RACGP *Standards for health services in Australian prisons* (2nd edition)

For consultation

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Contents

Introduction to the *Standards for health services in Australian prisons (2nd edition)*

Preamble

The Royal Australian College of General Practitioners (RACGP) supports health professionals, and their employer organisations to provide high quality healthcare to people detained in Australian prisons.

Who are the Prison Standards for?

Quality and safety standards are used in health services across the world as a means of promoting excellence in patient care[1], with accreditation against such standards promoting leadership, enhancing corporate culture and improving clinical performance.[2]

It is acknowledged that health services in Australian prisons are run by the relevant state or territory department of health or department of justice. The RACGP *Standards for health services in Australian prisons* (2nd edition) (Prison Standards) have been written principally for the multidisciplinary teams of health professionals who provide care to people in Australian prisons.

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

- provide healthcare for individuals within prisons
- integrate biomedical, psychological, social and environmental factors into the care they provide
- consider a patient's beliefs and values.

All people in prison must be able to access timely and effective primary healthcare, commensurate with the healthcare that would be available in the Australian community for their condition/s and identified level of vulnerability.[3] Where a health condition cannot be managed within the prison, care must be facilitated by referral for external opinions, expertise and/or investigation and treatment services.

In this context, Australian state and territory governments and employers of prison staff and health professionals working in the provision of prison health services are important audiences of the Prison Standards.

Challenges within the prison environment

Given the inherent vulnerabilities of groups of individuals who are detained within the Australian justice system, health services within prisons provide healthcare in a unique and challenging environment.

Some of these challenges include (but are not limited to):

- individuals may have limited choice to select their own healthcare provider
- transmission of communicable disease
- substance misuse, including the high rate of overdose associated with leaving prison

- the high level of trauma in the prison population
- the complex needs of culturally and linguistically diverse prisoners
- the prevalence of mental health issues.

The nature of the prison environment, combined with the experiences of many people prior to being imprisoned, contribute to increased vulnerability and risk of physical and psychological health problems. The provision of high-quality healthcare in the prison setting can therefore be a challenging undertaking.

An appreciation and understanding of how these complex issues impact on an individual's perception of physical and psychological health is important in achieving good quality healthcare from a whole person perspective. Because patients accessing medical practice in prison environments are deprived of their liberty, ethical considerations must be at the forefront of decision-making. The RACGP recognises that people who are in prison have a critical stake in the Prison Standards and acknowledges that they are also an important secondary audience.

Complexity of health challenges in prison

People who are detained in prison are considered to be one of the most vulnerable and disadvantaged groups in Australia. Compared to the general population, a large proportion of the prison population have experienced homelessness and periods of long-term unemployment.[4] Many of those who end up in prison are also likely to be or have been victims of sexual and/or domestic abuse and violence.[5]

In addition to socioeconomic vulnerabilities, people in prison have complex, long-term health needs characterised by a combination of mental health issues, trauma, alcohol and substance misuse, chronic health conditions and disability.[6] Mental health issues are also disproportionately prevalent among the prison population where close to 40% of prisoners report having had a history of mental health issues prior to imprisonment.[7] [8]

Frequency of high-risk behaviours (such as sharing of needles for intravenous drug use, unsafe sexual activity) mean communicable diseases are also more widespread in the prison population.[9] Consequently, people in prison have poorer health outcomes than the general Australian population which further entrenches existing social and health inequalities.[10] [11]

Older prisoners

The impact of these inequalities is evident in the health challenges faced by older prisoners. Older people now make up a large and growing proportion of the prison population. Prisoners are defined as older at around the age of 45 to 50 years' old, ten years younger than the general population.[12] The proportion of older prisoners has increased by over 75% since 2009.[13] Ageing is accelerated in prison where the presence of age-related illnesses and chronic health conditions is further exacerbated by the prison environment.[14]

As the proportion of older prisoners increase, so will the need for chronic disease management and specialist health services.[15] This will present a key challenge to the provision of health services with an

increased need for preventive health measures such as screening for cancers and other age-related health concerns.[16]

Female prisoners

In 2021, female prisoners account for 8% of the total prison population in Australia.[17] As a group, female prisoners face a disproportionate level of socioeconomic disadvantage and are considered to be the most vulnerable prisoner group in Australia.[18]

Evidence suggests that somewhere between 70-90% of all female prisoners have reported being past victims of abuse[19] [20] with a significant proportion – 36% – reporting a head injury in the past.[21] The median age of imprisoned females is 34 years, with a significant majority being mothers with dependent children.[22] [23] In 2017, 1 in 50 female prisoners was pregnant at the time of incarceration, with 20% of those female prisoners giving birth while in prison.[24] As a result, female prisoners have considerably different healthcare challenges that requires female-specific specialist health services.

Youth

Unsurprisingly, young people detained in Australia experience profound levels of entrenched socioeconomic and health disadvantage.[25] When compared to the general population, young people in prison not only report higher rates of alcohol and substance misuse, they are also more likely to have poorer health outcomes as a result of being incarcerated.[26]

The 2015 *Young People in Custody Health Survey* undertaken in New South Wales confirms that young people in custody have higher rates of alcohol and substance misuse than the general population.[27] The survey also found that young people in custody were not only more likely to have been in out-of-home care, but that they are also 6 times more likely to have experienced mental health issues than young people in the community.[28]

The prison setting is a unique environment for the provision of health services as it affords health professionals the opportunity to provide whole person care to those disadvantaged groups that are typically harder to reach.[29] Where possible, health services should seek to address health challenges that are more prevalent in the prison population than in the community.

Overrepresentation of Aboriginal and Torres Strait Islander people in prison

Aboriginal and Torres Strait Islander people are drastically overrepresented in each state and territory and across the Australian justice system. Aboriginal and Torres Strait Islanders comprise 28% of the Australian prisoner population, despite only making up 3.3% of the Australian population on 30 June 2018.[30] [31] [32]

The *Health of Australia's Prisoners 2018* found that Indigenous prisoners were more likely than non-Indigenous prisoners to have an extensive incarceration history. Almost half – 43% - of Indigenous prisoners had been incarcerated at least 5 times prior, compared with 25% of non-Indigenous prisoners. Indigenous women are imprisoned at an alarmingly high rate - 21 times the rate of imprisonment of non-Indigenous women in Australia.[33] Indigenous women also tend to be imprisoned at the younger median

age of 32 years compared to non-Indigenous women.[34] Further, the rate at which Indigenous women are detained on remand (unsentenced detention) is also higher – 42% – compared to non-Indigenous women at 38%.[35]

This overrepresentation also extends to young Indigenous people in prison. In 2020, Indigenous youth aged between 10 to 17 made up nearly half of all young people detained in juvenile detention centres.[36] This makes young Indigenous Australians 17 times more likely than their non-Indigenous counterparts to be in detention.[37] The provision of targeted and culturally safe health services to Indigenous prisoners is imperative given the concentration of Indigenous people in custody.[38]

Correctional practices need to maintain focus on and continue to address the systemic issues and disadvantages that Aboriginal and Torres Strait Islander people face as reflected in recommendations of documents including the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*, the *Pathways to Justice Report* and the findings and recommendations of the *Royal Commission into Aboriginal Deaths in Custody*.

The role of the RACGP

It has been 30 years since the final report of the *Royal Commission into Aboriginal Deaths in Custody* was delivered. Since then, the rate of Indigenous imprisonment has doubled and the death toll of Indigenous people in custody has risen to 474.[39]

As a peak representative body for Australian general practitioners, the RACGP plays a critical leadership role in challenging discrimination and institutional racism in healthcare.[40] Part of this work includes raising awareness about the interconnection between the health needs of Aboriginal and Torres Strait Islander people and the historical and cultural context within which these needs arise from.[41] Recognising the centrality of the holistic and whole-of-life definition of health held by Aboriginal and Torres Strait Islander people is vital to improving their long term health outcomes.[42] This is acknowledged in the Prison Standards in Criterion C2.1 – *Respectful and culturally appropriate care.*

Through its second *Reconciliation Action Plan*, the RACGP is committed to establishing a culturally safe organisation and advocating for equity in health outcomes for Aboriginal and Torres Strait Islander people. The RACGP advances this important work through its National Faculty for Aboriginal and Torres Strait Islander Health. The Faculty, governed by an Aboriginal-led council and an Education committee, celebrated its 10th anniversary in 2020.

Application of the Prison Standards in prison health services

The Prison Standards have been developed for application across health services provided to adult, juvenile and remand prisoners. This includes prison health services delivered through satellite health clinics that may be located outside of the prison health centre.

Health services provided to offenders (people subject to community corrections orders outside of prisons) lie outside the scope of the Prison Standards as it is assumed this cohort of patients will be

able to access primary healthcare from general practices in the wider community, for which the RACGP *Standards for general practices* will apply.

The RACGP holds no responsibility for the contractual arrangements and consequences regarding the accreditation of a prison. However, the RACGP strongly recommends that the Prison Standards be contractually applied across all prisons, to demonstrate how the health service provides quality, safe and effective care for people in prison.

Consent to medical treatment

In all jurisdictions, general principles for consent to medical treatment apply for young people under the age of 18. Regardless of their legal status, health practitioners may be required to obtain parental or guardian consent for any medical treatment to be administered to a young person under the age of 16.[43] With the exception of South Australia and New South Wales, no specific legislation exists in the other states or territories on when a young person is able to consent to medical treatment.[44] In most cases, health services and health practitioners may be required to make a competency assessment on the basis of the common law. [45] [46]

The RACGP strongly recommends that practitioners seek the advice of their colleagues or medical defence organisations if there are uncertainties.[47] [48]

How do the *Prison Standards* reflect the principles of quality and safety?

The Prison Standards aim to address the quality and safety of the healthcare provided to people in Australian prisons. The Prison health services (PHS) module – which provides setting specific indicators that, along with the Core and Quality improvement (QI) modules, form in essence the same standards that apply to, and are expected of, general practices delivered to the Australian community.

There is consistent evidence that shows that accreditation programs improve the process of care provided by healthcare services.[49]

Safety-related behaviours are affected by informal aspects of an organisation (such as its attitudes to safety)[50] and there is a need for processes and structures that support a safety culture. For example, it is important that infection control processes are documented in a meaningful way (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).[51]

In the context of the Prison Standards, the term cultural awareness is used in a broad sense to encompass both culturally appropriate and culturally safe care. The provision of both culturally appropriate and culturally safe health care are important aspects for prison health services to address to improve the health outcomes of culturally and linguistically diverse and Indigenous prisoners.

The Prison Standards do not, and cannot, address all the impacts on the health and wellbeing of people in Australian prisons. A range of issues impact on overall health and wellbeing (such as prolonged uncertainty, housing, nutrition, physical activity, access to meaningful activities including education and work-related skill development) that may have a bearing on the health outcomes of people in prison.

These issues and other related mental health issues are beyond the scope of the Prison Standards and must be prioritised by the organisations contracted to manage the day-to-day operations of prisons.

Indicators that focus on outcomes and patients

The Indicators in the Prison 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, your health service can develop systems and processes that reflect your preferred ways of working and choose how to demonstrate that you meet 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, making your team members more likely to follow them not only during accreditation, but continuously.

Development process

The RACGP developed the Prison Standards for staff working in prison health services, general practitioners (GP), health service managers, nurses, consumers, technical experts, and other stakeholders.

Modular structure

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

- Core (modified version of the Standards for the prison context)
- Quality improvement (QI) (modified, as per Core module)
- Prison health services (PHS).

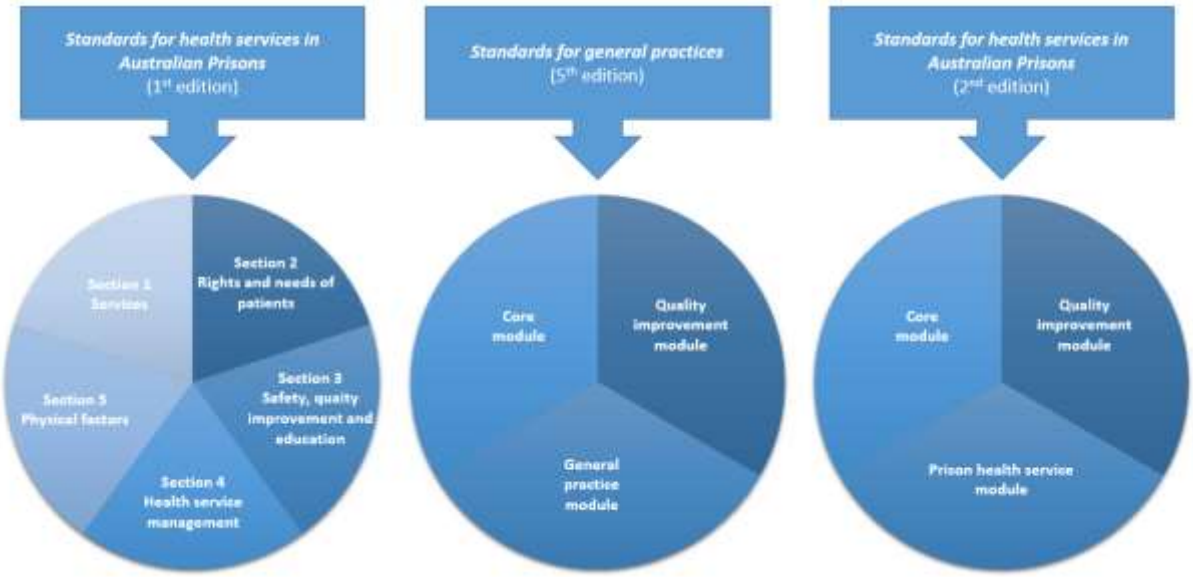
Indicators throughout both the Core and QI modules are the same as those in the Standards. The Core and QI modules were developed as a set of standards applicable to all primary health care environments in Australia. Some Criteria, Indicators and explanatory notes have been modified to suit the context of prison health services. All Core and QI Indicators have been retained; however, where

an Indicator may not be relevant to the current prison setting, this has been acknowledged in the explanatory notes.

Figure 1 illustrates this modular approach.

- Health services seeking accreditation against the Prison Standards must meet the requirements of all three modules:
    - Core
    - Quality improvement
    - Prison health service.

Figure 1: RACGP Standards modular structure



The numbering system works as explained below:

- The 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 PHS module).
- The Criteria for each Standard have a code indicating the module (C for Core, QI for Quality improvement and PHS for Prison health service), 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; PHS1.1 is the first Criterion for the first Standard in the Prison health service module.
- Each module starts with Standard 1: therefore, there is Criteria C1.1 and QI1.1 and PHS1.1.
- Each Criterion has one or more Indicators, labelled alphabetically (A, B, C, etc).

Table 1. Comparison between the 1st and 2nd editions *of the Standards for health services in Australian prisons*.	
Numbering in the *Standards for health services in Australian prisons* (1st edition)	Numbering in the *Standards for health services in Australian prisons* (2nd edition)
Section 1: Services **Standard 1.1:** Access to care **Criterion 1.1.1 –** Scheduling care in opening hours	**Module:** Prison health service **Standard 1:** Access to care **Criterion PHS1.1** – 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 have 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 this symbol ► are mandatory, which means that your health service must demonstrate that you meet this Indicator to achieve accreditation against the Prison Standards.

Indicators that are not marked with the mandatory symbol are aspirational. The RACGP encourages your health service 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

This edition is written in plain English, with less ambiguity and less technical language than in the previous edition of the Prison Standards.

Reduced citation 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*). Therefore, most of the relevant federal, state or territory and local legislation has not been cited in this document.

As federal, state or territory, and local legislation overrides any non-legislative standards, including those in this document, your health service is responsible for ensuring that you comply with relevant legislation.

If your service is accredited against the Prison Standards, you will have met some of your legislative requirements, but this does not mean that you have automatically met all of them, as the Prison Standards do not address all your obligations to relevant state and territory legislation (such as privacy and health information legislation).

Evidence-based standards

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

This evidence is based on two sources:

- Relevant studies and literature
- Level IV evidence (where studies are not available).

Level IV evidence is also known as evidence from a panel of experts. To ensure that this Level IV evidence is as robust as possible, the Prison Standards have been tested by health services in Australian prisons, 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 Prison Standards, you must be formally assessed against the Prison Standards by an accrediting agency approved under the National General Practice Accreditation Scheme (the NGPA Scheme), which commenced on 1 January 2017; a list of approved accrediting agencies can be found here.

The accreditation cycle

The accreditation cycle is three years. This means that if your health service is successfully accredited against the Prison Standards, the accreditation is valid for the period of three years from the time accreditation is achieved. To maintain your accreditation, you must be successfully reassessed for the next accreditation cycle.

Once accredited, it is expected that your health service will continually maintain the systems and processes you have been assessed against to ensure the high quality and safety of your health care provision.

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 Prison 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 one of whom must be an appropriately qualified nurse, health service manager, Aboriginal health worker or allied health professional with relevant experience in prisons.

Surveyor teams may include a third person, such as a non-health practitioner or consumer who has received appropriate training in the Prison 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 health service that includes two or more surveyors (one GP and one or more non-GP surveyors) 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 prisons.

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

Accreditation agencies

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

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

All surveyors

Surveyors must:

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

GP surveyors

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

- is vocationally registered under the *Health Insurance (Vocational Registration of General Practitioners) Regulations 1989* (Cth)
- holds Fellowship of the RACGP (FRACGP) or Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) if appointed after 31 October 2017
- has at least five years' full time equivalent experience as a vocationally registered general practitioner
- either:

    - is working at least two sessions a week for the last two years in face-to-face patient contact in an accredited Primary Health Care Service, or
    - has worked at least two sessions a week in face-to-face patient contact in an accredited Primary Health Care Service in the last two years
- satisfies their continuing professional development (CPD) requirements.

Non-GP surveyors

The survey visit's co-surveyor can be a qualified nurse, practice 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 Prison Standards
- has at least five years' full time equivalent experience
- either:
    - is working at least 16 hours a week for the last two years in an accredited Primary Health Care Service, or
    - has worked at least 16 hours a week in an accredited Primary Health Care Service in the last two years.

Core module

Core Standard 1

Communication and patient participation

Core Standard 2

Rights and needs of patients

Core Standard 3

Health service governance and management

Core Standard 4

Health promotion and preventive activities

Core Standard 5

Clinical management of health issues

Core Standard 6

Information management

Core Standard 7

Content of patient health records

Core Standard 8

Education and training of non-clinical staff

References

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.[52] Patients must be provided with the appropriate information they need to manage their condition.

The health service must also consider the communication needs of people involved in the care of the patient.

It is important to ensure only relevant information is conveyed to the prison staff. The prison staff should be provided only with the information needed to safely house the patient without infringing on the patient's privacy. A system should be in place to inform the prison staff of such requirements. Circumstances where this may occur include:

- access to food for diabetics
- the need to be housed separately or with other people
- physical accessibility needs
- the need to have access to medications that are permitted to be carried on a person signs and symptoms that require escalation and transfer of information to the prison health service.

It is preferable that such communication is done in writing and in a standardised format.

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 location
- details of how patients can directly contact the health service to make an appointment
- our consulting hours and details of arrangements for care outside normal opening hours
- our health service's communication policy, including when and how we contact 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 care with other providers can be requested/ coordinated
- 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 by the health service and how care can be accessed is important to all patients. Individuals in prison may not be aware of the presence of a health service within the prison.

Meeting this Criterion

The format of the information

You can provide this information in many formats, such as on printed information sheets, tailored pamphlets and/or by provision of information by staff of the health service or facility. 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 used by your patients. You could also display the languages spoken by the health service team on an information sheet or poster.

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:

- create and maintain an up-to-date information sheet that contains all the required information in language that is clear and easily understood

- utilise a digital health media board or television to promote information about the practice
- 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 including pictures)
- provide brochures, signs and/or digital media in the waiting room, that is 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.
- make contact details of interpreters available
- train health service team members so that they can use the interpreter service.

Criterion C1.2 – Communications

Indicator

C 1.2►A Our health service is responsive to communications from patients.

Why this is important

Effective communication with patients ensures that:

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

The prison-based health service needs to inform individuals in prison how they can access your health service, relevant staff, or arrangements in case of an urgent matter. More information on how your health service can communicate and be responsive to your patients' need is provided at Criterion PHS1.1 – *Responsive system for patient care*.

Meeting this Criterion

Communicating by written request

Your health service may receive written health service requests from patients in the prison. Best practice is that such requests are collected by the health service team. The use of prison staff to handle requests is not recommended.

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 health service request could be based solely on the written information provided by the patient and/or on reviewing the patient's health record. Where a written health service request is provided in a language not spoken by an available member of the health service team, translation must take place as soon as possible.

Informing the health service 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 may be unacceptable to record them on a sticky note)
- 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 additional needs

If patients (eg those with disability and those not fluent in English) need to use other forms of communication, consider using the services that are available, such as:

- the Translation and Interpreter Service (TIS National) for patients from a non-English speaking background (www.tisnational.gov.au)
- the National Relay Service (NRS) for patients who are deaf (www.relayservice.com.au).

Meeting each Indicator

C 1.2►A Our health service is responsive to communication from patients.

You must:

- use approved photo identification for identifying patients so that information is given to the right person
- document in each patient's health record when
    - team members have attempted to contact and have contacted the patient
    - a patient contacts the health service, the reason for the contact, and the advice and information the patient was given.
- demonstrate how members of the health service team attend to and triage written requests

You could:

- have a policy, procedure or flow chart that shows how to manage health service requests from patients
- educate reception staff about which health service requests need to be transferred to the clinical team
- have an appointment system that includes time for the clinical team to return messages to patients
- establish a process so that patients are advised of the health service's policy for checking and responding to health service requests.

Criterion C1.3 – Informed patient decisions

Indicator

C 1.3►A Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits, and risks.

C 1.3►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 may affect their ability to understand the information, make decisions or provide consent
- the most appropriate way to communicate potentially sensitive information (eg about sexually transmitted infections, blood-borne viruses and pregnancy results)
- the patient's cultural and linguistic background (eg you may need to use an interpreter to ensure that the patient understands everything that you have told them)
- other people who are involved in their care (with consent of the patient where 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 these factors must also be considered if you need to give information to other people involved in their care.

Further information provided to patients and other people involved in their care can be paper-based (eg leaflets, brochures).

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) may help patients to make informed decisions about their care. For this reason, practitioners need to:

- check the patient's understanding about the intervention
- if the patient has other people involved in their care, check their understanding of the intervention
- offer to discuss any issues about a patient's condition, proposed treatment and medicines that could be confusing
- recommend that patients seek further advice about their medicines, either from the practitioner themselves or the registered nurse on site.

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'.[53]

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 to 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 most people will have difficulty understanding complex health information and concepts
- providing health information in an unrushed manner using words 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)
- encouraging the patient 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.

Meeting each Indicator

C 1.3►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 which ensures that patients understand the information.

You could:

- use diagrams or flip charts in consultations to help explain health matters to patients
- use reputable digital information that supports a patient's discussion
- 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.

C 1.3►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
- make available a range of health information sheets that are brief (one to two pages long)
- display posters containing information about specific diseases, such as STIs, BBVs, mental health, drugs, alcohol, diabetes and chicken pox.

Criterion C1.4 – Interpreter and other communication services

Indicator

C 1.4►A Our health service endeavours to use an interpreter with patients who do not speak the primary language of our health service team.

C 1.4►B Our health service endeavours to use appropriate communication services to communicate with patients who have a communication impairment.

C 1.4C 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.[54]

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

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 that a patient 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
- what information (such as the need for an interpreter, the patient's preferred language, and 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 may appear comfortable with English, they may still benefit from being offered an appropriate interpreting service. Using another patient to act as an interpreter is poor practice, except in an emergency.

Communication with patients who have a communication impairment

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:[55]

- ask the person about the best way to communicate if you are unsure
- speak directly to the patient, even if there is a third party involved in the consultation for the purpose of interpreting
- 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 www.relayservice.com.au
- further information about how your health service can communicate with patients who have communication impairments is available at Communication Rights Australia (www.caus.com.au) and at Novita Children's Services (www.novita.org.au).

Translated and plain English resources

Consider having a directory of resources and services 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 culturally and linguistically diverse communities. Further information is available at www.healthtranslations.vic.gov.au

Meeting each Indicator

C 1.4►A Our health service endeavours to use an interpreter with patients who do not speak the primary language of our health service team.

You must:

- provide evidence that interpreters are used with 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
- register all your practitioners with TIS National
- use appropriately qualified interpreters
- make sure all team members can access a list of contact details for interpreter and other communication services.

C 1.4►B Our health service endeavours to use appropriate communication services to communicate with patients who have 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.

C 1.4C Our patients can access resources that are culturally appropriate, translated, and/or in plain English.

You could:

- maintain a list of resources and services from which your health service or 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 any out-of-pocket costs for healthcare they receive at 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.

The cost of primary healthcare provided to patients in prisons is not charged to patients. Where services are provided to patients at no cost, health service staff must inform the patient and reassure them that costs will not be recouped later.

Where a referral is required to an external service, patients must be informed that there may be a cost of engaging private services. Such referrals may also incur transport costs to the patient. Depending on the jurisdiction, some health services may refer patients privately via telehealth, as this may lead to shorter waiting times and elimination of transport costs.

Meeting this Criterion

Costs at your health service

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). In the context of incarceration, these circumstances are relatively uncommon and usually arise when the care is elective.

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. Costs may include charges beyond the scope of the health-related investigations (eg requiring a prison staff chaperone or associated transport charges). Your health service needs to seek and provide information about related additional costs to help patients make informed decisions about offsite medical treatment.

Meeting each Indicator

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

You must:

- inform patients about any out-of-pocket costs for healthcare they receive at your health service
- inform patients of extra costs of engaging private services.

You could:

- inform patients that where healthcare is provided at no cost, it will not be recouped later.

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 may 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 the patient can find out about the costs for that service.

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/nationalpriorities/charter-of-healthcare-rights

The RACGP's General practice patient charter (available at: https://www.racgp.org.au/running-a-practice/practice-standards/general-practice-patient-charter) is aligned with the ACSQHC's *Australian charter of healthcare rights*, and describes the responsibilities of patients.

Some states and territories have patient charters that are unique to that jurisdiction and are developed specifically for Aboriginal and Torres Strait Islander peoples.

All patients in your health service are entitled to receive evidence-based health care equal to the standard available in the general community. This is consistent with the United Nations *(1990) Basic Principles for the Treatment of Prisoners* (https://www.un.org/ruleoflaw/files/BASICP~2.PDF) and the *Guiding Principles for Corrections in Australia* (https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2019/04/7f/88fc42ada/guiding_principles_correctionsaustrevised2018.pdf).

Criterion C2.1 – Respectful and culturally appropriate care

Indicators

C 2.1►A Our health service, in providing patient healthcare, considers patients' rights, beliefs, and their religious and cultural backgrounds.

C 2.1►B Our patients receive information from the clinical team about the risks resulting from refusing a specific treatment, medicines, advice, or procedure.

C 2.1►C Our health service acknowledges a patient's right to seek other clinical opinions.

C 2.1►D Our patients in distress are provided with privacy.

C 2.1►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.*[56]

Cultural safety, defined in Binan Goonj: Bridging cultures in Aboriginal health as 'an outcome of health practice and education that enables safe service to be defined by those who receive the service',[57] is the consequence of behavioural changes that come about after there is cultural awareness.[58] 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'.[59]

Further detail relating to respectful and culturally appropriate care is provided at Criterion PHS 3.1 – *Qualifications, education and training of practitioners.*

Patients' rights

Patients have the right to respectful and culturally appropriate care that considers their religion and cultural beliefs, displays an acceptance of diversity and promotes their dignity, privacy and safety.

Respect for a patient 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 health service team members ask patients about their cultural identity and beliefs in order to update the patient's details, it is beneficial to explain that this helps the health service to provide culturally appropriate 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 anti-discrimination 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 to seek clinical opinions from other healthcare providers. However, there may not be an obligation on the health service to enact such a request in the prison setting.

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 include 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 may 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 incarceration).

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 needs to understand the proposed management and treatment. This may require the use of translating and interpreting services.

If a third party (such as a family member, carer or guardian) has an ongoing role in the day-to-day care of a patient, it is generally advisable to include them 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 prison, 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 may 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 may 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. In some jurisdictions there is provision for compulsory treatment in some circumstances.

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 prison settings, there are scenarios where it may 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 distressed patients

You may 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) 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 may cause patient resistance to certain care
- language barriers that may 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 local colleagues, senior colleagues in other prisons, ethicists and senior prison staff where the ethical dilemmas are centred around security issues, the relevant policy and state/territory department concerned with custody or healthcare (depending on the state this may be combined or separate). 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 may 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 healthcare needed.

Meeting each Indicator

C 2.1►A Our health service, in providing patient healthcare, considers patients' rights, beliefs, and their religious and cultural backgrounds.

You must:

- demonstrate that you have considered patients' rights, 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 anti-discrimination 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
- meet a patient's request for a practitioner of a specific gender, if possible
- have separate sections of the waiting room for men and women, where relevant and 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, queer, intersex and asexual (LGBTQIA) patients
- use a clinical audit tool to identify cultural groups in your population
- display signs acknowledging the traditional custodians of the land
- display Aboriginal or Torres Strait Islander art and 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.

C 2.1►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.

C 2.1►C Our health service acknowledges a patient's right to seek other clinical opinions.

You must:

- keep documentation of a patient's request 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.

C 2.1►D Our patients in distress are provided with privacy.

You must:

- provide a room or area where distressed patients 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.

C 2.1►E Our clinical team considers ethical dilemmas.

You must:

- document any ethical dilemmas that have been considered, and the outcome or solution
- document in the health record that where safety and security requires a third party must be present in the consultation, but the patient has not provided consent.

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

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

Indicator

C 2.2►A Our health service obtains and documents the prior consent of a patient when the health service introduces 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 also 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 prison staff, interpreters, registrars, chaperones/observers, and medical, allied health or nursing students.

If a patient has previously given prior 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's appointment is scheduled.

It is not acceptable to ask permission once a consultation has commenced, as some patients may 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 may 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 a prison setting, there are a number of situations where a practitioner or a patient may wish, or need, to have a chaperone present during a consultation. 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 a good idea to document this.

Patients not able to provide consent

If a patient is unable to provide consent (eg they have intellectual disability), the health service must seek 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 it may 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 under guard by prison staff). The practitioner needs to consider whether it is appropriate for the third party to remain present for the consultation. Unless there is a tangible risk to members of the health service team, prison staff should not be present during a consultation without the consent of the patient.

Health services operating in a high-security prison environment would usually have a third party present when seeing patients.

Patients escorted to appointments by prison staff

The prison may deem it necessary for a patient to be escorted by prison staff to an appointment at the health service or at an external medical facility. Where possible, health service staff must endeavour to provide privacy to the patient and the clinical team during the appointment.

Meeting each Indicator

C 2.2►A Our health service obtains and documents the prior consent of a patient when the health service introduces a third party to the consultation.

You must:

- document in their health record the patient's consent to the presence of a third party arranged by the health service
- document in the health record that where safety and security requires a third party must be present in a consultation, but the patient has not provided consent.

You could:

- maintain a policy about the presence of a third party during a consultation
- 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
- document the identity of a chaperone/observer.

Criterion C2.3 – Accessibility of services

Indicator

C 2.3►A Our patients with disabilities or additional needs can access our services.

Why this is important

In order to comply with the *Disability Discrimination Act 1992* (amended 2009), you need to ensure that people with disability or additional needs 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 other additional needs, must be able to easily and safely 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 are not fluent in English.

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

- using existing and emerging technology to give patients access to telehealth or video conferencing consultations
- having practitioners make visits to individual's living quarters, where appropriate.

Meeting each Indicator

C 2.3►A Our patients with disabilities or additional needs can access our services.

You must:

- have physical infrastructure and processes that enable patients with disabilities or additional needs 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
- 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 in order 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.[60]

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

Indicators

C 3.1►A Our health service plans and sets goals aimed at improving our services.

C 3.1B Our health service evaluates its progress towards achieving its goals.

C 3.1►C Our health service has a business risk management system that identifies, monitors, and mitigates risks in the health service.

C 3.1►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 prison 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 prison, and include how it will be implemented.

Having a plan helps to get the team working together towards a common goal. It also gives the team the ability to evaluate progress and helps the health service achieve 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 may be a merging of governance and management responsibilities. Other health services may be part of a wider group and have either public or private shareholders, and others still may 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.

Management need to appropriately communicate to staff any significant changes 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.[61]

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
- inadequate stock and delays in receiving pharmaceutical and equipment supplies.

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 was to occur
- mitigation/treatments.

If you fail to keep your risk register up to date, your risk mitigation strategies may not be adequate and new risks may 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.

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, 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 (available at www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx).

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 may 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 may be that the patient could benefit from an interpreter service or a legal representative.

Meeting each Indicator

C 3.1►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.

C 3.1B 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.

C 3.1►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.

C 3.1►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

Indicators

C 3.2►A All members of our health service team understand their role in the health service.

C 3.2►B Our health service has performance discussions with each team member.

C 3.2►C Our health service inducts new members of the health service team and familiarises them with our systems and processes.

C 3.2►D Our health service has at least one team member who has the primary responsibility for leading risk management systems and processes.

C 3.2►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 is 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 of critical incidents 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 critical incident audit conducted on your health service must be reported to your health service's governing body, where 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 prisons are recognised to be high risk environments for self-harm and suicide attempts. 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 put in place 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 loss of life or significant morbidity. The health service provider has a duty of care to identify if the health 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 they reflect the reality of each person's role.

Your health service must appoint one member of the team 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 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 the 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
- key public health regulations (such as reporting requirements for communicable diseases)
- 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

C 3.2►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.

C 3.2►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.

C 3.2►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.

C 3.2►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.

C 3.2►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/s 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

C 3.3►A Our health service has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases, security events, mass casualty events, unpredictable lockdown periods 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,[62] so it is crucial that your health service can continue to provide services during this time, if appropriate.

Emergencies may affect the health service or prison more broadly and a coordinated effort across the prison system, not just internal to the health service may be required. 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 a prison facility, your health service may be included as part of a wider facility's emergency response plan. As such, the plan may not be created in isolation. While your health service may 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 may 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, emergency situations such as natural disasters or security issues).
- 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, complete or participate in appropriate emergency planning and preparation and frequently identify, review and update the actions that need to be completed before and during an emergency. These actions may 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 prison)
- 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
- 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
- establishment of a temporary first aid station and rapid deployment of health services in the response and recovery period of an event.

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 this Indicator

C 3.3►A Our health service has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases, security events, mass casualty events, unpredictable lockdown periods 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

C 3.4►A Our health service team has the opportunity to discuss administrative matters with the principal practitioners, health service directors, health service and prison facility management, or owners when necessary.

C 3.4►B Our health service encourages involvement and input from all members of the health service team.

C 3.4►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,[63] [64] and that bullying and harassment can be a significant threat to quality care and patient safety.[65] Therefore, your health service needs to not only cultivate a just, open and supportive culture that preserves and values individual accountability and integrity, it 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 prison facility and have responsibility for patients' accessing healthcare (eg prison 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 in order to improve the treatment of patients and for their own professional development.

Meeting each Indicator

C 3.4►A Our health service team has the opportunity to discuss administrative matters with the principal practitioners, health service directors, health service and prison 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.

C 3.4►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
- 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.

C 3.4►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
- 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

C 3.5►A Our health service supports the safety, health, and wellbeing of the health service team.

C 3.5►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 (WHS) laws.

Inappropriate and disruptive behaviour within the health service and clinical team can risk patient safety. Although such behaviour might not be an obvious WHS or bullying issue, it can undermine both the culture of the setting and clinical care.[666768]

You should encourage members of the health service team to be immunised, in order 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?
- Ensure access to a duress alarm.
- Have safety cameras.
- Ensure your team members feel there is adequate security to perform their roles safely.

It is important that the layout of the facility complies with WHS 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* for more information) 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 all forms of intimidation, aggression and violence
- displaying signs that inform people of your zero tolerance policy
- a duress alarm system that the health service team can use if a patient is intimidating, aggressive, 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 the prison 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). 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. View or download this handbook at: www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home

The principles of catch-up vaccination are provided as part of the *Australian Immunisation Handbook*.

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 suspend 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.

Meeting each Indicator

C 3.5►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 WHS policy and procedure
- maintain a policy and procedure manual that includes WHS requirements
- develop and adhere to appropriate health service staff rosters
- include WHS 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

C 3.5►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)
- offer staff members' 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.

Criterion C3.6 – Research

Indicators

C 3.6►A Our health service has all research approved by an ethics committee.

C 3.6►B Our health service confirms that the appropriate indemnity is in place for the research, based on the level of risk.

C 3.6►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. View or download the Code at www.nhmrc.gov.au/guidelines-publications/r39

The Australian Institute of Aboriginal and Torres Strait Islander Studies has produced *Guidelines for ethical research in Australian Indigenous studies*. You could refer to these guidelines if your patient sample includes Aboriginal and Torres Strait Islander peoples. View or download these guidelines at http://aiatsis.gov.au/research/ethical-research/guidelines-ethical-research-australian-indigenous-studies

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 where you must obtain informed patient consent. Custodial patients considering participating in research projects must be informed that their participation can in no way impact on their incarceration nor be grounds for leniency.

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 at www.nhmrc.gov.au/_files_nhmrc/file/health_ethics/hrecs/att_2_-_list_of_human_research_ethics_committees_registered_with_nhmrc_february_2016.pdf

You can find details about the RACGP's National research and evaluation ethics committee at www.racgp.org.au/yourracgp/organisation/committees/national-committees/nreec

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 *Australian code for responsible conduct of research* 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 may 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 and risk

It is important to understand the potential risks that individual research activities may have on your health service and patients. You must confirm that the appropriate indemnity is in place for research, based on the research project's level of risk.

The NHMRC National statement on ethical conduct in human research 2007 (updated 2018) (National Statement) gauges research by the amount of risk it may pose to people involved in the research. The NHMRC describes low risk and negligible risk as follows:

> *The expression 'low risk research' describes research where the only foreseeable risk is one of discomfort. Research in which the risk for participants is more serious than discomfort is not low risk.*
>
> *The expression 'negligible risk research' describes research in which there is no foreseeable risk of harm or discomfort; and any foreseeable risk is no more than inconvenience.*[69]

Individual medical practitioners must ensure that they are insured or indemnified for every context in which they practise, including involvement in any medical research. It is recommended that health services obtain their own advice about whether they require indemnity insurance for any research.

An example of high-risk research is a clinical trial. If your health service is involved in a clinical trial, your health service will usually be indemnified by the sponsor (eg a university or 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, it is recommended that you discuss all potential risks with your health service team and the lead external researcher as well as your insurance broker or indemnity insurer to determine whether you require extra insurance to indemnify your practice for research.

To assist with these discussions, external researchers may be able to provide a written document outlining the level of risk their research will pose to your practice and/or patients.

In all cases, health service team members each need to ensure that their individual medical indemnity insurance covers their research activities, or purchase top-up or separate insurance cover that provides the appropriate level of indemnity required to participate in research. Failing to hold sufficient insurance cover may leave the health service practitioners with an uninsured personal liability in the event of an adverse event for which a claim is made. The costs of defending such a claim, even where the health service practitioners are not liable, may still be significant.

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 has developed *Guiding principles for managing requests for the secondary use of de-identified general practice data* to support health services to make informed decisions about releasing health service data. The use of de-identified data does not require specific or express consent. The RACGP recommends that patients be made aware of the health service's approach to the collection and security of healthcare information for primary and secondary purposes, and whether it provides de-identified data to third parties.

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

C 3.6►A Our health service has all research approved by an ethics committee. 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 National Statement on Ethical Conduct in Human Research 2007* (Updated 2018).
- consider the ethical needs of Aboriginal and Torres Strait Islander peoples.

C 3.6►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 general practitioners based on research activity level of risk.

You could:

- have a process addressing practice 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 where it is not explicit in your policy.

C 3.6►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,[70] 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.

A prison's health service may 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, identify risk factors for disease and discuss ways of achieving a healthy lifestyle.

Preventive healthcare consists of measures taken to prevent diseases (as opposed to treating them)[71] 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 Aboriginal or Torres Strait Islander origin?)
- medical or social conditions (eg did the patient experience childhood abuse?)
- residential citizenship status and first language
- LGBTQIA 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

Indicator

C 4.1►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 prison 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.[72]

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. The 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
- describing the services your health service provides 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 a prison setting, you must account for language barriers (ie English as a second language) and education levels. By providing information in documents such as brochures and fact sheets you will be encouraging patients to select information on health issues that may affect or interest them.

You can also tailor information so that it caters for your patient population.[73] 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 low English proficiency (eg in plain English, pictures, videos, digital health media)
- you can provide culturally appropriate material, including for Aboriginal and Torres Strait Islander peoples.

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. There are particular preventive health activities that can be tailored to the burden of disease for the patient cohort in the prison setting.

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 may also be transferred to national state-based registers (eg immunisation data, cervical screening and familial cancer registers) in order 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

C 4.1►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 regarding harm reduction measures and services
- 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.

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 may be an accepted level of evidence and may 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

C 5.1►A Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

C 5.1►B Our clinical team supports 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 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 online 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’ may 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

C 5.1►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.

C 5.1►B Our clinical team supports consistent diagnosis and management of 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:

- 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)
- use relevant clinical guidelines for treating patients who identify as Aboriginal or Torres Strait Islander origin, and for preventing and managing chronic diseases in these patients.

Criterion C5.2 – Clinical autonomy for practitioners

Indicator

C 5.2►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 a prison 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. The location of your health service and the policies of the prison may also impact the implementation of clinician decisions. Retaining autonomy (and relevant documentation) protects the clinician in instances where a decision is not implemented. Clinical staff have the right to advocate for improvements in the quality clinical care.

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 the Australian Health Practitioner Regulation Agency (AHPRA) (www.ahpra.gov.au).

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, and the provider of these services
- 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

C 5.2►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

C 5.3►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 may require immediate medical transfer, either within the prison or to an external care provider (eg hospital) and 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 may 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.

Further detail relating to clinical handover risks is provided at Criterion QI3.1 – *Managing clinical risks*.

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 share their information with another health professional)
- the patient is released from custody.

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, guardians and other relevant parties who will be involved in the clinical handover, according to the wishes of the patient.

Clinical handovers can be completed face to face, over the phone or by passing on written information (eg in hard copy, or by email or secure message delivery).

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.

Further information on clinical handover can be accessed at PHS 2.1►*A Our health service provides continuity of care* and PHS 2.4►B *Our health service supports the safe transport of patients (where practicable and possible*.

For information on patient communication is available at Criterion C1.2 – *Communications* and Criterion C1.3 – *Informed patient decisions*.

Meeting each Indicator

C 5.3►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 within and outside of the health service (including discharge clinical handover).

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

C 6.1►A Our health service uses recognised 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 patient identifiers reduces the risk of misidentifying patients and ensures that practitioners have the correct patient health record for each consultation. Rand Corporation, a nonprofit research organisation, provides further information about the importance of correctly identifying patients at www.rand.org/pubs/monographs/MG753.html

Meeting this Criterion

Correct patient identification is necessary when:

- a patient makes an appointment
- a patient presents to the health service for their appointment
- conducting and facilitating technology-based consultations (eg via telephone and internet-based video services)
- 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
- Gender (as identified by the patient)
- an individual identification number where it exists (eg prisoner number)
- a photo on an identification card.

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 prison ID). Any method to identify patients must be decided and used consistently across all aspects of the health service.

Your health service needs to be alert to the common use of aliases by prisoners, to ensure the right patient receives the right treatment.

Asking for patient identifiers

When asking for patient identifiers, health service team members must ask the patient to state the 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.

In the prison setting, a patient could use their identification card to confirm their identity.

When a patient is well known to the health service team, it may 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 must be able to request to remain anonymous when receiving care from your health service.[74] Patients may prefer to receive services anonymously if, for example, sensitive issues arise or they feel they may be at risk, such as in difficult relationships with inmates and prison staff. In these circumstances, the use of an alias or 'disguised identity' may be the most appropriate approach.

Where it is neither lawful nor practicable for a patient to remain anonymous, this must be communicated to the patient.

While patient anonymity may not be possible in prison, it is important to acknowledge a patient's right to request for anonymity. Record any request for anonymity in the patient health record.

Meeting each Indicator

C 6.1►A Our health service uses recognised patient identifiers to correctly identify patients and their clinical information.

You must:

- use approved 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.

Criterion C6.2 – Patient health record systems

Indicators

C 6.2►A Our health service has a system to manage our patient health information.

C 6.2►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, paper-based or a hybrid of both electronic and paper-based systems.

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 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 in order 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

C 6.2►A Our health service has a system to manage our patient health information.

You must:

- have a system to manage patient health information
- have all patient health information available and accessible when needed.

You could:

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

C 6.2►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 every relevant component of the hybrid system
- have all patient health information available and accessible when needed.

You could:

- transition to a completely computerised and integrated patient health information system.

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

Indicators

C 6.3►A Our patients are informed of how our health service manages confidentiality and their personal health information.

C 6.3►B Our patients are informed of how they can gain access to their health information we hold.

C 6.3►C In response to valid requests, our health service transfers relevant patient health information in a timely, authorised, and secure manner.

C 6.3►D Only authorised team members can access our patient health records, medication charts and other official documents.

Why this is important

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

- privacy legislation in your jurisdiction
- health information legislation in your jurisdiction
- long-standing legal and ethical confidentiality obligations
- other relevant state or territory laws (which may or may 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 in order to provide a health service, such as a person's:

- name
- health information (such as a medical or personal opinion) relating to their health, 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 relevant privacy legislation in your jurisdiction.

If unauthorised people have access to official documents they can misuse these documents, particularly to gain access to medication that has not been prescribed to them.

More information on privacy and patient dignity, including the involvement of non-health staff (eg prison staff) is provided in Criterion PHS5.1 – *Health service facilities*.

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.[75]

The RACGP's *Privacy and managing health information in general practice* explains the safeguards and procedures to implement in order 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 a prison. Your medical defense organisation can also provide information and advice about developing relevant strategies.

A 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 a privacy principle as set out in your state or territory privacy legislation, 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.

Refer to the RACGP's privacy policy template available at www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/privacy

Your health service must make your privacy policy available to patients. This could be provided during a patient consultation. The policy should be available in languages other than English, appropriate to your patient population.

Disclosure of patient health information to a responsible person

Your health service may be required to disclose necessary patient health information to an individual's nominated person (such as a carer or guardian). The disclosure of any patient health information is governed by your state/territory's privacy and health information legislation. You must act in accordance with the relevant laws in your jurisdiction.

Secure transfer of health information

When communicating information about patients to health services and government agencies, always use secure electronic communication.[76]

When transferring patient health information to others (eg patients, other health service providers, or in response to third-party requests), follow the requirements of relevant state or territory legislation 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* at www.racgp.org.au/running-a-practice/technology/workplace-technologies/improvements-through-technology/managing-external-requests-forpatient-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. 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 OAIC website at www.oaic.gov.au/privacy-law/other-privacy-jurisdictions

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.

Just as health service staff are not entitled to access criminal records (except for forensic psychiatrists and people involved in mental health care), prison staff are not entitled to access health records unless patient consent has been given. They should be provided with the necessary information to ensure safe care and as such should be enabled by a suitable system.

Meeting each Indicator

C 6.3►A Our patients are informed of how our health service manages confidentiality and their personal health information.

You must:

- maintain a privacy policy.

You could:

- maintain a patient health information management policy.

C 6.3►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.

C 6.3►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.

C 6.3►D Only authorised team members can access our patient health records, medication charts and other official documents.

You must:

- maintain a privacy policy
- securely store all official documents, including prescription forms, administrative records, templates and letterhead.

You could:

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

Criterion C6.4 – Information security

Indicators

C 6.4►A Our health service can identify a person (health service team member or prison staff member) who has primary responsibility for the electronic systems and computer security.

C 6.4►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.

C 6.4►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.

C 6.4►D Our health service has a business continuity and information recovery plan.

C 6.4►E Our health service has appropriate procedures for the storage, retention, and destruction of records.

C 6.4►F Our health service has a policy about the use of email.

C 6.4►G Our health service has a policy about the use of social media by staff of the health service.

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 other health professionals and other members of the health service team, 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, which is available at www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice to help meet the requirements of this Criterion.

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 prison 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, where these devices are used. 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 prisoners and non-health service staff (eg prison 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 heath 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, finger print 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 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 current edition of 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 may still be able to recover files that have been deleted but not removed.

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

Destroying information

Information created in a prison setting may be owned by the relevant government authority and destruction of such information must comply with the relevant legal requirements in your jurisdiction.

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 relevant destruction authority in your jurisdiction Most states and territories have guidelines on the retention and destruction of public health records.

You could also consult with your medical defence organisation so that you understand your legal requirements and manage the risks.

Where destruction of records is possible, engaging the services of an authorised records destruction company is recommended. 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 staff at your health service use email and social media, you must have policies for its use, especially for the use of identifiable medical details and correspondence with other health professionals. The health service team must be familiar with the policies, comply with them, and understand the risks associated with using email.

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

- communicating health information and steps taken to ensure patient privacy
- maintaining passwords and keeping them secure
- verifying and updating email addresses

For further information, please refer to the RACGP's *Using email in general practice – Guiding principles.*

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

C 6.4►A Our health service can identify a person (health service team member or prison 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.

C 6.4►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.

C 6.4►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.

C 6.4►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.

C 6.4►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.

C 6.4►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 or intranet

C 6.4►G Our health service has a policy about the use of social media by staff of the health centre.

You must:

- maintain a social media policy.

You could:

- put your social media policy on your website or intranet.

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

C 7.1►A Our health service has an individual patient health record for each patient, which contains all health information held by our health service about that patient.

C 7.1►B Our active patient health records contain, for each active patient, their identification details, contact location and demographic information.

C 7.1►C Our patient health records include records of consultations and clinical related communications.

C 7.1►D Our patient health records show that matters raised in previous consultations are followed up.

C 7.1►E Our health service routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.

C 7.1F Our health service routinely records the cultural backgrounds of our patients in their patient health record.

C 7.1►G Our patient health records contain, for each active patient, modifiable risk factors.

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. Details such as next of kin and emergency contact information are held by corrective services and your health service can access the information as needed.

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, letter or other 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 communications.

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 may be included in the patient health record, such as:

- any referrals to other healthcare providers or health services
- all medications required and used while in prison (because many people now take complementary and over-the-counter medicines that may 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 advance care plan
- the presence of a third party brought in by the patient or the health service
- any special advice or other instructions given to the patient.

Medicines the patient takes that were not prescribed or advised by the health service may be confiscated at the time an individual enters prison, making it unlikely for them to have such medicines. Your health service still needs to record those medicines the patient may have taken prior to being incarcerated.

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 may 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

You can collect information from a new patient by interviewing patients before the first consultation.

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. See Criterion C6.1 – *Patient identification* for more information about identifying patients.

If the patient's contact, next of kin, or emergency contact information is held by another agency (eg the state justice department), you must have a process to access relevant details from that agency when needed.

You must document if a patient refuses to provide their identification details or demographic information.

LGBTQIA patient demographic information

LGBTQIA data collection methods often do not distinguish between the labels people use about themselves and the labels other people might use about them. For example, people who are classified as transgender by others may self-identify simply as women or men. Someone who was assigned male at birth and whose documents list her sex as 'male' might select 'woman' as her gender and 'female' as her sex on a form and not identify themselves as transgender. Similarly, an intersex person might select male or female as their sex rather than nominating themselves as intersex. Same-sex practices in prison do not mean that these individual identify as part of the LGBTQIA community.

Your health service could do the following to improve the accuracy of responses when collecting information from LGBTQIA patients:

- Clearly explain how answers will be used and why they are being asked
- Use forms that allow patients to select more than one option
- Ask questions that distinguish between identity and descriptors of behaviour, attraction and experience ('male' and 'female' are examples of words that describe identity, whereas 'gay' and 'lesbian' are examples of words that describe behaviour, attraction and experience)
- Ask patients if they prefer gendered or non-gendered pronouns.

This information may conflict with that stored by corrective services.

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 may 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. Further detail relating to intercultural competence is provided at Criterion C2.1 – *Respectful and culturally appropriate care*.

Identifying patients of Aboriginal or Torres Strait Island origin, or another cultural background

Aboriginal and Torres Strait Islander people are over represented in the prison population[77,78] and are more likely to use health services when in prison rather than in a community setting.[79] Practitioners are encouraged to identify and record the Aboriginal or Torres Strait Islander status and cultural background of all patients, as this information can be an important indicator of clinical risk factors and therefore help practitioners to provide relevant care.

Before asking a patient any questions about their cultural background, explain that knowing such information helps the health service provide appropriate healthcare.

If your health service's clinical software does not contain fields for a given cultural background, you need to ensure that this information is clear and accessible in the patient's health record.

Routinely ask all patients the following question regardless of the patient's appearance, country of birth, or whether the health service team know of the patient or their family background:

'Are you of Aboriginal or Torres Strait Islander origin?'

All patients have the right to respond to this question as they see fit. If a patient indicates that they do not wish to answer the question, record 'Not stated/inadequately described'. The patient's response must be received without question or comment, and the response must be recorded without any amendments or annotations.[80]

Collecting information about a patient's cultural heritage before a consultation (eg by interviewing the patient) will help you to provide the most appropriate care.

Where patients were born, where they grew up, or where their parents are from may 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. It is good practice to record this information in the patient health record if it is relevant to their patient care.

Retaining health records of patients

Your health service must keep and securely store and dispose of health records of patients in accordance with legal obligations imposed by your relevant state or territory authority and legislation.

You must retain health records of all patients in accordance with relevant national, state or territory laws, as well as those governing the information created in prison (eg policies and guidelines for the destruction of records). This includes records of those patients who are no longer held in custody, have been released from custody or transferred to another prison. You may want to consult your medical defence organisation when creating the health service's policy about the retention of records of these patients and to understand your legal requirements regarding records owned by the relevant government entity.

Modifiable risk factors

Modifiable risk factors such as smoking, poor nutrition, alcohol and other drug use, and inadequate physical activity are associated with many diseases. Record these risk factors in the patient health record and review management plans at defined intervals.

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 may 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.[81]

Meeting each Indicator

C 7.1►A Our health service has an individual patient health record for each patient, which 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.

C 7.1►B Our active patient health records contain, for each active patient, their identification details, contact location 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.

C 7.1►C 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.

C 7.1►D 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.

C 7.1►E Our health service routinely records the Aboriginal 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.

C 7.1F 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).

C 7.1►G Our patient health records contain, for each active patient, modifiable risk factors.

You must:

- document information relating to modifiable 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

C 8.1►A Our non-clinical health service staff complete training appropriate to their role and our patient population.

C 8.1►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 may cover areas such as:

- your health service's procedures
- use of technology (hardware, systems and software)
- first aid
- medical terminology
- cross-cultural safety, including stigma and discrimination
- communicating with patients with additional needs
- safe operation of specific equipment
- managing access to medical appointments
- infection prevention and control training, including training on blood borne viruses (BBVs)
- providing emergency first aid/care to individuals when there are no health professionals available (for example, if a patient has an overdose).

Practitioners or other members of the health service team can deliver in-house 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.

Cardiopulmonary resuscitation training

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

C 8.1►A Our non-clinical health service staff complete training appropriate to their role and our patient population.

You must:

- provide evidence that non-clinical health service 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 work with interpreters
- demonstrate that health service team members have cultural awareness and seek to provide a culturally safe environment for their patients (see Criterion C2.1 – *Respectful and culturally appropriate care* for further 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.

C 8.1►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.

Quality improvement module

QI Standard 1

Quality improvement

QI Standard 2

Clinical indicators

QI Standard 3

Clinical risk management

References

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

QI 1.1►A Our health service has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI 1.1►B Our health service team shares information internally about quality improvement and patient safety.

QI 1.1►C Our health service seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI 1.1►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. Quality Improvement is more difficult in the prison setting than in mainstream community settings.

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 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 there are a large number of transient staff, it is important to document quality improvement systems and processes in order to retain the knowledge of these processes at the health centre.

Engaging the practice team

Quality improvement relates to many areas of a prison health service, so the collaborative effort of the entire health service team is necessary to achieve improvements in quality and safety of patients.

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

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

In order 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, suggestion boxes or other digital solutions 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 or other relevant parties
- responding to feedback from members of the health service team
- auditing clinical databases
- analysing near misses and errors.

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 allows you to:

- track quality improvement efforts
- identify whether improvements have been made or if efforts are required to address the quality issue
- reduce duplication of effort and time
- evaluate the plan and impact 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

QI 1.1►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 who has 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.

QI 1.1►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.

QI 1.1►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, suggestion boxes or digital solutions that the team can use to contribute their ideas
- create short surveys for the team to complete that are incorporated into a quality improvement plan.

QI 1.1►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

QI 1.2►A Our health service provides opportunities for feedback from patients and other relevant parties in accordance with the RACGP's *Patient feedback guide*.

QI 1.2►B Our health service analyses, considers, and responds to feedback.

QI 1.2►C Our health service informs patients 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.[82]

Patients appreciate knowing that their feedback is taken seriously and acted upon 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 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. Complaints may be a part of patient feedback and they are to be balanced with other aspects of the patient's experience when meeting this Criterion. 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.* This is available at: www.racgp.org.au/yourpractice/standards/standards5thedition/patient-feedback. 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 chooses 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 continuously throughout the three-year accreditation cycle.

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 existing services, appointment wait times), which health service staff could ask patients.
- describe how you gather patient feedback on practice development
- hold patient forums and information days.

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.

Using feedback

Regardless of the method you use to collect patient feedback, it must be analysed and used to improve the quality of the care you provide.

Some of the suggestions made by patients will not be practical or feasible for your health service, so you need to decide what feedback will be used 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 request their input on quality improvement activities that could be implemented
- consider which feedback aligns with the health service's strategic objectives.

Patients value knowing that their feedback has been respectfully considered and implemented where possible, so it is important to inform them of the quality improvement activities that you are planning to implement and those you have implemented in response to their feedback. You could include relevant information via your usual communication mechanisms (eg printed material, inmate radio service or video presentation). Alternatively, clinicians could discuss this with patients during a consultation.

Meeting each Indicator

QI 1.2►A Our health service provides opportunities for feedback from patients and other relevant parties in line 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.

QI 1.2►B Our health service analyses, considers, and responds to feedback.

You must:

- keep records that show that feedback has been considered/discussed and improvements have been made 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.

QI 1.2►C Our health service informs patients 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 the health service, in newsletters, on digital information screens and in notices in waiting rooms.

Criterion QI1.3 – Improving clinical care

Indicators

QI 1.3A Our health service team uses a nationally recognised medical vocabulary for coding.

QI 1.3►B Our health service uses relevant patient and 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 in order 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 (WHO'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. However, consider adding some standardised vocabulary.

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.

More information on patient health information can be found at Criterion C6.2 – *Patient health record systems* and Criterion C7.1 – *Content of patient health records*.

Improving clinical practice

Quality improvement is an essential part of routine care, which 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 prison population, such as changes to:

- rates of immunisation
- how the health service cares for Aboriginal and Torres Strait Islander patients
- how the health service cares for patients who have experienced isolation and disadvantage
- how the health service cares for patients with particular physical and psychological conditions, and conditions that are prevalent in the prison population
- systems used to identify risk factors for illnesses that are particularly prevalent in the health service's local community/prison (eg hepatitis B or hepatitis C) and ethnicity of patient populations (eg Aboriginal and Torres strait Islander patients)
- 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 in order 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.[83]

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. For example, an individual practitioner can complete a PDSA cycle to improve their individual clinical knowledge and skills.

Further information on clinical audits is available on the RACGP CPD 2020-22 Triennium website (https://www.racgp.org.au/education/professional-development/qi-cpd/2022-triennium).

Other sources of information

To improve the targeting and use of your prevention activities (eg blood-borne virus management, management of substance dependence), you may 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

QI 1.3A 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.

QI 1.3►B Our health service uses relevant patient and 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 blood borne virus prevalence.

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

QI 2.1►A Our active patient health records contain a record of each patient's known allergies.

QI 2.1►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 religion, ethnicity and cultural background
- preferred language and interpreter requirements.

Why this is important

Maintaining clear and accurate patient health records is essential if your health service is to provide high-quality care.[84] A good health summary helps practitioners, locums, registrars and students to obtain an overview of all components of the patient's care in order 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 risk factors (eg smoking, poor nutrition, alcohol and other substance use, physical inactivity) that can help practitioners to promote healthy behaviours
- 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 may also record:

- 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), sexuality and gender identity
- recent important events in a patient's life that could affect the patient's preferences, values, and care they require (eg childbirth or becoming a parent). It is good practice to ask patients if they are taking any medicines not prescribed by the practice or if they are using complementary therapies, and to record this information in their patient health record.

Meeting each Indicator

QI 2.1►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 practitioners ask patients about allergies

QI 2.1►B Each active patient health record has the patient's current health summary

You must:

- keep a current health summary in each active patient's health record
- have a current health summary for at least 75% of your active patient health records.

You could:

- conduct a regular audit of patient health records
- consider earliest release date and time of expiration of sentence.

Criterion QI2.2 – Safe and quality use of medicines

Indicators

QI 2.2►A Our patients are informed of the purpose, importance, benefits, and risks of their medicines and treatments

QI 2.2►B Our patients are made aware of their role in their own treatment.

QI 2.2►C Our clinical team accesses current information on medicines, and reviews our prescribing patterns, in accordance with best available evidence.

QI 2.2►D Our clinical team ensures that patients and other health providers to whom we refer them, receive an accurate and current medicines list.

QI 2.2►E Our clinical team ensures that medicines and medical consumables are acquired, stored, administered, supplied, and disposed of in accordance with manufacturers' directions, organisational policies 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, risks

Consumer Medicines Information leaflets (https://www.tga.gov.au/consumer-medicines-information-cmi) 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 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 may be appropriate to use visual media or translators.

Patients' role in their own treatment

Providing patients with education not only improves their knowledge, it 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.[85]

There are a number of resources that provides more information on medications and the purpose of their treatments. These include:

- the NPS MedicineWise 'Medicine Finder' (www.nps.org.au/medicines)
- the Victorian Government's 'Better Health Channel' (www.betterhealth.vic.gov.au).

This information could be provided to the patient via a patient information leaflet when they see a clinician or request the information through a health service request. Patients could also ask a nurse to provide more information and they could download information if required or ask the pharmacy to source written material.

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 [ASCEPT]) (https://shop.amh.net.au)
- Therapeutic Guidelines (www.tg.org.au)
- Therapeutic Guidelines: Antibiotic (www.tg.org.au) to promote and support informed prescribing of antibiotics
- Department of Veterans' Affairs (DVA) Medicines Advice and Therapeutics Education Services (Veterans' MATES) (www.veteransmates.net.au)
- the Australian Federation of AIDS Organisation (www.afao.org.au) for guidelines on the use of post-exposure prophylaxis.

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, including those obtained through diversion. Health services can endeavour, where possible, to administer medications as close to the appropriate time as possible.

The confirmed list of the patient's current medication must be included in letters of referral, including those for hospital admissions.

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

QI 2.2►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, posters or content from reputable sources to inform patients about medicines.

QI 2.2►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 role in their own treatment.

You could:

- provide patients with consumer medicine information

- provide patients with a written action plan.

QI 2.2►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.

You could:

- use a current clinical software program
- use current best-evidence medicine guidelines
- develop and implement policies or protocols in areas such as antibiotics and drugs of dependence.

QI 2.2►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:

- keep an accurate and current medicines list and referral letters in each patient's health record.

You could:

- conduct regular audits of patients' health record to bring medicines lists up to date and mark acute medications as non-current.

QI 2.2►E Our clinical team ensures that medicines and medical consumables are acquired, stored, administered, supplied, and disposed of in accordance with manufacturers' directions, organisational policies and relevant laws.

You must:

- acquire, store, administer, supply and dispose of medicine and medical consumables according to manufacturers' directions and relevant laws
- maintain a Schedule 8 medicines register.

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.[86] You need to foster a just, open and supportive culture in order 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.[87] 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.[88] It creates an environment where excellence in clinical care will flourish because all team members accept responsibility for the services and care the practice provides.[89],[90]

Criterion QI3.1 – Managing clinical risks

QI 3.1►A Our health service monitors, identifies, reduces and reports patient incidents in clinical care.

QI 3.1►B Our health service team makes improvements to our clinical risk management systems in order to prevent or reduce patient incidents (eg. 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'.[91] 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 may be exposed to avoidable future adverse events and the health service team may 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.

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 them reoccurring (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
- implement a clinical governance framework to help achieve a balance of 'find it', 'fix it' and 'confirm it' functions in order 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 may want to have your medical defence organisation check and approve your process for recording and responding to near misses and adverse events.

Practitioners are increasingly referred to as the 'second victims' of adverse events because they can often feel that they have failed the patient,[92] 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

Indicators

QI 3.1►A Our health service monitors, identifies, reduces and reports patient incidents in clinical care.

You must:

- implement and maintain an incident or event register.

You could:

- implement and maintain a clinical risk management policy
- conduct clinical audits and make changes to clinical care to reduce the risk of identified issues
- keep a record of team meetings and planning meetings where risks are discussed.

QI 3.1►B Our health service team makes improvements to our clinical risk management systems in order to prevent or reduce patient incidents (eg. near misses and adverse events) in clinical care.

You must:

- record the actions taken in response to events 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

QI 3.2A 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*, developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

Information on the Australian open disclosure framework is available at: www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework

Implementing the Australian open disclosure framework in small practices (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 is important so that a patient can:

- move on
- have better relationships with clinicians
- be more involved in their 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 health 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 may 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*.

There may be implications when health care is affected by something outside the health service's control. Ensure a process that involves prison staff where applicable.

Disclosure to the patient following an incident that caused harm is beneficial to both the patient and the health service. Disclosure may 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 may need to participate in open disclosure, and what kind of documentation they would require for risk management initiatives.

Meeting each Indicator

QI 3.2A 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.

Prison health service module

PHS Standard 1

Access to care

PHS Standard 2

Comprehensive care

PHS Standard 3

Qualifications of our clinical team

PHS Standard 4

Reducing the risk of infection

PHS Standard 5

Facilities in our health service

PHS Standard 6

Vaccine potency

References

PHS Standard 1: Access to care

Our health service provides timely care and advice for individuals in prison, 24 hours a day.

Your health service must have a system that provides care to patients 24 hours a day, 7 days a week. Standard 1 recognises that 24 hour care may not always mean access to a member of the health service team (ie accessible care may be provided by an appropriately qualified member of the health service team). This may not mean a member of the health service team is physically located at the prison at all times and can include appropriate protocols to access emergency healthcare when required.

This Standard includes criteria that relate to providing access to comprehensive care in a prison health service context. It includes the:

- 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 prison to receive care 24 hours a day, 7 days a week.

Criterion PHS 1.1 – Responsive system for patient care

Indicators

PHS 1.1►A Our health service provides different consultation types to accommodate patients' needs.

PHS 1.1►B Our health service maintains staffing for the safe delivery of care.

PHS 1.1►C Our health service can demonstrate that patients can directly access the health service by request during normal opening hours.

PHS 1.1►D Our health service has a reliable triage system that enables access to timely care.

PHS 1.1►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 in order 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. Consultations can include administration of medications and other forms of contact with the health service, not just a formal appointment with a GP or Medical Officer.

Your health service must ensure patients are aware of what to do in the event of an emergency. In the prison setting, it is not possible for patients to call or write to your health service directly. Your health service many therefore need to devise special strategies for prisoners to request an appointment in an emergency situation. For example, in an emergency a patient might attain the attention of a prison staff member who will then contact a nurse or after hours nurse manager for advice. Patients can also alert staff via an alarm in their cell.

Direct patient access to the health service allows for greater assurances of confidentiality and privacy, enhanced self-agency for individuals and minimisation of medicolegal 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 prison staff) to mediate their request for access. It is not appropriate for prison staff to triage patients who request medical attention. Triage by clinical staff allows for greater assurances of confidentiality and privacy for patients. 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 may 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).

In order to manage appointments, keep an appointment book (electronic or paper-based) in which you can arrange and record a variety of appointment types, including:

- 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 may also be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if an interpreter will be present. Some patients may always need longer appointments.

When there is an emergency, health service team members need to:

- update the patient waiting list
- if there are patients in a waiting area, explain to them that there has been an emergency and that this may increase their waiting time
- notify other patients who have not yet arrived that their appointment may 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 regard to both practitioner training and the number of staff available.

In remote locations 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. This may involve making arrangements with prison staff to access a 24/7 on-call medical service on behalf of the patient.

Technology-based consultations

Patient access to technology-based consultations (eg via telephone and internet based video services) may be limited in prison as individuals may not have access to telephones or other forms of electronic communication. However, your health service may facilitate technology-based consultations within the health service in place of face-to-face consultations where a member of the health service team is located off site.

When conducting a technology-based consultation, the practitioner must:

- confirm the identity of the patient using three patient identifiers (eg their full name, date of birth, and identification number)
- advise the patient of the security risks associated with technology-based consultations
- obtain the patient's prior written consent, if possible, before the consultation takes place
- use an appropriate interpreter with patients who do not have English as their first language.

More information on patient identification is provided in Criterion C6.1 – *Patient identification*.

The Medical Board of Australia's *Guidelines for technology-based patient consultations*[93] provides further information that you may find useful. You may 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. This training can be delivered in-house by a health service member, or by an external training provider.

As administrative staff members may 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 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 may make it necessary for administrative or other non-health staff members to assess the urgency of the need for care, effectively triaging patients.

A member of the health service team must be able to identify the urgency or prioritise the need for care.

Telephone triage is not applicable if individuals in prison as patients do not have access to telephones.

Managing cross-infection through triage

Some patients may have a communicable disease and your health service needs to reduce the risks of the health service team, prison staff, visitors 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.

Non-health stakeholders working at prison (eg prison 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 may 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 prison (eg via a staff member), effective triage can identify the risk of infection and affect appropriate action before a patient present at the health service.

Your health service must use transmission-based precautions for a patient known or suspected to be infected with a highly contagious infection (eg influenza). You can minimise exposure to other patients and the health service team by:

- implementing effective triage and appointment scheduling
- using personal protective equipment (PPE) (eg masks)
- implementing distancing techniques, such as:
    - spacing patients in the waiting room at least a metre apart
    - isolating the infected patient in a separate space (see Indicator PHS 4.1►E *Our health service has a dedicated space for patient isolation when a patient presents a risk of infection to others* for more information)
- strictly adhering to hand hygiene
- 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 prison service.

Meeting each Indicator

PHS 1.1►A Our health service provides different consultation types to accommodate patients' needs.

You must:

- provide multidisciplinary consultations 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
    - medication administration
    - 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 technology-based consultations.

PHS 1.1►B Our health service maintains staffing for the safe delivery of care.

You must:

- ensure that, in lieu of alternative arrangements, there is a sufficient number of staff available to meet the needs of your patient population
- ensure that available health service 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 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
- demonstrate the arrangements your health service has in place to provide advanced life support to child patients up to the age of 18, when needed.

PHS 1.1►C Our health service can demonstrate that patients can directly access the health service by request during normal opening hours.

You must:

- demonstrate how patients can access the health service during normal opening hours
- demonstrate how patients at the prison know where your health service is located and are informed about making requests to access the health service
- demonstrate how patients access care when no staff are available at your health service.

You could:

- display a sign, visible at all times, providing detail on how patients can make a request to access the health service
- educate patients on how they are able to make requests to access the health service.

PHS 1.1►D Our health service has a triage system that enables access to timely care.

You must:

- have a documented process for triage 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 prison 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
- provide evidence of monitoring performance against triage classifications
- display a sign in the waiting area advising patients who have a high-risk condition or deteriorating symptoms to advise reception staff
- provide evidence that administrative staff update the patient waiting list in an emergency, and that patients are advised that this may increase their waiting time.

PHS 1.1►E Our patients are aware of and can access care in an emergency.

You must:

- advise patients how they can access care in an emergency.
- ensure patients have access to timely care in an emergency

You could:

- ensure prison staff know how to contact the health service in an emergency.
- provide new arrivals to the prison with information and display information throughout the prison on how to access care in an emergency
- train reception staff 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 PHS 1.2 – Living quarters visits

Indicator

PHS 1.2►A Our patients can access medical care provided in living quarters when safe, reasonable and practical.

Why this is important

Individuals in prison who are unable to attend your health service (eg patients with disability or additional needs, 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 with consideration of security and safety requirements in the prison setting.

Living quarters visits

If the patient needs a consultation for their health in their quarters and it is appropriate, they will be seen by a clinical member of the team (eg if the patient is confined due to illness or disability, if urgent treatment can be provided faster and when you want to reduce the risk of infection).To determine the appropriate circumstances for a visit to living quarters, 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
- alternative arrangements if a living quarters visit is not feasible.

Members of the health service team need to know the conditions in which a visit to a patient's living quarters are 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 of living quarters 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 prison settings, would agree is reasonable.

Alternatives to living quarters visits

When a living quarters visit is neither safe nor reasonable your health service must be able to describe an alternative source of care that patients can access, such as telehealth consultations. In determining alternative systems of care, consider options offered by other prison health services when a living quarters visit is neither safe nor reasonable.

In deciding whether to offer telehealth 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

PHS 1.2►A Our patients can access medical care provided in living quarters visits when safe, reasonable and practical.

You must:

- document in a patient's health record when team members have made visits to a patient in their 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 that describes the circumstances when a living quarters visit is safe and reasonable.

Criterion PHS 1.3 – Care outside of normal hours of health service operation

Indicators

PHS 1.3►A Our patients are informed about how they can access after-hours care.

PHS 1.3►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 prison are unable to access community after hours health service providers and thus require a system to access urgent care if needed. Where possible and practicable, the need and priority for clinical care is not to be determined by prison staff.

The prison health service may be the only way for individuals in prison 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, you could use one or more of the following:

- clearly visible signage at the health service, in the accommodation living quarters, or areas where individuals in prison can make appointments and that indicates your normal operating hours and the arrangements for care outside of those hours
- inform prison staff.

Any messages or signage must be provided in the commonly used languages of your patient population and consideration should be given to providing information for people with poor literacy skills.

After-hours care

In order for your patients to be able to access care after-hours, your health service could deliver after-hours care directly. If your health service cannot provide after-hours care to individuals in prison directly, you could participate in a cooperative arrangement with another service to deliver after-hours care.

After-hours care may also be performed 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 to facilitate access to important patient information, particularly in an emergency.

If health service staff are unavailable outside of normal hours, you must discuss expectations with prison staff around arrangements for emergency care to be provided to patients outside of normal health service hours. More information on how your health service can engage with non-health service staff in the prison is provided at Criterion PHS2.3 - *Engaging with other services*.

Meeting each Indicator

PHS 1.3►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 so they can explain how patients can access after-hours care.

You could:

- provide new arrivals to the prison with information via your usual communication mechanisms and display information throughout the prison on how to access care in an emergency
- 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.

PHS 1.3►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
- 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
- place clearly visible signage with information about after-hours arrangements at the health service, in the accommodation living quarters, or areas where individuals in prison can make appointments.

PHS Standard 2: Comprehensive care

Our health service provides comprehensive care to our patients.

In Australia, people in prison are not limited by age, gender, body system, or disease process. As such, providing care to individuals in prison spans:

- prevention
- health promotion
- early intervention for those at risk
- antenatal and postnatal care
- management of acute, chronic and complex conditions, including conditions caused and/or exacerbated by being held in prison
- end-of-life care
- the entire health service population, whether in the health service facilities, patient's living quarters, or other facilities and spaces.

This Standard includes criteria that relate to:

- providing comprehensive care in a prison health service context
- the health service's system for recalls and reminders
- the coordination of care outside of the health service.

Criterion PHS 2.1 – Continuous and comprehensive care

Indicators

PHS 2.1►A Our health service provides continuity of care.

PHS 2.1►B Our health service provides comprehensive care.

PHS 2.1►C Our health service provides reception screening, for patients.

PHS 2.1►D Our health service provides coordinated care for our patients.

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. Continuity of care begins when a person enters a prison (including transfer of previous medical files), extends throughout the duration of their incarceration and extends beyond their release with transfer of relevant medical summaries to the next primary health care provider.

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.[94]

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.[95]

Patients who have continuity of care with a regular practitioner:

- report high levels of satisfaction with their experience of care[96]
- have lower rates of hospitalisation and emergency department attendances[97] [98]
- have lower mortality rates[99]
- have increased satisfaction and greater efficiency in investigating health problems[100]
- 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, nurse or health care 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, mental health, alcohol and other substance misuse, Aboriginal and Torres Strait Islander 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.[101]

The provision of comprehensive care is particularly important in prison communities where patients have reduced or no access to other healthcare services.

Trauma-informed care

Trauma-informed care can enhance accessibility of care, particularly for Stolen Generations and their descendants and people who have been incarcerated multiple times, given the prison environment has the potential to trigger feelings of distress and exacerbate pre-existing trauma. [102][103][104]

Health assessments

Health assessment on arrival at prison can detect significant conditions of public health importance, enabling treatment and surveillance to the benefit of other prisoners, prison staff and the community. Guidelines within most jurisdictions stipulate that a person entering prison is to be medically examined by a suitable qualified health professional within 24 to 72 hours of being received into prison.[105] [106] [107] A broad range of physical and mental health issues can be both exacerbated and caused by entry into prison. Communicable diseases are known to be more prevalent in the prison population due to at-risk behaviours such as injecting drug use, needle sharing, sexual practices, tattooing and physical violence.[108,109] Prison settings provide key opportunities for identifying and treating blood-borne viruses (BBVs) and sexually transmitted infections (STIs), reducing transmission and therefore morbidity and mortality.

An initial health assessment will allow the health service to identify vulnerable individuals such as those with disabilities, mental health concerns, pregnant women and individuals who have alcohol and other drug dependencies. It can also help to determine if an individual has any diseases or conditions which would represent a threat to public health or the prison population.

Following an initial assessment of an individual in prison, the practitioner can identify physical and/or mental illness and take necessary measures for new or continuing treatment and care. Health assessment on arrival allows the health service to:

- isolate an individual in prison who is suspected of a highly communicable disease that may impact public health for the period of infection, providing them with proper treatment and education on safe practices to avoid transmission.
- identify any chronic health conditions that may need to be addressed

- identify current medications the patient is on
- inform the patient about mechanisms of protection (such as immunisation to other vaccine preventable conditions) or ways to reduce exacerbations of their health condition.

Meeting this Criterion

Continuity of care in your health service

Prisoners may be frequently and rapidly transferred to alternative locations. To ensure continuity of care across health services in different prisons, your health service needs to develop a routine procedure for the way in which health information is transferred to a new location. This must be in accordance with state and federal privacy law.

For people in Australian prisons, health services act as coordinators of all healthcare services and as patient advocates. Patients in prisons have a restricted capacity to choose healthcare providers and are reliant on a health service to provide or coordinate their healthcare including mental healthcare, specialist healthcare, dental healthcare, allied healthcare and emergency healthcare. Your health service must ensure coordination and continuity of comprehensive care for your patients.

Comprehensive care

The provision of comprehensive care for individuals in prison includes:

- proactive health promotion and preventive care including physical health (encompasses appropriate developmental, age, gender appropriate, sexual health and obstetric health), mental health and active immunisation
- acute and chronic disease management
- infectious disease management including addressing public health impacts within the prison
- trauma informed care and mental health care including screening and access to counselling
- treatment for alcohol and other substance dependency
- advanced care planning and end of life care
- effective referral pathways to other specialised health care providers and services
- access to 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 that meet their needs.

While a regular practitioner or care team is preferred, a patient does not have to see the same practitioner in order for them to receive best outcomes, provided the service has systems that enable consistent safe, coordinated care.

Collecting information about a patient’s cultural heritage before a consultation (eg by interviewing the patient) 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 may indicate that they are at higher risk of developing certain health conditions. For example, Aboriginal and Torres Strait Islander people are more likely to have multiple chronic 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 patient within one month of arrival at the prison. 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 in order for them to understand the implications of health screening and give informed consent.

Health assessments of individuals in prison must:

- be conducted under the supervision of a medical professional
- use interpreters, when required
- be subject to patient consent
- be conducive to patient privacy and confidentiality
- include a comprehensive assessment
- be recorded in the patient's record.

Health assessments of individuals in prison could:

- Record the patient's:
    - languages and the need for an interpreter
    - medical history, including current patient concerns, current medicines, allergies, afl grand family medical history, injuries/accidents/hospitalisations, infectious conditions, immunisation history, chronic non-communicable diseases, risk factors and other issues
    - Aboriginal Torres Strait Islander status and any related information
    - 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
    - disability that requires communication assistance
    - appointment of a guardian
    - developmental health (for children and adolescents).
- include a physical examination of the patient
- provide the patient with preventive health care 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 may 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 may impact public health (eg active pulmonary tuberculosis)

Vaccines need to be administered according to the relevant Australian vaccination schedule[110],clinical guidelines as stipulated in the Australian Immunisation Handbook[111] as well as other state/territory 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 that patients can understand, whether that be in written or verbal form. Patients may not wish to participate in a health assessment if they are unable to read and understand the information about them.

Meeting each Indicator

PHS 2.1►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, including for chronic conditions
- demonstrate your health service's capacity to provide emergency care to patients when access to tertiary care is limited or impossible.

You could:

- document management plans in patient health records, including behaviour management issues especially for patients with complex or chronic health problems
- have a policy and procedures for recall and reminders
- provide a list of services offered by the health service (eg on an information leaflet).

PHS 2.1►B Our health service provides comprehensive care.

You must:

- demonstrate that the health service provides comprehensive care
- demonstrate that the patient receives planned care for the management of their chronic condition/s
- demonstrate your health service team is trained to attend to the needs of your patient population (children, individuals with disabilities, individuals with mental illness and women who are pregnant).

You could:

- record in each patient's health record their:
    - culture
    - Aboriginal and Torres Strait Islander status
    - preferred language
    - country of origin
    - country of birth
    - date of arrival
    - interpreter or other communication requirements
    - self-identified gender
    - mental health status.
- conduct a review of the patient's health assessment when the patient:
    - requests a review
    - declines treatment and support
    - is at significant risk of injury to themselves or another person
    - receives involuntary treatment or is removed from an involuntary order
    - has transferred from, or is being transferred to another service site
    - is being released from prison
    - is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

PHS 2.1►C Our health service provides arrival assessments, including screening, for patients.

You must:

- demonstrate that your health service provides screening on arrival for all consenting prisoners
- document arrival assessment and screening in the patient's record.

You could:

- record each patient's disease status and continuing medications in their health record.

PHS 2.1►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:

- implement a system for patients to request to see a particular practitioner
- show patient records that demonstrate that the health service strives to provide continuity of care
- 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.

Criterion PHS2.2 – Follow-up systems

Indicators

PHS 2.2►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.

PHS 2.2►B Our health service recalls patients who have clinically significant results.

PHS 2.2►C Our patients are advised of the health service's process for follow-up of tests and results.

PHS 2.2►D Our health service initiates and manages recall of patients for ongoing care.

PHS2.2►E Our health services monitors and records patient attendance.

PHS 2.2►F 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 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 patient deterioration has occurred.

It is best practice to inform patients of clinically significant results face to face, so the patient can ask questions and receive advice.

Health services must have a fit for 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. Continuity throughout the transfer of patient care is discussed further at Criterion PHS 2.4 *Transfer of care and the patient-practitioner relationship* and Criterion PHS 2.1 *Continuous and comprehensive 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. An individual's participation in their own health care is limited in the prison setting and reminders are for the practitioner or the clinic, not the patient. Failure to recall a patient may result in an adverse outcome and the responsible practitioner may 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 or not to follow the recommendations.[112] 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.[113]

Practitioners need to review results and reports and take appropriate action in a timely manner. The speed with which results or reports are acted upon 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 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 may be situations where it is unclear whether the follow-up of results has actually occurred or who is responsible for the follow-up.[114] It is good practice to assume that clinically significant test results ordered by practitioners who are not part of the regular health service team may 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.[115]

Sometimes it may 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. As prisoners may be moved between centres, it is important to have a system in place that ensures all results will be followed up by a practitioner who will be able to action care.

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 may 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.

Escalating concerns about a deteriorating patient

Members of the health service team must have an avenue to escalate incidents of patient deterioration 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 the use of escalation processes. These processes must allow health service team members to escalate concerns about a patient's condition until they are satisfied that the patient receives a resolution.

Having a process 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.

Your health service must provide all team members with a mechanism to call for emergency assistance at any time.

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
- upon 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
- to discuss why they do not want/no longer need treatment.

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
- the health service determines who is responsible for reviewing and acting on investigation results
- 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 upon 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 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. In the prison setting, reminders are sent to the health service for follow up and patients are called to the health service on the day they have been listed for review. 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
- 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.

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 prison 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 may 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 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 may be required in order for individuals in prison to receive timely care.

Telehealth consultations may 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 well-being
- clinical needs of patient
- clinical effectiveness of telehealth consultation
- patient preference
- 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.

For more information on providing safe and effective video consultations refer to the RACGP's *Telehealth video consultations guide*.

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 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 prison staff) who monitor individuals in prison, 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 in such circumstances.

Meeting each Indicator

PHS 2.2►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.

PHS 2.2►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 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.

PHS 2.2►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 a list of all pathology and radiology tests ordered to cross-reference when results are received
- maintain templates in a clinical software program to trigger recalls and reminders
- have a recall policy document.

PHS 2.2►D Our health service initiates and manages recall of patients for ongoing care.

You must:

- document in patient health records when reminders have been initiated by the health service and acted upon 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 they can tell patients about the process of sending out reminders
- have reminders sent through the clinical information system
- pre-emptively make an appointment for a patient to return for results on which it is anticipated management decisions will be based.

PHS2.2►E Our health services monitors and records patient attendance.

You must:

- document patient attendances
- demonstrate how non attendances are managed.

You could:

- have a health service team member responsible for monitoring and recording patient attendance

PHS 2.2►F High-risk (seriously abnormal and life-threatening) results identified outside normal hours of health service operation are managed by our health service.

You must:

- give diagnostic services a point of contact within the prison health service to whom significant abnormal results can be communicated
- have a process for managing high-risk results identified outside of normal health services operating hours.

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 PHS 2.3 – Engaging with other services

Indicators

PHS 2.3►A Our health service collaborates with other health services and relevant non-health stakeholders to deliver comprehensive care.

PHS 2.3►B Our health service has a collaborative arrangement with the justice/corrections/system staff of the prison in which we are located.

PHS 2.3►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 may include:

- allied health
- pharmacy
- diagnostic
- disability
- mental health
- torture and trauma
- alcohol and other substances
- dental
- sexual health
- hospitals.

For your health service in the prison setting, other services also include your relevant government departments.

Given coordination of care for individuals, families and communities is associated with improved health outcomes for patients,[116] engaging with other services is an important feature of providing high-quality healthcare.

Non-health stakeholders, such as prison staff (eg prison staff, social welfare staff, government personnel, etc.) may have involvement in the coordination of care for individuals in prison. These stakeholders could:

- accompany and/or transport individuals to health appointments within the prison and to external health services
- apply restraints to some individuals when they are transported outside the prison to attend appointments
- identify individuals who:
    - show signs of clinical deterioration from a mental health perspective
    - are undertaking food and fluid refusal
    - 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
- provide simple analgesics to individuals outside of clinic hours on instruction (verbal or handwritten) of a qualified practitioner if there is no health professional on site
- be the first responders to medical emergencies, particularly outside of staffed clinic hours needing to utilise AEDs 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 may have significant mental health issues impacting their behaviour
- be involved in complex case meetings where health issues that may impact a patient's behaviour and or that create a potential risk in the prison are discussed
- be involved in outbreak management (eg 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 may be providers within or outside of the health service and prison. 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).

Prisons may, for various reasons, subject individuals in prison to more restrictive incarceration for disciplinary issues (eg use of restraints, segregation). If this occurs, the health service must collaborate with health and security services involved in the prison in order to determine the cause for behaviour and best management strategies. The health service must also advocate for individuals if restrictive incarceration, 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 inter-professional collaboration so 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, 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
- 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 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 health care provider and or setting to where the referral is being made (eg the specialist consultancy)
- include any relevant capacity concerns or inability of the prison health service to provide follow-up or post procedural care.

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 may 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 (STI) 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.[117]

Emailing referrals

The RACGP has developed Practice policies and risk assessment 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 you respond to emails and other electronic communication in a timely and appropriate manner. Further detail relating to responsive systems for patient care is provided in Criterion PHS1.1 – *Responsive system for patient care*.

Telephone referrals

A telephone referral may 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 Justice. Some non-health stakeholders will have direct contact with individuals in prison and may be involved in an individual's access to health services (eg prison staff escorting an individual to your health service). Related content regarding how your health service manages confidentiality and their personal health information is available at Indicator C6.3►A *Our patients are informed of how our health service manages confidentiality and their personal health information*.

Meeting each Indicator

PHS 2.3►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 and health service team collaborates with other healthcare services including 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, prison management, stakeholders and patients are engaged in the review of the health service's strategic plan.

PHS 2.3►B Our health service has a collaborative arrangement with the justice/corrections/system staff of the prison in which we are located.

You must:

- have a procedure describing how the health service works with and within the prison system

PHS 2.3►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.

You could:

- use a clinical software program to generate referrals that are automatically populated with an up to date health summary
- 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 PHS 2.4 – Transfer of care and the patient–practitioner relationship

Indicators

PHS 2.4►A Our health service team manages patient transfers between staff in our health service.

PHS 2.4►B Our health service supports the safe transport of patients.

PHS 2.4►C Our health service facilitates timely transfer of patient care between health service teams when the request for transfer occurs.

PHS 2.4►D Our health service identifies the need for and facilitates the timely transfer of patients that require urgent medical attention.

PHS 2.4►E Our health service provides patients with information about the management of their health when they leave custody.

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 are released from prison may have difficulties in accessing and making the best use of health services. Individuals are also at an increased risk of adverse health outcomes in the first two weeks post release from prison.[118]

Negotiating the health system may be a complex undertaking, particularly for those with multiple health needs requiring numerous investigations and follow-up appointments.

Individuals who are released from prison to the community, may have backgrounds of trauma and disadvantage. These individuals can have increased vulnerability leaving the prison environment, 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 assists to ensure 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 may involve having a plan for the patient's care that is shared by the people providing the care. Further information on transfer of care can be accessed at Indicator C 5.3►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*.

Handover of patient care within the health service

Your health service must conduct timely handovers of patient care between practitioners, wherever it is possible to do so. This involves having the patient present during the handover.

External decisions regarding transfer

Decisions regarding patient transfer may be made by external stakeholders (eg the Department of Justice). Practitioners who provide care to individuals in prison must submit comprehensive evidence to any external decision makers when requesting a patient transfer or seeking to defer a 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 prison's location)
- identification of risks to the patient's health if a transfer is delayed or denied
- exacerbating factors in prison.

Transfer of patient care within the health service

At the request of the patient or practitioner, care may be transferred to another practitioner within your health service. Practitioners in your health service must recognise that the scope for patient transfer to occur is variable based on the size of the health service and the number of available clinical staff.

Where a health service in a prison has more than one health professional providing care, patients may be able to request consultations with a particular member of the clinical team. Where transfer of care to another health professional within the same health service occurs, the patient's health information needs to be readily accessible to facilitate continuity of care. The health service needs to comply with the requirements of the relevant state or territory legislation governing the transfer of patient health information. Where the health service produces a summary for transfer to another health provider it is useful to keep a copy of the summary in the patient's health record. It is recommended that a copy of the patient health information be transferred with the patient and that the health service retain the original health information.

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:

- 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
- notifying the custodial service of the decision as they are ultimately responsible for the welfare of the patient and may need to consider if alternative arrangements are required

- facilitating arrangements for the continuing medical care of the patient, including the transfer or appropriate management of all patient records.[119]

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 may wish to consult with its medical defence organisation, where necessary).

Transfer of patients to another prison

Patients may also be transferred to another prison.

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.

When planning care, the health service needs to consider the time required to transfer patients between facilities, taking into consideration any rest periods or provision of medications that may be required. The health service must also consider security requirements for individuals entering or exiting a facility. Health service staff have a responsibility to provide custodial or transport services with advice about the appropriate mode of transport, bearing in mind the patient's physical and mental health and the duration of the expected journey.

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 provide a discharge summary for patients leaving prison to support the ongoing care of the patient. This discharge summary should be made available to future health care providers, but also accessible to the patient.

The discharge summary needs to include information from the health service to the individual which informs future health providers of relevant physical and mental health history, important health conditions, current medications, results of significant investigations, allergies, treatment received (including vaccinations received, investigations undertaken and screening results) during incarceration and any ongoing treatment regimes.

Your health service must provide patients with information that facilitates the management of their health prior to leaving prison. This could include:

- a list of community based practitioners for their consideration
- ensuring patients have enough medication upon discharge until they see another provider
- emphasising to the patient the importance of follow up once discharged from the centre
- orientating patients to their community-based health services where possible
- advising patients how care is differently received outside of the health service/prison, when known and appropriate.

Where possible, health professionals should arrange for continuity of medication supply for a patient upon discharge.

Use of restraints

The health service must uphold the rights of an individual in prison 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 prison staff, and any staff transporting a patient are paramount.

In instances such as where an individual in prison is uncooperative, disruptive or violent, restraints could be considered as a last resort by clinical staff. If so, restraint must be used to the minimum extent necessary to provide care or transfer a patient. In prison, restraints are administered by prison staff under the advice of a member of the clinical team. If a chemical restraint is used, it must be administered and supervised by a member of the clinical team.

The health service must maintain a policy on the use of restraints and comply with relevant state and territory legislation.

Your health service will not make decisions regarding restraint in isolation of a governing body's policy. Your health service must:

- maintain a policy on the use of restraints
- 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 Justice)
- 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 injury received as a result of restraint
    - any further reporting of the use of restraint outside of the health service.

Meeting each Indicator

PHS 2.4►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
- demonstrate how your health service manages the transfer of relevant patient information to ensure continuation of care.

You could:

- maintain a policy about ceasing a patient's care
- provide referrals to other healthcare providers.

PHS 2.4►B Our health service supports the safe transport of patients (where practicable and possible).

You must:

- document the details of patient transfers to other health services
- document requests for patient transfer, both approved and denied by the relevant jurisdictional authority
- conduct discharge health assessments for patients leaving your health service
- have a policy for the use of restraints
- refrain from using restraints on patients during transfer and handover, except under exceptional circumstances.

You could:

- document a policy for the administration of chemical restraints by clinical staff.

PHS 2.4►C Our health service facilitates timely transfer of patient care between health service teams when the request for transfer occurs.

You must:

- document in the patient's health record details of the practitioner's decision to cease providing care, and the action taken
- transfer the patient's health information to another practitioner in response to 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 patients any delays in transfer of care the health service is aware of (eg an ambulance is going to be delayed by centre processes, such as security).

PHS 2.4►D Our health service identifies the need for and facilitates the timely transfer of patients that require urgent medical attention.

You must:

- 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 transfer or release.

You could:

- provide a health discharge summary from the health service to each patient transferred or released from the prison
- review the outcomes of treatment and support as well as ongoing follow-up arrangements for each patient prior to their transfer or release from the prison.

PHS 2.4►E Our health service provides patients with information about the management of their health when they leave custody.

You must:

- where patient departure from custody is known to the health service, document in the patient's health record that a discharge health assessment has been conducted
- where patient departure from custody is known to the health service, provide a health discharge summary to each patient discharged from the prison
- 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
- provide patients with information about the management of their health after being discharged from the health service and prison.

You could:

- review the outcomes of treatment and support as well as ongoing follow-up arrangements for each prisoner prior to their exit from the prison
- provide patients with enough medication upon discharge to last until they see another provider
- emphasise to patients the importance of follow up once discharged from the prison
- provide patients with details on community healthcare access, when possible

PHS 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 PHS 3.1 – Qualifications, education and training of healthcare practitioners

Indicators

PHS 3.1►A Members of our clinical team:

- have current national registration where applicable
- have accreditation/certification with their relevant professional association
- maintain appropriate professional indemnity insurance cover
- are credentialed according to the service delivery requirements of their organisation and legal requirements (eg. opioid agonist therapy, implanon etc)
- actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and professional organisation's requirements
- have undertaken training in cardiopulmonary resuscitation (CPR), in accordance with the recommendations of their professional organisation, or at least every 3 years
- for remote/rural locations, have undertaken training in advanced life support
- where treating children up to the age of 18 years, have undertaken training in basic pediatric life support.
- may include general practice registrars under appropriate supervision in accordance with the Standards for general practice training
- may include practitioners actively working towards Fellowship on a recognised general practice pathway
- may include practitioners with more than 10 years' experience in Australian general practice
- hold an equivalent qualification in a country other than Australia.

PHS 3.1►B Members of our clinical team practice in a culturally safe way.

PHS 3.1►C Members of our clinical team are trained to, wherever possible, prevent, minimise and safely respond to challenging behaviours.

PHS 3.1►D Our health service identifies and addresses discriminatory practices, where relevant.

PHS 3.1►E Our clinical team is trained to use the health service's equipment that they need to properly perform their role.

PHS 3.1►F Our clinical team has undergone training specific to the patient population health needs.

Why this is important

Having only practitioners who are suitably qualified reduces the risk of medical errors and means that your health service provides patients with safe, quality care.

All 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 (CPD)

Practitioners have the responsibility to maintain their relevant national registrations and appropriate professional indemnity insurance cover, have proof of their credentialing, and comply with their ongoing CPD requirements.

In some circumstances your health service will not have the information regarding professional indemnity insurance on file. You will need to have access to organisation records if required.

CPD and other training relevant to your position

Practitioners must consider what CPD and other training is relevant to their position and patient population. This may include development related to:

- cross-cultural safety
- Aboriginal and/ or Torres Strait Islander cultural awareness training
- communicating with patients with additional needs
- mental health and alcohol and other substance dependencies, including de-escalation of mental health crises and the management of self-harm behaviours
- managing ethical dilemmas.

CPD and other training can be undertaken by completing external courses, in-house programs, or ‘on the job’ training at the health service. The timeframe for training requirements, information on emergency response training and code expectations are up to individual services and specific needs setting.

General practice is a specialist discipline

To be considered a general practitioner (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 (FRACGP) or Fellowship of the Australian College of Rural and Remote Medicine (FACRRM).

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 CPD.

Registrars and doctors on a pathway to Fellowship must be supported, mentored and supervised by a recognised GP.

Where vocationally recognised GPs and doctors on a pathway to Fellowship are unavailable

Although it may not be possible to recruit vocationally recognised GPs in some areas, doctors in health services who are not recognised GPs need to be on an appropriate training pathway with appropriate supervision and qualified to meet the needs of the local community.

CPR training

All 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 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.

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 may include, but 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 access to a hospital and/or specialist services, clinical staff must undertake 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.

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 in order 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, in-house programs, or 'on the job' training at the health service.

Culturally safe practice

The health service team need to have culturally competent knowledge and skills in order to deal with the mental and physical vulnerabilities of those in prison. This knowledge and skill may include, but is not limited to:

- interpersonal communication skills
- understanding Aboriginal and Torres Strait Islander health values, beliefs and attitudes
- 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 to intercultural competence is provided at Criterion C2.1 – *Respectful and culturally appropriate care*.

Meeting each Indicator

PHS 3.1►A Members of our clinical team:

- have current national registration where applicable
- have accreditation/certification with their relevant professional association
- maintain appropriate professional indemnity insurance cover
- are credentialed according to the service delivery requirements of their organisation (eg. opioid replacement therapy, implanon etc)
- actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and professional organisation's requirements
- have undertaken training in cardiopulmonary resuscitation (CPR), in accordance with the recommendations of their professional organisation, or at least every 3 years
- for remote/rural locations, have undertaken training in advanced life support
- where treating children up to the age of 18 years, have undertaken training in basic pediatric life support general practice registrars under appropriate supervision in accordance with the Standards for general practice training
- may include general practice registrars under appropriate supervision in accordance with the Standards for general practice training
- may include practitioners actively working towards Fellowship on a recognised general practice pathway
- may include practitioners with more than 10 years' experience in Australian general practice
- hold an equivalent qualification in a country other than Australia.

You must:

- keep records of current registration of each practitioner
- keep records of each practitioner's CPD
- keep records of each practitioners credentials (eg. Implanon insertion/removal)
- keep records of each practitioner's CPR training.
- keep records of each GP's appropriate qualifications
- check current professional indemnity insurance cover of practitioners
- 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 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.
- keep copies of job advertisements that the health service has used to recruit GPs.

PHS 3.1►B Members of our clinical team practice in a culturally safe way.

You must:

- demonstrate that health service team members have intercultural knowledge and skills
- create a culturally safe environment for staff and prisoners.

You could:

- provide training for the health service team on intercultural knowledge and skills
- provide training in relevant language skills relevant to the prison population.
- provide health service staff with access to cultural awareness training
- provide health service staff with information about external cultural awareness training
- provide in-house cultural awareness sessions and refreshers for staff.

PHS 3.1►C Members of our clinical team are trained to, wherever possible, 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.

PHS 3.1►D Our health service identifies and addresses discriminatory practices, where relevant.

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 discriminatory practices associated with stigma and bias training
- provide health service staff with information about external discriminatory practices associated with stigma and bias training
- provide in-house discriminatory practices associated with stigma and bias sessions and refreshers for staff.

PHS 3.1►E Our clinical team is trained to use the health service's equipment that they need to properly perform their role.

You must:

- be able to demonstrate that the practitioners in the health service team have 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 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
- educate clinical team members so they know how to use the health service equipment relevant to their role.
- keep a register of issues, near misses, or adverse events related to the use of equipment.

PHS 3.1►G Our clinical team have 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.

PHS Standard 4: Reducing the risk of infection

Our health service has systems that reduce the risk of infections.

Infection prevention and control is critical in prison health services. As care in prison 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 in order to reduce the risk of cross-infection and transmission of disease.

Criterion PHS 4.1 – Infection prevention and control, including sterilisation

Indicators

PHS 4.1►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 prison 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 documented evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

PHS 4.1►B Our health service has a written, service-specific policy that outlines our infection control processes.

PHS 4.1►C Our health service has a clinical team member who has primary responsibility for educating the health service team about infection prevention and control.

PHS 4.1►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 personal protective equipment (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.

PHS 4.1►E Our health service has a dedicated space for patient isolation when a patient presents a risk of infection to others.

PHS 4.1►F Our patients are informed about respiratory etiquette, hand hygiene, and precautionary techniques to prevent the transmission of communicable diseases.

PHS 4.1G 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.

PHS 4.1H Our health service provides access to harm reduction programs

PHS 4.1►I Our patients have access to a needle and syringe program

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 spreading between individuals.

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* (the Infection control standards) for guidance about how to record the education of health service team members and evaluate their competency in this area. The Infection control standards are available at: www.racgp.org.au/your-practice/standards/infectioncontrol

All members of the health service team must:

- have easy access to personal protective equipment (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.

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 control standards, which recommend the use of standard and transmission-based precautions (eg hand hygiene, PPE such as heavy-duty

protective gloves, gowns, plastic aprons, masks and eye protection, or other protective barriers) when cleaning, performing procedures, dealing with spills and handling waste.

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.

Transmission-based precautions need to be taken when patients are known to be, or suspected to be, infected with highly infectious agents (eg influenza, hepatitis B). You can minimise exposure to other patients and the health service team by:

- implementing effective triage and appointment scheduling
- using PPE (eg masks)
- implementing distancing techniques, such as:
    - spacing patients in the waiting room at least one metre apart
    - isolating the infected patient in a separate space
- strictly adhering to hand hygiene.

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 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 including access to post-exposure prophylaxis where required
- management of blood and body-substance spills
- hand hygiene
- environmental cleaning of clinical and nonclinical areas of the health service
- use of aseptic and sterile procedures
- procedures for reprocessing (sterilising) instruments (if relevant) onsite or offsite, 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 prison population. A member of the clinical team must visit quarantined individuals regularly to assess the impact of isolation on their physical and mental health and should practice normal infection control procedures as described above.

The health service must only isolate or quarantine an individual when absolutely necessary in order 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 multi-resistant organism transmission. The health service clinical team member responsible for coordinating prevention and control of infection must collaborate with all relevant stakeholders within the prison as well as external authorities to minimise risk of outbreak within the prison 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 reduction programs

Your health service could implement a range of harm reduction programs relevant to its patient population.

The implementation of needle and syringe exchange programs and opioid agonist therapy (OAT) has been shown to help reduce disease transmission among people who inject drugs in prisons and in community settings.[120] Implementing harm reduction 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 blood-borne viruses) among those who inject drugs and others in the prison and community. Other strategies that could be implemented include the distribution of condoms and lubricant.

The treatment of BBVs/STIs has both individual and collective benefits, including the health of people in prisons and a safer work environment for staff. Without prevention and harm reduction measures, treatment alone may not always be sufficient.

Quality improvement activities/audits

Your health service may 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 provides guidance on waste management that you may 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.

Tracking the sterility of medical instruments and tracing patients

If your health service adheres to and monitors a validated sterilisation process, it may not be necessary to track medical devices or trace patients on whom they have been used. Nonetheless, it may 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 may want to refer to the details of the sterilisation process. So that you can do this, you need to enter in to 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. In order 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

PHS 4.1►A Our health service has at least one clinical team member who has primary responsibility for:

- coordinating prevention and control of infection
- 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 documented 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 clinical team member who has primary responsibility for infection control and sterilisation

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.

PHS 4.1►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 or an infection prevention and control consultant when developing the health service policy
- conduct regular audits to confirm compliance with the health service policy.

PHS 4.1►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 prevention 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.

PHS 4.1►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 personal protective equipment (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.

PHS 4.1►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(s) 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.

PHS 4.1►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, masks, tissues and rubbish bins available for team members and patients
- have brochures or posters available at the health service and throughout the prison, in the commonly used languages of your patient population, that explain respiratory etiquette, hand hygiene etiquette and social distancing processes
- display a sign in the waiting area advising patients who have a high-risk condition or deteriorating symptoms to tell reception staff members
- discuss changes to laws and guidelines relating to infection control, local outbreaks and public health alerts at team meetings, and document these discussions.

PHS 4.1G 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.

PHS 4.1H Our health service provides access to harm reduction programs.

You could:

- provide access to an opioid agonist therapy program
- provide discrete access to condoms and lubricants

PHS 4.1►I Our patients have access to a needle and syringe program

You must:

- provide access to sterile needles and syringes
- provide disposal sites for used needles and syringes.

You could:

- provide access to substance misuse counselling
- provide information to patients on the prevention of transmission of blood-borne viruses (eg HIV, hepatitis B, and hepatitis C).

PHS 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 have 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 PHS 5.1 – Health service facilities

Indicators

PHS 5.1►A Our health service's facilities are fit for purpose.

PHS 5.1►B All face-to-face patient consultations in our health service take place in an appropriate consultation or examination space, barring exceptional circumstances.

PHS 5.1►C Our health service uses consultation rooms that permit patient privacy and confidentiality.

PHS 5.1►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.

PHS 5.1►E Patients that require observation are monitored in an appropriate environment.

PHS 5.1►F Our health service has accessible toilets.

PHS 5.1►G Our health service has accessible hand-cleaning facilities.

PHS 5.1►H Our health service is visibly clean.

Why this is important

Prison health service facilities are a blend of health and custodial environments. As such, your health service may not have direct operational control over the environment and it is important to work collaboratively with other entities to ensure that the clinical environment is appropriate.

Without appropriate facilities, the patient care you provide can be compromised and patient safety may 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. It is acknowledged that it may be difficult to preserve ideal levels of patient privacy and confidentiality while ensuring the safety and security of health service staff in the prison setting.

Meeting this Criterion

Design and layout

Your facilities must be fit-for-purpose, with the design and layout enabling privacy and security. Health service staff must be able access to consultation spaces and areas to have confidential discussions away from other patients, prisoners and prison staff.

Health service staff and patients must also have access to facilities such as toilets and hand-cleaning facilities. Your waiting area will accommodate a usual number of patients, noting that this is specific to the location of your health service and the patient population. For example, patient numbers during a pandemic outbreak would be exceptional. This would also take into account the security protocols in place for the management of patient appointments. 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, prison staff 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, if appropriate
- 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.

In prison settings, non-health staff (eg prison staff) are involved in a prisoner'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 may decide to not discuss their health or receive treatment if the prison has mandated the presence of a third party who the patient does not consent to having present. In circumstances where a prison officer needs to be within auditory and visual range of the consultation, where practicable health service staff must make every effort to minimise the ability for the prison officer to hear private details, without

compromising their own safety. Health service and prison staff need to have a mutual understanding of the way in which the privacy and confidentiality of patient consultations and health information will be maintained in this context.

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 in order 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 prison, including prisoners, you could have them sign a written contract that outlines a schedule, suitable products to be used areas to be cleaned and minimum expected standards of cleanliness. You could also consider having the cleaners record their work in a log.

Meeting each Indicator

PHS 5.1►A Our health service's facilities are fit for purpose.

You must:

- ensure the health service facilities are fit for purpose.

PHS 5.1►B All face-to-face patient consultations in our health service take place in an appropriate consultation or examination space, barring in exceptional circumstances.

You must:

- have dedicated consultation spaces.

PHS 5.1►C Our health service uses consultation spaces that permit patient privacy and confidentiality.

You must:

- demonstrate/be able to describe how your health service provides privacy and confidentiality to patients without compromising the health and safety of health service staff and other patients.

You could:

- provide patient privacy screens.

PHS 5.1►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.

PHS 5.1►E Patients that require observation are monitored in an appropriate environment

You must:

- ensure required information is handed over if the prison staff are responsible for monitoring the patient.

PHS 5.1►F 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.

PHS 5.1►G 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).

PHS 5.1►H 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 or prisoners
- use a cleaning log.

Criterion PHS5.2 – Health centre equipment

Indicators

PHS 5.2►A Our health centre has equipment that enables us to provide comprehensive primary care and resuscitation, including:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- dermatoscope
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask)
- equipment for minor surgery and removal of skin lesions
- intravenous access
- electrocardiograph
- emergency medicines
- examination light
- eye examination equipment (e.g. fluorescein staining)
- gloves (sterile and non-sterile)
- height measurement device
- measuring tape
- equipment for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- personal protective equipment (PPE)
- pulse oximeter
- scales
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer with small, medium and large cuffs
- spirometer
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips, including pregnancy testing kits
- vaginal specula, as appropriate
- visual acuity charts
- the ability to view x-rays

PHS 5.2►B Our health service maintains our clinical equipment in accordance with each manufacturer's recommendations.

PHS 5.2►C Our health service has one or more height-adjustable beds.

PHS 5.2►D Each health centre has a defibrillator.

PHS 5.2E Our health centre 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.[121]

Other research shows that (despite the efforts of practitioners, policy makers and consumer advocates) people with a disability continue to experience poorer health outcomes in a range of areas when compared to the broader population.[122] 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.[123] Using height-adjustable beds may also reduce workplace injuries because it may 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 centre can reduce the risk of fatality from cardiac arrest.[124] Your health centre must have protocols in place to ensure timely access to the AED in instances where it is not in close proximity to the health service.

Most cases of sudden cardiac arrest are due to ventricular fibrillation that can be returned to a perfusing 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.[125]

CPR alone will not save someone who is in ventricular

fibrillation but CPR combined with early defibrillation will increase their chances of survival.[126]

Point of care testing allows for:

- 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 in 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.[127]

For more information, refer to the RACGP Standards for point-of-care testing (5th edition)

Meeting this Criterion

Range of equipment

Your health service must have all the equipment necessary to provide services that meet the needs of the prison community and support the procedures performed in the health service. This may mean that you have some equipment that other health services may not need, but is relevant to your location or patient population. For example, it is likely that your health service will need equipment and medicines to treat patients who are suffering from drug overdoses or drug withdrawal.

PPE can include masks, plastic aprons, gowns, goggles/glasses, face shields, gloves and swabs.

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 which 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 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 centre must have timely access to an electrocardiograph and spirometry and the clinical team must be properly trained to use that equipment, and analyse the results.

Automated external defibrillator

Your health centre must have an automated external defibrillator (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,[128] 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

PHS 5.2►A Our health centre has equipment that enables us to provide comprehensive primary care and resuscitation

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.

PHS 5.2►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.

PHS 5.2►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.

PHS 5.2►D Each health centre has a defibrillator.

You must:

- have a defibrillator

You could:

- ensure that all members of the health service team know how to access an AED when required.

PHS 5.2E 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 PHS 5.3 – Portable equipment

Indicator

PHS 5.3►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 trolley), including for medical emergencies which contains:

- disposable gloves
- equipment for maintaining an airway in adults and children
- medicines for medical emergencies
- sharps container
- sphygmomanometer
- stethoscope
- syringes and needles in a range of sizes
- thermometer
- torch.

Why this is important

Members of the health service's clinical team must be prepared to visit individuals in prison outside of the health service, including living quarters and other areas of the centre. Clinical team members must be available at short notice to help in emergencies that take place within the prison.

Having portable equipment available by way of an equipment trolley gives practitioners immediate access to core equipment and medications so they can provide the necessary care in these situations. This is particularly important when a prison has more than one health service in different locations within the facility.

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 may 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 may 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 prison 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
- aspirin
- 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
- post-exposure prophylaxis
- 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).

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.

Meeting each Indicator

PHS 5.3►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 trolley), including for medical emergencies, containing the items listed under the Indicator.

You must:

- have portable equipment that your clinical team can access
- store medicines according to legal requirements
- make sure that medicines are in date.

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.

PHS 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 are exposed to direct ultraviolet light. You must therefore maintain the potency of your vaccines in order 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 PHS 6.1 – Maintaining vaccine potency

Indicators

PHS 6.1►A Our health service has at least one team member who has primary responsibility for cold chain management in the health service.

PHS 6.1►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.*

PHS 6.1►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.

PHS 6.1►D Our health service has a written, 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 in order 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 purpose-built vaccine refrigerator. Purpose-built vaccine refrigerators are specifically designed to store vaccines between +2°C and +8◦C, and are the only type of refrigerator recommended for storing vaccines.

Do not use cyclic defrost or bar refrigerators because 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 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 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. Your health service needs to ensure that you are meeting the legislative obligations in relation to cold chain management.

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 which 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 in order 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

PHS 6.1►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.

PHS 6.1►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.

PHS 6.1►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.

PHS 6.1►D Our health service has a written, 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.

Glossary

Term	Definition
Aboriginal or Torres Strait Islander Status	A way of recording and identifying a patient's response when the health service asks them, 'Are you of Aboriginal and/or Torres Strait Islander origin?' The standard response options should be provided either verbally or in written form: • No • Yes, Aboriginal • Yes, Torres Strait Islander For people of both Aboriginal and Torres Strait Islander origin, both 'Yes' boxes should be marked when in written form
Aboriginal and Torres Strait Islander health worker/practitioner	A member of the Aboriginal and Torres Strait Islander health workforce. Roles include, but are not limited to: • providing clinical functions • liaison and cultural brokerage • health promotion • environmental health • community care • administration • management and control • policy development • program planning. An Aboriginal and Torres Strait Islander health worker/practitioner is often an Aboriginal and Torres Strait Islander person's first point of contact with the health workforce, particularly in remote parts of the country
Access	The ability of patients to obtain services from the health service
Accreditation	A formal process to assess a practice's delivery of healthcare against the RACGP's *Standards for health services in Australian prisons*
Action plan	A document that lists the steps to be taken to achieve a specific goal
Active patient	A person who is incarcerated in the custodial system.

Active patient health record	The health record of an active patient
Administrative staff members	Members of the practice team who provide clerical or administrative services and who do not perform any clinical tasks with patients
Adverse event	An adverse event, or incident, is any event or circumstance arising during care that could have or did lead to unexpected actual harm, loss or damage. Incidents include near misses, sentinel events and unsafe acts
Adverse medicines event	An adverse event caused by a medicine; this includes harm that results from the medicine itself (an adverse drug reaction) and potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident)
After-hours service	A service that provides care outside the normal opening hours of a health service, whether or not that service deputises for other health services, and whether or not the care is provided physically in or outside the clinic
Allied health professional	A health professional who collaborates with doctors and nurses to provide optimal healthcare for patients (eg physiotherapist, dietician, podiatrist)
Appointment system	The system that a health service uses to assign consultations to patients and practitioners
Backup	A copy of all the files stored on a computer's or server's hard drive made onto another device such as a portable drive or an offsite server
Buddy system	A system that enables a 'buddy' to follow up results and correspondence or continue the care of patients on behalf of an absent colleague
Business continuity plan	A plan that specifies how a practice will continue providing services if it is affected by disasters of various levels of severity
Care outside of normal opening hours	Clinical care that is provided to the health service's patient when the health service is normally closed

Carer	A person who provides care and support to a family member or friend.
Chaperone	An impartial observer to a consultation between a practitioner and a patient
Clinical governance	A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of a patient's care, from one professional person or group to another
Clinical indicator	A measure, process, or outcome used to assess a particular clinical situation against the RACGP's *Standards for health services in Australian prisons*, and determine whether the care delivered was appropriate
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 a patient will be harmed if they do not receive further medical advice, treatment or other diagnostics • the likely seriousness of the harm
Clinical team	All members of the practice team who have health qualifications that qualify them to perform clinical functions A clinical team is part of the broader health service team
Clinical team member	An individual member of the clinical team who has health qualifications that qualify them to perform clinical functions
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 practice team

Cold chain management	The system of transporting and storing vaccines from the place of manufacture to the point of administration in order 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: • direct contact with an infected person • direct contact with an infected person's discharges • indirect means
Complaint	Any verbal or written expression of dissatisfaction or concern with an aspect of the general practice. A complaint may be made using, for example, a complaints process, consumer 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
Consequence	The effect that an event had, has, or would have, on one or more of the practice's objectives
Consultation note	A note in a patient's health record, made during or after a consultation, that contains relevant information about the consultation
Continuity of care	When a patient experiences a series of discrete healthcare events and/or services that are coherent, connected and consistent with their medical needs and personal circumstances
Cooperative	A group of general practices that have an arrangement to work together to provide care to patients outside of the normal opening hours of their practices
Cultural background	Details of a patient's ethnic or cultural heritage that the service has collected and recorded
Cultural safety	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
Custodial service	An entity, usually a state/territory government agency that is responsible for overseeing the administration and operations of one or more prisons under its legal and operational jurisdiction

	A custodial service is also responsible for the welfare of all prisoners held within its prison/s.
Demographic	A particular sector of a population
Disability	Term for any or all of the following components: • Impairments resulting in problems in body function or structure • Activity limitations resulting in difficulties in executing activities • Participation restrictions resulting in problems in involvement in life situations
Discrimination	Different treatment or consideration of a patient based on particular characteristics (such as gender, age, ethnicity or religion). Positive discrimination enhances the care given to the patient, and negative discrimination potentially reduces, or does reduce, the quality of that patient's care
Duty of Care	The legal obligation to safeguard others from harm while they are in your care, using your services, or otherwise exposed to your activities
Electronic communication	The transfer of information (including, but not limited to, patient health information) within or outside the service using email, internet communications, text message or facsimiles
Emergency contact	The person whom a patient has nominated to be contacted in an emergency
Encryption	The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity
Enrolled nurse	A nurse who works under the direction and supervision of a registered nurse as stipulated by the relevant nurse registering authority, but remains responsible for their own actions and accountable for the delegated nursing care they provide
Environmental cleaning	The process of removing all visible dust, soils and other material from a surface

Ergonomic assessment	The process of evaluating the extent to which a workstation or workspace is designed to minimise the risk of injury and to maximise productivity. This is also referred to as a workstation assessment
Ethical dilemma	The need to choose between two courses of action, both 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
Firewall	Security software that prevents unauthorised (and usually external) access to information stored on a private network, and controls the flow of data according to specific rules defined by the service/centre
Follow up	Activities that are the logical and responsible steps to take after taking earlier related actions, including: • making a phone call to find out the status of tests and results that are expected but have not yet been received • contacting a patient to discuss a report, test or results
Gender	A social classification based on someone's (perceived or projected) identity as being masculine or feminie. (The word 'sex' refers to the biological characteristics that categorise males and females)
General practice	The provision of patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities
General practitioner (GP)	A registered medical practitioner who: • 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
Guardian	A person who has been given the legal authority to make decisions on personal matters on behalf of another individual. These matters include decisions on financial and legal matters, as well as health and medical treatments

	This person can either be appointed by a statutory authority or by the individual
Hardware	The physical components of a computer, including monitors, hard drives and central processing units
Harm	A damaging effect on a person, such as disease, injury, suffering, disability or death. Harm may be physical, social or psychological
Health centre	A physical site where one or more health service/s is situated. The health centre is responsible for the health services situated within or as a satellite to its site
Health information	A subset of patient'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 a patient's wishes about future healthcare and health services
Health outcome	The health status of an individual, group of people or specific population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals (eg nurses and specialists)
Health promotion	The process of enabling people to improve and increase their control over their health. As well as influencing an individual's behaviour, it also encompasses a wide range of social and environmental interventions
Health service	A service that provides medical care. May be situated within a health centre, or provided by the health centre at another location
Health service management	The strategic planning, reviewing and implementation of processes that increase a health service's efficiency and contribute to 'excellence in healthcare'
Health service team	All people who work or provide care within the health service (eg GPs, receptionists, health service managers, nurses, allied health professionals)

Health service team member	An individual member of the health service team who provides care within the service (eg a GP, receptionist, practice manager, nurse, allied health professional)
Health summary	Documentation usually included in a patient's health record that provides an overview of all components of the patient's healthcare (eg 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 appropriate, timely manner
Home visit	A general practice consultation conducted in the patient's (or someone else's) home
Human research ethics committee (HREC)	A committee constituted according to National Health and Medical Research Council requirements that reviews applications from people or organisations undertaking research projects involving human subjects
Human resources	People who work in an organisation OR An area of business management that addresses the recruitment, training and management of the people who work in an organisation
Hybrid patient health record system	A combination of paper-based or electronic systems used by one or more practitioners to enter patient information
Incident	An event or situation that resulted, or could have resulted, in: • unintended and/or unnecessary harm to a person • a complaint, loss, damage or claim for compensation
Indemnity	Provides security or protection against a loss or other financial burden. Medical indemnity insurance is a compulsory condition of registration for all medical practitioners in Australia
Individual healthcare identifier	A patient's unique 16-digit number allocated by the Department of Human Services (each eligible Australian patient who seeks healthcare is allocated one)

Induction program	Training provided to new team members to introduce them to the practice and its systems, processes and structures
Infection	The invasion and reproduction of pathogenic (disease-causing) organisms inside the body that can cause tissue injury and can lead to disease
Infection control measures	Actions to prevent the spread of pathogens between people in a healthcare setting
Information management	The policies, processes and systems that govern the creation, use and storage of information
Information security	The protection of the confidentiality, integrity and availability of information
Interpreter service	A service that provides trained language interpretation or translation, either face to face or by telephone
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 the: • patient having received and understood sufficient and appropriate information, and being aware of the material risks • patient having 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 treatment
Issue	A relevant event that was not planned (eg a problem, query, concern or risk) and requires action
Lifestyle risk factors	Habits or behaviours that people choose to engage in that, if changed, can directly affect some medical risk factors by reducing the likelihood of developing disease
Medical consumable	A medical product used for a therapeutic purpose that is not pharmaceutical and is not re-usable (eg a syringe)

Medical deputising service	A service that arranges for, or facilitates, the provision of medical services to a patient by a medical practitioner (deputising doctor) during the absence of, and at the request of, the patient's GP (principal doctor)
Medicine	A drug or other preparation for the treatment or prevention of disease
Mission	The overall function of an organisation
Natural immunity	Immunity to a particular infection that is not the result of vaccination or previous infection but it is inherent in the genetic make-up of an individual, family, etc
Near miss	An incident that did not cause harm, but could have
Network	A group of connected computers and peripheral devices used to store and share information electronically
Next of kin	A person's closest living relative or relatives, as identified by that person
Normal opening hours	The advertised opening hours of a practice
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 professionals
Nurse practitioner	A registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role where their scope of practice is determined by the context in which they are authorised to practice
Open disclosure	A method clinicians are encouraged to use in order to communicate with and support patients, their family, and carers who have experienced harm while receiving, or as a result of receiving, healthcare
Opioid agonist therapy	A treatment where prescribed opioid agonists are given to patients who live with opioid addiction

Organisational chart	A description (often presented visually) of an organisation's structure, which includes areas (eg departments, division, properties), hierarchies, roles, responsibilities and professional relationships between individuals
Other visit	A general practice consultation in a facility other than the general practice or the patient's home (eg residential aged care facility)
Outside of normal opening hours	The hours other than the practice's normal opening hours
Over-the-counter medicine	Medicines that people can purchase from retailers (such as pharmacies, supermarkets and health food stores) for self-treatment
Patient	A person who is seeking or receiving healthcare and in relevant circumstances, can also refer to a carer (eg if you need to explain treatment to a patient who has intellectual disability, you may also need to explain the treatment to the patient's carer or guardian)
Patient health information	A patient's name, address, Medicare number and any information (including opinions) about the patient's health
Patient health record	Information, held about a patient, in paper form or electronic form, which may 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 • work health and safety reports
Performance monitoring	A formal and structured process used to monitor and document a team member's performance in their role
Personal protective equipment (PPE)	Equipment used to prevent and control infection, including appropriate gloves, waterproof gowns, googles, face shields, masks and footwear

Position description	A document describing a team member's role, responsibilities and conditions of employment
Prison	A facility in which sentenced prisoners are held for the period of their custodial sentence. This includes unsentenced (remand) prisoners. The prison is responsible for the management of and the delivery of day-to-day operations within the facility
Practitioner/clinician	A member of the practice team who has health qualifications that qualify them to perform clinical functions
Qualified	Holding the educational or other qualifications required to perform a specific activity (eg administer first aid) or hold a special role (eg GP, registered nurse)
Quality assurance	The maintenance of a desired level of quality in a service or product, especially by attending to every stage of the process of delivery or production
Quality improvement	One or more activities undertaken by a service to monitor, evaluate, or improve the quality of healthcare it delivers
Quality improvement and Continuing Professional Development (QI&CPD)	Educational activities endorsed by the RACGP that lead to improved quality of clinical care
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
Relevant family history	Information about a patient's family history that the practitioner considers important in order to provide appropriate clinical care to the patient
Respiratory etiquette	Public health measures used to reduce the spread of respiratory infections (ie encouraging people to cover their mouth or nose when coughing or sneezing, use tissues to blow their nose,

	dispose of used tissues, and wash their hands after touching their nose)
Risk	An event or set of events that, if they occurred, would adversely affect the achievement of objectives
Risk management	Systematic application of principles, approaches and processes to: • identify, assess and minimise risks • plan appropriate responses • implement appropriate responses when required
Risk matrix	A matrix used to categorise risks according to their probability and the severity of the effects they would cause
Risk register	A document used to record problems and issues that could result in a risk becoming a reality, and the steps taken to minimise the likelihood or effect of the risk
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 patient population) and an understanding of what their peers (or services in the same area) would agree was safe and reasonable
Safety	The condition that means potential risks and unintended results are avoided or minimised
Schedule 8 medicines	Drugs that have a recognised therapeutic need and are legally available only by prescription because they are drugs of dependence and therefore have a higher risk of misuse and abuse
Screensaver	A software program that displays constantly changing images or dims the brightness of a display screen. It is used to: • protect the screen from having an image etched onto its surface • restrict unauthorised access to the computer, and the information displayed on the screen before the screen saver begins
Security	The administrative, technical and physical safeguards in an information system that protect it and its information against unauthorised disclosure, and limit access to authorised users in accordance with an established policy

Server	A computer that provides services to users connected to the network running the server. Services can include printing, access to files and software applications, and central storage of data
Sociable hours	The after-hours period from 6.00-11.00 pm on weeknights
Social media	Online social networks used to disseminate information through online interaction
Standard precautions	Methods and practices that health professionals use to prevent infection of themselves and others, based on the assumption that all blood and body fluids are potentially infectious
Sterile	A condition characterised by the absence of protozoa, spores, mycobacteria, fungi, Gram-positive and Gram-negative bacteria, chlamydia, Rickettsia, mycoplasma and viruses
Sterile barrier system	The packaging for items placed in a steriliser
Sterilisation	A validated process used to render a product free from all forms of viable micro-organisms (the nature of microbial death is described by an exponential function, and although the probability that all microbes have died can be reduced to a very low number, it can never be reduced to zero)
Strategy	A method or plan for an organisation to achieve its short-term, medium-term, and long-term goals
Technology-based consultations	Consultations that use any form of technology to communicate (such as video-conferencing and telephone), instead of face-to-face interactions
Telephone triage	A method of determining, over the phone, the nature and urgency of problems and providing directions in order to achieve the required level of care
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers
Tracking and tracing	Part of a sterilisation process that refer to batch control identification of instruments used for a procedure on a patient

Transmission-based precautions	Methods and practices that health professionals use to prevent infection of themselves and others, when a patient is known or suspected to be infected with a highly transmissible infection such as influenza and when standard precautions may not be sufficient to prevent infection. Transmission-based precautions include droplet precautions, airborne precautions and contact precautions, and involve the use of appropriate measures such as triage, PPE and isolation
Triage	Patient prioritisation based on where resources can be best used or are most needed
Unsociable hours	The following after-hours periods: • Weekdays – 11.00 pm – 8.00 am • Saturdays – before 8.00 am and after 12.00 pm • Sundays and public holidays – any time
Urgent	Requiring immediate action or attention
Values	Principles that stipulate how the organisation and the health service team are expected to behave
Vision	A declaration of an organisation's objectives

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