RACGP *Standards for after-hours services*

The modular format of the RACGP *Standards for general practices* (5th edition) has enabled the development of general practice standards for a range of settings. As such, the RACGP *Standards for after-hours services* (the Standards for after-hours services) will be fit for purpose.

To be accredited against the Standards for after-hours services, a service must first meet the following definition of an after-hours service for the purposes of accreditation:

- the after-hours service accepts appointments and provides patient care only within the after-hours period as defined by Medicare
- after-hours services are non-routine and predominantly of a general practice nature
- except where specifically exempted, the service can meet all the mandatory Indicators in the Core, Quality Improvement and After-Hours Services modules.

The after-hours service needs to meet the requirements of the following modules:

- Core
- Quality Improvement
- After-Hours Services.

Given that the Core and Quality Improvement modules apply to a variety of general practice settings (including after-hours), they have been included for context. Please note that the RACGP is seeking your feedback on:

- the applicability of the Core and Quality Improvement modules; and
- the After-Hours Services module.

Stakeholders are invited to review the modules and provide feedback as appropriate. We have also included some specific questions throughout the After-Hours Services module for your consideration. Alternatively, when reviewing the After-Hours Services module, you could use the following questions to guide your response:

- **Is the content in the explanatory material for each Criterion relevant?**
- **Are there any Indicators that you believe your service would have difficulty meeting? If so, why?**
- **Are there any Indicators that do not make sense or are unclear? If so, why?**
- **Are there any Indicators that are not applicable to your service? If so, why?**
- **Is there anything you would like added to the After-Hours module?**

The RACGP Patient Feedback Guide (the Guide) and the Resource Guide are also available for review at http://www.racgp.org.au/your-practice/standards/standardsdevelopment/consultation-phase-documents/. After-hours services will need to meet patient feedback requirements under Criterion QI1.2 – Patient feedback. Please review the Guide in line with the requirements of QI1.2 and respond to the following:

- **What additional topics could be included in the Guide to make collecting patient feedback more meaningful for your service?**
- **Are there any specific questions relevant to after-hours services that should be included in the Guide? If so, please provide them with your feedback.**

Please submit your feedback to standards@racgp.org.au by **29 September 2017**. All stakeholder feedback will be published, unless you state otherwise.

Contents

Introduction **3**

Development process 3

Revised structure 3

Evidence-based standards 6

Accreditation 6

The Resource Guide 9

The After-Hours Services module applicability 9

Module 1: Core Module **11**

Standard 1: Communication and patient participation 12

Standard 2: Rights and needs of patients 26

Standard 3: Practice governance and management 37

Standard 4: Health promotion and preventive activities 58

Standard 5: Clinical management of health issues 62

Standard 6: Information management 69

Standard 7: Content of patient health records 83

Standard 8: Education and training of the practice team 90

Module 2: Quality Improvement module **93**

Standard 1: Quality improvement 94

Standard 2: Clinical indicators 105

Standard 3: Clinical risk management 112

Module 3: After-Hours Services module **117**

Standard 1: Providing patient care in the after-hours period 118

Standard 2: Qualifications of our clinical team 140

Standard 3: The after-hours service facilities 146

Standard 4: Reducing the risk of infection 160

References **169**

Glossary **172**

Introduction

The RACGP *Standards for after-hours services* follow the same modular structure as the RACGP *Standards for general practices* (5th edition). These standards have been developed to improve the quality and safety of health services. They also provide services with a way of identifying and addressing any gaps they have in their systems and processes.

See page 9 for a full list of after-hours service types that these Standards are applicable to.

Development process

The draft RACGP *Standards for after-hours services* (hereafter 'the Standards for after-hours services') were developed by the RACGP in consultation with general practitioners, practice managers, nurses, consumers, technical experts, and many other stakeholders.

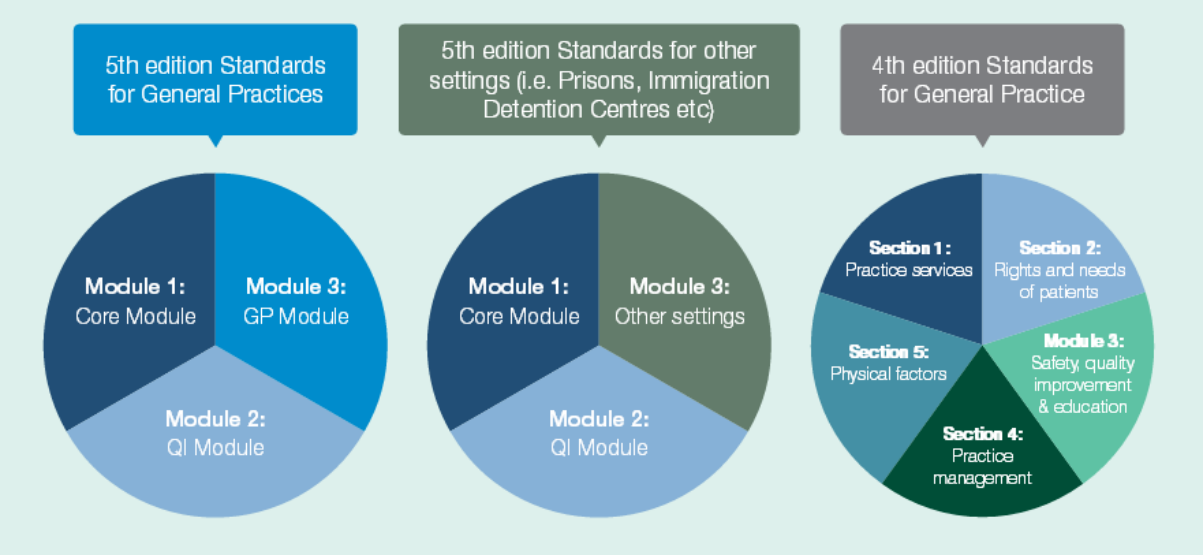
Revised structure

The 4th edition Standards included additional information for 'services providing care outside normal opening hours', to assist services providing care outside normal opening hours meet the requirements of the 4th edition Standards.

Following the modular structure of the 5th edition Standards, after-hours services seeking accreditation against the Standards for after-hours services must meet the requirements of the following modules:

- Core
- Quality Improvement
- After-Hours Services.

Figure 1: RACGP Standards modular structure



Terminology

Reference made to ‘practice(s)’ in the Core and Quality Improvement modules should be interpreted’ as ‘service(s)’ for after-hours services.

Definition of an after-hours service for the purposes of accreditation

An after-hours service must meet the following criteria to be accredited against the RACGP *Standards for after-hours services*:

- the after-hours service accepts appointments and provides patient care only within the after-hours period as defined by Medicare
- after-hours services are non-routine and predominantly of a general practice nature
- except where specifically exempted, the service can meet all the mandatory Indicators in the Core, Quality Improvement and After-Hours Services modules.

1. Numbering of Criterion and Indicators

Structure of the 4th edition Standards

Section 1: Practice Services

Standard 1.1: Access to care

Criterion 1.1.1 – Scheduling care in opening hours

Indicators - ► A. Our practice can demonstrate that we have a flexible system for determining the order in which patients are seen, to accommodate patients' needs for urgent care, non-urgent care, complex care, planned chronic disease management, preventive healthcare and longer consultations.

Structure of the Standards for after-hours services

Module: After-Hours Services module

Standard 1: Providing patient care in the after-hours period

Criterion: AHS1.1 – Arrangements with practices

Indicator: ► A. Our service has formal arrangement(s) in place to provide after-hours services to patients on behalf of the nominated practice(s).

Each Module starts with **Standard 1**, therefore there is Criterion **C1.1** AND **QI1.1** AND **AHS1.1**

2. Indicators that focus on outcomes and patients

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

For example:

Process-focused Indicator	Outcome-focused Indicator
Our service has a documented system to identify, follow up and recall patients with clinically significant results.	Our service recalls patients with clinically significant results.

By focusing on outcomes, your 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. This will give your service greater flexibility and greater team ownership of your processes and systems.

3. Fewer Indicators

There are fewer Indicators than there were in the 4th edition. This was achieved by:

- removing duplication
- merging Indicators that shared a similar theme
- focusing on outcomes rather than processes.

4. Restructured explanatory notes

The explanatory notes for each Criterion now include three sections:

- *Why this is important*
  which explains why the Indicators are important from a quality and safety perspective
- *Meeting this Criterion*
  which sets out ways that your practice can choose to demonstrate that it meets the Indicator and/or Criterion.
- *Meeting each Indicator*

  which contains a list of some of the mandatory and optional ways your service can choose to demonstrate how they meet the Indicator.

This change was made as a direct result of feedback from stakeholders collected during the development of the 5th edition Standards.

5. Plain English

In response to feedback from stakeholders, this edition is written in plain English, eliminating ambiguity and minimising the use of technical language.

6. Could and must

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

- could is used to indicate that something is optional
- must is used to indicate that something is mandatory.

7. Federal, state or territory legislation

Most federal, state or territory legislation has not been included in this document. General practices are already responsible for ensuring that they comply with relevant legislation. Federal, state or territory, and local legislation overrides any non-legislative standards.

However, legislation has been cited where it is particularly important to a defined aspect of general practice (for example, Criterion 7.3 Confidentiality and privacy of health information).

If your service is accredited against the Standards, you would have met some of your legislation requirements, but it does not mean that you have automatically met all of them. This is because the Standards do not specify all of the relevant state and territory legislative requirements.

Evidence-based standards

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

This evidence is based on two sources:

- relevant studies
- where studies are not available, Level IV evidence – otherwise known as evidence from a panel of experts. To ensure that this Level IV evidence is as robust as possible, the Standards have been tested by Australian general practices and consumers, and the testing was overseen by an expert committee consisting of GPs, academic GPs and nurses, practice management, and a consumer representative.

Accreditation

Services that wish to be accredited against the Standards must be formally assessed by an accrediting agency approved under the National General Practice Accreditation Scheme (the Scheme). The Scheme commenced on 1 January 2017. Services wishing to be accredited will need to ensure they select an approved accrediting agency. A list of approved accrediting agencies can be found **here.**

Requirements for accreditation bodies

The RACGP has developed requirements that accrediting bodies must meet in order to be granted

permission to use the Standards to assess general practices.

The RACGP considers that an independent review of the practice that includes two or more surveyors (one GP and one or more non-GP surveyors) will foster genuine collaboration and sharing of expertise amongst peers. In addition, we support accreditation as a voluntary scheme. The length of accreditation cycle is three years.

In order to use the Standards, accrediting bodies are required to demonstrate the following to the RACGP:

- an in-depth understanding of:
  - the Standards
  - the nature of general practice in Australia
  - requirements for training and vocational registration of GPs
- an accreditation assessment framework that includes a single on-site component that is conducted once every three years for each service location
- the capacity to efficiently accredit general practices across Australia
- a governance and advisory structure that includes GPs with considerable experience in general practice
- a commitment not to refuse an application for accreditation from a practice that meets the RACGP definition of an after-hours service, regardless of location or size, and not to financially or otherwise discriminate against a practice because of size or location.

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, practice manager, allied health professional or Aboriginal health worker/practitioner with relevant experience in general practice.
- Surveyor teams may include a third person, who may be an appropriately trained non-health practitioner or consumer, if appropriate.

All surveyors

- Surveyors must demonstrate a good understanding of confidentiality issues relating to general practice, personal health information, and patient privacy.
- Surveyors must meet requirements relating to their previous and recent experience before being allowed to conduct survey visits.
- Surveyors must complete ongoing surveyor training as required by the Scheme to maintain their competence and knowledge of the Standards.

GP surveyors

- GP surveyors must be vocationally registered under the *Health Insurance (Vocational Registration of General Practitioners) Regulations 1989* (Cth).
- GP surveyors appointed after 31 October 2017 must hold Fellowship of the RACGP or Australian College of Rural and Remote Medicine (ACRRM).
- GP surveyors must have at least five years fulltime or equivalent part-time experience as a vocationally registered GP.
- GP surveyors must be working at least two sessions a week for the last two years in face-to-face patient contact in an accredited general practice.
- GP surveyors must satisfy their College's requirements for their continuing professional development program.

Non-GP surveyors

- Non-GP surveyors can be an appropriately qualified nurse, practice manager, allied health professional, or Aboriginal health worker or health practitioner.
- Non-GP surveyors must have at least five years full time equivalent experience.
- Non-GP surveyors must be working at least 16 hours a week for the last two years in an accredited general practice.

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

Mandatory ► and aspirational Indicators

Indicators marked with this symbol ► are mandatory, which means that your practice must demonstrate that you meet this Indicator in order to achieve accreditation against the Standards.

Indicators that are not marked with the mandatory symbol are aspirational Indicators. We encourage all practices to meet the aspirational Indicators, but it is not essential to achieve accreditation.

The assessment process

There are independent accreditation agencies that have trained surveyors who will assess general practices. Each practice selects an accreditation agency to assess their practice.

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

Demonstrating compliance

Previous editions of the Standards dictated how practices must demonstrate compliance with the Standards (e.g. interview, document review, observation). The 4th edition Standards focused on process measures.

However, because these Standards are outcomes-focused, your practice can choose how you demonstrate that you meet the intent of each Indicator. You will have met the Indicator if your practice team can demonstrate compliance to the surveyor's satisfaction, with evidence when required. This approach gives you greater scope to set up systems and processes that reflect your working arrangements and will be easier to maintain after your assessment.

In the explanatory notes of each Criterion, there is a section titled 'Meeting each Indicator' that includes some examples. These examples will guide you to meet each Indicator. It is not an exhaustive list, and we encourage you to develop methods that best suit the needs of your practice.

The Resource Guide

RACGP has developed a Resource Guide to accompany the Standards. The Resource Guide contains useful supplementary information to the Standards to help practices meet the Indicators. The Resource Guide is available via this link http://www.racgp.org.au/your-practice/standards/standardsdevelopment/consultation-phase-documents/.

The After-Hours Services module applicability

Type of service	Type of operations	Modules applicable for accreditation
An after-hours service provides after-hours care within a physical facility and provides home or other visits.	This service will have a physical facility that only operates in the after-hours period and may provide home and other visits.	If the service meets the RACGP definition for after-hours services, then this service would be eligible to be accredited under Core, QI, After-Hours Services modules.
An after-hours service only provides home or other visits.	This service has a physical operations facility to undertake administrative functions, triage patients by phone and store medical supplies. The service only provides home and other visits.	If the service meets the RACGP definition for after-hours services, then they are eligible for accreditation under Core, QI, After-Hours Services modules. However, some Indicators will not be

		applicable. These are clearly labelled in the Criterion.
Other models such as: • co-located services • services managed by regional primary care healthcare organisations or state services.	Co-located services are clinics that provide after-hours primary healthcare and are located within a public hospital, near or adjacent to its emergency department (ED).	If the service meets the RACGP definition for after-hours services, they are eligible for accreditation under Core, QI, After-Hours Services modules.

Module 1: Core Module

Standard 1: Communication with patients 37
Standard 2: Rights and responsibilities of patients 12
Standard 3: Practice governance and management 26
Standard 4: Health promotion 58
Standard 5: Clinical management of health issues 62
Standard 6: Continuity of care 68
Standard 7: Information management 69
Standard 8: Patient health records 83
Standard 9: Education and training of the practice team 90
References 93

Standard 1: Communication and patient participation

Our practice provides patient-centred, timely and accurate communications.

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 patient and the practice team
    - the patient and other clinicians in the practice.

Communication must be patient-centred. This means that the practice team consider the patient's values, needs and preferences, and give the patient time to provide input and participate actively in decisions regarding their healthcare[1]. Patients are to be provided with the appropriate information they need to manage their condition.

The communication needs of carers and other relevant parties also needs to be considered by the practice.

Criterion C1.1 – Practice information

Indicators

► A. Our patients can access up to date information about the practice. At a minimum, this information contains:

- our practice address and telephone numbers
- our consulting hours and details of arrangements for care outside normal opening hours
- our practice's billing principles
- our list of practitioners
- our practice's communication policy, including receiving and returning telephone calls and electronic communication
- our practice's policy for managing patient health information (or its principles and how full details can be obtained from the practice)
- the process we use to follow-up on results
- how to provide feedback or make a complaint to the practice
- information on the range of services we provide.

Why this is important

Information about the practice, including the range and cost of services provided by the practice, is important to all patients.

Meeting this Criterion

Format of the information

Practices can provide this information in many formats, such as an information sheet and the practice's website. Pictures and simple language versions help patients who would otherwise be unable to read or understand the information. The practice needs to update this information regularly, so that it remains accurate. Ideally the information is updated as soon as any of it changes.

If your practice serves specific ethnic communities, provide access to written information in the languages most commonly used by your patients. You could also display the languages spoken by the practice team on an information sheet or on your website.

Advertisements in your practice information

If your documents and other material providing information about your practice contain local advertisements, include a disclaimer that states that the inclusion of advertisements is not an endorsement by the practice of these services or products.

Meeting each Indicator

C1.1► A

You must:

- **Make practice information available to patients.**
- **Update practice 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.
- Create and maintain an up-to-date website that contains all the required information about the practice in clear, simple language.
- Provide alternative ways to provide the information to patients who are unable to read or understand the information sheet. For example, versions in languages other than English, and pictures.
- Provide brochures and/or signs in the waiting room, written in English and languages other than English, explaining:
    - the practice's policy regarding its collection, storage, use, and disclosure of personal and health information
    - the costs and fees of the practice
    - available services
    - after-hours services.
- Display a list of names of the practice team members on duty.
- Make contact details of interpreters available.
- Train practice team members so that they can use the interpreter service.

Criterion C1.2 – Telephone and electronic communications

Indicator

► A. Our practice manages telephone calls, telephone messages, and/or electronic messages from patients.

Why this is important

Effective communication with patients via telephone and electronic communication (e.g. emails and texts) ensures that:

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

Meeting this Criterion

Communicating by telephone

Before putting a caller on hold, reception staff must first ask if the matter is an emergency.

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

- family name and given names
- date of birth
- gender (as identified by the patient)
- address
- patient health record number where it exists
- Individual Healthcare Identifier.

A Medicare number is not an approved identifier. Medicare numbers are not unique and some people have more than one Medicare number because they are members of more than one family and are on multiple cards. Also, some Australian residents and visitors may not have a Medicare number[2].

Communicating by electronic means

If you choose to communicate with patients using electronic means, such as email, secure messaging or SMS, you must:

- adhere to the Australian Privacy Principles, the *Privacy Act 1988* and any state-specific legislation

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

If you allow patients to contact the practice by email, make the patient aware of how long they can expect to wait for a response. Patients should also be made aware that they should not use email to contact the practice in an emergency.

Informing the clinical team of communications

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

Develop procedures about the following:

- How messages are communicated. Internal electronic messaging systems are useful for this.
- How messages are recorded (e.g. 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 special needs

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

Online appointments

If your patients can make appointments on-line:

- select the technology and system that best suits your practice's requirements

- decide which appointments are appropriate for on-line bookings. For example, many practices offer this option only for routine, non-urgent appointments.

Meeting each Indicator

C1.2► A

You must:

- **use three approved forms of identification for identifying patients over the phone so that information is given to the right person.**
- **On each patient's health record, note entries of:**
  - **when team members have attempted to contact (e.g. left phone message) and contacted the patient,**
  - **when a patient contacts the practice, the reason for the contact, and the advice and information the patient was given.**

You could:

- Have a recorded phone message (which may be an introductory message or 'on hold' message) that tells patients to call 000 if they have an emergency.
- Have a policy, procedure, or flow chart that shows how to manage messages from patients.
- Document what information and advice the practice team can and cannot give to patients over the phone or electronically.
- Educate reception staff about which messages need to be transferred to clinical team.
- Have an appointment system that includes time for the clinical team to return messages to patients.
- If your email system allows it, have an automatic email response when all emails are received that includes the practice's telephone number and when the email will be replied to.
- Establish a process so that patients are advised of the practice's policy for checking, responding to, and sending emails.

Criterion C1.3 – Informed patient decisions

Indicators

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

► B. Our patients receive information to support the diagnosis, treatment, and management of conditions.

Why this is important

Patients have the right to make informed decisions about their health, medical treatments, referrals and procedure. Practices 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 verbally provide information 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 (e.g. about sexually transmitted infections, blood-borne viruses, and pregnancy results)
- the patient's cultural and linguistic background (e.g. you may need to use an interpreter to check that the patient understands everything that you have told them)
- the patient's family members 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
- if you need to give the information to a carer, make sure that the carer understands the information
- limiting the amount of information patients are given to avoid overwhelming them.

Further information provided to patients can be paper-based or on-line (e.g. leaflets, brochures, and links to reputable websites).

Information about interventions

Providing 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 is reliant upon a carer, also check their understanding of the intervention
- offer to discuss any issues about a patient's condition, proposed treatment and medicines that could be confusing
- direct patients to reliable health and medicine websites where they can find further information
- recommend that patients seek further advice about their medicines from their pharmacist.

Health literacy

Individual health literacy is defined 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'[3].

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 then providing them with information based on that assessment helps to make patients fully aware of and understand their diagnosis, condition, treatment options and the possible risks or side effects of medications or treatments.

Practitioners can build a patient's health literacy by:

- recognising the patient's needs and preferences and tailoring communication accordingly
- assuming that most people will have difficulty understanding and applying complex health information and concepts
- providing health information in an unrushed manner using words that the patient understands
- using multiple communication strategies to confirm that information has been delivered and received effectively
- providing access to targeted information such as leaflets, websites and online support groups
- encouraging the patient, carer and other relevant parties to speak up if they have difficulty understanding the information provided
- using proven methods of communicating information about the risks of treatment options.

Meeting each Indicator

C1.3► A

You must:

- **Obtain patient consent for a third party (e.g. interpreter) to be present at consultations when the patient needs help to understand.**
- **Have a process for patients to receive information in an understandable way.**

You could:

- Use diagrams or flip charts in consultations to help explain health matters to patients.
- Use tools that help the practitioner and the patient to share the decision- making, in order to establish a supportive and effective partnership with the patient.
- Provide patients with the information they need to understand and manage their health, such as paper copies of information sheets and direction to reputable websites.

C1.3► B

You must:

- **In the patient's health record, document the treatment options and associated risks and side effects that you have explained and discussed with the patient.**
- **Document a patient's refusal of any clinician's advice in the patient's health record.**

You could:

- Provide patients with information sheets and instructions on health conditions, treatments, and medicines.
- Make available a range of health information sheets that are one or two pages long.
- Have information relating to culturally specific health information (e.g. Aboriginal health) in the waiting room and consultation rooms.
- Display posters containing information about specific diseases, such as diabetes and chicken pox.

Criterion C1.4 – Interpreter and other communication services

Indicators

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

► B. Our practice endeavours to use appropriate communication services to communicate with patients who have a communication impairment.

C. 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[4].

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 practice team

Unless specifically requested by the patient, avoid using a family member or friend of the patient as an interpreter because:

- Information about the patient's diagnosis may not be translated effectively, which might result in harm to the patient. For example, a Medical Board complaint alleged that a patient's death was caused because the practitioner used the patient's daughter to translate instead of using an interpreter[5].
- It may impose unreasonable responsibility and stress on these individuals, particularly children and youth.
- It might upset the friendship dynamics and family relationships.[6]

Appropriately qualified medical interpreters are the preferred choice. Interpreters can be accessed free of charge by private medical practitioners (defined as General Practitioners and Medical Specialists) providing Medicare-rebatable services. They can also be accessed by reception staff to arrange appointments and provide results of medical tests. This free Interpreting Service is available through the Translating and Interpreting Service (TIS National). For more information see www.tisnational.gov.au.

Consider writing a policy that explains how the practice 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 (e.g. placing a specific flag in the patient health record.)

- how to use the practice's telephones when using interpreting services (e.g. setting up a three-way conversation or using speaker phones)
- that the national interpreter symbol is to be displayed 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 on a patient's health record and referral letters
- the training that the practice team receives on engaging interpreters.

Although Aboriginal and Torres Strait Islander people may appear comfortable with English, they may still benefit from being offered an appropriate interpreting service.

Communication with patients who have a communication impairment

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

Practitioners should consider the following when communicating with a patient with a communication impairment[7]:

- Ask the person about the best way to communicate if you are unsure.
- Speak directly to a person with a disability, even if a person without a disability accompanies him or her.
- Put the person first, not their disability. For example, use the term "a person with a disability" rather than "a disabled person".
- If you know the person's name, address them by their name.
- Offer assistance if it appears necessary, but do not assume a person with a disability needs or will accept it. Wait for acceptance and instruction before proceeding.
- Respect peoples wishes.
- Extend your hand to shake when meeting someone.

Practices need to be aware of how to access the National Relay Service (NRS) for patients who are deaf or have a hearing or speech impairment (see www.relayservice.com.au).

Further information on how your practice can communicate with patients who have communication impairments is available at www.caus.com.au/www/home/ and https://www.novita.org.au/.

Translated or Plain English resources

Consider having a directory of resources, services, on-line tools and websites that will help you provide information translated into languages other than English. If most of your patients speak English, you do not need these resources in paper copy, as you might not use them often.

For example, 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 can be found at http://www.healthtranslations.vic.gov.au

Meeting each Indicator

C1.4► A

You must:

- **Provide evidence that interpreters are used with patients who do not speak the primary language of our practice team**
- **Enter details of any translation services used in the patient's health record.**

You could:

- Have a practice policy related to the use of interpreter and communication services.
- Demonstrate registration with TIS for all practitioners in the practice.
- Demonstrate use of interpreters through TIS data and patient health records.
  Give practice team members a list of contact details for interpreter and other communication services.
- Educate practice team members so that they know how to contact and use the translating and interpreter services.

C1.4► B

You must:

- **Provide evidence that appropriate communication services are used to communicate with patients who have a communication impairment**
- **Enter details of any communication services used in the patient's health record,**

You could:

- Educate practice team members so they know how to contact and use services such as Auslan for patients who are hearing impaired.

C1.4C

You could:

- Maintain a list of websites and services where 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 practice

Indicator

► A. Our patients are informed about out-of-pocket costs for healthcare they receive at our practice.

► 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.

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

Meeting this Criterion

Costs at your practice

Inform patients of the possible cost of additional treatments or procedures before beginning the treatment or procedure. To make sure that patients understand, consider a patient's communication needs, such as the need for an interpreter or for translated or plain English materials.

Consider:

- placing information about the practice's billing policy on your website
- displaying billing information in waiting areas
- explaining your billing policy in person to new patients.

Costs for referred services

It is not necessary for you to know or provide the exact costs of referred and investigative services. To the best of your knowledge, and before you make a referral or request for investigation, inform patients that these services could attract an out-of-pocket cost. This means explaining that a service will either be covered by Medicare or that the patient can expect to pay a gap payment/private fee.

If a patient asks for exact information about the costs of such services, encourage them to contact the service provider.

Meeting each Indicator

C1.5► A

You must:

- **Inform patients about out-of-pocket costs for healthcare they receive at our practice.**

You could:

- Place information about the practice's billing policy on your website.

- Display billing information in waiting areas.
- Explain the billing policy in person to patients.

C1.5► B

You must:

- **Let the patient know when 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.
- Maintain a register of referral networks.
- Develop a contact list of local service providers.

Standard 2: Rights and needs of patients

Our practice respects the rights and needs of patients.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) Charter of Healthcare Rights aims to create a common understanding of the rights of people receiving healthcare. It is available at www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

The RACGP Patient Charter (available at www.racgp.org.au/gppatientcharter) is aligned with the ACSQHC Charter of Healthcare Rights, and describes the responsibilities of patients.

Some states and territories have patient charters developed specifically for Aboriginal and Torres Strait Islander peoples, which are unique to that state or territory.

Criterion C2.1 – Respectful and culturally appropriate care

Indicators

► A. Our practice, in providing patient healthcare, considers patients' rights, beliefs, religious and cultural backgrounds.

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

► C. Our practice acknowledges a patient's right to seek other clinical opinions.

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

► E. Our clinical team considers ethical dilemmas.

Why this is important

The ideal patient-clinician 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.

Respectful and culturally appropriate care

Cultural awareness and sensitivity begins with learning about other cultures and cultural beliefs. Cultural awareness is defined 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'[8].

Cultural safety is the consequence of behaviour changes that come about after there is cultural awareness[9]. It is defined as 'an outcome of health practice and education that enables safe service to be defined by those who receive the service'.[10] Strategies 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'[11].

Patients have the right to respectful 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. Patients have a corresponding responsibility to be respectful and considerate towards their practitioners and other practice team members.

Practices need to understand their patient population, so they can provide the most appropriate care. When clinical 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 practice to provide culturally sensitive care.

All members of the practice team need to have appropriate interpersonal skills so they can successfully interact with patients and colleagues.

The practice team must observe their responsibilities under Commonwealth anti-discrimination legislation when dealing with patients. The states and territories also have similar legislation that will be relevant to the jurisdiction in which the practice operates.

Refusal of treatment and second opinions

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

Ethical dilemmas

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

Meeting this Criterion

Respectful and culturally appropriate care

Practices 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 including, but not limited to, those associated with forced migration.

Practitioners have professional obligation to take reasonable care when taking a history from a patient and developing management plans. 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 services. Practitioners must ensure there is clear and effective communication in the clinician-patient relationship so that practitioners can effectively manage the patient's healthcare.

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

Patients will also feel respected if the reception staff are positive, friendly, attentive, empathetic and helpful.

Managing health inequalities

Your practice needs to be aware of any health inequalities that exist in your local area. You could investigate your practice data or use publically available data to understand your practice population.

When you understand any health inequalities that exist in your local area, you could choose to prioritise these individuals and/or communities according to their need for primary healthcare.

One way of addressing the health inequalities of some individuals, families and communities is by providing targeted, culturally appropriate care to these patients. In these cases, the RACGP believes the general practice is still providing initial, continuing, comprehensive and coordinated medical care to individuals, families and communities, despite targeting a specific patient group.

Refusal of treatment or advice

Patients may refuse a practitioner's recommended course of action, including advice, procedure, treatment or referral to other care providers. In this case, the practice may manage any associated risks by recording in the patient's health record:

- the refusal
- the action taken
- any other relevant information, such as an indication that the patient intends to seek another clinical opinion.

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.

Second opinions

If the practitioner is aware that the patient is seeking another clinical opinion they should offer to provide a referral to the provider who is to give that opinion. Document the following information 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.

Dealing with distressed patients

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

Ethical dilemmas

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

- patient-practitioner relationships and boundaries

- professional differences
- patients giving gifts
- emotionally charged clinical situations including a patient's unwanted pregnancy, terminal illness and issues of euthanasia
- reporting a patient to the Driver Licensing Authority regarding a patient's unfitness to drive
- the decision to treat a friend, colleague or family member
- a patient's request for a medical certificate.

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

Practices may also provide ongoing training to help practitioners deal with ethical dilemmas, and encourage the practice team to participate in reflective discussions about situations that present ethical dilemmas.

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

Meeting each Indicator

C2.1► A

You must:

- **Provide evidence that you consider patients' rights, beliefs, religious and cultural backgrounds when providing healthcare.**

You could:

- Maintain a cultural safety policy for the practice team and patients so that your practice team knows they are required to provide care that is respectful of a person's culture and beliefs, and that is free from discrimination.
- Ensure that the practice team know how to help patients feel culturally safe in the service.
- Maintain a patients' rights and responsibilities policy.
- Maintain a policy about ceasing a patient's care.
- Maintain policies and processes relating to patient health records.
- Maintain an anti-discrimination policy.
- In recruitment interviews, discuss cultural awareness and cultural safety.
- Provide access to cultural awareness and cultural safety training for the practice team and keep records of the training in the practice'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, if culturally appropriate for your patient population.
- The clinical team have discussed and identified 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 signage 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 clinic rooms.
- Provide resources appropriate to the health literacy and cultural needs of your patients.

C2.1► B

You must:

- **Keep appropriate documentation in the patient's health record.**
- **Record complaints from patients.**
- **Develop a process outlining the role of the clinical team when a patient refuses treatment, advice, or a procedure.**

You could:

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

C2.1► C

You must:

- **Provide referrals to other healthcare providers.**
- **Keep appropriate documentation in the patient's health record**

You could:

- Include this information in new patient registration forms.

C2.1► D

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.

C2.1► E

You must:

- **Document any ethical dilemmas that have been considered and the outcome or solution.**

You could:

- Develop a policy or procedure that explains how the clinical team must manage ethical dilemmas.
- Discuss ethical dilemmas at clinical team meetings.
- Provide a buddy or mentoring system where ethical dilemmas can be discussed.
- Use a clinical intranet or group email to pose common ethical dilemmas for the clinical team to consider and discuss solutions to solve the ethical dilemmas.
- Display a notice regarding any ethical dilemmas that practitioners may have in the waiting room.
- Show that the clinical team are prepared to refer patients elsewhere for treatment.

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

Indicator

► A. Our practice obtains and documents the prior consent of a patient when the practice 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 practice is complying with privacy legislation and the patient's confidentiality rights.

Documenting the presence of a third party in the patient 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 practice

Before the consultation commences, the practice must ask the patient if they consent to have a third party present during the consultation. Third parties can be interpreters, medical, allied health or nursing students on placement, registrars, and chaperones.

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 the 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 practice must seek the patient's permission when the patient makes an appointment, or, failing that, when they arrive at reception.

It is not acceptable to ask permission in the consulting room, as some patients may feel uncomfortable to refuse 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 identify at a later date 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 (e.g. nurse, medical student) or initials. Your medical defence organisation can provide advice on how best to develop a system for recording the presence third parties in your practice.

Chaperones

In a general practice 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. Clear documentation must occur when a chaperone is used. 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. It is recommended to document if the offer of a chaperone is declined by the patient.

Patients not able to provide consent

If a patient is unable to provide consent (e.g. they have an intellectual disability), the practice must seek consent from a legal guardian or advocate who has been appointed to oversee the interests of the patient.

Third parties who accompany the patient

When a patient is accompanied to the practice by a third person (such as a family member or carer), 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, e.g. when a patient is in a violent relationship. The practitioner should consider whether it is appropriate for the third party to remain present for the consultation.

Meeting each Indicator

C2.2► A

You must:

- **Document the patient's consent to the presence of a third party arranged by the practice in the health record.**

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 practice team.
- Place signs in the waiting room when medical or nursing students are at the practice and observing consultations.
- Document the identity of the chaperone.

Criterion C2.3 – Accessibility of services

Indicator

► A. Our patients with disabilities or special needs can access our services.

Why this is important

Practices need to ensure that people with a disability or special needs can access the practice and its services, in ways that maintain their dignity, in order to comply with the federal Disability Discrimination Act (1992).

Meeting this Criterion

Access is important

Practices need to ensure that all patients, including those with disability or other special needs, can easily and safely physically access the practice's premises and services. This can be achieved by:

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

Practices could improve their non-physical access for patients with disabilities or special needs. For example:

- Your practice could use existing and emerging technology to give patients access to telehealth or video conferencing consultations.
- Practitioners could make home visits, where appropriate.

Accessible parking

Where possible, patients with a disability need to be able to park their vehicles within a reasonable distance of the practice. Parking bays that are specifically marked for the use of patients with a disability parking entitlement must be large enough to accommodate the loading and unloading of wheelchairs.

Assistance animals

Some of your patients could have an assistance animal that they want to have with them during a visit to your practice. These animals are not pets, they are specifically trained disability support animals that enable a person with disability to safely participate in personal and public life activities. Under the Federal Disability Discrimination Act 1992 (amended 2009) an assistance animal is defined in three ways. That is that the animal is either:

(a) accredited under a State or Territory law to assist a person with a disability to alleviate the effects of disability; or
(b) accredited by an animal training organisation prescribed in the regulations; or
(c) is trained to assist a person with a disability to alleviate the effect of the disability and meets standards of hygiene and behaviour that are appropriate for an animal in a public place.

Assistance animals may support patents who:

- are blind or have low vision
- are deaf or hard of hearing
- require physical support for mobility or other functional tasks
- experience episodic and serious medical crisis (e.g. epilepsy, changes in blood pressure or blood sugar)
- experience psychiatric disorders such as Post-Traumatic Stress Disorder, anxiety, hallucinations, panic attacks or suicidal ideation[12].

Under the Federal Disability Discrimination Act 1992 (amended 2009) all assistance animals are guaranteed access to all public places in Australia. For further information see the Australian Human Rights Commission website.

Meeting each Indicator

C2.3► A

You must:

- **Have physical infrastructure or processes that enable patients with disabilities or special needs to access your services.**
- **Access to disability parking.**

You could:

- Use pictures on signs to help patients with an intellectual disability or visual impairment.
- Provide a transport service to help patients who cannot otherwise get to the practice.
- Provide home visits for patients who are unable to leave their home.

Standard 3: Practice governance and management

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

Practice governance relates to the principles, methods and processes that clinicians and health service managers follow in order to support patient safety and quality care. It also helps practices to set, measure, and achieve their social, fiscal, legal and human resources objectives.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) notes that good practice governance is:

- participatory
- consensus-oriented
- accountable
- transparent
- responsive
- effective and efficient
- equitable and inclusive
- compliant with legislation[13].

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

Criterion C3.1 – Business operation systems

Indicators

► A. Our practice plans and sets goals aimed at improving our services.

B. Our practice evaluates its progress towards achieving its goals.

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

► D. Our practice has a complaints resolution process.

Why this is important

Planning, setting and evaluating goals

A business needs to operate successfully to create an environment where quality clinical care can be delivered. To operate a business successfully, strategic thinking and business planning is as important as financial budgeting and reporting. A documented business plan (that is linked to your strategy and includes how it will be implemented) is an effective way of measuring your progress, and increases the likelihood of achieving your practice's objectives.

Having a plan in place helps to get the team working together towards a common goal. It also gives the team the ability to evaluate progress and helps the practice achieve consistency, quality in its operations and conduct continuous quality improvement.

Practice governance arrangements and structure will vary depending on the size and complexity of the practice. In smaller practices there may be a merging of governance and management responsibilities. Some practices may be part of a wider corporate group and have either public or private shareholders. Others may be government bodies or not for profit community based organisations. Having a clear understanding of ownership and governance arrangements can guide appropriate policy and performance frameworks. It is the responsibility of the practice to define its governance structures relative to its own requirements.

Business risk management

Managing safety and risk is part of quality assurance, and therefore a significant part of practice management. Clinical risks need to be managed, but so too do business risks. If the business fails, the practice 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 practice understand potential problems and identify how you can improve your services[14].

Meeting this Criterion

Planning, setting and evaluating goals

A strategic plan could be developed that documents your practice's direction and objectives. The strategic plan could include:

- the practice'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 practice (e.g. with fewer than 10 practice staff), you may wish to consider having an action plan that sets out the goals and progress instead of a strategic plan.

You can evaluate the practice's progress against its strategy and goals in a number of ways, including:

- having it as an agenda item in team meetings
- scheduling strategy planning and evaluation meetings at defined intervals
- reviewing the practice patient population data and outcomes
- seeking patient feedback
- having 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 practice's business risk management strategy include:

- poor record keeping
- IT system failures
- poor system for updating patient contact details and following up test results
- lack of documentation of the consent process
- work health and safety incidents from equipment that is not maintained in accordance with the manufacturer's recommendations
- inadequate number of practice staff on during busy times.

A risk register is a good way to record problems that could result in a risk becoming a reality. This helps you to identify potential risks and take action to reduce the likelihood or severity. The type of business risks practices might face can include:

- conflicts of interest
- workforce planning
- unexpected sick leave
- unplanned emergencies (e.g. environmental)
- updates to the IT security system.

Mitigating business risk enables your practice to operate successfully, allowing you to give more focus to providing quality patient care.

A risk matrix could be developed to help you define the level of each identified risk (e.g. Low, Moderate, High, Extreme), based on a combination of:

- the likelihood of an event, and
- the severity of its impact if it was to occur.

There are risks when practices fail to keep their risk register up to date. Risk mitigation strategies may not be fully completed and new risks may not be identified, potentially exposing the practice to adverse impacts on healthcare and practice operations You could schedule regular risk management meetings and/or include risk management as a standing agenda item for team meetings so identified risks are reviewed, updated, and minimised.

Managing complaints

Practices must have a receptive attitude to patient feedback and complaints. If you receive a patient complaint, try to resolve the issue directly within the practice team. If the complaint cannot be resolved by the practice team, contact your medical defence organisation to seek 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 practice will always try to resolve complaints directly.

Read Section 3 of the *MBA Code of Conduct* that contains advice about managing complaints at the practice level (available at www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx). Basic steps include:

- 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 or to another practice
- 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. Practices must advise their patients of this option.

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

Meeting each Indicator

C3.1► A

You must:

- **Plan and set business goals.**

You could:

- Create a statement of the practice's ethics and values.
- Maintain a business strategy.
- Maintain an action plan.

C3.1 B

You could:

- Maintain progress reports against the action plan.
- Create a strategy for continuous quality improvement.
- Implement quality improvement initiatives.

C3.1► C

You must:

- **Maintain a documented risk management process.**
- **Develop procedures to mitigate risks.**

You could:

- Maintain a risk register.
- Maintain a log of risks for smaller practices.
- Keep a record of meetings where risks have been identified and managed.

C3.1 ►D

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

► A. All members of our practice team understand their role in the practice.

► B. Our practice undertakes performance discussions with each team member.

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

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

► E. Our practice has at least one team member who coordinates the resolution of administrative and/or other 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 (for example, in position descriptions):

- the practice 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 various aspects of the practice's operations.

Performance monitoring

The objectives of performance monitoring are to assess the performance of an individual and to determine how the practice 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 practice team members understand:

- the principles and policies under which the practice operates
- the day-to-day operations of the practice
- key work 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 in the practice or contacting the practice.

Meeting this Criterion

Roles and responsibilities

Your practice 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 practice team must understand what their role and responsibility is.

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:

- performance monitoring
- lines of accountability
- recruitment for the role
- training and development
- remuneration management
- succession planning.

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

Performance monitoring

One way that 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 practices where informal processes generally work better than formal processes.

If you decide to introduce formal performance discussions (e.g. every six months), consult with your practice team to ensure that the process is practical and fair. Many organisations that have successfully implemented performance discussions spent a substantial amount of time training the managers and practice team about the process.

The performance monitoring system could cover:

- setting standards for performance
- assessing performance against the standards
- providing and receiving feedback about job 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 practice team member. These discussions are not intended to be disciplinary in nature. Practitioners in the practice team could choose to undertake performance discussions with other practitioners, rather than with other practice staff, such as the practice manager.

Induction program

The following information could be included in your induction program:

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

Meeting each Indicator

C3.2► A

You must:

- **Ensure members of the practice team understand their role when they commence working at the practice.**
- **Ensure that practice team members work within the scope of their role.**

You could:

- Create position descriptions.
- Create an organisational chart.
- Maintain a practice policy document.
- Show records of contracts or letters of agreement with external providers.

C3.2► B

You must:

- **Regularly monitor the performance of the practice team.**

You could:

- Implement a formalised performance monitoring process.
- Have regular catch-ups between managers and their practice team members.
- Establish development goals for members of the practice team.

C3.2► C

You must:

- **Have a system to induct members of the practice team.**

You could:

- Keep accurate and up-to-date employment files on each member of the practice team.
- Maintain a human resources policy and procedure manual.
- Create templates and checklists for inducting new team members.
- Maintain a documented recruitment process.

C3.2► D

You must:

- **Ensure that the team member responsible for risk management understands their role.**

You could:

- Maintain a human resources policy and procedure manual.
- Create position descriptions.

C3.2► E

You must:

- **Maintain a record of how complaints have been managed.**

You could:

- Maintain a complaints register
- Create position descriptions.
- Have minutes or notes of practice meetings that show that patients' complaints have been considered and discussed there.

Criterion C3.3 – Emergency response plan

Indicator

► A. Our practice has an emergency response plan for unexpected events, such as natural disasters, pandemic diseases, or an unplanned absence of clinical team members.

Why this is important

In an emergency, the demand for healthcare services generally increases, especially in the event of a pandemic[15], so it is crucial that your practice can continue to provide services during this time, if appropriate.

If your practice is prepared for an emergency, you are more likely to provide effective continuity of care for your patients, and continue operating your business as smoothly as possible.

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

Meeting this Criterion

In an emergency, practices may experience the following issues:

Patients

- increased demand for services
- disruption to the normal health system functioning, e.g. inability to transfer patients to hospital

Infrastructure and systems

- minor or significant damage to the practice's infrastructure
- loss of access to vital information
- loss of access to essential systems, networks, and communication
- reduced capacity or, or the loss, of key practice staff
- practice closure.

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, undertake appropriate emergency planning and preparation activities. This includes an ongoing process of identifying, reviewing, and updating the actions that need to be completed during an emergency, and may include:

- having a documented emergency response plan
- appointing an emergency management coordinator
- undertaking local and other research to identify, for example, local emergency services, the local geography, and previous events that have affected the community
- providing the practice team with relevant education and training
- testing components of the emergency response plan 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:

- how to communicate with patients and other services
- contact details of all members of the practice team
- contact details for response agencies and other health services
- details about the practice such as accounts, service providers (e.g. insurance, lawyers, telephone, internet, utilities), insurance policy numbers
- how the practice will triage and run clinical sessions during an emergency
- the practice's policy on infection control
- details of equipment needed to manage an emergency
- how to manage unplanned absenteeism of multiple practice team members including succession planning
- the practice's policy on the management of patients' health information including computer and paper-based systems.

In case your practice needs to close due to an emergency, you must have a recovery plan that details the process that the practice team could take to re-establish the practice's operations, when appropriate to do so.

Meeting each Indicator

C3.3► A

You must:

- **Maintain an emergency response plan.**
- **Educate the whole practice team about the emergency response plan.**

You could:

- Create a position description for a team member.

- Create and test mock scenarios.
- Discuss processes at team meetings, particularly the practice's evacuation process.
- Undertake succession planning for key practice staff.
- Encourage the sharing or skills and knowledge among practice team members.

Criterion C3.4 – Practice communication and teamwork

Indicator

► A. Our practice team has the opportunity to discuss administrative matters with the principal practitioners, practice directors, practice management, or owners when necessary.

► B. Our practice encourages involvement and input from all members of the practice team.

► C. Our clinical team discusses the practice'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[16], and that bullying and harassment can be a significant threat to quality care and patient safety [17]. Therefore, your practice 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 practice 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 practices to build teamwork is to schedule regular meetings where all members of the practice team are encouraged to contribute to discussions. For small practices, 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 practice team with the opportunity to discuss administrative issues with the practice directors and/or owners when necessary. When the practice owner is not a member of the practice, the practice 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 practices.

Good communication between the manager/employer and the practice 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 practice, the practice team, and the patients. 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 that people have. The clinical team must have access to up-to-date resources about a range of clinical issues, to improve the treatment of patients and for their own professional development.

Meeting each Indicator

C3.4► A

You must:

- **Educate the practice team about the practice communication channels.**
- **Develop a process for the practice team to escalate issues.**

You could:

- Keep a record of meetings.

C3.4► B

You must:

- **Ensure the practice team is aware of the practice communication channels they can use to provide input.**
- **Develop a process for the practice team to escalate issues.**

You could:

- Encourage all practice team members to attend team meetings, and keep a record of meetings.
- During recruitment interviews and inductions, inform both prospective and current members of the practice team that they are encouraged to be involved in practice operations by providing input and feedback on improving business operations.

C3.4► C

You must:

- **Ensure access to up-to-date and accurate clinical guidelines.**

You could:

- Keep a record of clinical team meetings.
- Create and document a buddy system.
- Use the practice intranet or email to facilitate discussions.

Criterion C3.5 – Work health and safety

Indicators

► A. Our practice supports the safety, health, and wellbeing of the practice team.

► B. Our practice team is encouraged to obtain immunisations recommended by the current edition of the Australian Immunization Guidelines as appropriate to their duties and immunisation status.

Why this is important

Each practice owner/manager is responsible for providing a safe working environment. This includes being genuinely concerned for the health, safety and wellbeing of the whole practice team. The practice owner/manager is obliged to meet their responsibilities as an employer by adhering to relevant state/territory and federal work health and safety (WH&S) and occupational health and safety (OH&S) legislation and law.

Inappropriate and disruptive behaviours within the clinical team can risk patient safety. Although these behaviours might not be seen as an overt work health and safety or bullying issue, they can undermine both the culture of the setting and clinical care[18-20].

Practices are to encourage members of the practice 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 requirements will depend on the risk presented by the type of practice and each practice team member's duties.

Meeting this Criterion

Safety of your practice team

Having an adequate number of practice team members present for the size of your practice during normal practice hours contributes to the safety and wellbeing of the practice team, as well as allowing telephone calls to be answered promptly, appointments made accurately and according to urgency, and medical emergencies to be managed appropriately.

When operating outside normal opening hours, consider the safety and security of team members, especially if they are on their own. Consider, for example:

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

Ensure that the layout of the facility complies with WH&S requirements, and consider how individual desks are configured so that practice 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 practice team

Practices can support the health and wellbeing of the practice 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 risks of harm to patients
- a plan for re-allocating patient appointments if a practitioner is unexpectedly absent from the practice can minimise the burden on the other practitioners
- making information about support services available to the practice team can help them identify and deal with pressures and stressors. This is particularly important in geographical areas where there are small practice teams.

Dealing with violence

Patient aggression and patient-initiated violence in healthcare settings continues to be an issue. Your practice could include patient-initiated violence in your risk management strategy (Criterion C3.1 – Business operation systems) Typically, such strategies include:

- a zero tolerance policy towards violence
- displaying signs that inform people of the zero tolerance policy
- detailed steps to take when dealing with violence
- setting up a duress alarm system that the practice team can use if a patient is threatening or violent, and have a response plan if the alarm is triggered
- contacting the police 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), a practitioner can end the professional relationship during a consultation or by letter or telephone, depending on safety considerations. Practices are to keep a record of the process, and any subsequent contact that the patient has with the practice.

Practice team immunisation

Check the *Australian Immunisation Handbook* to identify recommended vaccinations for healthcare workers. This is available at www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home .

Practitioners and other members of the practice team are to be offered and encouraged to have, immunisations recommended by the current edition of the Australian Immunization Guidelines and/or offered testing of, or encouraged to test, their natural immunity to vaccine-preventable disease or immunisation status. These services can be undertaken by the practice team member's own GP or by the practice if appropriate.

Practices could consider the wellbeing of practice team members who are not immunised in the case of disease outbreaks. For example, during a disease outbreak, practices could suspend non-immunised team members as a way of preventing transmission of the disease to patients who cannot be immunised for medical reasons.

Meeting each Indicator

C3.5► A

You must:

- **Include work health and safety requirements in team member recruitment interviews and inductions.**

You could:

- Maintain a WH&S/OH&S policy and procedure.
- Maintain a policy and procedure manual.
- Develop and adhere to appropriate practice staff rosters.
- Include WH&S as a standing agenda item on team meetings.
- Maintain an appointment book that shows scheduled breaks.
- Create appropriate building, workstation and desk design and layouts.
- Provide the practice team with access to support services.

C3.5► B

You must:

- **Provide clinical team members with access to the current *Australian Immunisation Handbook***

You could:

- Record each practice team member's immunisations in their employment file (with their consent).
- Offer to subsidise immunisations for the practice team

Criterion C3.6 – Research

Indicator

► A. Our practice ensures that all research is approved by an ethics committee and is indemnified.

► B. Our practice transfers identified patient health information to a third party for quality improvement or professional development activities, only after we obtain patient consent.

Why this is important

The NHMRC has developed an Australian Code for the Responsible Conduct of Research. The Code provides guidance on responsible research practices and promotes integrity of research. The Code is available at https://www.nhmrc.gov.au/guidelines-publications/r39

There are guidelines for Ethical Research in Australian Indigenous Studies. These guidelines could be referred to if Aboriginal and Torres Strait Islander peoples are included in your patient sample. This information is available 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 the legislative requirements relating to privacy. Even if your practice is using de-identified patient health information, there are still some situations where you must obtain informed patient consent (other situations do not require informed patient consent).

A Human Research Ethics Committee (HREC) will review research proposals to ensure that they are ethically acceptable and in accordance with relevant standards and guidelines. A HREC will decide on the requirements for patient consent necessary for your research project. You can find details of the RACGP HREC at http://www.racgp.org.au/yourracgp/organisation/committees/national-committees/nreec/

There are many HRECs operating in institutions and organisations across Australia. A list of HRECs registered with the NHMRC is available at:
https://www.nhmrc.gov.au/_files_nhmrc/file/health_ethics/hrecs/att_2_-_list_of_human_research_ethics_committees_registered_with_nhmrc_february_2016.pdf

The Code and consent requirements apply even if a member of the practice team is not conducting research themselves, but, for example, is contributing to someone else's research.

Meeting this Criterion

The NHMRC defines research as that which:'... 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 practice team must be familiar with the NHMRC Code when participating in research. If there has been no research conducted in the practice, then this Indicator is not applicable.

In addition, you may wish to develop a policy that includes information on:

- the process and documentation on ethics approval
- the use of a specific area in the practice
- data storage, record keeping, and compliance with privacy legislation
- practice team training requirements
- communication provided to patients.

Research indemnity

Practices must ensure that appropriate insurance is in place to indemnify them for research.

If your practice is involved in a clinical trial, then your practice will usually be indemnified by the sponsor (e.g. drug company). Practices need to ensure the indemnity covers their liabilities, and if not then get a separate insurance policy or indemnity. When the research is not a clinical trial, practices must ensure that they have their own insurance to cover research.

In all cases, individual GPs within the practice would need to ensure that their medical indemnity insurance covers their research activities.

Quality improvement activities, ethics and consent

In general, a practice's quality improvement or clinical audit activities are for the purpose of seeking to improve the delivery of a particular treatment or service. This is not considered the 'primary purpose' for patient health information according to the Australian Privacy Principles, therefore the practice would need to seek specific consent for this use of patients' health information for these activities.

Practices are encouraged to include information about quality improvement activities and clinical audits in the practice policy on managing health information. Practices could seek patient consent by including this information in new patient registration forms. Practices must make patients aware that refusing to participate in research will not affect the care they receive at the practice.

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 practice.

Meeting each Indicator

C3.6► A

You must:

- **Provide all required evidence of ethics approval and indemnity for research activities.**

- **Maintain records of any research activity that has gone through the ethics approval process.**
- **Retain patient consent documentation for the required period.**

You could:

- Maintain a practice policy on participating in research that complies with the NHMRC guidelines.
- Consider the ethical needs of Aboriginal and Torres Strait Islander people.

C3.6► B

You must:

- **Keep a record of the patient's consent to use patient health information for the purposes of quality improvement activities, in the health record.**
- **Make patients aware that refusing to participate in research will not affect the care they receive at the practice.**
- **Maintain a privacy policy.**

You could:

- Maintain a patient health information management policy.

Standard 4: Health promotion and preventive activities

Our practice 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 increase their control over, and improve their health. It extends beyond influencing an individual's behaviour to include a wide range of social and environmental interventions[21], such as education programs and changes to legislation 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 can reinforce this in various ways, such as in written materials, in the practice's 'on-hold' telephone messages and in education clinics that help people self-manage their chronic diseases.

For most Australians, general practices are the primary entry point to healthcare, and therefore have a crucial role in promoting health, illness prevention and preventive care. For example, a patient can visit their practitioner to have regular check-ups, 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, and to detect them in their early and often in asymptomatic stages as opposed to treating them[22], based on relevant current clinical and other guidelines. According to 2013 data from the Australian Institute of Health and Welfare, the leading cause of preventable deaths in Australia is coronary heart disease[23].

A holistic approach to care encourages a practice to consider and respond to each patient's individual circumstances when providing health promotion, preventive care, early detection, and intervention. The individual circumstances of Aboriginal and Torres Strait Islander peoples may need special consideration.

Practices 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

► A. Our patients receive appropriately tailored information on health promotion, illness prevention, and preventive care.

Why this is important

Health promotion is: the process of enabling people to increase control over the determinants of health and thereby improve their health[24].

Health promotion focuses on:

- prevention, promotion and protection rather than on treatment
- both populations and individuals
- factors and behaviours that cause illness and injury rather than the illness and injury itself[25].

Practices play a key role in health promotion, illness prevention and preventive care. Practices can also co-ordinate with other health professionals and key agencies to achieve health promotion and preventive care activities.

Meeting this Criterion

Providing a systematic approach to preventive care

Assessing a patient's health risks is a key component of preventive care, and can be done by aiming for early detection of disease through, for example, the cervical cancer and bowel cancer screening programs.

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

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

Reminder systems that help ensure that patients undergo regular screening and checks need to protect the privacy and confidentiality of each patient's health information.

If you choose to cease using a reminder system, it is good practice to advise patients, so that they can set up their own system for ensuring that they have regular screenings and checks.

Providing information to patients

Practitioners can verbally provide education about health promotion and preventive care during a consultation. Patients could be offered interpreters for these consultations if necessary, so that they completely understand the care provided.

By providing information in documents such as brochures and fact sheets (paper-based and on your website), and referring patients to other reliable websites, 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[26]. 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 and 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 (e.g. in plain English, in pictures, in videos)
- you can provide culturally appropriate material (e.g. for Aboriginal and Torres Strait Islander patients).

Managing patient information to support preventive care

When you collect information about a patient's health, for example, the patient's family medical history, record the information in the patient's health summary and health record. 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 may be instances where establishing the patient's complete family medical history may be challenging or not readily available. As this information might be sensitive, appropriate consideration and respect must be given.

Some information may also be transferred to national state-based registers (e.g. immunisation data, cervical screening, and familial cancer registries) in order to improve care. If your practice 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 for others inclusion is mandated (e.g. HIV infection)
- remind patients when they need to have another screening, and not rely on patients receiving reminders from these registries.

Meeting each Indicator

C4.1► A

You must:

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

You could:

- Use preventive health guidelines and resources.
- Use decision support tools.
- Have up-to-date pamphlets and brochures.
- Provide information on the practice website.
- Run preventive health activities, such as diabetic education groups or groups to help patients cease smoking.
- Have a reminder system.

Standard 5: Clinical management of health issues

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

Contemporary practice is based on the best available evidence for Australia's current primary healthcare systems. 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
- practices provide access to up-to-date clinical information and have appropriate support processes in place.

Criterion C5.1 – Diagnosis and management of health issues

Indicators

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

► 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 when providing healthcare, so that your practice can achieve consistent and tailored healthcare, according to community and patient demographics.

Applying clinical guidelines consistently helps to:

- provide consistency in diagnosis and management of health issues
- minimise variation of care between clinicians
- provide continuity of care for 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 practice.

Meeting this Criterion

Practices need to make sure that clinical guidelines are current, based on best available evidence and are accessible, whether on-line or paper-based. It is important to maintain a current version of the clinical software databases that include drugs guides, medical dictionaries, coding classifications and consumer medicine information.

When clinical teams discuss clinical care, they must always compare their discussions with 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. Good communication between members of the clinical team can help to ensure a consistent approach to clinical care. While face-to-face meetings of the clinical team are preferred, communication tools such as message systems and notice boards can be useful to raise and address clinical issues.

Meeting each Indicator

C5.1► A

You must:

- **Have current, best evidence and accurate clinical guidelines available in electronic and/or hard copy for the practice team to access.**

You could:

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

C5.1►B

You must:

- **Have current, best evidence and accurate clinical guidelines available in electronic and/or hard copy for the practice team to access.**

You could:

- Keep records of clinical team meetings about the use of clinical guidelines.
- Have clinical team members explain how they discuss the care of patients with other team members, while ensuring patient confidentiality.
- Educate the practice team so that they can find and use resources and guidelines.
- Ensure that the practice team know what evidence-based resources and guidelines they use regularly.
- Establish and maintain a system that the practice team can use to pass on messages to other team members (e.g. a communication book, internal mail, and an email system).
- Ensure that clinical team members know what specific clinical guidelines the practice uses for patients who identify as an Aboriginal or Torres Strait Islander person, how to access them, and how to use them to support evidence-based practice, including in the prevention and management of chronic diseases.

Criterion C5.2 – Clinical autonomy for practitioners

Indicator

► A. Our clinical team can exercise autonomy, to the full scope of their practice, skills and knowledge in 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 the best level of care for each individual patient, based on their clinical judgement and current clinical and other guidelines.

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 their practice. Further information on relevant codes of conduct is available at 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 of 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 they use
- how and when to schedule follow-up appointments with each patient.

Practitioners must still comply with the policies and procedures of the practice.

Meeting each Indicator

C5.2► A

You must:

- **Give practitioners autonomy with respect to:**
  - **overall clinical care of their patients**
  - **referrals to other health professionals**
  - **requesting investigations**
  - **duration and scheduling of appointments.**

You could:

- Maintain a policy ensuring clinical autonomy for practitioners in the context of delivering evidence-based care, and according to their scope of practice, skills, and knowledge.

Criterion C5.3 – Clinical handover

Indicator

► A. Our practice manages the handover of patient care.

Why this is important

Clinical handover of patient care occurs frequently in a practice and can be to other members of the clinical team and to external care providers.

The omission of, or inadequate transfer of care is a major risk to patient safety and can result in serious adverse patient outcomes. Consequences can include:

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

It can also result in legal action.

Meeting this Criterion

Clinical handover needs to occur whenever there is a crossover of care by different providers. 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 practice
- there is a shared care arrangement (e.g. a team is caring for a patient with mental health problems)
- there is an emergency such as handover to hospitals or ambulance
- the patient requests this, for example uploading shared health summaries to the patients shared electronic health record.

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

- tell the patient who will take over their care
- be aware of patient's goals and preferences
- support patients, carers and other relevant parties to be involved in clinical handover, in accordance with the wishes of the patient.

Clinical handovers can be completed face-to-face, via written information, via telephone and by electronic means, such as secure message delivery or email.

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

- how to use the progress notes in the patient health record during a clinical handover
- how to have a safe clinical handover when practices use electronic health records. For example, the use of healthcare identifiers that uniquely identify the individual patient
- the process for giving and receiving information relating to home visits, after-hours services, hospital discharges and care provided by other healthcare professionals such as specialists
- how to record the clinical handover in the consultation notes
- how to report near misses, and failures in clinical handover procedures
- the use of a 'buddy system' where one 'buddy' follows up results and correspondence or continues the care of the patient when a colleague is absent.

Meeting each Indicator

C5.3► A

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 leave - unexpected or expected**

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. This must be followed by a statement written by the GP with the reason for the referral.
- Have a written policy explaining how to conduct internal and external handovers, including to locum practitioners.
- Have a standard form to be used for ambulance transfers.
- Aim for face-to-face handovers, where 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 where appropriate.
- Keep a register of handover lapses and mistakes.
- Create and document a buddy system.
- Use internal messaging or internal email to communicate between the clinical team.

- Use practice software such as patient information and management systems that permit uploads of shared health summaries/records or event summaries to their national shared electronic health record at the request of the patient

Standard 6: Information management

Our practice 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. Practices are required to comply with the relevant state and federal legislation relating to the collection, storage, use, disclosure, and disposal of patient's health and personal details.

Criterion C6.1 – Patient identification

Indicator

► A. Our practice uses a minimum of three approved patient identifiers to correctly identify patients and their clinical information.

Why this is important

General practice works on a trust system and there is no formal requirement for patients to provide documented verification of identification. Correct patient identification ensures that the attributes captured to verify an individual match the details held by the practice when providing clinical care. Correct verification of patient identities maintains patient safety and confidentiality. Not identifying a patient correctly can have serious, potentially life-threatening consequences for the patient.

Using three approved patient identifiers minimises the risks of misidentifying patients and ensures that a practitioner has the correct patient health record for each consultation. For further information about the importance of correctly identifying patients, go to http://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 practice for their appointment
- you communicate with a patient over the telephone or electronically
- a patient telephones asking for a repeat of a prescription
- a patient sees more than one practitioner during a practice visit
- a patient record is accessed
- you collect and manage information (e.g. scanned documents, x-rays) about a patient.

Approved patient identifiers are items of information that are accepted for use to identify a patient and include the patient's:

- name (family and given names together are one identifier)
- date of birth
- gender (as identified by the patient)
- address
- patient health record number where it exists
- Individual Healthcare Identifier.

Some Australian residents and visitors may not have a Medicare number[2].

Asking for patient identifiers

When asking for patient identifiers, practice team members must ask the patient to state a minimum of three identifiers, such as their name, date of birth, and address while remaining mindful of privacy and confidentiality issues. Practice staff should not provide the identifying information recorded for patients to confirm.

A patient could hand over a form of government issued photographic documentation to confirm their identity attributes, such as their drivers licence.

When a patient is well known to the practice team, it may appear unnecessary or illogical to check their identifying attributes. However, it is common for practices to have patients with identical and similar names or dates of birth and to therefore mismatch patients and patient health records. Some practices overcome this by routinely asking patients to verify their address and other particulars each time they attend. This also helps the practice to maintain accurate contact details for each patient.

Patients who wish to remain anonymous

Wherever it is lawful and practicable, patients must be able to remain anonymous when receiving care from your practice[27]. Patients may choose to receive services anonymously where sensitive issues arise or if they feel they may be at risk, such as in domestic violence situations or vexatious relationships. In these circumstances the use of alias, or 'disguised identity' may be the most appropriate approach.

Meeting each Indicator

C6.1► A

You must:

- **Use a minimum of three approved patient identifiers to confirm a patient's identity.**

You could:

- Keep a prompt sheet at reception to remind reception staff to ask for approved patient identifiers.
- For small practices or practices familiar with their patients, you could explain to patients the reasons for identifying them at each visit (e.g. safety reasons, opportunity to update patient details).

Criterion C6.2 – Patient health record systems

Indicator

► A. Our practice has a system to manage our patient health information.

► B. Where our practice is using an active hybrid patient health record system, a record 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 operating in practices are generally electronic, paper-based or a hybrid of both electronic and paper-based systems.

Where one or more of your practitioners enters patient information into a paper-based system and one or more uses electronic files, this is considered an active hybrid patient health record system.

A fully electronic patient health record system is preferable to a paper-based or hybrid patient health record system. An electronic system improves the legibility of clinical notes, is more accessible, reduces duplication and can support clinical decision-making (e.g. alerts can be set for patient allergies, details of past and current medications dosages are accessible, and the patient's detailed medical history is accessible). If your practice protects and backs up your electronic patient health records appropriately, you are less liable than paper records to loss through misfiling, natural disaster, fire or theft.

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 (e.g. a medicines list on a computer) and some information being recorded on another system (e.g. past medical history on hand-written notes), or some information not being recorded at all.

Meeting this Criterion

Your practice must select a patient health record system that suits the needs of your practice. Whether your practice chooses to use an electronic, paper-based or a hybrid patient health record system, it is important that your practice has established a system to manage your patient information. You must be able to identify which patient health records system your practice is using and your practice could demonstrate how your system operates.

Active hybrid patient health record systems

If you have an active hybrid patient health record system:

- all practitioners in your practice, including locums, must know that there is an active hybrid patient health record system
- 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 practice uses a hybrid patient health record system and where information is recorded.
- you must work towards the electronic recording of at least allergies and medications.

Meeting each Indicator

C6.2► A

You must:

- **Have a system to manage patient health information.**
- **Make sure all the patient health information is available and accessible when needed.**

You could:

- Use clinical software to manage patient health information.
- Conduct audits to identify gaps in patient information.
- Provide education to the practice team on any updates to clinical software.

C6.2► B

You must:

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

You could:

- Transition to a computerised patient health information system.

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

Indicators

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

► B. Our patients are informed of the processes we follow to give them access to their health information.

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

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

Why this is important

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

- The Australian Privacy Principles (APPs) contained in the *Privacy Act 1988.*
- Long-standing legal and ethical confidentiality obligations.
- In some jurisdictions additional, and occasionally health specific legislation.

Practices are subject to stringent privacy obligations because they provide health services and hold health information. Health information is a subset of personal information requiring greater than usual protection (because it is by definition sensitive information) and can include any information collected in order to provide a health service, such as:

- a person's name and address
- a person's bank account details
- a person's Medicare number
- a person's health information (such as a medical or personal opinion) relating to their health, disability, or health status.

Sometimes details about a person's medical history or other information (such as details of an appointment) can identify the person, even if there is no name attached to that information. This is still considered health information and therefore must be protected in accordance with the *Privacy Act 1988*.If unauthorised people have access to prescription pads and/or other official documents they can misuse these documents, particularly to gain access to un-prescribed medication.

Meeting this Criterion

Consider and address all privacy requirements, how to manage the responsibilities of the practice team and the risks associated with keeping health records. This includes reviewing and developing policies about your practice's use of:

- computer systems and IT security
- systems that automatically generate letters or referrals
- email
- social media
- file sharing applications[28].

The RACGP's *Handbook for the management of health information in general practice* provides further information about safeguards and procedures required by general practices in order to meet appropriate legal and ethical standards concerning the privacy and security of patient health records. Your medical defence organisation can also provide information and advice about developing strategies to manage these risks.

A privacy policy

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

Information about collecting health records

- the definition of a patient health record
- the kinds of personal information that the practice collects and holds
- how the practice collects, stores, uses, protects and discloses personal information
- the purposes for which the practice collects, holds, uses and discloses personal information;
- how patients can deal with the practice anonymously.

Patients' interactions about their privacy and health information

- how patients can access and correct personal information at the practice
- how a patient may complain about a breach of the Australian Privacy Principles, or a registered APP code (if any) that binds the practice, and how the practice will deal with such a complaint.

Disclosure of patients' health information to a third party

- obtaining informed patient consent when transferring health information
- where health information is likely to be disclosed
- whether health information is likely to be disclosed overseas and, if so, where and how

- how the practice uses document automation technologies, particularly to ensure that only the relevant medical information is included in referral letters.

For further information, refer to the RACGP's Privacy Policy template and visit www.oaic.gov.au/

Your practice must make your privacy policy available to patients. This could be on your website, or reception staff could produce the practice's privacy policy, when requested by a patient.

Disclosure of patient health information to responsible person

The disclosure of necessary health information by an organisation to an individual's responsible person (such as a carer) is permitted by the Privacy Act 1988, providing it is reasonably necessary, in the context of providing a health service to that individual and the individual is physically or legally incapable of consenting or communicating that consent. If a situation arises where a carer is seeking access to a patient's health information, practices are encouraged to contact their medical defence organisation for advice before such access is granted.

Secure transfer of health information

Secure electronic communication should be the preferred and default method of communication of all health services and government agencies communicating with general practice regarding patients[29]. Follow the processes in the APPs and all requirements of the state or territory legislation governing the transfer of patient health information to correctly transfer patient health information to others (e.g. patients, other health service providers, or in response to third party requests). For further advice on which data should be extracted from the patient health record and transferred, see the RACGP Guide for managing external requests for patient information. Contact your insurers if you have any concerns about third party requests for the transfer of patient health information.

Familiarity with requirements

The practice team must read and understand the privacy policy and understand the need for confidentiality of patient health information. As well as being familiar with the APPs, team members need to be familiar with the relevant state/territory privacy and health records legislation. For more information, the Office of the Australian Information Commissioner (OAIC) website provides specific information on privacy legislation in all jurisdictions: https://www.oaic.gov.au/privacy-law/other-privacy-jurisdictions

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

Staff have a responsibility to use patient information only for its intended purpose and for the benefit of the patients. Members of the practice team with access to patient records are granted this access to allow them to perform their roles and provide efficient service to the patients and the practice team itself.

Meeting each Indicator

C6.3► A

You must:

- **Maintain a privacy policy.**

You could:

- Maintain a patient health information management policy.

C6.3► B

You must:

- **Maintain a privacy policy.**

You could:

- Have the practice team understand the need for confidentiality and sign confidentiality agreements, and store them in the employment files.
- Maintain a patient health records policy.

C6.3► C

You must:

- **Maintain a privacy policy.**

You could:

- Keep a record of the patient's consent to communicate electronically in the patient health record.
- Undertake regular privacy training.
- When communicating electronically with or about patients, protect the patient's privacy by the use of a Secure Message System or other method of encryption, unless the patient has provided informed agreement to her or his information being sent without such protection.

C6.3► D

You must:

- **Maintain a privacy policy.**
- **Securely store prescription forms, administrative records and templates such as letterhead, and other official documents.**

You could:

- Maintain a patient health information management policy.
- Have the practice team understand the need for confidentiality and sign confidentiality agreements, and store them in the employment files.
- Maintain a patient health records policy.
- Ensure appropriate access is provided to each role, based on position descriptions.

Criterion C6.4 – Information security

Indicators

► A. Our practice has a team member who has primary responsibility for the electronic systems and computer security.

► B. Our practice does not store or temporarily leave the personal health information of patients where members of the public could see or access that information.

► C. Our practice's clinical software is accessible only via unique individual passwords that give access to information according to the person's level of authorisation.

► D. Our practice has a business continuity and information recovery plan.

► E. Our practice has appropriate procedures for the storage, retention, and destruction of records.

► F. Our practice has a policy about the use of email.

► G. Our practice has a policy about the use of social media.

Why this is important

Maintaining the privacy and security of health information held by a practice is a legal obligation and includes maintaining computer security.

Practices are increasingly using electronic communication to communicate with patients and other health professionals, therefore practices need an email policy and a social media policy.

Meeting this Criterion

The current edition of the RACGP's *Computer and information security standards* (CISS) 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 and the use of computers.

You could refer to this document (available at www.racgp.org.au) so that you satisfy the requirements it specifies.

Designated practice team member

Your practice must have a designated practice team member who has the primary responsibility for computer security. Their responsibilities include:

- knowing who and when to call for expert advice
- giving contact details of any external expert used by the practice to relevant practice team members
- educating the practice team about data security

- ensuring that the practice team follow security protocols and policies.

Keeping health information concealed

Computer screens must be positioned so that only appropriate members of the practice team can see confidential information. Automated privacy protection tools (such as screen savers) must be used to prevent unauthorised access to computers when they are left unattended (e.g. 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 need to be as secure as your practice's desktop computers and network, particularly because they are potentially more accessible to people outside the practice.

Restricting access to clinical software

If you have given different members of the practice team different levels of access to patient health information:

- document who has what access
- make sure that practice team members understand why they must keep their software passwords private.

Business continuity plan

If your practice 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 practice's business continuity plan needs to include:

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

Replacing IT equipment

When IT equipment needs to be replaced or upgraded, refer to the current edition of the RACGP's *Computer and information security standards* to make sure that you do not inadvertently lose or transfer key information. Just deleting records does not clear data from a computer system, as people may still be able to recover deleted files.

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

If you are considering destroying clinical records for patients who are no longer patients of the practice, have not been seen for many years or who have outdated results in their records, consult with your medical defence organisation to understand particular state and territory legal requirements, or other risk management considerations.

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

Practices also need to consider processes for the disposal of computer hard drives and other storage media.

Email and social media policies

If your practice uses email and social media, you must have policies for their use. The practice team must be familiar with the policies, comply with the policies, and understand the risks associated with using email and social media. It is important that the policies are also made available to patients.

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

- maintaining passwords and keeping them secure
- processes to verify and update email addresses
- informing patients of possible risks to their privacy in the use of standard unencrypted email
- obtaining patient consent to communicate with them via email

Please refer to the RACGP's guide for the use of email for further information. If your practice does not use email, have a policy that states this.

Practitioners registered with the Australian Health Practitioner Regulation agency (AHPRA) are required to comply with their social medial policy.

The RACGP's guide for the use of social media in general practice contains guidance around safe and professional usage of social media within general practice. It also contains a social media policy template in compliance with AHPRA's social media policy that can be adapted to your practice.

Meeting each Indicator

C6.4► A

You must:

- **Maintain a privacy policy.**

You could:

- Maintain a patient health information management policy.

- Create a position description outlining the roles and responsibilities relating to computer security.

C6.4► B

You must:

- **Maintain a privacy policy.**

You could:

- Maintain a patient health information management policy.
- Have a physical layout that means patient health information is not in view of members of the public.
- Use password-protected screensavers.
- Use a shredder and/or have a secure document-shredding agreement with a reputable provider.
- Wipe all information off hard drives and photocopiers before disposing of them.

C6.4► C

You must:

- **Maintain the security of the clinical software passwords of each individual practice team member.**
- **Maintain a privacy policy.**

You must:

- Maintain an information technology policy.
- Ensure appropriate access is provided to each role, based on position descriptions.
- Maintain a logout register for laptops and mobile phones.
- Maintain secure passwords for portable devices.
- All devices have current anti-virus software.

C6.4► D

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.**

You could:

- Maintain a patient health information management policy.
- Undertake regular privacy training.
- Store back-ups offsite in a secure location.

- Maintain an emergency generator.

C6.4► E

You must:

- **Maintain a privacy policy.**

You could:

- Maintain a patient health information management policy.
- Maintain an information technology policy.
- Undertake regular privacy training

C6.4► F

You must:

- **Maintain an email policy.**

You could:

- Put your email policy on your website.
- Have an automated response when a patient emails the practice to advise when their email is likely to be responded to.

C6.4► G

You must:

- **Maintain a social media policy.**

You could:

- Put your social media policy on your website.

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, in paper or electronic form

Criterion C7.1 – Content of patient health records

Indicators

► A. Our practice has an individual patient health record for each patient containing all health information held by our practice.

► B. Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact information.

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

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

► E. Our practice routinely records the identification of Aboriginal and Torres Strait Islander status of our patients in their patient health record.

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

► G. Our patient health records contain, for each active patient, lifestyle risk factors.

Why this is important

Consultation notes and patient health records are a way of managing risks. Medical defence organisations have identified that failure to follow up problems and issues that patients have previously raised pose a considerable risk to practices and practitioners.

Meeting this Criterion

System to store patient health information

Practices need to have an effective system to store patient's 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 (so that files do not become incompatible). This will help protect against the possibility of superseded versions of medical software not being able to run properly on more modern hardware and operating systems. You may need to consider retaining older hardware and operating systems so that you can store and retrieve older records.

Collecting information from patients

Practices can collect information from a new patient using a generic form, on paper or electronically, or by privately interviewing patients before the first consultation.

You must have a system that ensures that patient information (including the contact details of their emergency contact) is updated regularly so that it remains accurate.

Practices need a patient identification process to ensure that the right patient is matched to the right record and is therefore receiving the right treatment.

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 'M' - may select woman as her gender and 'F' as her sex on a form and not identify themselves as transgender. Similarly, intersex people may select male or female as their sex rather than nominating themselves as intersex.

You practice could do the following to improve the accuracy of responses when collecting information from LBGTQIA patients:

- use anonymous collection methods
- clearly articulate how answers will be utilised and why they are being asked
- have the ability to select more than a single option and provide more than one response
- ask questions that distinguish between identity and descriptors of behaviour/ attraction/ experience.

Content of patient health records

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

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

Consultation notes must contain the following information:

- date of consultation
- who conducted the consultation (e.g. by initial in the notes, or by audit trail in an electronic record)
- method of communication (e.g. face-to-face, email, telephone or other electronic means)
- patient's reason for consultation
- relevant clinical findings
- diagnosis (if appropriate)
- recommended management plan and, where appropriate, expected process of review
- any medicines prescribed for the patient (include the name, strength, directions for use, dose frequency, number of repeats and date on which the patient started/ceased/changed the medication)
- the presence of a third party brought in by the practice (e.g. medical student).

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 in order to enable continuous improvement of clinical care and patient outcomes.

Other information that may be included in the patient health record:

- any referrals to other healthcare providers or health services
- emails sent to and by the patient.
- medicines the patient takes that were not prescribed or advised within the practice
- complementary and over-the-counter medicines
    - Because many people now take that may react adversely with conventional medicines, you could document the use of complementary medicines (whether prescribed by a member of the clinical team or self-reported by the patient) as you would other medicines.
- any relevant preventive care information collected, such as currency of immunisations, blood pressure, waist measurement, height and weight (body mass index)
- any relevant lifestyle risk factors such as smoking, nutrition, alcohol, physical activity and recreational drug use
- allergies
- immunisations
- an Advance Care Plan
- any special advice or other instructions given to the patient.

Collecting information over time

Because information about a patient is gathered over more than one consultation, it is important that information about 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 your ability to provide care that is tailored to the patient's needs and circumstances.

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

Practices are encouraged to identify and record the Aboriginal and Torres Strait Islander status and cultural background of all patients, as this information can be an important indication of clinical risk factors and can help practitioners to provide relevant care.

Practices must ask all patients the following question, regardless of the patient's appearance, country of birth, or whether the practice team know of the patient or their family background:

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

Be mindful that some patients may indicate that they do not wish to answer the question. In this case the response would be 'Not stated / inadequately described'. A missing response on a returned form should be followed up immediately and should not be automatically regarded as a refusal to respond.

All patients have the right to respond to this question as they see fit. The patient's response should be received without question or comment, and the response should be recorded without any amendments or annotations[30].

Before asking this question, or any questions relating to a patient's cultural background, explain that knowing such information helps the practice provide appropriate healthcare.

Collecting this information before a consultation, such as from a new patient form assists you to provide the most appropriate care.

Depending on where patients were born, where they grew up or where their parents are from, some patients may be at higher risk of certain health conditions. Information relating to the patient's ethnicity, country of birth, and language spoken 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 patient care.

Retaining health records of active and inactive patients

Your practice must keep and securely store and dispose of health records of active and inactive patients in accordance with legal obligations imposed by the Privacy Act 1988 and the APPs. An inactive patient is generally defined as a patient who has not attended the practice/service more than twice in the past two years.

It is recommended that you retain inactive patient health records as required by relevant national, state or territory legislation. You may want to consult your medical defence organisation when deciding on the practice's policy on the retention of records of inactive patients.

Lifestyle risk factors

Lifestyle risk factors such as smoking, nutrition, alcohol and physical activity are associated with many diseases. Record these risk factors in the patient health record and review managements plans at defined intervals.

Routinely record patients' 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 to assess children's growth and development. The practitioner must know which health checks need to occur at what intervals, in accordance with best practice[31].

Meeting each Indicator

C7.1► A

You must:

- **Maintain individual health records for each patient that include all required information.**
- **Maintain a privacy policy**.

You could:

- Maintain a patient health information management policy.
- Ensure handwritten records are legible.
- Ensure new patient forms ask for all required information
- During inductions, cover policies and processes relating to patient health records.

C7.1► B

You could:

- **Maintain a privacy policy.**
- **Ensure patient health records show the patient's preferred emergency contact (who may or may not be the patient's next of kin).**

You could:

- Maintain a patient health information management policy.
- Ensure new patient forms ask for all required information.

C7.1► C

You must:

- **Maintain a privacy policy.**
- **Include a copy of email correspondence with the patient in their patient health record.**

You could:

- Maintain a patient health information management policy.
- Ensure documents scanned into electronic health records are clear and can be easily read.

C7.1► D

You must:

- **Maintain a privacy policy**.

You could:

- Maintain a patient health information management policy.
- Use flags for follow-up in the consultation notes.

C7.1► E

You must:

- **Maintain a privacy policy**.
- **Ensure patient health records show identification of Aboriginal and/or Torres Strait Islander status.**

You could:

- Maintain a patient health information management policy.

C7.1 F

You could:

- Maintain a patient health information management policy.
- 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 new patient forms, and enter this information into your clinical software system (in a specific field or in general notes).

C7.1► G

You must:

- **Maintain a privacy policy.**
- **In the patient health record, document information such as height, weight, blood pressure, etc.**

You could:

- Maintain a patient health information management policy.

Standard 8: Education and training of the practice team

Our practice team is appropriately qualified and trained to perform their role.

This Standard focuses on the systems that the practice uses to ensure that members of the practice team receive continuing education and training that is appropriate for their role.

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

Indicators

► A. Our non-clinical staff undertake training appropriate to their role and our patient population.

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

Why this is important

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

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

Meeting this Criterion

Training relevant to the role

Training may cover areas such as:

- practice procedure
- use of technology (hardware, systems, and software)
- first aid
- medical terminology
- medical practice reception
- Aboriginal and Torres Strait Islander health
- Aboriginal and Torres Strait Islander cultural awareness
- cross-cultural safety
- Communication with patients with special needs
- safe operation of specific equipment.

Practitioners or other members of the practice team can deliver in-house or ‘on the job’ training in practice-specific areas, such as:

- using the patient health records system
- making appointments
- recognising medical emergencies when patients present in reception
- confidentiality requirements
- familiarisation with the practice’s policies and procedures.

Cardiopulmonary resuscitation training

Because administrative staff may be present during a medical emergency, they could be trained in CPR so that they can help the clinical team.

CPR training for 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 ARC guidelines on instructor competencies.

CPR training that is completed solely on-line does not meet the ARC requirement that trainees physically demonstrate their skills at the completion of the CPR course.

Meeting each Indicator

C8.1► A

You must:

- **Provide access to relevant training for non-clinical staff.**

You could:

- Record qualifications in employment files.
- Specify required practice team qualifications in job descriptions.
- Keep training logs that record training that non-clinical team members have completed.
- Keep a training and development calendar.
- Conduct annual performance planning and store documents that identify training needs and training completed.

C8.1► B

You must:

- **Provide evidence that non-clinical staff complete CPR training every three years.**

You could:

- Keep training logs that record training that non-clinical team members have completed.
- Keep a training and development calendar.
- Conduct annual performance planning and store documents that identify training needs and training completed.

Module 2: Quality Improvement module

Standard 1: Quality improvement 93
Standard 2: Clinical indicators 93
Standard 3: Clinical risk management 93
References 93

Standard 1: Quality improvement

Our practice undertakes quality improvement activities to support the quality of care provided to our patients.

The Standards encourage quality improvement and enable practices to identify opportunities to make changes that will improve patient safety and care.

Quality improvement can be achieved in a number of ways, one of which is the regular review of your practice's structures, systems, and clinical care.

Improvement needs to be based on the practice's own information and data that can be collected in a number of ways, including through patient and practice team feedback and audits of clinical data.

All members of the practice team need to have opportunities to contribute to the practice's quality improvement activities.

Criterion QI1.1 – Quality improvement activities

Indicators

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

► B. Our practice team internally shares information about quality improvement and patient safety.

► C. Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

► D. Our practice team can describe areas of our practice that we have improved in the past three years.

Why this is important?

Making quality improvements to the practice's structures, systems and clinical care that are based on the practice's information and data, leads to improvements in patient safety and care.

If your practice team are engaged with the practice's safety and quality systems, this will help the practice to implement its quality improvement activities.

Meeting this Criterion

Roles and responsibilities

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

Engaging the practice team

Quality improvement can relate to many areas of a practice, so the collaborative effort of the entire practice team is necessary if improvements in quality and safety of patient care are to be achieved. You could improve engagement by establishing a quality improvement team made up of members from all parts of the practice team, such as doctors, nurses, administrative staff, etc.

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

Some ways that practices can determine engagement and seek feedback from the practice team on quality improvement initiatives and performance include:

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

Quality improvement activities

Improvement in general practice can involve examining practice structures, systems and clinical care. Relevant patient and practice data can help you determine where quality improvements can be made (e.g. to patient access, to management of chronic disease, to preventive health).

Quality improvement activities can include:

- changes to the day-to-day operations of the practice, such as changes to:
    - scheduling of appointments
    - normal opening hours
    - record-keeping practices
    - how patient complaints are handled
    - systems and processes
- a response to feedback or complaints from patients, carers or other relevant parties
- a response to feedback from members of the practice team
- an audit of clinical databases
- an analysis of near misses and errors.

Maintain a quality improvement plan and a register of quality improvement activities undertaken

Your practice could maintain a quality improvement plan and a register of quality improvement activities. This would show what quality improvement activities have been undertaken and the activity outcomes.

A quality improvement plan and register would enable:

- tracking of quality improvement efforts
- demonstration of whether improvements were made or whether other efforts are required to address the quality issue
- reduce duplication of effort and time
- provision of a learning tool for members of the practice team contemplating undertaking improvement activities.

Meeting each Indicator

QI1.1► A

You must:

- **Demonstrate that the team member with primary responsibility for quality improvement activities in the practice can describe their role.**

You could:

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

QI1.1► B

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 practice team.
- Keep a record of planning meetings where quality improvement activities are discussed.

QI1.1 ► C

You must:

- **Keep a record of feedback received from the practice team about quality improvement systems.**

You could:

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

QI1.1► D

You must:

- **Demonstrate quality improvements made to the practice or practice systems, in response to feedback, complaints, or audits.**

You could:

- 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

► A. Our practice seeks feedback from patients, carers and other relevant parties in accordance with the RACGP's *Patient Feedback Guide*.

► B. Our practice can demonstrate how we have analysed and responded to feedback and considered feedback for quality improvement.

► C. Our practice promotes how we have responded to feedback and used feedback for quality improvements.

Why this is important

Collecting and responding to feedback about patient 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[32].

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

Meeting this Criterion

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

Collecting feedback

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

- What kind of information you are seeking: broad or 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 language spoken at home.

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

- a questionnaire developed by a commercial company that is approved by the RACGP
- a questionnaire developed in accordance with the RACGP's *Patient Feedback Guide*
- a focus group developed in accordance with RACGP's *Patient Feedback Guide*
- interviews developed in accordance with RACGP's *Patient Feedback Guide*
- a specific method that your practice decides on that meets the requirements of the RACGP's *Patient Feedback Guide* and is approved by the RACGP.

The RACGP's Patient Feedback Guide provides more detail on how to collect feedback from your patients. This is available at http://www.racgp.org.au/your-practice/standards/resources/patient-feedback/

Collecting feedback all at once

You could choose to collect feedback from patients about their experience of accessing health care at your practice once in the three-year cycle.

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

You could choose to seek feedback from patients on an ongoing basis over a 3-year period instead of conducting an all at once process.

For example, you could:

- have short questionnaires focusing on specific areas of interest (e.g. a new service, a change to the waiting areas). These questionnaires could be completed on paper, via electronic tablets available at the practice, through a link on the website or on-line using a tool.
- send an SMS to patients asking for feedback on a specific area of interest (patients have consented to receiving SMSs from your practice)
- hold patient forums and information days
- have an electronic tablet at the practice door so patients could quickly rate an aspect of their visit to your practice (e.g. give it a score out of 5).

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

The RACGP's *Patient Feedback Guide* provides more detail on how to go about collecting ongoing feedback from your patients.

Collecting feedback from carers and other relevant parties

Your practice needs to get feedback from carers and other relevant parties. To do this, you could offer carers and other relevant parties feedback forms or a suggestion box at reception. Where possible patients, carers and other relevant parties should be encouraged to raise any concerns with the practice team directly. In response, your practice needs to attempt to resolve these concerns within the practice.

Using feedback

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

Some of the suggestions made by patients will not be practical or feasible for your practice. It is up to the individual practice to decide what feedback will be used and to prioritise activities based on the feedback.

After collecting and analysing patient feedback, reflect on the results, identify key issues and decide on a quality improvement plan. You could do this by:

- convening a team meeting dedicated to this activity
- seeking team members' opinions on the priority of the patient feedback activities to be addressed
- sending each team member a summary of the feedback and asking them for their thoughts on what quality improvement activities could be implemented
- considering which feedback matches the practice's strategic planning process.

Because patients value knowing that their feedback has been respectfully considered and implemented where possible, inform patients of the quality improvement activities that you will implement. For example, you could display posters in the waiting area, include relevant information on the practice's website and in your newsletter, and send letters to patients. If you have received a lot of feedback on something that is not feasible, (e.g. putting a coffee maker in the waiting room), then you could tell patients why this suggestion is not viable for your practice.

Meeting each Indicator

QI1.2► A

You must:

- **Provide evidence that you have sought feedback from your patients in line with the requirements of the RACGP's *Patient Feedback Guide*.**

You could:

- Use the *RACGP Patient Feedback Guide* to develop your own patient feedback process.
- Use a commercially available survey that is approved by the RACGP.
- Create a short survey using an online package.
- Conduct face-to-face patient feedback sessions, such as focus groups or interviews.
- Seek feedback from patients about specific areas of the practice.

QI1.2► B

You must:

- **Provide evidence that you address and discuss issues raised by patients and have made improvements in response to their feedback.**

You could:

- Discuss patient feedback responses at team meetings.

- Create specific action plans to address issues raised.
- Share results and outcome reports on issues addressed with the practice team.
- Incorporate improvements into relevant policies and procedures.
- Have feedback forms and a suggestion box in reception.

QI1.2► C

You must:

- **Provide evidence that you have responded to feedback received.**

You could:

- Communicate how you have responded to patient feedback on the practice's website, creating newsletters and displaying posters in waiting rooms.

Criterion QI1.3 – Improving clinical care

Indicators

A. Our practice team uses a nationally recognised medical vocabulary for coding.

► B. Our practice uses relevant patient and practice data to make improvement to clinical practice (e.g. chronic disease management, preventive health).

Why this is important

Using a nationally recognised medical vocabulary helps practices 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 as part of quality improvement activities such as: practice audits; Plan, Do, Study, Act (PDSA) cycles; and processes to identify patients with particular medical conditions (e.g. registers for chronic diseases such as diabetes).

Meeting this Criterion

Standardised clinical terminology

Using a nationally recognised medical vocabulary means key details of a consultation are recorded in a standardised way. These details can include why a patient attends the practice, the problems managed during a consultation, referrals and investigations requested. Relevant data can then be retrieved for auditing, quality improvement, and continuity of care.

Using a nationally recognised medical vocabulary enables more reliable data extraction and analysis of your practice's data and avoids the ambiguity caused by free text descriptions in a patient's health record.

Nationally recognised medical vocabularies, such as The 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 general practice clinical software systems in Australia use a recognised medical vocabulary (for example DOCLE, PYEFINCH, SNOMED-CT, ICPC and ICPC2+).

Not all software systems use a recognised medical vocabulary, so if yours is one of these, you could consider using another method to include a recognised medical vocabulary in your patient health records.

You do not necessarily need to re-code existing information previously recorded as free text, particularly if there are important details in a patient's medical history that are difficult to formally code, but it might be a useful addition to a past medical history.

You should develop a policy and process to implement a recognised medical vocabulary to ensure consistency for newly created records and when updating records.

Quality improvement to improve clinical practice

Quality improvement is an essential part of routine care. It is important that the Standards encourage quality improvement and identify opportunities to make 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 practice population, such as changes to:

- rates of immunisation
- how the practice cares for patients with diabetes or hypertension
- the systems used to identify risk factors for illnesses that are particularly prevalent in the practice's local community (such as cardiovascular disease)
- antibiotic prescribing as an activity specifically designed to improve clinical care or the health of the entire practice population.

Improving clinical practice through clinical audit

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. A clinical audit has two main components:

- an evaluation of the care that a practice and the individual practitioners within it provides
- a quality improvement process.

Research indicates that 'audit and feedback is widely used as a strategy to improve professional practice, either on its own or as a component of multifaceted quality improvement interventions', and that 'audit and feedback generally leads to small but potentially important improvements in professional practice'. [33]

Improving clinical practice through Plan, Do, Study, Act (PDSA) cycles

You could also choose to complete a PDSA cycle to improve your clinical practice. PDSA cycles encourage the individual practitioner or the practice 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, based on existing ideas and research, or implement practical ideas that have been proven to work elsewhere.

It is a cyclical model because the benefit you planned for is not always achieved after one PDSA cycle. Therefore, the initial PDSA can be refined and the cycle repeated in an effort 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 and PDSA cycles is available in the RACGP's *QI&CPD Handbook*

Other sources of information

To improve the targeting and use of your prevention activities (e.g. smoking cessation, weight management), 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.
- reviews and analysis of certain MBS claims data to identify gaps in the delivery of comprehensive primary healthcare to priority populations (eg Items 715 and/or 723);
- data reports that benchmark the practice to identify gaps, areas and opportunities for improvement to assist in health service planning. This can be done by participating in quality improvement programs that are provided by regional healthcare coordination organisations.

Meeting each Indicator

QI1.3 A

You could:

- Use patient management software to code patient health information.
- Keep clinical data and reports, including rates of childhood vaccinations, completed adult health checks, and updated risk factors.

QI1.3 ► B

You must:

- **Conduct a quality improvement activity such as a PDSA 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 practice team Participate in an audit of antibiotic prescribing.

Standard 2: Clinical indicators

Our practice records and uses patient data to support quality improvement activities.

Having accurate and up-to-date information about patients helps your practice provide safe, high-quality care, and ensure 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 enables best practice prescribing.

Criterion QI2.1 – Health summaries

Indicators

► A. Our active patient health records contain a record of known allergies.

► B. Our active patient health records have a 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 (e.g. smoking, nutrition, alcohol, physical activity)
- social history, including cultural background.

Why this is important

Maintaining clear and accurate patient health records is essential if your practice is to provide high quality care[34]. 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 for the patient.

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 whole-patient care
- highlight lifestyle problems and risk factors (e.g. smoking, alcohol, nutrition, physical activity status) that can help practitioners with health promotion
- 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 practices to work towards 100% of active records containing a current health summary including a record of known allergies. For the purposes of this Criterion, practices must demonstrate that:

- at least 90% of active patient health records contain a record of known allergies, and

- at least 75% of active patient health records contain a current health summary.

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 practice uses a hybrid health record system, you must record the patient's allergy status in the same system that 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 (e.g. urban, rural, remote), sexuality, and gender identity
- recent important events in a patient's life that could affect the patient's preferences, values, and the care they require. For example, changes in accommodation, family structure, and employment.

It is good practice to ask patients if they are taking any medicines not prescribed by the practice or having complementary therapies, and to record this information in the patient health record.

Meeting each Indicator

QI2.1► A

You must:

- **Show that active patient health records include records of known allergies.**

You could:

- Demonstrate that GPs ask patients about allergies at known data collection points.

QI2.1► B

You must:

- **Show that active patient health records include a current health summary.**

You could:

- Conduct a regular practice audit of patient health records.

Criterion QI2.2 – Safe and quality use of medicines

Indicators

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

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

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

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

► E. Our clinical team ensures that medicines, samples, and medical consumables are acquired, stored, administered, supplied, and disposed of in accordance with manufacturers' directions and legislative requirements.

Why this is important

Patients need to understand the rationale for taking medications and the benefits and risks associated with particular medicines so that 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.

Patients must not use medicines, samples, and 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 (CMI) leaflets can help patients to understand the purpose, options, benefits and risks of their medicines. It is particularly important that patients understand the difference between generic drugs and trade-named drugs so dosage problems are avoided. If a patient cannot read or the information is not available in the patient's language, using visual media or translators may be appropriate.

Patients' role in their own treatment

Providing patients with education not only improves their knowledge, it is associated with improved adherence to treatment plans. One of the most commonly recommended strategies to improve patients' adherence is to build the patient-practitioner relationship[35].

There are also on-line resources you could tell patients about, so that they can find out more about their medications and the purpose of their treatments. These include:

- http://www.nps.org.au/medicines

- www.betterhealth.vic.gov.au

Using and reviewing best practice treatment

Your practice should use guidelines for quality use of medicines. Some available resources include:

- The Australian Medicines handbook, in which the RACGP is a partner
- Therapeutic Guidelines (www.tg.org.au)
- DVA Mates (https://www.veteransmates.net.au/)

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 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 regime, and identify the need for any further education/support.

Practitioners also need to ask the patient about any medicines that were not prescribed or advised within the practice because of the potential for side effects and drug interactions.

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

When you change a patient's medication, it is good practice to provide the patient with a new medicines list, particularly when the patient is taking more than one medicine.

Storage of medicines

To ensure patients' safe use of medicines, vaccines and other healthcare products, store these products appropriately and securely, and do not use or distribute them after their expiry dates. You could appoint a designated person to have primary responsibility for the proper storage and security of medicines, vaccines, and other healthcare products.

Requirements relating to the acquisition, use, storage, and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation, and practices need to comply with these requirements.

Meeting each Indicator

QI2.2► A

You must:

- **Keep documentation regarding discussions of medicines and treatments in the patient health record.**

You could:

- Use videos, brochures, or posters to inform patients about medicines.

QI2.2► B

You must:

- **Include evidence that clinical team members have discussed patients roles in their own treatment.**

You could:

- Provide consumer medicine information to patients
- Provide patients with a written action plan

QI2.2► C

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 practice policies/protocols in areas such as antibiotics and drugs of dependence.

QI2.2► D

You must:

- **Keep a current medicines list and referral letters in patient health records.**

You could:

- Conduct regular audits of the patient health record to ensure that medicine lists are up to date and acute medications are marked as non-current

QI2.2► E

You must:

- **Show that medicines, samples, and medical consumables are acquired, stored, administered, supplied, and disposed of according to manufacturers' directions and legislative requirements.**

You could:

- Maintain an S8 medicines register.

Standard 3: Clinical risk management

Our practice 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[36]. Practices 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 which could have resulted, or did result, in unnecessary harm to a patient .[37] Both are valuable learning opportunities which carry insights into improving practice and preserving life and health.

While individual accountability and integrity should be preserved, blaming individual practitioners is not necessarily going to help you to identify problems in systems and processes. It's far more effective to be thoughtful and supportive.

Members of the practice team must know how to and whom to report a near miss or adverse event, or unanticipated patient outcome. Clinical governance is a management and organisational framework for clinical quality improvement [38] through which organisations are responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish [13, 39]. All members of the practice team, no matter how junior, should feel empowered to recognise and report patient safety incidents without fear of recrimination, so that the practice can take necessary action to reduce or eliminate the possibility of a similar event occurring again.

Criterion QI3.1 – Managing clinical risks

Indicators

► A. Our practice monitors, identifies, and reports near misses and adverse events in clinical care.

► B. Our practice team makes improvements to our clinical risk management systems in order to prevent near misses and adverse events in clinical care.

Why this is important

Patient safety incidents in clinical care occur in all health settings. Incidents that cause harm are referred to as adverse events[40].

If the practice does not make improvements after identifying an incident that resulted in a near miss or adverse event, patients may be exposed to avoidable adverse events and the practice team may increase their risk of medico-legal action.

If practices use systems to recognise and analyse near misses and adverse events, they can identify, implement and test solutions to prevent their reoccurrence.

Meeting this Criterion

Most practitioners and practices already manage clinical risk on a daily basis. Many have informal and ad hoc methods aimed at preventing near misses and adverse events.

You can:

- establish a system so that practitioners talk to trusted peers or supervisors for advice
- use a more formal process that includes conducting practice discussions about 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 and reduce the likelihood of recurrence
- establish a system so that members of the practice team know how and who to report a near miss or unanticipated adverse event, and know that they can do so without fear of recrimination
- implement a clinical governance framework to help achieve a balance of 'find it, fix it, and confirm it' functions in relation to improving 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 delivered and patient health outcomes
    - Fix it: once the gaps in quality care have been identified, you can implement strategies to address the issue
    - Confirm it: measure the improvement using an effective evaluation process.
- Keep copies of the practice's risk or critical incident register.

Practices may want to have their medical defence organisation check and approve their process for recording and acting on near misses and adverse events.

Practitioners are increasingly referred to as 'second victims' of adverse events as they may feel that they have failed the patient[41]. This can lead to practitioners second-guessing their clinical judgement and knowledge. Practices could consider how they support practitioners after an adverse-event has occurred.

Meeting each Indicator

QI3.1► A

You must:

- **Implement and maintain an incident or event register.**

You could:

- Implement and maintain a clinical risk-management policy.
  Show that you conduct clinical audits and demonstrate changes to clinical care that have reduced risk.
- Keep a record of team and planning meetings where risks are discussed.

QI3.1► B

You must:

- **Record the actions taken in response to events recorded on the incident or event register.**

You could:

- Record revisions to policies and procedures that have been shown to reduce risk.

Criterion QI3.2 – Open disclosure

Indicator

A. Our practice follows an open disclosure process based on the Australian Open Disclosure Framework.

Why this is important

Open disclosure is defined 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. Information on the Open Disclosure Framework is available at www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework/ The Open Disclosure Framework for small practices (as opposed to hospitals) is available at www.safetyandquality.gov.au/publications/implementing-the-australian-open-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 patient can:

- move on
- have better relationships with clinicians
- be more involved in their care.

Meeting this Criterion

Your practice must follow an open disclosure process following an incident that causes harm to your patient/s. Open disclosure includes:

- acknowledgement to the patient that something has gone wrong, either in response to their enquiry or initiated by the practice
- an apology or expression of regret (including the word "sorry")
- a factual explanation of what happened
- an opportunity for the patient to relate their experience
- an explanation of the steps being taken to manage the event and prevent recurrence.

Open disclosure is a discussion and an exchange of information that may take place over several meetings. Practices should listen to what the patient says in response to the open disclosure made by

the practice and as a result demonstrate that the practice has leant from the incident. This information could be linked to the practice's 'near miss register'. Practices could get advice from medical defence organisation//insurers on what kind of documentation they would require for risk management initiatives.

Disclosure to the patient following an incident that caused harm to the patient is beneficial to the patient and the practice. 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 because of the incident. Contact your medical defence organisation for further guidance and advice about when you may need to participate in open disclosure.

Meeting each Indicator

QI3.2 A

You could:

- Maintain an open disclosure process and encourage all members of the practice team follow the process
- Ensure policies and guidelines that align with the Australian Open Disclosure Framework are developed and implemented.
- Keep a record of any discussions and apologies.
- Implement any quality improvement initiatives, such as the development of a new brochure to provide patients more information on a particular issue.
- Link any open disclosure incidents to the "adverse events and near miss" register.
- Practitioners are aware of the Open Disclosure Framework for small practices and understand when they might need to undertake open disclosure.
- Open disclosure is discussed at practice team meetings.
- Open disclosure is discussed during induction.
- Relevant practice team members can provide a verbal account of the open disclosure process they undertook in response to an incident

Module 3: After-Hours Services module

Module 3: After-Hours Services module 117
Standard 1: Providing patient care in the after-hours period 118
Criterion AHS1.1 – Arrangements with practices 119
Criterion AHS1.2 – Responsive system for patient care 122
Criterion AHS1.3 – Safety of the service team 125
Criterion AHS1.4 – Home and other visits 127
Criterion AHS1.5 – Continuity of care 130
Criterion AHS1.6 – Follow up systems 132
Criterion AHS1.7 – Engaging with other services 136
Standard 2: Qualifications of our clinical team 140
Criterion AHS2.1 – Qualifications, education and training of healthcare practitioners 141
Standard 3: The after-hours service facilities 146
Criterion AHS3.1 – Service facilities 147
Criterion AHS3.2 – Service Equipment 152
Criterion AHS3.3 – Doctor’s Bag 157
Standard 4: Reducing the risk of infection 160
Criterion AHS4.1 – Infection prevention and control, including sterilisation 161

Standard 1: Providing patient care in the after-hours period

Our service provides patient care in the after-hours period.

After-hours services provide patient care when practices are not providing patient services. After-hours services provide patients access to medical care for conditions that are not life threatening, but require urgent medical attention in the after-hours period. These conditions may include, for example:

- respiratory infections
- migraines
- gastroenteritis
- ear infections
- urinary tract infections
- injuries from falls.

After-hours services do not undertake routine care. These services are provided during normal opening hours by the patient's usual GP or practice. Therefore, after-hours services should not provide the following services:

- prescription repeats
- medication reviews
- routine immunisations
- referrals
- health checks
- management of chronic and complex conditions.

This Standard includes Criterion that relate to:

- Providing care in the after-hours service period, covering:
  - scheduling of after-hours care
  - the triage of patients so that the most appropriate care is provided
  - conducting home and other visits and care in the after-hours period.
- the coordination of care outside of the service
- the system the service has for recalls and reminders.

Criterion AHS1.1 – Arrangements with practices

Indicators

► A. Our service has formal arrangement(s) in place to provide after-hours services to patients on behalf of the nominated practice(s).

► B. Our service obtains feedback from practices for which we provide after-hours services and uses practice feedback for quality improvement activities.

►C. Our service collects details of the patient's usual practice/GP.

► D. Our service provides timely reporting of the care provided to a patient back to their usual practice/GP.

Why this is important

Formal arrangements between after-hours services and practices aim to strengthen the networks between daytime practices and after-hours services in local areas, so that patients can access care over the 24-hour period.

When an after-hours service is affiliated with a general practice through a formal agreement, the service can maintain continuity of care for that patient. However, formal arrangements should not restrict after-hours services from providing care to any patients requiring urgent care in the after-hours period.

When your service collects the details of the patient's usual GP, your service is required to send a timely report detailing the care provided, back to the patient's usual GP.

Meeting this Criterion

Formal arrangements between after-hours services and practices

Formal arrangements between after-hours services and practices could outline methods for communication between the services, geographical area of operation, times of operation and information required from each party to provide patient care.

At a minimum, any formal arrangement must detail how the after-hours service will:

- remind all patients that after-hours services are a supplementary service and that it is important that the patient has their own GP for ongoing and comprehensive care
- send a summary detailing the clinical management of the patient to the patient's regular GP by the next business morning (with the patient's consent and preferably via secure message delivery).

Feedback from practices

Your service needs to obtain feedback from practices that you have arrangements with. It is important that you understand how satisfied practices and their patients are with your service. This information can be used to inform your service operations and continuous quality improvement initiatives. For example, you could gather feedback from the practice on the quality and timeliness of the care you provide to their patients and respond to this feedback as appropriate.

Details of the patient's usual GP

Your service must collect the details of the patient's usual practice/GP. This will enable timely reporting of the care provided to the patient's usual GP. In circumstances where your service is aware of patients who do not have a usual practice/GP and are using the service for routine care, your service needs to tell the patient that your service does not provide routine care. Instead, you could provide the patient with information regarding the benefits of having a usual GP/practice and provide the patient with a list of practices in their area.

Communication with the patient's usual GP

Your service needs to demonstrate that you provide timely reporting of the care provided back to the patient's nominated GP. This report must be provided to the patient's regular GP the following morning and include all necessary information relating to the consultation, for example, the medical condition, treatment provided and medications prescribed.

Meeting each Indicator

AHS1.1 ► A. Our service has formal arrangement(s) in place to provide after-hours services to patients on behalf of the nominated practice(s).

You must:

- **Maintain formal arrangements with all the practices you provide after-hours services for.**

You could:

- Demonstrate the communication methods you use with the practices you provide after-hours services for.

AHS1.1 ► B. Our service obtains feedback from practices for which we provide after-hours services and uses practice feedback for quality improvement activities.

You must:

- **Demonstrate established methods to obtain feedback from the practices your service provides after-hours services for.**

- **Keep records that show you considered and discussed issues raised by practices and have made improvements in response to their feedback.**

You could:

- Demonstrate how feedback has been analysed, responded to and considered for quality improvement.

AHS1.1 ► C. Our service collects details of the patient's usual practice/GP.

You must:

- **Include the details of the patient's usual practice/GP in the patient's health record.**

You could:

- Provide patients with information regarding the benefits of having a usual GP/practice.

AHS1.1 ► D. Our service provides timely reporting of the care provided to a patient back to their usual practice/GP.

You must:

- **Establish processes to send the patient's nominated practice/GP a report of the care provided by the next morning.**

You could:

- Maintain a list of contact details of the practices that you provide after-hours services for.

Criterion AHS1.2 – Responsive system for patient care

Indicators

► A. Our service has the flexibility to provide longer consultations, if required.

► B. Our service has a triage system.

► C. Our recorded phone message advises patients to call 000 in case of an emergency.

Why this is important

After-hours services are designed to treat acute, episodic illnesses and injuries that require urgent medical attention, but are not life threatening. To accommodate the needs of patients in the after-hours period, it is important that your service provide different consultation types. However, patients who attempt to use your service for non-urgent conditions or routine care must be told to attend their usual practice during normal opening hours, instead of using an after-hours service.

The service needs to be able to identify the patient's needs and provide care accordingly so that patients receive appropriate and timely care. To identify the patient's needs, triaging needs to be performed by suitably qualified staff such as GPs or nurses using appropriate protocols.

When patients call the service in the case of an emergency, do not put the patient on hold, instead direct the patient to contact 000. In some cases, it might be necessary for your service to arrange an ambulance to attend the patient.

Meeting this Criterion

Consultations

It is important that patients are able to access care that is flexible and recognises different patient needs. Services therefore need to have the flexibility to provide longer consultations, if required.

In order to manage appointments, your service needs to maintain an appointment system (paper or electronic) in which you can arrange and record appointments.

Triage

Services need to have triage protocols to follow when patients contact the after-hours service. The staff triaging calls must be able to determine the needs of the patient, and schedule an appropriate consultation accordingly. To appropriately triage patients, services must employ GPs and nurses or professionals with suitable training. Appropriate triaging of patients is essential to identify patients attempting to use after-hours services for routine care.

For non-urgent issues or requests for appointment, the after-hours service needs to advise the patient to call their usual GP during normal business hours.

Managing cross infection through triage

Some patients will have contagious illnesses, and your service needs to reduce the risks of the service team and other patients becoming infected. Staff need to be familiar with the service's infection control procedures, including the use of standard and special precautions, spills management and environmental cleaning.

Effective telephone triage can identify the risk of infection before patients use the service.

Use transmission-based precautions for a patient known or suspected to be infected with a highly transmissible infection such as influenza. You can minimise exposure to other patients and staff by:

- implementing effective triage and appointment scheduling
- using Personal Protective Equipment (PPE) such as masks
- implementing distancing techniques
- spacing patients in the waiting room at least one metre apart
- isolating the infected patient in a separate room
- strictly adhering to hand hygiene
- conducting a home visit.

Technology-based consultations

Services may consider delivering technology-based patient consultations (eg via telephone and internet-based video services such as Skype) in place of face-to-face consultations.
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 address)
- advise the patient of the security risks associated with technology-based consultations.

Technology based consultations are not a substitute for home or other visits and are only to be provided as an option for patients when it is not safe or reasonable for your service to provide a home or other visit.

The Medical Board of Australia's Guidelines: Technology-based patient consultations [42] provides further information that you must be aware of. You may also wish to obtain advice from your medical defence organisation regarding the suitability of providing advice by telephone or electronic means.

Meeting each Indicator

AHS1.2► A Our service has the flexibility to provide longer consultations, if required.

You must:

- **Demonstrate that the service provides different consultation types to accommodate patient needs.**

You could:

- Keep an appointment system (paper or electronic) showing a variety of appointment types including:
  - long appointments
  - short appointments
  - urgent appointments
  - home and other visits.
- Display a sign in the patient waiting area and/or on the service website explaining short, standard and long appointments, urgent, home and other visits.
- Demonstrate that your service offers patients technology-based consultations, where appropriate.

AHS1.2► B Our service has a triage system.

You must:

- **Demonstrate there is a triage system.**
- **Demonstrate that triage staff have appropriate qualifications and training.**

You could:

- Provide evidence that triage guidelines are available at reception and/or on the service website.
- Have a triage flowchart available for reception and clinical staff.
- Display a sign in the waiting area and/or on the service website to advise patients with high-risk or condition deteriorating symptoms to let reception staff know.
- Establish a system to advise patients of the approximate wait for medical treatment.

AHS1.2► C Our recorded phone message advises patients to call 000 in case of an emergency.

You must:

- **Have a recorded phone message (which may be an introductory message or 'on hold' message) that advises patients to call 000 if they have an emergency.**

You could:

- Train reception staff in triage and how to respond to an emergency.

Criterion AHS1.3 – Safety of the service team

Indicators

►A. Our service provides a safe environment for all team members in the after-hours period.

Stakeholder question: Can you identify any other safety considerations (unique to providing care in the after-hours period) that should be included under this Criterion?

Why this is important

It has been reported that GPs consider after-hours work to be more dangerous when compared to working in usual business hours [43]. GPs are more likely to experience violence if they work in an after-hours cooperative clinic or conduct home visits in the after-hours period [43].

Service staff are particularly vulnerable in the after-hours period. Team members working in the after-hours period are generally more isolated due to decreased staffing levels and attending home visits alone. As a result, your service team face unique safety risks when providing care in the after-hours period, particularly staff providing home and other visits.

It is important that your service mitigates these safety risks by making sure that your service has systems in place to ensure the safety and security of your staff.

Meeting this Criterion

Safe working environment

Your service needs to maintain a safe work environment for your service team to work in. To do this, your service needs to meet requirements under *Criterion C3.4 – Work health and safety responsibilities* in the Core module. Services need to adhere to relevant state/territory and federal work health and safety (WH&S) and occupational health & safety legislation. It is important that your service considers the additional and unique risks faced by your service staff when providing a safe working environment for your service team.

To ensure the safety and security of your staff, your service needs to develop strategies to reduce any risks to the safety of your practice team.

Reducing risk to service staff

All members of the service team need to understand the risks associated with undertaking home and other visits. The RACGP resource '*General practice – A safe place'* outlines strategies that can be used to mitigate safety risks to you staff [44]. For example, your service could undertake the following precautions:

- Ensure all staff are routinely offered the use of an appropriate escort person for home visits.
- Keep a database of all patients who have special management instructions and divert all patients who are flagged to receive alternative after-hours care.

- Flag patient files to ensure staff are warned if they are likely to be unwelcome at the home, or if the patient (or their family) has a known history of violence.
- Keep a record of the registration numbers, makes, models and colour of each staff member's car.
- Provide personal duress alarms to staff.
- Ensure procedures are in place and followed if staff cannot be contacted or do not return/check in as expected.

Meeting each Indicator

AHS1.3►A Our service provides a safe environment for all team members in the after-hours period.

You must:

- **Develop risk mitigation strategies for service staff working in the after-hours period.**

You could:

- Include safety procedures in the staff induction program.
- Educate staff on self-defence (physical and non-physical).
- Demonstrate policy and procedures for staff working in the after-hours period.
- Encourage staff to participate in identifying ways to improve the safety of your services.

Criterion AHS1.4 – Home and other visits

Indicators

► A. Patients can access home and other visits, when safe and reasonable.

Why this is important

Patients need to be able to access care as required, even when they are not able to physically attend an after-hours service.

Some after-hours services only provide home or other visits, and do not have a physical practice that patients can attend. Services that only provide visit based care are not designed to be used by patients for convenience. Your service must only be used in the following circumstances:

- when a patient's usual GP or practice is not available
- the patient has an urgent health concern that cannot be delayed until the next day.

After-hours services can often perform home and other visits on behalf of a general practice. It is important that these visits are not seen as an alternative to the care provided by the patient's normal GP.

Meeting this Criterion

Who can perform home or other visits?

Only a member of the clinical team can provide home and other visits. In some situations, a GP is required and in other situations, another member of the team, such as a nurse is able to perform the required duties. At times, it is appropriate for other health professionals, such as nurses or Aboriginal health workers, to attend home visits under the supervision of a suitably qualified doctor, or by themselves as part of a GP led team.

Process for home and other visits

Home and other visits can be offered when:

- the patient is confined due to illness or disability
- urgent treatment can be given more quickly by visiting
- the risk of infection is minimised if the patient is seen at home or in another setting.

To determine the circumstances under which a home and other visit is offered, your service could have policies that specify:

- factors that the service considers home and other visits safe and reasonable
- geographical limits for home and other visits
- personal circumstances and health concerns that necessitate a home visit
- the support available from the service to practitioners providing home and other visits

- possible alternative arrangements if a home or other visit is not available.

It is important that all members of the service team understand the conditions under which a home or other visit is deemed appropriate based on the service's policy.

Defining 'safe and reasonable' in the local context

Your service needs to decide what is 'safe and reasonable' in your local context and considering your service's location and patient population. 'Reasonable' covers when it is clinically appropriate to conduct a home visit as well as when the circumstances mean that it is considered reasonable that a home visit takes place rather than the patient attending a physical after-hours service. One measure is to consider what your peers (particularly those in the same area) would agree is safe and reasonable.

Access to alternative sources of care

In a situation where a home or other visit is neither safe nor reasonable and a patient cannot attend a physical after-hours service, you need to be able to describe an alternative system of care that these patients can access. Depending of the severity and urgency of the patient's condition, you could suggest that the patient attend an emergency department, call an ambulance or access a GP telephone advice line.

Other options include forming an arrangement with an accredited home visiting service or conducting a technology-based consultation. Your service needs to decide whether to offer video or telephone consultations as an alternative to face-to-face consultations by considering:

- patient and service team safety
- patient clinical needs
- clinical effectiveness
- patient preference
- location of the service
- availability of technology-based facilities
- the conditions of your professional indemnity insurance.

Meeting each Indicator

AHS1.4► A Patients can access home and other visits, when safe and reasonable.

You must:

- **Demonstrate how your service provides home and other visits to patients, when safe and reasonable.**

You could:

- Maintain a policy on circumstances when home visits are deemed safe and reasonable.

- Demonstrate that all members of the service team understand the conditions under which a home or other visit is deemed appropriate based on the service's policy.
- Keep records showing entries of when team members have provided home and other visits and the time they occurred.
- Maintain records of Medicare billings showing home and other visits that have occurred.
- Demonstrate that patients are advised of how they can access care when home visits are not considered safe or reasonable.

Criterion AHS1.5 – Continuity of care

Indicator

► A. Our service encourages continuity of care with the patient's usual GP.

►B. Our service facilitates the transfer of care of a patient when it is not appropriate for a patient to use the service.

Stakeholder question: Are there any other situations where your service would need to transfer a patient's care?

Why this is important

Continuity of care is the degree to which a patient experiences a series of discrete healthcare events as coherent, connected and consistent with their medical needs and their 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.

It has been reported that continuity of care:

- supports the provision of quality patient care [16]
- reduces the use of emergency departments and preventable hospital admissions [45] [46]
- contributes to an overall lowering of costs, increased patient satisfaction, and greater efficiency [47].

Your service plays a key role in supporting continuity of care. To maintain a patient's continuity of care, it is important to establish strong methods of communication and information exchange between your service and the patient's usual practice.

You need to have a system to ensure the patient can still access care in the after-hours period, if you identify that it is not appropriate for a patient to use your service.

Meeting this Criterion

Continuity of care

To facilitate and optimise clinical handover of care back to the patient's regular GP, a consultation summary document detailing the clinical management of the patient must be forwarded to the patient's usual GP the following morning. The after-hours clinical team members could explain the importance of this process and seek permission from the patient to do this.

Issues of confidentiality must be considered when using any form of communication.

Your service must encourage and support patients to see their regular GP or practice for non-urgent and/or routine care, and only utilise an after-hours service when this is not possible.

Facilitating the transfer of care of a patient

There might be instances where you identify that it is not appropriate for a patient to use your service. For example, a patient may need their care transferred to the emergency department or a patient may have been identified as violent. If you identify that it is not appropriate for a patient to use your service then you need to have a system to transfer their care and ensure that the patient can still access care, where necessary.

Meeting each Indicator

AHS1.5► A Our service encourages continuity of care with the patient's usual GP.

You must:

- **Demonstrate methods of communication with the patient's regular GP.**

You could:

- Maintain a list of practices in the region, to assist patients to find a usual practice.

AHS1.5►B Our service facilitates the transfer of care of a patient when it is not appropriate for a patient to use the service.

You must:

- **Transfer the patient's care to another practitioner or service when it is not appropriate to provide patient care.**

You could:

- Maintain a policy about transferring a patient's care.
- Provide referrals to other healthcare providers.
- Educate the practice team on situations where a patient's care should be transferred.

Criterion AHS1.6 – Follow up systems

Indicators

► A. Pathology results, imaging reports, investigation reports and clinical correspondence initiated by our service are:

- reviewed
- electronically notated, or, if on paper, signed or initialled
- acted on where required
- incorporated into the patient health record
- forwarded to the patient's regular GP/ practice.

► B. Our service ensures clinically significant results are followed up within an appropriate time.

► C. Our patients are advised of the process for follow-up of tests and results.

► D. Our service alerts a patient's regular GP/ practice of clinically significant results.

Stakeholder question: Are there any situations where your service would need to recall a patient?

Why this is important

The urgent and episodic nature of after-hours care lends to the ordering of fewer investigations, when compared to day time general practice services. However, there will on occasion be patients who do require your service to order investigations.

The information gained from tests can affect the choices that a patient, the GP, and other clinicians make about the patient's care. Clinically significant results need to be followed-up quickly and appropriately so that action can be taken. This can reduce the likelihood of an adverse patient outcome.

After-hours services must follow-up patients with clinically significant results and alert the patient's usual GP/practice of these results, in addition to the usual information provided to the patient's usual GP.

Failure to follow-up with a patient may result in an adverse patient health outcome and the responsible practitioner may face medico-legal action.

Meeting this Criterion

Timely review and action on tests and results

When your service prepares a consultation summary for the patient's usual GP, you must include the details of any requests for further investigations you have made for the patient. When your service receives test results, you must forward a copy to the patient's usual GP.

Your service must have safeguards that ensure that potentially clinically significant information does not get 'lost in the system'. GPs working in after-hours services are obliged to ensure that all test results they receive are recorded and appropriately followed up with their patients[48]. This includes pathology and diagnostic test results ordered by a non-GP specialist or other health professional that are copied back to the GP/practice.

GPs need to review results and reports and take appropriate action in a timely manner. The speed with which results/reports are acted on will depend on the practitioner's judgment of the clinical significance of the result/report, and the context.

Clinical significance of results

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 likely seriousness of the harm
- the burden of taking steps to avoid the risk of harm.

The clinical significance of a test or result should be considered in the context of the patient's history and presenting problems. 'Clinically significant' does not necessarily mean only 'abnormal' results. Clinically significant is a judgement made by the GP that information is clinically important for a particular patient in the context of that patient's healthcare.

Following–up patients

You must have a process for following-up clinically significant results with patients. A follow-up occurs when a GP decides that a patient's clinically significant results need to be reviewed within a specified period.

Your follow-up process could be outlined in a written policy for staff to follow and could include:

- a definition of clinically significant results within context
- the process to follow to alert the patient's usual GP of the clinically significant results
- a statement that responsibility for reviewing and identifying results as clinically significant rests with the GP
- how the results of tests are followed up if after-hours doctors do not work regularly at your service
- guidelines that ensure that tests and results are reviewed and acted upon in a timely manner.

Your service can also choose to document your follow-up system, including who is responsible for monitoring and follow-up of patients with clinically significant results.

Your service staff induction must cover the follow-up system.

If your service uses a separate administrative or management system for billing and appointments and a clinical information system for patient healthcare details, make use of their functions that allow them to exchange follow up information where required.

If you need to initiate follow-up contact with a patient, do so in a reasonable manner (taking into account all circumstances to determine the number, frequency, and nature of the attempts to contact the patient). For example, you may decide to make up to three telephone calls at different times of the day and then attempt to contact the patient by mail or email. Document each attempt (also document any voicemails you leave) in the patient's health record.

Meeting each Indicator

AHS1.6► A Pathology results, imaging reports, investigation reports and clinical correspondence initiated by our service are:

- reviewed
- electronically notated, or, if on paper, signed or initialled
- acted on where required
- incorporated into the patient health record
- forwarded to the patient's regular GP/ practice.

You must:

- **Demonstrate your process for the review and management of test results.**
- **Demonstrate your process for forwarding results to the patient's regular GP/ practice.**

You could:

- Maintain a policy for review and management of results.
- Maintain a procedure for review and management of results.
- Document the patient's agreement that they are responsible for having the recommended tests performed and for obtaining the results.

AHS1.6► B Our service ensures clinically significant results are followed up within an appropriate time.

You must:

- **Record attempts to contact the patient regarding their clinically significant tests and results in patient health record.**

You could:

- Nominate a staff member who is responsible for the follow-up.
- Maintain a recall policy document for staff to follow.
- Maintain templates within a clinical software program to trigger follow-ups.

- Document a staff member's role with the recall process in their position description.

AHS1.6► C Our patients are advised of the process for follow-up of tests and results.

You must:

- **Demonstrate your patients are advised of your process for follow-up of tests and results.**

You could:

- Demonstrate that staff can explain how patients are advised of the process to receive results.
- Nominate a staff member who is responsible for the follow-up process.
- Maintain a follow-up policy document for staff to follow.
- Display your follow-up process on your website.

AHS1.6►D Our service alerts a patient's regular GP/ practice of clinically significant results.

You must:

- **Demonstrate your service's process for the timely alerting of a patient's regular GP/practice of clinically significant tests and results.**

You could:

- Nominate a staff member who is responsible for the follow-up process.
- Maintain a follow-up policy document for the staff to follow.

Criterion AHS1.7 – Engaging with other services

Indicators

► A. Our service engages with other health services, when required.

► B. Our service's referral letters are legible and contain all required information.

► C. Our service provides a copy of referral letters to the patient's regular GP/practice.

Stakeholder questions:

- Does your service engage with other services?
- Does your service provide patient referrals to other services?

Why this is important

After-hours services do not routinely refer patients to other services. In some circumstances however, your service might need to engage with other healthcare providers and other services, such as hospitals, diagnostic and pathology services.

The patient's regular GP needs to be aware of any referrals ordered by your service, in order to provide ongoing comprehensive patient care.

Meeting this Criterion

Contributing to comprehensive care with other services

Your service should be aware of the local healthcare providers and services that can support patients. This includes having access to up-to-date written or electronic information about local health, disability, community and mental health services, and how to engage with them, so that you can coordinate patient care with these services when required.

It is important that your service understands the different referral arrangements for public and private providers.

Referral information

After-hours services do not routinely refer patients to other services. Although, in some cases you may need to send a referral letter to integrate the care of patients with external healthcare providers.

If your service does send a referral letter, it must:

- include the name and contact details of the referring doctor and the service
- be legible
- include the patient's name and date of birth, and at least one other patient identifier
- explain the purpose of the referral

- contain enough information (the relevant history, examination findings, and current management) so that other healthcare providers can provide appropriate care to the patient
- not include sensitive patient health information that is not relevant to the referral
- include a list of known allergies, adverse drug reactions and current medicines
- identify the healthcare setting to where the referral is being made (e.g. the specialist clinic)
- identify the patient's usual GP/practice.

If appropriate referrals could also contain the following information:

- the name of the healthcare provider to whom the referral is being made, if known
- any relevant information that will help other healthcare providers deliver culturally safe and respectful care (eg language spoken, the need for an interpreter or other communication requirements).

Patient information in referrals

Most of the information needed for a referral may be found in the patient's health summary. Many services routinely incorporate a copy of the patient health summary into a referral letter or attach the summary as a separate document. Only clinically relevant patient health information should be provided in a referral letter. Information is clinically relevant if it is required by the healthcare practitioner to diagnose and treat the patient. You may consider offering patients the opportunity to read a referral letter before it is sent.

Services must consider their obligations under the Privacy Act 1988 before they use or disclose any health information[49]. As the Privacy Act 1988 does not prescribe how a healthcare organisation should communicate health information, you may use a variety of communication methods as long as you take reasonable steps to protect the information and the privacy of the patient.

Email referrals

The RACGP has developed a matrix that shows the risk associated with emailing certain types of information to patients or other healthcare providers, depending on your practice's policies and processes. The matrix is available at www.racgp.org.au/your-practice/ehealth/protecting-information/email

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 take reasonable steps to protect the information and the patient's privacy.

Your practice needs to have systems so you respond to emails and other electronic communication in a timely and appropriate manner.

Telephone referrals

In the case of an emergency or other unusual circumstance, a telephone referral may be appropriate. All telephone referrals must be recorded 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.

Send copies to the patients' regular GP

To support continuity of care, the service must have a system in place to ensure that all referrals ordered are forwarded to the patient's regular GP. This is important for continuity of care, so that the patient's regular GP can maintain a comprehensive understanding of all the care that their patients are receiving.

Meeting each Indicator

AHS1.7► A Our service engages with other health services, when required.

You must:

- **Demonstrate that staff are aware of local healthcare providers.**

You could:

- Maintain an up-to date electronic or hard-copy register of service providers and organisations for patient referrals.
- Keep an easily accessible list of pharmacies including the roster of on-call pharmacists.

AHS1.7► B Our service's referral letters are legible and contain all required information.

You must:

- **Provide evidence of referral letters in patient notes with all required information included.**

You could:

- Maintain a policy on referral documents that includes using at least three patient identifiers.
- Maintain a procedure for gaining consent from patients when referrals are sent electronically.
- Include electronic transmission of referrals in the service's privacy policy.
- Maintain a standard referral template that includes all relevant details.

AHS1.7► C Our service provides a copy of referral letters to the patient's regular GP/practice.

You must:

- **Demonstrate how copies of referral letters are provided to the patient's regular GP/practice.**

You could:

- Nominate a staff member who is responsible for ensuring that copies of all referral letters are sent to the patient's regular GP/practice.

Standard 2: Qualifications of our clinical team

Our clinical team is appropriately qualified and trained to perform their role.

This Standard focuses on the systems that the service uses to verify qualifications and training of the clinical team.

Services support and encourage quality improvement and risk management through appropriate education and training of the clinical team.

Criterion AHS2.1 – Qualifications, education and training of healthcare practitioners

Indicators

► A. Members of our clinical team:

- have current national registration where applicable
- have accreditation/certification with their relevant professional organisation
- actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and/or 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.

► B. GPs working in our service are either:

- a vocationally registered (VR) GP, or
- a registrar or medical practitioner on the pathway to Fellowship, or
- a non-VR GP (see definition under *Meeting this Criterion*)

Where recruitment of recognised VR GPs, registrars or medical practitioners on the pathway to Fellowship or Non-VR GPs has been unsuccessful, our service demonstrates that practitioners are supervised and have the qualifications and training necessary to meet the needs of our patients.

► C. Our clinical team is trained to use the service's equipment that is relevant to their role.

► D. Our clinical team is aware of the potential risks associated with equipment use.

Why this is important

Ensuring that all healthcare practitioners are suitably qualified can reduce the risk of medical errors and ensures that your service provides patients with safe, high quality care. Clinicians will generally be working in a small team or on their own in the after-hours period. Therefore, your clinicians need to have appropriate skills to meet the unique needs of patients in the after-hours period.

All healthcare practitioners must:

- be suitably qualified and trained
- maintain the necessary knowledge and skills that enable them to provide good clinical care
- comply with the professional development requirements of the relevant professional organisation, whether or not the individual is a member of the organisation
- comply with the code of conduct of the relevant professional organisation, whether or not the individual is a member of the organisation

- work within their scope of practice and competencies
- meet supervision requirements.

Meeting this Criterion

Registration, credentialing, and CPD

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

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:

- Aboriginal and Torres Strait Islander health
- Aboriginal and Torres Strait Islander cultural awareness
- cross-cultural safety
- communication with patients with special needs
- managing ethical dilemmas.

CPD and other training can be undertaken through external courses, in-house programs, or 'on the job' training at the service.

General practice is a specialist discipline

General practice is a distinct discipline in medicine and requires specific training. Doctors in general practices 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).

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; and who maintains professional competence for general practice through continuing professional development.

Vocationally registered and non-vocationally registered GPs

A VR GP is a GP on the Medicare Vocational Register or Fellows List and who is therefore eligible to access A1 Medicare rebates.

A Non-VR GP is a GP who either:

- has graduated before 1996 and is not on the Medicare Vocational Register

- is an International Medical Graduate with more than 10 years' experience in general practice under a 3GA program.

Patient services provided by Non-VR GPs are supported by A2 Medicare rebates.

Where vocationally recognised GPs are unavailable

In some areas it may be unachievable to recruit vocationally recognised GPs or non-VR GPs as described above. In these circumstances, doctors who have not yet met the equivalent of the RACGP Fellowship, or are not recognised non-VR GPs, need to be assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP. Adequate professional and personal support for doctors entering general practice is critically important.

Cardiopulmonary resuscitation (CPR) training

All healthcare practitioners must be trained in CPR so that they can provide care in emergencies.

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

The Australian Resuscitation Council (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.

Service equipment

Training requirements depend on the specific service equipment and the relevance of the equipment to the clinical team's role. The clinical team must be trained on how to use service equipment safely, in order to avoid any adverse events. There must be an assessment of whether specific training is required for service equipment, such as the height-adjustable bed, point-of-care testing equipment or the defibrillator (if the service has one), and to determine whether ongoing training is required. Appropriate training can be undertaken through external courses, in-house programs or 'on the job' training at the service.

Meeting each Indicator

AHS2.1► A Members of our clinical team:

- have current national registration where applicable
- have accreditation/certification with their relevant professional organisation
- actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and/or 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.

You must:

- **Keep records of current practitioner registration.**
- **Keep records of continuous professional development (CPD).**

You could:

- Keep training logs that record training that practitioners have completed.
- Keep a training and development calendar.
- Conduct annual performance reviews that identify learning and development goals.
- Store documents that identify training needs and completed training of each member of the service team.

AHS2.1► B GPs working in our service are either:

- a vocationally registered (VR) GP, or
- a registrar or medical practitioner on the pathway to Fellowship, or
- a non-VR GP (see definition under *Meeting this Criterion*)

You must:

- **Provide evidence that GPs are appropriately qualified**
- **Where recruitment of recognised GPs has been unsuccessful, demonstrate that doctors have the qualifications and training necessary to meet the needs of patients.**
- **Provide evidence of attempts and/or procedures to recruit VR-GPs.**

You could:

- Demonstrate how your service advertises for GPs.
- Use an agency to recruit GPs.

AHS2.1►C Our clinical team is trained to use the service's equipment that is relevant to their role.

You must:

- **Provide evidence of service team training on the safe use of equipment.**

You could:

- Keep training logs that record training that practitioners have completed, particularly in specialist or emergency equipment.
- Keep a training and development calendar, highlighting when refresher training needs to be completed.
- Conduct annual performance reviews that identify learning and development goals.

- Store documents that identify training needs and completed training of each member of the service team.
- Ensure that the clinical team knows how to use service equipment relevant to their role.

AHS2.1 ►D Our clinical team is aware of the potential risks associated with equipment use.

You must:

- **Provide evidence that training includes coverage of potential risks associated with equipment use.**

You could:

- Create a reporting register of issues, near misses, or adverse events with equipment.

Standard 3: The after-hours service facilities

Our service facilities and medical equipment are appropriate for the provision of patient care during the after-hours period.

It is important that the service provides an environment and necessary infrastructure for the service team to undertake safe and effective patient consultations.

Services must ensure that practitioners and other clinical staff have access to the medical equipment they need to provide care to patients, whether in the service's consultation rooms or during home or other visits.

Criterion AHS3.1 – Service facilities

Indicators

► A. Our physical service facilities are fit for purpose.

► B. Our service ensures that all patient consultations take place in an appropriate consultation or examination space.

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

► D. Our service has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time.

► E. Our service has accessible toilets.

► F. Our service has accessible hand-cleaning facilities.

► G. Our service is visibly clean.

For services providing care outside normal opening hours that only provide visit-based care, Indicators D, E and G are not applicable.

Why this is important

Without appropriate service facilities, patient care may be compromised – putting patient safety at risk. Therefore, services need to provide an environment that enables staff to perform their duties safely and effectively.

You must consider the context that your service operates within when meeting the Indicators in this Criterion. For example, services providing care outside normal opening hours that only provide visit-based care will have different services facilities to after-hours services with physical consultation rooms. However, it is important that services providing visit-based care only, still maintain physical operations facilities.

Meeting this Criterion

Design and layout in physical facilities

The physical facility of your service needs to be fit-for-purpose, and satisfy requirements relating to privacy, security, design and layout, consultation spaces (if applicable), and access to facilities such as toilets.

The layout of the service could be designed to give reception staff clear sight of the waiting areas, so that they can see and monitor waiting patients.

Services can also consider the cultural requirements for their patients in areas such as the waiting room.

Consultation rooms need to be kept at a comfortable temperature.

Services providing visit based care only need to maintain vehicle(s) stocked with all necessary equipment and maintain an operations facility to carry out administrative functions, triage patient calls over the phone or website and store medical supplies.

Privacy and patient dignity

All services must take reasonable efforts to protect the patient's privacy during a consultation. There are a range of circumstances in which patient confidentiality may be compromised when care outside normal opening hours is being provided. Patient privacy is as relevant in an environment outside a practice (e.g. patient's home and residential aged care settings) as within the practice setting.

The dignity of the patient must be protected by the use of appropriate visual and auditory privacy.

Visual privacy ensures that others cannot see the patient during the consultation and that they 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
- practitioners leaving the room while a patient is undressing and dressing
- providing an adequate curtain or screen
- finding a private area when conducting a home or other visit.

Auditory privacy ensures that other people cannot overhear a consultation. This can be achieved by:

- having solid doors (instead of doors with paper cores)
- playing appropriate background music to mask conversations between staff and patients
- finding a private area when conducting a home or other visit.

In circumstances where visual and auditory privacy is compromised or not possible, such as during home or other visits or nurses' treatment bays, the service must attempt to find an area that is appropriate to undertake the consultation.

Location of toilets and hand-cleaning facilities

Ideally, toilets are to be located within the service's facilities operating from a physical location, but if this is not possible, they must be close to the service. Toilets need to be easily accessible, well lit and signposted. Services could also provide separate toilets for staff and patients.

All services will need to ensure that effective hand cleaning (e.g. with alcohol based hand rub) can occur during any consultation. Services providing home and other visits must have adequate hand-cleaning facilities that can be used outside of the physical service facility.

Wash basins need to be in or close to the toilets to minimise the possible spread of infection. Staff and patients need to be able to access them easily.

Environmental cleaning

Your service could appoint one member of the team who has the primary responsibility for ensuring that appropriate cleaning processes are in place.

If your service engages commercial cleaners for environmental cleaning, create a written contract that outlines a cleaning schedule, suitable cleaning products to be used, and areas to be cleaned, and have the cleaners sign this contract. You could also consider having the cleaners record their work in a cleaning log.

Meeting each Indicator

AHS3.1►A Our physical service facilities are fit for purpose.

You must:

- **Demonstrate that your service's physical facilities are fit for purpose.**

You could:

- Structure the physical layout of the facility so that it includes consulting rooms, toilets, and hand-cleaning facilities.
- Maintain a reliable heating and cooling system.
- Demonstrate that the service's operations facility includes administrative functions, triage centre, storage for medical supplies.
- Ensure that vehicles contain all necessary equipment to undertake home and other visits.

AHS3.1►B Our service ensures that all patient consultations take place in an appropriate consultation or examination space.

You must:

- **Demonstrate that all patient consultations take place in a dedicated consultation or examination space.**

You could:

- Maintain a process for identifying an appropriate consultation or examination space when providing visit based care.
- Ensure consultation spaces have auditory and visual privacy.
- Ensure the layout of the consultation space maintains confidentiality.
- Include in the orientation of new doctors, the service's process for ensuring the patient's privacy during home and other visits.

AHS3.1►C Our service uses consultation spaces that permit patient privacy and confidentiality.

You must:

- **Maintain consultation spaces that permit patient privacy and confidentiality.**

You could:

- Ensure patient privacy screens are available.
- Ensure consultation spaces have auditory and visual privacy.
- Demonstrate a process for maintaining confidentiality and privacy during home and other visits.

AHS3.1► D Our 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:

- **Demonstrate how your patient waiting area is appropriate for your usual number of patients.**

You could:

- Ensure that the waiting areas has an adequate number of seats.
- Ensure that reception staff can monitor the waiting area.

AHS3.1► E Our service has accessible toilets.

You must:

- **Demonstrate how patients can access toilet facilities.**

You could:

- Consider separate toilets for service staff and patients.
- Have adequate signage to indicate the location of toilets and other facilities.

AHS3.1►F Our service has accessible hand-cleaning facilities.

You must:

- **Demonstrate how the service has access to effective hand washing during home and other visits.**

You could:

- Demonstrate your service's process for undertaking effective hand cleaning during all consultation types (e.g. both within the physical facility and during home and other visits).

AHS3.1►G Our service is visibly clean.

You must:

- **Demonstrate the methods used to maintain cleanliness of your service.**

You could:

- Ensure that the vehicles used for home and other visits are visibly clean, particularly in the area where medical equipment is stored.
- Use a written agreement with commercial cleaners.
- Use a cleaning log.
- Provide washable children's furniture and play equipment.
- Ensure that the operations facility is visibly clean, particularly where medical equipment is stored.

Criterion AHS3.2 – Service Equipment

Indicators

► A. Our service has equipment for comprehensive primary care and emergency resuscitation, where relevant:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask)
- intravenous access
- emergency medicines
- examination light
- eye examination equipment (e.g. fluorescein)
- gloves (sterile and non-sterile)
- measuring tape
- equipment for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- personal protective equipment (PPE)
- pulse oximeter
- spacer for inhalation
- specimen collection equipment
- sphygmomanometer (with small, medium and large cuffs)
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips, including pregnancy testing kits.

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

► C. Our service has one or more height adjustable beds.

► D. Our service has timely access to a spirometer and electrocardiograph.

E. Our service has timely access to a defibrillator.

For services providing care outside normal opening hours that only provide visit-based care, Indicator C is not applicable.

Stakeholder question: Are there any other pieces of equipment that should or should not be included under this Criterion?

Why this is important

Services need to have equipment that enables them to treat acute, episodic illnesses and injuries in the after-hours period and emergency resuscitation as required. You need to consider what equipment your service requires to meet the needs of the care you provide. Services providing visit based care only will require different equipment when compared to physical facilities.

Equipment needs to be maintained to ensure that it is in good working order when required.

Research shows that pulse oximeters are useful to diagnose and assess hypoxia[50].

Other research shows that (despite the efforts of medical practitioners, policy makers and consumer advocates), people with disability continue to experience poorer health outcomes in a range of areas compared to the broader population[51]. One reason has been the lack of height adjustable examination beds in health services, resulting in fewer opportunities for patients with a disability to have thorough and dignified clinical examinations. Using height adjustable beds may also reduce workplace injuries because it will reduce the need for practitioners to help patients onto an examination bed that is too high.

Having an automated external defibrillator (AED) can reduce the risk of fatality from cardiac arrest[52]. Although sudden cardiac arrest is rare in after-hours primary healthcare, when it does occur, a practitioner needs to be able to have a lead role in resuscitation[53]. Most cases of sudden cardiac arrest are due to ventricular fibrillation that can be returned to a normal sinus rhythm with the use of an AED. Using an AED is easy and can cause no harm as AEDs analyse the cardiac rhythm and will only deliver a shock if it is necessary. Survival rates after sudden cardiac arrest drop 7-10% for every minute without defibrillation [54]. CPR alone has a 5% survival rate but CPR combined with early defibrillation increases the survival rate to 50%[55].

Meeting this Criterion

Range of equipment

Your service must have all the equipment necessary to provide care that meets local needs. Your service's equipment must support the procedures the service performs, including equipment that is relevant to their location or patient population.

Personal protective equipment (PPE) can include P2/N95 masks, plastic aprons, gowns, goggles/glasses, face shields, gloves, swabs.

Maintaining clinical equipment

Your 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 service and schedules for servicing and maintenance.

Equipment that requires calibration or that is electrically or battery powered (e.g. electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales, and defibrillators) must be serviced regularly in accordance with the manufacturer's instructions to ensure it remains in good working order. You could keep receipts from any external equipment testing and calibration companies to schedule regular maintenance checks. You may also choose to maintain a checklist of equipment used in your consultation rooms to record dates of servicing and to conduct regular checks that maintenance is up to date.

You must store all hazardous materials, including liquid nitrogen and oxygen, securely.

Height adjustable beds

The following guidelines have been provided by disability advocacy groups when purchasing height adjustable beds:

- preferred minimum range of height adjustment: 45-95 cm
- preferred minimum weight capacity: 175 kg
- preferred minimum width of table: 71 cm
- preferred minimum length: 193 cm
- number of sections: two sections (so the head section can be raised).

You may also consider purchasing other features and equipment for your height adjustable beds.

Electrocardiograph and spirometer

You must have timely access to an electrocardiograph and a spirometer. You can purchase this equipment or make arrangements with a service that has this equipment (e.g. a nearby local hospital) so that you have timely access to the equipment.

If you have an electrocardiograph or spirometer on site, staff must be properly trained to:

- use and maintain the equipment
- analyse results.

You must determine what 'timely access' means for your service, based on clinical need and what peers would consider an acceptable timeframe.

Automated external defibrillator (AED)

Decide whether your service needs to install an AED (either fixed or mobile), based on the risks of harm from cardiac arrest, by considering:

- the location of your service in relation to the nearest AED, hospital or other emergency services
- the number and composition of service staff, patients and other persons who use your service (an AED is useful in workplaces where there are large numbers of members of the public[55])
- records of injuries, illnesses and near misses.

If you have an AED:

- it must be maintained according to the manufacturer's specifications
- staff must be properly trained to use and maintain the equipment
- it must be placed where it is clearly visible and accessible, and not exposed to extreme temperatures
- it must be clearly signed.

Services who provide home and other visits may wish to consider purchasing a mobile AED that can be transported.

Consulting with staff

In accordance with Safe Work Australia recommendations[56], consider consulting with staff before making decisions on health and safety matters and deciding what new facilities the service needs.

Meeting each Indicator

AHS3.2►A Our service has equipment for comprehensive primary care and emergency resuscitation (see list above)

You must:

- **Provide evidence of all required equipment (see list above).**

You could:

- Maintain a checklist for consultation room equipment.
- Maintain an equipment register, including all of the required equipment.
- Perform a regular audit of the service equipment.

AHS3.2►B Our service maintains our clinical equipment in accordance with manufacturer's recommendations.

You must:

- **Demonstrate all required equipment is in good working order.**

You could:

- Keep a maintenance log including receipts from any external equipment testing and calibration companies.

AHS3.2►C Our service has one or more height adjustable beds.

You must:

- **Provide evidence of one or more height-adjustable beds.**

You could:

- Have a height adjustable bed in each consultation space.

AHS3.2►D Our service has timely access to a spirometer and electrocardiograph

You must:

- **Provide evidence that the service has timely access to a spirometer and electrocardiograph.**

You could:

- Ensure service staff can explain how they can access spirometer and electrocardiograph, when necessary.

AHS3.2 E Our service has timely access to a defibrillator.

You could:

- Provide evidence that the service has a defibrillator.
- Conduct a risk assessment to determine if a defibrillator is required onsite.
- Provide evidence that services who provide home and other visits have a mobile AED.
- Ensure service staff can explain how defibrillation services are accessed by patients if required.

Criterion AHS3.3 – Doctor's Bag

Indicator

► A. Each of our practitioners has access to a fully equipped doctor's bag for routine visits and emergency care, containing:

- auriscope
- disposable gloves
- equipment for maintaining an airway in adults and children
- in-date medicines for medical emergencies
- service stationery (including prescription pads and letterhead)
- sharps container
- sphygmomanometer
- stethoscope
- syringes and needles in a range of sizes
- thermometer
- tongue depressors
- torch.

Why this is important

Practitioners must be prepared to undertake home and other visits and must be available at short notice to help in emergencies. In these situations, practitioners are expected to use their doctor's bag so that they have immediate access to core equipment, medications, and stationery so that they can provide the necessary care.

Meeting this Criterion

Equipping doctor's bags

All practitioners in your service must have ready access to a doctor's bag that contains core equipment, medications and stationery, and to which they can add equipment in regular use (e.g. auriscope, ophthalmoscope or stethoscope) to make the bag ready for use.

If you are a small service, you may have only one bag that is shared by your practitioners.

If you are a medium or large service, you may have multiple bags so that more than one practitioners can simultaneously use a bag when required.

Storing doctor's bags

You must store the bag/s securely, and in accordance with state and territory legislation.

Medicines in doctor's bags

To ensure patients' safe use of medicines, services 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, and services need to be aware of and comply with these requirements.

Decide what general medicines you need to keep in your doctor's bag/s based on:

- the geographical area the service covers
- the health needs of the local community
- the type of clinical conditions likely to be encountered
- the shelf life and climatic vulnerability of each medicine.

Suggested emergency medicines may include:

- adrenaline
- ADT
- atropine sulphate
- benztropine mesylate
- benzylpenicillin
- broad spectrum parenteral antibiotic
- clonazepam
- dexamethasone sodium phosphate or hydrocortisone sodium succinate
- diazepam
- frusemide
- glucose 50% and/or glucagon
- glyceryl trinitrate spray or tablets
- hyoscine butylbromide
- lignocaine
- methoxyflurane
- metoclopramide hydrochloride or prochlorperazine
- midazolam
- morphine sulphate or appropriate analgesic agent
- naloxone hydrochloride
- oxytocin
- phytomenadione
- promethazine hydrochloride
- salbutamol aerosol

- tramadol.

Pharmaceutical Benefits Scheme - emergency drugs for doctor's bags

Through the Pharmaceutical Benefits Scheme (PBS), certain medications are provided to prescribers without charge, so that, in emergencies, you can supply these medications free to patients.

A list of these medications available for doctor's bags is available at www.pbs.gov.au/browse/doctorsbag, and the Emergency Drug (doctor's bag) Order Form is available from Medicare for eligible prescribers.

You must have:

- an up-to-date logbook that lists the emergency drug stocks in the doctor's bag
- a system for checking expiry dates and replacing drugs that have expired.

Emergency drugs for children

A list of paediatric emergency drugs and their dosages can be found in the Royal Children's Hospital Paediatric Pharmacopoeia, available at ww2.rch.org.au/clinicalguide/forms/drugDoses.cfm

Consider the items in the list above when deciding which to include in a doctor's bag.

GP's knowledge of medicines in doctor's bags

All GPs must be familiar with the medicines that are in their doctor's bag, including the general usage, suggested dosage and possible side effects.

The RACGP recommends that GPs seek appropriate and ongoing education on these medicines.

Meeting each Indicator

AHS3.3►A Each of our practitioners has access to a fully equipped doctor's bag for routine visits and emergency care (see list above).

You must:

- **Provide evidence that a doctor's bag is accessible to practitioners.**

You could:

- Ensure practitioners are familiar with medicines included in the doctor's bag, and their suggested dosage and possible side effects**.**
- Ensure clinical staff can explain how to equip the doctor's bag.
- Maintain a checklist for doctor's bag contents.
- Perform a regular audit of the doctor's bag contents.

Standard 4: Reducing the risk of infection

Our service has systems that reduce the risk of infections.

Infection prevention and control is critical in healthcare. Primary healthcare is increasingly delivered by teams that include doctors, nurses and other health professionals. All members of the service team are responsible for preventing and controlling infection in the service. All staff must be educated and competent in effective infection prevention and control in order to reduce the risk of cross-infection and transmission of disease.

Criterion AHS4.1 – Infection prevention and control, including sterilisation

Indicators

► A. Our 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 documentary evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

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

► C. Our service has a clinical team member who has primary responsibility for providing staff education in infection prevention and control.

► D. All members of our service team manage risks of potential cross-infection within our service by methods including:

- 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.

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

F. Our service records the sterilisation load number from the sterile barrier system in the patient's health record when sterile items have been used, and also records the patient's name against those load numbers in a sterilisation log or list.

Why this is important

Having systems with clear lines of accountability and responsibility is part of good governance and encourages improvement in safety and quality care for patients.

It is important to keep patients of the service and staff safe from infection. Infection prevention and control reduces the risk of infection travelling from patient to patient, or patient to service staff.

Meeting this Criterion

Infection prevention and control

Your service must appoint at least one member of the clinical team who has primary responsibility for processes to prevent and control infection, including:

- hand hygiene
- provision of sterile instruments
- environmental cleaning
- spills management
- service team immunisations
- educating the practice team.

These responsibilities are to be documented, and staff need to understand and comply with these processes.

Staff education

To reduce the risk of infection, all staff need to be educated on infection prevention and control processes.

Staff education about effective infection prevention and control begins during staff induction, and will continue throughout their employment. Education needs to be relevant to each person's particular role. Implementing policies and procedures that include triage protocols, and developing tools such as checklists, will help to ensure that all staff understand their own and others' roles and responsibilities relating to infection.

Refer to the RACGP's *Infection prevention and control standards for general practices and other office-based and community-based practices* (the Infection Control Standards) for guidance on recording staff education and evaluating the competency of staff in this area. The Infection Control Standards are available at www.racgp.org.au/your-practice/standards/infectioncontrol

All members of the service team must:

- have easy access to PPE (eg masks, gloves, gowns, protective eye wear)
- receive education about the proper use of PPE
- have a clear understanding of the purpose of PPE and how to apply, remove and dispose of it appropriately.

It is important that your team's antibiotic prescribing is in accordance with relevant national standards. Your service could provide education to the service team on your antimicrobial stewardship (AMS) program, including policies and procedures and how to find information on appropriate antibiotic prescribing.

Practitioners must have access to appropriate guidelines, such as the Therapeutic Guidelines: Antibiotic, to promote and support informed prescribing of antibiotics. Your service could also make other

resources available to help all health professionals reinforce to patients the important messages about appropriate antibiotic use and actions that can be taken to reduce antimicrobial resistance.

Managing cross-infection within the service

It is important that risks of cross-infection within the service are minimised. Your service needs to ensure staff are familiar with the use of standard and special precautions, spills management and environmental cleaning.

Refer to and adhere to the applicable sections of the Infection Control Standards. The Infection Control Standards recommend the use of hand hygiene, Personal Protective Equipment (PPE) (including 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 are to be applied to all services, assuming that all blood and body substances, including respiratory droplet contamination, are potentially infectious.

Your service needs to apply transmission-based precautions when patients are known to be, or suspected to be, infected with highly transmissible infectious agents (e.g. influenza). You can minimise exposure to other patients and staff by:

- implementing effective triage and appointment scheduling
- using PPE such as masks
- implementing distancing techniques when patients attend the service:
  - spacing patients in the waiting room at least one metre apart
  - isolating the infected patient in a separate room
- strict adherence to hand hygiene.

It is important that your service advises patients how they can reduce the spread of infection while using the service. For example, you can display signs in the waiting room (for services with physical practice facilities) and have tissues, rubbish bins, and antimicrobial hand sanitiser available.

Infection control policy

Develop policies, procedures, and tools such as checklists to ensure that adequate steps are taken for the complete sterilisation process. Your infection control policy must contain:

- the name of the team member/s responsible for infection control and sterilisation processes
- immunisation that staff receive, in accordance with recommendations in the current Australian Immunisation Handbook
- the appropriate use and application of standard and transmission-based precautions
- management of sharps injury
- management of blood and body substance spills
- hand hygiene

- environmental cleaning of clinical and nonclinical areas of the service
- use of aseptic and sterile procedures
- procedures for reprocessing (sterilising) instruments (if relevant) on or off site, and ensuring there is documentary evidence that this reprocessing is monitored and has been validated
- waste management, including the safe storage and disposal of clinical waste and sharps
- where patients and staff access PPE
- how and when staff are educated on the appropriate application, removal and disposal of PPE.

Educating patients

Practitioners could share decision-making with patients during consultations by discussing the likely benefits, harms and risks of antibiotics. Patient-centred discussions could focus on:

- why antibiotics may not be appropriate
- antibiotic resistance
- advice on self-management of conditions.

You could display posters, provide leaflets, air health television channels, or provide website details with information on antimicrobial resistance and the appropriate prescribing of antibiotics.

Quality improvement activities/audits

Involving practitioners in quality improvement activities may improve clinical practice. Practitioners could also conduct a clinical audit to identify their patterns of antibiotic prescribing and monitor compliance with the service's policies on antibiotic prescribing.

Provision of appropriately disinfected and sterile instruments and equipment

The clinical team member who has primary responsibility for infection prevention and control processes needs to ensure that equipment and instruments used in patient care are appropriately cleaned and disinfected or sterilised. The level of processing of instruments and equipment is appropriate to the risk of infection posed by their reuse.

Instruments required to be sterile in use can either be purchased as single use sterile items or re-processable items reprocessed by the service or by an off-site sterilisation facility.

If the offsite sterilisation facility is accredited (e.g. an accredited practice or Australian Council on Healthcare Standards accredited hospital), the service is required to have a copy of the facility's accreditation certificate.

If the offsite facility is not accredited, the service needs to assure itself that the facility would meet accreditation requirements for sterilisation and have copies of the facility's relevant documents, including:

- reprocessing

- sterilisation policies and procedures
- results of annual validation.

Any reprocessable instruments used during home and other visits need to be transported appropriately to the sterilisation facility.

Waste management

Refer to and adhere to the applicable sections of the RACGP's Infection Control Standards, which provides guidance on waste management that services may consider when developing an infection prevention and control policy.

Keeping up-to-date

Keep up-to-date with changes in legislation and guidelines for infection prevention and control and implement them promptly. Have systems for monitoring and obtaining information about public health alerts regarding national and local infection outbreaks, such as pandemic influenza, measles and pertussis.

Tracking the sterility of reusable medical instruments and tracing patients

The need to track medical devices or trace patients on whom they have been used may not be necessary if a validated sterilisation process is strictly adhered to and monitored. Nonetheless, it may be helpful to be able to trace patients and track medical devices in case there is a failure in processing or reprocessing or there is a medico-legal issue relating to infection control.

To prove that the medical instruments used were sterilised correctly you may want to 'look back' at the details of the sterilisation process in any individual case. In order to do this, enter into the patient's health record the sterilisation load number from the sterile barrier system that the instruments came in. If an issue arises later, you can use this load number to refer back to the sterilisation log to recheck the results of that particular cycle. Unfortunately, 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 trace all patients on whom those items were used. To enable this, record patient identifiers (e.g. 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 in the case of items reprocessed on-site or keep a list for items sterilised off-site or purchased sterile. Your service is required to keep this log onsite even if your instruments are sterilised offsite.

Meeting each Indicator

AHS4.1► A Our 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 documentary evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

You must:

- **Demonstrate that the clinical team member with primary responsibility for infection control and sterilisation can describe their role.**

You could:

- Demonstrate the team member with primary responsibility for infection prevention and control and education is stated in their job description/s.
- Show that you discuss any changes to legislation and guidelines for infection control and any local outbreaks and public health alerts at service staff meetings.
- Maintain a policy and procedure manual on infection prevention and control covering all aspects relevant to your service.

AHS4.1► B Our service has a written, service specific policy that outlines our infection control processes.

You must:

- **Maintain a service-specific infection control policy.**

You could:

- Review the policy on an annual basis.
- Consult with the service team when developing the service's policy.
- Conduct regular audits to confirm compliance with the service's policy.

AHS4.1► C Our service has a clinical team member who has primary responsibility for providing staff education in infection prevention and control

You must:

- **Demonstrate that the clinical team member with responsibility for educating staff in relation to infection control can describe their role.**

You could:

- Demonstrate the team member with responsibility for infection prevention and control and education is stated in their job description/s.

- Show that you cover infection control in induction and ongoing staff education programs.
- Show that you discuss any changes to legislation and guidelines for infection control and any local outbreaks and public health alerts at staff meetings.
- Include an education component in the infection-control policy.

AHS4.1► D All members of our service team manage risks of potential cross-infection within our service by methods including:

- 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:

- **Demonstrate that the service team manages risks of potential cross-infection within the service through describing hand hygiene practices, use of PPE and triage of patients with potential communicable diseases.**
- **Show that you have safe sharps storage and disposal and safe clinical waste disposal.**
- **Provide evidence that the service team have access to Personal Protective Equipment.**

You could:

- Maintain a policy and procedure manual on infection control.
- Maintain a cleaning policy.
- Maintain a cleaning log.
- Show that you discuss any changes to legislation and guidelines for infection control and any local outbreaks and public health matters at staff meetings.

AHS4.1► E 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.**
- **Have facilities for hand cleaning in all consultation and treatment areas.**
- **Have tissues and rubbish bins available in the waiting room.**
- **Describe how patients are informed of the importance of respiratory etiquette.**

You could:

- Have alcohol-based hand rubs at the reception desk.
- Make brochures, posters or website links or information available at reception on respiratory etiquette and hand hygiene processes.

- Maintain a policy and procedure manual on infection control.
- Maintain a cleaning policy.
- Maintain a cleaning log.
- Show that you discuss any changes to legislation and guidelines for infection control and any local outbreaks and public health matters at staff meetings

AHS4.1 F Our service records the sterilisation load number from the sterile barrier system in the patient's health record when sterile items have been used, and also records the patient's name against those load numbers in a sterilisation log or list.

You could:

- Show evidence of sterilisation load numbers in the patient's health record when sterile items have been used.
- Have a log or list that records the patients name against sterilisation load numbers.

References

1. Epstein, R.M., et al., *Measuring patient-centered communication in patient-physician consultations: theoretical and practical issues.* Soc Sci Med, 2005. **61**(7): p. 1516-28.
2. Australian Government Department of Health. *Healthcare Identifiers Service – Frequently Asked Questions Q4.Why not use existing Medicare numbers?* 2015 23 March 2015 [cited 2015 24 November]; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-ehealth-consultation-faqs#q4.
3. Australian Commission on Safety and Quality in Health Care, *NATIONAL STATEMENT ON HEALTH LITERACY: Taking action to improve safety and quality.* 2014.
4. National Health and Medical Research Council, *General Guidelines for Medical Practitioners on Providing Information to Patients*. 2004, National Health and Medical Research Council: Canberra, ACT.
5. Queensland Health Interpreter Service. *Interpreter Service FAQ*. [cited 2015 18 November]; Available from: https://www.health.qld.gov.au/multicultural/interpreters/QHIS_FAQ.asp.
6. Mohr, J.J. and P.B. Batalden, *Improving safety on the front lines: the role of clinical microsystems.* Qual Saf Health Care, 2002. **11**(1): p. 45-50.
7. Department of Human Services. *Communication with people with disabilities*. Available from: http://www.dhs.vic.gov.au/for-business-and-community/community-involvement/people-with-a-disability-in-the-community/communicate-and-consult-with-people-with-a-disability/communication-with-people-with-disabilities.
8. *Cultural Awareness definition*. Available from: http://www.culturaldiversity.com.au/resources/practice-guides/cultural-awareness.
9. RACGP National Faculty of Aboriginal and Torres Strait Islander Health. *Cultural awareness education and cultural safety training*. Available from: http://www.racgp.org.au/download/Documents/AHU/cabooklet.pdf.
10. Eckermann AK, e.a., *Binan Goonj: Bridging Cultures in Aboriginal Health*. Vol. 2nd edition. 2006: Churchill Livingstone.
11. Williams R, *Cultural safety--what does it mean for our work practice?* Australian and New Zealand Journal of Public Health, 1999. **23**(2): p. 213-4.
12. Australian Human Rights Commission. *Assistance animals and the Disability Discrimination Act 1992 (Cth)*. Available from: https://www.humanrights.gov.au/our-work/disability-rights/projects/assistance-animals-and-disability-discrimination-act-1992-cth.
13. Australian Commission on Safety and Quality in Health Care, *The National Safety and Quality Health Service Standards.*, in *Standard 1 Governance for Safety and Quality in Health Service Organisations*. 2012, Australian Commission on Safety and Quality in Health Care: Sydney, NSW.
14. Australian Council for Safety and Quality in Health Care, *Better Practice Guidelines on Complaints Management for Health Care Services*. 2004, Australian Council for Safety and Quality in Health Care: Canberra, ACT.
15. The Australian Government Department of Health. *History of pandemics*. 19 January 2011 [cited 2015 November 18]; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/about-pandemic-history.
16. Starfield, B., et al., *Ambulatory specialist use by nonhospitalized patients in us health plans: correlates and consequences.* J Ambul Care Manage, 2009. **32**(3): p. 216-25.
17. Longo, J. and D. Hain, *Bullying: A hidden threat to patient safety.* Nephrology Nursing Journal, 2014. **41**(2): p. 193.

18. Bismark, M.M., et al., *Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia.* BMJ quality & safety, 2013: p. bmjqs-2012-001691.

19. Pearson, C.M. and C.L. Porath, *On the nature, consequences and remedies of workplace incivility: No time for "nice"? Think again.* The Academy of Management Executive, 2005. **19**(1): p. 7-18.

20. Rosenstein, A.H. and M. O'Daniel, *A survey of the impact of disruptive behaviors and communication defects on patient safety.* The Joint Commission Journal on Quality and Patient Safety, 2008. **34**(8): p. 464-471.

21. World Health Organisation. *Definition of Health Promotion*. [cited 2015 November 18]; Available from: http://www.who.int/topics/health_promotion/en/.

22. Katz, L.D.A., A. N. D., *Preventive Medicine, Integrative Medicine & The Health of The Public*, in *IOM Summit on Integrative Medicine and the Health of the Public* 2009: Washington DC.

23. Australian Government Australian Institute of Health and Welfare. *Leading causes of death*. [cited 2015 November 18]; Available from: http://www.aihw.gov.au/deaths/leading-causes-of-death/.

24. World Health Organization. *The Ottawa Charter for Health Promotion*. 1986; Available from: https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf.

25. Australian Institute of Health and Welfare, *Public health programs in Australia, extracted from Public health expenditure in Australia, 2008–09*, in *Health and welfare expenditure series*, AIHW, Editor. 2011, Australian Institute of Health and Welfare: Canberra, ACT.

26. Edgar, T. and J.E. Volkman, *Using communication theory for health promotion: practical guidance on message design and strategy.* Health Promot Pract, 2012. **13**(5): p. 587-90.

27. NSW Ministry of Health. *PRIVACY MANUAL FOR HEALTH INFORMATION*. 2015; Available from: http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf.

28. Medical Observer. *How to manage your medico-legal risk*. [cited 2015 18 November]; Available from: http://www.medicalobserver.com.au/professional-news/how-to-manage-your-medico-legal-risk.

29. *RACGP position statement: The use of secure electronic communication within the health care system*. September 2016; Available from: http://www.racgp.org.au/download/Documents/e-health/RACGP-position-statement-The-use-of-secure-electronic-communication-within-the-health-care-system.pdf.

30. Australian Institute of Health and Welfare, *Taking the next steps: identification of Aboriginal and Torres Strait Islander status in general practice*, in *Cat. no. IHW 100*. 2013, AIHW: Canberra.

31. *MBS Health Assessments Items 701, 703, 705, 707 and 715*. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_general_factsheet.

32. Doyle, C., L. Lennox, and D. Bell, *A systematic review of evidence on the links between patient experience and clinical safety and effectiveness.* BMJ Open, 2013. **3**(1).

33. Ivers, N., et al., *Audit and feedback: effects on professional practice and healthcare outcomes.* Cochrane Database Syst Rev, 2012. **6**: p. Cd000259.

34. Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, in *8.4 Professional Behaviour - Medical records*. March 2014, Medical Board of Australia.

35. Aslam, I. and S.R. Feldman, *Practical Strategies to Improve Patient Adherence to Treatment Regimens.* South Med J, 2015. **108**(6): p. 325-31.

36. Walton M, B.B., *Topic 6: Understanding and managing clinical risk*, in *Multi-professional Patient Safety Curriculum Guide*. 2011, World Health Association: Malta.

37. Runciman W, H.P., Thomson R, Van Der Schaaf T, Sherman H, Lewalle P. ,, *Towards an International Classification for Patient Safety: key concepts and terms.* International journal for quality in health care. , 2009. **21**(1): p. 18-26.

38. Buetow SA, R.M., *Clinical governance: bridging the gap between managerial and clinical approaches to quality of care.* Quality in health care, 1999. **September 1:8**(3): p. 184-90.

39. Scally G, D.L., *Clinical governance and the drive for quality improvement in the new NHS in England.* BMJ, 1998. **317**(61).

40. World Health Organisation, *The Conceptual Framework for the International Classification for Patient Safety version 1.1*. January, 2009.

41. Scott, S.D., et al., *The natural history of recovery for the healthcare provider "second victim" after adverse patient events.* Qual Saf Health Care, 2009. **18**(5): p. 325-30.

42. Medical Board of Australia, *Guidelines for technology-based patient consultations*. 2012, Medical Board of Australia.

43. Magin, P.J., et al., *Experiences of occupational violence in Australian urban general practice: a cross-sectional study of GPs.* Med J Aust, 2005. **183**(7): p. 352-6.

44. RACGP, *General practice – A safe place A guide for the prevention and management of patient-initiated violence*. 2015, The Royal Australian College of General Practitioners: Melbourne

45. Lin, I.P., S.C. Wu, and S.T. Huang, *Continuity of care and avoidable hospitalizations for chronic obstructive pulmonary disease (COPD).* J Am Board Fam Med, 2015. **28**(2): p. 222-30.

46. Gunther, S., et al., *What aspects of primary care predict emergency admission rates? A cross sectional study.* BMC Health Services Research, 2013. **13**(1): p. 11.

47. Haggerty, J., et al., *Continuity of care: a multidisciplinary review.* BMJ, 2003. **327**(7425): p. 1219 - 1221.

48. Royal Australian College of General Practitioners, *Position Statement Non-GP initiated testing*. 2011, Royal Australian College of General Practitioners.

49. Commissioner, O.o.t.A.I., *Australian Privacy Principles. Privacy Act 1988*, in *Chapter 11: APP 11 — Security of personal information* March 2015, Office of the Australia Information Commissioner: Canberra ACT.

50. Potter, V.A., *Pulse oximetry in general practice: how would a pulse oximeter influence patient management?* Eur J Gen Pract, 2007. **13**(4): p. 216-20.

51. Physical Disability Council of New South Wales, *Report on access to adjustable height examination tables by people with disabilities at general practices*. 2009, Physical Disability Council of New South Wales: Sydney.

52. Health Quality Ontario, *Use of automated external defibrillators in cardiac arrest: an evidence-based analysis.* Ont Health Technol Assess Ser, 2005. **5**(19): p. 1-29.

53. Hudson, L. and I. Jacobs, *Defibrillators--their use in general practice.* Aust Fam Physician, 2008. **37**(1-2): p. 63-4.

54. Larsen, M.P., et al., *Predicting survival from out-of-hospital cardiac arrest: a graphic model.* Annals of emergency medicine, 1993. **22**(11): p. 1652-1658.

55. Iqbal, Z. and J. Somauroo, *Automated external defibrillators in public places: position statement from the Faculty of Sport and Exercise Medicine UK.* British Journal of Sports Medicine, 2015. **49**(21): p. 1363-1364.

56. Safe Work Australia, *Model Code of Practice*, in *First Aid in the Workplace*. 2015, Safe Work Australia.

Glossary

This glossary contains the definitions of terms used in this document.

Term	Definition
Aboriginal and Torres Strait Islander Status	A way of recording and identifying a patient's response when the practice asks them the standard Indigenous Australian status question: 'Do you identify as an Aboriginal or Torres Strait Islander person?'
Aboriginal health worker/practitioner	A member of the Indigenous health workforce. Roles include: • providing clinical functions • liaison and cultural brokerage • health promotion • environmental health • community care • administration • management and control • policy development • program planning. They are often and Indigenous 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 practice.
Accreditation	A formal process to assess a practice's delivery of healthcare against the RACGP's *Standards for general practices*.
Action plan	A document that lists the steps to be taken to achieve a specific goal.
Hybrid patient health record system	A combination of paper-based or electronic systems used by one or more practitioners to enter patient information.
Active patient	A patient who has attended the practice/service three or more times in the past two years.
Active patient health record	The health record of an active patient.
Administrative staff	Members of the practice team who provide clerical or administrative services and who do not perform any clinical tasks with patients.
Adverse drug reaction	See *Adverse medicines event*.

Adverse event	An incident in which harm resulted to a person receiving healthcare (e.g. the patient was given a drug that they have an allergy to and they had an allergic reaction).
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 general practice, whether or not that service deputises for other general practices, and whether or not the care is provided physically in or outside of the clinic.
Allied health professional	A health professional who collaborates with doctors and nurses to provide optimal healthcare for patients (e.g. physiotherapists, dieticians, podiatrists).
Alternative medicine	Alternative medicine is not part of Australia's traditional or dominant healthcare system. The term is used interchangeably with the term 'complementary medicine' and sometimes the term 'traditional medicine' in some countries.
Antivirus software	Software that protects a computer or network from programs that can adversely affect how the computer or network operates. For example, viruses can corrupt other programs, destroy or modify data, and affect how the computer or network operates.
Appointment system	The system that a practice 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 off-site server.
Buddy system	A system whereby a 'buddy' follows up results and correspondence or continues the care of patients on behalf of an absent colleague. If a practitioner has a 'buddy' system to hand over care, this should be standardised and previously agreed, rather than ad hoc. Such arrangements do not necessarily have to be documented in the consultation notes, although the identity of the treating GP does need to be recorded.
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.
CALD	Culturally and linguistically diverse.

Care outside normal opening hours	Clinical care that is provided to the practice's patients when the practice is normally closed. (Different practices can have different opening and closing hours.)
Carer	Someone who provides care and support to a family member or friend who is frail, or has a disability, mental illness, chronic condition, or terminal illness.
Chaperone	An impartial observer to a consultation between a practitioner and a patient.
Clinical-based care	Care that is provided when a patient attends a general practice, in contrast to care provided at another location, such as a home, school, workplace, or public space.
Clinical governance	The system (such as policies, along with the implementation and monitoring of them), that make clinicians and health service managers jointly accountable for patient safety and the quality of care patients receive.
Clinical handover	The transfer, from one professional person or group to another, of professional responsibility and accountability for some or all aspects of a patient's care.
Clinical indicator	A measure, process, or outcome used to assess a particular clinical situation against the Standards, and determine whether the care delivered was appropriate.
Clinical management area	A physical space in the practice where clinical care is delivered.
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, and • the likely seriousness of the harm.
Clinical team	All those members of the practice team who have health qualifications that qualify them to perform clinical functions.
Clinical team member	An individual member of the practice 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 affected person • direct contact with an affected 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.
Complementary medicine	See *Alternative medicine*.
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	The degree to which a patient experiences a series of discrete healthcare events and/or services as coherent, connected and consistent with their medical needs and personal circumstances.
Cooperative	A group of general practices that have an arrangement to work together to provide care to patients outside the normal opening hours of their practices.
Could	In this document, it is used to indicate that something is optional.
Credentialing	The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners in order to form a view about their competence, performance and professional suitability to provide safe, high quality healthcare services in specific organisational environments.
Cultural background	Details of a patient's ethnic or cultural heritage that the practice 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. Health service organisations have a responsibility to 'develop and sustain healthcare services that are free from discrimination and delivered in a manner that shows respect for patients and consumers' (quoted from Roles in Realising

	the Australian Charter of Healthcare Rights released by the Australian Health Ministers in 2008).
Cycle monitoring	Monitoring of the sterilisation cycle to ensure that the correct temperature, pressure, and time have been achieved for each cycle.
Disability	An umbrella 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 an individual may experience in involvement in life situations.
Disaster recovery plan	A documented plan of the actions the practice will take to retain and restore patient health information in the case of an event (such as a power failure) that would otherwise mean that some or all of the information would be unavailable.
Discrimination	Different treatment or consideration of a patient based on particular characteristics (such as gender, age, ethnicity, 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.
Documented standardised clinical terminology	The structured vocabulary that clinical practices use to accurately and consistently describe the care and treatment of patients.
Duty of care	The legal obligation to safeguard others from harm while they are in your care, or using your services, or otherwise exposed to your activities.
Early detection and intervention	The detection of early stages of a disease and the prompt and effective intervention to prevent the progression of the disease.
Electronic communication	The transfer of information (including but not limited to patient health information) within or outside the practice using email, internet communications, SMS, or facsimiles.
Emergency contact	The person who 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 his/her actions and accountable for the delegated nursing care s/he provides.
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 and 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 practice.
Follow up	Activities that are the logical and responsible steps to take after taking earlier related actions. For example: • making a phone call to find out the status of tests and results that are expected but not yet been received • contacting a patient to discuss a report, test, or results.
Gender	A classification based on socially constructed differences between men and women that result in roles and expectations being assigned according to whether someone identifies (or is identified) as male or female. (The word 'sex' refers to the biological and physiological characteristics that define men and women.)
General practice	General practice is the provision of patient-centred, continuing, comprehensive, coordinated primary care to individuals, families, and communities.
General practitioner	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.
Hardware	The physical components of a computer, including monitors, hard drives, and central processing units.
Harm	Impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological.
Healthcare-associated harm	Harm arising from or associated with plans or actions taken during the provision of healthcare, rather than an underlying disease or injury[40].
Health information	A subset of a 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, a group of people or a population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals, such as nurses and specialists.
Health promotion	The process of enabling people to increase their control over, and improve their health. More than just influencing an individual's behaviour, it includes a wide range of social and environmental interventions.
Health summary	Documentation usually included in a patient's health record that provides an overview of all components of the patient's healthcare. For example, current medications, relevant past health history, relevant family history, allergies, and adverse drug reactions.
High-risk results	Clinical test results that are seriously abnormal and life-threatening and need to be communicated in an appropriately timely manner.
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.
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.
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 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.
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 has received and understood sufficient and appropriate information and is aware of the material risks • the patient has the mental and legal competence to give consent.
Informed refusal	A patient's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment.
Interpreter service	A service that provides trained language interpretation or translation, either face-to-face or by telephone.
Issue	A relevant event that was not planned (e.g. a problem, query, concern, or risk) and requires action.
Known allergy	A hypersensitive reaction to a medicine or other substance that is made known to a GP (see also *Adverse drug reaction*).

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 (e.g. 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 list	An accurate recording of a patient's medications, comprising: • a list of all current medicines including prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently • recent changes to the medication list • past history of adverse drug reactions including allergies • past history of recreational drug use.
Medicine	A drug or other preparation for the treatment or prevention of disease.
Mission	The overall function of an organisation.
Must	In this document, it is used to indicate that something is mandatory.
Natural immunity	Immunity to a particular infection that is not the result of vaccination or previous infection but is inherent in the genetic make-up of an individual, species, family, etc.
Near miss	An incident that did not cause harm but could have.
Need (As used in this document in phrases such as 'a practice needs to', and 'you need to'.)	Must, if the action is determined to be reasonable. When interpreting and complying with these Standards, determine what 'needs' to be done by considering what is reasonable, given all relevant circumstances of the situation.
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 the 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 workers.
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	The way in which clinicians are encouraged to communicate with and support patients, their family, and carers who have experienced harm while receiving, or as a result of receiving, healthcare.
Organisational chart	A description (often presented visually) of an organisation's structure, which includes areas (e.g. departments, division, properties), hierarchies, roles, responsibilities, and professional relationships between individuals.
Other visit	A general practice consultation conducted somewhere other than the general practice or the patient's home (e.g. residential aged care facility, a workplace).
Outcomes indicators	Ways of measuring the effects of care on patients and communities.
Outside 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. In relevant circumstances, the term also refers to a carer. For example, if you need to explain treatment to a patient who is intellectually disabled, you will need to explain the treatment to the patient's carer.
Patient health information	A patient's name, address, account details, Medicare number and any information (including opinions) about the patient's health.
Patient health record	Information, in paper or electronic form, held about a patient, 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, and 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. PPE includes appropriate gloves, waterproof gowns, goggles, face shields, masks, and footwear.
Physical facilities	The buildings and equipment used to provide clinical care to patients.
Policy and procedures manual	A document containing the practice's policies and procedures.
Position description	A document describing a team member's role, responsibilities, and conditions of employment.
Practice information sheet	A document that contains information that patients need to know about the services the practice provides, and how to access those services. It must not be hand-written.
Practice management	The strategic planning, reviewing, and implementation of processes that increase a practice's efficiency and contribute to 'excellence in healthcare'.
Practice team	Everyone who works or provides care within the practice (e.g. GPs, receptionists, practice managers, nurses, allied health professionals).
Practice team member	An individual member of the practice team who provides care within the practice (e.g. a GP, receptionist, practice manager, general practice nurse, allied health professional).
Practitioner or clinician (see also *Clinical team*)	A member of the practice team who has health qualifications that qualify them to perform clinical functions.
Privacy of health information	The protection of personal and health information to prevent unauthorised access, use, and dissemination.
Process indicators	Ways of identifying and evaluating the processes used to give and receive care.
Qualified	Holding the educational or other qualifications required to perform a specific activity (e.g. administer first aid) or hold a specific role (e.g. general practitioner, 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 that a practice undertakes to monitor, evaluate, or improve the quality of healthcare it delivers.
QI&CPD Quality improvement and continuing professional development	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.
Relevant social history	Information about a patient's social history (including employment, accommodation, family structure) that the practitioner considers important in order to provide clinical appropriate care to the patient.
Respiratory etiquette	Public health measures used to reduce the spread of respiratory infections by encouraging people to cover their mouth when coughing or sneezing, use tissues to blow their nose, dispose of tissues into waste, 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 practice that was based on relevant factors (e.g. the practice's location and patient population) and an understanding of what their peers (or practices in the same area) would agree was safe and reasonable.
Safety	The condition that means that 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, abuse, and dependence.
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, including the information displayed on the screen before the screensaver begins.
Security	The safeguards (administrative, technical, physical) 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.
Seronegative	Giving a negative result in a blood serum test (for example for the presence of a virus).
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, central storage of data).
SNAP	An acronym that refers to the four major risk factors of a patient's health: Smoking history, Nutrition, Alcohol consumption, and Physical activity.
Sociable hours	The after-hours period between 6 pm and 11 pm on weeknights.
Social media	Online social networks used to disseminate information through on-line interaction.
Spaulding classification	A system that categorises medical devices according to the risk of infection involved with their use.
Standard clinical practice	Activities that the public or professional peers might reasonably expect a practice to undertake.
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, medium, and long-term goals.

Structure indicator	A measure, process, or outcome used to assess material resources, facilities, equipment and the range of services provided at a general practice.
Technology-based consultations	Consultations that use any form of technology to communicate (such as video-conferencing, internet and telephone), instead of face-to-face interactions.
Telephone triage	A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care.
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers.
Tracking and tracing	Part of a sterilisation process that refers to batch control identification of instruments used for a procedure on a patient.
Transmission-based precautions	Methods and practices that health professional 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 triage, personal protective equipment, isolation, and other measures.
Triage	Patient prioritisation based on where resources can be best used or are most needed.
Unsociable hours	The following after hours periods: • weekdays - 11 pm to 8 am • Saturdays - before 8 am and after 12 noon • Sundays and public holidays - any time.
Urgent	Requiring immediate action or attention.
Values	Principles that stipulate how the organisation and the practice team are expected to behave.
Vision	A declaration of an organisation's objectives.