:

- assigned sex at birth
- variations of sex characteristics
- gender.

You could:

- record in each active patient health record the patient's assigned sex at birth
- record in each active patient health record whether the patient has variations of sex characteristics
- record in each active patient health record the patient's gender.

Criterion QI2.2: Safe and quality use of medicines

Indicators

QI2.2▶ A Our patients are informed of the purpose, importance, benefits and risks of their medicines and treatments.

QI2.2▶ B Our patients are made aware of their role in their own treatment.

QI2.2▶ C Our clinical team accesses current information on medicines, and reviews our prescribing patterns, in accordance with best-available evidence.

QI2.2▶ D Our clinical team ensures that patients and other health providers to whom we refer them receive an accurate and current medicines list.

QI2.2▶ E Our clinical team ensures that medicines, samples and medical consumables are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and relevant laws.

Why this is important

If patients understand the reason for taking medications, and the benefits and risks associated with particular medicines, they can make informed decisions about their treatment and will be more likely to follow the recommended treatment plan.

Having access to current information about medicines enables practitioners to engage in best practice prescribing of medications for patient care.

Antimicrobial resistance is a significant and growing global health issue that must be addressed in a unified and strategic manner. By including an antimicrobial stewardship program in your service, you can help to maintain the effectiveness of antibiotics.

Antimicrobial stewardship can help prevent the emergence of antimicrobial resistance and decrease preventable healthcare-associated infection.

Patients must not use medicines, samples or medical consumables that have been prescribed for other patients and/or after their expiry dates.

Meeting this criterion

Medication purpose, options, benefits and risks

Consumer Medicines Information (CMI) leaflets can help patients to understand the purpose, options, benefits and risks of their medicines.

It is particularly important that patients understand the difference between generic drugs and trade-named drugs so that dosage problems are avoided. If a patient has low levels of literacy, or the information is not available in the patient's preferred language, it might be appropriate to use visual media or translators.

Patients' role in their own treatment

Providing patients with education not only improves their knowledge but is also likely to improve their adherence to treatment plans. One of the most commonly recommended strategies to improve patients' adherence is to build the patient–practitioner relationship.⁴

You could also tell patients about a number of electronic resources so that they can find out more about their medications and the purpose of their treatments. These include:

- the NPS MedicineWise [Medicine Finder](#)
- the Victorian Government's [Better Health Channel](#).

Using and reviewing best practice treatment

Your health service could use guidelines for the quality use of medicines. Some available resources include:

- the [Australian medicines handbook](#) (jointly owned by the RACGP, the Pharmaceutical Society of Australia, and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists
 - [Therapeutic Guidelines](#)
 - [Therapeutic Guidelines: Antibiotic](#) to promote and support informed prescribing of antibiotics
 - Department of Veterans' Affairs [Medicines Advice and Therapeutics Education Services \(Veterans' MATES\)](#).

You could reinforce key messages with patients about appropriate antibiotic use and actions that can be taken to reduce antibiotic resistance.

Current medicines list

Practitioners need to regularly review a patient's current medications to ensure that the list in their health record is up to date and to reduce the risk of errors being made when prescribing or referring.

Take particular care when prescribing medicines that sound alike or look alike, particularly when selecting from drop-down boxes in clinical information systems.

A practitioner must:

- confirm a patient's current medicines list and known allergies before prescribing or changing treatment
- mark acute medications, including antibiotics, as non-current when they are no longer required (some clinical software packages will automatically mark acute medicines as non-current when the calculated duration of the supply has expired)
- use reviews of the patient's medicines list as an opportunity to assess the patient's compliance with their medication regimen, and identify the need for any further education or support.

Practitioners also need to ask the patient about any medicines that were not prescribed or advised within the health service because of the potential for side effects and drug interactions.

The confirmed list of the patient's current medication must be included in letters of referral, including those for hospital admissions.

When a practitioner changes a patient's medication, it is good practice to provide the patient with a new medicines list, particularly when the patient is taking more than one medicine.

Storage of medicines

To ensure patients' safe use of medicines, vaccines and other healthcare products, store these products appropriately and securely, and do not use or distribute them after their expiry dates. You could appoint a designated person to have primary responsibility for the proper storage and security of medicines, vaccines and other healthcare products.

Requirements relating to the acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation, and health services need to comply with these laws.

Meeting each indicator

QI2.2▶A Our patients are informed of the purpose, importance, benefits and risks of their medicines and treatments

You must:

- keep documentation regarding discussions of medicines and treatments in the patient's health record.

You could:

- use videos, brochures or posters to inform patients about medicines
- refer patients to relevant approved electronic information portals.

QI2.2▶B Our patients are made aware of their role in their own treatment.

You must:

- keep records that show that clinical team members have discussed the patient's roles in their own treatment.

You could:

- provide patients with consumer medicine information
- provide patients with a written action plan.

QI2.2▶C Our clinical team accesses current information on medicines, and reviews our prescribing patterns, in accordance with best-available evidence.

You must:

- keep documentation relating to medicines reviews in patient health records, including information given to the patient about the purpose, importance, benefits and risks of their medicines
- use a current clinical software program.

You could:

- use current best-evidence medicine guidelines
- develop and implement policies or protocols in areas such as antibiotics and drugs of dependence.

QI2.2▶D Our clinical team ensures that patients and other health providers to whom we refer them receive an accurate and current medicines list.

You must:

- maintain an accurate and current medicines list in each patient's health record
- include an accurate and current medicines list with patient referral letters.

You could:

- conduct regular audits of each patient's health record to bring medicines lists up to date and mark acute medications as non-current.

QI2.2►E Our clinical team ensures that medicines, samples and medical consumables are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and relevant laws.

You must:

- acquire, store, administer, supply and dispose of medicines, samples and medical consumables according to manufacturers' directions and relevant laws
- maintain a Schedule 8 medicines register (if your health service administers Schedule 8 drugs).

You could:

- maintain a continuity plan considering the risks associated with the storage of Schedule 8 medicines and compliance with drugs of dependency permits.

QI Standard 3

Clinical risk management

Our health service has clinical risk-management systems to improve the safety and quality of our patient care.

Clinical risk management is the process of improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm, and then acting to prevent or control those risks.⁵ You need to foster a just, open and supportive culture to minimise and respond to near misses and adverse events.

Adverse events and near misses are events or circumstances that could have resulted, or did result, in unnecessary harm to a patient.⁶ Both are valuable learning opportunities from which you can gain insights into how to improve your health service and preserve life and health.

While individual accountability and integrity is essential, blaming individual practitioners does not identify inherent problems in your systems and processes. It is far more effective to be thoughtful and supportive.

Members of the health service team must know how and whom to report a near miss or adverse event, or an unanticipated patient outcome.

The clinical governance of your health service gives you management and organisational structure for continuously improving the quality of your services and patient care.⁷ It creates an environment where excellence in clinical care will flourish because all team members accept responsibility for the services and care the health service provides.^{8,9}

Criterion QI3.1: Managing clinical risks

Indicators

QI3.1 ► A Our health service monitors, identifies, responds to and reports near misses and adverse events in clinical care.

QI3.1 ► B Our health service team makes improvements to our clinical risk-management systems to prevent near misses and adverse events in clinical care.

Why this is important

Patient safety incidents in clinical care occur in all health settings. Incidents that cause harm are referred to as 'adverse events'.¹⁰ Those that had the potential to cause harm, but did not, are referred to as 'near misses'.

If the health service does not make improvements after identifying an incident that resulted in a near miss or an adverse event, patients might be exposed to avoidable future adverse events and the health service team might increase their risk of medico-legal action.

If you use systems to recognise and analyse near misses and adverse events, you can identify, implement and test solutions to prevent them happening again.

This includes having systems and processes in place to support infection prevention and control.

Meeting this criterion

Most practitioners and health services already manage clinical risk on a daily basis. Many have informal and ad-hoc methods aimed at preventing near misses and adverse events.

To reduce near misses and adverse events, you could:

- establish a system so that practitioners talk to trusted peers and supervisors for advice
- use a formal process of discussing within the health service what went wrong and how to reduce the likelihood of it happening again
- use structured techniques to analyse the causes of near misses and adverse events to reduce the likelihood of recurrence
- establish a system so that members of the health service team know how and to whom to report a near miss or adverse event, and that they can do so without fear of recrimination
- establish a system so that members of the health service team are aware of critical incidents and how to avoid critical incidents in the future if found to have occurred (for more information on critical incident reporting, refer to [Criterion C3.2: Accountability and responsibility](#))
- keep copies of the health service's risk or critical incident register
- monitor the effectiveness of systems and processes for infection prevention and control (eg standard precautions)
- implement a clinical governance framework to help achieve a balance of 'find it', 'fix it' and 'confirm it' functions to improve the quality and safety of care
- find it: use tools, such as clinical audits and performance indicators, to identify where quality-improvement programs could improve the quality of care and patient health outcomes

- fix it: after identifying where improvements can be made, implement strategies to address the issue
- confirm it: measure the outcomes of the improvement using an effective evaluation process.

You might want to have your medical defence organisation check and approve your process for recording and responding to near misses and adverse events.

To reduce near misses and adverse events during periods of crisis, emergency or disaster, your health service must ensure that it has appropriate systems in place to receive relevant public health notifications. You must also ensure that the information is distributed to all health service team members in a timely manner.

Practitioners are increasingly referred to as the 'second victims' of adverse events because they can often feel that they have failed the patient,¹¹ which can lead to them second-guessing their clinical judgement and knowledge. You could therefore consider how to support practitioners after an adverse event has occurred.

Meeting each indicator

QI3.1 ► A Our health service monitors, identifies, responds to and reports near misses and adverse events in clinical care.

You must:

- implement and maintain an incident or event register
- review existing monitoring processes and activities to identify if there are any deficiencies or if amendments are required.

You could:

- implement and maintain a clinical risk-management policy
- conduct clinical audits
- make and document changes to reduce the risk of identified issues and to prevent adverse outcomes
- keep a record of team meetings and planning meetings where risks are discussed.
- include near misses and adverse events as a standing agenda item at team meetings.

QI3.1 ► B Our health service team makes improvements to our clinical risk-management to prevent near misses and adverse events in clinical care.

You must:

- record the actions taken in response to events recorded on the incident or event register.

You could:

- record revisions to policies and procedures that have been shown to reduce risk.

Criterion QI3.2: Open disclosure

Indicator

QI3.2A Our health service follows an open disclosure process that is based on the **Australian Open Disclosure Framework**.

Why this is important

Open disclosure is defined in the **Australian Open Disclosure Framework** as ‘an open discussion with a patient about one or more incidents that resulted in harm to the patient while they were receiving healthcare’.

The RACGP has endorsed the Australian Open Disclosure Framework, which was developed by the ACSQHC.

Implementing the Australian Open Disclosure Framework in small services (as opposed to hospitals) is available at www.safetyandquality.gov.au/publications/implementing-the-australianopen-disclosure-framework-in-small-practices

Health professionals have an obligation to:

- respectfully explain to patients when things go wrong
- offer an expression of regret or genuine apology (if warranted)
- explain what steps have been taken to ensure that the mistake is not repeated.

Communicating openly and honestly following adverse events is a way of showing compassion towards patients and can improve patient–practitioner relationships and allow patients to be more engaged in their own care.

Meeting this criterion

The Australian Open Disclosure Framework states that open disclosure includes:

- acknowledgement to the patient that something has gone wrong, either in response to their enquiry or initiated by the service
- an apology or expression of regret (including the word ‘sorry’)
- a factual explanation of what happened
- an opportunity for the patient to share their experience with the health service
- an explanation of the steps being taken to manage the event and prevent a recurrence (eg changes to service provision, policy, procedures and guidelines).

Open disclosure is a discussion and exchange of information that might take place over several meetings. To meet this criterion, team members need to listen to what the patient says in response to the health service’s open disclosure and demonstrate that the health service has learnt from the incident. Incidents and near misses can be recorded in the patient’s record as per the Australian Open Disclosure Framework.

Disclosure to the patient following an incident that caused harm is beneficial to both the patient and the health service. Disclosure might also be appropriate where no harm appears to have been caused, especially if there is reasonable likelihood of harm resulting in the future as a result of the incident.

Contact your medical defence organisation and insurers for further guidance and advice about when you might need to participate in open disclosure, and what kind of documentation they would require for risk-management initiatives.

Meeting each indicator

QI3.2A Our health service follows an open disclosure process that is based on the [Australian Open Disclosure Framework](#).

You could:

- maintain an open disclosure process and encourage all members of the health service team to follow the process
- develop and implement policies and guidelines that align with the Australian Open Disclosure Framework
- keep a record of any discussions and apologies
- implement quality-improvement initiatives (eg develop a brochure to give patients more information about a particular issue)
- record any incidents in the patient's record
- maintain a system to manage complaints that promotes patient satisfaction and records outcomes
- educate practitioners about the Australian Open Disclosure Framework for small health services so that they understand when they might need to undertake open disclosure
- discuss open disclosure at team meetings
- discuss open disclosure during induction.

References

1. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* 2013;3:e001570.
2. Ivers N, Jamtvedt G, Flottorp S, et al. Audit and feedback: Effects on professional practice and healthcare outcomes. *Cochrane Database Syst Rev* 2012;6:CD000259.
3. Medical Board of Australia. Good medical practice: A code of conduct for doctors in Australia. Canberra, ACT: MBA, 2014.
4. Aslam I, Feldman, SR. Practical strategies to improve patient adherence to treatment regimens. *South Med J* 2015;108(6):325–31.
5. World Health Organization. Patient safety curriculum guide: Multi-professional edition. Geneva: WHO, 2011.
6. Runciman W, Thomson R, Van Der Schaaf T, Sherman H, Lewalle P. Towards an international classification for patient safety: Key concepts and terms. *Int J Qual Health Care* 2009;21(1):18–26.
7. Buetow SA, Roland M. Clinical governance: Bridging the gap between managerial and clinical approaches to quality of care. *Qual Health Care* 1999;8(3):184–90.
8. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney, NSW: ACSQHC, 2012.
9. Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61.
10. World Health Organization. Conceptual framework for the international classification for patient safety (version 1.1). Geneva: WHO, 2009.
11. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider 'second victim' after adverse patient events. *Qual Saf Health Care* 2009;18(5):325–30.

Immigration detention facilities module

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IDF Standard 1

Access to care

Our health service provides timely care and advice for individuals in detention, 24 hours a day.

Your health service must have a system in place to provide care to patients 24 hours a day, seven days a week. Standard 1 recognises that 24-hour care might not always mean access to a member of the health service team. This might be an external health advice service that is coordinated and contracted by the health service provider and staffed by appropriately qualified staff.

This standard includes criteria that relate to providing access to comprehensive care in an immigration detention facility health service context. They include:

- triage of patients so that the most appropriate care is provided
- ability for the health service to conduct visits to patient's living quarters
- ability for individuals in detention to receive care 24 hours a day.

Criterion IDF1.1: Responsive system for patient care

Indicators

IDF1.1 ► A Our health service provides different consultation types to accommodate patients' needs.

IDF1.1 ► B Our health service maintains staffing for the safe delivery of care.

IDF1.1 ► C Our health service can demonstrate that patients can directly access the health service during normal opening hours.

IDF1.1 ► D Our health service has a triage system that enables access to timely care.

IDF1.1 ► E Our patients are aware of, and can access, care in an emergency.

Why this is important

The health service team is required to be able to identify patients' needs and provide appropriate care to treat patients effectively. Patients need to be referred to the right clinician to receive the right level of care within an appropriate period. Patients with urgent needs must be seen quickly.

Your health service must ensure patients are aware of what to do in the event of an emergency. When patients call the health service in the event of an emergency, they are not to be put on hold and must be directed to alert immigration detention facility staff (eg security staff) immediately.

Direct patient access to the health service allows for greater assurances of confidentiality and privacy, enhanced self-agency for individuals and mitigation of medico-legal risk arising from reliance on non-clinical staff to identify medical needs. Patients must have direct access to the health service where possible and not have to rely on other parties (such as non-health members of the immigration detention facility staff) to mediate their request for access. Health services must endeavour to facilitate patients' access to onsite or telephone interpreters and to translated health information if the health staff do not speak a patient's preferred language.

Meeting this criterion

Consultations accommodate different patients' needs

Patients must be able to access care that is flexible and reflects their particular needs.

Based on patients' needs, you are required to provide different:

- multidisciplinary consultations that meet the needs of your patients (eg these might include services from a GP, mental health nurse, psychologist)
- types of consultation (eg brief or extended duration)
- types of care (eg complex and preventive)
- levels of access (eg appointment systems, walk-in, urgent services).

To manage appointments, keep an appointment book (electronic or paper-based) in which you can arrange and record a variety of appointment types, including, but not limited to:

- long
- short
- walk-in
- recall
- reserved times for urgent appointments on the day.

Members of the health service team must assess the length of consultation a patient requires based on the patient's needs. For example, the health service team could suggest a longer consultation if the patient is attending for multiple or complex problems, chronic disease management or procedures. Longer consultations might also be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if the patient's carer or interpreter will be present. Some patients might always need longer appointments.

When there is an emergency, health service team members need to:

- update the patient waiting list
- explain to waiting patients that there has been an emergency and that this might increase their waiting time
- notify other patients who have not yet arrived that their appointment might be later than scheduled.

Your health service does not require a formal appointment system to meet this criterion. For example, some health services do not take appointments, but accept patients on a walk-in basis. If your health service prioritises patients according to urgency of need, and adequately informs patients of anticipated waiting times, you are accommodating patients' needs.

Maintaining staffing for the safe delivery of care

Your health service must ensure that, in lieu of alternative arrangements, there are staff available to meet the needs of your patient population in terms of both practitioner training and the number of staff available.

In remote locations (including offshore facilities) where access to alternative care (eg hospital) is not possible, staff trained in basic life support must be available. If your health service's patient population includes children up to the age of 18 years, staff trained in paediatric life support must be available. In addition, advanced life support could be provided remotely (eg telehealth support to rural area nursing staff or other staff).

If there are times your health service has no staff available, you must be able to explain arrangements for your patient population to access care.

Telehealth consultations

You can conduct telehealth patient consultations (eg via telephone and internet-based video services) in place of in-person consultations. When conducting a telehealth consultation, the practitioner must:

- confirm the identity of the patient using three patient identifiers (eg their full name, date of birth and address)
- advise the patient of the security and privacy risks associated with telehealth consultations
- obtain the patient's prior written consent, if possible, before the consultation takes place.

You could:

- offer telehealth consultations in line with advice provided in the RACGP's *Guide to providing telephone and video consultations* in general practice.

The Medical Board of Australia's [Guidelines for technology-based patient consultations](#) provides further information that you might find useful.¹ You might also wish to obtain advice from your medical defence organisation regarding the suitability of providing advice by telephone or electronic means.

Triage

All members of the health service team must know how the health service:

- identifies patients with an urgent medical need
- identifies medical emergencies and reprioritises appointments accordingly
- seeks urgent medical assistance from a clinical team member
- deals with patients who have urgent medical needs when the health service is fully booked/at capacity or at surge capacity.

Training could be provided so that administrative staff members and members of the clinical team can identify patients in need of urgent care. Training for triage protocols can be delivered inhouse by a health service member or by an external training provider.

As administrative staff members might need to access patient health records so they can inform the clinical team of triage responses, they must know and comply with requirements relating to confidentiality of patient health records.

If patients have direct access to your health service (eg by telephone or walk-in), they might share their health concerns with non-health staff (eg the person who answers the phone or who is available when the patient enters the service). This might make it necessary for administrative or other non-health staff members to assess the urgency of the need for care, effectively triaging patients.

Therefore, administrative staff members need to know:

- that they must ask: 'Is the matter urgent or can you wait/may I put you on hold?' before asking the patient to wait
- which presentations they need to transfer to the clinical team.

Telephone triage is not applicable if individuals in detention do not have access to telephones.

Managing cross-infection through triage

Some patients might have a contagious illness, and your health service needs to reduce the risks of the health service team and other patients becoming infected. The health service team must be familiar with the health service's infection-control procedures, including the use of standard and transmission-based precautions, spills management, and environmental cleaning. Refer to [Criterion IDF4.1: Infection prevention and control, including sterilisation](#) for more information about infection prevention and control.

Non-health stakeholders working at the immigration detention facility (eg security staff) must be aware of triage procedures for a patient. These staff must notify the health service if they are concerned about an individual (eg that the individual might have a highly contagious infection, or is at high risk of harm).

If patients have the ability to contact the health service from elsewhere in the immigration detention facility (eg by phone, via a staff member), effective triage can identify the risk of infection before a patient presents at the health service.

Your health service must use transmission- and/or aerosol-based precautions for a patient known or suspected to be infected with a highly transmissible infection. You can minimise exposure to other patients and the health service team by:

- implementing effective triage and appointment scheduling
- determining and applying the most appropriate transmission- and/or aerosol-based precautions to adopt, in addition to standard precautions (eg type of personal protective equipment [PPE], including particulate respirators, surgical masks, gowns, protective eyewear and gloves)
- implementing distancing techniques, such as:
 - spacing patients in the health service in line with relevant health authority guidance
 - isolating the infected patient in a separate space (refer to **Criterion IDF4.1: Infection prevention and control, including sterilisation** for more information).
- strictly adhering to the use of standard and transmission- and/or aerosol-based precautions
- conducting a living quarters visit
- employing a public health approach to outbreak control (including contact tracing, screening and treating contacts) and communicating this to the broader immigration detention facility.

Meeting each indicator

IDF1.1 ► A Our health service provides different consultation types to accommodate patients' needs.

You must:

- provide consultations across a variety of medical disciplines relevant to your patient population
- provide a variety of consultation types and retain evidence of this.

You could:

- document and keep up-to-date care plans, reviews and health summaries in each patient's health records
- keep an appointment system (electronic or paper-based) showing a variety of appointment types, including:
 - long
 - short
 - walk-in
 - recall
 - reserved times for urgent appointments on the day.
- display a sign in the patient waiting area explaining short, standard and long appointments
- display a sign, visible at all times, providing the contact details for urgent care that is available outside normal opening hours
- offer telehealth consultations.

IDF1.1 ► B Our health service maintains staffing for the safe delivery of care.

You must:

- ensure that, in lieu of alternative arrangements, there is adequate staff availability to meet the needs of your patient population

- ensure that available staff are trained to meet the needs of your patient population
- ensure patients have immediate access to clinical staff trained in advanced life support
- ensure child patients up to the age of 18 years have immediate access to clinical staff trained in paediatric life support.

You could:

- demonstrate alternative arrangements your health service has in place if no staff are available at your health service (eg on-call arrangements)
- demonstrate alternative arrangements your health service has in place to provide advanced life support to patients when needed.

IDF1.1 ► C Our health service can demonstrate that patients can directly access the health service during normal opening hours.

You must:

- demonstrate how patients can request access to the health service during normal opening hours
- demonstrate how patients at the facility where your health service is located are informed about making requests to access to the health service
- demonstrate how patients access care when no staff are available at your health service.

You could:

- display signs in commonly used languages, visible at all times, providing detail on how patients can make a request to access the health service.

IDF1.1 ► D Our health service has a triage system that enables access to timely care.

You must:

- have a triage system that enables access to timely care
- prioritise patients according to urgency of need, and retain evidence of this
- demonstrate how your health service responds to requests for consultation when the immigration detention facility is below capacity, at capacity or at surge capacity.

You could:

- have triage guidelines at the reception area
- have a triage flowchart available for reception staff members and the clinical team
- display a sign in the waiting area and areas around the immigration detention facility where patients make health service appointments advising patients who have a high-risk condition or deteriorating symptoms to advise appropriate staff members (eg immigration detention facility security staff, health service reception staff)
- show evidence that administrative staff members update the patient waiting list if there has been an emergency, and that they explain to patients that this might increase their waiting time.

IDF1.1 ► E Our patients are aware of, and can access, care in an emergency.

You must:

- ensure patients have access to timely care in an emergency
- advise patients how they can access care in an emergency.

You could:

- display information on posters or leaflets throughout the facility, in the commonly used languages of your patient population, that advise patients to alert immigration detention facility staff (eg security staff) if they have an emergency
- train reception staff members in triage and how to respond to an emergency
- have triage guidelines at the reception area
- have a triage flowchart available for reception staff members.

Criterion IDF1.2: Living quarters visits

Indicator

IDF1.2▶A Our patients can access medical care provided in living quarters when safe, reasonable and practicable.

Why this is important

Individuals in detention who are unable to attend your health service (eg patients with disability or impairment, or those with a contagious infection) need to be able to access care within their living quarters from your health service team.

Meeting this criterion

You need to consider how to provide continuity of care to patients who are not able to physically attend the health service.

Making visits to patients' living quarters

A member of the clinical team normally performs a visit to a patient's living quarters.

It is appropriate to visit a patient at their living quarters, instead of them coming into the health service, when:

- the patient is confined due to illness or disability
- urgent treatment can be provided more quickly
- you want to reduce the risk of infection.

To determine the circumstances in which a visit to living quarters is offered, your health service could have policies that specify:

- factors to be considered when deciding if a living quarters visit is safe and reasonable
- personal circumstances and health concerns that necessitate a living quarters visit
- possible alternative arrangements if a living quarters visit is not possible.

Members of the health service team need to know the conditions in which a visit to a patient's living quarters is deemed appropriate according to the health service's policy.

Defining 'reasonable' in the local context

Your health service needs to decide what is 'reasonable' in your local context, with consideration of your health service's location and patient population. To determine if a living quarters visit is 'reasonable', consider:

- if it is clinically appropriate to conduct a living quarters visit
- whether it is safe to conduct a living quarters visit based on issues, such as potential for violence or risk of infection
- whether the circumstances mean the patient needs to be visited at their living quarters instead of coming into the health service.

One approach is to consider what your peers, particularly those working in immigration detention settings, would agree is reasonable.

Your health service team needs to manage the risk of cross-infection during a visit to living quarters as they would at the health service (see [Criterion IDF4.1: Infection prevention and control, including sterilisation](#)). This includes:

- ensuring health service team members who will be conducting visits to living quarters have the skills to assess the risk of transmission of infection and determine the type of precautions required to minimise that risk
- providing PPE to all members of the health service team who will be conducting visits to living quarters
- prescreening patients and other third parties who will be present at the appointment for symptoms, as routine clinical assessment
- ensuring that clinicians themselves are not a risk to patients and other third parties (ie consider an individual clinician's infection or exposure status prior to conducting a visit to living quarters).

Additional risk-screening and mitigation measures will need to be put in place in the event of a pandemic or local disease outbreak, including minimising close contact and the number of people present during the home visit.

Alternatives to living quarters visits

When a living quarters visit is unreasonable, your health service must be able to describe an alternative source of care that the patients can access, such as telehealth or video consultations. When determining alternative systems of care, you could consider what other immigration detention facility health services do when a living quarters visit is unreasonable.

In deciding whether to offer video consultation services as an alternative to face-to-face consultations, you need to consider:

- patient safety
- patients' clinical needs
- clinical effectiveness
- patient preference
- availability of telehealth facilities
- conditions of your professional indemnity insurance.

Meeting each indicator

IDF1.2▶A Our patients can access medical care provided in living quarters where safe, reasonable and practicable.

You must:

- record in patients' health record when team members have made visits to patient living quarters
- tell patients about how they can access care when a living quarters visit is unreasonable, and provide evidence that these conversations have occurred.

You could:

- have a policy explaining the circumstances that would make a living quarters visit reasonable.

Criterion IDF1.3: Care outside of normal hours of health service operation

Indicators

IDF1.3▶A Our patients are informed about how they can access after-hours care.

IDF1.3▶B Our patients can access after-hours care.

Why this is important

Patients sometimes require medical care outside the normal hours of health service operation. Individuals in detention are unable to access community after-hours health service providers, and therefore require a system to support them to access urgent care if needed.

The immigration detention facility health service might be the only way for individuals in detention to receive medical attention. If this is the case, your health service must have arrangements in place with the clinical team to ensure care can be provided at any time.

Meeting this criterion

Informing patients about care outside of normal hours of health service operation

Your health service must inform patients of your normal hours of health service provision and the arrangements for care outside of those hours. To do this, use one or more of the following:

- health service staff remind patients of the arrangements for after-hours care when they visit the service
- clearly visible signage at the health service, in the accommodation living quarters or areas where individuals in detention can make appointments that indicates your normal operating hours and the arrangements for care outside of those hours
- relevant information on your health service's written materials (eg orientation book, pamphlets)
- inform immigration detention facility non-health staff.

Any messages or signage must be provided in the commonly used languages of your patient population.

After-hours care

For your patients to be able to access care after-hours, your health service could deliver after-hours care directly.

It is recognised that after-hours care might not always mean access to a member of the health service team. After-hours care might also be provided on behalf of your health service; however, there must be a direct and continuing relationship between your health service's clinical team and the clinicians who perform the after-hours care on their behalf.

This could be done by having:

- formal arrangements in place with other providers, such as a medical deputising service, to deliver after-hours care
- an agreement with local healthcare providers that operate outside of your normal opening hours.

If your health service uses other services to provide care, you must agree on and document:

- details of the arrangements
- how and when you receive documentation and information about care provided to your patients outside of normal opening hours
- how the providers of after-hours care can contact the health service in an emergency or under exceptional circumstances.

Regardless of how your health service ensures patients can access after-hours care, your patient health records must contain reports or notes on after-hours care that is provided by, or on behalf of, your health service.

If you have arrangements with any external providers, give them after-hours contact details for one or more clinical team members so that, if required, they can access important information about the patient, particularly in an emergency.

If health service staff are unavailable outside of normal hours of health service operation, you must communicate with immigration detention facility staff who have a responsibility for individuals in detention to discuss expectations around emergency care provided to patients outside of normal hours of health service operation. Refer to [Criterion IDF2.3: Engaging with other services](#) for more information on how your health service can engage with non-health service staff in the immigration detention facility.

Meeting each indicator

IDF1.3▶ A Our patients are informed about how they can access after-hours care.

You must:

- ensure patients are informed about how they can access after-hours care
- educate the health service team members and relevant immigration detention facility staff so they can explain how patients can access after-hours care.

You could:

- have signs in the waiting area, the immigration detention facility's living quarters and at the health service's entrance explaining how patients can access after-hours care
- maintain an after-hours voicemail message that clearly states how to access after-hours care
- obtain contact details for any other health services for which your health service provides after-hours care in case the service needs to be contacted in an emergency that involves one of their patients.

IDF1.3▶ B Our patients can access after-hours care.

You must:

- include details of after-hours care the patient has received in the patient's health record (eg entries made by the health service team, treatment reports from the health service that provided the care).

You could:

- maintain a roster showing which health service team members are on-call for after-hours care
- participate in a cooperative arrangement with another health service to deliver after-hours care
- have formal arrangements in place with other providers, such as a medical deputising service, to deliver after-hours care
- have an agreement with local healthcare providers that operate outside of your normal hours of operation
- place signage with information about after-hours arrangements in the accommodation living quarters where individuals in detention make appointments.

IDF Standard 2

Comprehensive care

Our health service provides comprehensive care to our patients.

People detained in immigration detention facilities are not limited by age, gender, body system or health problem. As such, providing care to individuals in detention spans:

- prevention
- health promotion
- early intervention for those at risk
- management of acute, chronic and complex conditions, including conditions caused and/or exacerbated by being held in detention
- palliative and end-of-life care
- the entire health service population, whether in the health service facilities, patient's living quarters, or other facilities and spaces.

In addition, people detained in immigration detention facilities might have a range of existing medical conditions due to:

- common communicable and non-communicable diseases in their country of origin
- conditions and available medical services in their country of origin
- conditions related to their involvement with the criminal justice system, such as substance use disorders or mental health problems
- inconsistent access to healthcare
- adverse childhood experiences
- exposure to torture and trauma (including in their country of origin and/or en route to Australia)
- consequences of prolonged uncertainty (eg related to migration status, separation from family)
- unconventional travel arrangements to Australia.

This standard includes criteria that relate to:

- providing comprehensive care in an immigration detention facility health service context
- the health service's system for recalls and reminders
- the coordination of care outside of the health service.

Criterion IDF2.1: Continuous and comprehensive care

Indicators

IDF2.1 ► A Our health service provides continuity of care.

IDF2.1 ► B Our health service provides comprehensive care.

IDF2.1 ► C Our health service provides arrival assessments, including screening, for individuals in detention.

IDF2.1 ► D Our health service provides coordinated care for our patients.

IDF2.1 E Our health service has a process for patients to request to see their preferred practitioner.

IDF2.1 ► F Members of our clinical team are trained to prevent, minimise and safely respond to challenging behaviours.

IDF2.1 ► G Our health service escalates unresolved clinical concerns to a senior clinician for review.

IDF2.1 ► H Our health service escalates incidents of clinical deterioration to a senior clinician for review.

Why this is important

Continuity of care

Continuity of care is when a patient experiences a series of discrete healthcare events as coherent, connected and consistent with their medical needs and personal circumstances. Continuity of care is distinguished from other attributes of care because of two key characteristics: It refers to care that takes place over time and focuses on individual patients.

When patients visit the same practitioner over a period of time, they develop a patient–practitioner relationship, which has been shown to reduce adverse events.²

Continuous care fosters a coordinated approach to the management of a patient’s health requirements based on the current practitioner’s access to information about past events and understanding of the patient’s personal circumstances.³

Patients who have continuity of care with a regular practitioner:

- report high levels of satisfaction with their experience of care⁴
- have lower rates of hospitalisation and emergency department attendances^{5,6}
- have lower mortality rates⁷
- have increased satisfaction and greater efficiency in investigating health problems⁸
- are more likely to receive appropriate and patient-centred care.

There are three types of continuity of care:

- Informational continuity: The flow of information from one healthcare event/consultation to others, particularly via documentation, handovers and reviews of notes from previous consultations.
- Management continuity: The consistency of care provided by multiple people involved in a patient’s care.
- Relational continuity: The sense of connection between the patient and their doctor or healthcare team.

Comprehensive care

Comprehensive care is an important part of quality healthcare.

Communities benefit considerably from having localised health services offering a range of health and medical services, including aged care, preventive care, palliative care, immunisation, women's health, men's health, children's health, after-hours services and care at a patient's living quarters. If patients are able to access a comprehensive range of services from one primary health provider, it reduces demand for more complex and expensive services in the secondary and tertiary health sectors.⁹

The provision of comprehensive care is particularly important in immigration detention facilities – captured communities where patients have reduced or no access to other healthcare services.

Health assessments

A health assessment is necessary to determine whether a person is sufficiently medically stable to be placed in an immigration detention facility.

A health assessment on arrival at an immigration detention facility can detect significant conditions of public health importance, enabling treatment and surveillance to the benefit of the people detained at the facility and the community.¹⁰

A broad range of physical and mental health issues have been identified that can be both exacerbated and caused by immigration detention, particularly prolonged detention.¹¹⁻¹⁴ This can be the case even if individuals present no symptoms at the time of first being detained.¹⁵

An initial health assessment will allow the health service to identify vulnerable individuals, such as unaccompanied minors, individuals with disabilities, children, pregnant women, and individuals who have experienced torture and trauma. For those entering detention from a correctional services environment, an initial health assessment can identify care needed for their particular context, including related to continuity of care. It can also help to determine if an individual has any diseases or conditions which would represent a threat to public health.

Following an initial assessment of an individual in detention, the practitioner can identify physical and/or mental illness and take necessary measures for new or continuing treatment. Health assessment on arrival allows the health service to:

- identify, record and report to the relevant authorities any signs or indications that an individual in detention might have been exposed to torture and trauma, as well as identify any signs of psychological distress suggestive of experiences of trauma
- isolate an individual in detention who is suspected of a highly contagious condition that might impact public health (eg active pulmonary tuberculosis) for the period of infection, providing them with proper treatment
- determine what setting is most suitable for the individual to be detained (eg in an immigration detention facility, hospital), including whether the individual is fit to live in shared accommodation
- determine how fit an individual in detention is to work and exercise.

Trauma-informed care

Medical consultation might be a source of anxiety for people seeking asylum, especially those experiencing psychological consequences of torture and trauma. Symptoms, such as memory loss, confusion, poor concentration and self-blame, might affect the patient's capacity to hear and understand instructions and to provide information to the doctor.¹⁶ Clinicians provide trauma-informed care, demonstrating awareness of these issues and the impact that they might have and should consider and allow for this, as part of their clinical practice.

Meeting this criterion

Continuity of care in your health service

Your health service could have a system that enables patients to see their choice of health service team member, even if you do not have a formal written appointment system. This could be a note in the patient's health record indicating which practitioner they saw the last time they attended the health service, or whom they prefer to see.

If a patient's preference is unable to be met, inform the patient and explain why their preference cannot be met on this occasion.

Where practitioners visit the health service and are not permanently based at the immigration detention facility, continuity of care can be maintained for that practitioner's usual patients by ensuring those individuals in detention are aware when their preferred practitioner will be on site and available. An individual's preferred practitioner could be a general practitioner, nurse, or other practitioner.

When a practitioner leaves your health service, it is courtesy to notify that practitioner's usual patients and, if appropriate, tell them how they can access their health information if required.

Comprehensive care

The provision of comprehensive care for individuals in detention includes:

- proactive health-promotion and preventive care, including physical (encompasses appropriate developmental, age, gender appropriate, sexual health, obstetric and refugee health)
- acute and chronic disease management
- infectious disease management, including addressing public health impacts within the detention facility
- trauma-informed healthcare and mental healthcare, including screening and access to counselling and specialised treatment for individuals who have experienced torture and trauma
- treatment for substance dependency
- advance care planning and end-of-life care
- effective referral pathways to other specialised healthcare providers and services
- access to child and adolescent and adult psychiatrists, dental specialists, optical, pathology and radiology services
- access to appropriate prostheses and sensory and mobility aids required by an individual to carry out their normal activities of daily living
- appropriate care for individuals across the life span.

Patients must have access to a range of health professionals who meet their needs.

While a regular practitioner or care team is preferred, a patient does not have to see the same practitioner for them to receive best outcomes, provided the service has systems that enable safe, coordinated care.

Collecting information about a patient's cultural heritage before a consultation (eg by using a new patient form) will help practitioners to provide the most appropriate care. This includes a patient's country of origin, preferred language and interpreter requirements, ethnicity, culture, religion and self-identified gender.

Where patients were born, where they grew up or where their parents are from might indicate that they are at higher risk of developing certain health conditions. Similarly, this and other information, such as the language spoken at home, can help to identify patients who require specific care or targeted interventions.

If the health service's medical software does not have specifically coded fields to record this information (or particular answers), the health service must record the information in the patient's health record so it is easily identifiable and apparent.

Health assessments

A health assessment should ideally be completed for each individual who enters detention within one month of arrival at the immigration detention facility. A health assessment could be completed over several appointments, allowing the practitioner to build rapport with a patient and ensure comprehensiveness.

Practitioners must explain to patients the concepts of a health assessment, screening and disease prevention so that they understand the implications of health screening and provide informed consent.

Health assessments of individuals in detention must:

- be conducted by a team of health professionals, including GPs
- use interpreters, when required
- be subject to patient consent
- be conducive to patient privacy and confidentiality
- include a comprehensive risk assessment
- be recorded in the patient's record.

Health assessments of individuals in detention could:

- record the patient's:
 - languages and the need for an interpreter
 - medical history, including current patient concerns, current medicines, allergies, family medical history, injuries/accidents/hospitalisations, infectious conditions, immunisation history, chronic non-communicable diseases, risk factors and other issues
 - migration history, including country of birth, countries/places of transit, date of arrival in Australia and visa information
 - social history, including family composition, education and literacy
 - sexual health
 - psychological health, including any history of torture and trauma
 - developmental health (for children and adolescents)
- include a physical examination of the patient
- provide the patient with preventive healthcare advice and information
- validate any information about an individual's health previously recorded or otherwise communicated by non-clinical staff
- initiate interventions and referrals as indicated, which might include:
 - assessing the risk of self-harm or suicide

- recommending isolation of an individual in detention who is suspected of a highly contagious condition that might impact public health (eg active pulmonary tuberculosis)
- advising whether an individual is fit to be detained and/or live in shared accommodation.

For accompanied children, health assessment on arrival at the immigration detention facility must occur with the permission and involvement of their parents. If the child is unaccompanied, an appropriate guardian or advocate must be present. An identified guardian must hold the best interests of the child as the highest priority in the child's health assessment.

Vaccines need to be administered according to the Australian vaccination schedule and other recommended vaccinations.

Ensuring individuals understand what their health assessment involves and contributes to is important for encouraging their participation. This information needs to be provided in a language patients can understand, whether that be in written or verbal form. Patients might not wish to participate in a health assessment if they are unable to read and understand the information about them.¹⁷

Health services also need to ensure patients rest, ideally prior to an initial health assessment, as fatigue might obstruct their capacity to provide informed consent.

Where health assessments cannot be carried out at the health service (eg during an after-hours period), the health service needs to have a process in place whereby the individual can be accompanied to the nearest healthcare service (eg hospital) to have this assessment made.

Escalating concerns about clinical deterioration

Members of the health service team must have an avenue to escalate incidents of clinical deterioration in patients to a senior clinician for review. The health service must have processes in place for these escalations (eg triggers to escalate and procedures to follow in particular circumstances) and train staff in how matters are escalated. Your health service must allow its team members to escalate concerns about a patient's condition until they are satisfied that the patient receives a resolution.

Having a procedure to escalate incidents of concern helps protect patient safety, resolve the concern and promote interdisciplinary teamwork within and outside of the health service.

To ensure continuity of care, the outcomes of any incidents escalated outside of the health service must be reported back to the health service team.

An escalation procedure needs to consider the different patient cohorts that reside in the immigration detention facility and multidisciplinary care that can be required to care for certain cohorts.

Your health service must provide all team members with a mechanism to call for emergency assistance at any time.

Meeting each indicator

IDF2.1 ► A Our health service provides continuity of care.

You must:

- demonstrate that the health service provides continuity of care
- use a clinical handover system when clinicians are away or on leave
- have a process for recall
- demonstrate your health service's capacity to provide emergency care to patients.

You could:

- document management plans in patient health records, especially for patients with complex or chronic health problems
- have a policy and procedure for follow-up systems
- generate reports that demonstrate continuity of care (eg you could use your health service data to demonstrate this).

IDF2.1 ► B Our health service provides comprehensive care.

You must:

- demonstrate that the health service provides comprehensive care
- demonstrate your health service team is trained to attend to the needs of your patient population (including children, individuals with disabilities, individuals with mental illness and women who are pregnant).

You could:

- provide a list of services offered by the health service
- generate reports on the proportion of patients who had a preventive practice provided in the past year (this could include a health assessment, vaccination, cervical screen or completed cycle of care)
- have a policy and procedure for follow-up systems
- record in each patient's health record their:
 - culture
 - preferred language
 - country of origin
 - country of birth
 - date of arrival
 - interpreter requirements
 - birth sex, self-identified gender and preferred pronouns
 - mental health status
- conduct regular reviews of patients' health assessments.

IDF2.1 ► C Our health service provides arrival assessments, including screening, for individuals in detention.

You must:

- demonstrate that your health service provides screening on arrival for all consenting individuals in detention
- document arrival assessment and screening in the patient's record
- record each patient's disease status and continuing medicines in their health record as soon as they become available to your health service.

You could:

- conduct regular reviews of patients' arrival assessments and screening, alongside ongoing health assessments.

IDF2.1 ► D Our health service provides coordinated care for our patients.

You must:

- demonstrate how patient care is coordinated among multiple practitioners at your health service
- maintain comprehensive patient health records that promote coordination of care among multiple practitioners
- record disease status, allergies, adverse drug reactions and medications in patient health records.

You could:

- maintain comprehensive patient health summaries
- document contemporaneous clinical notes that outline patient history, examination, differential diagnoses and a clear management plan for each consultation, where relevant
- implement a system for patients to request to see a preferred practitioner
- show patient records that demonstrate that patients consistently see the same practitioner
- document tests and investigations ordered by the patient's practitioner in the patient's record
- demonstrate that members of the health service team can find out who the patient's preferred practitioner is when asked.

IDF2.1E Our health service has a process for patients to request to see their preferred practitioner.

You could:

- document a process for patients to see their preferred practitioner when possible
- show patient records that demonstrate that patients consistently see the same practitioner
- provide notices in the waiting room when a practitioner is unavailable
- have a policy to ask patients which practitioner they would like the appointment with.

IDF2.1 ► F Members of our clinical team are trained to prevent, minimise and safely respond to challenging behaviours.

You must:

- demonstrate that members of your clinical team are trained to prevent, minimise and safely respond to challenging behaviours.

You could:

- provide training for the health service team on how to prevent, minimise and safely respond to challenging behaviours
- provide your health service team with information about external training providers
- display posters and leaflets in your health service that promote safety and appropriate behaviours for patient–practitioner interaction.

IDF2.1 ► G Our health service escalates unresolved clinical concerns to a senior clinician for review.

You must:

- maintain clinical escalation policy and procedures
- provide training for all health service staff on clinical escalation.

You could:

- maintain clinical escalation procedures specific to certain patient cohorts within the immigration detention facility.

IDF2.1 ► H Our health service escalates incidents of clinical deterioration to a senior clinician for review.

You must:

- maintain clinical escalation policy and procedures
- provide training for all health service staff on clinical escalation
- provide all health service team members with a mechanism to call for emergency assistance.

You could:

- maintain clinical escalation procedures specific to certain patient cohorts within the immigration detention facility.

Criterion IDF2.2: Follow-up systems

Indicators

IDF2.2▶A Pathology results, imaging reports, investigation reports and clinical correspondence that our health service receives are:

- reviewed
- electronically notated, or if on paper, signed or initialled
- acted on where required
- incorporated into the patient health record.

IDF2.2▶B Our health service recalls patients who have clinically significant results.

IDF2.2▶C Our patients are advised of the health service's process for follow up of tests and results.

IDF2.2▶D Our health service initiates and manages patient reminders.

IDF2.2▶E High-risk (seriously abnormal and life-threatening) results identified outside normal hours of health service operation are managed by our health service.

Why this is important

The information gained from tests can affect the choices that a patient and relevant practitioners make about the patient's care. Clinically significant results need to be communicated quickly and appropriately so that suitable action can be taken, which can reduce the likelihood of an adverse patient outcome.

Your health service must ensure that patients who present to your health service with persisting health issues are appropriately investigated, provided with symptomatic relief, and referred and followed up appropriately. Your health service must also ensure that it has capacity to escalate urgent external referrals and/or requests for transfer if wait times are long and clinical deterioration has occurred.

It is best practice to inform patients of clinically significant results in person so the patient can ask questions and receive advice. When an in-person consultation is not possible, consider whether the use of telehealth platforms is appropriate to convey this information.

Health services must have a fit purpose follow-up system to avoid fragmented care. As multiple members of the health service team will provide care to a patient, there is a heightened importance on having an effective follow-up system to manage that patient's recalls and reminders. Refer to [Criterion IDF2.4: Transfer of care and the patient–practitioner relationship](#) for more information on continuity throughout the transfer of patient care.

Using recalls and reminders to proactively contact patients about their care means that patients will be more likely to, for example, come back to the health service to discuss a test result or undergo a preventive activity, such as cancer screening. Failure to recall a patient might result in an adverse outcome and the responsible practitioner might face medico-legal action.

Meeting this criterion

Timely review and action on tests and results

After a practitioner has advised a patient of tests or other required action and the consequences of inaction/refusal, and the patient has understood this advice, it is the patient's decision whether to follow the recommendations.¹⁸ Some patients do not follow recommendations for a variety of reasons, which might include their particular circumstances, financial difficulties, fear, ignorance, personality traits, expectations, beliefs or cultural background.

Practitioners are obligated to ensure that results from all tests they have ordered are recorded and appropriately followed up with their patients.¹⁹

Practitioners need to review results and reports and take appropriate action in a timely manner. The speed with which results or reports are acted on and the effort taken to contact the patient to discuss the results will depend on the practitioner's judgement of the clinical significance of the result or report.

Responsibility for follow up of tests initiated by another practitioner

Clear systems and protocols for the follow up of tests and results are critical, especially given the increasing use of electronic communication and the potential for multiple healthcare professionals to be involved in a patient's care. It is useful for members of the health service team to have a complete record of all medical tests performed on a patient, and for this to be recorded in the patient's health record. The RACGP encourages health professionals to work collaboratively when a patient needs tests, and for health professionals outside of the health service to inform the patient's preferred practitioner of tests they perform.

There might be situations where it is unclear whether the follow up of results has actually occurred or who is responsible for the follow-up.²⁰ It is good practice to assume that clinically significant test results ordered by practitioners who are not part of the regular health service team might not have been appropriately actioned. Once a practitioner views the results, they should assume clinical stewardship to act on that result, particularly if they are unsure if the ordering clinician has acted on the results.²¹

Sometimes it might be to the patient's benefit if their regular practitioner acts on test results that have been initiated by another health professional. Clear lines of communication between the health service and external health professionals are essential when participating in collaborative care of a patient.

Clinical significance of results

The clinical significance of a result must be considered in the context of the patient's history and presenting healthcare issues.

'Clinically significant' does not necessarily mean only 'abnormal' results. The practitioner makes a judgement as to whether information is or is not clinically important for a particular patient in the context of that patient's healthcare. While a practitioner will generally decide that an abnormal result is clinically important and requires further action, they might also decide that a normal result requires further action.

The follow-up system needs to accommodate different types of follow up that are based on the patient's needs and clinical significance of the case.

Consider the following factors to determine if a result is clinically significant and therefore requires action:

- the probability that the patient will be harmed
- the seriousness of the harm.

Recalling patients

You must have a process for recalling patients. A recall occurs when a practitioner decides that a patient needs to be reviewed within a specified period. For example, you might recall a patient:

- when you receive a clinically significant test result
- on receipt of significant correspondence from another practitioner (eg after a mental health assessment by a psychologist or psychiatrist)
- after diagnosis of a significant condition, such as type 2 diabetes.

If you receive results that are adverse or unexpected, ask the patient to make an appointment with a practitioner or other appropriate health professional to discuss the results and their implications. You can also provide any necessary counselling during the consultation.

Your recall process could be explained in a written policy, including:

- a definition of clinically significant results
- a statement that the patient's preferred practitioner is responsible for reviewing results and deciding whether they are clinically significant
- how to recall a patient, clearly outlining the roles and responsibilities of different members of the health service team, including what information different team members can convey and how to convey it. For example, if reception staff members are responsible for contacting patients with clinically significant results to make an appointment, explain the best type of language to use in such a conversation (eg 'Your doctor wants you to make an appointment this week to discuss the results of your recent tests')
- guidelines about what information needs to be recorded (eg clinical discussions and outcomes) in patient health records
- standard forms and letters for recalling patients
- guidelines that ensure tests and results are reviewed and acted on in a timely manner.

Your health service can also document your recall system, including who is responsible for monitoring and follow up of recalls.

Your induction process must cover the recall system.

Some software allows you to flag recall appointments so that you are prompted to contact patients who do not return as expected.

Record all attempts to contact and recall patients about clinically significant tests and results in the patient's medical record.

Reminders

A reminder occurs when a patient is added to a recommended preventive activity list that is managed on a periodic basis. Reminders are used to help manage chronic disease management and preventive care and can be set up before or during a consultation by noting in a patient's health record when the patient is due to return to the health service for a routine check. Reminders help to ensure patients have preventive health checks. For example, your health service could remind patients who are:

- in the high-risk susceptibility demographic for influenza, prompting them to come in and have the vaccine before the start of the influenza season
- due for immunisations, including children and high-risk groups
- due for a routine screen, such as a cervical screening test or mammogram.

Some medical software will display a prompt when a patient's health record is opened so the practitioner is informed that the patient is due for a preventive or clinical activity. Consider having your information system automatically generate text messages, emails or letters to patients.

If your health service sends a reminder to a patient and the patient does not make an appointment, the health service is not required to follow up, although it is good practice to record the reminder in the patient's health record.

Communicating tests and results to patients

If you need to initiate follow-up contact with a patient, determine the number, frequency and nature of the attempts you will make to contact the patient (eg whether direct communication can be made between the health service and the patient, or whether immigration detention facility staff need to notify a patient).

Your health service needs to be able to identify unexpected significant results when they are received, particularly if the significance of such results was not discussed with the patient during the consultation. In these circumstances, you need to consider how to sensitively inform the patient, who might not anticipate or understand the significance of the results.

Your explanation must be clear when explaining test results to the patient, and you must check that the patient understands what you are telling them. When the patient understands the information, they can give legally effective informed consent or exercise their right to a legally effective informed refusal. A patient who makes a decision based on insufficient or unclear information is not making an informed decision.

Remote consultations and follow up

Patients must receive the same quality of care whenever possible, regardless of whether the consultation is delivered face to face or remotely (eg phone or telehealth). In circumstances where no alternative exists, a telehealth consultation will be better than no consultation at all to enable patients access to timely care. Remote follow up might be required (eg in remote or offshore facilities) for individuals in detention to receive timely care.

Telehealth consultations might not always be appropriate. There must be a triage process to determine if an initial consultation can be carried out by telehealth, which is conducted by a clinical team member and considers:

- patient safety and wellbeing
- the clinical needs of patient
- the clinical effectiveness of telehealth consultation
- patient preference
- the need for and availability of appropriate clinical assistance at the patient end.

If the need for clinical assistance at the patient end has been identified, those providing it must have the appropriate skills and training to perform necessary assessments and examinations.

Telehealth consultations need to be carried out with a camera and microphone at both sites (ie the patient and the practitioner have access to this technology). Each participant needs to have access to internet with sufficient bandwidth to guarantee reasonable transmission of video signal and sound.

Your health service must ensure a patient has privacy when taking part in a remote consultation. Practitioners and patients could do so by using a quiet room where they are not disturbed during the consultation.

Telehealth services present an opportunity for existing services to expand accessibility for their patients and increase flexibility in service delivery. However, face-to-face consultations must be prioritised over telehealth consultations wherever possible.

Follow up of high-risk (seriously abnormal and life-threatening) results identified outside of normal health service operating hours

Your health service must manage seriously abnormal and life-threatening results identified outside of normal operating hours so that you can provide prompt and adequate follow-up.

Your health service must have a process so that pathology and diagnostic services can contact the health service in urgent circumstances so information about the patient can be accessed.

Your health service must explain to practitioners or staff outside of the health service team (eg immigration detention facility staff) who monitor individuals in detention, what you expect them to do if they receive urgent and life-threatening results for one of your patients. These people have a responsibility to contact the health service manager or patient's regular practitioner/team in such circumstances.

Meeting each indicator

IDF2.2▶A Pathology results, imaging reports, investigation reports and clinical correspondence that our health service receives are:

- reviewed
- electronically notated, or if on paper, signed or initialled
- acted on where required
- incorporated into the patient health record.

You must:

- record details of a practitioner's review of pathology results in the patient's health record
- have a process to review and manage results received by the health service.

You could:

- have a policy and/or documented procedures for reviewing and managing results
- implement follow-up procedures for telehealth and phone settings.

IDF2.2▶B Our health service recalls patients who have clinically significant results.

You must:

- document in the patient's health record each attempt to contact and recall patients about clinically significant results
- have a process for recalling patients with clinically significant results.

You could:

- have a designated health service team member who is responsible for the recall process
- have a recall policy for health service team members to follow
- maintain templates in a clinical software program to trigger recalls
- include recall responsibilities in relevant position descriptions
- have recalls sent through the clinical information system.

IDF2.2▶C Our patients are advised of the health service's process for follow up of tests and results.

You must:

- document in the patient's health record what follow up has occurred and what treatment, if any, was required

- educate the health service team members so they can tell patients about the process to receive results
- document conversations about test results in the patient's notes.

You could:

- have a health service team member who is responsible for the recall process
- maintain templates in a clinical software program to trigger recalls and reminders
- have a recall policy document.

IDF2.2▶ D Our health service initiates and manages patient reminders.

You must:

- document in patient health records when reminders have been initiated by the health service and acted on by the patient
- document the recall and reminder system, including who is responsible for monitoring and follow up.

You could:

- maintain templates in a clinical software program to trigger recalls and reminders
- educate the health service team so that they can tell patients about the process of sending out reminders
- have reminders sent through the clinical information system.

IDF2.2▶ E High-risk (seriously abnormal and life-threatening) results identified outside normal hours of health service operation are managed by our health service.

You must:

- have a documented policy that outlines the process for your health service's management for high-risk results identified outside of normal opening hours
- give diagnostic services the contact details of the practitioner who ordered the investigation.

You could:

- educate health service team members about how anyone who provides diagnostic services or receives high-risk results outside of normal opening hours can contact the health service team member/s who have access to the patient's health record
- provide current contact details to diagnostic services
- provide the contact details of the health service team members who can be contacted outside of normal opening hours when a diagnostic service receives high-risk patient results outside of normal opening hours.

Criterion IDF2.3: Engaging with other services

Indicators

IDF2.3▶A Our health service collaborates with other health services and relevant non-health stakeholders to deliver comprehensive care.

IDF2.3▶B Our health service considers the role of immigration detention facility non-health staff and works with those staff to manage patient safety.

IDF2.3▶C Our health service's referral letters are legible and contain all required information.

Why this is important

By working cooperatively with other healthcare providers and services, you can provide optimal care to patients whose healthcare requires integration of multiple services. These services might include:

- allied health
- pharmacy
- diagnostic
- social work
- disability
- community health
- mental health
- torture and trauma
- hospitals.

Given that coordination of care for individuals, families and communities is associated with improved health outcomes for patients,²² engaging with other services is an important feature of providing high-quality healthcare.

Non-health stakeholders, such as immigration detention facility staff (eg security staff, social welfare staff, government personnel) might have involvement in the coordination of care for individuals in detention. These stakeholders could:

- accompany and/or transport individuals to health appointments within the immigration detention facility and to external health services
- apply restraints to some individuals when they are transported outside the facility to attend appointments (refer to [Criterion IDF2.4: Transfer of care and the patient–practitioner relationship](#) for more information on the use of restraints)
- identify individuals who:
 - show signs of clinical deterioration from a mental health perspective
 - are refusing food and fluid
 - are withdrawing socially/not engaging in their normal activities
 - have self-harmed or attempted suicide.

- support and monitor individuals who are considered to be at moderate to high risk of suicide who are not able to be transferred to external psychiatric facilities
- provide simple analgesics to individuals outside of clinic hours if there is no health professional on site
- be the first responders to medical emergencies, particularly outside of staffed clinic hours needing to utilise automated external defibrillator and contact emergency services
- in remote locations, be responsible for individuals subject to medical isolation due to contagious infections, such as active pulmonary tuberculosis and influenza
- be responsible for initiating and implementing behaviour management plans for individuals with challenging behaviours who might have significant mental health issues impacting their behaviour
- be involved in complex case meetings where health issues that might impact a patient's behaviour and/or that create a potential risk in the immigration detention facility are discussed
- be involved in outbreak management (eg mosquito control, ensuring compliance with hand sterilisation, cleaning procedures, gastro and scabies outbreaks)
- ensuring individuals stay in isolation if diagnosed with a highly communicable disease.

Your health service must communicate with these stakeholders to discuss expectations around care provided to patients and the stakeholders' involvement in coordination of that care.

Meeting this criterion

Coordinating comprehensive care with other services

Your health service must be aware of the local healthcare providers and services that can support patients. These might be providers within or outside of the health service and immigration detention facility. This awareness includes having access to up-to-date written or electronic information about local providers delivering health, disability, community and mental health services. For example, you could have a register of these services (which will be particularly useful for new members of the health service team).

Immigration detention facilities might, for various reasons, subject individuals in detention to more restrictive detention for disciplinary issues (eg use restraints). If this occurs, the health service must collaborate with health and security services at the immigration detention facility to determine cause for behaviour and best management strategies. The health service must also advocate for individuals if restrictive detention, behavioural management strategies and/or the use of restraints are exacerbating existing physical and/or mental health issues.

Your health service needs to have processes to engage with other healthcare providers, foster good working relationships and support interprofessional collaboration so that you can achieve good collaborative patient care with these services when required. Your health service's strategic plan (refer to [Criterion C3.1: Business operation systems](#) for more information) needs to be reviewed in conjunction with other relevant healthcare providers, and could include regular review of needs analysis, resource planning and service evaluation. This could be developed with the participation of health service staff, immigration detention facility management, stakeholders and patients.

Your health service needs to understand the different referral arrangements for public and private providers.

Referral letters

Referral letters are critical in integrating the care of patients with external healthcare providers.

Referral letters must:

- include the name and contact details of the referring doctor and the health service
- include the demographic and professional details of the referring practitioner
- be legible
- include the patient's name and date of birth, and at least one other patient identifier
- include the patient's country of origin, ethnicity, preferred language and their need for an interpreter
- include the patient's preference to consult with a health practitioner of a particular gender
- explain the purpose of the referral
- contain enough information (relevant history, examination findings and current management) so that the other healthcare provider can provide appropriate care to the patient
- not include sensitive patient health information that is not relevant to the referral
- include a list of known allergies, adverse drug reactions and current medicines
- identify the healthcare provider and or setting to where the referral is being made (eg the specialist consultancy).

If appropriate, referrals could also contain the name of the healthcare provider to whom the referral is being made, if known.

Patient information in referrals

Most of the information needed in a referral might be found in the patient's health summary. Although many health services routinely incorporate a copy of the patient's health summary into a referral letter, or attach the summary as a separate document, you only need to provide clinically relevant patient health information. Information is clinically relevant if the practitioner who is receiving the referral needs that information to diagnose and treat the patient. For example, information regarding a patient's previous termination of pregnancy or sexually transmissible infection is unlikely to be of clinical relevance to a physiotherapist, but likely would be to an obstetrician or gynaecologist. You could also offer patients the opportunity to read a referral letter before it is sent.

You must consider your obligations under the *Privacy Act 1988* before using or disclosing any health information.²³

Emailing referrals

The RACGP has developed a **matrix** that shows the risk associated with emailing certain types of information to patients or other healthcare providers, depending on your health service's policies and processes. Although the *Privacy Act 1988* does not prescribe the method of communication a healthcare organisation uses to pass on health information to patients or third parties, it does require that you must take reasonable steps to protect the information and the patient's privacy.

Your health service needs to have systems so that you respond to emails and other electronic communication in a timely and appropriate manner. Refer to **Criterion IDF1.1: Responsive system for patient care** for more information.

Telephone referrals

A telephone referral might be appropriate in the case of an emergency or other unusual circumstance. You must record details of the telephone referral in the patient's health record.

Keep copies of referrals

For medico-legal and clinical reasons, keep copies in the patient's health record of all referrals made.

Working with non-health stakeholders

Your health service will engage with various non-health stakeholders, including those contracted by the Department of Home Affairs. Some non-health stakeholders will have direct contact with individuals in detention and might be involved in an individual's access to health services (eg security staff escorting an individual to your health service). Refer to [Criterion C6.3: Confidentiality and privacy of health and other information](#) for more information on how your health service manages confidentiality and personal health information.

Meeting each indicator

IDF2.3▶ A Our health service collaborates with other health services and relevant non-health stakeholders to deliver comprehensive care.

You must:

- be able to demonstrate that your health service collaborates with other healthcare services and relevant non-health stakeholders
- provide evidence that the health service team has been made aware of local healthcare providers and relevant non-health stakeholders
- provide evidence that the health service has a strategic plan for collaboration with other relevant service providers.

You could:

- maintain an electronic or paper-based register of healthcare service providers and organisations for patient referrals
- regularly update the register and include the date of the update
- keep an easily accessible list of pharmacies, including the roster of on-call pharmacists
- include discharge letters in patient health records, along with records that show they are acted on appropriately
- provide evidence that your health service regularly reviews its strategic plan for collaboration with other relevant service providers
- demonstrate how health service staff, immigration detention facility management, stakeholders and patients are engaged in the review of the health service's strategic plan.

IDF2.3▶ B Our health service considers the role of immigration detention facility non-health staff and works with those staff to manage patient safety.

You must:

- maintain a defined process for health service staff to work with relevant immigration detention facility non-health staff to manage patient safety
- demonstrate how patient confidentiality and privacy are protected when immigration detention facility non-health staff are involved in the patient's interaction with the health service.

You could:

- have a procedure for asking patients to consent to immigration detention facility non-health staff being present during a consultation
- provide evidence that your health service regularly reviews its strategic plan for collaboration with immigration detention facility non-health staff
- provide training and guidance to immigration detention facility non-health staff on how they interact with patients and the health service.

IDF2.3▶C Our health service's referral letters are legible and contain all required information.

You must:

- write referral letters that include all mandatory information
- keep a copy of each referral in the patient's health record
- use a clinical software program to generate referrals that are automatically populated with a comprehensive health summary.

You could:

- have a policy that states referral documents must include at least three patient identifiers
- have a procedure for asking patients to consent to referrals being sent electronically
- include relevant information about electronic transmission of referrals in the health service's privacy policy.

Criterion IDF2.4: Transfer of care and the patient–practitioner relationship

Indicators

IDF2.4▶A Our health service team manages patient transfers between staff in our health service.

IDF2.4▶B Our health service supports the safe transport of patients.

IDF2.4▶C Our health service identifies the need for, and facilitates, timely transfer of patient care when the request for transfer occurs.

IDF2.4▶D Our health service identifies the need for, and facilitates, the timely transfer of patients who require urgent external medical care.

IDF2.4▶E Our health service provides patients with information about the management of their health when they leave detention.

Why this is important

In addition to ensuring that clinical care is consistent with the best-available evidence, it is important that there is continuity in the clinical care provided to the patient. Whether the patient requires transfer to another practitioner at your health service or at another health service, you must have a system that ensures the patient receives continuous and coordinated care.

People who have had refugee-like experiences might have difficulties in accessing and making the best use of health services. Negotiating a new and unfamiliar health system might be a complex undertaking, particularly for those with multiple health needs requiring numerous investigations and follow-up appointments.²⁴

Individuals who are transferred out of immigration detention facilities, either to the community, another facility or returning to another country, might have backgrounds of trauma and disadvantage (eg individuals who have previously been in prison). These individuals can have increased vulnerability leaving the immigration detention facility, including separation from family and a lack of support.

Meeting this criterion

Ensuring continuity of care during patient transfer

Management continuity involves having a consistent and coherent approach to the management of a health condition that is responsive to the patient's changing needs, and ensures that the people providing services are not working at 'cross purposes'. An example is ensuring that doctors and psychologists treating a patient with depression provide consistent advice to the patient about their treatment and care. Management continuity is particularly important for people with chronic or complex diseases. For example, it might involve having a plan for the patient's care that is shared by the people providing the care.

Handover of patient care within the health service

It might not be practical to have patient present during handover (eg when being transferred to a facility interstate, into the community or outside of Australia). However, wherever it is practical to do so, your health service must conduct warm handovers of patient care between practitioners. This involves having the patient present during the handover.

External decisions regarding transfer

Decisions regarding patient transfer might be made by external stakeholders (eg the Department of Home Affairs). Practitioners who provide care to an individual in detention must submit comprehensive evidence to any external decision-makers when requesting a patient transfer. This evidence must include, at a minimum:

- the patient's condition(s)
- reason for transfer (eg why there is a need for tertiary care, or why that care is not possible in the immigration detention facility's location)
- identification of risks to the patient's health if a transfer is delayed or denied
- exacerbating factors in detention.

Transfer of patient care within the health service

At the request of the patient or practitioner, care might be transferred to another practitioner within your health service. The scope for patient transfer to occur will depend on the size of the health service and the number of available clinical staff.

Other than in emergencies, practitioners have the discretion to discontinue treatment of a patient. Situations in which this could occur include when the practitioner thinks they can no longer provide the patient optimal care, or when the practitioner no longer considers it appropriate to treat the patient (eg when a patient has behaved in a threatening or violent manner, or where there has been a significant breakdown in the patient–practitioner relationship).

When the practitioner requests transfer of care, the health service must facilitate, to the best of its ability, the transfer of the patient to another practitioner. This involves:

- informing the patient (at a consultation, or by phone or letter) as to the reason for the decision to transfer care
- taking reasonable steps to ensure the person to whom you delegate, refer or hand over has the qualifications, experience, knowledge and skills to provide the care required
- facilitating arrangements for the continuing medical care of the patient, including the transfer or appropriate management of all patient records.²⁵

You could have a documented process for discontinuing a patient's care, which includes what to do in the event the patient makes subsequent contact with the practitioner (eg the health service might wish to consult with its medical defence organisation, where necessary).

Transfer of patient to another immigration detention facility

Patients might also be transferred to another immigration detention facility.

If a patient is transferred to another health service, it is good practice to keep a copy of information sent to the new health service in the instances that issues subsequently arise.

The health service needs to consider the time required to transfer patients between facilities, as well as security requirements for individuals entering or exiting a facility, when planning care.

Your health service has a professional and ethical obligation to provide emergency care to patients, regardless of transfer arrangements.

Patient discharge

Your health service needs to conduct a discharge health assessment for patients leaving detention. An appropriate health summary needs to be provided to support the ongoing care of the patient. This health summary should be made available to future healthcare providers, but also be accessible to the patient.

The discharge assessment needs to include a health discharge summary from the health service to the individual, which informs future health providers of relevant physical and mental health history (including identification of exposure to torture and trauma), treatment received (including vaccinations received, investigations undertaken and screening results) during detention and any ongoing treatment regimes.

Your health service must provide patients with information about the management of their health when they leave detention. This could include:

- ensuring patients have enough medicines on discharge until they see another provider
- emphasising to the patient the importance of follow up once discharged from the facility
- orientating patients to the community and available health services by providing details on community healthcare access, when known and appropriate
- advising patients how care is differently received outside of the health service/facility, when known and appropriate.

Health professionals should consider the risks of failure to continue medication if inadequate supply is provided to a patient on discharge, such as discontinuation of active pulmonary tuberculosis, epilepsy or antipsychotic treatment, and provide counselling to the patient to reduce risks of this occurring.

Where appropriate, the practitioner needs to link relevant community health providers to the discharge assessment to facilitate ongoing care.

Use of restraints

The health service must uphold the rights of an individual in detention to be treated in the least restrictive environment and to the extent that it does not impose serious risk to the individual or others. The safety of the patient, health service and immigration detention facility staff, and any staff transporting a patient, is paramount.

Restraints must be considered as a last resort. If restraints are used, they must be used to the minimum extent necessary to provide care or transfer a patient in instances where they pose a risk to themselves or others. If a chemical restraint is used, it must be administered and supervised by a member of the clinical team.

When and how restraints are used might be a shared decision between your health service and the Australian Government.

Your health service must:

- maintain a policy on the use of restraints, noting the use of restraints might be a shared decision between your health service and the Australian Government
- respect the safety and dignity of any individual being restrained
- demonstrate how the health service policy on the use of restraints integrates with any policies enforced by an agency (eg the Department of Home Affairs)
- document all use of restraints, including:
 - the assessment for use of restraint
 - the reasons for restraint
 - the instruments and method used to restrain an individual
 - any further reporting of the use of restraint outside of the health service.

Unless under exceptional circumstances and on medical grounds as directed by a member of the clinical team or staff transporting a patient outside of the immigration detention facility, instruments of restraint must be avoided.

Meeting each indicator

IDF2.4►A Our health service team manages patient transfers between staff in our health service.

You must:

- demonstrate how your health service maintains continuity throughout the transfer of patient care
- document in the patient's health record details of the patient's decision to cease receiving care, and the action taken
- transfer the patient's health information to another practitioner.

You could:

- maintain a policy about ceasing a patient's care
- have patients present when transferring care between staff in your health service
- provide referrals to other healthcare providers.

IDF2.4►B Our health service supports the safe transport of patients.

You must:

- document the details of patient transfers to other health services
- document requests for patient transfer, both approved and denied by the Department of Home Affairs
- conduct discharge health assessments for patients leaving your health service
- refrain from using restraints on patients for clinical reasons during transfer and handover, except under exceptional circumstances.

You could:

- document a policy for the use of restraints.

IDF2.4►C Our health service identifies the need for, and facilitates, timely transfer of patient care when the request for transfer occurs.

You must:

- document in the patient's health record details of the practitioner's decision or preference to cease providing care, and the action taken
- transfer the patient's health information to another practitioner in response to approved requests for a transfer of care.

You could:

- advise patients and record in patients' records the estimated waiting time for transfer
- maintain a policy about transferring a patient's care
- provide referrals to other healthcare providers
- communicate to individuals in detention any delays in transfer of care the health service is aware of (eg an ambulance is going to be delayed by immigration detention facility processes, such as security).

IDF2.4►D Our health service identifies the need for, and facilitates, the timely transfer of patients who require urgent external medical care.

You must:

- document in the patient's health record that a need for timely transfer has been identified
- document in the patient's health record that a transfer has occurred
- demonstrate how a patient's health information is made available to the patient or another health service with the patient's consent following discharge from your health service.

You could:

- document in the patient's health record that a discharge health assessment has been conducted
- provide a health discharge summary from the health service to each patient discharged from the immigration detention facility
- review the outcomes of treatment and support as well as ongoing follow-up arrangements for each patient prior to their exit from the immigration detention facility
- provide a patient's discharge summary to another health provider, on request, where that provider has the patient's consent to obtain their health information.

IDF2.4►E Our health service provides patients with information about the management of their health when they leave detention.

You must:

- provide patients with information about the management of their health after being discharged from the health service and immigration detention facility.

You could:

- provide patients with enough medicines on discharge until they see another provider or can access an alternative supply
- emphasise to patients the importance of follow up once discharged from the immigration detention facility
- provide patients with details on community healthcare access, when known and appropriate
- advise patients how care is differently received outside of the immigration detention facility, when known and appropriate
- provide advice to patients about particular facilities or community organisations that might be useful in facilitating their integration to the community and links with community-based care.

IDF Standard 3

Qualifications of our clinical team

| Our health service team is appropriately qualified and trained to perform their role.

This standard focuses on the systems that the health service uses to verify qualifications and training of the clinical team.

You can support and encourage quality improvement and risk management by providing appropriate education and training of the clinical team.

Criterion IDF3.1: Qualifications, education and training of healthcare practitioners

Indicators

IDF3.1 ► A Members of our clinical team:

- have current national registration where applicable
- have accreditation/certification with their relevant professional association
- actively participate in continuing professional development relevant to their position and in accordance with their legal and professional organisation's requirements
- have undertaken training in CPR, in accordance with the recommendations of their professional organisation, or at least every three years

IDF3.1 ► B Our health service has, at any time, at least one clinical team member available to patients who has:

- undertaken training in advanced life support, if the health service is in a rural or remote location
- undertaken training in basic paediatric life support, if the health service treats children up to the age of 18 years
- undertaken training in advanced paediatric life support, if the health service is in a rural or remote location and treats children up to the age of 18 years.

IDF3.1 ► C Doctors working in our health service are one or more of the following:

- specialist GPs
- GPs in training under appropriate supervision in accordance with the *Standards for general practice training*
- medical practitioners actively working towards Fellowship on a recognised general practice training pathway
- medical practitioners with more than 10 years' experience in Australian general practice
- have general registration as medical practitioners
- hold an equivalent qualification in general practice from a competent authority nation.

IDF3.1 ► D Members of our clinical team have cultural awareness and seek to provide a culturally safe environment for their patients.

IDF3.1 ► E Our health service identifies and addresses discriminatory practices associated with stigma and bias to ensure equitable practices and access to services.

IDF3.1 ► F Our clinical team has undergone training specific to the patient population health needs.

IDF3.1 ► G Our clinical team is trained to use the health service's equipment that they need to perform their role safely and effectively.

Why this is important

Having only healthcare practitioners who are suitably qualified reduces the risk of medical errors and means that your health service provides patients with safe, quality care.

All healthcare practitioners must:

- be suitably qualified and trained
- maintain the knowledge and skills that enable them to provide quality clinical care
- comply with the professional development requirements and code of conduct of the relevant professional organisation, regardless of whether they are a member of the organisation
- work within their scope of practice and competencies.

Meeting this criterion

Registration, credentialing and continuing professional development

Practitioners have the responsibility to maintain their relevant national registrations, have proof of their credentialing, and comply with their ongoing continuing professional development requirements.

Continuing professional development and other training relevant to your position

Practitioners must consider what continuing professional development and other training are relevant to their position and patient population. This might include development related to:

- cross-cultural safety
- communicating with patients with communication needs (eg patients from CALD backgrounds or with a communication impairment)
- mental health, substance use disorders, trauma-informed care, blood-borne viruses and other health concerns associated with the population
- managing ethical dilemmas.

Continuing professional development and other training can be undertaken by completing external courses, inhouse programs, or 'on-the-job' training at the health service.

General practice is a specialist discipline

To be considered a GP, doctors need to be appropriately trained and qualified in the discipline of general practice and be either vocationally recognised, or have achieved Fellowship of the RACGP or ACRRM.

The RACGP defines a GP as a registered medical practitioner who:

- is qualified and competent for general practice in Australia
- has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities
- maintains professional competence for general practice by undertaking continuing professional development.

GPs in training and doctors on a pathway to Fellowship must be supported, mentored and supervised by a recognised specialist GP.

Where vocationally recognised GPs and doctors on a pathway to Fellowship are unavailable

Although it might not be possible to recruit vocationally recognised GPs in some areas, doctors in health services who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the local community.

CPR training

All healthcare practitioners must be trained in CPR so they can help in emergencies.

CPR training can be conducted by an accredited training provider or by clinical team members, if appropriate. These clinical team members must have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies.

The ARC requires that CPR trainees physically demonstrate their skills at the completion of the CPR course. CPR training that is completed solely online does not meet this requirement.

For clinical team members, CPR must be undertaken in accordance with CPR recommendations set by their professional organisation, or at least every three years.

Training in advanced life support

Advanced life support is the provision of effective airway management, ventilation of the lungs and production of a circulation by means of techniques additional to those of basic life support. The techniques involved in advanced life support might include, but is not be limited to:

- advanced airway management
- vascular access/drug therapy
- defibrillation.

Patients need to have access to advanced life support in emergencies. As such, for remote and rural locations without timely access to a hospital and/or specialist services, your health service must have at least one clinical staff member available to patients with training in advanced life support.

Children up to the age of 18 years need to have access to:

- basic paediatric life support.
- advanced paediatric life support in remote/rural locations.

Rural and remote locations are those classified by the Modified Monash Model as rural and remote (classifications MMM3–7).

Health service equipment

Training requirements depend on the specific equipment at your health service, and the equipment's relevance to the clinical team member's role. The clinical team must be trained in how to use the health service's equipment safely to avoid any adverse events. Practitioners must assess whether specific training is required to use the health service's equipment, such as the height-adjustable bed, point-of-care testing equipment and the defibrillator, and determine whether ongoing training is required. Appropriate training can be undertaken by completing external courses, inhouse programs or 'on-the-job' training at the health service.

Intercultural competency

The health service team need to have knowledge and skills in intercultural competence to deal with the mental and physical vulnerabilities of those detained at the immigration detention facility.

These knowledge and skills might include, but are not limited to:

- interpersonal communication skills
- understanding of global and national migration patterns
- cognisance of global areas of domestic turmoil or social, economic, and/or political upheaval
- government policy related to migration in Australia
- public health implications of migration
- public and individual health hazards
- identifying health emergencies and the need for transfer of care
- self-protection and occupational health issues
- physical and mental health issues of vulnerable persons
- geographical, cultural and religion-related diversity in health beliefs and attitudes.

Your health service's non-clinical staff must also have knowledge and skills in intercultural competence. Further detail relating training for to non-clinical health service staff is provided at [Criterion C8.1: Education and training of non-clinical staff](#).

Meeting each indicator

IDF3.1 ► A Members of our clinical team:

- have current national registration, where applicable
- have accreditation/certification with their relevant professional association
- actively participate in continuing professional development relevant to their position and in accordance with their legal and professional organisation's requirements
- have undertaken training in CPR in accordance with the recommendations of their professional organisation, or at least every three years.

You must:

- keep records of current registration of each practitioner
- keep records of each practitioner's continuing professional development
- keep records of each practitioner's CPR training.

You could:

- keep training logs that record training that practitioners have completed
- keep a calendar that lists opportunities for training and professional development
- conduct annual performance reviews that identify learning and development goals
- store documents that record training needs and completed training of each member of the health service team.

IDF3.1 ► B Our health service has, at any time, at least one clinical team member available to patients who has:

- undertaken training in advanced life support, if the health service is in a rural or remote location
- undertaken training in basic paediatric life support, if the health service treats children up to the age of 18 years

- undertaken training in advanced paediatric life support, if the health service is in a rural or remote location and treats children up to the age of 18 years.

You must:

- for remote/rural locations, keep record of the clinical team member(s) with training in advanced life support
- where treating children up to the age of 18 years, keep record of the clinical team member or members with training in basic paediatric life support
- for remote/rural locations where treating children up to the age of 18 years, keep record of the clinical team member or members with training in advanced paediatric life support.

You could:

- keep training logs that record training that practitioners have completed
- keep a calendar that lists opportunities for training and professional development
- conduct annual performance reviews that identify learning and development goals
- store documents that record training needs and completed training of each member of the health service team.

IDF3.1 ► C Doctors working in our health service are one or more of the following:

- specialist GPs
- GPs in training under appropriate supervision in accordance with the *Standards for general practice training*
- medical practitioners actively working towards Fellowship on a recognised general practice training pathway
- medical practitioners with more than 10 years' experience in Australian general practice
- have general registration as medical practitioners
- hold an equivalent qualification in general practice from a competent authority nation.

You must:

- keep records of each GP's appropriate qualifications
- employ doctors who have the qualifications and training necessary to meet the needs of patients, if you have not been able to recruit recognised GPs.

You could:

- keep copies of job advertisements that the health service has used to recruit GPs.

IDF3.1 ► D Members of our clinical team have cultural awareness and seek to provide a culturally safe environment for their patients.

You must:

- demonstrate that health service team members have intercultural knowledge and skills
- create a culturally safe environment for staff and individuals in detention.

You could:

- provide training for the health service team on intercultural knowledge and skills

- demonstrate how health service staff are aware of how various conditions (eg mental health conditions) can present in different cultures
- provide training in relevant language skills relevant to the patient population.

IDF3.1 ► E Our health service identifies and addresses discriminatory practices associated with stigma and bias to ensure equitable practices and access to services.

You must:

- demonstrate how your health service identifies discriminatory practices associated with stigma and bias
- demonstrate how your health service addresses discriminatory practices associated with stigma and bias.

You could:

- provide health service staff with access to cultural awareness training
- provide health service staff with information about external cultural awareness training
- provide inhouse cultural awareness sessions and refreshers for staff.

IDF3.1 ► F Our clinical team has undergone training specific to the patient population health needs.

You must:

- provide evidence that clinical staff are provided with relevant training.

You could:

- record each member's qualifications in employment files
- specify required qualifications in job descriptions for each clinical role in the health service team
- keep training logs that record training that clinical team members have completed
- keep a training calendar listing opportunities for professional development and training that has been completed
- conduct annual performance reviews that identify learning and development goals
- store documents that record training needs and training completed.

IDF3.1 ► G Our clinical team is trained to use the health service's equipment that they need to perform their role safely and effectively.

You must:

- be able to demonstrate that the health service team has been provided with training on the safe use of equipment.

You could:

- keep training logs that record training that practitioners have completed, particularly in the use of specialist or emergency equipment
- keep a training and development calendar, showing when refresher training needs to be completed
- conduct performance reviews that identify learning and development goals
- store documents that record training needs and completed training of each member of the health service team

- educate clinical team members so they know how to use the health service equipment relevant to their role
- register any issues, near misses or adverse events related to the use of equipment in your health service's incident or event register (as per [Criterion Q13.1: Managing clinical risks](#))
- record any discussions, actions and/or quality improvement taken in response to events related to the use of equipment in your incident or event register.

IDF Standard 4

Reducing the risk of infection

| Our health service has systems that reduce the risk of infections.

Infection prevention and control are critical in immigration detention facility health services. The unique environment of the detention setting is such that unusual, exotic or particularly contagious infections might be encountered. As care in immigration detention facility health services is delivered by teams that include doctors, nurses and other health professionals, all members of the health service team are responsible for preventing and controlling infection in the health service. The health service team must be educated and competent in the control and prevention of infection to reduce the risk of cross-infection and transmission of disease.

Criterion IDF4.1: Infection prevention and control, including sterilisation

Indicators

IDF4.1 ► A Our health service has at least one clinical team member who has primary responsibility for:

- coordinating prevention and control of infection
- coordinating control of infectious outbreaks within the immigration detention facility and communication with relevant health authorities regarding these
- coordinating the provision of an adequate range of sterile equipment (reprocessed or disposable)
- where relevant, having procedures for reprocessing (sterilising) instruments on or off site, and ensuring there is documentary evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

IDF4.1 ► B Our health service has a written, service-specific policy that outlines our infection-control processes.

IDF4.1 ► C Our health service has a clinical team member who has primary responsibility for educating the health service team about infection prevention and control.

IDF4.1 ► D All members of our health service team manage risks of potential cross-infection in our health service by methods that include:

- good hand hygiene practices
- the use of PPE
- triage of patients with potential communicable diseases
- safe storage and disposal of clinical waste including sharps
- safe management of blood and body fluid spills.

IDF4.1 ► E Our health service has a dedicated space for patient isolation when a patient presents a risk of infection to others.

IDF4.1 ► F Our patients are informed about respiratory etiquette, hand hygiene and precautionary techniques to prevent the transmission of communicable diseases.

IDF4.1G Our health service records the sterilisation load number from the sterile barrier system in the patient's health record when sterile items have been used, and records the patient's name against those load numbers in a sterilisation log or list.

IDF4.1 ► H If our health service manages blood and blood products, it distributes and handles blood and blood products in accordance with manufacturer's recommendations, legislation and jurisdictional requirements.

IDF4.1I Our health service provides access to harm-minimisation programs.

Why this is important

Having systems with clear lines of accountability and responsibility is part of good governance and the delivery of safety and quality care of patients.

It is important to keep patients and the health service team safe from infection. Infection prevention and control reduces the risk of infection travelling from patient to patient, or from patient to members of the health service team.

Meeting this criterion

Infection prevention and control

Your health service must have at least one member of the clinical team who has primary responsibility for the health service's processes to prevent and control infection, including:

- hand hygiene
- provision of sterile instruments
- environmental cleaning
- spills management
- health service team immunisations
- educating the health service team.

These responsibilities must be documented, and the health service team must understand and comply with these processes.

Educating the health service team

To reduce the risk of infection, all members of the health service team must be educated about infection prevention and control processes based on their role. This education could begin during induction and continue throughout their employment.

Policies and procedures that include triage protocols and tools, such as checklists, will help all members of the health service team to understand their own and others' roles and responsibilities relating to infection.

Refer to the current edition of the RACGP's *Infection prevention and control standards* for guidance about how to record the education of health service team members and evaluate their competency in this area.

All members of the health service team must:

- have easy access to PPE (eg masks, gloves, gowns, protective eye wear)
- receive education about the proper use of PPE
- have a clear understanding of the purpose of PPE and how to apply, remove and dispose of it appropriately.
- Antimicrobial stewardship

It is important that your health service team's antibiotic prescribing is in accordance with relevant national standards. Your health service could provide education to the health service team on your antimicrobial stewardship program, including policies and procedures and how to find information on appropriate antibiotic prescribing.

Practitioners must have access to appropriate guidelines, such as the Therapeutic guidelines: Antibiotic, to promote and support informed prescribing of antibiotics.

Your health service could also make other resources available to help all health professionals reinforce to patients the important messages about appropriate antibiotic use and actions that can be taken to reduce antimicrobial resistance.

Managing the risk of cross-infection in the health service

Risks of cross-infection in the health service must be minimised.

The health service team members need to know how to implement standard and transmission-based precautions, spills management and environmental cleaning.

Refer to and follow the applicable sections of the *Infection prevention and control standards*, which recommend the use of standard and transmission-based precautions (eg hand hygiene and PPE, such as heavy-duty protective gloves, gowns, plastic aprons, masks and protective eyewear, or other protective barriers) when cleaning, performing procedures, dealing with spills and handling waste. Prescribing the correct levels of PPE, in addition to other hierarchy of controls, will ensure that healthcare workers are protected from infection.

Standard precautions must be applied at all times, based on the assumption that all blood and body substances, including respiratory droplet contamination, are potentially infectious.

Implement standard and transmission- and/or aerosol-based precautions, as determined by a risk assessment, during recognised periods of increased risk of transmission or because of potentially infectious patients. You can minimise exposure to other patients and the health service team by:

- conducting a risk assessment and identifying strategies to eliminate or minimise the risk of transmission
- implementing effective triage and appointment scheduling
- determining and applying the most appropriate transmission- and/or aerosol-based precautions to adopt, in addition to standard precautions (ie type of PPE, including particulate respirators, surgical masks, gowns, protective eyewear and gloves)
- implementing distancing techniques, such as:
 - spacing patients in the health service in line with relevant health authority guidance
 - isolating the infected patient in a separate space.
- reconsidering the use of services dependent on equipment that presents a heightened cross-infection risk (eg spirometry) in line with expert recommendations, and whether referral to another service is appropriate or available.

Educate patients on how they can reduce the spread of infection while at the health service. For example, you can display signs in the waiting room and have tissues, rubbish bins and alcohol-based hand sanitiser available.

Infection-control policy

Develop policies, procedures and tools, such as checklists, so that adequate steps are taken during the complete sterilisation process. Your infection-control policy must contain:

- the name of the team member/s responsible for infection control and sterilisation processes
- the appropriate use and application of standard and transmission-based precautions
- management of sharps injury
- management of blood and body-substance spills
- hand hygiene

- environmental cleaning of clinical and non-clinical areas of the health service
- use of aseptic and sterile procedures
- procedures for reprocessing (sterilising) instruments (if relevant) on or off site, ensuring there is documented evidence this reprocessing is monitored and has been validated
- use of appropriate medical isolation for individuals with communicable diseases
- waste management, including the safe storage and disposal of clinical waste and sharps
- where patients and the health service team can access PPE
- how and when health service team members are educated on the appropriate application, removal and disposal of PPE.

Providing appropriately disinfected and sterile instruments and equipment

The clinical team member who has primary responsibility for infection prevention and control processes must ensure that equipment and instruments used in patient care have been appropriately cleaned and disinfected or sterilised. The appropriate level of processing of instruments and equipment is determined by the risk of infection posed by their reuse.

Instruments that must be sterile in use can be:

- single-use sterile items
- items that are reprocessed by the health service or by an offsite sterilisation facility.

If you use an accredited offsite sterilisation facility (eg an accredited general practice or Australian Council on Healthcare Standards accredited hospital), your health service must have a copy of the facility's accreditation certificate.

If you use a non-accredited offsite facility, your health service must be satisfied that the facility would meet accreditation requirements for sterilisation, and keep copies of the facility's relevant documents, including:

- reprocessing policies and procedures
- sterilisation policies and procedures
- results of annual validation.

Isolation

Your health service must have a dedicated area/s where infectious patients can be isolated and observed. Isolating infected patients can minimise the risk of infection transmission. Isolated patients must be observed, receive continuing medical care, and have access to bathroom facilities. Quarantined individuals must be able, to the extent that it is reasonably possible, to participate in meaningful activities equivalent to the rest of the immigration detention facility population. A member of the clinical team must visit quarantined individuals regularly to assess the impact of isolation on their physical and mental health.

The health service must only isolate or quarantine an individual when absolutely necessary to protect others. The reasons for quarantine must be:

- explained to the individual
- recorded in the individual's health record
- reported to health service's governing body.

Isolation areas require additional cleaning, especially where there is a risk of multiresistant organism transmission. The health service team member responsible for coordinating prevention and control of

infection must collaborate with all relevant stakeholders within the immigration detention facility, as well as external authorities, to minimise risk of outbreak within the immigration detention facility population.

If your health service has greater demand for isolation than its facilities can accommodate, who is placed in isolation must be determined by the clinical team, with priority given to patients whose infection requires airborne precautions.

Your health service must develop, implement, assess and revise policies regarding isolation space based on its patient population demography and the service's specialties.

Harm-minimisation programs

Your health service could implement a range of harm-minimisation programs relevant to its patient population.

The implementation of needle and syringe exchange programs and opioid replacement therapy has been shown to help reduce disease transmission among injecting drug users.^{26,27} Implementing harm-minimisation programs in your health service will allow you to better plan for the use of drugs, needles and syringes by your patient population and educate patients on the prevention of disease transmission (eg HIV) among those who inject drugs and others in the immigration detention facility and community.

Quality-improvement activities/audits

Your health service might wish to involve its practitioners in quality-improvement activities that will improve clinical practice. Practitioners could also conduct a clinical audit to identify their patterns of antibiotic prescribing and monitor compliance with the health service's policies on antibiotic prescribing.

Waste management

Refer to and follow the applicable sections of the *Infection prevention and control standards*, which provide guidance on waste management that you might consider when developing an infection prevention and control policy.

Keeping up to date

Keep up to date with changes in laws and guidelines relating to infection prevention and control, and implement them promptly. Establish:

- systems for monitoring and obtaining information about public health alerts for national and local infection outbreaks, such as pandemic influenza, measles and pertussis
- protocols for managing outbreaks of infectious disease, in line with local, state and national guidance.

Tracking the sterility of medical instruments and tracing patients

Whenever your health service uses and sterilises reusable equipment, instruments and devices, implement a traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying the patient, the procedure and the reusable equipment, instruments and devices that were used.

If sterile single-use items are used from an external medical company, ensure that these are documented as such (ie a separate chart), including the date, patient, and the instrument used, batch number and company. This ensures that if that company later identifies that an infection-control breach has occurred, your health service can easily identify and inform the patient and take appropriate measures.

If your health service adheres to and monitors a validated sterilisation process, it might not be necessary to track medical devices or trace patients on whom they have been used. Nonetheless, it might be helpful to have the ability to trace patients and track medical devices in case there is a failure in processing or reprocessing, or if medico-legal issues arise relating to infection control.

To verify that the medical instruments used in any individual case were sterilised correctly, you might want to refer to the details of the sterilisation process. So that you can do this, you need to enter into the patient's health record the sterilisation load number from the sterile barrier system that the instruments came in. If an issue arises, you can use this load number to refer back to the sterilisation log to recheck the results of that particular cycle. However, it is important to note this does not actually prove that the instruments were sterile at the time of use.

If a process failure is identified after the release of sterile items for use, it is helpful to be able to identify all patients on whom those items were used. To achieve this for items:

- reprocessed onsite: record patient identifiers (eg name and/or record number or date of birth) for each patient next to each item or pack listed in the load details in the steriliser log
- sterilised offsite or purchased sterile: keep a list of the items onsite.

Meeting each indicator

IDF4.1 ► A Our health service has at least one clinical team member who has primary responsibility for:

- coordinating prevention and control of infection
- coordinating control of infectious outbreaks within the immigration detention facility, and communication with relevant health authorities regarding these
- coordinating the provision of an adequate range of sterile equipment (reprocessed or disposable)
- where relevant, having procedures for reprocessing (sterilising) instruments on or off site, and ensuring there is documentary evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

You must:

- have at least one identified clinical team member who has primary responsibility for infection control and sterilisation
- ensure that the health service team members' immunisations are documented (with their consent).

You could:

- identify the team member who has primary responsibility for infection prevention and control in their position description
- discuss changes to laws and guidelines relating to infection control, local outbreaks and public health alerts at team meetings, and document these discussions
- maintain a policy and procedure manual on infection prevention and control that covers all aspects relevant to your health service.

IDF4.1 ► B Our health service has a written, service-specific policy that outlines our infection-control processes.

You must:

- maintain an up-to-date service-specific infection-control policy.

You could:

- review the policy on an annual basis
- consult with the health service team when developing the health service policy
- conduct regular audits to confirm compliance with the health service policy.

IDF4.1 ► C Our health service has a clinical team member who has primary responsibility for educating the health service team about infection prevention and control.

You must:

- have at least one clinical team member who has responsibility for ensuring that all members of the health service team receive appropriate education about infection control and sterilisation.

You could:

- identify the team member who has primary responsibility for infection prevention and control education in their position description
- include infection control in induction and ongoing education programs for the health service team
- discuss any changes to laws and guidelines relating to infection control, local outbreaks and public health alerts at health service team meetings, and document these discussions
- include statements about education in the infection-control policy.

IDF4.1 ► D All members of our health service team manage risks of potential cross-infection in our health service by methods that include:

- good hand hygiene practices
- the use of PPE
- triage of patients with potential communicable diseases
- safe storage and disposal of clinical waste, including sharps
- safe management of blood and body fluid spills.

You must:

- be able to demonstrate that health service team members manage risks of cross-infection
- ensure the health service team has access to PPE
- safely store and dispose of sharps and clinical waste.

You could:

- maintain a policy and procedure manual on infection control
- maintain a cleaning policy
- maintain a cleaning log
- discuss changes to laws and guidelines relating to infection control, local outbreaks and public health alerts at health service team meetings, and document these discussions.

IDF4.1 ► E Our health service has a dedicated space for patient isolation when a patient presents a risk of infection to others.

You must:

- have a dedicated area where infectious patients can be isolated and observed
- maintain policy and procedures regarding isolation, based on your health service's patient population demography and specialties.

You could:

- have a policy for the triage of patients requiring isolation
- maintain policy and procedures in place for the dedicated cleaning of isolation spaces.

IDF4.1 ► F Our patients are informed about respiratory etiquette, hand hygiene and precautionary techniques to prevent the transmission of communicable diseases.

You must:

- have a policy on infection control.

You could:

- have hand washing facilities, hand sanitiser, tissues and rubbish bins available for team members and patients
- have brochures or posters available at the health service and throughout the immigration detention facility in the commonly used languages of your patient population that explain respiratory etiquette and hand hygiene processes
- display a sign in the waiting area advising patients who have a high-risk condition or deteriorating symptoms to tell reception staff members
- maintain a procedures manual on infection control
- maintain a cleaning policy
- maintain a cleaning log
- discuss changes to laws and guidelines relating to infection control, local outbreaks and public health alerts at team meetings, and document these discussions.

IDF4.1G Our health service records the sterilisation load number from the sterile barrier system in the patient's health record when sterile items have been used, and records the patient's name against those load numbers in a sterilisation log or list.

You could:

- show evidence that sterilisation load numbers are recorded in the patient's health record when sterile items have been used
- have a log or list that records the patient's name against sterilisation load numbers.

IDF4.1 ► H If our health service manages blood and blood products, it distributes and handles blood and blood products in accordance with manufacturer's recommendations, legislation and jurisdictional requirements.

You must:

- store, distribute and handle blood and blood products in accordance with manufacturer's recommendations, legislation and jurisdictional requirements.

You could:

- have at least one clinical team member who has responsibility for ensuring that all members of the health service team receive appropriate education about the storage, distribution and handling of blood and blood products
- identify the team member who has primary responsibility for blood and blood products education in their position description.

IDF4.11 Our health service provides access to a harm-minimisation programs.

You could:

- provide access to a needle and syringe exchange program
- provide access to an opioid replacement therapy program
- educate patients on the safe disposal and acquisition of needles and syringes.

IDF Standard 5

Health service facilities

Our health service's facilities and medical equipment are appropriate for providing comprehensive patient care.

You must provide a safe and effective environment for your health service team and patients.

You must ensure that your health service team has access to the appropriate medical equipment they need to provide comprehensive care to their patient population, whether in the health service's rooms or elsewhere (where practitioners will need to access fully stocked portable equipment).

Criterion IDF5.1: Health service facilities

Indicators

- IDF5.1 ► A** Our health service's facilities are fit for purpose.
- IDF5.1 ► B** All face-to-face patient consultations in our health service take place in an appropriate consultation or examination space.
- IDF5.1 ► C** Our health service uses consultation spaces that permit patient privacy and confidentiality.
- IDF5.1 ► D** Our health service has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time.
- IDF5.1 ► E** Our health service has accessible toilets.
- IDF5.1 ► F** Our health service has accessible hand-cleaning facilities.
- IDF5.1 ► G** Our health service is visibly clean.

Why this is important

Without appropriate facilities, the patient care you provide can be compromised and patient safety might be put at risk. Your facility must therefore provide an environment that enables the health service team members to perform their duties safely and effectively.

Meeting this criterion

Design and layout

Your health service facilities must be fit for purpose, and the design and layout must enable privacy, security, consultation space and access to facilities, such as toilets and hand-cleaning facilities.

The layout of the health service will ideally provide reception staff members clear sight of the waiting areas, so that they can see and monitor waiting patients.

You could also consider the cultural requirements of your patients in areas, such as the waiting room.

Consultation rooms need to be kept at a comfortable temperature.

Privacy and patient dignity

A well-designed layout can help to maintain patient privacy and confidentiality. For example, you could consider whether:

- there is adequate sound proofing between internal walls
- there are areas where private conversations can be held
- the computer screens in the reception area are hidden from the view of patients and other visitors
- private and confidential discussions in the reception area (on the phone and directly with patients) can be overheard
- the layout, music and other features of the reception area protect patient privacy during discussions (eg protection of details, such as unique patient identifiers and medical information).

You must protect the dignity of each patient by ensuring both visual and auditory privacy.

Visual privacy ensures that others cannot see the patient during the consultation, and that the patient can undress in private and be covered as much as possible during an examination. This can be achieved by practitioners:

- using a gown or sheet to cover patients
- leaving the room while a patient is undressing and dressing
- providing an adequate curtain or screen
- finding a private area.

Auditory privacy ensures that other people cannot overhear a consultation. This can be achieved by the health service:

- having solid doors (instead of doors with paper cores)
- using draught-proofing tape around door frames and a draught-excluder at the base of doors
- playing appropriate background music to mask conversations between members of the health service team and patients
- finding a private area.

Audio- or video-monitoring devices must not be present in the health service.

In detention settings, non-health immigration detention facility staff (eg security) might be involved in a detained individual's day-to-day activities, including escorting them to health service appointments. Your health service must ensure that patient privacy and dignity is maintained when non-health stakeholders are present. A patient might decide to not discuss their health or receive treatment if the immigration detention facility has mandated the presence of a third party who the patient does not consent to having present.

More information regarding your health service's privacy policy and privacy of health information is provided in [Criterion C6.3: Confidentiality and privacy of health](#) and other information.

Location of toilets and hand-cleaning facilities

Toilets need to be easily accessible and well signposted. They will ideally be located inside the health service, but if this is not possible, they must be as close to the health service as possible.

You could provide separate toilets for the health service team and patients.

Washbasins need to be in, or close to, the toilets so as to reduce the possible spread of infection, and the health service team and patients need to be able to access them easily.

Environmental cleaning

Your health service could appoint one member of the health service team who has the primary responsibility for ensuring that appropriate cleaning processes are in place.

If your health service engages commercial cleaners for environmental cleaning, or uses cleaners provided by the immigration detention facility itself, you could have them sign a written contract that outlines a schedule, suitable products to be used for areas to be cleaned and minimum expected standards of cleanliness. You could also consider having the cleaners record their work in a log.

Environmental cleaning must be intensified in the event of a pandemic or other infectious disease outbreak. This includes increasing the frequency of cleaning high-touch surfaces (eg door handles, tables and handrails), disinfecting surfaces after cleaning and terminal cleaning. You might need to refer to local, state and national public health guidance to determine if there are any additional cleaning requirements.

Meeting each indicator

IDF5.1 ► A Our health service's facilities are fit for purpose.

You must:

- ensure the health service facilities are fit for purpose.

IDF5.1 ► B All face-to-face patient consultations in our health service take place in an appropriate consultation or examination space.

You must:

- have dedicated consultation spaces.

IDF5.1 ► C Our health service uses consultation spaces that permit patient privacy and confidentiality.

You must:

- have consultation spaces that provide auditory and visual privacy.

You could:

- provide patient privacy screens.

IDF5.1 ► D Our health service has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time.

You must:

- have a dedicated patient waiting area with adequate seating for the health service's usual number of patients.

You could:

- configure the reception area so reception staff members can monitor the waiting area.

IDF5.1 ► E Our health service has accessible toilets.

You must:

- be able to demonstrate how patients can access toilet facilities when required during a consultation.

You could:

- have appropriate signs to indicate the location of toilets and other facilities.

IDF5.1 ► F Our health service has accessible hand-cleaning facilities.

You must:

- provide patients with access to effective hand-cleaning facilities.

You could:

- provide alternatives for effective hand cleaning that ensures hand hygiene during a consultation (eg with alcohol-based hand rub).

IDF5.1 ► G Our health service is visibly clean.

You must:

- be able to demonstrate that the health service is regularly cleaned.

You could:

- have a written and signed agreement with commercial cleaners
- use a cleaning log.

Criterion IDF5.2: Health service equipment

Indicators

IDF5.2▶A Our health service has equipment that enables us to provide comprehensive primary care and emergency resuscitation, including:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask)
- intravenous access
- electrocardiograph
- emergency medicines
- examination light
- eye examination equipment (eg fluorescein staining)
- gloves (sterile and non-sterile)
- height measurement device
- measuring tape
- equipment for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- PPE
- pulse oximeter
- scales, including for infants
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer with small, medium and large cuffs
- spirometer
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips, including for pregnancy testing
- testing kits
- vaginal specula
- visual acuity charts
- the ability to view X-rays.

IDF5.2▶B Our health service maintains our clinical equipment in accordance with each manufacturer's recommendations.

IDF5.2▶C Our health service has one or more height-adjustable beds.

IDF5.2▶D Our health service has a defibrillator.

IDF5.2E Our health service has point-of-care testing equipment.

Why this is important

You need to have equipment that enables your health service to provide comprehensive primary care and emergency resuscitation.

Equipment needs to be maintained so that it is always in good working order whenever it is needed.

Research shows that pulse oximeters are useful to diagnose and assess hypoxaemia.²⁸

Other research shows that (despite the efforts of medical practitioners, policy makers and consumer advocates) people with a disability continue to experience poorer health outcomes in a range of areas when compared with the broader population.²⁹ One reason for these poorer health outcomes has been the lack of height-adjustable examination beds in health services, resulting in fewer opportunities for patients with disability to have thorough and dignified clinical examinations.³⁰ Using height-adjustable beds might also reduce workplace injuries, because it might reduce the need for practitioners to help patients onto an examination bed that is too high.

Having an automated external defibrillator (AED) in your health service can reduce the risk of fatality from cardiac arrest.³¹

Most cases of sudden cardiac arrest are due to ventricular fibrillation that can be returned to a normal sinus rhythm with the use of an AED. Using an AED is relatively straightforward and cannot cause harm, as they analyse the cardiac rhythm and will deliver a shock only if necessary. Survival rates after sudden cardiac arrest drop by 7–10% for every minute without CPR and defibrillation.³²

CPR alone has a 5% survival rate, but CPR combined with early defibrillation increases the survival rate to 50%.³³

Point-of-care testing allows for:

- healthcare practitioners' ability to make immediate and informed decisions about patient care, which will result in improved clinical management
- greater patient compliance with pathology requests, especially for at-risk patients
- greater convenience and satisfaction for patients because of the speed of diagnosis and treatment decisions
- more opportunities for patients to engage with the health service team.³⁴

Meeting this criterion

Range of equipment

Your health service must have all the equipment necessary to provide services that meet the needs of the immigration detention facility community and support the procedures performed in the health service. This might mean that you have some equipment that other health services might not need, but is relevant to your location or patient population.

PPE can include masks, plastic aprons, gowns, goggles/glasses, face shields, gloves and swabs.

Scales for infants are only required in a health service if infants are detained at the immigration detention facility.

Maintaining clinical equipment

Your health service must ensure that all clinical equipment is maintained and in working order at all times. You could maintain a register that lists all clinical equipment in the health service, along with schedules for servicing and maintenance.

Equipment that requires calibration, or that is electrical or battery powered (eg electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales and defibrillators), must be serviced regularly in accordance with the manufacturer's instructions so that it remains in good working order. You could keep receipts from companies that have provided external equipment testing and calibration so you can schedule regular maintenance checks. You could also maintain a checklist of equipment used in your consultation rooms so you can record dates of servicing and regularly check that maintenance is up to date.

You must store all hazardous materials, including liquid nitrogen and oxygen, in accordance with work health and safety regulations.

Height-adjustable beds

Follow these guidelines when purchasing height-adjustable beds:

- Preferred minimum range of height adjustment: 45–95 cm
- Preferred maximum weight capacity: 175 kg
- Preferred minimum width of table: 71 cm
- Preferred minimum length: 193 cm
- Number of sections: two (so that the head section can be raised)

You could also consider purchasing other features and equipment for your height-adjustable beds, such as stirrups for gynaecological examinations.

Electrocardiograph and spirometer

Your health service must have an electrocardiograph and a spirometer, and the clinical team must be properly trained to use and maintain that equipment, and analyse the results.

AED

Your health service must have AED and:

- it must be maintained according to the manufacturer's specifications
- the health service team must be properly trained to use and maintain it
- it must be placed where it is clearly visible and accessible, and not exposed to extreme temperatures
- there must be clear signs to indicate where it is located.

Consulting with the health service team

In accordance with Safe Work Australia recommendations,³⁵ consider consulting with the health service team before making decisions on health and safety matters, and before deciding what new facilities the health service needs.

Meeting each indicator

IDF5.2▶ A Our health service has equipment that enables us to provide comprehensive primary care and emergency resuscitation. Refer to list under the **indicator on page 176**.

You must:

- **have all required equipment.**

You could:

- maintain a checklist of equipment that you need in consultation rooms
- maintain an equipment register, including all of the required equipment
- perform a regular audit of the health service's equipment
- have at least one team member who has primary responsibility for stock take and supervision on the continuous supply of equipment.

IDF5.2▶B Our health service maintains our clinical equipment in accordance with each manufacturer's recommendations.

You must:

- demonstrate that you keep all clinical equipment in good working order in accordance with manufacturers' recommendations.

You could:

- keep a maintenance log that includes receipts from any external companies that test and calibrate equipment.

IDF5.2▶C Our health service has one or more height-adjustable beds.

You must:

- have at least one height-adjustable bed.

You could:

- have a height-adjustable bed in each consultation space.

IDF5.2▶D Our health service has a defibrillator.

You must:

- have a defibrillator

You could:

- educate the health service team so they know how patients can access defibrillation when required.

IDF5.2E Our health service has point-of-care testing equipment.

You could:

- have point-of-care testing equipment at your health service
- describe your health service's requirements for point-of-care testing
- provide training to clinical staff in the use of point-of-care testing equipment.

Criterion IDF5.3: Portable equipment

Indicator

IDF5.3▶A Each of our practitioners has access to portable equipment (such as an equipment bag or trolley) when attending to patients outside of the health service's regular consultation space, containing:

- auriscope
- disposable gloves
- equipment for maintaining an airway in adults and children
- hand sanitiser
- in-date medicines for medical emergencies
- sharps container
- sphygmomanometer
- stethoscope
- surgical mask
- syringes and needles in a range of sizes
- thermometer
- tongue depressors
- torch.

Why this is important

Members of the health service's clinical team must be prepared to visit individuals in detention outside of the health service facility, including living quarters and other areas of the immigration detention facility. Clinical team members must be available at short notice to help in emergencies that take place within the immigration detention facility.

Having portable equipment available by way of an equipment bag or trolley gives practitioners immediate access to core equipment and medications, so they can provide the necessary care in these situations.

Meeting this criterion

Portable equipment

Members of your clinical team must have ready access to a portable equipment that they can take outside the health service facilities or use in an emergency.

If you are a small health service, you might only require one set of portable equipment (eg one bag or one trolley) that is shared by your clinical team. If you are a medium or large health service, you might require multiple sets so multiple practitioners can simultaneously use the equipment when required.

Storing portable equipment

You must store portable equipment securely and in accordance with state and territory laws.

Deciding what to include in your portable equipment

Determine which medications you need to include based on the:

- location of the health service
- health needs of the immigration detention facility's community
- types of clinical conditions likely to be encountered
- shelf life and climatic vulnerability of each medicine.

To ensure patients' safe use of medicines, you must store these products appropriately and securely, and not use or distribute them after their expiry dates.

Requirements relating to the acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation with which you must comply.

Suggested emergency medicines include:

- adrenaline
- atropine sulphate
- benztropine mesylate
- benzylpenicillin
- cephalosporin antibiotic
- chlorpromazine/haloperidol
- clonazepam
- dexamethasone sodium phosphate/
hydrocortisone sodium succinate
- diazepam
- frusemide
- glucose 50% and/or glucagon
- glyceryl trinitrate spray/tablets
- hyoscine butylbromide
- lignocaine
- methoxyflurane
- metoclopramide hydrochloride/prochlorperazine
- midazolam
- morphine sulphate/appropriate analgesic agent
- naloxone hydrochloride
- oxytocin
- phytomenadione
- promethazine hydrochloride
- salbutamol aerosol
- tramadol.

Your health service needs to determine what medicines from the above list it stores, based on its location. Some items in the above list are necessary where there is decreased access to other health services (eg hospitals).

You must have:

- an up-to-date logbook that lists the emergency drug stocks your health service keeps with its portable equipment
- a system for checking expiry dates and replacing expired drugs.

Emergency drugs for children

A list of paediatric emergency drugs and their dosages can be found in the Royal Children's Hospital Melbourne's [Clinical practice guidelines – Emergency drug doses](#). Consider the items in the list above when deciding which to include with your portable equipment.

Practitioners' knowledge of medicines in your portable equipment

All practitioners must be familiar with the medicines that are in your health service's portable equipment, including their general use, suggested dosages and possible side effects.

The RACGP recommends that practitioners seek appropriate and ongoing education on these medicines.

PPE

PPE is used by staff to minimise the risk of infection. PPE refers to a variety of barriers used to protect mucous membranes, airways, skin and clothing from contact with blood and body substances. This might include gloves, water impermeable aprons/gowns, masks, protective eyewear and footwear.

The choice of appropriate PPE to include in a doctor's bag is determined by the risk of infection and transmission-based precautions. At a minimum, your doctor's bag requires PPE for standard precautions (gloves, gown, surgical mask and protective eyewear). Additional PPE could be provided if a previsit risk assessment indicates risk of transmission via the contact, droplet or airborne routes.

More information on the use of PPE is available in Section 1.4: Precautions and Section 1.5: Personal protective equipment in the RACGP *Infection prevention and control standards for general practices and other office-based and community-based practices* (5th edition).

Meeting each indicator

IDF5.3▶ A Each of our practitioners has access to portable equipment when attending to patients outside of the health service's regular consultation space (such as an equipment bag or trolley), containing the items listed under the [indicator on page 180](#).

You must:

- have portable equipment that your clinical team can access
- store medicines in accordance with legislative requirements.

You could:

- educate clinical team members about the medicines included with the portable equipment, including their suggested dosage and possible side effects
- educate the clinical team members so they know how to properly stock the portable equipment
- maintain a checklist of the portable equipment contents
- perform a regular audit of the portable equipment contents.

IDF Standard 6

Vaccine potency

| Our health service maintains the potency of vaccines.

As vaccines are delicate biological substances, they can become less effective or destroyed if they are not kept within an optimal temperature range or if they are exposed to direct ultraviolet light. You must therefore maintain the potency of your vaccines to ensure they are effective in improving immunity against disease.

A cold chain is a series of temperature-controlled storage and distribution activities (also called a 'supply chain'). An unbroken cold chain is a supply chain that never exceeds or drops below a designated safe temperature range. A cold chain helps to maintain the shelf life and potency of vaccines.

Criterion IDF6.1: Maintaining vaccine potency

Indicators

IDF6.1 ► A Our health service has at least one team member who has primary responsibility for cold chain management in the health service.

IDF6.1 ► B The team member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the *National vaccine storage guidelines: Strive for 5*.

IDF6.1 ► C The team member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:

- ordering and stock rotation protocols
- maintenance of equipment
- annual audit of our vaccine storage procedures
- continuity of the cold chain, including the handover process between designated members of the health service team
- accuracy of our digital vaccine refrigerator thermometer.

IDF6.1 ► D Our health service has a written, health service-specific policy that outlines our cold chain processes.

Why this is important

The success of any vaccination program depends on the potency of vaccines when they are administered to patients. To maintain their potency, vaccines need to be transported and stored within the temperature range of 2–8°C. As vaccines are delicate biological products, they become ineffective if they are not transported and stored within this temperature range.

Meeting this criterion

Nominating a person with primary responsibility

Your health service must nominate a member of the clinical team to take responsibility for cold chain management and compliance with cold chain management guidelines.

The team member responsible for cold chain management must be trained so they have the knowledge and skills required to ensure that vaccines remain potent.

All members of the health service team must know which team member has primary responsibility for cold chain management so they can seek advice and support from this person to ensure vaccine potency.

Your health service needs to have a process for the nominated person to hand over to another designated and trained member of the clinical team when they are unavailable.

Your health service's quality assurance and risk-management processes can include self-auditing of your health service's cold chain management.

Choosing a refrigerator

Your health service must store vaccines in a reliable refrigerator that is capable of maintaining a stable temperature and large enough to store a sufficient number of vaccines to meet your health service's needs (with consideration of frequency and size of orders).

Do not use cyclic defrost refrigerators, as their internal temperatures fluctuate considerably.

Domestic refrigerators (including bar fridges) are not built or designed to store vaccines and must not be used for vaccine storage. Refer to your state or territory health department for further advice.

Monitoring the refrigerator's temperature

Your health service must:

- monitor and record the minimum and maximum temperatures of refrigerators in which any vaccine is stored at least twice a day on each day the health service is open (ideally at the beginning and end of the day)
- view and consider (but not record) the current temperature every time a refrigerator storing a vaccine is opened
- take appropriate action if the temperature is not stable or within the required range.

Data loggers or digital thermometers in refrigerators

Your health service can use data loggers or digital thermometers to verify the efficacy of your cold chain and to conduct quality control checks of the temperature of refrigerators storing vaccines. Data loggers are small electronic devices that continuously measure temperatures, with the data uploaded to computer software so that you can view and monitor the results. Some vaccine refrigerators come with inbuilt data loggers, but you can also purchase an external data logger if necessary.

Data loggers will help you identify and record:

- the accuracy of the thermometer
- temperature fluctuations inside the refrigerator, including the duration of the fluctuations
- areas in the refrigerator that are potentially too cool or too warm to store vaccines.

Cold chain management

To be confident of the potency of vaccines stored in your health service, you must:

- document and follow routine processes to maintain the cold chain, identify risks to the potency of vaccines (such as a loss of power) and implement appropriate strategies to manage this risk
- provide all members of the health service team who handle vaccines with ongoing education that is appropriate to their level of responsibility and forms part of their professional development
- be aware of what action is required if the temperature of the refrigerator has not been maintained within the required range.

Self-auditing

Your health service could conduct a self-audit of your cold chain management every 12 months as part of your routine quality assurance and risk-management process to ensure you only administer potent vaccines. An example of a self-audit is contained in the [National vaccine storage guidelines: Strive for 5](#).

Meeting each indicator

IDF6.1 ► A Our health service has at least one team member who has primary responsibility for cold chain management in the health service.

You must:

- have a team member who has primary responsibility for cold chain management
- educate the team member with primary responsibility for cold chain management about their role
- inform the health service team members so they know who is responsible for cold chain management
- have a process to transfer cold chain management when the team member with primary responsibility is unavailable.

You could:

- include education about cold chain management in induction and ongoing training for the health service team.

IDF6.1 ► B The team member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the *National vaccine storage guidelines: Strive for 5*.

You must:

- maintain a cold chain management policy and procedure
- have a team member who is responsible for the health service complying with the current edition of the *National vaccine storage guidelines: Strive for 5*.

You could:

- conduct an audit of vaccine storage to determine whether it complies with the *National vaccine guidelines: Strive for 5*.

IDF6.1 ► C The team member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:

- ordering and stock rotation protocols
- maintenance of equipment
- annual audit of our vaccine storage procedures
- continuity of the cold chain, including the handover process between designated members of the health service team
- accuracy of our digital vaccine refrigerator thermometer.

You must:

- maintain a cold chain management policy and procedure
- have procedures that require a written record of all monitoring of refrigerators in which vaccines are stored, including the temperature.

You could:

- create a template to make monitoring and recording of refrigerator temperatures easier
- create a roster for monitoring cold chain compliance.

IDF6.1 ► D Our health service has a written, health service-specific policy that outlines our cold chain processes.

You must:

- maintain a cold chain management policy and procedure.

You could:

- review the cold chain management policy once a year
- discuss the cold chain management policy in team meetings.

References

1. Medical Board of Australia. Guidelines for technology-based patient consultations. Medical Board of Australia, 2012.
2. Menec VH, Sirski M, Attawar D, Katz A. Does continuity of care with a family physician reduce hospitalizations among older adults? *J Health Serv Res Policy* 2006;11(4):196–201.
3. Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London, UK: The King's Fund, 2018.
4. van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: A systematic and critical review. *J Eval Clin Pract* 2010;16(5):947–56.
5. Steering Committee for the Review of Government Service Provision. Report on government services 2019. Public hospitals. Canberra, ACT: Productivity Commission, 2019. Available at www.pc.gov.au/research/ongoing/report-on-government-services/2019/health/public-hospitals [Accessed 10 August 2022].
6. Western Australia Primary Health Alliance. Comprehensive primary care: What patient centred medical home models mean for Australian primary health care. Belmont, WA: WAPHA, 2016.
7. World Health Organization. Continuity and coordination of care: A practice brief to support implementation of the WHO framework on integrated people-centred health services. Geneva: WHO, 2018.
8. Hollander MJ, Kadlec H, Hamdi R, Tessaro A. Increasing value for money in the Canadian healthcare system: New findings on the contribution of primary care services. *Healthc Q* 2009;12(4):32–44.
9. Gunther S, Taub N, Rogers S, Baker R. What aspects of primary care predict emergency admission rates? A cross sectional study. *BMC Health Serv Res* 2013;13(1):11.
10. King K, Vodicka P. Screening for conditions of public health importance in people arriving in Australia by boat without authority. *Med J Aust* 2001;175(11–12):600–2.
11. United National High Commissioner for Refugees. And the Office of the High Commissioner for Human Rights Global roundtable on alternatives to detention of asylum-seekers, refugees, migrants and stateless persons: Summary conclusions. 2011. Available at www.unhcr.org/refworld/docid/4e315b882.html [Accessed 10 August 2022].
12. Dudley M. Contradictory Australian national policies on self-harm and suicide: the case of asylum seekers in mandatory detention. *Australas Psychiatry*. 2003;11(Suppl1):S102–8.
13. von Werthern, Robjant, Chui Z, et al. The impact of immigration detention on mental health: A systematic review. *BMC Psychiatry*. 2018;18(1):382.
14. Green J, Eagar K. The health of people in Australian immigration detention centres. *Med J Aust* 2010;192(2):65–70.
15. Jesuit Refugee Service. Europe: Becoming vulnerable in detention. 2011. Available at www.unhcr.org/refworld/docid/4ec269f62.html [Accessed 10 August 2022].
16. Foundation House. Caring for refugee patients in general practice. 4th edition. Melbourne: The Victorian Foundation for Survivors of Torture Inc, 2012.
17. Nkulu Kalengayi FK, Hurtig A-K, Nordstrand A, Ahlm C, Ahlberg BM. 'It is a dilemma': Perspectives of nurse practitioners on health screening of newly arrived migrants. *Global Health Action*. 2015;8:27903.
18. Bird S. The duty of GPs to follow up patients. *Aust Fam Physician* 2013;42(4):245–47.
19. The Royal Australian College of General Practitioners. Position statement: Non-GP initiated testing. South Melbourne, Vic: RACGP, 2011.
20. Best Practice Advocacy Centre New Zealand. Taking responsibility for test results: A discussion. Best Tests. 2014. Available at www.bpac.org.nz/BT/2014/August/testresults.aspx [Accessed 10 August 2022].
21. British Medical Association. Acting upon test results in an electronic world. BMA, 2016. Available at www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/testresults-in-an-electronic-world [Accessed 10 August 2022].
22. Department of Health and Ageing. The national evaluation of the second round of coordinated care trials: Final report. Canberra, ACT: DOHA, 2007.
23. Office of the Australia Information Commissioner. Australian Privacy Principles. Privacy Act 1988. Canberra: OAIC, 2015.
24. Victorian Refugee Health Network. Engaging and supporting general practice in refugee health: Briefing paper – Key issues for consideration. 2014. Available at https://refugeehealthnetwork.org.au/wp-content/uploads/Briefing-Paper_2014_December_Primary-Care-Project_FINAL.pdf [Accessed 15 August 2022].
25. Medical Board of Australia. Chapter 8.4: Professional behaviour – Medical records. In: Good medical practice: A code of conduct for doctors in Australia. Medical Board of Australia, 2014.

26. Strike C, Watson T, Lavigne P, et al. Guidelines for better harm reduction: evaluating implementation of best practice recommendations for needle and syringe programs (NSPs). *Int J Drug Policy* 2011;22(1):34–40.
27. Platt L, Minozzi S, Reed J, et al. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev*. 2017 Sep 18;9(9):CD012021.
28. Potter VA. Pulse oximetry in general practice: How would a pulse oximeter influence patient management? *Eur J Gen Pract* 2007;13(4):216–20.
29. Physical Disability Council of New South Wales. Report on access to adjustable height examination tables by people with disabilities at general practices. Sydney: Physical Disability Council of New South Wales, 2009.
30. Physical Disability Council of New South Wales. Report on access to adjustable height examination tables by people with disabilities at general practices. Sydney: Physical Disability Council of New South Wales, 2009.
31. Health Quality Ontario. Use of automated external defibrillators in cardiac arrest: An evidence-based analysis. *Ont Health Technol Assess Ser* 2005;5(19):1–29.
32. Larsen MP, Eisenberg MS, Cummins RO, Hallstrom AP. Predicting survival from out-of-hospital cardiac arrest: A graphic model. *Ann Emerg Med* 1993;22(11):1652–58.
33. Iqbal Z, Somauroo J. Automated external defibrillators in public places: Position statement from the Faculty of Sport and Exercise Medicine UK. *Br J Sports Med* 2015;49(21):1363–64.
34. Department of Health and Ageing. Point-of-care testing in general practice trial: Final report. Canberra: DHA, 2009.
35. Safe Work Australia. Model code of practice: First aid in the workplace. Safe Work Australia. 2015.

Glossary

This glossary contains the definitions of terms used in this document.

Term	Definition
Access	The ability of individuals in detention to obtain services from the immigration detention centre's health service.
Accreditation	A formal process to assess a health service's delivery of healthcare against the RACGP's <i>Standards for health services in Australian immigration detention facilities</i> .
Administrative staff	Staff employed by the health service who provide clerical or administrative services and who do not perform any clinical tasks with patients.
Advanced life support	The provision of effective airway management, ventilation of the lungs and production of a circulation by means of techniques additional to those of basic life support. These techniques might include, but are not limited to, advanced airway management, vascular/drug therapy and defibrillation.
After-hours service	A service that provides care outside the normal opening hours of the health service, whether or not that health service deputises care to other providers, and whether or not the care is provided physically in or outside of the health service.
Allied health	A health professional who collaborates with doctors and nurses to provide optimal healthcare for individuals in detention (eg physiotherapists, dietitians, podiatrists).
Alternative place of detention (APOD)	APODs can accommodate any individual who is detained by the Australian Government. APOD facilities might include hospital accommodation, hotels, schools and rented accommodation in the community.
Appointment system	The system that a health service uses to assign consultations to patients and practitioners.
Asylum seeker	Asylum seekers are the people who have sought protection as a refugee, but whose claim for refugee status has not yet been assessed.
Basic life support	The preservation of life by the initial establishment, and/or maintenance, of airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.
Buddy system	A system whereby a 'buddy' follows up results and correspondence, or continues the care of patients on behalf of an absent colleague. If a practitioner has a buddy system to hand over care, this must be standardised and previously agreed on, rather than ad hoc. Likewise when other practitioners hand over patient care, ie registered nurse, nurse practitioners. Such arrangements do not necessarily have to be documented in the health service notes, although the identity of the treating practitioner does need to be recorded.
Care outside normal opening hours	Clinical care that is provided to the individuals in detention when the health service is normally closed.

Carer	A family member, friend or paid helper who provides care and support to an individual who is frail, has a disability, mental illness, chronic condition, or terminal illness, or otherwise requires and consents to having someone care and support them.
Clinical decision-making tools	Electronic or paper-based supports to assist practitioners and their patients make decisions. Tools commonly assist the patient (and practitioner) to go through several necessary steps: Listing the options available, quantifying the benefits and harms of each, and then ensuring that the patient's preferences are articulated and then incorporated into the final decision.
Clinical handover	The transfer from one clinical professional or group to another of clinical professional responsibility and accountability for some or all aspects of a patient's care.
Clinical information system	A computer-based system designed for the collection, storage, retrieval and reporting of clinical and patient information to assist in healthcare delivery processes.
Clinical risk-management system	A system to manage the risk of errors and adverse events in the provision of healthcare.
Clinical significance	A way of referring to an assessment of the probability that an individual in detention will be harmed if they do not receive further medical advice, treatment or other diagnostics, and the likely seriousness of the harm.
Clinical team	Staff employed by the health service and immigration detention centre who have health qualifications and provide clinical care for individuals in detention.
Code of conduct	A set of principles that characterise good practice and explicitly state the standards of ethical and professional conduct that professional peers and the community expect of members of the health service team.
Cold chain management	The system of transporting and storing vaccines from the place of manufacture to the point of administration to keep the vaccines within the temperature range of 2–8°C.
Communicable disease	An infectious disease that is transmissible from one person to another, or from an animal to a person, by: <ul style="list-style-type: none"> • direct contact with an affected person (or animal) • direct contact with an affected person's (or animal's) bodily fluids • indirect means.
Competent authority	The Medical Board of Australia approves the following competent authorities: <ul style="list-style-type: none"> • General Medical Council (GMC), UK – For the Professional and Linguistic Assessments Board examination or for graduates of GMC-accredited medical courses in the UK • Medical Council of Canada (LMCC) • Educational Commission for Foreign Medical Graduates of the United States (USMLE) • Medical Council of New Zealand (NZREX) • Medical Council of Ireland (graduates of medical courses in Ireland accredited by the Medical Council of Ireland).

Complaint	Any verbal or written expression of dissatisfaction or concern with an aspect of the health service. A complaint might be made using, for example, a complaints process, patient surveys or focus groups.
Confidentiality	The act of keeping information secure and/or private, so that it is only ever disclosed to an authorised person.
Consultation space	'Consultation space' is a term to describe the physical environment in which the provision of healthcare and other services are provided to patients.
Continuity of care	The degree to which a patient experiences a series of discrete healthcare events and/or services as coherent, connected and consistent with their medical needs and personal circumstances.
Cultural background	Details of a patient's ethnic or cultural heritage that the health service has collected and recorded.
Cultural safety	<p>The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs.</p> <p>Health service organisations have a responsibility to 'develop and sustain healthcare services that are free from discrimination and delivered in a manner that shows respect for residents and consumers' (quoted from Roles in Realising the Australian Charter of Healthcare Rights released by the Australian Health Ministers in 2008).</p>
Disability	<p>An umbrella term for any one, or combination, of the following:</p> <ul style="list-style-type: none">• impairments resulting in problems in body function or structure• activity limitations resulting in difficulties in executing activities• participation restrictions resulting in problems an individual might experience in involvement in life situations.
Discrimination	Different treatment or consideration of an individual in detention based on particular characteristics (such as gender, age, ethnicity, religion). Positive discrimination enhances the care given to the detainee, and negative discrimination potentially reduces, or does reduce, the quality of the individual's care.
Electronic communication	The transfer of information (including, but not limited to, an individual's health information) within or outside the health service using email, internet communications, SMS or facsimiles.
Encryption	The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity.
Ethical dilemma	The need to choose between two or more courses of action, each of which will result in an ethical principle being compromised.
Ethics (or code of behaviour)	The principles adopted by an organisation to ensure that all its decisions and actions conform to normal and professional principles of conduct.
Event summary	A document detailing a patient's significant health information, their presenting concern, and any diagnosis and advice given or action taken by the practitioner when a service provides healthcare to the individual.

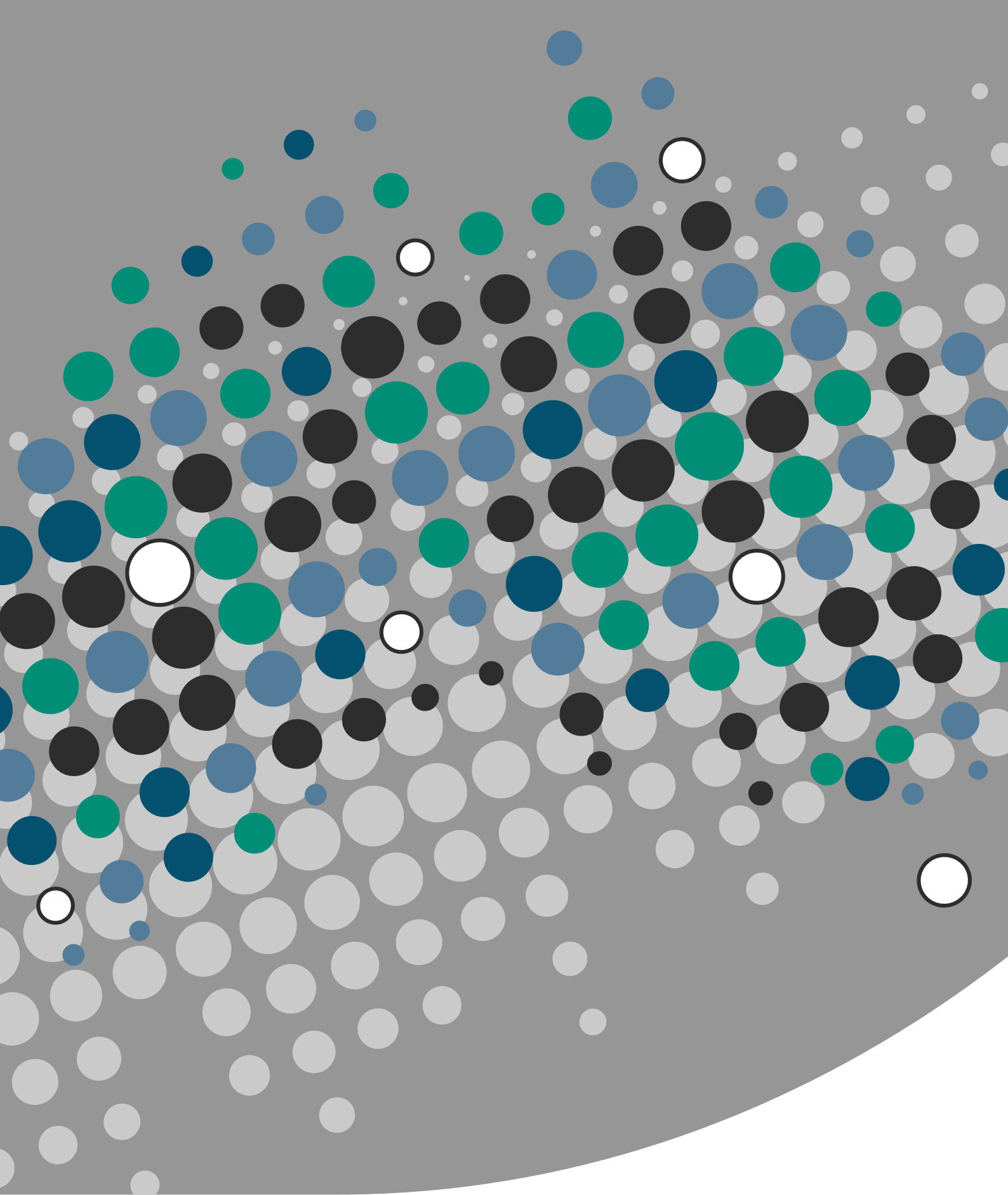
Follow up	Activities that are the logical and responsible steps to take after taking earlier related actions. For example: <ul style="list-style-type: none">• making a phone call to find out the status of tests and results that are expected, but not yet been received• contacting a patient to discuss a report, test, or results.
Gender	Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. 'Non-binary' is an umbrella term describing gender identities that are not exclusively male or female.
General practitioner	A registered medical practitioner who: <ul style="list-style-type: none">• is qualified and competent to provide general practice anywhere in Australia• has the skills and experience to provide patient-centred, continuing, comprehensive coordinated primary care to individuals, families and communities• maintains professional competence in general practice.
Health information	A subset of an individual's personal information that is collected in connection with the provision of a health service. It includes information or opinions about the health or disability of an individual, and an individual's wishes about future healthcare and health services.
Health outcome	The health status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent or circumstance performed, provided or controlled by a doctor or other health professional, such as nurses and specialists.
Health promotion	The process of enabling people to increase their control over, and improve, their health. More than just influencing an individual's behaviour, it includes a wide range of social and environmental interventions.
Health record	Information in paper or electronic form held about an individual in detention that might include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information, legal information and reports, and work health and safety reports.
Health service	The facility used on site at an immigration detention centre to provide primary healthcare, including nurse and general practitioner consultations, to individuals in detention.
Health service team	The multidisciplinary group of health professionals providing services to individuals in detention, including doctors, nurses, nurse practitioners, allied health practitioners, pharmacists and other medical practitioners.
Health summary	Documentation included in a patient's health record that provides an overview of all components of the patient's healthcare to facilitate clinical handover and continuity of care. For example, current medications, relevant past health history, relevant family history, allergies and adverse drug reactions.
High-risk results	Clinical test results that are seriously abnormal and life-threatening and need to be communicated in an appropriately timely manner.

Hospitalisation	The admission of an individual in detention to hospital for treatment.
Innate variations of sex characteristics	'Variations of sex characteristics' refers to people with innate genetic, hormonal or physical sex characteristics that do not conform to medical norms for female or male bodies. It refers to a wide spectrum of variations to genitals, hormones, chromosomes and/or reproductive organs. Other umbrella terms used to describe being born with variations of sex characteristics are 'intersex' or 'differences/disorders of sex development'.
Intersex	People who are born with genetic, hormonal or physical sex characteristics that are not typically male or female.
Immigration detention centre	A facility where individuals are detained if they have overstayed their visa, breached their visa conditions, had their visa cancelled and/or have been refused entry at Australia's entry ports
Immigration detention facility	A secure facility, including immigration detention centres, immigration transit accommodations and alternative place of detentions, established and run by the Australian Government to detain people because of their migration status, including: <ul style="list-style-type: none"> • people who have arrived in Australia without a visa, including people seeking asylum • people who have had their visa cancelled on character grounds, including people who have recently completed a prison term • students who have had their visa cancelled because they breached a condition/s of their visa • people who have overstayed their visa • non-nationals who are alleged to have been illegally fishing in Australian territorial waters.
Immigration transit accommodation	Closed detention facilities that are intended: <ul style="list-style-type: none"> • for low-risk individuals • for short-term detention • to have less intrusive security measures than immigration transit accommodation.
Individual in detention	A person held in custody at an immigration detention facility.
Infrastructure	The physical and organisational structures and utilities (eg buildings, fencing, power supplies, plumbing) needed for the operation of the health service.
Information security	The protection of the confidentiality, integrity and availability of information.
Informed consent	The written or verbal consent that a patient gives to the proposed investigation, proposed treatment or invitation to participate in research, when they understand the relevant purpose, importance, benefits and risks. For consent to be valid, a number of criteria need to be satisfied, including: <ul style="list-style-type: none"> • the patient has received and understood sufficient and appropriate information and is aware of the material risks • the patient has the mental and legal competence to give consent.

Informed refusal	A patient's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment.
Interpreter service	A service that provides trained language interpretation or translation, either face to face or by telephone.
LGBTIQA+	Initialism for lesbian, gay, bisexual, transgender, intersex, queer and asexual, or other gender and sexual diversities. Other common variations include LGBTI and LGBTIQ.
Living quarters	A room or lodging (accommodation) allocated to an individual in detention or their family, where the individual resides during their stay at the immigration detention centre.
Living quarters visit	A healthcare consultation conducted in the patient's (or someone else's) living quarters.
Locum practitioners	A practitioner, such as a general practitioner or nurse, who works in the place of the regular practitioner when they are absent, or when a health service is short staffed.
Medical deputising service	A service that arranges for, or facilitates, the provision of medical services to an individual in detention by a medical practitioner (deputising doctor) during the absence of, and at the request of, the individual's principal healthcare team.
Medication	Substances used to treat an illness or medical condition. They can be a prescription medicine, or over-the-counter medication, and can include complementary medicines.
Medicine	A drug or other preparation for the treatment or prevention of disease.
Modified Monash Model (MMM)	The MMM defines whether a location is a city, rural, remote or very remote. MMM classifications include: <ul style="list-style-type: none"> • MMM1 – Metropolitan • MMM2 – Regional centres • MMM3 – Large rural towns • MMM4 – Medium rural towns • MMM5 – Small rural towns • MMM6 – Remote communities • MMM7 – Very remote communities
Non-health stakeholders	Staff employed or contracted by the immigration detention centre who are directly or indirectly involved in the coordination of care provided to individuals in detention (eg immigration detention centre security staff, social welfare staff, government personnel)
Nurse	A registered nurse who can demonstrate competence in the provision of nursing care. A registered nurse practices independently and interdependently, and has accountability and responsibility for their own actions and the delegation of care to enrolled nurses and other healthcare workers.

Over-the-counter medicine	Medicines that people can purchase from retailers (such as pharmacies, supermarkets and health food stores) for self-treatment.
Paediatric	Medicine and health services dealing with children and their diseases.
Practitioner	A member of the health service team who has qualifications that qualify them to perform clinical functions.
Privacy of health information	The protection of personal and health information to prevent unauthorised access, use and dissemination.
Qualified	Holding the educational or other qualifications required to perform a specific activity (eg administer first aid) or hold a specific role (eg general practitioner, registered nurse)
Quality improvement	One or more activities that a health service undertakes to monitor, evaluate or improve the quality of healthcare delivered.
Recall	The process of requesting a patient to attend a consultation to receive further medical advice on matters of clinical significance.
Referral	The process of sending or directing a patient to another practitioner.
Refugee	Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.
Relevant family history	Information about a patient's family history that the practitioner considers important so as to provide appropriate clinical care to the patient.
Safe and reasonable	A desired description of the outcome of a clinical care decision made by a health service that was based on relevant factors (eg the health service's location and population) and an understanding of what professional peers would agree was safe and reasonable.
Sex	A person's assigned sex at birth, determined by sex characteristics observed at birth or infancy. A person's sex can change over the course of their lifetime and might differ from their assigned sex at birth.
Sex characteristics	A person's chromosomal, gonadal and anatomical characteristics associated with sex.
Shared electronic health record	Shared electronic health records contain information that can be managed, added to and accessed across multiple healthcare organisations.
Social media	Online social networks used to disseminate information through online interaction.
Telehealth	The use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance. Telehealth services use information and communications technologies to deliver health services and transmit health information over both long and short distances. It is about transmitting voice, data, images and information.

Telephone triage	A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care.
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers.
Trans and cis	'Trans' and 'cis' are terms that describe the experience or modality of gender (and are used as prefixes to gender; ie transgender and cisgender), rather than a gender label itself. The trans experience occurs when an individual's gender differs from that presumed for them at birth. The cis experience occurs when an individual's gender is the same as what was presumed for them at birth.
Triage	Prioritisation of patient presentations based on where resources can be best used or are most needed.
Urgent	Requiring immediate action or attention.



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