



RACGP



National Faculty of Aboriginal
and Torres Strait Islander Health
Working Together



Interpretive guide to the
**RACGP Standards for general
practices (4th edition)**
for Aboriginal community
controlled health services





Interpretive guide to the RACGP *Standards for general practices* (4th edition) for Aboriginal community controlled health services

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The Food Gatherers, by John Weeronga Bartoo

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Story: Survival

Not only did man have to go walkabout for food, but also the animals upon which he depends for survival must move about to forage for food.

The painting shows a woman's camp, for these are the providers of most of the food – consisting mainly of roots and berries and nuts, small animals such as lizards, snakes, possum and goanna, and seeds for flour. There is a hunter's camp; they are the ones who hunt and kill the larger animals, kangaroo and emu, and also catch fish and birds. There are tracks of the animals – goanna, possum, snake, kangaroo and emu. Then there are the plants and wildflowers upon which the animals, as well as man and the insects, such as the honey ant, depend.

So it was that they only took enough each day to survive, ensuring that the land would replenish the larder and that future generations could survive.

But when we take more than we need, the land became sick, its dependants began to diminish and future generations are in peril.

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We recognise the traditional custodians of the land and sea on which we work and live



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Foreword

Since 2007 the Office for Aboriginal and Torres Strait Islander Health (OATSIH) has provided support for Aboriginal community controlled health services to become accredited against various Australian healthcare standards, including the Royal Australian College of General Practitioners' (RACGP) *Standards for general practices*. This support included funding for the College to develop the 2010 guide to the RACGP *Standards for general practices* (3rd edition).

In 2011, with the impending introduction of a fourth edition of the RACGP *Standards*, OATSIH again provided funding for the College's National Faculty of Aboriginal and Torres Strait Islander Health to develop this version of the *Interpretive guide*, to align with the updated *Standards*. The faculty worked closely with the National Aboriginal Community Controlled Health Organisation (NACCHO) as well as its state and territory affiliates and representative member services to produce this *Interpretive guide*.

We are immensely proud of the collaboration that took place between these organisations and the quality of the final product. We believe the process has included the key elements of communication, consultation, inclusion and respect that are so necessary in any cross-sectoral work to improve the health outcomes of Aboriginal and Torres Strait Islander peoples.

While Aboriginal community controlled health services are very committed to achieving RACGP and other forms of accreditation, it is important that they can identify the relevance of the *Standards* to their own health services and communities. We believe the *Interpretive guide* has achieved this, and that it will contribute to ongoing quality and safety improvements in the health services delivered to Aboriginal and Torres Strait Islander communities.

Thank you to OATSIH, the RACGP National Faculty of Aboriginal and Torres Strait Islander Health, NACCHO and all affiliates for their contribution to this very worthwhile resource.



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Chair
National Aboriginal Community
Controlled Health Organisation



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and Torres Strait Islander Health

Acknowledgements

The development of the *Interpretive guide* to the RACGP *Standards for general practices*, to align with the fourth edition of the *Standards*, was funded by the Office for Aboriginal and Torres Strait Islander Health. It was undertaken by the RACGP National Faculty of Aboriginal and Torres Strait Islander Health in collaboration with the National Aboriginal Community Controlled Health Organisation and its state and territory affiliates.

We wish to acknowledge the great contribution to the *Interpretive guide* made by our external writers, Dr Hung Nguyen and Kim Thompson, who worked for many months to develop the content. This work included drawing on their own expertise and knowledge of accreditation against the *Standards*, conducting a literature review to source additional information and resources, and participating in two stakeholder workshops to learn more about what the Aboriginal community controlled health services (ACCHS) sector wanted. They then worked together, and with the RACGP project manager, to develop the content for the *Interpretive guide* in line with stakeholder preferences.

Dr Lester Mascarenhas wrote a section on continuous quality improvement (CQI), found in appendix B.

The RACGP National Faculty of Aboriginal and Torres Strait Islander Health consulted extensively in developing this guide. This consultation was primarily with people in the ACCHS sector, but also with a number of external stakeholders. The people acknowledged below attended two one-day workshops in Melbourne, often travelling considerable distances to do so. In addition, they worked with their colleagues to evaluate the guide to the RACGP *Standards for general practices* (3rd edition), and to review and provide feedback on successive working versions of this edition.

We are grateful to each and every contributor. It is due to their continued engagement, professionalism, enthusiasm and hard work that the final *Interpretive guide* is reflective of the ACCHS sector, and likely to be owned by member services as a key resource – both to achieve accreditation against the *Standards* and to continue to improve their delivery of safe, high-quality healthcare services to their communities. Special thanks go to Anthony Carter, NACCHO's accreditation policy officer, and accreditation staff from state and territory affiliates.

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Introduction

Background

In 2011 the Royal Australian College of General Practitioners was funded by the Office for Aboriginal and Torres Strait Islander Health to develop this guide. The objective was to update the 2010 guide to the RACGP *Standards for general practices* (3rd edition) to align with the fourth edition of the RACGP *Standards*.

For an overview of the key differences between the third and fourth editions of the *Standards*, see www.racgp.org.au/standards

Purpose

The purpose of the *Interpretive guide* is to explain the *Standards* in a meaningful way for Aboriginal community controlled health services by taking into account their context, culture and service delivery models. This aims to make it easier for such services to understand the requirements of the *Standards* and how they apply to their everyday practice, both in order to prepare for accreditation and to identify opportunities for continuous quality improvement. An interpretive guide, reflecting practices and language familiar to ACCHS staff, is also consistent with the values of self-determination and community control. In the long run, the guide will also help ACCHSs to provide safe, high-quality medical care in a changing and complex health environment.

The specific objectives of the *Interpretive guide* are to:

- interpret each Standard, criterion and indicator in a way that is meaningful to the sector
- provide examples for each indicator that a service could identify to show how it meets that criterion
- provide examples of good practice relevant to Aboriginal community controlled health services
- identify similar standards or criteria that Aboriginal community controlled health services may be accredited against
- define key terms used in the *Standards*
- provide links to additional resources that may be helpful in addressing each criterion.

The RACGP's increased focus on continuous quality improvement CQI is reflected in the fourth edition of its *Standards*. The *Interpretive guide* could also be used as a tool to support staff in a continuous process of learning and quality improvement.

The *Interpretive guide* is a companion document to the *Standards for general practices*. It should always be used as a secondary reference, to help users better understand how a Standard or criterion may be interpreted for an Aboriginal community controlled health service.

The *Interpretive guide* does not replace the *Standards for general practices*, and the *Standards* should be used as the primary source of authoritative information.

Development of the guide

This guide was developed by the Royal Australian College of General Practitioners in partnership with the National Aboriginal Community Controlled Health Organisation as well as its state and territory affiliates; a number of other organisations, including member services and assessing agencies, assisted.

These groups commenced work in July 2011 with an evaluation of the first *Interpretive guide*, via an online survey. Their findings were discussed in a one-day stakeholder workshop in August 2011. Stakeholders represented at this workshop included NACCHO, state and territory affiliates, member services, OATSIH, Australian General Practice Accreditation Limited (AGPAL), General Practice Australia (GPA) ACCREDITATION *plus* and RACGP.

The survey results showed that affiliates and member services wanted the *Interpretive guide* to the RACGP *Standards* to be structured in a similar fashion to the *Interpretive guide* to the Quality Improvement Council (QIC) *Health and community services standards* (6th edition). In its funding agreement, OATSIH also required the College to use a format similar to, and to include additional sections from, the QIC *Interpretive guide*. Consequently the content and structure of this edition of the RACGP *Interpretive guide* is significantly different to that of the *Interpretive guide* to the third edition of the *Standards*.

Three writers, Dr Hung Nguyen, Kim Thompson and Jill Dixon, then prepared the content according to this feedback, and presented it to stakeholders for review at a second workshop in March 2012. It was also reviewed by colleagues from the RACGP Clinical Improvement Unit, to check for alignment with the *Standards*. A new version was then developed, taking into account stakeholder feedback. This version was again reviewed by affiliates and member services, including services preparing for accreditation against the *Standards*. This was distributed in May 2012 for further, more extensive, feedback, obtained through the original stakeholder group as well as Aboriginal community controlled health services that were preparing for accreditation.

After incorporating the second round of external feedback into the final version, on 20 June 2012 both the RACGP National Faculty of Aboriginal and Torres Strait Islander Health and the RACGP National Standing Committee – Standards for General Practices endorsed the *Interpretive guide*, followed exactly one month later by the RACGP Council. The NACCHO Board endorsed the *Interpretive guide* on 24 August.

Who is the guide for?

This guide is designed for use by staff members in Aboriginal community controlled health services that wish to prepare for accreditation against the RACGP *Standards*, and for any of their supports (including NACCHO and affiliates).

Users of the guide are strongly urged to do so in the way that suits them best. It is likely that users will prefer some sections to others, depending on their experience and knowledge. Staff with experience in preparing for accreditation against the *Standards* may only want to refer to the guide on occasion, perhaps to clarify a word or concept, or to identify additional resources, a sample policy or template. Staff with little or no experience may use the guide much more extensively, at least initially.

Keep in mind that the guide is intended to be used in conjunction with the primary document, the *Standards for general practices*, which is available in hard copy from the RACGP, or in PDF version at www.racgp.org.au/standards. If there appears to be a difference between the two publications the information and advice provided in the *Standards* has priority over any interpretation or description in the *Interpretive guide*.

Structure of the Standards

The *Standards* are set out in five sections:

1. Practice services
2. Rights and needs of patients
3. Safety, quality improvement and education
4. Practice management
5. Physical factors

Each of these sections contains between one and seven Standards. Each Standard has one or more criteria, and each of these describes ways in which a service may demonstrate how it meets the criterion's requirements. Most criteria have indicators, some of which are flagged, which means they need to be met. Other indicators are not flagged and your service can decide for itself whether it wants to demonstrate how it meets that indicator.

The *Interpretive guide* uses the same structure.

Alignment of the Standards

The RACGP *Standards* contain some similar criteria to those in other standards. These include the International Organization for Standardization (ISO) *9001:2008 Quality management standards*; the Quality Improvement Council *Health and community service standards (6th edition)*; and the standards developed by the Australian Commission on Safety and Quality in Health Care.

The RACGP criteria that are similar to those in the ISO and QIC standards are identified at the end of each Standard. This is because you may be able to use evidence collected through obtaining accreditation against the RACGP *Standards* to meet some of these other standards, or vice versa.

In addition, your attention is drawn to the work of the Australian Commission on Safety and Quality in Health Care. This organisation was established in 2006 to lead and coordinate improvements in safety and quality in healthcare across Australia. Through wide consultation the Commission developed the *National safety and quality health service standards* in 2011. To support these, three draft guides were developed – for day procedure services, for hospitals and for dental practices.

While primary healthcare services, including ACCHSs, are not required to be accredited against the *National safety and quality health service standards*, the RACGP has incorporated key elements from them into the fourth edition of the *Standards*, to reflect the importance of safety and quality in primary healthcare. These criteria are:

- Criterion 1.5.2 Clinical handover
- Criterion 3.1.3 Clinical governance
- Criterion 3.1.4 Patient identification
- Criterion 5.3.1 Safe and quality use of medicines.

If you would like more information about the *National safety and quality health service standards*, you can find them at www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards



Structure of the guide

The guide is structured into a number of sections for each Standard, starting in each case with an overview, followed by more specific information for each criterion within that Standard. The sections are as follows:

Standards

Overview of this Standard

This section introduces and gives an overview of the general intent of the whole Standard.

Other information for this Standard

At the end of each Standard, you will find additional information that will further assist you to address the intent of the Standard and the requirements for accreditation.

- **What these words mean**, which provides definitions of technical terms (shown in blue).
- **Related external standards**, which identifies other standards or criteria, both in the RACGP *Standards* or the QIC or ISO standards, to which you may be able to cross-refer.
- **Useful resources**, which lists key documents – including and especially the relevant section of the *Standards* – and publications offering more information to help you better understand the requirements of the Standard. Some of these resources contain sample policies, procedures or templates that may help you address a gap in your own service's processes.

Criteria

Each criterion is described in several ways. You do not need to go through every one of these. It is recommended that you explore the different kinds of descriptions, and then decide which is of greatest use to you. The descriptions are:

In a nutshell

This section gives a brief, plain English explanation of the criterion, the main areas or functions within your service that are likely to be responsible for it, and the staff who are likely to manage it.

Indicators and what they mean

In this section, each indicator is explained in the context of the ACCHS sector. Note that, as indicated in the *Standards for general practices*, the symbol ► means the indicator is flagged and must be met. The indicators without this symbol are not flagged, and your service can choose whether it wants to provide evidence that it meets this indicator or not.

Case study

The case studies are theoretical, not real; they describe some of the ways that an Aboriginal community controlled health service might demonstrate good practice in relation to this criterion. Not all of these good practices are required by the *Standards* but they represent many practical and creative things ACCHSs can do to ensure they deliver services of high safety and quality to their community. This is particularly the case for rural and remote services that may need creative solutions to the unique challenges they face, such as their remoteness and climate or staffing and funding issues. Note that these theoretical case studies are not definitive and you will be able to add some of your own examples of good practice.

Showing how you meet the criterion

This section offers examples of the kind of evidence a health service may produce for accreditation purposes, to demonstrate how it meets the indicator or criterion.

Note: when thinking about the evidence – including policies and procedures – that may demonstrate your compliance with any Standard, it is recognised that your health service may already have certain cultural practices and protocols in place as part of its cultural safety and competency framework. This is in line with good practice in services providing care to culturally diverse communities. These practices and protocols may also reflect community expectations of Aboriginal community controlled health services. We recommend that where these cultural practices occur, you document or provide other evidence of them. Usually they can be found in your induction or orientation packages or they may be part of the cultural orientation that is provided for new staff. Referring to these documents can help you develop the policies for this and other Standards. This is also a good way of demonstrating the cultural practices particular to your health service.

Appendices

There are three appendices.

- Appendix A: tips to help services preparing for accreditation.
- Appendix B: a brief overview of continuous quality improvement.
- Appendix C: focus groups as a method for obtaining patient feedback.

A note on terminology

Where possible, words are expressed in plain English. Highly technical words or jargon are avoided. Where technical words are used, a definition is provided and the word highlighted in the text, in [blue](#).

This is not trying to dumb down the the *Standards*, but to ensure that information is communicated clearly to a diverse range of users, including people for whom English may be their second, third or fourth language.

Note that the wording of each Standard and criteria is exactly as in the *Standards for general practices*. You can interpret some of these words in terms that relate to your own service. For example, where the word practice is used in the *Standards*, this term can be interpreted to mean health service; and where the word patient is used in the *Standards*, this term can be interpreted to mean client.

Throughout the guide, reference is made to the words standard, criterion and indicator. These are commonly used terms in standards documents and accreditation guidelines, and are defined below and on the following page:

Standards

These are the set of specifications covering the operations of an organisation. If organisations can demonstrate that they meet or exceed these specifications, they can be said to comply with the standards.¹

1. OATSIH Accreditation manual: a handbook for Aboriginal and Torres Strait Islander community controlled health organisations (2010)

Criterion

A standard on which a judgement or decision can be based.² Each Standard has a number of criteria, which are then considered by the assessing agency to determine whether the health service has met the overall requirements of the Standard.

Indicator

A sign that shows the condition or existence of something.³ Most criteria have a number of indicators, or signs, to explain how your health service can meet the Standard. Some evidence that can be provided is likely to be quantitative, or in numerical or statistical form (for example, a percentage). Other evidence is more likely to be qualitative, or descriptive (for example, an interview with staff or patients). Mostly, the *Standards* do not specify what evidence you could provide to demonstrate how your service meets a particular indicator. This means it is generally up to you to decide what evidence you will use.

Some indicators in the *Standards* are flagged as mandatory. This means that they must be met for accreditation purposes. Others are not flagged, and you can decide whether your service will provide evidence or not.

See also the glossary of terms in the *Standards for general practices* or on the website at www.racgp.org.au/standards/glossary

Accreditation

Accreditation is used in a number of industry sectors to ensure that organisations meet a set of standards relevant to the products, programs or services they deliver. It involves the organisation being reviewed by an external team to assess the extent to which it has met an approved set of standards.

With some sectors, such as the building industry, the standards may be reasonably clear and measurable, both by the organisation itself and by the external standards assessing agency. In the health sector, the standards can also be tangible and relatively easy to measure and monitor (for example, patient health records). However, some standards or criteria are less tangible or visible (for example, collaborating with patients), and thus are more difficult to measure and monitor on a day-to-day basis.

This means that it can be difficult for a health service to be confident that every day it is delivering high quality and safe services to its patients. For this reason, amongst others, external accreditation is a vital means by which a health service can demonstrate to its patients, board and community that its services are safe and of high quality, that it has effective systems for important areas, such as risk management, and that it is actively committed to quality improvement. This is not just because of the accreditation certificate that the service can proudly display in its reception area, but also because through the accreditation process it will receive vital feedback on where it is doing well and where it can improve, in relation to the *Standards*.

For more information on the accreditation process, read the *Accreditation manual: a handbook for Aboriginal and Torres Strait Islander community controlled health organisations* (2010), published by the Department of Health and Ageing, with the assistance of NACCHO and affiliates. You can get a copy through your state or territory affiliate, through OATSIH, or online at www.health.gov.au/internet/main/publishing.nsf/Content/OATSIH_Accreditation_Manual

2. Merriam-Webster dictionary at www.merriam-webster.com/dictionary/criterion

3. Merriam-Webster dictionary at www.learnersdictionary.com/search/indicator

Why would our health service want accreditation?

The *Standards for general practices* provide a framework for the quality and safety of the services your health service delivers to its patients. Seeking accreditation against the *Standards* is a clear way of demonstrating to your patients, staff and community that your service takes the safety and quality of their healthcare seriously. Achieving accreditation means that your service has been assessed as having reached defined standards of excellence in safety and quality in primary healthcare. This should be a matter of great pride to the service itself, its patients and the community.

However, the accreditation certificate is only one tangible outcome of accreditation. There are many other benefits that flow from accreditation, some of them less tangible.

- Through the process of preparing for accreditation, your staff will engage in a variety of activities to learn more about what each Standard requires and what your service currently does to address that Standard. They will also learn more about what might need to be done if a gap exists between what the Standard requires and what the service is currently doing. These learning opportunities can bring huge benefits to the individual staff member or team, and to the service itself.
- Any time you take action to address any identified gaps, you have achieved a significant improvement for your service. Those improvements will often benefit staff as well as patients, because of improved job satisfaction.
- Because some of the Standards require your service to have processes in place to identify and address various kinds of risk, it is less likely your service will be exposed to these risks, and/or will be better able to manage them if it is.
- Other Standards relate to the sustainability of your service, or of the programs it offers to the community. When these are incorporated into your service's normal business and clinical processes, there is a greater chance of survival and growth over the long term.
- OATSIH currently provides funding for Aboriginal community controlled health services seeking to become accredited against a range of healthcare-related standards, including the RACGP *Standards*.
- Eligibility requirements to participate in some government initiatives, especially the Practice Incentives Program Indigenous Health Incentive, include accreditation against the *Standards*.
- The *Standards* can be a useful way to train doctors and GP registrars in the quality and safety standards and processes of your service.

Note: Unless otherwise mentioned, please assume that any reference in this guide to the *Standards for general practices* refers to the 4th edition.

The *Standards* are regularly reviewed. See www.racgp.org.au for updates.



Section 1

Practice services

Standard 1.1

Access to care

Our practice provides timely care and advice.

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Standard 1.3

Health promotion and prevention of disease

Our practice provides health promotion and illness prevention services that are based on patient need and best available evidence.

Standard 1.4

Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

Standard 1.5

Continuity of care

Our practice provides continuity of care for its patients.

Standard 1.6

Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Standard 1.1

Access to care

Our practice provides timely care and advice.

Overview of this Standard

This Standard is about community members' and patients' access to healthcare, and the timeliness of this access. It is also about how your health service communicates information about access to its community and its patients.

When preparing to address this Standard you will need to [demonstrate](#) that:

- your opening hours are flexible, and you recognise and are responsive to different patient needs
- you take into account the patient and community need for home or other visits as well as the safety of your [clinical team](#) who have responsibility for providing home and other services
- you provide information over the phone or by email, if that is the best way to do this, and if it is clinically safe
- you clearly communicate to your community and patients the out-of-normal-opening-hours medical care available
- you have a formal written agreement in place with any other services you have arrangements with to provide after-hours care to patients or community members requiring [urgent](#) attention
- you have considered the risks in providing your patients with non-face-to-face information and advice – for example, via telephone and electronic means – in light of your [privacy and confidentiality](#) obligations.



Criterion 1.1.1 Scheduling care in opening hours

Our practice has a flexible **system** that enables us to accommodate patients' clinical needs.

In a nutshell

Your health service is able to demonstrate that it provides for and recognises:

- different types of patient needs
- different types of consultations
- different skill sets of professional staff to adequately cater to those needs.

Your health service will also need to demonstrate that it has a triage system – a way of responding to life-threatening and urgent medical matters. All staff members who come into contact with patients need to know this system.

Key team members

- Clinic manager/nurse
- Administrative staff
- Clinical staff

Key organisational functions

- Community consultation
- Population health
- Appointment systems (if used)
- **Triage** protocols and staff training
- Documentation of health records
- Communication policies for internal and external communications

Indicators and what they mean

Table 1.1 explains each of the indicators for this criterion. Refer to page 8 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.1**Criterion 1.1.1 Scheduling care in opening hours**

Indicators	What this means and helpful hints
<p>► 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.</p>	<p>Your health service provides patient care that:</p> <ul style="list-style-type: none"> • is flexible and recognises different patient needs by providing different types of consultation (long or short), different types of care (complex care, preventive care), and different levels of access (appointment system or walk-in service) • is responsive to patients' needs for urgent care • clearly communicates to the community and patients about opening hours and clinic service • clearly communicates information to patients about waiting times or the order in which patients will be seen.
<p>► B. Our practice can demonstrate how we identify, prioritise and respond to life-threatening and urgent medical matters (triage).</p>	<p>Your health service has policies and procedures for emergency and life-threatening medical situations by having a triage system. This system is known and understood by all staff who come into contact with patients. Administrative and clinic staff need to be able to describe your service's triage system and how it works. Your triage system includes procedures for clinical and administrative staff that outline:</p> <ul style="list-style-type: none"> • how to identify patients with urgent health needs, including how to recognise when urgent medical assistance is needed, and how to ask patients the right questions to identify when urgent assistance is needed • how to quickly get urgent health assistance, when needed, for patients who come to the health service • how to manage patients who have urgent health needs when the health service is full • how to keep track of, and record in writing, triage responses by administrative and clinical staff • the triage training provided to administrative and clinical staff.
Services providing care outside normal opening hours	
<p>► C. Our service obtains feedback, from practices for which we deputise, about the quality and timeliness of our care provided for their patients.</p>	<p>If your service has an arrangement to provide after-hours care for patients of another clinic or health service, it has a procedure for obtaining feedback from that clinic about the quality of your care and how quickly that care is provided to those patients.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it has a flexible system to accommodate its patients' clinical needs. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service provides a variety of appointment types on a daily basis to meet different patient needs. These include short, standard, long and emergency appointment slots, to provide different kinds of healthcare to suit the needs of the community. Use of these different appointment types is monitored, so changes can be made if it is clear that patients need a different mix of appointment types.

Because many new patients don't understand how the appointment system works, the service's staff members try to help them. For example, if a first consultation takes longer than planned, the doctor tries to extend it, as long as it doesn't hold up other patients too much. If the patient has to make another appointment to fit everything in, the doctor or the receptionist will explain to the patient how the appointment system works, so that they know what to do next time. This means that if a patient presents with complex care requirements, or if a family member attends, wanting medical assistance too, they are helped to understand how to work within the appointment system in the future.

New patients are given longer initial appointments, so that the doctor can take the time needed to get to know them and establish a relationship. Because the service understands that trust is an essential element of its healthcare, it recognises that the first appointment may achieve nothing other than allowing patients to start trusting the doctor.

Some appointments are kept free at the end of every day for walk-ins, which allow for extra family members and patients to be seen without prior arrangements or appointment bookings. A doctor and other clinical staff are rostered with no appointments to run a walk-in clinic at these times. If there are no walk-ins at the time allowed, they use that time to do other tasks, such as reviewing pathology reports, writing referrals or other administrative duties. This arrangement means that the doctor may also be able to respond to more

urgent matters as well, such as emergency walk-in patients who have been appropriately triaged by reception staff or other clinical staff.

Some regular patients are given longer appointments, because they have multiple or complex health problems. Others are given longer appointments because reception staff know that they need plenty of time with the doctor in order to explain their problem and have it treated properly.

A sign on the service's front door clearly shows its opening hours and explains how to get emergency care when it is closed. Inside the service, information sheets are available with details of opening hours, types of appointments available (including walk-ins), appropriate contact details for bookings and advice for seeing different clinical staff. The message on the answering machine clearly says how to get emergency care when the service is closed.

The service has a triage [policy](#), which clearly defines triage roles for clinical and non-clinical staff members. This is available in hard copy and electronic format to be easily accessible to all staff, including locum, visiting and part-time staff. All staff are provided with triage training on their first day, as part of orientation, and this is documented in the training calendar and staff training records. In addition, triage flow charts and guidelines are readily accessible to reception and clinical staff, to remind them of the triage system. This means that reception and administration staff are skilled at knowing what to do when a patient requires urgent medical assistance, even if the service is fully booked at the time.

Transport is provided to enable patients in remote areas and outstations to access the health service. This reduces the need for home visits and ensures more urgent matters are attended to in a timely manner. It also allows recalls to be followed up in a timely manner. The planner/calendar provided in

the waiting area, reception and staff common areas shows everyone the days when outstation/outreach clinics are held and the locations they are held.

Patient feedback shows that patients understand the need for and are happy to wait while the service attends to urgent or life-threatening matters, because they know the service tries to be flexible when attending to their own needs.

Showing how you meet Criterion 1.1.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Keep an appointment book (paper or electronic) showing a variety of appointment types, including:
 - long appointments
 - short appointments
 - walk-in appointments
 - recall appointments
 - reserved appointment times for urgent appointments on the day.
- Show evidence that staff members update the patient waiting list if there has been an emergency and that they explain to patients that this may increase their waiting time to see the doctor and other clinical staff.
- Have signs for long appointments.
- Have triage guidelines at reception area.
- Make a triage flowchart available for reception and clinical staff to refer to.
- Have staff induction and training records documenting triage training activities.
- Display a sign on the front of the clinic giving contact details for patients requiring urgent care outside normal opening hours.
- Keep staffing rosters.
- Display a sign on the door and have an after-hours phone message advising patients how to access care out of normal opening hours.
- Display a sign in the waiting area to advise patients with high-risk symptoms to let reception know.
- Ensure your service's health records show documentation of care plans, reviews and up-to-date health summaries.
- Ensure Medicare billings include item numbers for consultations such as health assessments, chronic disease care plans, diabetes and asthma cycles of care.
- Ensure remote clinics keep an emergency call-out log for the clinic-run ambulance and a procedural flow chart for medical emergencies and evacuations that involve the local district medical officer (DMO) and hospital.
- Keep a memorandum of understanding (MOU) or other agreement with a deputising service.
- For health services providing care outside normal opening hours:
 - keep an MOU or other agreement with the service
 - annually renew the agreement to provide deputising services
 - conduct an annual questionnaire relating to service provision.

Criterion 1.1.2 Telephone and electronic communications

Patients of our practice are able to obtain timely advice or information related to their [clinical care](#) by telephone and electronic means (where in use) where a GP determines that this is clinically safe and that a face-to-face consultation is unnecessary for that patient.

In a nutshell

Your health service may give information or provide advice regarding clinical care to patients over the telephone or by electronic means. Your service needs to decide what information can be given to patients in this way, and by which staff members. This criterion is about providing good quality information when it is safe to do so.

Key staff members

- Reception staff
- Clinical staff
- Clinical leaders
- Administration

Key organisational functions

- Internal and external communications policies
- Triage protocols and staff training
- Patient confidentiality and privacy
- Patient health records policy and procedures
- Clinical risk-management systems
- Patient information management systems and processes
- Patient identification policy and procedure

Indicators and what they mean

Table 1.2 explains each of the indicators for this criterion. Refer to page 11 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.2**Criterion 1.1.2 Telephone and electronic communications**

Indicators	What this means and handy hints
<p>► A. Our practice team can demonstrate how we receive and return telephone and (if applicable) electronic messages from patients.</p>	<p>Your service has policies or procedures in place that clearly set out:</p> <ul style="list-style-type: none"> • the kind of information and advice that can be given to patients over the phone or electronically. This is usually information such as confirming appointment times or passing on simple messages from the doctor • the kind of information and advice that cannot be given over the phone or electronically. This is usually more sensitive information such as STI and HIV test results, pregnancy results or test results that need to be explained by a doctor • a method for reception staff to know how to receive patient phone calls, which ones they need to transfer to a doctor, nurse, Aboriginal health worker (AHW) or other staff, and how (and where) to record messages and pass them onto the doctor, nurse, AHW or other staff • a method for identifying patients over the phone that guarantees the information is provided to the right person. This usually includes three different personal questions about the patient (see definition of patient identifiers in Standard 1.6). Your service may also have a way to identify family members who have permission from the patient to receive information about them. A method for finding out who has been given permission and how to identify that family member could also be included • an email policy to ensure patients are told of the risk to their confidentiality when using email to communicate with the service. Patients can also be told how often you check emails, and the best way to contact the service for urgent matters. The policy could also clearly state the situations in which email can be used to give information and advice to patients because, even when encrypted, it poses a higher risk to confidentiality than other forms of communication – especially because there is no way of identifying the person receiving the email.
<p>► B. For important communications, there is evidence of practice/ patient telephone or electronic advice and information in our patient health records.</p>	<p>Staff who have responsibility for giving important clinical information and advice to patients by phone or email are trained to write that information in patient health records. This could include the time and date the information is given as well as the kind of information that was provided.</p> <p>It is also recommended that doctors and clinical staff get permission from patients who would like to receive clinical information and advice by phone or email, and that this is recorded in the patient's health record. When giving their permission, patients could also be told of any fees and costs they may be charged. This can be done via a printed handout written in simple language that explains the charges and costs. If there are no fees for services, this is also stated clearly.</p>
<p>► C. Our practice's on-hold message (if we have one) provides advice to call 000 in case of an emergency.</p>	<p>Your service gives advice to call 000 to patients who are put on hold so that they have an alternative way of getting urgent medical attention and advice if needed. If necessary your service gives this advice in community languages.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure its patients are able to obtain timely advice or information about their clinical care, when appropriate, by telephone or electronic means. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service has a system in place to ensure that current phone numbers and an alternative contact for patients are available to staff. It also has a paper-based and/or electronic messaging system. The doctors return phone calls after lunch before seeing the next lot of patients.

The reception area has a list for each doctor, detailing who will be allowed to interrupt them while they are seeing a patient. For example, Dr Best will only take phone calls from other doctors or the local hospital emergency department staff but Dr Practice will take phone calls from other doctors, specific patients he has been trying to contact, pharmacists and Royal Flying Doctor Service staff members.

The service has a set protocol for switching the answering machine system on and checking that the message is correct at the end of each day.

Staff members ask patients their name, address and date of birth (if known) before giving any information over the phone. Sometimes the staff also ask for patients' skin name if they have one.

Staff members make a note in patients' health files when they receive a phone call from, or make a phone call to, patients about clinical matters. Staff also record any advice or information they have given to patients and if they have made an appointment to see patients face to face.

Patients' files will contain a note if the patient has given staff consent to contact someone else on their behalf.

Staff members' training logs show attendance at a privacy and confidentiality training session.

Showing how you meet Criterion 1.1.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a paper-based messaging system.
- Maintain an electronic messaging system (email, SMS texts, voicemail and messages).
- Ensure reception staff can demonstrate that they know which phone calls need to be transferred to doctors or other staff who provide healthcare for patients.
- Ensure the appointments book shows that doctors, nurses and other clinical staff have time set aside during the day for returning phone calls to patients.
- Keep a policy, procedure or flow chart showing how to deal with phone calls from patients.
- Ensure that patients' health records show entries of when staff members talked about clinical matters to patients either by phone or email.
- Take notes that show when patients called, their reason for calling and what advice they were given.
- Ensure that when someone rings your service and is placed on hold they will hear a message advising them to hang up and call 000 in case of an emergency.

Criterion 1.1.3 Home and other visits

Regular patients of our practice are able to obtain visits in their home, residential aged-care facility, residential care facility or hospital, both within and outside normal opening hours where such visits are deemed safe and reasonable.

In a nutshell

Your health service ensures that its patients can receive home and other visits, both during and outside normal opening hours. It has a written policy describing the circumstances in which home visits could take place. When creating a home-visit policy, your health service must consider the patients' and the community's need for home visits as well as the safety of clinical staff who provide home visits, and try to strike a balance between the two.

Key team members

- Practice manager
- Clinical staff
- Reception staff
- Driver
- Community liaison officer

Key organisational functions

- Home and other visits policy
- Clinical staff safety policy
- Documenting patient health records
- Clinical staff personal safety and care
- Provision of [continuity of care](#) to patients and the community

Indicators and what they mean

Table 1.3 explains each of the indicators for this criterion. Refer to page 14 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.3
Criterion 1.1.3 Home and other visits

Indicators	What this means and handy hints
▶ A. There is evidence that patients of our practice access home and other visits both within and outside normal opening hours.	It is a regular part of your health service to provide home and other visits to patients within and outside normal hours. This may be because home visits have been common practice, are due to community expectations or are part of an existing policy regarding access to care. For example, many Aboriginal medical services have a policy about providing out-of-hours care because they want to ensure that patients of Aboriginal and Torres Strait Islander origin have access to a health service.
▶ B. Our practice team can demonstrate our practice's policy on home and other visits, both within and outside normal opening hours, and the situations in which a visit is deemed appropriate.	Your clinical staff understand and follow your health service's policy on home and other visits. When the policy is updated, clinical staff are given the appropriate training and information about the updated policy. This also means that the clinical staff can easily explain and describe the situations where a home and other visit could be made and when it would not be considered safe and reasonable.
▶ C. Our practice has a written policy on home and other visits, both within and outside normal opening hours.	<p>Your health service's written policy on home or other visits contains clear guidelines about:</p> <ul style="list-style-type: none"> • the situations and times in which a home or other visit could be made. Generally, this would include the types of medical situations involved and when it is safe and reasonable to do so (see the case study on page 20 for examples of what might not be safe and reasonable) • its definition of safe and reasonable. This may depend on issues such as availability of other medical services in your community, the types of medical problems that would require a visit or what would be considered a reasonable distance for staff to travel for a home visit. The definition should consider the situation with regards to the medical needs of patients, and the safety of clinical staff doing the visit (see page 16 of the <i>Standards</i> for guidelines on the safety of health professionals when conducting home visits) • the geographic area that your health service will cover for home and other visits • the situations and places in which home visits are deemed not safe or reasonable, and in such situations whether there is alternative medical care for patients, how far that is and how patients could get to the alternative medical care • the staff who could do the home or other visit. For example, it should be done by a vocationally recognised and qualified GP; if the GPs are not recognised, they have been assessed for entry to general practice and have the appropriate supervision, mentoring and support in their education. Where nurses or Aboriginal health workers do home visits by themselves, the policy could state the situations under which they may do so. This might be when they are supervised by a qualified GP, either on site or by phone, or remotely using the DMO service by telephone or video conferencing when required.



Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it provides appropriate home and other visits for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's health team provides outreach/ outstation health clinics to communities in several locations each month. These outreach clinics are set in a regular routine so the community members know when the clinics are due. The outreach clinic dates (for example, every second Thursday) are included in the health service information sheet and on posters in the waiting area.

The staff members are aware that, in line with the health service's staff wellbeing policy, home visits are done up to a radius of 50km and two staff members conduct visits together. Staff members are required to fill in a log sheet of the patient's name and location and the expected time of return from the home visit. Staff members have either a mobile phone or two-way radio for emergency communication back to the service.

If there is only one clinician in the community at the time, they take a satellite phone with calls to the service diverted to it. If no clinician is available at the time, the district medical officer, community liaison officer or driver is contacted.

Home and other visits are assessed for the possibility of violence, and if this is likely the police will be asked to accompany staff members making the visit. Police are requested to attend where a patient is threatening suicide or if there is evidence of a threatening or abusive person present.

The occupational health and safety policy and procedures provide guidance for staff about what to do or who to call if they feel unsafe. This might include asking the patient to meet at the health service, or to have a female family member present if the patient is male and the clinician is female.

The health service policy on home visits and staff safety contains at a minimum that patients are asked to restrain dogs and turn on outside lights at night.

Staff members document home visits in patient health records, including date, time, reason for visit and treatment provided. Medicare item numbers for home visits are utilised when they apply.

Showing how you meet Criterion 1.1.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Provide staff interviews, showing that the written policy and procedures match the actual process used by the health service staff.
- Keep in-service logs on policy and procedures.
- Provide staff inductions and ongoing training processes and records.
- Keep health records showing entries of when staff members have provided home visits and the time they occurred.
- Keep Medicare billings.

Criterion 1.1.4 Care outside normal opening hours

Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours.

Amended in July 2015

In a nutshell

Your health service needs to make sure that safe and reasonable arrangements are in place for the medical care of its patients outside normal opening hours. This can be done in many ways. You may provide the out-of-hours care itself, or you may make arrangements with another health service (an accredited medical deputising service or the local hospital) to provide out-of-hours care. Alternatively your service may make arrangements through a co-operative of health services. Where arrangements have been made, it is a good idea to have written agreements that clearly set out the terms and conditions of the service. Information about the after-hours service should also be made easily and prominently available to patients, along with important information such as fees and costs associated with the after-hours care.

Key team members

- Practice manager
- Clinical staff
- Reception staff

Key organisational functions

- After-hours policy
- Formal agreements with after-hours service provider
- Privacy and confidentiality policy
- Documentation and maintenance of patient health records
- Access to patient health records policy
- After-hours care promotion and staff training
- Staff communications system
- Quality and continuity of medical care
- Patient access to after-hours care
- Patient communication and informed choice

Indicators and what they mean

Table 1.4 explains each of the indicators for this criterion. Refer to Criterion 1.1.4 Care outside normal opening hours of the *Standards for general practices for explanations* of some of the concepts referred to in this criterion.

Table 1.4**Criterion 1.1.4 Care outside normal opening hours**

Indicators	What this means and handy hints
<p>► A. Practices are aware of the arrangements in place for their patients to access after-hours care.</p>	<p>Your health service knows of the arrangements that are in place for the medical care of patients outside normal opening hours. These arrangements need to be in writing and to be well known to staff and patients. This means that:</p> <ul style="list-style-type: none"> • Where your health service provides its own out-of-hours medical care, you have an arrangement in place that is well known to staff, such as an easily accessible roster. Where a doctor is responsible for after-hours care, a notice to staff with this information and a process for communicating this to patients would be sufficient evidence. • Where your health service has an arrangement with another health service to share after-hours care, you should enter into a formal arrangement that clearly sets out who provides the service, when it is provided, the area it covers and what communication and follow-up arrangements have been made between the two services. • Where your health service makes an arrangement for another health service to provide after-hours care, you enter into a formal agreement, such as a contract with an accredited medical deputising service, that clearly sets out the terms of the agreement, including for communication and follow-up arrangements. • Where your health service makes an arrangement for patients to go to the local hospital or an after-hours facility for after-hours care, you should have a formal agreement with the other service provider that clearly sets out the terms of the arrangement. • If the hospital is reluctant to enter into a formal agreement (for example, through an MOU), your health service is advised to continue to request an MOU with the hospital every six months and document the correspondence (or lack thereof). • Where your health service does not provide its own out-of-hours medical care or have formal arrangements in place with other services as noted above, you must know what arrangements are in place within your local area for patients to access out-of-hours medical care. <p>Formal agreements with out-of-hours medical service providers could include the following aspects:</p> <ul style="list-style-type: none"> • an agreed time frame for the out-of-hours service provider to provide feedback or a report about the medical care they gave your patients (as early as practicable) • an agreed way of providing access to patient health information (or your health service's doctor) to the out-of-hours doctor, such as in an emergency or in exceptional circumstances • an agreement about who can provide the out-of-hours care, such as the qualification and experience of doctors, or that Aboriginal health workers are supervised by a qualified doctor and the conditions of that supervision

Table 1.4 (continued)

Indicators	What this means and handy hints
	<p>Your patients need to know how they can access care outside normal opening hours.</p> <p>You may do this through:</p> <ul style="list-style-type: none"> • a message on your telephone answering machine, call diversion system or paging system clearly telling patients about where to go for out-of-hours care • notices, posters or other information about the out-of-hours service prominently displayed for patients' attention • relevant information available on your website, practice leaflets and new patient information packs.
<p>► B. Practices have processes in place to alert their patients to these arrangements</p>	<p>Where possible, community language(s) should be used to communicate information to patients.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it provides care outside normal opening hours for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service has an equipped ambulance, and staff are rostered on to provide after-hours care to patients. All patients seen out of hours have entries in their health files that include the date, time, presenting problem, provisional diagnosis, treatment, investigations, planned follow-up and any referrals or transfer to another facility for further care.

The health service has a defined policy on safe and reasonable arrangements for the provision of after-hours care. This details the hours in which after-hours care is provided; the distance from the health service that staff are permitted to travel, as well as who to inform before they travel and the route they are taking; which staff members may participate in the after-hours care roster; the down time before staff are expected to be back at work if they have been called out after hours; and when it would be reasonable to delay having a consultation until normal opening hours (for example, if it would be safe for the consultation to take place at this time).

There are two satellite health services. One has a formalised written agreement with the local hospital that the hospital will provide after-hours care to the patients of the service and will provide faxed or encrypted email reports of presentations to the hospital back to the service each morning. The second health service participates in an after-hours roster with two other medical practices where the doctors provide after-hours care; these services fax reports after being the on-call practice to the other practices each morning. There is also a formalised written agreement signed by each of the practices and doctors who participate in the after-hours roster.

Pathology providers are given a copy of the after-hours roster so the relevant clinical staff members can be contacted in case abnormal or life-threatening conditions or results are identified after hours and need to be addressed immediately.

Showing how you meet Criterion 1.4.4

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Provide an induction and training process and records.
- Maintain an after-hours roster showing which staff are on call.
- Maintain a formal after-hours agreement with another health service that shows how after-hours care is shared.
- Maintain a contract with another health service that will provide after-hours care on behalf of your service.
- Maintain a formal agreement with a local hospital, which details that your patients can access after-hours care for urgent presentations.
- Ensure staff members are able to explain how your patients can access care after hours.
- Ensure remote area health services have a 4WD ambulance that is manned by a combination of doctor, remote area nurse and Aboriginal health workers.
- Ensure community members are aware that the staff member who is on call for after-hours care is the person who has the ambulance parked outside their house.
- Ensure that on-call staff members have the contact details for the Royal Flying Doctor Service and have been trained in liaising with this service in case of emergency.

- Ensure patient health records have entries of after-hours care given, either as direct entries by your staff or as scanned entries of treatment reports from the other health service that provided the care.
- Maintain an after-hours voicemail message that clearly states how to get care after hours.
 - Ensure this message indicates that out-of-hours care is only available for medical situations that can't wait for a consultation during normal opening hours.
- Put up signs about after-hours care in the waiting area and on the outside of your health service.
- Ensure staff members have access to the on-call roster and contact details of who is providing after-hours care.
- Ensure staff members know how pathology providers can contact the relevant staff with seriously abnormal or life-threatening results after hours.
- Ensure your service sends reports of patients seen out of hours on behalf of an after-hours cooperative to their nominated health service or GP by fax or secure email.
- Ensure your service has contact details for the health services it provides after-hours care for if urgent contact is needed in relation to one of their patients.
- Provide evidence of current registration and qualifications of health professionals.

Other information for this Standard

What these words mean

Administrative staff

(adapted from the *Standards'* glossary)

Staff employed by the service who provide clerical or administrative services (for example: filing, reception, community liaison, driving) and who do not perform any clinical tasks with patients.

Clinical care

Healthcare that is provided to patients in a clinical setting. This generally involves taking account of a patient's health history, what the patient has to say and, where necessary, physical examination. This is followed by advice, investigation and/or treatment. Finally, where necessary, it may involve referring patients to another practitioner for specialised care.

Clinical team

(adapted from the *Standards'* glossary)

The members of the practice team who have qualifications related to healthcare and who do clinical work. These could include Aboriginal health workers, nurses, doctors and allied health professionals.

Continuity of care

(adapted from the *Standards'* glossary)

The extent to which a series of separate healthcare events is experienced by a patient as part of the same process, connected and consistent with their medical needs and personal context.

Cooperative care

Where a number of health services in a geographic area cooperate to provide specific parts of medical care such as sharing after-hours care.

Demonstrate

Clearly shows the existence or truth of something by giving proof or evidence. For example the health service staff may show and explain how something works in practice. Staff may explain how the triage policy and procedures work through flow charts and active staff communication; the in-service training schedule shows how often in-service occurs, the topic presented, who attended and their feedback.

Deputise

Act as a substitute (in place of someone) such as when a health service arranges for another medical clinic/practice to provide care for its patients on its behalf when it is closed.

Normal opening hours

(adapted from the *Standards'* glossary)

The advertised opening hours of the health service.

Patient health information

(adapted from the *Standards'* glossary)

This include a patient's name, address, account details, Medicare number and any health information (including opinion) about the person.

Policy

A set of principles, rules or guidelines published by an organisation and made available to its staff to help it reach its goals.

Privacy and confidentiality

Privacy is about a patient's right to have information about themselves not be known to and by other people, or shared with other people without their permission.

Confidentiality means that all information about the patient that is told to a doctor, nurse, Aboriginal health worker and other staff or held in health records is kept in a safe place so that other people cannot get to it or be told about it. Confidentiality is a professional obligation that health professionals and the health service have to the patient.

Procedures

Step-by-step, written rules about how something is to be done. Everybody knows and follows these rules so that things are done consistently. Procedures come from policies, which are general rules about good practice.

System

(adapted from the *Standards'* glossary)

An organised and coordinated method or procedure. For example a triage system helps a health service to ensure it is properly organised to respond to emergency and life-threatening medical situations.

Triage

Triage is derived from the French word *trier*, which means to sort out or choose. Triage is when staff at the clinic sort out and put in order of importance the patients who may need urgent medical help or not. This helps to work out the type of care needed and how quickly patients must be cared for.

Urgent

(adapted from the *Standards'* glossary)

A health need requiring immediate action or attention.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.1 Access to care:

- 1.6 Knowledge management
- 1.7 Risk management
- 2.1 Assessment and planning
- 2.2 Focusing on positive outcomes

The ISO *Standards* include the following requirements that are relevant to Standard 1.1 Access to care:

- 5.2 Customer focus
- 6.1 Provision of resources
- 7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*, and a triage support guide:

- sehpa.com.au/policy-procedure-manual
- sehpa.com.au/triage-support-guide

The AH&MRC's *Policy and procedure manual for Aboriginal community controlled health services in rural NSW* (3rd edition) has a section on patient telephone and electronic contact on pages 61 and 62, and a section on appointment management on page 64:

- www.ahmrc.org.au/index.php?option=com_docman&task=cat_view&gid=28&Itemid=45

The AMSANT *Administration manual* includes drafts for developing your own health service policy, which includes sections on access and equity, appointments and patient services:

- [Proforma%20Health%20Service%20Policy.doc](#)

The AMSANT *Administration manual* also includes a draft for developing your own communications policy:

- www.amsantmanual.com/proforma/policies/Proforma%20Communications.doc

There is also information on dealing with violent or intimidating clients in the occupational health and safety (OH&S) section of the AMSANT *Administration manual*:

- www.amsantmanual.com/09healthandsafety.html

Andrew Knight and Tony Lembke's *Australian Family Physician* (Vol. 40, No. 1/2, January/February 2011) article 'Appointments: Getting it right' shares lessons about improving appointment scheduling:

- www.racgp.org.au/afp/2011/januaryfebruary/appointments

The Australian Medical Association has a position statement on personal safety and privacy for doctors:

- <http://ama.com.au/nod/2182>

The RACGP publications *Keeping the doctor alive: a self care guidebook for medical practitioners* and *General practice – a safe place* are both useful:

- www.racgp.org.au/peersupport
- www.racgp.org.au/gpsafeplace

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make **informed decisions** regarding their care.

Overview of this Standard

This Standard is about providing patients with information about your health service in order to promote access to care, and to eliminate, as much as possible, potential barriers to that access. This Standard is also about the communication and information factors that contribute to informed patient decision-making. For Aboriginal community controlled health services, language and culturally appropriate resources are important elements of patient communication about all aspects of the health service delivery. These are especially important because of cultural, language and other barriers to effective communication.

When preparing to address this Standard your health service could consider issues such as:

- culturally safe practices among clinical and reception staff
- cross-cultural communication skills of clinical and reception staff
- appropriate use of interpreting services, cultural brokers and Aboriginal health workers by clinical and reception staff
- community expectations of access to and communication from the health service.



Criterion 1.2.1 Practice information

Our practice provides patients with adequate information about our practice to facilitate access to care.

In a nutshell

Your health service gives to its community and patients all the information that they need in order to use its services effectively. This can be in writing, such as a notice or information sheet, or a combination of writing and pictures or diagrams. It can be communicated verbally if that works better. Whichever form the information takes, it needs to be clear and easily understood so that patients understand how your health service works and how they can use its services.

Key team members

- Practice manager
- All clinical staff
- Reception staff

Key organisational functions

- Practice information sheet
- Patient communication
- Communication policies
- Billing policies and functions
- Patient health information management policy
- Follow-up management processes
- Patient complaints process and protocol

Indicators and what they mean

Table 1.5 explains each of the indicators for this criterion. Refer to page 21 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.5**Criterion 1.2.1 Practice information**

Indicators	What this means and handy hints
<p>► A. Our practice information sheet is available to patients, and is accurate and contains at a minimum:</p> <ul style="list-style-type: none"> • our practice address and telephone numbers • our consulting hours and arrangements for care outside our practice's normal opening hours, including a contact telephone number • our practice's billing principles • our practice's communication policy, including receiving and returning telephone calls and electronic communication • our practice's policy for the management of patient health information (or its principles and how full details can be obtained from the practice) • the process for the follow-up of results • how to provide feedback or make a complaint to the practice including contact details of the local state or territory health complaints conciliation body. 	<p>The information sheet you provide patients to inform them about your health service and how you communicate with them should be up to date, accurate and at the very least contain the following information:</p> <ul style="list-style-type: none"> • your health service address and telephone numbers • your opening hours and your after-hours arrangements, including a contact telephone number • any costs and fees charged for services. This includes information about how costs and fees can be paid, and an idea of the approximate costs for common types of treatment • information about how your service normally contacts and communicates with patients. This can include a description of the roles of your Aboriginal liaison officers and cultural brokers – who they are, how they work and how they normally contact patients • any situations when your service may contact patients by phone or electronically • your health service's policy for managing patient health information • how your health service follows up with patients about their results. This can also include your Aboriginal liaison officers and cultural brokers – who they are, how they work and how they may contact you • what patients can do if they are not happy with your service. If your health service has a policy of dealing with complaints internally, it is important you let patients know about the process you will follow when you receive a complaint. You will need to provide the name and contact number of the person in your organisation who has authority to deal with complaints (for example, the health service manager). Contact numbers also need to be provided for external organisations that patients can contact, such as the state or territory health ombudsman. You will also need to explain that feedback and complaints are confidential.

Table 1.5 (continued)

Indicators	What this means and handy hints
<p>► B. Our practice team can demonstrate how we communicate essential information to patients who are unable to understand our practice information sheet.</p>	<p>If the patients in your health service cannot read your information sheet, your staff need to be able to demonstrate they know of alternative means of explaining essential information. This could include explaining the information to patients orally and checking that they understand.</p> <p>For example, if patients from a number of language groups visit your service, the practice information sheet would be available in those languages. Or your staff would be able to explain things orally, through an interpreter if needed. If your service uses an interpreter, your staff need to know how to use the interpreter service.</p> <p>You could also provide some information through a mixture of diagrams, symbols and simple English (or another language). You may also want to consider the size of the letters and words for people who may have a problem with vision.</p>
<p>► C. If our practice has a website, the information is accurate and contains at a minimum the information included on our practice information sheet and meets the advertising requirements of the MBA Code of Conduct.</p>	<p>Any business that provides a regulated health service needs to meet the guidelines for advertising under the Health Practitioner Regulation National Law 2009 (see Medical Board of Australia (MBA) Code of Conduct at www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx).</p> <p>Any information provided on your health service website needs to be in the public interest, and to be factual, honest, accurate, clear, verifiable and not misleading. It needs to contain information that is consistent with your health service information sheet.</p> <p>Your website may also contain:</p> <ul style="list-style-type: none"> • a clear statement of the services offered • contact details of the health service including email and telephone numbers • the gender of the practitioners • the hours the health service is open and how to access care after hours • advice on the availability of wheelchair access to the health service • information about the fees that are charged and/or bulk-billing arrangements.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it provides the right information to its patients to enable them to access care. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service understands that some patients might not feel comfortable coming to the service. To ensure these patients have access to the service, some of the information it provides is in visual or graphic form, to communicate the message that every community group can feel they belong here. The waiting room has paintings and other artwork from community groups, to help patients know that everyone is welcome. The receptionists are friendly and helpful, so that new patients feel glad they have come to the service. (An example of a helpful receptionist is one who provides patients with relevant information, if they can.)

Staff emphasise to patients the importance of attending a scheduled appointment. If patients have concerns about the appointment, they are encouraged to talk about their concerns so that they can be dealt with. If a patient has difficulty getting to the health service for the appointment, staff will try to arrange transport – with the service’s driver, or with a neighbour, perhaps. If staff are unable to arrange transport, they will arrange a home visit instead.

The health service’s information sheet is clear, up to date and provides information in community languages about staff members, opening hours, services provided, how to provide feedback, after-hours arrangements and contact details. The information sheet contains many pictures and diagrams and a larger font version is available for those with vision impairment.

Staff members orally explain details about the service to patients who cannot read the information sheet. This could include explaining the different staff members who work in the service and what their roles are, and telling patients when and how the service will contact them and for what reasons. Reasons could include follow-up of investigations and recalls for primary health activities – for

example, immunisations, health assessments or care-plan activities. Because there is a lot of information, staff members are happy to go through it again later if any patient forgets or didn’t understand it properly the first time.

In addition to the information sheet, the service publishes a newsletter each quarter, in community languages. This newsletter details what outreach and specialist clinics are being held, where and when, and who to contact to arrange access to these. The newsletter also includes features that coincide with national health promotions – for example, diabetes week or pink ribbon or domestic violence awareness campaigns. If new staff members join the team, a feature is run including a brief introduction of the staff member, their role and how to contact them. In some cases, the service enters the above information on a whiteboard in each waiting area, instead of publishing a newsletter.

The staff member responsible for maintaining the website reviews it regularly, and updates it with details of any new staff members or changes in services as these occur.

The waiting room contains a brochure on patient health information management. This brochure explains that patients’ health records are generally kept in an electronic format only available to the staff members directly providing care to a patient or helping to organise their care. It tells patients that, with their permission, their health records will be used to send them reminders about coming to the service for immunisations, health checks, diabetes cycle-of-care activities and Pap smears (if applicable). The brochure also explains how patients can provide feedback or complaints to management, or the state or territory health complaints ombudsman.

All staff, including reception staff, have a responsibility to answer patients' questions and to take time to explain things if patients don't understand. Before staff assume that what they have said has been properly communicated, they will check the patient has understood. Staff also know that sometimes the information sheet is not enough, and that they may need to explain to patients what they need to do to access the service in the most effective way.

Showing how you meet Criterion 1.2.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain an up-to-date service information sheet that contains all the required information.
- Provide brochures and/or signs in the waiting room, written in community languages, showing:
 - the service's policy regarding what it does with health information
 - the costs and fees of the health service
 - how to get after-hours care.
- Provide photographs and names of the staff members on duty.
- Have a suggestion box in the waiting room, which is checked regularly.
- Have a process for dealing with suggestions and complaints.
- Ensure contact details for interpreters are available.
- Ensure staff can demonstrate that they know how to use the interpreter service.
- Ensure that the website indicates:
 - available services
 - telephone numbers
 - practitioner details including gender
 - opening hours
 - how to get after-hours care
 - if wheelchair access is available
 - if consultations are bulk-billed or a fee is charged.

Criterion 1.2.2 Informed patient decisions

Our practice gives patients sufficient information about the purpose, importance, benefits, risks and possible costs associated with proposed investigations, referrals or treatments, to enable patients to make informed decisions about their health.

In a nutshell

Your clinicians provide information about any investigation, referral or treatment they suggest, so that patients can make informed decisions about their health. This information includes:

- why the clinician is suggesting an investigation, referral or treatment
- how important it is that the patient follows the suggestion
- what benefits the suggested investigation, referral or treatment will have
- what things might go wrong and how likely and serious they might be
- any possible costs associated with an investigation, referral or treatment.

Key team members

- Practice manager
- Health service doctors
- Other clinical staff (under direction of the doctor)

Key organisational functions

- Patient communication
- Communication policies
- Documenting patient health records
- Informed consent policy
- Informed patient decision-making
- Clinical resources
- Cultural resources

Indicators and what they mean

Table 1.6 explains each of the indicators for this criterion. Refer to page 23 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.6
Criterion 1.2.2 Informed patient decisions

Indicators	What this means and handy hints
<p>► A. Our clinical team can demonstrate how we provide information to our patients about the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments.</p>	<p>The information you provide to your patients about their healthcare needs to be clear, easy to understand and as free of medical jargon as possible.</p> <p>When your clinical staff propose an investigation, referral or treatment to patients, they are advised to clearly state its:</p> <ul style="list-style-type: none"> • purpose • importance • benefits • risks • possible costs. <p>How you communicate information is just as important as what you communicate. It needs to be delivered in simple, clear language. Where appropriate, you could use diagrams or pictures as well as written or spoken words for patients with limited visual, language and literacy skills, or whose first language is not English.</p> <p>It is important that your clinical staff consider patients' physical, visual or cognitive capacity to understand the information being provided. Similarly, language and cultural differences need to be considered when discussing the information so that both patient and doctor have a shared understanding of the issue at hand.</p> <p>It is also important that your staff avoid assuming patients understand everything they have been told. This is especially important if your clinicians and patients are from different cultural backgrounds. Your staff could also check to make sure patients understand, and allow enough time for them to take in and talk about all the information. It may take several sessions for a good understanding to be developed on both sides.</p> <p>Where there is a carer involved, you will need to provide information to the carer as well as the patient.</p>

Table 1.6 (continued)

Indicators	What this means and handy hints
► B. Our clinical team can describe how we use leaflets, brochures or written or electronic information to support our explanation of the diagnosis and management of conditions when appropriate.	<p>Your clinical staff can show the range of additional clinical and other resources they use when explaining to patients the diagnosis and treatment of conditions. This could include leaflets, diagrams, brochures, information sheets, computerised programs and the internet.</p> <p>In culturally diverse contexts, this could also include clinical staff working with interpreters, cultural brokers or Aboriginal health workers to provide the information to patients. Culturally appropriate graphics may also be useful if there are language differences between your clinicians and patients.</p> <p>When a patient refuses care or does not follow a doctor's advice after they have been given enough information to make an informed decision, the doctor should record that refusal in the patient's health record.</p>
► C. Our clinical team can describe how we provide information (printed and otherwise) about medications and medicine safely to patients.	<p>Clinical staff need to know if your service provides this information through leaflets, diagrams, brochures, information sheets, computerised programs or the internet, and be able to communicate this to patients. For some patients your staff may need to include verbal communications.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure its patients are given enough information to make informed decisions. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community. (See also the case study for Criterion 5.3.1 Safe and quality use of medicines.)

The health service maintains a shame-free, non-judgemental environment, to ensure patients don't feel embarrassed to ask questions about their treatment. The service has proper information and communication systems to ensure GPs and their patients have a shared understanding about all aspects of proposed investigations, referrals or treatments. The aim of the service is to improve patients' [health literacy](#) so that they can make informed decisions and participate in managing their own health.

The health service has a range of visual resources for GPs and other health professionals to use when explaining their recommendations for patients. Some of these resources have been developed by external organisations familiar with the culture and language of local community groups, and they often include graphics to communicate important messages.

GPs take as long as they need to explain things in order to help patients make appropriate decisions. Often, they will also check to ensure patients understand what they have said; to do this, they may use tools such as the teach-back technique (see [Useful resources on page 44](#)). GPs will often show patients the information they themselves use – such as charts, recommendations and relevant decision-support tools. In addition, there are many charts and posters on the wall of the consulting room that GPs can show to patients when discussing their health and offering recommendations. Where necessary, an Aboriginal health worker will also participate in the consultation, to further assist communications.

If a lot of complex information is discussed during an appointment, at the next one the GP will ask the patient how they went with the previous session.

This is to check whether they have thought about it or talked about it with other people, or if they may need to discuss it again with the GP.

The health service offers a patient-assisted transport scheme to assist remote patients to travel into town for specialist or hospital appointments. This provides an opportunity for patients to discuss proposed treatments or procedures directly with the specialist or surgeon.

The health service policy manual has clear guidelines on what constitutes informed consent and how this is to be documented in patient health files. These files (electronic or paper-based) contain documented evidence of signed consent forms for procedural treatments.

Staff members organise for pharmacists to do a home medicines review for patients who require it under the QUMAX program, where it is available.

Staff members provide patients with handouts that provide information about medicines, including instructions for use, possible side effects, when to seek advice or potential problems. Staff also use flip charts on the use of medicines and demonstrate how to use inhalers and spacers.

Showing how you meet Criterion 1.2.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Use diagrams in consultations to explain health problems.
- Use flip charts.
- Document in health records that possible risks or side effects associated with treatment options have been discussed and explained.
- Ensure health videos are available in the service for patients to view.
- Show that information sheets and instructions on medicines are given to patients when new medications are prescribed.

- Show that with patients' permission a cultural broker or carer is included in the consultation to assist with clarifying information when required.
- Make available a range of one- to two-page health information sheets.
- Ensure various Aboriginal-specific health brochures are available in the waiting room and consultation rooms.
- Ensure that refusal of any doctor's advice is documented in the patient health records.
- Have posters up on the service's walls.

Related RACGP criteria

Criterion 1.7.1 Patient health records

Criterion 1.2.4 Costs associated with care initiated by the practice

Criterion 4.2.1 Confidentiality and privacy of health information

Criterion 2.1.1 Respectful and culturally appropriate care

Criterion 1.2.3 Interpreter and other communication services

Our practice provides for the communication needs of patients who are not **proficient** in the primary language of our clinical team and/or who have a communication impairment.

In a nutshell

Clinical staff at your health service know how to use an interpreter service, how to work with a cultural broker or how to use other communication processes when interacting with patients who do not speak the same language as staff or who have a communication or hearing impairment. Clinical staff have an obligation to understand patients' problems. Patients have a right to understand the information and recommendations provided by clinical staff.

Key team members

- Practice manager
- Clinical staff
- Cultural brokers
- Interpreters

Key organisational functions

- Interpreting service manual/protocol
- Clinical resources
- Cultural resources

Indicators and what they mean

Table 1.7 explains each of the indicators for this criterion. Refer to page 25 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.7

Criterion 1.2.3 Interpreter and other communication services

Indicators	What this means and handy hints
<p>► A. Our clinical team can describe how they communicate with patients who do not speak the primary language of our staff or who have a communication impairment.</p>	<p>Your clinical staff can describe how they engage the translating and interpreter service and/or service-based cultural brokers or interpreters in communicating with patients who do not speak the staff member's primary language. Your staff can also access services and information to help them communicate effectively with patients who have a communication impairment.</p> <p>It is recommended that your health service establish a policy for situations where patients express a wish to use relatives and friends to interpret. In establishing the policy, it is recommended it state that:</p> <ul style="list-style-type: none"> • documented patient consent is required for any third party, including an interpreter, to be present in a consultation • an independent interpreter is preferable • it is acceptable that family or friends interpret where the problem is relatively minor • there may be a risk that the family or friend could put their own interpretation into the communication • there can be risks if family or friends are used in sensitive clinical situations • it is not appropriate to use children as interpreters.
<p>► B. Our practice has a list of contact details for interpreter and other communication services including the translating and interpreter service.</p>	<p>See pages 25–26 of the <i>Standards for general practices</i> for information on interpreting services for GPs.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it provides interpreter and other communication services for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service's patient records identify if patients have a communication impairment or do not speak the main language used at the service, and need an interpreter. The service's electronic appointment system will flag that an interpreter of any kind is required. Patient health files have records of when interpreter services have been used.

The reception and consultation rooms have a list of interpreter contact details, which includes staff members and other people who provide interpreter services, including in [Auslan](#). The policy and procedure manual contains details of when to use the interpreter service and how to document in patient health files when these services are used.

When interviewed, staff members can describe how they contact and book interpreter services, including Auslan services, if required. All staff who need to use an interpreter know how to work with them. This includes knowing:

- how to determine whether an interpreter is needed
- how to prepare the interpreter before the consultation
- how to conduct the patient consultation with the interpreter.

Showing how you meet Criterion 1.2.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Ensure and show that staff know how to contact and use the translating and interpreter service as well as Auslan services for patients who are deaf.
- Provide staff a list of contact details for interpreter and other communication services.
- Ensure contact details for interpreter and other communication services are kept both in reception and in consultation rooms.
- Ensure staff members can describe when it is appropriate to use family and friends to interpret, and how they do this.

Criterion 1.2.4 Costs associated with care initiated by the practice

Our practice informs patients about the potential for out-of-pocket expenses for healthcare provided within our practice and for referred services.

In a nutshell

Costs can be a major barrier to care, especially for many Aboriginal and Torres Strait Islander communities. Your service needs to inform patients about potential out-of-pocket costs before they make the decision to proceed with care. Although it may be difficult to accurately predict the cost of care, you can help your patients make informed decisions by letting them know of any possible costs over and above consultation fees, and answering their questions. Clear communication will help patients plan and prepare for any unexpected eventualities.

Key team members

- Practice manager
- Health service doctors

Key organisational functions

- Billing policies and function
- Patient communications

Indicators and what they mean

There are no indicators for this criterion. Refer to page 27 of the *Standards for general practices* for a listing of the components of health costs.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it tells patients about any out-of-pocket expenses. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

All services and consultations provided at the service are bulk-billed and additional costs for patients are kept to a minimum.

The service participates in as many Close the Gap campaign initiatives as it can, and explains to patients any of the financial aspects that may be related to the care they receive. This includes medicines and other pharmacy services, referrals to specialists, and health assessment and prevention programs.

Reception staff have a list of available external health service providers. When making appointments with these providers on behalf of the patients, staff phone to check for any out-of-pocket costs patients are likely to receive.

The service has negotiated for local pathology and radiology providers to bulk-bill patients it refers to them. It also has a list of external specialists, pathology or radiology providers and advises patients if those providers will bulk-bill or charge a fee that must be paid at the time of service.

The service makes available to patients a list of services it provides, such as:

- pathology
- radiology
- dressings
- electrocardiogram (ECG)
- spirometry
- consultations (short, standard, long)
- diabetes education classes
- care plans for chronic disease management
- travel, accommodation and other costs for patients – including, if it is offered, an escort from a remote community to accompany patients to a regional or city hospital and other

available assistance (for example, contacting the Aboriginal liaison officer at the hospital and requesting for patients to be met when they disembark from transport and escorted to the hospital or accommodation).

The list states if these are bulk-billed or if they may incur out-of-pocket costs that must be paid at the time of service.

Other information for this Standard

What these words mean

Auslan

The sign language of the Australian deaf community.

Clinical team

(from the *Standards*' glossary)

The members of the practice team who have qualifications related to health and who perform clinical functions.

Documented patient consent

When patients are asked for, and have given, their consent to healthcare and clinical procedures, this needs to be recorded in writing, in the patient's health records – either by a doctor, nurse, Aboriginal health worker or other staff member, or by the patient (with the original kept in the patient's health records).

It is recommended that a documented consent records exactly what has been consented to with a date and time attached.

Health literacy

The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Informed decisions

When patients are able to make good decisions about their healthcare based on information provided to them by clinical staff, they are making informed decisions. The kind of information patients need varies according to the nature of the decision, but if treatments, investigations or referrals are suggested, patients need to be told the purpose, importance, benefits, risks and costs involved. Once patients have understood the information provided, and are able to make a decision based on this, they are making an informed decision.

Interpreter

A person who translates from one language into another, orally or visually (Auslan interpreters).

Proficient

Competent or skilled in doing or using something.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.2 Information about the practice:

1.6 Knowledge management

The ISO *Standards* include the following requirements that are relevant to Standard 1.2 Information about the practice:

5.2 Customer focus

6.1 Provision of resources

7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The North Carolina Program on Health Literacy toolkit provides resources to help develop patient health literacy, as well as information on the teach-back method:

- www.nchealthliteracy.org/toolkit
- www.nchealthliteracy.org/toolkit/tool5.pdf

The Kimberley Interpreting Service has guidelines for working with interpreters:

- www.kimberleyinterpreting.org.au/i_workwith.html

The Medical Board of Australia offers a PDF of its Medical guidelines for advertising of regulated health services:

- www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

The State Government of Victoria's *Health translations* directory is also useful:

- www.healthtranslations.vic.gov.au

Standard 1.3

Health promotion and prevention of disease

Our practice provides [health promotion](#) and illness prevention services that are based on patient need and best available evidence.

Overview of this Standard

This Standard is about your health service having a consistent and planned approach to the early detection, prevention and management of the major chronic diseases in its community. It is also about your health service's health promotion strategy – how it provides the community and patients with the best information and evidence about health and how to prevent health problems.

Criterion 1.3.1 Health promotion and preventive care

Our practice provides health promotion, illness prevention and preventive care, and a reminder system based on patient need and best available evidence.

In a nutshell

Criterion 1.3.1 has two aspects:

- education and health promotion – this is generally about how your health service provides information and knowledge to patients, families and communities about achieving good health and preventing illness. It is also about current knowledge on managing chronic diseases such as diabetes.
- a **systematic approach** to preventive healthcare – this is generally about how your health service puts systems in place to help you detect and manage patients' health problems at the earliest possible stage.

This criterion is particularly important for Aboriginal community controlled health services in their efforts to achieve better preventive health outcomes for their communities.

Key team members

- Health service manager
- Clinical staff

Key organisational functions

- Health promotion strategy
- Preventive care strategy and systems
- Early detection and intervention strategy and systems
- Patient communication policies

Indicators and what they mean

There are no indicators for this criterion. However, because of its importance, it may be helpful for your health service to establish its own evidence or indicators for health promotion and preventive care activity. Some examples of evidence include:

- the use of preventive health guidelines and resources, including those listed on page 30 of the *Standards*
- the use of decision support tools
- an active recall and reminder system
- up-to-date, plain language pamphlets and brochures
- information on the website
- a DVD library available for loan
- preventive health activities, such as diabetic education groups or groups to help patients quit smoking
- the contents of health records, showing health promotion and disease prevention activities
- up-to-date health summaries
- health promotions during NAIDOC Week and other planned community events.

Case study

Below is a description of the ways in which an Aboriginal Community Controlled Health Service can ensure effective health promotion and preventive care for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service's dietitian and Aboriginal health worker run a weekly cooking class that includes nutrition information, food preparation and healthy food choice education. They also run a fruit and vegetable program, where fruit and vegetable hampers are provided for families in conjunction with health checks, dental checks and hearing checks.

The service has effective systems in place for early detection of illness in its patients, and in the community as a whole. For patients it uses the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* (2nd edition) to ensure it provides appropriate screening and preventive care. At the community level the service provides school health checks at a certain time every year, and relevant community-wide health screenings. It also uses information from data collected in its health records to target health promotion activities; for example, it uses its data on anaemia in children under 5 years old for its No Anaemia Day promotion.

Staff members use large mirrors mounted at child height for the health service's trachoma prevention program. This program involves the children washing their faces and then checking in the mirror to see how 'clean and shiny' they are. It also gives staff members the opportunity to screen for skin infections as well as for trachoma symptoms.

Service dental staff run dental hygiene programs at local preschools and primary schools, and distribute dental 'show bags' with toothbrushes, toothpaste, stickers and handouts.

The health service participates in national, state or territory reminder systems and registers, such as the Australian Childhood Immunisation Register and the National Cervical Screening Program. Staff also participate in NAIDOC Week and community days, and provide health information to patients and community members. Awareness calendars about state health events are made available in the

service, and health promotion events and activities are planned to coincide with state and national promotions.

Clinical staff use regular consultations as an opportunity for health promotion and preventive care. In addition, the service runs an active reminder system to encourage patients to have appointments for reviews, screening and health assessments.

The service ensures that patient health information collected by clinical staff is routinely documented in consultation notes and transferred to a complete patient health summary. Consequently its patient health files have comprehensive, up-to-date health summaries, which include information on health risk factors (such as smoking status, weight, height and alcohol consumption) as well as relevant social and family history. As a result, these files are a useful place to find information about a patient's health status, and a resource in the early detection of illness or management of a chronic disease.

The service's pathology providers send reports that summarise its diabetes and cervical screening activities and these are included in the patient health summaries.

Regular systems are in place as part of the health service's early detection strategy. These include patient disease-prevention surveys, disease registers, recall and reminder systems, and local service directories.

The health service uses a system of flags or other reminders in patients' electronic or paper-based records to assist it in identifying and/or targeting health promotion and prevention activities. In electronic records, this system triggers an alert when transferring to patient files information collected from private pathology providers – diabetes or cervical screening results, for example. In paper-based records, it could include general information about a patient's smoking status.

The service uses easy and effective ways to educate patients about illness prevention. This includes providing up-to-date, take-home information such as brochures, pamphlets and other resources, all written in plain language. Patients then have an opportunity to read the information, understand it in their own time and accept the importance of taking action themselves.

The service also provides culturally appropriate information (written, visual and audio-visual) in the community languages of its culturally diverse patients. It ensures that clinical staff use appropriate resources during consultations – for example, they may be spoken or visual and include diagrams and simple language. In addition, the waiting room and consultation rooms have a wide range of current, culturally appropriate brochures and pamphlets available for patients.

The health service is selective in the information it makes available to its patients and community, including information on the internet sites it uses or recommends. It uses the checklist in the RACGP green book (see page 29 of the *Standards*) and asks appropriate questions before sharing information or making recommendations. Appropriate questions include:

- Is it well explained and clear?
- Are there any culturally offensive materials attached?
- Is the information accurate and reliable?
- Does it apply to the local context?
- Does it explain the importance of patients taking action themselves?

The service obtains the required consent when transferring patient information, such as immunisation or cervical screening data, to national registers or state- and territory-based systems. It informs patients of their right to opt out where it is available, using the RACGP's new patient form, ordered via www.racgp.org.au/healthrecords

Related RACGP Standards and criteria

Criterion 1.4.1 Consistent evidence-based practice

Criterion 1.7.1 Patient health records

Other information related to this Standard

What these words mean

Health promotion

(adapted from the *Standards*' glossary)

Preventive health activities that reduce the likelihood of disease occurring.

The World Health Organisation's Ottawa Charter 1986 defines health promotion as 'the process of enabling people to increase control over, and to improve, their health'. See more at www.who.int/healthpromotion/conferences/previous/ottawa/en/

Systematic approach

An approach or strategy for a particular activity, such as a Pap smear reminder, that is built into an organisation's system to ensure that is done regularly (such as every year or every month) and consistently (there are very limited ways of doing it and this usually involves following set processes and protocols).

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.3 Health promotion and prevention of disease:

3.4 Community and professional capacity building

The ISO *Standards* include the following requirements that are relevant to Standard 1.3 Health promotion and prevention of disease:

5.2 Customer focus

6.1 Provision of resources

7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. Refer to page 28 of the *Standards* for explanations of some of the concepts mentioned to in this criterion. On page 30 of the *Standards* you will find a list of useful preventive care resources for your health service.

The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The following websites provide further information and resources in relation to health promotion and preventive care:

- www.healthpromotion.org.au
- www.health.vic.gov.au/healthpromotion
- <http://australia.gov.au/topics/health-and-safety/health-promotion>
- www.phaa.net.au/atsih.php

Standard 1.4

Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

Overview of this Standard

This Standard is about making sure all clinical staff, especially multidisciplinary teams, demonstrate an evidence-based, consistent approach to patient-centred care, in line with current clinical guidelines. Standard 1.4 is also about maintaining and respecting the skills of GPs in the course of providing holistic care to a patient. Another important aspect of this Standard is regular communication between clinical staff about approaches to healthcare delivery, and about your health service's expectations of the safety and quality of healthcare.



Criterion 1.4.1 Consistent evidence-based practice

Our practice has a consistent approach for the diagnosis and management of conditions affecting patients in accordance with best available evidence.

In a nutshell

Your health service provides its staff with ready access to key clinical guidelines in order to enable a consistent clinical approach to the diagnosis and management of health conditions. The clinical guidelines need to be relevant to the community, up to date and based on the best available evidence. Good communication between your team members can support a consistent approach to diagnosis and management.

Key team members

- Health service manager
- Clinical staff

Key organisational functions

- Clinical health management practices and protocols
- Staff internal and professional communication policies
- Clinical resources
- Culturally safe and competent clinical practice
- Quality and safe clinical practice

Indicators and what they mean

Table 1.8 explains each of the indicators for this criterion. Refer to page 31 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion and a list of resources that support evidence-based practice.

Table 1.8**Criterion 1.4.1 Consistent evidence-based practice**

Indicators	What this means and handy hints
<p>► A. Our clinical team uses current clinical guidelines relevant to general practice to assist in the diagnosis and management of our patients.</p>	<p>Your health service uses clinical guidelines for health conditions relevant to general practice, your community and your patient demographics – for example, Aboriginal and Torres Strait Islander or homeless youth. Where your health service operates in a culturally diverse context, you will need to ensure that the set of clinical guidelines you use accommodates the issues relevant to that diverse population's health.</p> <p>The clinical guidelines need to be current and based on the best available evidence. See pages 31–32 of the <i>Standards for general practices</i> for a list of resources that support evidence-based practice.</p> <p>It is important your clinicians are advised when particular clinical guidelines are updated by the independent body that developed them, and that the updated guidelines are easily accessible for clinical staff during their working day.</p>
<p>► B. Our clinical team can describe how we ensure consistency of diagnosis and management of our patients.</p>	<p>Your clinical staff understand the importance of consistency in diagnosis and healthcare management, and they work as a team to manage individual patients, where needed. Clinical staff can describe the systems in place to ensure management continuity. These systems can include:</p> <ul style="list-style-type: none"> • the use of clinical guidelines, and culturally safe practices and resources • regular team or clinical staff meetings • other means of staff communication about health management, such as books and whiteboards. <p>Management consistency is especially important for patients with chronic diseases as it reduces confusion and misunderstanding in the management of their health conditions. Also, patients value consistency and quality in their healthcare. A consistent management approach enhances patient trust and this in turn encourages patients to work in partnership with their doctor and clinical staff to gain good health outcomes.</p>

Table 1.8 (continued)

Indicators	What this means and handy hints
<p>► C. Our clinical team can demonstrate how we communicate about clinical issues and support systems within our practice.</p>	<p>Your clinical staff need to have an effective way of communicating with each other about clinical healthcare and management, both generally and for each individual patient. This is demonstrated when your health service encourages staff to use systems and processes to discuss issues related to patient diagnosis and management. It could include measures to ensure that:</p> <ul style="list-style-type: none"> • staff have easy access to paper-based and/or electronic resources (including clinical guidelines) that support consistent evidence-based practice • clinical staff are aware of and engage in culturally safe practices • there are regular face-to-face clinical staff meetings to discuss management and patient communication issues.
<p>► D. Our clinical team can explain how we access and use specific clinical guidelines for patients who identify as Aboriginal or Torres Strait Islander.</p>	<p>Because of the particular health disadvantages experienced by Aboriginal and/or Torres Strait Islander peoples, your health service needs to use specific guidelines – for example, guidelines for the screening, prevention and management of major chronic conditions in the community. Clinical staff need to have easy access to these clinical guidelines.</p> <p>With the development of decision-support tools clinical staff could use systems that make relevant sections and recommendations of these guidelines readily available for each consultation.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure consistent, evidence-based care for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's staff have access to, and use, evidence-based resources and clinical guidelines in either electronic or printed format. These resources and guidelines include:

- the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* (2nd edition)
- the Central Australian Rural Practitioners Association *Standard treatment manual* (5th edition)
- the *Minymaku kutju tjukurpa women's business manual* (4th edition)
- the *Clinical procedures manual for remote and rural practice* (2nd edition)
- the *Medicines book for Aboriginal health workers* (2nd edition)
- the *Australian medicines handbook*
- the *Guidelines for preventive activities in general practice* (6th edition) (the RACGP red book)
- *Putting prevention into practice; guidelines for the implementation of prevention in the general practice setting* (the RACGP green book)
- *Aboriginal primary healthcare: an evidence-based approach* (2nd edition).

The health service regularly updates its electronic health record software to include the most recent medicines information, clinical guidelines, decision-support tools and health-assessment templates. For commonly used guidelines, it develops clinical protocols to help staff put them into practice.

When the service inducts new staff it gives them advice on where they will find resources and guidelines, and any other available communication methods – for example, clinical staff meetings. All staff are promptly informed about updates to clinical information and resources.

The part-time staff have established a communications book in which they leave messages for each other about patients who have had changes in treatment or who need to be followed up. They also use the communication book if there has been a major change in the service's protocol or guidelines.

The service holds, and documents, regular clinical team meetings that include discussions on available new treatments as well as current processes that may improve how the service provides care to its patients. These meetings are also an opportunity for staff members to share their knowledge with others. If multiple staff members see the same patient, they talk together when necessary, to ensure they are on the same track.

'Ensuring correct patient, correct site, correct procedure' charts are located in all consulting and treatment rooms in the service, to remind staff to check they have the right patient before starting the consultation, doing any treatment or using a medical record.

The service has an outreach clinic located in a remote area and each Friday the remote area nurse holds ward rounds via telephone with the doctor who visits the clinic each month. They discuss any problems the nurse may have had during the week and review treatment options for patients.

Showing how you meet Criterion 1.4.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Make current clinical guidelines available in electronic and/or hard copy for staff to access.
- Ensure and show that electronic health record software is regularly updated to the most recent version.
- Keep records of clinical team meetings about the use of clinical guidelines.
- Have regular clinical team meetings that are documented.
- Ensure that when asked, staff members can show how they find and use resources and guidelines.
- Keep a communication book, internal mail and/or email system to pass on important messages to other staff members.
- Keep well-documented health records, treatment and care plans in patient health records.
- Ensure that when asked, staff members can explain how they discuss the care of patients with other staff members, while ensuring patient confidentiality.
- Ensure that when asked, staff members can show what evidence-based resources and guidelines they use regularly.
- Ensure that when asked, staff members can explain what steps they take to help patients feel culturally secure in the service.
- Ensure that when asked, clinical staff members can explain what specific clinical guidelines the service uses for patients who identify as Aboriginal or Torres Strait Islander, how they access them and how they use them to support evidence-based practice, including in the prevention and management of chronic diseases.

Criterion 1.4.2 Clinical autonomy for general practitioners

Our practice ensures that all GPs in our practice can exercise autonomy in decisions that affect clinical care.

In a nutshell

Your doctors are free to make decisions about clinical care, based on evidence. See page 34 of the *Standards for general practices* for the kinds of decisions doctors are free to make within the boundaries of evidence-based practice.

All members of your healthcare team should also be able to make clinical judgements within the limits of their training, scope of practice and competency, and within the capacity of the service in which they are working. Clinical decisions need to be undertaken within a framework of evidence-based care, ethical obligations and culturally safe practice.

Key team members

- All clinical staff

Key organisational functions

- Human resources policy and procedures (qualifications and certifications)
- Staff training and induction
- Credentialing
- Defining scope of practice
- Clinical governance
- Clinical risk-management systems

Indicators and what they mean

There are no indicators for this criterion. [Clinical autonomy](#) is important to protect the safety and quality of healthcare, and could be considered in relation to Criterion 1.4.1 Consistent evidence-based practice. Together, these criteria mean that GPs should be free to make decisions about patient care as long as they make ethical decisions, use good clinical judgement and draw on the best available evidence for each patient. This is also consistent with the basic principles of Aboriginal community controlled health services, such as integrated, holistic care and self-determination.

Some examples of evidence for this criterion include:

- maintaining a policy ensuring clinical autonomy for general practitioners and other health professionals in the context of delivering evidence-based care, and according to their scope of practice, knowledge and skills, and consistent with their role in the team

- ensuring GPs have autonomy with respect to:
 - overall clinical care of their patients
 - referrals to specialists and other health professionals
 - ordering of pathology, imaging or other investigations
 - scheduling of follow-up appointments
 - acceptance of new patients
 - duration and scheduling of appointments (in conjunction with other members of the healthcare team)
 - supplies and equipment used by the health service (in conjunction with other members of the healthcare team)
- where a GP is not present all of the time, ensuring arrangements for the above are delegated to the practice nurse with clear and agreed guidelines in place
- ensuring all healthcare staff use current clinical guidelines as relevant
- providing evidence that health professionals adhere to their own professional obligations and codes of conduct or ethics
- ensuring that when asked, clinical staff members can demonstrate how they determine when to recall patients for follow-up care and the length of appointment required
- ensuring that when asked, clinical staff members can explain how they can make decisions about who they refer to, length and scheduling of appointments and when they recall patients
- ensuring that a patient health file review or audit demonstrates a variety of specialist referrals by different doctors.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that its GPs (and other health professionals) are free to make decisions about clinical care, based on evidence. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service has well-developed systems and processes in place to enable GPs and other members of the healthcare team to exercise discretion in making independent clinical judgements for their patients within the context of evidence-based care, and as appropriate to their role in the team. These systems and processes include:

- a system for ensuring that all healthcare staff qualifications have been checked and are current (credentialing)
- a system for ensuring that all healthcare staff have the skills and experience to do the job they have been given (defining scope of practice)
- the consistent use of recommendations from agreed clinical guidelines as appropriate for the service's patient population
- awareness and understanding of relevant codes of professional conduct
- the development of a service-specific code of practice that incorporates critical elements of all relevant external codes of conduct. This is the service's key resource for identifying and communicating expectations regarding the healthcare team's professional and ethical obligations for delivering safe, quality healthcare to the community.

There is a policy outlining the kinds of clinical decisions that can be made by different members of the healthcare team, and which decisions need to be referred to the senior clinician. This policy also emphasises that the board has decision-making powers in relation to a range of areas, but it must not interfere with the ability of the GPs and other health professionals to make the most appropriate clinical decisions for their patients.

Some decisions are made after discussion with the whole healthcare team. These decisions include:

- duration and scheduling of appointments
- supplies and equipment used by the health service.

There are regular clinical staff team meetings to share and discuss matters affecting autonomous decision-making as appropriate to each team member's role. For the remote health centre, these meetings are held by teleconference.

In addition to oversight of longer-term care such as care plans, regular clinical supervision is undertaken with each member of the healthcare team. This is where GPs and nurses or health workers discuss clinical and other issues relating to their current patients and programs. For the remote health centre, these supervision sessions are held by teleconference.

All of the above discussions include consideration of how and when traditional medicines or other accepted forms of treatment can be administered alongside those covered by clinical guidelines.

GPs understand the importance of working within a multidisciplinary team, and they all participate fully in this process. They ensure that processes are in place for appropriate decision-making by other members of the healthcare team when they are not present, and that issues or concerns are followed up as soon as possible. When it is important that other team members understand their exercise of clinical autonomy, the GPs will explain their decision in a team meeting.

Other information for this Standard

What these words mean

Clinical autonomy

Doctors have clinical autonomy when they are not controlled by others or by outside forces in relation to matters of clinical care. They are independent in their decision-making in the care of their patients. Their primary obligation is to the patient and in the best interest of the patient and not to persons or any group of people outside this doctor–patient relationship.

Clinical guidelines

Clinical guidelines may be developed by government agencies, institutions or organisations (such as professional societies or governing boards), or by the convening of expert panels. They can be used to assess and evaluate the quality and effectiveness of healthcare – for example, in terms of measuring improved health as well as increased consistency in services or procedures performed, and in outcomes of healthcare delivered.

The National Health and Medical Research Council (NHMRC) developed a 2011 standard for clinical practice guidelines, stating that a clinical practice guideline must:

- provide guidance on an aspect of clinical practice that is clearly defined, and for which guidance is needed
- be developed by a multidisciplinary group that includes relevant experts, health professionals for whom the guideline is intended, and consumers affected by the clinical practice guideline, and which is not unduly influenced by conflicts of interest
- be based on the best available scientific evidence
- make clear, feasible recommendations for health professionals in the Australian healthcare system
- include a plan for dissemination and considerations of how the guideline can be implemented effectively.

Primary healthcare

The NACCHO website describes primary healthcare as follows:

Primary healthcare is the first level of contact of individuals, families and the community with the healthcare system, and in Aboriginal communities this is usually through an ACCHS or satellite Aboriginal community health clinic that it services.

Read the full definition at www.naccho.org.au/aboriginal-health/definitions

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.4 Diagnosis and management of health problems:

3.3 Incorporation and contribution to good practice

The ISO *Standards* include the following requirements that are relevant to Standard 1.4 Diagnosis and management of health problems:

5.2 Customer focus

6.1 Provision of resources

7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures.

Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The RACGP website contains access to clinical guidelines that it endorses:

- www.racgp.org.au/your-practice/guidelines

The following websites are also useful in learning more about relevant clinical guidelines:

- www.healthinfolnet.ecu.edu.au
- www.health.qld.gov.au/cdg
- www.joannabriggs.edu.au
- www.clinicalguidelines.gov.au

Standard 1.5

Continuity of care

Our practice provides [continuity of care](#) for its patients.

Overview of this Standard

This Standard is about continuity of care, a concept that has two components setting it apart from other definitions of care (see definition in the *Standards'* glossary). First, it is care provided over time; second, it is care that focuses on individual patients. Continuity of care focuses on how your health service provides patients with:

- the ability to request their preferred GP
- a clinical handover system that ensures safe and ongoing healthcare delivery
- a rigorous follow-up and recall system for [clinically significant](#) tests and results.

Criterion 1.5.1 Continuity of comprehensive care and the therapeutic relationship

Our practice provides continuity of **comprehensive care** to patients.

In a nutshell

Continuity of care refers to the situation where patients experience an episode of care as complete, or consistent, or **seamless** even if it is provided in a number of different consultations by different providers. Such continuity is associated with improved patient health outcomes and satisfaction. There are three types of continuity in healthcare, each dealing with a different level at which health services provide ongoing care to patients:

- the continuing relationship between patients and their doctors, known as relational continuity
- the consistent way in which different health professionals provide healthcare to the one patient, known as management continuity
- the continuity with which information about patients is communicated and documented by healthcare professionals, known as information continuity.

You could address all three types of continuity in your response to this criterion. Aspects of Criterion 1.4.1 Consistent evidence-based practice are also relevant here.

Key team members

- Health service manager
- All clinical staff
- Administrative staff

Key organisational functions

- Policies and processes for the appointment system
- Rotation and rostering system for availability of GPs and clinical staff
- Patient information management system
- Policy and processes for access to patient information
- Patient consent policy
- Patient communication policy and processes
- Patient confidentiality and privacy policies
- Electronic communications policies

Indicators and what they mean

Table 1.9 explains each of the indicators for this criterion. Refer to page 35 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.9

Criterion 1.5.1 Continuity of comprehensive care and the therapeutic relationship

Indicator	What this means and handy hints
<p>► A. Our staff can describe how patients can request their preferred GP when making an appointment or attending our practice.</p>	<p>Your patients have choices when they request an appointment with their preferred GP. These choices are reflected in your health service's:</p> <ul style="list-style-type: none"> • processes to ensure that, as often as possible, patients can see the doctor they ask to see • appointment system, with an appropriate rostering and rotation system for GPs • appointment system, which endeavours to allow patients' choice of GP and times they can see them. <p>You can further assist patient choice by prominently displaying easily understandable information notices about GPs and their availability, and offering advice that, for practical reasons, it won't always be possible to meet patients' requests to see a preferred GP.</p>
<p>► B. Our practice team can describe how we encourage continuity of comprehensive care.</p>	<p>Continuity of comprehensive care means that your health service has systems in place for three different types of continuity:</p> <ul style="list-style-type: none"> • relational continuity, where your service offers information and choice to patients about the GPs they could ask to visit. This can include an appointment system and information about GPs in the reception and waiting rooms. Relational continuity can extend to other clinical staff – for example, nurses and Aboriginal health workers • management continuity, where your service has protocols and policies in place that ensure consistency of care between different clinical staff members. This can be demonstrated through strategies such as: <ul style="list-style-type: none"> – regular clinical-team meetings that discuss individual patient care – up-to-date record keeping and case notes on patient records – alert systems, communications systems and protocols that enable effective communication between clinical staff members about patient care • informational continuity, where your service has handover and review protocols between healthcare providers. Your clinical staff are also required to keep up-to-date consultation notes in patient health records. Also helpful in multidisciplinary health services that provide out-of-hours care are policies and protocols that set out how patient information is to be recorded and by whom. Regular clinical-team meetings can also encourage informational continuity for complex case patients.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure appropriate continuity of care for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service recognises that an essential element for its patients is the relationship they have with their GP and other health service providers. It also acknowledges that trusting relationships take time to be established and need to be respected. The service therefore does whatever it can to make sure all patients get to see the GP or health providers that they have this good relationship with.

Reception staff understand the importance of relationships in maintaining continuity of care. They also behave in a friendly, respectful way to every patient, and try to establish relationships of trust that reinforce those developed by patients with their health providers. Sometimes reception staff offer to make appointments for patients with the external health providers to whom they have been referred, because they know some patients find doing this themselves to be difficult.

GPs and other health staff members have individual appointment books and there is a rotating roster for GPs on walk-in appointment mornings; this is to facilitate patient requests for appointments with a preferred GP. An audit of patient health records will show that most active patients generally see the same GP, clinical staff member or health worker.

The service's staff actively use the recall and reminder system in the patient management and clinical software, and pop-up reminders alert health staff about scheduled events for individual patients.

An audit of patient health records will show that patients with complex or chronic health needs have active management plans in place. These are managed by a care coordinator, who is employed by the service.

Notices are put in the waiting room listing when visiting doctors or allied health staff are due to visit.

Showing how you meet Criterion 1.5.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Have individual appointment books for GPs, nurses, allied health and Aboriginal health workers.
- Rotate GPs on walk-in sessions.
- Ensure health records show ongoing care provided by a particular GP where possible.
- Have notices in the waiting room if a GP is on leave, including details of when that GP is due back.
- Ensure that health records for ongoing or long-term patients show that they have been coming to the service for more than 2 years, demonstrating their preference for the health service.
- Maintain minutes of clinical-team meetings.
- Run a recall and reminder system.
- Keep a communications book.
- Document management plans in patient health files, especially for those with complex or chronic health problems.
- Maintain a clinical handover system.

Criterion 1.5.2 Clinical handover

Our practice has an effective [clinical handover](#) system that ensures safe and continuing healthcare delivery for patients.

In a nutshell

A missed or inadequate handover can have serious consequences for patients and your service, and increases the risk of legal action. Thus, your service should have documented policies and protocols in place that encourage consistent and effective clinical handover, and that your handover processes and communications are diligently applied and well documented. An important part of successful clinical handovers is your service's capacity to identify gaps and breakdowns in handover communications and improve them to minimise recurrence.

A key objective of effective clinical handover is for any clinician to be able to look at patient health records and continue appropriate quality care. This requires effective clinical note taking, information entry into the correct sections of the health records and good health summaries and social background information.

Key team members

- Health service manager
- Clinical staff
- Locum clinical staff

Key organisational functions

- Clinical handover communication systems and protocols, within the health service and external to it (for example, outside health services, pathology services, shared care, medical deputising services)
- Patient records policies and processes
- Locum clinical staff orientation
- Clinical risk-management systems and policy

Indicators and what they mean

Table 1.10 explains each of the indicators for this criterion. Refer to page 37 of the *Standards for general practices* for an explanation of concepts referred to in this criterion.

Table 1.10
Criterion 1.5.2 Clinical handover

Indicator	What this means and handy hints
<p>► A. Our practice team can demonstrate how we ensure an accurate and timely handover of patient care.</p>	<p>It's a good start for your service to have a comprehensive clinical handover communication policy and protocol, and to ensure that it is known to clinical staff, including locums. Handover communications can be face-to-face, written, verbal (telephone) and electronic (email).</p> <p>Comprehensiveness means considering different situations in which handovers occur and having written policies, protocols or guidelines that set out the best way of achieving effective handovers for these situations. The policies and protocols could include:</p> <ul style="list-style-type: none"> • a clear definition of the term clinical handover • provisions for timely, standardised and consistent practices by relevant clinical staff, such as: <ul style="list-style-type: none"> – recording handovers in consultation notes – routinely reading patient records prior to consultation – noting and processing urgent follow-ups • clear guidelines for: <ul style="list-style-type: none"> – handovers among clinical staff within your service – handovers outside your service, such as standardised referral methods to other service providers; standardised referral information details; and clarification of who has responsibility for care – handling shared-care patients, such as standardised requests for notification of other providers' cessation of shared care, or standardised alerts for when your service ceases care of a shared-care patient – clinical handovers with medical deputising services, providing for when handovers are made, how often (for example, in a 'timely and appropriate manner') and who is responsible for the handover – handovers to emergency departments, such as face-to-face to the ambulance service, followed by telephone handover to the emergency department. If a patient does not require an ambulance, your service needs to ensure that sufficient information (including language and/or cultural information) is provided to the emergency department in order to facilitate prompt and appropriate care – handovers from urgent pathology results, especially in out-of-hours situations. If abnormal or life-threatening results are identified, your health service should have an arrangement in place for quick access to the relevant GP by the pathology provider. The arrangement should allow for timely access to GPs so they can make informed and appropriate medical decisions. Similarly, guidelines should be established for follow-up of urgent and critical pathology results, especially where the GP is not on duty • provisions for identifying breakdowns and gaps in clinical handover systems. This means your staff are encouraged to report breakdowns in systems through a culture of trust and open communication. You can achieve this through a clear process of how reporting is done, who is responsible for investigation and analysis, and a clear understanding of the consequences of reporting (changed processes rather than blaming staff) • appropriate cultural safety resources for health services that operate in culturally diverse contexts, especially for locum clinical staff with limited experience of the cultural and community contexts. <p>An essential part of demonstrating this indicator is found in the written policies, protocols and guidelines that accompany practice and behaviour. Most health services generally have good clinical handover systems and communication practices, and it is essential that these practices are documented in writing. This encourages consistency in practices and behaviour, and allows for the easy identification of gaps and breakdowns in the system and for the necessary improvements to be made.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure effective clinical handover for its patients. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's policy and procedure manual clearly identifies the requirements for both internal and external clinical handover and includes examples of template forms to be used.

The service uses a standardised form based on iSoBAR utilising the following: Identification of patient; Situation & status; Observations; Background & history; Assessment & Actions; Responsibility & risk management. This may be modified when required to Identification; Situation; Observation; Background; Agree a plan; Read back.

Staff members providing clinical care access the same resources and information to make sure patients receive consistent advice. Staff members can describe the process used to handover to another practitioner in the practice, or to a locum or external health provider.

Patient feedback indicates that the service's handover protocols between it and external providers, including hospitals, work effectively.

A register of slips, lapses and mistakes is maintained and staff discuss the documented issues at clinical staff meetings, where they identify actions for improvement.

If a doctor employed by the service is retiring, leaving or taking extended leave, patients are told at least 4 weeks before this happens. They are also told who will take over their care while their usual doctor is away. A clinical handover, either written, face-to-face or via telephone, is done by the doctor to the replacement doctor.

Showing how you meet Criterion 1.5.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Have a written policy regarding handover, both internal and external, including to locum doctors or other doctors in the practice.
- Ensure health files contain copies of referral letters to allied health services, other doctors, specialists and ambulance or Royal Flying Doctor Service staff.
- Maintain service-level agreements with medical deputising services or after-hours cooperative arrangements, setting out the responsibilities of all parties.
- Show that you aim for face-to-face handovers, where possible.
- Have a standardised form for ambulance transfers.
- Have a shared-care arrangement (for example, team care of a patient with mental health problems).
- Keep a register of slips, lapses and mistakes.
- Provide examples of how any breakdown in the clinical handover system was identified and addressed.
- Use a clinical software program to generate referral letters that are automatically populated with the requirements listed in criterion 1.6.2

Related RACGP Standards and criteria

Criterion 1.1.2 Telephone and electronic communication

Criterion 1.5.3 System for follow-up of tests and results

Criterion 1.6.2 Referral documents

Criterion 3.1.2 Clinical risk-management systems

Criterion 1.5.3 System for follow-up of tests and results

Our practice has a system for the follow-up and review of tests and results.

In a nutshell

A rigorous follow-up system for tests and results is essential to minimise potential harm to patients and ensure your health service meets its clinical and legal obligations to patients. Documenting your follow-up system is the key to maintaining consistency and minimising potential risks from failure to adequately follow up tests and results. It is recommended your health service's follow-up system clearly defines areas of risk and develops mechanisms for dealing with them. An effective follow-up system clearly sets out:

- different mechanisms for dealing with normal results, abnormal results (urgent and non-urgent) and important tests or referrals
- different mechanisms for the follow-up of clinically significant results and of clinically significant tests
- how tests and results are communicated to patients to ensure they have sufficient information to make informed decisions.

Key team members

- Health service manager
- Clinical staff
- Reception staff

Key organisational functions

- Recall system and processes
- Follow-up system and processes
- Pathology review and management policy
- Patient communication policy and processes
- Patient informed consent
- Patient health record
- Patient records management system

Indicators and what they mean

Table 1.11 explains each of the indicators for this criterion. Refer to page 40 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.11

Criterion 1.5.3 System for follow-up of tests and results

Indicators	What this means and handy hints
<p>► A. Our patient health records contain evidence that all pathology results, imaging reports, investigation reports and clinical correspondence received by or performed in our practice have been:</p> <ul style="list-style-type: none"> • reviewed by a GP • signed or initialled (or the electronic equivalent) • where appropriate, acted upon in a timely manner. 	<p>Part of your health service's follow-up system provides that patient health records contain all relevant information about pathology tests and results, their review by a GP and the discussions the GP has with patients about their results. This requires that the following are recorded in your patient health records:</p> <ul style="list-style-type: none"> • all pathology results, imaging reports, investigation reports and clinical correspondence received by your health service • a GP's review of pathology results and reports, and notes on the follow-up instructions required • a GP's signature or initial for each review • a record of when and what action was taken, if follow-up has occurred. This needs to be done in a timely manner, and to refer to the mechanisms in place to deal with different types of results (normal, abnormal, clinically significant) • discussions with patients, including a brief but accurate record of patient discussions and outcomes when communicating clinically significant results and tests.
<p>► B. Our practice team can describe the system by which pathology results, imaging reports, investigation reports and clinical correspondence received by our practice are:</p> <ul style="list-style-type: none"> • reviewed • signed or initialled (or the electronic equivalent) • acted on in a timely manner • incorporated into the patient health record. 	<p>It is important that your health service's follow-up system provides clear guidelines about how results and tests are processed, and includes:</p> <ul style="list-style-type: none"> • a description of who has responsibility for reviewing test results, and how they document that review process • details of who can sign or initial the test results, and how they document that process • details of who determines the next course of action, including the type of action required (follow-up on information; follow-up with patient; recall the patient) and the level of urgency attached to the action, as well as how they document that process • a description of the processes and circumstances where investigation results are incorporated into the health record (by the GP once it has been reviewed, or by another clinical staff member upon consultation with the GP).

Table 1.11 (continued)

Indicators	What this means and handy hints
<p>► C. Our practice has a written policy describing the review and management of pathology results, imaging reports, investigation reports and clinical correspondence received by our practice.</p>	<p>Your health service has a written policy that sets out a process for review and management of results. This policy clearly states:</p> <ul style="list-style-type: none"> • the people with responsibility for reviewing results • the processes to deal with: <ul style="list-style-type: none"> – normal results – abnormal results – urgent results – non-urgent results – follow-up of tests – follow-up of clinically significant results • who has responsibility for contacting patients for follow-up and recall • a definition of timeliness, with a process to deal with situations where both patient and GP may forget to follow up results and tests • how follow-up information can be communicated with patients, and the circumstances in which different kinds of communication are appropriate (phone, email, by mail, face-to-face) • the processes and circumstances for incorporating the results into the health record (always by the GP once it has been reviewed, or by another clinical staff member upon consultation with the GP) • the kind of information required to be recorded in patient records with regards to review and management of results (such as when patients are contacted, how often they were contacted, and a record of clinical conversations with patients) • the provisions for timely review and action on results.
<p>► D. Our practice team can describe how patients are advised of the process for the follow-up of results.</p>	<p>Your health service has a written policy about communicating pathology results, and the process for follow-up of results, to patients. The earlier this is done in the doctor–patient relationship, the better.</p> <p>This process should be reinforced by other clinical staff members and reception staff when the opportunity arises. This could be done by adopting different strategies for different members of the team:</p> <ul style="list-style-type: none"> • the clinical team could provide information about the process during the first clinical consultation, prior to tests being ordered, and when results are communicated to patients • the reception team could provide information via phone, at reception, by handing out patient information brochures or by prominently displaying information about the process in the reception area. <p>Where appropriate, your service should endeavour to provide patients with the information in their community language, or through the use of interpreters or visual representation. You should also consider culturally safe clinical practice in the delivery of test result information to patients of Aboriginal and Torres Strait Islander descent.</p>

Table 1.11 (continued)

Indicators	What this means and handy hints
<p>► E. Our practice team can describe how we follow up and recall patients with clinically significant tests and results.</p>	<p>Members of your clinical and reception staff clearly understand the difference between clinically significant tests and clinically significant results, and the health service's follow-up and recall process for both. Staff can demonstrate that they have an understanding of patient confidentiality and privacy when actioning follow-up and recall procedures. They are also aware of where to find the written policy and processes when required.</p>
<p>► F. Our practice has a documented system to identify, follow up and recall patients with clinically significant results.</p>	<p>Your health service has a written policy that sets out a process for follow-up and recall of patients with clinically significant results. The policy includes:</p> <ul style="list-style-type: none"> • a definition of clinically significant results • a statement that responsibility for reviewing and identifying clinically significant results rests with the GP • details about the follow-up process, clearly outlining the roles and responsibilities of different staff members • an outline of the kind of information different staff members can convey, and how they can convey it. If, for example, reception staff are identified as having responsibility for contacting patients with significant results to make an appointment, the outline indicates how they could do so (for example, 'Your doctor wants you to make an appointment [indicate when] to discuss the results of your recent tests') • guidelines about the kind of information that needs to be recorded (contact details, clinical discussions and outcomes) in patient health records • where appropriate, provision of standardised forms and letters for follow-up and recall of patients • provision for timely review and action on tests and results.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure appropriate follow-up of tests and results for its patients. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service policy and procedure manual clearly sets out the process and documentation required for the follow-up and review of tests and results, including clinically significant tests and results. It also identifies who is responsible for managing the process. The policy and procedure manual incorporates a flow chart clearly showing the review and recall process and this flow chart is displayed in consulting rooms and at reception.

The staff induction process includes the system of following up tests and results, including clinically significant tests and results. The service's staff members' understanding of the system for following up clinically significant tests and results is consistent with the organisation's documented policy and process.

The documents that reception staff scan into patient health records relating to tests, results or specialists' appointments have been reviewed, dated, initialled and actioned as required.

The service uses a clinical software program to manage recalls. The appointment book has urgent appointments available for those patients who need to be recalled, either on the day or the day after. Reception staff flag patients in the appointment book who have appointments for a recall and these patients are not removed from the recall list until they have attended their appointment. When an appointment is made for a patient for recall, the appointment date and time is documented in the patient's health record.

It is clearly explained to patients why it is important that they have the tests ordered by the GP.

Patient health records show evidence of results being reviewed, actioned and patients being recalled for further care. Staff members document in patient health records attempts made to contact patients for recall – for example, date, time, method (phone, letter, physical visit) and if an attempt was successful or not.

Transport drivers often hand-deliver letters or messages to patients, letting them know that staff members at the service are trying to contact them. The transport driver will also phone the service to make appointments for patients and book transport at the same time, if required.

Showing how you meet Criterion 1.5.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Ensure that pathology results in patient health files show evidence of review by GPs as required.
- Ensure patient health files show a record of attempts to contact and recall patients in relation to clinically significant tests and results.
- Ensure patient health files show when follow-up has occurred, and treatment if any required.
- Document the review and recall system, including who is responsible for monitoring and follow-up of recalls.
- Ensure and show that staff induction includes the review and recall system.
- Show that you cover follow-up in staff interviews.
- Audit health records.
- Maintain in-service training records.
- Maintain flow charts of processes.
- Include follow-up in job descriptions.
- Maintain templates within a clinical software program.
- Maintain a policy and procedure manual.

Other information for this Standard

What these words mean

Clinical handover

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

The Australian Medical Association has developed a *Safe handover: Safe patients* guideline, which can be downloaded from ama.com.au/node/4064

Clinically significant

(adapted from the *Standards'* glossary)

A judgement made by a health professional that a result is clinically important for a particular patient in relation to that patient's healthcare. For example, the judgement may be that a result is abnormal and clinically important for that particular patient, or abnormal but not clinically important for that patient; or it could be a result is normal but still clinically important for that particular patient.

Comprehensive care

The RACGP definition of general practice uses the term comprehensiveness, meaning that general practitioners are not limited by age, gender, body system, disease process or service site. The scope of clinical practice is challenging, spanning prevention, health promotion, early intervention for those at risk, and the management of acute, chronic and complex conditions within the practice population whether in the home, practice, health service, outreach clinic, hospital or community.

See more at www.racgp.org.au/whatisgeneralpractice

The NACCHO definition of primary healthcare incorporates the concept of comprehensive care. Read further at www.naccho.org.au/aboriginal-health/definitions

Continuity of care

Continuity of care has two components that set it apart from other definitions of care. First, it is care provided over time. The patient is provided care by

the same GP or service provider over a prolonged period of time, in which they have developed a sense of affiliation with the GP or the service. Secondly, it is care that focuses on individual patients. This focus on the individual patient relates to the care provider tailoring healthcare to the individual patient's health needs, so that even when care is provided by different clinicians the patient feels it is all part of the same service. It is consistent, holistic and not fragmented. Sometimes, this may also include a consideration of other aspects of the patient's life, such as their social, cultural, spiritual and economic circumstances.

Seamless

Having no awkward transitions, interruptions or indications of disparity.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.5 Continuity of care:

- 2.2 Focusing on positive outcomes
- 2.5 Coordinating services and programs
- 3.1 Service agreements and partnerships

The ISO *Standards* include the following requirements that are relevant to Standard 1.5 Continuity of care:

- 5.2 Customer focus
- 6.1 Provision of resources
- 7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The Victorian Healthcare Association's *Managing clinical risk in primary health care* can be accessed at:

- www.vha.org.au/uploads/VHA-Clinical-Risk-ONLINE.pdf

The Australian Commission on Safety and Quality in Health Care has produced a number of resources and publications on clinical handover. While most relate to hospital and other kinds of handover, many of the basic principles apply to a primary healthcare setting:

- www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/national-clinical-handover-initiative-pilot-program

The Greater Western Area Health Service's *Clinical handover for Greater Western AHS allied health professionals* is a modified iSoBAR system:

- www.archi.net.au/documents/resources/qs/clinical/clinical-handover/implementation/ccebar-ahps.pdf

The WA Country Health Service's allied health clinical handover project, known as Back to the Bush, has significant findings for allied health professions. This project investigated the key issues arising from clinical handover between physiotherapists and occupational therapists working in acute tertiary metropolitan health services and their collegial counterparts working in rural health services. Its findings identified current methods and processes of handover and determined areas where improvement was required. The transferability of the iSoBAR tool to the needs of allied health professionals was considered, along with its potential adaptations. Download the report from:

- www.wacountry.health.wa.gov.au/index.php?id=644

The Managing Two Worlds Together project explores the system of care for Aboriginal patients from rural and remote areas of South Australia and parts of the Northern Territory. It examines their patient journeys and what happens when they come to the city for hospital care. It also includes useful patient journey mapping tools:

- www.flinders.edu.au/medicine/sites/health-care-management/research/mtwt

Standard 1.6

Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

Overview of this Standard

This Standard is about engagement, coordination and interaction with a range of health, community, disability and other services to ensure optimal patient care. Coordinated care arises from planning and coordinating available health services to provide a seamless patient interaction and experience. This experience is underpinned by your health service ensuring a continuing and good relationship with other relevant health service providers. The principles of patient confidentiality and privacy need to be maintained in the [referral](#) process. Appropriate coordination of patient care is managed by:

- having available to clinical staff an accessible and up-to-date register of health, community and disability services
- ensuring referral letters provide adequate and clinically relevant patient health information and preserve patient confidentiality.

Criterion 1.6.1: Engaging with other services

Our practice engages with a range of health, community and disability services to plan and facilitate optimal patient care.

In a nutshell

Good working relationships with other service providers and networks will support the provision of comprehensive care to your patients. Your health service could have information registers easily accessible to your clinical team for easy and up-to-date referrals. These are a good resource to facilitate the planning and coordination of comprehensive healthcare in order to meet individual patients' health needs.

Key team members

- Health service manager
- Office administration staff
- Clinical staff

Key organisational functions

- Register of health, community and disability service providers
- Networking and collaboration with health, community and disability service providers
- Referral protocols

Indicators and what they mean

Table 1.12 explains each of the indicators for this criterion. Refer to page 45 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.12
Criterion 1.6.1 Engaging with other services

Indicators	What this means and handy hints
<p>► A. Our practice team can demonstrate how we plan and coordinate comprehensive care by our interaction with other services such as:</p> <ul style="list-style-type: none"> • medical services including diagnostic services, hospitals and specialist consultant services • primary healthcare nurses • allied health services • pharmacists • disability and community services • health promotion and public health services and programs. 	<p>Your health service provides easily accessible resources for clinical staff to plan and coordinate comprehensive care in collaboration with other services. This resource is typically a register of (usually locally) available services, such as those identified in this indicator. But because ACCHSs aim to provide holistic care to their patients, you may interact with a much wider range of services, including schools, employment and housing agencies, and social workers.</p> <p>The register should be regularly updated with important contact details such as location, phone numbers and, where appropriate, the main contact person for different query types. Where appropriate, information about referral arrangements could also be included.</p> <p>It is recommended that in rural and remote services, and where appropriate, the register also includes:</p> <ul style="list-style-type: none"> • contact information of cultural liaison officers and/or cultural mentors • interpreters or interpreting-service phone numbers • other culturally appropriate information for clinical staff. <p>Information could be in either written or electronic form. It is also important to demonstrate that your clinical staff can access the information easily (that is, if stored electronically, they have access to the system).</p>
Services providing care outside normal opening hours	
<p>► B. Our service seeks feedback about the quality and responsiveness of our service from the practices whose patients we see.</p>	<p>If you offer a service after hours, it is inevitable you will see patients who do not usually present to your service but to another GP in another service. When this happens your service is expected to regularly seek feedback from these practices about the quality and responsiveness of your after-hours service to their patients.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can engage with other services to provide good healthcare for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service is proactive in identifying external services within its region with whom it could work to enhance patient care and improve the health and wellbeing of the community. These services go beyond healthcare providers and extend to schools, housing and employment agencies, sports clubs and social workers. The health service tries to build good working relationships with all these other services.

The health service holds regular meetings with all the key external services it works with, so that issues and opportunities common to all can be discussed.

Many staff within the health service are responsible for maintaining contact with the external services, as appropriate to their role and responsibilities. Where appropriate – for example, if there are personnel changes or a new service or program developed by the external agency – the staff member will report that back to the health service, so that records can be updated.

Some of the external services with whom the health service has developed a strong relationship now partner with the health service on various activities. For example, they might undertake training together, share resources such as meeting rooms or jointly deliver a preventive health workshop to the community.

Key details of each external agency are recorded on an electronic and paper-based register of services, which the practice manager reviews and updates at the end of each quarter. The paper-based register includes clinical services as well as local organisations with which the service deals, and is located at the reception desk. The electronic register is incorporated into the clinical software program. Individual staff members add to the register when new services/organisations are used.

The Medicare Local list of practitioners, specialists and allied health providers is also kept at the reception desk for easy reference, along with the roster of on-call pharmacies. This allows staff to let patients know which pharmacy is available on weekends.

The remote clinic has the 24-hour contact details for the Royal Flying Doctor Service and standardised forms for transfer of patients out of the community.

Showing how you meet Criterion 1.6.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Keep an electronic or hard-copy register of service providers and organisations to which staff may refer patients.
- Update the register regularly and document the date of update within the register.
- Keep an easily accessible list of pharmacies including the roster of on-call pharmacies.

Criterion 1.6.2: Referral documents

Our referral documents to other healthcare providers contain sufficient information to facilitate optimal patient care.

In a nutshell

A good referral provides adequate patient information for the safe and effective care of your patients by other service providers. Referral letters need to contain at least three approved patient identifiers, the purpose of the referral and relevant health information. Your communication of health information should be secure, and patients need to be informed of the contents of referral documents.

Key team members

- Health service doctors

Key organisational functions

- Proforma referral letter
- Referral protocols
- Patient confidentiality and privacy policy

Indicators and what they mean

Table 1.13 explains each of the indicators for this criterion. Refer to page 46 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.13
Criterion 1.6.2 Referral documents

Indicators	What this means and handy hints
<p>► A. Our practice can demonstrate that referral letters are legible, contain at least three approved patient identifiers, state the purpose of the referral and where appropriate:</p> <ul style="list-style-type: none"> • are on appropriate practice stationery • include relevant history, examination findings and current management • include a list of known allergies, adverse drug reactions and current medications • the doctor making the referral is appropriately identified • the healthcare setting from which the referral has been made is identified • the healthcare setting to which the referral is being made is identified • if known, the healthcare provider to whom the referral is being made is identified • if the referral is transmitted electronically then it is done in a secure manner • a copy of the referral is retained in the patient health record. 	<p>Referral letters are a key tool in integrating your patient care with external healthcare providers. A referral letter should contain information that allows other healthcare providers to make appropriate medical and other decisions. It needs to be legible, printed or written on appropriate practice stationery (including letterhead, address and contact details) and to contain sufficient information, including:</p> <ul style="list-style-type: none"> • at least three patient identifiers (see What these words mean) • relevant history, examination findings and current management • a list of known allergies, adverse drug reactions and current medications • the identity of the referring doctor • the healthcare setting from which the referral is made (for example, a general practice or an emergency room) • the healthcare setting to which the referral is made (for example, the emergency ward in hospital or a specialist consultancy) • the healthcare provider, where known, including the identity of the relevant practitioner (name of specialist) • any culturally appropriate information to facilitate culturally safe practices by other health service providers (for example, the need for an interpreter). <p>If sent electronically, a referral should be encrypted, unless patients have provided informed consent for it to be sent otherwise. In any event, it is important that your service protects patient confidentiality.</p> <p>You should keep a copy of the referral letter in patient health records.</p> <p>Only clinically relevant patient health information should be provided in referral letters. Relevant means information that is required by healthcare practitioners in the diagnosis and treatment of patients. For example, a previous termination of pregnancy or an STI would be unlikely to be of clinical relevance to a physiotherapist, but would be important in an obstetric or gynaecological referral.</p> <p>It is important to consider your patients' informed consent and your protection of patient confidentiality when writing referral letters. This consideration covers both the information to be included, and the way the information is transmitted. It means you should inform patients of the contents of the referral letter and, where appropriate, offer them the opportunity to read the contents or provide them with a copy. Where a referral letter is sent electronically, you need to ensure the email is encrypted, and that it complies with standards for secure transmission of patient health information (see Criterion 4.2.2 Information security).</p> <p>Where telephone referrals have been made, you need to document them in patient health records. You should also record here other relevant information, such as the time and date of the referral and any patient health information provided to other health service providers.</p> <p>Out-of-hours health services should forward a copy of any referral letters they may initiate to the health service provider to whom they are contracted.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure appropriate referrals to other healthcare providers for its patients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service's clinical software package provides standard referral document templates that include the service name, address and contact details as well as a field for the doctor making the referral. The templates also automatically include three patient identifier fields and a field for relevant history, in addition to the other requirements outlined in criterion 1.6.2. The service's electronic referrals are encrypted. Any handwritten referrals are copied into paper patient health records or scanned into electronic patient health records.

Staff members record the date, time and content of any telephone referrals they make for patients. Any appointments made for patients in relation to a referral are also documented in their health record.

The remote clinic has standardised forms for use with the Royal Flying Doctor Service.

Showing how you meet Criterion 1.6.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a policy on referral documents that includes using at least three patient identifiers.
- Audit patient health records, demonstrating that appropriate referral letters are prepared, patient informed consent is provided and patient confidentiality is protected.
- Ensure new patient demographic sheets are filled out and included with the patient referral documents.
- Maintain a standard referral template that includes the service's details.
- Run [encryption](#) software.

Related RACGP Standards and criteria

Criterion 4.2.2 Information security

Criterion 3.1.4 Patient identification

Other information for this Standard

What these words mean

Clinically relevant

Directly applicable to patient care.

Encryption

(from the *Standards'* glossary)

The process of converting plain text characters into cipher text (meaningless data) as a means of protecting the contents of the data and guaranteeing its authenticity.

Optimal

Best or most favourable.

Patient health record

(from the *Standards'* glossary)

Information held about a patient in hard or soft form which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information and legal and OH&S reports.

Patient identifiers

Identifying patients correctly and consistently is a vital process to ensure patient safety and confidentiality. Criterion 3.1.4 in the *Standards* requires that health services adopt three patient identifiers to make sure the person is matched to the correct health record and to the correct treatment. These can be any three of the following health service-approved identifiers:

- patient name (family and given, and or cultural, skin, clan or bush name)
- date of birth
- gender
- address (may be recorded as community, outstation or homeland)
- hospital record number, or equivalent
- family relationships
- for a patient who was part of a multiple birth, the order in which the patient was born (for example, the second of twins).

Note that Medicare numbers are not approved identifiers.

Referral

(from the *Standards'* glossary)

To send or direct a patient to another practitioner or service.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.6 Coordination of care:

- 2.5 Coordinating services and programs
- 3.1 Service agreements and partnerships
- 3.2 Collaboration and strategic positioning

The ISO *Standards* include the following requirements that are relevant to Standard 1.6 Coordination of care:

- 5.2 Customer focus
- 6.1 Provision of resources
- 7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Overview of this Standard

This Standard is about providing safe and high standards of patient care via the accurate and sufficient recording of patients' information, including their current health status. Accurate and up-to-date consultation notes along with relevant, **legible** correspondence and reports that are easily accessible by relevant clinicians promote this requirement. In addition, recording patients' cultural and social backgrounds alerts clinical staff to health risks faced by patients from diverse cultural groups.



Criterion 1.7.1: Patient health records

For each patient we have an individual patient health record containing all the **health information** held by our practice about that patient.

In a nutshell

Your patients must each have a **dedicated** health record where your clinicians document the minimum required personal, social and other health information in order to facilitate an ongoing and high level of care. These health records also need to contain all documents your service holds that relate to patients, including correspondence, test results and reports (such as legal and WorkCover reports).

Key team members

- Staff responsible for obtaining initial patient health records (such as the receptionist or Aboriginal health worker)
- Clinical staff
- Health service manager

Key organisational functions

- Patient records policy and processes
- Electronic records policy
- Culling policy
- Patient confidentiality and privacy policy
- Patient informed consent policy

Indicators and what they mean

Table 1.14 explains each of the indicators for this criterion. Refer to page 49 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.14
Criterion 1.7.1 Patient health records

Indicators	What this means and handy hints
<p>► A. There is evidence that each patient has a legible individual patient health record containing all health information held by our practice about that patient.</p>	<p>Each of your patients needs to have a dedicated health record containing the health information your practice holds about them. It is important this information is legible and up to date and that it routinely includes:</p> <ul style="list-style-type: none"> • patient identification, contact details and demographic information (where appropriate) including cultural information such as language or clan affiliations • medical history • consultation notes, including notes from out-of-hours care providers and home visits • letters and correspondence from hospitals, consultants and health and allied health professionals • clinical correspondence, investigations, referrals and test results • reports, correspondence and information relating to each patient that may have a bearing on their emotional and physical well-being. This includes WorkCover and legal reports.
<p>► B. Where our practice has an active hybrid medical record system, for each consultation/interaction, our practice can demonstrate that there is a record made in each system indicating where the clinical notes are recorded.</p>	<p>There are inherent risks associated with a hybrid system because it increases the chance of insufficient recording of information, or of recording information in the wrong system. Where a hybrid system exists, your health service needs to minimise these risks by ensuring that:</p> <ul style="list-style-type: none"> • notes are kept in both types (or sites) of records to maintain continuity of information for doctors and other clinical staff • records are easily accessible and available when needed. <p>In the interest of risk management, the RACGP recommends that where a hybrid system exists, services work towards moving to electronic recording of important and clinically significant information such as allergies, adverse drug reactions and medications.</p>
<p>► C. Our active patient health records include patient identification, contact and demographic information (where appropriate) including:</p> <ul style="list-style-type: none"> • the patient's full name • date of birth • gender • contact details. 	<p>Active patient health records should include, at a minimum, the patient identification and contact information identified in this indicator. You could also include demographic information, where appropriate; this includes cultural information such as language, clan affiliations and other health service-approved patient identifiers. Patient identifiers could include:</p> <ul style="list-style-type: none"> • patient name (family and given, and/or cultural, skin, clan or bush name) • date of birth • gender • address (may be recorded as community, outstation or homeland) • hospital record number or equivalent • family relationships • for a patient who was part of a multiple birth, the order in which they were born (for example, the second of twins).

Table 1.14 (continued)

Indicators	What this means and handy hints
<p>► D. Our practice can demonstrate that we routinely record the person the patient wishes to be contacted in an emergency.</p>	<p>Your patient information should also include an up-to-date emergency contact; a process is also needed for doing this. For example, at the return of a patient who has not been to your service in a while, you may require them to fill out an updated patient information sheet. Alternatively, prompts could be built into electronic records for clinical staff to ask the question.</p>
<p>► E. Our practice can demonstrate that we routinely record Aboriginal and Torres Strait islander status in our active patient health records.</p>	<p>Recording a patient's Aboriginal and Torres Strait Islander status provides important information for clinical staff in their treatment. It is important because differences in clinical risk factors between Aboriginal and Torres Strait Islander peoples and other cultural groups dictate how clinical staff approach a patient's healthcare.</p> <p>All patients should be asked the question 'Are you of Aboriginal or Torres Strait Islander origin?' regardless of their appearance, country of birth or whether staff know them or their family background.</p> <p>The RACGP position is that this standard national question should be asked in all general practices. However it recognises that many ACCHSs use the three-part definition, which consists of:</p> <ul style="list-style-type: none"> • descent (of Aboriginal and Torres Strait Islander descent) • self-identification (identifies as Aboriginal or Torres Strait Islander) • community recognition (accepted as Aboriginal or Torres Strait Islander by the community they live in).
<p>F. Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.</p>	<p>A patient's cultural background can provide important indicators of clinical risk factors, as some factors are more prevalent in different cultural and social groups. Recording cultural backgrounds in patient records that reflect evidence-based clinical risk factors could be a good start in meeting this criterion. This alerts doctors to tailor clinical assessment and consultation to the patient's underlying health needs.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that it maintains patient health records for its patients. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

Every patient of the health service has an individual electronic patient health record. If a staff member records an episode of care in a patient's paper-based health record, a note is also entered into the patient's electronic health file to refer to the paper-based record and vice versa.

Patients' health files identify the person the patient wants to be contacted in case of emergency and staff are aware this may not be the same person who is listed as the next of kin.

The service's staff training includes cultural awareness and safety training. This teaches staff to ask new patients to complete a new patient form, which asks if the patient identifies as Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander or any other cultural background. This is so staff members can provide health prevention and management activities for Aboriginal and/or Torres Strait Islander patients.

Information about patients is correctly and consistently recorded in their active patient health records. If a patient is unable to read, a staff member will take the patient to a consulting room and go through the form with them and document their answers. Existing patient details are updated annually with this additional information, using a similar form. The service also updates electronic and paper-based patient health records with any changes to patient information regarding Aboriginal and Torres Strait Islander status.

Annual reports submitted to funding bodies include the numbers of Aboriginal, Torres Strait Islander, Aboriginal and Torres Strait Islander and non-Indigenous patients of the service.

Health service clinical and program staff members provide monthly statistics to

management, which include the numbers of Aboriginal, Torres Strait Islander, Aboriginal and Torres Strait Islander and non-Indigenous patients seen by staff.

Administration staff collate and review data received by Medicare Australia in relation to the service's participation in the Practice Incentives Program Indigenous Health Incentive.

The service has an information disaster recovery plan to retrieve electronic patient health records in the event of an adverse incident, such as a system crash or power failure. The plan is tested on a regular basis to ensure backup protocols work properly. See also the case study for Criterion 4.2.2.

Showing how you meet Criterion 1.7.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain individual health records for each patient.
- Ensure handwriting in paper-based health files is legible.
- Ensure documents scanned into electronic health records are clear and easily able to be read.
- Ensure that, where a hybrid medical record system is used, both electronic and paper health records have a record of a consultation. For example, if the consultation was recorded in the paper health record then an entry is made in the electronic record, noting that the full consultation notes are to be found in the paper record.
- Conduct interviews with staff members.

- Ensure patient health record audits show:
 - the name of the person the patient would like contacted in an emergency; this may not be the same person listed as their next of kin
 - identification of Aboriginal and/or Torres Strait Islander status for all patients.
- Maintain up-to-date new and current patient forms.
- Show that you cover patient health records during staff inductions.
- Maintain patient health files.
- Utilise Medicare Australia Practice Incentives Program Indigenous Health Incentive data.
- Send annual reports to funding bodies.
- Maintain a policy and procedure manual.

Related RACGP Standards and criteria

Criterion 1.2.2 Informed patient decisions

Criterion 1.7.2: Health summaries

Our practice incorporates health summaries into active patient health records.

In a nutshell

Health summaries are concise, up-to-date reports included in active patient health records that allow clinical staff to provide safe, quality patient care. Health summaries contain core health information – such as known allergies, [adverse drug reactions](#), current medications, current health problems, immunisations, relevant past health history, health risk factors and relevant family or social history – to enable safe and relevant clinical care, even if that care is provided by a clinician who is not the patients' usual clinician.

Key team members

- Clinical staff
- Health service manager

Key organisational functions

- Patient health records policy
- Patient confidentiality and privacy policy
- Patient communications policy

Indicators and what they mean

Table 1.15 explains each of the indicators for this criterion. Refer to page 52 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.15
Criterion 1.7.2 Health summaries

Indicators	What this means and handy hints
<p>► A. Our practice can demonstrate that at least 90% of our active patient health records contain a record of known allergies.</p>	<p>It is important that known allergies are recorded for each individual patient, and this indicator requires you do this for at least 90% of active patient health records. Where no allergy is known, it is important to record 'no known allergies' in the health records to indicate it has been checked with the patient. Demonstrating this indicator could mean asking the question during regular patient information collection points, and recording the response on the new patient health record sheet and in the health summary sheet. Prompting doctors and other clinical staff to ask about allergies via the electronic health record system is also effective.</p>
<p>► B. Our practice can demonstrate that at least 75% of our active patient health records contain a current health summary. A satisfactory summary includes, where appropriate:</p> <ul style="list-style-type: none"> • adverse drug reactions • current medicines list • current health problems • relevant past health history • health risk factors (e.g. smoking, nutrition, alcohol and physical activity) • immunisations • relevant family history • relevant social history including cultural background where clinically relevant. 	<p>When a member of your clinical team consults with patients, information about the consultation should be recorded in the consultation notes, and updated in the health summary, especially for active patient health records. This includes information about social and family circumstances.</p> <p>Because of the impact that recent life events (such as a death) and other circumstances or events (such as housing, employment) may have on the health of Aboriginal and Torres Strait Islander patients, this information could also be recorded in the health summary.</p> <p>The RACGP recognises that specialist health services such as ACCHSs have a team of clinical and other staff responsible for the care of patients, rather than just the GP. Where this occurs, patient interactions between those staff members need to be recorded in patient health records as soon as practicable after the consultation or visit.</p>
<p>C. Our practice has documented standardised clinical terminology (such as coding) which the practice team uses to enable data collection for review of clinical practice.</p>	<p>Coding provides a standardised means of recording information. This is particularly important for commonly used clinical terminology.</p> <p>It is preferable that your health service adopts a nationally recognised coding system so that visiting clinical staff, locum staff and out-of-hours service providers can easily understand the information. The use of consistent terminology is especially important for chronic disease registers and for clinical audits that drive quality improvement. It also leaves little room for error or guessing by other clinical staff members when they consult with patients or read patient health records.</p> <p>Coding should be used to complement other important information, rather than to replace it all. Where detailed health and other information is required, it should be recorded so that context, details and clinically significant information can be easily understood. Excessive use of coding may be more confusing and unnecessary in these instances.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure there is sufficient information in the health records of its patients. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

If a patient has an allergy, the type of reaction is also documented; for example, **anaphylaxis**, swelling, rash or nausea. Patients who do not suffer from allergies have their health file marked with 'no known allergies', so other staff members know that those patients have been asked if they have any allergies. This is because if the allergy section is left blank it could be incorrectly assumed that either the question has not been asked or that the patient does not have any allergies.

The health summary section in patient health records contains information on adverse drug reactions as well as patients' health risk factors such as smoking status, nutrition, alcohol consumption and physical activity, as well as any relevant family history. There are some communities whose members do not disclose relevant family history; in these cases it is documented in the patient health file that relevant family history was asked and the patient chose not to disclose. This way it is not assumed by other health providers that the question has not been asked, so that the patient is not continually asked questions on family history.

The health summary section in patient health records contains information on a patient's relevant social history, including cultural background. This may include type of employment, if any (many jobs may expose a person to potential health hazards, and lack of employment or under-employment can be stressful), and environmental factors such as housing, cooking facilities and access to fresh food and clean water, shopping facilities and transport. There are some communities whose members do not disclose relevant social history; in these cases it is documented in the patient health file that relevant social history was asked and the patient chose not to disclose. This way it is not assumed by other health providers that the question has not been asked, so the patient is not continually asked questions on social history.

Health workers and nursing staff routinely undertake health assessments of patients and record their allergy status, adverse drug reactions, current medicines, past history, social history, family history, risk factors and relevant cultural history in the patient consultation

notes. This information forms the basis of an up-to-date health summary.

If a patient does not wish to discuss their clinical, family or social history with a staff member an entry is made in the file in the relevant area noting that the patient chose not to disclose. This ensures it is documented that the information was requested, so that when file audits are conducted it is clear that staff are endeavouring to cover all areas of a full history.

The staff induction covers the service's clinical software program and its policy relating to the use of coding contained within the clinical software program. The practice of free texting within the fields of the software program is actively discouraged. Clinical staff members are encouraged to document within the consultation notes more complex histories or diagnosis options that do not fall within the generic coding fields. The service actively contributes to chronic disease registers and participates in clinical audits, using the coding system.

A 3-monthly audit and data cleansing is performed prior to running reports and data extraction.

Showing how you meet Criterion 1.7.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Conduct an audit of patient health records.
- Conduct data cleansing of clinical software programs.
- Ensure and show that staff induction covers use of clinical software and documentation protocols such as recording 'no known allergies', or 'patient does not wish to disclose family history'.
- Maintain a policy and procedure manual.

Criterion 1.7.3 Consultation notes

Each of our patient health records contains sufficient information about each consultation to allow another member of our clinical team to safely and effectively carry on the management of the patient.

In a nutshell

Sufficient, legible and easy-to-understand consultation notes provide crucial information for the safety and quality of ongoing patient care.

Key team members

- Clinical staff

Key organisational functions

- Patient confidentiality and privacy policy
- Patient communications policy

Indicators and what they mean

Table 1.16 explains each of the indicators for this criterion. Refer to page 55 of the *Standards for general practices* for explanations of some of the concepts referred to in this criterion.

Table 1.16
Criterion 1.7.3 Consultation notes

Indicators	What this means and handy hints
<p>► A. Our patient health records document consultations including consultations outside normal opening hours, home or other visits and telephone or electronic communications where clinically significant, comprising:</p> <ul style="list-style-type: none"> • date of consultation • patient reason for consultation • relevant clinical findings • diagnosis • recommended management plan and, where appropriate, expected process of review • any medicines prescribed for the patient (including name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed) • complementary medicines used by the patient • any relevant preventative care undertaken • any referral to other healthcare providers or health services • any special advice or other instructions • who conducted the consultation (e.g. by initial in the notes, or audit trail in an electronic health record). 	<p>Patient health records should contain consultation information that your health service collects about the relevant patient, including the information identified in Indicator A. This includes consultations by your health service's GPs, home visits (where available), out-of-hours consultations, telephone conversations and other electronic communications that are clinically significant. Similar information should be recorded by other clinical staff who consult or interact with patients (such as nurses or Aboriginal health workers).</p> <p>It is recommended that consultation notes are recorded as soon as practicable after consultations and visits/interactions.</p>
<p>► B. Our patient health records show evidence that problems raised in previous consultations are followed up.</p>	<p>Consultation notes should of themselves provide a trail of healthcare given to individual patients. They should identify where problems raised in a consultation need to be followed up, and record that they were followed up. Health records themselves are vital ways of ensuring this happens.</p> <p>It is recommended that follow-up notes are built into the consultation or record sheet to alert other clinical staff of the need for follow-up; examples include flags in electronic records, or coding in a special column on the sheet. It is recommended that you consider a system of identifying and actioning follow-up procedures to minimise risks in failure to follow-up.</p>

Table 1.16 (continued)

Indicators	What this means and handy hints
<p>► C. Our practice can demonstrate that we are working toward recording preventive care status (e.g. currency of immunisation, smoking, nutrition, alcohol, physical activity, blood pressure, height and weight [body mass index]).</p>	<p>As part of your preventive care processes, it is recommended that you develop a routine procedure for gathering general health information from patients on a regular basis. Routinely gathering information such as patients' height, weight and blood pressure assists in the early detection of health risks and diseases.</p> <p>This indicator is particularly important for ACCHSs, because of the higher incidence of a number of chronic diseases in Aboriginal and Torres Strait Islander populations. The development of resources such as the <i>National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people</i> significantly enhance this process.</p> <p>Clinically significant information such as patients' health needs and goals, preventive health activities, medical conditions, preferences and values all contribute to determining clinical care approaches that are responsive to patient needs.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure effective consultation notes are maintained for its patients. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service's patient health files contain clear and accurate information about who performed the consultation, the date of consultation and the reason for consultation, as well as a history and review of medication including any over-the-counter medication taken by the patient. The files also include clear and accurate information about examinations, observations, diagnoses or provisional diagnoses, tests or investigations ordered, a plan of management, any medication prescribed, referrals to internal and external health providers, advice or special instructions and any planned review or follow-up.

The health service's policy and procedure manual documents the activities to be undertaken when

screening a patient. These include blood pressure, blood sugar level, height, weight, history and review of immunisations.

The service's clinical software program contains proforma health assessment templates for patients of varying ages that at a minimum meet the Medicare Benefits Schedule requirements.

The staff member responsible for scanning paper-based correspondence into the electronic patient health file undertakes random monthly audits to check that scanned information can be easily read. If it appears that the quality of the scanned documents is poor, advice is sought from the service's information technology provider.

Showing how you meet Criterion 1.7.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a policy and procedure manual.
- Conduct an audit of patient health records.
- Keep Medicare billing records.
- Keep an appointment book.

Other information for this Standard

What these words mean

Active patient

(from the *Standards*' glossary)

A patient who has attended the service three or more times in the past 2 years.

Active patient health record

The record of an active patient.

Adverse drug reaction

(from the *Standards*' glossary)

The harm that results from a medicine.

The glossary in the *Standards* also defines the term 'adverse medicines event' as an adverse event due to a medicine. This includes an adverse drug reaction, but also covers the potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medications.

Allergy

Allergies occur when a person's immune system reacts to substances in the environment that are harmless for most people. These substances are known as allergens and are found in house dust mites, pets, pollen, insects, moulds, foods and some medicines.

Most allergic reactions are mild to moderate, and do not cause major problems, even though for many people they may be a source of extreme irritation and discomfort. However, a small number of people may experience a severe allergic reaction called anaphylaxis. It is a serious condition that requires immediate lifesaving medication. Some of the more frequent allergens that may cause anaphylaxis are peanuts, shellfish, insect stings and drugs.

Anaphylaxis

This is a type of allergic reaction in which the immune system responds to otherwise harmless substances from the environment. Unlike other allergic reactions, however, anaphylaxis can kill. Reaction may begin within minutes or even seconds of exposure, and rapidly progress to cause airway constriction, skin and intestinal irritation, and altered heart rhythms. In severe cases, it can result in complete airway obstruction, shock and death.

Dedicated

Assigned or allocated to a particular person (or in another context, to a particular project, purpose, or function).

Health information

Health information, as defined in the Commonwealth *Privacy Act 1988*, is a specific type of personal information. Health information includes information or an opinion about the physical or mental health or disability of an individual. It also includes information or an opinion about:

- a health service provided, or to be provided, to an individual
- an individual's express wishes about the future provision of health services to him or her
- other personal information collected in connection with the donation of human tissue
- genetic information that is or could be predictive of the health of individuals or their relatives or descendants.

You will find more information about the Privacy Act as it relates to health information by reading section 62 on the Australian Law Reform Commission website, accessible at www.alrc.gov.au/publications/report-108

If your organisation is a health service provider, health information includes all of the above plus any other personal information collected to provide or in providing a health service.

Hybrid medical record system

A hybrid medical record system is one that uses both paper-based and electronic record keeping systems or where records are physically kept in more than one location.

Quality News (summer 2012, page 20) discusses the AGPAL definition of hybrid records as:

an active patient health record wherein some patient health information is routinely recorded and stored electronically, and other patient health information is routinely recorded and stored in hard copy. The potential risks associated with hybrid patient health records include the possibility of important issues being overlooked and incomplete patient health records.

Legible

(With reference to handwriting or print) Clear enough to read, capable of being read. This includes documents that are scanned in a patient health file, which must be clear and able to be read.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the *QIC Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 1.7 Content of patient health records:

2.2 Focusing on positive outcomes

The ISO *Standards* include the following requirements that are relevant to Standard 1.7 Content of patient health records:

5.2 Customer focus

6.1 Provision of resources

7 Product realisation

Useful resources

The *Standards for general practices* include specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The Australian Institute of Health and Welfare publishes *National best practice guidelines for collecting Indigenous status in health data sets*:

- www.aihw.gov.au/guidelines-for-collecting-indigenous-status/

The RACGP National Faculty of Aboriginal and Torres Strait Islander Health has published a guide to *Identification of Aboriginal and Torres Strait Islander people in Australian general practice*:

- www.racgp.org.au/yourracgp/faculties/aboriginal/guides/identification/

John Gardiner-Garden's *Research Note No. 18 (2000-2001)* article 'The definition of Aboriginality' is available at:

- www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/CIB/cib0203/03Cib10

The NACCHO definition of Aboriginality:

- www.naccho.org.au/aboriginal-health/definitions

The Victorian Healthcare Association's *Managing clinical risk in primary health care* is available at:

- www.vha.org.au/uploads/VHA-Clinical-Risk-ONLINE.pdf

Section 2

Rights and needs of patients

Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.



Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.

Overview of this Standard

This Standard is about your health service adopting practices that respect the rights and needs of patients. Health services do this by taking a collaborative approach with patients – in health service delivery, during clinical consultations and through communication and feedback.

Patients have a right to be treated in a culturally respectful and appropriate way. This includes the right not to be discriminated against, and the right to feel culturally safe and comfortable in all encounters with administrative and clinical staff. Patients also have a right to determine who will be present during clinical encounters, which means consent for [third-party](#) presence needs to be obtained prior to the clinical consultation.

Patients have a right to be heard, and to provide feedback about your health service. Feedback means that patients feel involved in decisions about healthcare delivery and this helps improve your health service's response to patient needs.



Criterion 2.1.1: Respectful and culturally appropriate care

Our practice provides respectful and culturally appropriate care for patients.

In a nutshell

This criterion is about providing healthcare that is culturally appropriate, and is respectful of your patients' right to be treated with dignity, privacy and safety, and their right to accept or reject recommended treatment options or clinicians. It is also about observing obligations under the *Federal Discrimination Act 1992*, as well as relevant state and territory disability services Acts and equal opportunities Acts that prohibit discriminatory treatment of people based on their personal characteristics.

Aboriginal and Torres Strait Islander peoples have long experienced poor health consequences as a result of racially discriminatory policies. A growing body of current evidence suggests that discrimination and racism are linked to adverse health conditions amongst Indigenous people. Aboriginal community controlled health services are well positioned to ensure respectful and culturally appropriate care for all the communities they serve.

Key team members

- All health service staff

Key organisational functions

- Codes of conduct of various professional bodies
- Patient rights policy
- Cessation of patient care protocols
- Patient records policy and processes
- Anti-discrimination policy
- Cultural safety policy and processes

Indicators and what they mean

Table 2.1 explains each of the indicators for this criterion. Refer to page 58 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 2.1

Criterion 2.1.1 Respectful and culturally appropriate care

Indicators	What this means and handy hints
<p>► A. Our practice does not discriminate against or disadvantage patients in any aspect of access, examination or treatment.</p>	<p>Your health service does not discriminate against, or disadvantage, patients. To be sure this happens on a day-to-day basis, your service is advised to have an anti-discrimination policy that sets out expectations of employees regarding non-discriminatory behaviour towards patients. This includes everyone who is able to influence the patient experience, including part-time, contract, locum and volunteer staff.</p> <p>It is important that the policy is reinforced with the requisite training or information sessions, and appropriate performance management processes regarding patients' rights to access, examination and treatment free from all forms of discrimination. The policy needs to be reinforced with a complaints mechanism.</p>
<p>► B. Our clinical team can demonstrate how we provide care for patients who refuse a specific treatment, advice or procedure.</p>	<p>Your health service is advised to have a policy (for example, a patient rights and responsibilities policy) that acknowledges patients' right to accept or reject specific treatment, advice or procedures in the context of ongoing care. It could provide guidelines for responding to, and recording, instances when a patient refuses a specific treatment, advice or procedure. The information to be recorded could include:</p> <ul style="list-style-type: none"> • details of the refusal • the specific treatment, advice or procedure being refused • referrals to other care providers • an explanation of the action taken.
<p>► C. Our clinical team can describe what they do when a patient informs them that they intend to seek a further clinical opinion.</p>	<p>Your clinical team know what to do when a patient informs them that they intend to seek a second opinion. When this occurs, information could be recorded, such as:</p> <ul style="list-style-type: none"> • the patient's desire to seek a second opinion • referrals to other care providers (where given) • an explanation of the action taken (where occurred). <p>Clinical staff could encourage patients to notify your health service when they intend to follow another healthcare provider's management advice. This will allow your clinical staff an opportunity to discuss potential risks (if any) of this decision.</p>

Table 2.1 (continued)

Indicators	What this means and handy hints
<p>► D. Our practice team can describe what they do to transfer care, in a timely manner, to another GP in our practice or to another practice when a patient wants to leave the GP's care.</p>	<p>Your clinical team acknowledges a patient's right to be transferred to the care of another GP, or a GP in another service, and can initiate a timely and appropriate transfer of patient health records to another health service, where a transfer of care is requested by a patient. Protocols could be in place to provide for:</p> <ul style="list-style-type: none"> • the relevant copies of health records to be transferred (in compliance with requirements of state or territory legislation governing transfer of health records) • the transfer of records in a timely manner • the security of information being transferred.
<p>► E. Our practice team can describe arrangements for informing a patient and transferring the care of a patient whom a GP within our practice no longer wishes to treat.</p>	<p>It is suggested your health service has a policy on cessation of patient care to cover instances where GPs may consider it no longer appropriate that they treat a patient. These instances could include when a patient behaves in threatening or violent manner or where there has been a significant breakdown of the health professional–patient relationship. Note: while this criterion refers to GPs and doctors, other healthcare professionals should be included because they can face similar issues.</p> <p>The policy could provide guidelines to assist the treating GP/other clinician if they wish to stop treating the patient. These guidelines could include:</p> <ul style="list-style-type: none"> • an emphasis on the timely transfer of patient health records to another health service • a process for staff to follow if the patient makes subsequent contact with the health service, including which staff member would be responsible for contact (for example, the health service manager) • a statement that the service's professional and ethical obligation to provide emergency care could mean that a doctor may be required to provide care to discontinued patients in medical emergencies. <p>Although doctors have a right to discontinue treatment, this does not override their professional and ethical obligation to provide emergency care. It is recognised that in rural and remote locations, it may be difficult for your health service to uphold a doctor's decisions to discontinue treatment of a patient. Refer to Section 2 of the MBA code of conduct (details in the Useful resources section on page 116) for helpful advice on these areas.</p>

Table 2.1 (continued)	
Indicators	What this means and handy hints
<p>► F. Our practice team can describe how our practice provides privacy for patients and others in distress.</p>	<p>Distressed people need to be made comfortable in a private area rather than in a public area. There is no obligation to have a dedicated room for these situations, but your health service is advised to have a plan in place for when these situations occur. A protocol on dealing with distressed people could include:</p> <ul style="list-style-type: none"> • details of the staff member (preferably one with clinical experience) who should be contacted when a distressed person presents at your health service • the room that can be used (for example, the nearest available consulting room) • what actions the attending staff member needs to take (for example, provide a general wellbeing check, or to stay with the person until a doctor is available) • advice to document the situation in the patient health records, or in an incident report for a person who is not a patient, where the distress involves significant risk.
<p>G. Our practice team can identify important/significant cultural groups within our practice and outline the strategies we have in place to meet their needs.</p>	<p>ACCHSs need to be culturally competent and safe for all patients. It is important that your health service is aware of the different communities whose members visit it, and that it has in place cultural safety policies, protocols and processes across the whole of the health service. This includes the availability of cultural safety training in relation to all these communities. This training should be extended to all clinicians, including visiting specialists and locum GPs.</p> <p>Cultural safety practices need to be in place not only during clinic consultations but during interactions at reception and elsewhere. Cultural safety should inform all aspects of your health service's delivery, including preventive health programs, public health education campaigns and all policies and protocols that impact on patient care. Your staff need to be trained and have knowledge of, skills in, and commitment to, cultural safety practices.</p> <p>Updated cultural awareness and safety resources need to be easily available and accessible for all staff. Appropriate staff – including human resources employees, cultural mentors, cultural liaison officers, Aboriginal health workers, cultural brokers and/or cultural educators – may also provide ongoing advice.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure respectful and culturally appropriate care for its clients and community. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service takes the rights of patients very seriously. This is not just because of its legal requirements but also because of its understanding that trust between healthcare providers and their patients is a fundamental prerequisite for safe and quality healthcare. This is reinforced at every point of contact patients (and their carers, if relevant) have with service staff, including reception and administrative staff.

Effective communication is regarded as a vital means of promoting patient rights, and service staff use effective communication strategies to ensure there is good understanding on both sides.

The rights of patients are respected even when the GP may disagree with a decision a patient has made. This includes when a patient decides to seek a further opinion; to refuse to follow advice, procedures or treatments; or to be transferred to another GP or a GP in another service. The GP will try to communicate clearly what they believe the consequences of such decisions may be, but they will also encourage patients to explain the reasons for their decision, and will listen to them. The GP will try to work with patients to help them reach a decision that is best for their overall healthcare and wellbeing.

If there is a trusting relationship, patients may be more likely to tell GPs something that they may otherwise not disclose. This means GPs can actually help with a problem they didn't know about before – for example, that the medication they prescribed was too expensive. If they cannot help, GPs still show respect for things that patients consider to be important, such as the use of traditional medicine or traditional healers.

If any patient still wants to seek a second opinion, refuses treatment or advice, or requests a transfer of care, the service assists them to do this, and this is clearly documented in their health record.

The concept of culturally safe care outlined in the service's policy and procedure manual extends not

just to its Aboriginal and/or Torres Strait Islander patients – the majority of its patient population – but to the relatively small number of patients from other cultures who also use the service. Cultural safety training is provided for all staff (including part-time, visiting and locum staff), and issues about culturally appropriate behaviours are openly discussed. The service's staff induction includes directions on the polite, friendly and culturally safe way in which it expects its patients to be treated both in person and on the telephone.

The policy and procedure manual documents that staff members do not use rude or insulting language in the content of a patient's health records. Contents of health records are to be factual and clear to prevent other staff members from misinterpreting treatment plans or the patient history.

Aboriginal health workers are actively used as part of the clinical team, health promotion and program development and delivery. They also act as cultural mentors to non-Indigenous staff.

Gender-appropriate staff members are used where possible and appropriate, for consultations or as a chaperone.

The physical layout of the health service allows for separate entry and waiting areas for male and female patients (if patients choose to utilise them). A transport service is provided to assist patients who are geographically isolated or financially disadvantaged to access the service.

The health service has a distressed persons protocol, which describes what actions its staff should take in relation to a person who is upset. This includes which staff member(s) need to be contacted, especially in the case of a patient with mental health issues, and the designated room for use for distressed people. The protocol also distinguishes between those people who are in physical distress or injured and those who are emotionally distressed and require privacy.

Showing how you meet Criterion 2.1.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a cultural safety policy.
- Maintain a patient rights policy.
- Maintain cessation of patient-care protocols.
- Maintain patient records policies and processes.
- Maintain an anti-discrimination policy.
- Show that you provide a transport service for patients unable to access the service.
- Maintain separate entry and waiting rooms for men and women, if culturally appropriate.
- Show that you provide gender-appropriate staff members to act as chaperones.
- Maintain a policy and procedure manual.
- Show that cultural safety is covered in staff member interviews.
- Keep documentation in patient's notes.
- Provide referrals to other healthcare providers.
- Provide a room to ensure privacy for distressed patients.
- Provide cultural safety training for staff members; document it in the staff training log.
- Keep reports of community consultation processes.
- Record patient feedback, including complaints.

Related RACGP Standards and criteria

Criterion 1.5.2 Clinical handover

Criterion 1.7.1 Patient health records

Criterion 2.1.2: Patient feedback

Our practice seeks and responds to patients' **feedback** on their experience of our practice to support our quality improvement activities.

In a nutshell

A recognised outcome of healthcare is a health service's ability to both seek and respond to patients' experiences of their healthcare, whether good or bad. Your health service can achieve this by having a mechanism for patient feedback, analysis of that feedback and a plan to improve health service delivery in direct response to that feedback.

Key team members

- Health service manager
- All health service staff

Key organisational functions

- Patient feedback policy and processes
- Service planning and evaluation meetings
- Patient complaints policy and process
- Legal and regulatory compliance (health service delivery, complaints and professional indemnity insurance)
- Patient communication policy
- Practice information sheet
- Service delivery charters or principles
- Risk management and control
- Health service and professional indemnity insurance policy and procedures

Indicators and what they mean

Table 2.2 explains each of the indicators for this criterion. Refer to page 62 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion. Further essential reading for this criterion is a patient feedback guide and FAQ section on patient feedback requirements located at www.racgp.org.au/standards/fourthedition/patientfeedback

Table 2.2
Criterion 2.1.2 Patient feedback

Indicators	What this means and handy hints
<p>► A. Our practice has a process for seeking and responding to feedback from patients and other people and our practice team can describe the process.</p>	<p>Your health service should have in place a mechanism that allows for:</p> <ul style="list-style-type: none"> • patients to provide feedback when they want to (for example, a feedback/suggestion box) • analysis of that feedback (for example, regularly emptying the box and analysing feedback to create reports for staff to consider and discuss at meetings) • the development of a plan of action in direct response to that feedback (for example, an agenda item for the regular health staff meeting). <p>It is important that this mechanism is easy for patients to use. It is equally important that all staff have an understanding of how the process works.</p>
<p>► B. Our practice has a complaints resolution process and makes contact information for the state/territory health complaints agencies readily available to patients if we are unable to resolve their concerns ourselves.</p>	<p>Your health service should have a system for patients to make complaints. This can be set out in a patient complaints policy and procedures document, which is made known to all staff members. Information about the complaints process needs to be made known to patients. This can be done via a notice on the board or a take-home leaflet; alternatively, staff need to be able to describe that process when asked by patients.</p> <p>This process would include the delegation of a staff member as the person primarily responsible for communication with patients about complaints (such as the health service manager).</p> <p>Patients need to know what to do if they are not satisfied with the response to their complaint, and the service should provide patients with contact information for the state/territory health complaints agencies (such as Health Complaints Commissioner).</p> <p>Section 3.11 of the MBA's <i>Good medical practice: a code of conduct for doctors in Australia</i> (www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx) provides advice about managing complaints. Basic steps include:</p> <ul style="list-style-type: none"> • acknowledging the patient's right to complain • working with the patient to resolve the issue • providing a prompt, open and constructive response (such as explanation, or apology or both) • ensuring that the patient is still able to utilise your health service during the complaints handling process (such as referring them to another doctor or AHW) • complying with relevant laws, policies and procedures that deal with health complaints. <p>If your health service has a policy of allowing patients access to your board members for complaints, explain to patients the process involved and provide the relevant contact details.</p> <p>It is advisable that your health service also contacts the relevant insurer when the complaint involves a clinical team member. Advice should be sought from the insurer before taking action.</p>

Table 2.2 (continued)

Indicators	What this means and handy hints
<p>► C. At least once every 3 years, our practice actively seeks feedback about patients' experience of our practice by:</p> <ul style="list-style-type: none"> • using a validated patient experience questionnaire that has been approved by the RACGP or • developing and using our own individual practice-specific method that adheres to the requirements outlined in the RACGP <i>Patient feedback guide: learning from our patients</i> (questionnaire or focus group or patient interviews). 	<p>The RACGP <i>Patient feedback guide: learning from our patients</i> is essential reading for this criterion. It is accessible from the RACGP website at www.racgp.org.au/standards/fourthedition/patientfeedback</p> <p>In addition to having processes to encourage patients to provide feedback and to make complaints if they wish, it is important your health service actively and systematically seeks feedback from its patients.</p> <p>The information gained from this more formal process is more likely to capture all aspects of the patient experience, and from a wider range of patients. It will provide a more reliable basis for developing and implementing quality improvements based on patient feedback. This process provides important information to your service about where it is doing well and where it could improve. It also allows your service to compare one group of patients with another (for example, from services delivered at different locations) and to monitor its service quality over time (for example, to measure the effect of a new service or improvements to an existing service).</p> <p>The RACGP <i>Patient feedback guide: learning from your patients</i> outlines six dimensions of the patient experience that need to be covered:</p> <ul style="list-style-type: none"> • access and availability • information provision • privacy and confidentiality • continuity of care • communication skills of clinical staff • interpersonal skills of clinical staff. <p>There are two options for the collection of patient feedback, explained more fully in the <i>Patient feedback guide</i>:</p> <ul style="list-style-type: none"> • a validated patient experience questionnaire, which has been approved by the RACGP • a practice-specific method of collecting patient experience feedback (questionnaire, focus groups or patient interviews), also approved by the RACGP.* <p>There are advantages and disadvantages to each of the methods described above. Many are outlined in the <i>Patient feedback guide</i>, and we recommend that you understand these and choose the method most appropriate for your health service. Health services with patients from culturally diverse backgrounds need to also consider issues such as language, cultural safety and cultural protocols when choosing methods for feedback collection. This will reduce the possible barriers to patients' participation in feedback processes.</p>
<p>► D. Our practice can demonstrate improvements we have made in response to analysis of patient feedback.</p>	<p>An important part of patient feedback is your health service's capacity to put in place changes in response to that feedback, and to demonstrate that you have done this. Depending on the type of feedback – how significant or urgent it is – your service's response to the feedback can be immediate (at regular staff meetings), annually (at planning day) or every 2 to 3 years (part of the strategic plan).</p> <p>Improvements made need to be incorporated into relevant policies and procedures, where appropriate, and communicated to all staff.</p>

Table 2.2 (continued)

Indicators	What this means and handy hints
E. Our practice provides information to patients about practice improvements made as a result of their input.	<p>Patients value being heard. It is recommended that when you have analysed feedback findings and instigate change as a result, you communicate this back to patients. This communication may be with an individual patient where appropriate – for example, about actions taken if the patient has made a complaint or suggestion. If actions from informal or individual patient feedback affect all patients, then information regarding that improvement would be given to all patients.</p> <p>Actions from your systematic 3-yearly patient feedback process need to be communicated to all patients. You could provide this information in many ways, such as:</p> <ul style="list-style-type: none"> • at annual general meetings and in annual reports • in an electronic bulletin • via health service posters or notice boards • via newsletters • on your website • to the relevant individual patient.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can obtain and respond to patient feedback. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service's patient information sheet tells how a patient can discuss issues with the service directly. It emphasises that the service values critical as well as positive feedback, and that there will be no negative consequences for a patient resulting from a complaint. The service has a designated staff member with whom patients can lodge complaints or discuss issues, either verbally or in writing. This staff member keeps a record of complaints and how the complaints were resolved or, if a complaint could not be resolved, the reason why not.

The service provides the contact details for the state/territory health complaints agency if the patient is unwilling to complain to the service directly, or if the patient feels that the service hasn't addressed their complaint properly.

The service has a suggestion box in the waiting room. Reception staff empty it weekly and give the suggestions to the designated staff member. Suggestions are discussed at team meetings and action taken if agreed. The service keeps a logbook of any changes or improvements made as a result of a patient complaint or feedback. Staff speak directly to individual patients who have made suggestions that result in a change or improvement about the change made as a result of their suggestions.

Program staff members get feedback from their clients at the end of any program that is run, either in the form of a written questionnaire or by conducting interviews or focus groups. The feedback is provided in a report to management for review. Improvements that are agreed are planned and implemented in the next program.

* Note that 'If a practice decides to develop its own practice-specific method, then after the initial development, pre-testing and refinement (but prior to collecting information from patients), the practice needs to apply to the RACGP to have its method approved as suitably rigorous to meet the requirements of the *Standards*. (The RACGP *Patient feedback guide: learning from our patients*, p2).

An RACGP-approved patient feedback survey is completed at least once every 3 years. The results of the survey are distributed to all staff for review. All staff members are asked to offer suggestions regarding the feedback issues that are appropriate for improvement and action, and then prioritise areas for action. The priorities are based on key areas that show clear potential for achievable improvement. A record of improvements or changes is documented in a quality improvement record book.

Changes that are implemented are included in the service's newsletter and on the waiting room notice board. The service's website also includes information on changes that have been made as a result of client feedback or suggestions. The service also uses local media to promote or announce major changes in service delivery and highlights that the changes are as a result of client feedback and suggestions.

Showing how you meet Criterion 2.1.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a complaints policy and procedures.
- Show that you have designated a person to receive and handle complaints or suggestions.
- Maintain a complaints register.
- Keep a suggestion box in the reception area.
- Show that you run community forums and information days.
- Make available a service information sheet.
- Make available a patient information sheet documenting the contact details for state/territory health complaints agencies.
- Include patient feedback/complaints information in the board manual.
- Maintain an RACGP-approved patient experience questionnaire.
- Provide patient feedback reports.

- Show that you address issues at team meetings, annual planning days and/or strategic planning agendas.
- Address patient feedback/complaint issues in the newsletter.
- Provide patient feedback information on the notice board.
- Provide patient feedback information on the website.
- Provide patient feedback information in the local media, where appropriate.

Related RACGP Criteria

Criterion 1.2.1 Practice information.

Criterion 2.1.3: Presence of a third party

The presence of a [third party](#) observing or being involved in clinical care during a consultation occurs only with the prior consent of the patient.

In a nutshell

Obtaining prior consent from the patient for the presence of a third party in the consultation room is vital.

Key team members

- Reception staff
- All clinical staff

Key organisational functions

- Patient communications policy
- Patient consent policy
- Patient confidentiality and privacy policy
- Patient health records
- Patient consent (intellectual disability) policy
- Patient rights and responsibilities

Indicators and what they mean

Table 2.3 explains each of the indicators for this criterion. Refer to page 65 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 2.3

Criterion 2.1.3 Presence of a third party

Indicators	What this means and handy hints
<p>► A. Our practice team can demonstrate how we obtain the prior consent of a patient for the presence of a third party during the consultation.</p>	<p>Your patients need to give consent to a third party being present in the consultation room. This consent needs to be obtained prior to the consultation appointment. Patients should not be asked for consent after they have entered the room, because this will make them feel ambushed, and possibly uncomfortable about refusing.</p> <p>Third parties include:</p> <ul style="list-style-type: none"> • health and allied health professionals (including GP registrars and international medical graduates) • health and allied health or nursing students on placement • interpreters • carers • chaperones • relatives and friends of patients. <p>Consent for a third party presence in a consultation, like consent to clinical procedures, needs to be informed. This means your patients are informed (verbally and/or in writing) about:</p> <ul style="list-style-type: none"> • who specifically may be in the consultation • the reasons they would be there • how the patient, the primary health professional and the third party could benefit from the third party's presence • their right to refuse the presence of the third party halfway through the consultation • the third party's obligation to maintain the patient's confidentiality. <p>Once consent has been obtained, the clinical staff member should record the verbal or written consent in patient health records.</p> <p>It is important to ensure that consent is current – that when a patient has given consent for a third-party presence at prior consultations, the patient continues to consent for each and every consultation where a third party is present. A patient can withdraw consent for third-party presence if desired.</p> <p>Where patients with intellectual disabilities are involved, the question may arise as to whether they have capacity to provide consent. Legal guardians or advocates may be appointed to oversee their interest. It is highly recommended that your health service develop a patient consent (intellectual disability) policy. For more information about guardianship, please refer to the link in the Useful resources section on page 116.</p> <p>Similar issues arise with regards to children giving consent.</p>



Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure prior consent is given for the presence of a third party. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's policy and procedure manual describes the process in relation to having a third party present in consultations, and for obtaining patient consent, either verbally or in writing. It also describes the importance of documenting this in patient health records. The policy clearly states that patients should be asked for such consent when they make an appointment or when they arrive at reception. Consent is not to be sought when patients are already in the consulting room. The policy clearly states that patients should never feel pressured into having a third party present or involved in their clinical care.

The staff induction manual includes the requirement that new staff members have read and understood the policy regarding the presence of a third party. Staff members are made aware that a third party also includes family members and it is not to be assumed that a patient is happy to have their partner/spouse or other relative in the consultation with them.

A sign is placed in the waiting area to notify patients when the service has medical students or other health professionals observing the consultations. The sign also emphasises that patients do not have to have these third parties in their consultation if they do not want to. Consent is documented in patient health records.

- Make sure third-party presence is covered in the staff induction manual.
- Place signs in the waiting room when medical or nursing students are at the service and observing.
- Keep documented records of verbal consent in patient health records.

Showing how you meet Criterion 2.1.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a policy on the presence of a third party in consultations.

Other information for this Standard

What these words mean

Cultural safety

This is about creating an environment that is safe for people, where there is no threat or challenge to their sense of identity, or their culture's approach to health. The environment is safe because it promotes shared respect, meaning, knowledge and experience. It is about a meaningful cross-cultural interaction where there is no domination of one cultural point of view over another.

Feedback

Information about reactions to a product, a person's performance of a task, or a service provided, which is used as a basis for improvement. Patient feedback is the views and opinions of patients and service users on the care they have experienced.

Focus group

Gathering small groups of people together to discuss and explore their views in detail, which provides qualitative information, in this context, for quality improvement activities.

A focus group is a planned group discussion within which a moderator asks a small number of patients to discuss key issues about their experiences of care from your health service.

Questionnaire

A group of questions designed to obtain people's feedback about a topic. For health services, it provides a standardised way of asking a selection of patients for their feedback so you can generalise the results to the rest of your patients. Questionnaires can highlight key areas for improvement and tell you what people think but not necessarily why they feel that way.

Third party

Someone other than the patient who is present during a consultation with a health professional. It may be a medical or nursing student, a nurse, an Aboriginal health worker or a family member.

Validated

Where the value of a questionnaire has been evaluated. This involves establishing that the

questionnaire produces results that are reliable and valid. In other words, the results will be the same if the questionnaire is administered again, and the questionnaire measures what it is meant to measure.

Refer to the RACGP's *Patient feedback guide: learning from our patients* to learn about the advantages and disadvantages of questionnaires and focus groups. It can be downloaded at www.racgp.org.au/standards/fourthedition/patientfeedback

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the *QIC Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The *QIC Standards* include the following standards that are relevant to Standard 2.1 Collaborating with patients:

- 2.2 Focusing on positive outcomes.
- 2.3 Ensuring cultural safety and appropriateness
- 2.4 Consumer rights

The *ISO Standards* include the following requirements that are relevant to Standard 2.1 Collaborating with patients:

- 5.2 Customer focus
- 6.1 Provision of resources
- 7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures.

Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

You are strongly advised to read the *Patient feedback guide: learning from your patients* and the RACGP-approved, validated surveys and FAQs:

- www.racgp.org.au/standards/fourthedition/patientfeedback

If your service decides to develop its own method for collecting patient feedback, an application form can be obtained from the RACGP by emailing standards@racgp.org.au

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The Medical Board of Australia's *Good medical practice: a code of conduct for doctors in Australia* is available at:

- www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Northern Territory Health has produced a complaints brochure with examples and information:

- www.health.nt.gov.au/Agency/Complaints_and_Compliments/index.aspx

The Picker Institute Europe provides a useful guide, *Using patient feedback*:

- www.pickereurope.org/usingpatientfeedback

The RACGP has a position statement on the use of chaperones:

- www.racgp.org.au/support/policies/clinical-and-practice-management

Guardianship information can be found on the website of the Human Rights and Equal Opportunity Commission:

- www.hreoc.gov.au/disability_rights/hr_disab/areas/appendices.htm#app1

Section 3

Safety, quality improvement and education

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Overview of this Standard

This Standard is about your health service's capacity to deliver and maintain a high standard of clinical care by ensuring and improving quality and safety for patients. Having sound, clear policies and guidelines for your service and its staff helps you to maintain and improve safe and high-quality clinical care. You may achieve this by focusing on four aspects of clinical health management:

- quality improvement – regularly reviewing and improving your service's clinical structures, systems and clinical care
- clinical risk management – putting in place clinical systems and protocols that minimise the level of risk to patients
- clinical governance – actively promoting and encouraging safe and high-quality clinical care through clear policies, guidelines and accountability
- patient identification – putting in place a process of patient identification that minimises the risk of adverse events associated with misidentification and maintains confidentiality and accuracy in patient health record keeping.



Criterion 3.1.1: Quality improvement activities

Our practice participates in [quality improvement](#) activities.

In a nutshell

Quality improvement activities increase quality and safety for patients. The best quality improvements are the result of team efforts, and involve looking at your health service's structures, systems and clinical care, and planning, implementing, reviewing and further improving what your service does in a regular and systematic way.

Key team members

- Health service manager
- CEO/director
- Clinical and administrative staff
- Board

Key organisational functions

- Quality improvement plan
- Quality improvement tools
- Service planning and evaluation meetings
- All related clinical and service delivery policies and protocols
- Service delivery charter or principles
- Patient feedback policy and processes
- Clinical and health service [data](#) collection and use
- Clinical audits

Indicators and what they mean

Table 3.1 explains each of the indicators for this criterion. Refer to page 68 of the *Standards for general practices* for more information, resources and explanations of some of the concepts referred to in this criterion.

Table 3.1
Criterion 3.1.1 Quality improvement activities

Indicators	What this means and handy hints
<p>► A. Our practice team can describe aspects of our practice that we have improved in the past 3 years.</p>	<p>Your health service undergoes regular quality improvement activities, and your staff know about these improvements. These activities could include regularly monitoring, reviewing and providing plans for action drawn from data in areas such as:</p> <ul style="list-style-type: none"> • patient feedback • day-to-day operations (for example, appointments, opening hours, patient record keeping and patient complaints handling) • clinical care (for example, referral protocols, clinical handovers, immunisation rates, Pap smear rates, child and adult health checks, and identifying health risk factors based on your patient population) • health service data (for example, audit of clinical databases, analysis of near misses and mistakes) • complaints handling processes and results. <p>Reviewing, developing and implementing plans of action to improve clinical care and systems, when documented, are all evidence of quality improvement activities. It is recommended you conduct these activities on a regular basis, and as necessary in relation to clinical risk management. These activities are, ideally, collaborative efforts from all members of your health service team. They are most effective when they take place in a way that helps staff feel empowered, safe to contribute and confident of implementing change effectively.</p> <p>In situations of near misses or mistakes, it is recommended that your health service undergo quality improvements to immediately address what has gone wrong, and ensure they don't happen again.</p>
<p>► B. Our practice uses relevant patient and practice data for quality improvement (e.g. patient access, chronic disease management, preventative health).</p>	<p>Data collection is crucial because it gives you a bird's eye view of what has been happening in your health service. Using the appropriate data will help you to identify your service's strengths and weaknesses and how to improve on them. It is important to collect data carefully so that it makes a reliable basis for quality improvement activities. See examples of data in Indicator A.</p> <p>Some health services may not have sophisticated information technology. In these instances, data from immunisation records, recall systems, chronic health registers and the like are also useful to help identify quality improvement activities. It is vital that all data your health service relies on for quality improvement comes from your service.</p> <p>Following the Council of Australian Governments' (COAG) National Indigenous Reform Agreement, a set of 24 national key performance indicators (nKPIs) has been approved by the Australian Health Ministers' Advisory Council (AHMAC) for reporting by Commonwealth and state and territory government-funded services that provide healthcare to Aboriginal and Torres Strait Islander peoples.</p> <p>Commonwealth government-funded services commenced reporting 11 nKPIs (for 2011–12 data) in July 2012. Reports due in July 2013 (for 2012–13 data) will include a further eight nKPIs; reports due in July 2014 (2013–14 data) will include a further five nKPIs, using detailed specifications to be determined by AHMAC during 2012–13. Consistent with COAG agreements, it is anticipated that nKPI data for subsequent years will also be collected from state and territory government-funded services.</p> <p>Services will be able to use the nKPIs to generate and view a wide range of reports and charts about their activities; these can also be used to participate in CQI programs, projects and other data quality initiatives.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can participate in quality improvement activities. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service identifies areas for improvements at regular team meetings and annual planning meetings, based on data collected by the service itself. Priority topics are determined by adverse events, near misses and mistakes, patient feedback and staff feedback, as well as monitoring of issues arising from usual operations in reception, administration and clinical areas of the health service.

Some areas the health service has addressed – and improved on – were important to improving patients' experience of the centre. These areas include scheduling appointments and catering for walk-in clients; changing opening hours; changing incident reporting; and handling of near misses and adverse events.

The health service prides itself on its public health activities and seeks to monitor these via, for example, immunisation rates in the under-5s, and flu vaccinations in the elderly and in patients with chronic diseases. The service keeps a database for each of its core programs, such as chronic disease, under-5s, women's health, men's health and antenatal care programs. Further, the service has reliable patient management software that is able to collate patient data into meaningful reports of their demographics, clinical presentations and how they were managed. This data helps the health service to make decisions about changes to its services.

The service's GPs are encouraged to participate in clinical audits. Some are free, such as the National Prescribing Service's clinical audits for GPs. Other clinical audits the service conducts on a regular basis include how it manages patients with diabetes, high cholesterol, high blood pressure and those with depression, to identify areas for clinical improvement.

The health service actively participates in more intensive quality improvement cycles, through the support and facilitation of external organisations such as One21Seventy and the Improvement Foundation. It shares information and learns from other participating ACCHSs, using collaborative learning processes and good use of information technology.

Clinical and administrative staff members are aware of the introduction of the nKPIs and their use in reporting to the Office for Aboriginal and Torres Strait Islander Health. The service plans to identify and implement a quality improvement activity for each of the first 11 indicators.

Showing how you meet Criterion 3.1.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a quality improvement plan based on collated patient feedback, clinical data and reports, incident reports and other data.
- Keep clinical data and reports, including rates of childhood vaccinations, completed adult health checks and updated risk factors.
- Maintain a quality improvement plan based on a [clinical audit](#) completed by staff.
- Maintain a continuous improvement register.
- Use patient management software.
- Use a clinical program database.
- Keep agenda and minutes for planning meetings.
- Prepare reports to funding bodies.
- Prepare reports on use of patient feedback, clinical audits and other improvement achievements.

Related RACGP Standards and criteria

Criterion 2.1.2 Patient feedback

Criterion 1.3.1 Health promotion and preventive care

Criterion 3.1.2 Clinical risk-management systems

Our practice has clinical risk-management systems to enhance the quality and safety of our patient care.

In a nutshell

Minimising the level of risk to patient safety and care means that your health service needs to have documented systems in place to help it identify, monitor and change practices that cause mistakes and near misses. Risk management is also about planning for contingencies such as natural disasters, pandemic diseases or sudden, unexpected absence of clinical team members.

There are three core elements to risk management.

Clinical knowledge and skill

Clinical staff are expected to have the minimum core skills and knowledge required to do their job. This also includes an awareness of their skills limitations, and a willingness to appropriately refer patients. Thoroughly documenting clinical care in patient health records and investigating unsuccessful treatments are also good risk-preventive measures. Sound clinical skills need to be supported by a culture of open communication and reporting, so that concerns about unsafe work practices are identified and reported in a spirit of learning. Fundamental strategies include:

- keeping up to date with evidence-based healthcare findings
- taking a thorough history and examination and documenting it in the clinical record
- being aware of your own limitations and referring patients appropriately

- investigating further if treatment is not working
- making use of protocols, checklists and diagnostic support aids
- looking after yourself
- preventing and dealing with fatigue
- reporting your concerns if you think that unsafe work practices are forced on you.

Communication

Risks can be minimised where there is a culture of open, safe communication. At the consultation level, doctor–patient relationships based on trust and honesty encourage informed consent and safe clinical care. At the health service level, open and regular communication with other health professionals (internal and external) ensures early detection and identification of near misses and mistakes with a view to implementing change that prevents their recurrence. Risks can be minimised by:

- building a doctor–patient relationship based on trust and honesty
- listening to patients and showing empathy
- minimising interruptions during consultations
- managing unrealistic patient expectations
- communicating with your health service staff
- encouraging an environment in the health service where patients feel

welcome and culturally safe and staff are skilled in all aspects of managing patients

- keeping open channels of communication with the health and health-related facilities you interact with (for example hospitals, radiology practices, pharmacies)
- managing adverse events or complaints in a way that does not leave patients feeling abandoned or that their concerns are ignored
- ensuring your consent process allows patients to understand the implications of a proposed treatment, medication or other procedure so they can make up their own mind as to whether they want to have it or not.

Systems

A risk-management system is made up of a series of sub-systems that interconnect to ensure consistent quality and safety in patient care. These systems need to be regularly monitored and changed in

response to adverse events, mistakes and near misses. It is not sufficient for adverse events, mistakes and near misses to be identified and managed as one-off events. Without identifying the causes of near misses and mistakes, and changing systems to prevent further occurrences, more serious and dire consequences will inevitably follow. Systems and processes that can be finetuned to decrease medico-legal risk include:

- complaints-handling process
- tracking of tests ordered and referrals made
- documentation of clinical consultations
- recording of appointments, cancellation and any failure to attend
- infection-control procedures
- recruitment, training and management of staff
- management of confidentiality and privacy.

Key team members

- Designated risk-management coordinator
- Health service manager
- CEO/director
- Administrative and clinical staff
- Board

Key organisational functions

- Clinical risk-management policies and protocols
- Staff recruitment, training and management
- Communication policies (internal/external/patient–clinician)
- Patient consent
- Culturally safe and competent clinical practice

- Documentation and maintenance of patient health records
- Networking and collaboration with other health providers
- Clinical staff personal safety and care

Indicators and what they mean

Table 3.2 explains each of the indicators for this criterion. Refer to page 71 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.2
Criterion 3.1.2 Clinical risk-management systems

Indicators	What this means and handy hints
<p>► A. Our practice team can demonstrate how we:</p> <ul style="list-style-type: none"> regularly monitor, identify and report near misses and mistakes in clinical care identify deviations from standard clinical practice that may result in patient harm. 	<p>Your health service should have a clinical risk-management system and protocols to help it regularly monitor, identify and report near misses and mistakes along with any potentially harmful deviations from standard practice in clinical care. The system should include the core elements of risk management (clinical knowledge and skill; communication; systems) and set out how your health service plans to minimise risks in these core areas.</p> <p>Staff members need to:</p> <ul style="list-style-type: none"> receive training and be kept up to date with existing policies and protocols around the identification and reporting of near misses and mistakes receive training and be kept up to date with standard clinical practice so they know how to identify deviations (changes) from standard practice that may result in patient harm know the identity of the designated risk-management staff member, and reporting processes/protocols for near misses and mistakes feel safe and empowered to recognise and report near misses and mistakes without fear or recrimination.
<p>► B. Our practice has documented systems for dealing with near misses and mistakes.</p>	<p>It is highly recommended that your service keep an event register to record de-identified near misses and mistakes. This register should be regularly reviewed and plans of action developed and implemented to address the problems identified.</p> <p>The designated clinical risk-management staff member should have responsibility for monitoring the event register, investigating each event and developing, implementing and monitoring change processes that reduce or better manage clinical risk.</p> <p>It is recommended that clinicians notify their medical defence organisation of all events or circumstances that they perceive might give rise to a claim. This should be done before any action is taken to resolve a complaint or apologise for a mistake in clinical care.</p>
<p>► C. Our practice team can describe improvements made to our systems to prevent near misses and mistakes in clinical care.</p>	<p>Clinical staff members should be kept up to date about improvements made to systems in order to prevent near misses and mistakes. It is also important for staff to know the how and why of changes to systems.</p> <p>Fostering a culture where the focus is on addressing problems and systems, rather than blaming individuals, is the most effective way to minimise risks at the clinical level.</p>

Table 3.2 (continued)

Indicators	What this means and handy hints
<p>► D. Our practice monitors system improvements to ensure successful implementation of changes made to our clinical risk-management systems.</p>	<p>Monitoring, identification, implementation and further monitoring – a cyclical process – is a very effective way of ensuring continuing quality and safety in patient care. A strategy of ‘find it, fix it and confirm it’ could fulfil this function. The ‘confirm it’ step helps monitor improvements to make sure they are successful.</p> <ul style="list-style-type: none"> • Find it: your health service could use clinical audits or monitoring of performance indicators to identify where improvements can be made to reduce risk, enhance quality of care and improve patient health outcomes. • Fix it: once gaps are identified, your health service could implement strategies to address the problem (for example, redesign clinical services, or revise policies and procedures). • Confirm it: make sure that changes implemented to reduce risk actually do this; confirmation can be measured by an evaluation process, such as a re-audit of health or service indicators.
<p>► E. Our practice has a contingency plan for adverse and unexpected events such as natural disasters, pandemic diseases or the sudden, unexpected absence of clinical staff.</p>	<p>Your health service needs to have contingency plans for unusual events that may disrupt patient care. Such events could include natural disasters or disease outbreaks that overstretch your service’s capacity. It is recommended that the contingency plan be documented as a policy (with processes established to guide staff). The plan could include partial or complete closure of your health service (for example, where there is a sudden, unexpected absence of key members of the clinical team) or suspension of non-emergency services so that staff can focus on disease outbreaks. Your policy/protocol should also clearly designate a primary person responsible for coordinating and overseeing the contingency plan.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can participate in clinical risk-management activities. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service recognises that near misses and mistakes happen, as do deviations from standard clinical practice. However, it is proactive in identifying, rectifying and continually trying to prevent near misses and mistakes in order to reduce clinical risk. This is a formal process that is documented in the service's policy and procedures manual. The formal process includes having an incident report process, allowing time to formally discuss anything that went wrong and to implement change to reduce the likelihood of it happening again.

Sometimes the service uses a structured technique to understand the causes of an error as the basis for implementing change to reduce the likelihood of it happening again. One of these easy-to-use techniques is called root cause analysis, and it can be used in a team setting (see Module 10 Managing quality in the *RACGP General practice management toolkit*. Details in the Useful resources section on page 136).

At the service, staff know who to report incidents to and feel comfortable doing so because there is a culture of open communication, support for staff and consistent use of clinical risk-management systems.

The board takes a great interest in clinical risk management and the service reports to it every quarter on the incidence of near misses and mistakes, and what it is doing to rectify problems.

The service has a policy and set of procedures for adverse and unexpected events that are possible in the local area. These include floods, bushfire and severe storms, pandemic disease or the sudden unexpected absence of clinical staff. These events can disrupt patient care and have the potential to damage health records and computer systems essential for ongoing, safe patient care.

The health service ensures it receives special emergency bulletins from government sources such as the Commonwealth chief medical officers, state centres for disease control and the Bureau of Meteorology.

Showing how you meet Criterion 3.1.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a clinical risk-management policy and protocol.
- Maintain an incident or event register.
- Maintain staff training records.
- Keep records of staff members' knowledge about and experience with adverse events, near misses and mistakes, and of changes implemented to prevent their recurrence.
- Show that you conduct clinical audits demonstrating changes to clinical care that have reduced risk.
- Maintain key performance indicators that demonstrate a reduced number of mistakes and near misses.
- Keep minutes of team and planning meetings where risks are discussed.
- Record revisions to policies and procedures that have been shown to reduce risk.
- Maintain contingency plans for unexpected events, including floods and severe storms.
- Show that you have a designated staff member with primary responsibility for risk management.

Criterion 3.1.3 Clinical governance

Our practice has clear lines of accountability and responsibility for encouraging improvement in safety and quality of clinical care.

In a nutshell

Your health service has in place a system of accountability that enables clinicians and other staff to maintain and improve high-quality healthcare to patients. This means that at least one person should have the role of clinical leader with accountability for developing and overseeing the clinical governance framework, and other staff may take on other important roles. See page 76 of the *Standards for general practices* for more information about these roles.

The focus should be on achieving:

- a high standard of safe, quality healthcare
- a culture of accountability and openness through an effective and well-communicated risk-management system (for clinical and general staff)
- continued improvement to health service delivery through review, education and training, and staff management (such as clinical audits, basic and ongoing education).

In an ACCHS context, the focus on teamwork – in particular multidisciplinary teams – and tailoring service delivery to meet localised needs should also be recognised when considering clinical

governance models. Good communication and information-sharing skills and processes are also required. Effective clinical governance for your health service may also include identifying and documenting accountability for systems such as:

- patient travel
- sharing patient information with other health services in your region
- population-based health checks (for example, school-wide health checks or STD checks)
- community-based palliative care
- cultural safety and competence induction and training of non-Indigenous staff
- integration of multidisciplinary services within your health service (for example, physio, nutrition or using a maternal/child health community health service model rather than GP-focused model).

Key team members

- Director of clinical services/clinical team leader
- CEO/director
- Health service manager
- Board
- Clinical leaders
- Administrative and clinical staff

Key organisational functions

- Clinical governance framework
- Human resources (documenting accountability and responsibilities in position descriptions)
- Performance management process
- Continuing education and training of all staff (including internal communications and training policies)
- Clinical audit reports
- Risk management (clinical and general risk management and controls)
- Clinical health management practices and protocols
- Research and development activities and reports
- Clinical safety (clinical staff safety policy, patient informed consent policy, culturally safe and competent clinical practice)
- Quality improvement reports
- Staff communication (including internal communications policies, staff meetings, clinical staff meetings)

Indicators and what they mean

Table 3.3 explains each of the indicators for this criterion. Refer to page 76 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.3
Criterion 3.1.3 Clinical governance

Indicators	What this means and handy hints
<p>► A. Our practice has leaders who have designated areas of responsibility for safety and quality improvement systems.</p>	<p>Your health service ensures good clinical governance by appointing clinical leaders (such as a medical director or public health officer) with designated accountability and responsibility for specified areas of clinical care. In a small service, this could mean one clinical leader. In a larger, multidisciplinary team, this could mean several clinical leaders who are responsible for different areas of clinical governance. These areas could include infection control, ongoing education and training, clinical audits, risk management, quality improvement, complaints management or patient feedback.</p> <p>The allocation of clinical leaders means that your health service could ensure that:</p> <ul style="list-style-type: none"> • an organisational culture of participation and leadership in safety and quality improvement is resourced, supported, recognised and rewarded • you hold all staff accountable and involved in monitoring and improving care and services • a culture of safety and quality is promoted that solves problems rather than allocates blame. <p>The clinical leadership role is also to develop a systematic approach to monitoring, managing and improving safety, and to ensure that staff are clear about their responsibilities and accountabilities when it comes to clinical safety and quality patient care. A clinical leader could ensure that your health service has:</p> <ul style="list-style-type: none"> • a team-based approach to care, where members have clear roles and responsibilities for improving patients' clinical outcomes • accurate records of each patient's health history • support structures to assist members of the clinical team in providing evidence-based care • mechanisms to identify and prevent clinical risk for your health service, the staff and patients • systems and procedures to share information and learn from each other about clinically safe practices, and implementing solutions to prevent future harm to patients • strategies to maintain consistency in care delivery and outcomes for patients • procedures to ensure timely and equitable access to care • accurate registers of patients with chronic conditions • systems to manage chronic disease patients, and to proactively identify those at risk or those who could benefit from early intervention • the capacity to extract clinical data and collate them to guide improvements to your health service.
<p>► B. Our practice shares information about quality improvement and patient safety within the practice team.</p>	<p>Good clinical leadership engages all clinical staff members in a commitment to excellence. This is best achieved when a culture of openness and mutual respect is promoted to allow for open discussions about problem areas, and can usually be done at clinic team meetings. It is therefore recommended that a regular agenda item for team meetings would be to discuss quality improvement and patient safety issues in your health service.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can participate in clinical governance. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service has formed a clinical governance committee whose terms of reference include:

- designated accountability and responsibility for key areas of patient safety and quality improvement
- open communication and reporting of safety and quality issues and events, and active participation in the development, implementation and monitoring of solutions
- development of an organisational culture that does not blame but instead looks for solutions to problems and learns from mistakes
- staff involvement at all levels to monitor and improve healthcare systems
- active support of management.

The health service manages its staff to ensure best practice and clinical competence. All staff have responsibilities for relevant aspects of clinical governance clearly written into their position descriptions and the service's performance management system addresses these through induction and ongoing training, performance planning and performance review.

Clinical staff's continuing professional development (CPD) activities are recorded and kept up to date in accordance with the requirements of their profession. Clinical staff are rostered to deliver in-services on clinical topics. Sometimes external presenters are invited to present at these regular in-services. Staff attendance at these in-services and education events is recorded.

Internal communication about clinical governance issues, activities and outcomes is extensive and takes place verbally at meetings and presentations and through documented reports and updates.

The board takes an active leadership role with respect to clinical governance matters, and staff are regularly invited to make presentations at board meetings about significant clinical governance issues and achievements.

Showing how you meet Criterion 3.1.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Ensure the clinical leader's role and position description includes designated accountability and responsibilities for defined areas of clinical care.
- Ensure position descriptions for other clinical staff include any specific roles and responsibilities for aspects of clinical governance.
- Keep clinical governance committee agendas and minutes.
- Keep clinical staff meeting agendas and minutes.
- Keep board meeting agendas and minutes.
- Keep clinical governance reports.
- Ensure that team and annual planning meeting documents show that staff discuss quality improvement and patient safety issues, confirm who is responsible for key areas of safety and quality improvement activity, and confirm who has overall accountability for the safety and quality of clinical care (clinical governance).

Criterion 3.1.4: Patient identification

Our patients are correctly identified at each encounter with our practice team.

In a nutshell

Correct patient identification is vital for patient safety and confidentiality. Your health service should routinely check patient identity by the use of three approved patient identifiers for each patient encounter. This minimises the risks of mis-identification and mismatches when patients undergo procedures or clinical tests, or when references are made to medical results.

Key team members

- Reception staff
- Clinical staff

Key organisational functions

- Patient confidentiality and privacy policy
- Patient health records policy and procedures
- Patient information management systems and processes
- Patient communication (including telephone and electronic communications policies)
- Appointment systems
- Clinical risk management
- Referral protocols

Indicators and what they mean

Table 3.4 explains each of the indicators for this criterion. Refer to page 78 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.4

Criterion 3.1.4 Patient identification

Indicators	What this means and handy hints
<p>► A. Our practice has a patient identification process using three approved patient identifiers and the practice team can describe how it is applied.</p>	<p>Your health service could have a standing policy that at each encounter with the service, patients are required to provide at least three health service-approved identification indicators to staff. It is important that your policy requires staff members to ask patients to state their identifying information rather than to simply confirm the information the staff member provides. These encounters include the following situations:</p> <ul style="list-style-type: none"> • when making appointments • at reception • in the clinic • writing prescriptions, referrals • giving or entering results or correspondence into records. <p>Accepted patient identifiers include:</p> <ul style="list-style-type: none"> • client name (family and given, and/or cultural, skin, clan or bush name) • date of birth • gender • address (may be recorded as community/outstation/homeland) • hospital record number or equivalent • family relationships • for a client who was part of a multiple birth, the order in which the client was born (for example, the second of twins). <p>Note that Medicare numbers are not approved identifiers.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that it correctly identifies patients at each encounter. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's patient health files contain at a minimum three approved patient identifiers. The service's reception staff routinely check that the address and contact details held on file are the current ones for the patient.

A prompt sheet containing approved patient identifiers is kept at reception to remind staff they must ask patients to indicate (not verify) their identity at each encounter with the health service.

A protocol is in place that at each service encounter or activity patients are identified even if they are well known to the service and staff. Staff members routinely ask patients their name, address and date of birth prior to commencing a consultation. The protocol includes instructions that staff ask specific questions such as 'What is your name? Your address? Your date of birth?'

Clinical staff members check patient identification using three approved patient identifiers before any procedural treatment is provided. Staff members are mindful of privacy and confidentiality issues when asking for patient identifiers.

Staff members are encouraged to report incidents of patient mis-identification if they occur and to record them in the health service's event register so the event can be reviewed and analysed. In this way, existing processes can be varied or new processes can be implemented to reduce the risk of mis-identification recurring and causing harm to other patients in the future.

Showing how you meet Criterion 3.1.4

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Show that you use health service-approved patient identifiers.
- Show that you maintain appropriate reception processes.
- Use patient health files.
- Keep a prompt sheet at reception.

Related RACGP Standards and criteria

Criterion 1.7.1 Patient health records

Criterion 1.6.2 Referral documents

Criterion 3.1.2 Clinical risk-management systems

Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy

Other information for this Standard

What these words mean

Approved patient identifier

(from the *Standards'* glossary)

Items of information accepted for use in patient identification.

To meet the RACGP *Standards* a minimum of three health service-approved indicators is required. Accepted patient identifiers include:

- client name (family and given, and/or cultural, skin, clan or bush name)
- date of birth
- gender
- address (may be recorded as community/outstation/homeland)
- hospital record number or equivalent
- family relationships
- for a client who was part of a multiple birth, the order in which the client was born (for example, the second of twins).

A Medicare number is not an approved identifier.

Clinical audit

A review of a specific area of clinical care in order to better manage or improve clinical care. The key component of a clinical audit is that performance is reviewed (or audited) to ensure that what should be done is being done, and that if it is not a framework is developed to enable improvements to be made. GPs are required to complete clinical audits as part of their RACGP Quality Improvement & Continuing Professional Development (QI&CPD) program requirements.

Clinical governance

(adapted from the *Standards'* glossary)

A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care.

This is the term used to describe an accountable and systematic approach to maintaining and improving the safety and quality of patient care within a health system. It is about the ability to produce effective change so that high-quality care is achieved. It requires clinicians and administrators to take

individual and joint responsibility and be accountable for making sure this occurs.

Clinical leadership

This is both a set of tasks to lead improvements in the safety and quality of healthcare, and the attributes required to successfully carry the tasks out. This can include:

- participating in setting the safety and quality agenda, taking responsibility for implementing that agenda and being accountable for the results
- acting as a champion for improvement
- providing advice in determining priorities for allocation of resources to support best practice
- taking the lead in prioritising, designing and improving processes of care
- driving a culture of openness and team participation.

Data

Information in raw or unorganised form. When organised, it can be analysed to help identify possible improvements.

Mistakes

(adapted from the *Standards'* glossary)

These are errors or adverse events that result in harm. For example, a GP may have prescribed a sulphur drug to a patient who is allergic to it; the patient developed an anaphylaxis and was treated in hospital. Note that in the context of clinical risk management there are no assumptions made about the cause of the mistake. It is recognised that a mistake may be made because of a system error or human error.

National key performance indicators

Key performance indicators are measures of the performance of the health service in a number of important areas. They allow the service to define and measure progress towards its objectives.

The Australian Institute of Health and Welfare website (<http://meteor.aihw.gov.au/content/index.phtml/itemId/457994>) describes the national key performance indicators project:

As part of the National Indigenous Reform Agreement, the Council of Australian Governments (COAG) agreed that the Department of Health and Ageing, in partnership with the state and territory health departments and in collaboration

with the Australian Institute of Health and Welfare, would develop a set of national key performance indicators for Indigenous-specific primary healthcare services.

The Indigenous primary healthcare national key performance indicators will monitor, inform, and provide a direct line of sight between the activities of federal and state- and territory-funded services that provide primary healthcare to Aboriginal and Torres Strait Islander peoples, and the COAG Closing the Gap targets, in particular the targets for life expectancy and child mortality.

The indicators will enable monitoring of the contribution of this part of the health system in achieving Closing the Gap targets. The nKPIs are intended to:

- indicate the major health issues pertaining to the regular client population of Indigenous-specific primary healthcare services (especially those of maternal health, early childhood and the detection and prevention of chronic diseases)
- outline the extent to which government-funded Indigenous-specific primary healthcare services collect, record and review pertinent data on these issues, and
- reveal changes in health risks or outcomes that may be driven by the quality of care that government-funded services provide to their clients.

Near misses

(adapted from the *Standards*' glossary)

These are incidents that did not cause harm but could have done so. For example, a GP prescribed a sulphur drug where the patient was known to be allergic to it; however, the patient checked with the pharmacist and did not take it.

Organisational culture

The shared beliefs and behaviours of people in an organisation. The simplest definition is: the way we do things around here.

Quality improvement

(from the *Standards*' glossary)

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

activities, including clinical audits using a tool such as CAT or 'plan, do, study, act' cycles, undertaken within the service.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 3.1 Safety and quality:

- 1.9 Integration of safety and quality
- 3.3 Incorporation and contribution to good practice
- 1.7 Risk management

The ISO *Standards* include the following requirements that are relevant to Standard 3.1 Safety and quality:

- 4 Quality management system
- 5 Management responsibility
- 6 Resource management
- 7 Product realisation
- 8 Measurement, analysis and improvement

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

See Appendix B, page 128, in the *Standards for general practices* for more on clinical governance and quality.

See also the RACGP *Standards* website www.racgp.org.au/standards/311 for more information about quality improvement tools and other resources.

See Appendix B, page 215, in this guide for an overview of continuous quality improvement.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

Research conducted by Phillips et al identifies key health service areas covered by a clinical governance framework:

- www.mja.com.au/public/issues/193_10_151110/phi10475_fm.html

See seven key areas to address in clinical governance, summarised from *Improving quality through clinical governance in primary care*:

- www.racgp.org.au/your-practice/standards/standardsforgeneralpractices/standard3-1/3-1-3

The Victorian Quality Council has some useful resources on clinical governance including:

- www.health.vic.gov.au/qualitycouncil/pub/improve/leading.htm
- www.health.vic.gov.au/qualitycouncil/pub/improve/clinicalleader.htm

The Victorian HealthCare Association Clinical Governance in Community Health Project has developed a number of model policies, resources, tools and links that may be useful for health services in implementing clinical governance:

- www.vha.org.au/clinicalgovernance.html

The Australian Primary Care Collaboratives program helps general practitioners and primary healthcare providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions, and promote a culture of quality improvement in primary healthcare:

- www.apcc.org.au/about_the_APCC

One21seventy, the National Centre for Quality Improvement in Primary Healthcare, provides tools, training and support for primary healthcare services to use:

- www.one21seventy.org.au/Public/AboutUs.aspx

The Australian Institute of Health and Welfare provides information on the nKPI project:

- meteor.aihw.gov.au/content/index.phtml/itemId/430638

The Queensland Aboriginal and Islander Health Council have developed a set of core indicators in Aboriginal health that provide a framework to develop quality improvement activities based on specific health indicators to review and improve upon:

- www.qaihc.com.au/wp-content/plugins/download-monitor/download.php?id=QAIHC-Core-Indicators-V2-Sept-2010.pdf

The RACGP tools for general practice feature several resources for managing various kinds of risk, including the *General practice management toolkit*:

- www.racgp.org.au/publications/tools#8

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Overview of this Standard

This Standard is about your health service encouraging and supporting all staff members to maintain their qualifications and continue to develop expertise in their relevant roles, so that they can all contribute to quality improvement and risk management. This can include:

- meeting the CPD requirements set by relevant professional bodies
- attending formal courses or training to familiarise staff with health service policies and protocols
- on-the-job training or any other education and training that enables staff to effectively and safely perform their roles.

Crucially, as staff members may be present during medical emergencies, all staff should be trained in cardiopulmonary resuscitation (CPR) at least every 3 years.

Criterion 3.2.1: Qualifications of general practitioners

All GPs in our practice are appropriately qualified and trained, have current Australian registration and participate in continuing professional development.

In a nutshell

General practice is a distinct discipline that requires suitable training and qualifications. These qualifications need to be maintained through regular participation in CPD activities. If your health service is unable to recruit **vocationally registered GPs**, other doctors can be recruited so long as they have the qualifications and training necessary to meet the needs of your patients or they are enrolled in a recognised general practice training program and are supervised, mentored and supported in their education.

See the Useful resources section on page 148 for more about GP supervision in remote health services.

Key team members

- Health service manager
- Doctors

Key organisational functions

- Human resources management
- Staff records
- Staff training and CPD calendar and records

Indicators and what they mean

Table 3.5 explains each of the indicators for this criterion. Refer to page 80 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.5

Criterion 3.2.1 Qualifications of general practitioners

Indicators	What this means and handy hints
<p>► A. All our doctors can provide evidence of appropriate current national medical registration.</p>	<p>National medical registration means registration with the Medical Board of Australia (see Australian Health Practitioners Regulation Agency in the Useful resources section on page 148).</p>
<p>► B. Our practice demonstrates that all our doctors are recognised GPs, with the exception of:</p> <ul style="list-style-type: none"> • doctors enrolled in a recognised general practice training program • other specialists practising within their specialty • trainees undertaking a placement to gain experience in general practice as part of another specialist training program. <p>Where recruitment of recognised GPs has been unsuccessful, our practice demonstrates that doctors have the qualifications and training necessary to meet the needs of our patients.</p>	<p>Ideally all the doctors at your health service will be recognised GPs. If they are not, then they should fit into one of the exemption categories listed in indicator B.</p>
<p>► C. Our practice can provide:</p> <ul style="list-style-type: none"> • evidence of satisfactory participation in the RACGP QI&CPD program by all our GPs, or • evidence that our doctors participate in quality improvement and continuing professional development to at least the same standard as the RACGP QI&CPD program. 	<p>Your doctors should be suitably trained and qualified to carry out their professional role. They also need to maintain their skills by participating in continuing professional development – for example, the RACGP QI&CPD program or another program to at least the same standard as the RACGP QI&CPD program.</p>
<p>► D. Our GPs have undertaken training in cardiopulmonary resuscitation in accordance with RACGP QI&CPD recommendations.</p>	<p>The RACGP recognises that CPR skills may diminish over time due to infrequent use. The RACGP QI&CPD program requires GPs to undertake CPR training in accordance with Australian Resuscitation Council (ARC) guidelines at least once every 3 years.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that its GPs are appropriately qualified and trained, have current Australian registration and participate in continuing professional development. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

All new GP staff members are credentialed prior to being offered employment. All GP employment files contain copies of current Australian medical registration (every year) and CPD points (every 3 years), which includes the completion of a basic CPR course. The service ensures that GP registrars are supervised and enrolled in approved training courses.

All new GPs, including locums, participate in an induction program, and are provided with the necessary information they need to perform affectively in their roles, including cultural safety training. This includes ensuring they know how to access different sections of the Medicare website (www.medicareaustralia.gov.au/provider) for all the relevant information it contains. New staff members are provided with a mentor to provide support and advice as required.

Administrative staff access the AHPRA practitioner registration website (www.ahpra.gov.au) to ensure all GPs have current Australian registration. Copies of registration certificates are placed in each staff member's employment file. Administration staff maintain a register of professional registration expiry dates for GPs.

Position descriptions include formal designation of responsibility for specific roles in addition to core job functions – such as continuous quality improvement, complaints management, information technology, risk management, cleaning, infection control, sterilisation or vaccine management.

All staff members participate in an annual [performance management](#) planning and review, which includes a review of training undertaken and the identification of training required or requested for the next year.

Staff members can describe their roles and responsibilities and this is consistent with documented position descriptions. In the smaller satellite clinics a number of these responsibilities are included in the one staff member's position description. The main clinic has a number of staff members who are allocated only one core responsibility and this is also included in their position descriptions.

Training calendars from state health departments, Medicare Locals, local health services and NACCHO state or territory affiliates are available in varied locations within the service and are also distributed by email to staff.

The health service's strategic plan includes a staff training and development plan, with a budget.

[Clinical supervision](#) is provided to staff members when required.

Administration staff maintain a register of all staff members' CPR training and its expiry. The service organises CPR training in accordance with RACGP guidelines (in other words, consistent with ARC guidelines) for all staff members to attend. CPR training should be at least once every 3 years but some health professionals consider it should be done annually.

Showing how you meet Criterion 3.2.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Annually update employee files for each GP with current registration records.
- Utilise the recruitment process, including certification that your health service was unsuccessful in recruiting a recognised GP where applicable, if this was the case.
- Keep QI&CPD records.
- Conduct annual performance planning and keep review documents indicating identification of training needs and training completed.
- Keep training log records for GPs.
- Keep a training and development calendar.

Criterion 3.2.2: Qualifications of clinical staff other than medical practitioners

Other members of our clinical team are appropriately qualified and trained, have relevant current Australian registration and participate in continuing professional development.

In a nutshell

All members of your clinical team are required to be suitably qualified and trained, and to have maintained their skills through participation in the CPD requirements of their relevant profession. Clinical team members are required to undertake CPR training at least every 3 years.

Key team members

- Health service manager
- Clinical team
- Medical staff with training responsibilities

Key organisational functions

- Human resources management
- Staff records
- Staff training and CPD calendar and records

Indicators and what they mean

Table 3.6 explains each of the indicators for this criterion. Refer to page 82 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.6

Criterion 3.2.2 Qualifications of clinical staff other than medical practitioners

Indicators	What this means and handy hints
<p>► A. All our nurses and allied health professionals:</p> <ul style="list-style-type: none"> • have current national registration where applicable • have appropriate credentialing and competence • work within their current scope of practice • actively participate in continuing professional development relevant to their position in accordance with their professional organisation's requirements. 	<p>All your clinical team members who provide clinical care need to take responsibility for maintaining their own knowledge and skills, and to work within the limits of their competence and scope of practice. The role of the service is to ensure that this requirement is followed.</p> <p>National registration for nurses and allied health professionals means registration with the appropriate board of the Australian Health Practitioners Regulation Agency. See Useful resources on page 148.</p>
<p>► B. Our other team members involved in clinical care have appropriate qualifications, training and competence and participate in continuing professional development relevant to their roles.</p>	<p>Professional bodies have their own training requirements, professional standards of practice, continuing professional development and codes of conduct. Like doctors, other clinical team members need to have appropriate qualifications, training and competence and should participate in relevant continuing professional development.</p> <p>It is advisable that your health service maintains records of appropriate qualification and continuing professional development that clinical staff participate in. All staff qualifications, training and professional development information should be kept with the relevant staff member's files.</p> <p>Clinical staff members need to be able to responsibly undertake delegated duties as required.</p>
<p>► C. Our other team members involved in clinical care have undertaken training in CPR in accordance with the requirements of the relevant registration Act or professional organisation or at least every 3 years.</p>	<p>The RACGP recognises that CPR skills may diminish over time due to infrequent use, and CPR skills are therefore required to be refreshed every 3 years for all clinical staff. It is preferable that CPR training occur annually, where possible.</p> <p>Training in CPR may be conducted by medical staff, preferably with a current CPR instructor's certificate that complies with the ARC guidelines on instructor competencies. Training can also be conducted by an accredited training provider. Note: training that is solely online does not meet ARC requirements.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that other members of its clinical team are appropriately qualified and trained, have current Australian registration and participate in continuing professional development. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

All new clinical staff members are credentialed prior to being offered employment. The service's clinical staff member employment files contain a training log and copies of certificates and qualifications.

Administrative staff access the AHPRA practitioner registration website (www.ahpra.gov.au) to ensure that all nurses, Aboriginal health practitioners and allied health professionals have current Australian registration, where required. Administration staff maintain a register of professional registration expiry dates for nurses and allied health professionals.

Note that the Aboriginal and Torres Strait Islander Health Practice Board (www.atsihealthpracticeboard.gov.au/Registration/Forms.aspx) advice is as follows:

Practitioners who intend on practicing as an Aboriginal and Torres Strait Islander health practitioner must apply for national registration. Those Aboriginal health workers who are not required by their employer to use the title "Aboriginal and Torres Strait Islander health practitioner", "Aboriginal health practitioner" or "Torres Strait Islander health practitioner", are not required to be registered, and can continue to work using their current titles (for example, "Aboriginal health worker", "drug and alcohol worker" and "mental health worker").

Position descriptions include formal designation of responsibility for specific roles. These might include complaints management, information technology, risk management, cleaning, infection control, sterilisation, vaccine management and quality improvement.

All staff members participate in an annual performance planning and review, which includes a discussion of training undertaken and the identification of training required or requested for the next year. Training for all clinical staff includes cultural safety training.

The health service's strategic plan includes a staff training and development plan, with a budget. Training calendars from state health departments, Medicare

Locals, local health services and NACCHO state or territory affiliates are available in varied locations within the service and are also distributed by email to staff.

Clinical supervision is provided to staff members when required.

New staff members are provided with a mentor to provide support and advice as required.

Staff members can describe their roles and responsibilities and this is consistent with documented position descriptions. In the smaller satellite clinics a number of these responsibilities are included in one staff member's position description. The main clinic has a number of staff members who are allocated only one core responsibility and this is also included in position descriptions.

Administration staff maintain a register of all staff members' CPR training and its expiry. The service organises annual CPR training for staff members.

Showing how you meet Criterion 3.2.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Keep employee files with current registration records.
- Keep staff training logs.
- Mention staff qualifications in job descriptions.
- Conduct annual performance planning and keep review documents indicating identification of training needs and training completed.
- Keep a training and professional development calendar.

Criterion 3.2.3: Training of administrative staff

Our administrative staff participate in training relevant to their role in the practice.

In a nutshell

Your administrative staff are suitably qualified and regularly participate in training relevant to their role in your health service.

Key team members

- Health service manager
- [All administrative staff](#)
- Medical and clinical staff with training responsibilities

Key organisational functions

- Human resources management and administration
- Staff training and CPD calendar and records

Indicators and what they mean

Table 3.7 explains each of the indicators for this criterion. Refer to page 84 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 3.7

Criterion 3.2.3: Training of administrative staff

Indicators	What this means and handy hints
<p>► A. Our administrative staff can provide evidence of training relevant to their role in the practice.</p>	<p>Your administrative staff – such as receptionists, health service managers, health service drivers and cultural liaison officers – need to be provided with training relevant to their role. Training may include formal courses, or may be provided by suitably qualified medical, clinical and management staff. It can be provided in areas such as health service management, computers, software applications, first aid, medical terminology, health service reception and cross-cultural training.</p> <p>Training can also be provided on the job, and include teaching staff how to:</p> <ul style="list-style-type: none"> • use a patient health records system • make appointments • recognise medical emergencies when patients are in reception • understand confidentiality requirements • familiarise themselves with the health service policy and procedures manual. <p>Triage training, appropriate to the role, needs to be provided to administrative staff to reduce patient risk. For example, reception staff could be trained to recognise medical emergencies, prioritise appointments, act in a culturally sensitive manner or know when and how to consult with a nurse or doctor to assess the degree of medical urgency in a particular situation (see also Criterion 1.1.1).</p>
<p>► B. Our administrative staff have CPR training at least every 3 years.</p>	<p>The RACGP recognises that CPR skills may diminish over time due to infrequent use, and CPR skills are therefore required to be refreshed every 3 years. It is preferable that CPR training occur annually, where possible. This is important as administrative staff may be present during a medical emergency.</p> <p>Training in CPR may be conducted by medical staff, preferably with a current CPR instructor's certificate that complies with the ARC guidelines on instructor competencies. Training can also be conducted by an accredited training provider. Note: training that is solely online does not meet ARC requirements.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that its administrative staff participate in training relevant to their role. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service's budget includes a line item for administrative staff training.

Administrative staff employee files contain evidence of courses, in-services and training attended. Staff performance planning and review processes include an area of identified training that individual staff members would like to attend or need to attend to be competent in their role.

The service receives, and distributes to staff members, information about training opportunities and other resources appropriate to their roles.

The service's strategic plan includes a staff training and development plan, with a budget. Training calendars from state health departments, Medicare Locals, local health services and NACCHO state or territory affiliates are available in varied locations within the service and are also distributed by email to staff. Training for all administration staff includes cultural safety training.

General staff meetings include on-the-job training in the form of revision of policies, protocols, procedures and distribution of resources. Staff members receive triage training on the job as part of their induction program and the service provides for annual revision.

New administrative staff participate in induction training and are allocated a buddy for 3 months, to help them understand administration processes and procedures.

All staff members participate in an annual performance management planning and review, which includes both a review of training undertaken and the identification of training required or requested for the next year.

Showing how you meet Criterion 3.2.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- List staff qualifications in employee files.
- Keep staff training logs.
- Mention staff qualifications in job descriptions.
- Keep a training and development calendar.
- Conduct annual performance planning and keep review documents indicating identification of training needs and training completed.

Other information for this Standard

What these words mean

Administrative staff

(from the *Standards*' glossary)

Staff employed who provide clerical or administrative services and who do not perform any clinical tasks with patients.

Clinical supervision

A formal process where an experienced healthcare professional meets regularly with one or more healthcare staff to discuss and think about their work, with the aim of continually improving their practice.

Credentialing

The Australian Commission for Safety and Quality in Health Care defines credentialing as

The process used to verify the qualifications and experience of [health professionals] to determine their ability to provide safe, high-quality healthcare services within a specific healthcare setting.

See www.safetyandquality.gov.au/our-work/credentialing

Performance management

The process of planning with staff what they should be doing in the coming period, linking individual performance to organisational needs and ongoing communication, and evaluating their performance.

Scope of practice

The range of roles, functions, responsibilities and decision-making processes that a health professional performs in the context of their practice. An individual's scope of practice is influenced by their education, knowledge, experience, currency and skills. Determining someone's scope of practice ensures that they have the qualifications and experience to safely perform the work that the service is asking them to do.

Vocationally registered GPs

A GP on the RACGP Fellows list or the Vocational Register (grandparented) with Medicare, or a GP on the Australian College of Rural and Remote Medicine Fellows List with Medicare.

Being a vocationally registered GP gives access to special Medicare item numbers and higher Medicare rebates.

GPs with vocational registration are required to fulfil the RACGP QI&CPD criteria or the Australian College of Rural and Remote Medicine's professional development program in order to retain vocational registration. This involves a combination of educational activities and assessment/audit of practice, which is completed in rolling 3-year periods (triennia).

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 3.2 Education and training:

1.3 Human resources

The ISO *Standards* include the following requirements that are relevant to Standard 3.2 Education and training:

6.2 Human resources

7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the RACGP *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

Information on the RACGP QI&CPD program:

- www.racgp.org.au/education/cpd

Standards (4th edition) factsheets:

- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

Information and resources relating to GP supervision in remote health services include:

- www.rvts.org.au/training.aspx
- ntgpe.org/index.php/about-us

Susan Wearne's *Australian Family Physician* (Vol. 34, No. 12, December 2005) article 'General practice supervision at a distance: Is it remotely possible?' is archived at:

- <http://dspace.flinders.edu.au/jspui/bitstream/2328/11878/1/2005101590.pdf>

Australian Resuscitation Council guidelines:

- www.resus.org.au/policy/guidelines/index.asp

The Medical Board of Australia code of conduct sets out expectations on good patient care, such as recognising and working within limits of a doctor's competence and scope of practice, and ensuring adequate knowledge and skills. It also sets out expectations for maintaining professional performance and behaviour:

- www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

The Australian Health Practitioner Regulation Agency contains a list of the 14 national boards:

- www.ahpra.gov.au/Health-Professions.aspx

The Australian Association of Practice Managers conducts educational and professional development activities for members:

- www.aapm.org.au/education.aspx

For competency standards for registered nurses, midwives, nurse practitioners and enrolled nurses, see the Australian Nurses and Midwifery Council:

- www.anmc.org.au

For resources for nurses in general practice, such as *A guide for the supervision of enrolled nurses in general practice*, contact the Australian Practice Nurses Association. Email admin@apna.asn.au or telephone 1300 303 184 (free call).

The Australian Medicare Local Alliance has information on nursing in general practice:

- www.amlalliance.com.au/medicare-local-support/nigp

Details of the Royal College of Nursing Australia professional development services can be found on their website:

- www.rcna.org.au/wcm/default.aspx

Information about training for Aboriginal and Torres Strait Islander health workers can be found on the Australian Indigenous HealthInfoNet website:

- www.healthinfonet.ecu.edu.au/health-systems/health-workers/health-workers-workforce/training

Details of the Australian Physiotherapy Association's CPD scheme can be found at their website:

- physiotherapy.asn.au

Details of the Australian Psychological Society's CPD program for members can be found at their website:

- www.psychology.org.au

Details of the Pharmaceutical Society of Australia's CPD program can be found at their website:

- www.psa.org.au/education/about-cpd

Details of the Dietitians Association of Australia Accredited Practising Dietitian program can be found at their website:

- daa.asn.au/for-health-professionals/apd-program

Details of the Australian College of Social Work's CPD policy can be found at their website:

- www.aasw.asn.au/whatwedo/continuing-professional-development

Section 4

Practice management

Standard 4.1

Practice systems

Our practice demonstrates effective human resource management.

Standard 4.2

Management of health information

Our practice has an effective system of managing patient information.

Standard 4.1

Practice systems

Our practice demonstrates effective human resource management.

Overview of this Standard

This Standard is about effective human resource (HR) management systems, which are critical to the provision of safe and high-quality healthcare. They are particularly important in the ACCHS sector, where programs, services, staffing and delivery systems are often comprehensive and complex.

Human resource management systems should provide guidance and support to members of staff as they carry out their roles and responsibilities. A good human resource management system will better support the delivery of good clinical care. An important part of this system is the support structure that needs to be put in place to ensure compliance with occupational health requirements and the promotion of staff health and wellbeing.



Criterion 4.1.1: Human resource system

Our practice supports effective human resource management.

In a nutshell

Having a good HR management system means that your health service is better positioned to deliver good clinical care. Effective human resource management, even for smaller health services, is important. It should include key elements such as clearly defined roles and responsibilities for all staff, provision for appropriate induction and training, HR administration processes, two-way communication and a performance management process. It should also provide for leadership in key aspects such as quality improvement, risk management and infection control, a good induction or orientation process and effective communications systems. Providing for effective staff support and development processes is also a good staff retention strategy.

Key team members

- CEO/director
- Health service manager
- Human resources manager
- Senior clinical and administrative staff

Key organisational functions

- Human resources management
- Orientation/induction processes and package for new staff
- Communication policies and procedures
- Quality and safe clinical practice
- Risk management and control
- Staff complaints process
- Staff records
- Staff training
- Cultural safety workplace policy and processes

Indicators and what they mean

Table 4.1 explains each of the indicators for this criterion. See page 87 of the *Standards for general practices* for more information about key elements of good human resource management in a clinical environment.

Table 4.1

Criterion 4.1.1 Human resource system

Indicators	What this means and handy hints
<p>► A. All members of our practice team have position descriptions and can describe their role in the practice.</p>	<p>Staff roles and responsibilities need to be clearly defined in a documented position description, and to be understood by your individual staff members. The best position descriptions are those that can be utilised to form the basis for staff planning, evaluation and lines of accountability.</p> <p>Ideally, a position description would include:</p> <ul style="list-style-type: none"> • an overall description of the job, with general areas of responsibility listed • the essential functions of the job • the required knowledge, abilities and skills • the required education and/or experience • the line of accountability • a description of physical demands (including OH&S requirements) • a description of the work environment (including OH&S requirements) • any cultural safety requirements. <p>The position description needs to be updated as a staff member's roles and responsibilities change.</p>
<p>► B. Our practice has an induction system that orientates new GPs and other members of our practice team to the practice's specific systems.</p>	<p>Induction is crucial for all ACCHSs. It provides an opportunity to orientate new staff members not only to the day-to-day operations of the health service but also to the social, cultural and community information and knowledge of the local Aboriginal and/or Torres Strait Islander community.</p> <p>An induction system could orient new staff members to the following:</p> <ul style="list-style-type: none"> • the day-to-day operations of the health service • the service's clinical risk-management processes • occupational health and safety • infection control • quality improvement • local social and cultural practices and traditions • local and regional (and sometimes state and interstate) health and community services • clinical governance system • key policies and procedures • privacy and confidentiality of patient health information (including relevant communication policies) • cross-cultural communication and orientation • the local health environment (including relevant key public health regulations and local public health issues) • specialised protocols for rural or remote regions (such as patient travel or emergency evacuations).

Table 4.1 (continued)

Indicators	What this means and handy hints
► C. Our practice team can identify the person(s) with primary responsibility for leading our practice's quality improvement and risk-management processes.	<p>Your health service has an identified leader (or leaders) in the key areas of continuous quality improvement and risk management. This criterion cross-references with Criterion 3.1.3 Clinical governance, where safe, high-quality care is achieved by ensuring accountability and consistency.</p>
► D. Our practice team can identify the person(s) who coordinate the seeking of administrative feedback and the investigation and resolution of administrative and/or other complaints.	<p>Your health service has an appointed person or persons responsible for coordinating and seeking administrative feedback and managing complaints. This could be a health service or human resources manager.</p> <p>Some of the issues that may fall within this area include feedback or complaints on:</p> <ul style="list-style-type: none"> • policies and procedures • staff/patient complaints • recruitment and employment • communication structures and processes • occupational health and safety • performance management.
► E. Our practice team can discuss administrative matters with the principal GPs, practice directors or owners when necessary.	<p>An open communication channel between staff members and management is crucial to maintain a high standard of human resources management. Administrative/HR systems, like clinical systems, are subject to quality improvement and risk management. The two systems are interrelated, and when problems and issues are identified and addressed, this will lead to better outcomes for both human resource management and health service delivery.</p> <p>Your health service could have a communication system in place for staff members to discuss administrative matters with management. This could include a process for two-way communication with the board. The communication system would also include a complaint handling procedure, which ensures that confidentiality and due process is observed at all times.</p>

Table 4.1 (continued)

Indicators	What this means and handy hints
<p>► F. Our practice can show evidence of regular practice discussions that encourage involvement and input from members of the practice team.</p>	<p>It is important that your health service encourages a culture of fairness, support, transparency, cohesion and collaborative relationships between management and staff. In general, this will lead to improved patient outcomes and enhanced patient safety, as well as enhanced staff satisfaction.</p> <p>Regular team meetings amongst administrative staff, clinical staff and whole of health service staff are a good way to maintain a high level of involvement and input from all staff members. These meetings need to be conducted in an open and transparent manner, and to be clearly documented.</p>
<p>G. Our practice has a system to monitor team members' performance against their position descriptions.</p>	<p>Documented position descriptions form the basis of staff accountability and performance evaluation. Recruitment, training and development, performance review, remuneration management and succession planning can all be developed from a good position description.</p> <p>A performance management policy and process is an important mechanism to allow managers to regularly and systematically review staff performance, guide staff development and plan future roles and tasks through a two-way communication process. This policy could also allow for more informal ongoing supervision and feedback, and for the management of underperforming staff and unacceptable behaviour.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that it has an effective human resource system. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service has a human resources policy and plan, linked to its business plan. This covers policies and procedures to address recruitment and selection, induction, performance management, training and development, management and leadership.

All staff have documented position descriptions that outline the responsibilities of their job and upon which annual performance reviews are based. Position descriptions are updated, if required, after the annual performance review. Staff members who have been delegated responsibility for specific roles have these responsibilities included in their position descriptions. These roles may include complaints management, information technology, risk-management systems, cleaning, infection control, sterilisation, vaccine management, quality improvement.

There is an induction program, tailored to individual needs. It includes general items such as:

- welcome to the service
- administration, telephone procedures and appointments
- triage and medical emergencies
- processes for patient management
- patient health records and confidentiality
- human resources – job descriptions and specific roles, staff appraisals, training
- occupational/workplace health and safety
- infection control including standard precautions and immunisation
- schedule 8 drugs (if kept on the premises)
- clinical autonomy for GPs and other health professionals
- complaints and patient feedback process and who is responsible

- clinical risk-management system and who is responsible
- organisational structure
- multidisciplinary teamwork
- cultural awareness and security.

Health professionals also have a specific induction checklist for clinical matters in addition to the general staff induction process. When completed this is placed in the employment file and includes the following:

- prescriber number, provider number and medical registration details
- Medicare information: online claiming for Medicare and the Department of Veterans' Affairs, Practice Incentives Program (PIP), Service Incentive Payments and General Practice Immunisation Incentive Individual General Practitioner details and forms
- Australian Childhood Immunisation Register: application, Agreement under section 46E(2) of the *Health Insurance Act 1973*, bank account details for immunisation providers, General Practice Immunisation Incentives Practice report (G11020A) request
- Health Professional Online Services (HPOS) application, registration for prescription shopping program, National Prescribing Services (clinical audits and activities for PIP)
- Aboriginal and Torres Strait Islander health assessment and chronic disease management processes
- evidence of training in
 - cultural awareness and security
 - multidisciplinary teamwork
 - clinical governance
 - updating the health service information sheet
 - setting up appointment sessions and appointment times in appointment book (paper-based or electronic)
 - infection control
 - computers: username and password for main server, clinical and accounting software, installing public key infrastructure if applicable, login process, prescription sheets, resource access, training in clinical software, if required

- occupational health & safety and service policies: proof of immunisation or consent or refusal of offer form signed, confidentiality form signed, working with children check undertaken
- clinical: clinical guidelines, pathology and x-ray providers, local hospitals, specialist referral, ECG and spirometry, emergency trolley, equipment and doctors/retrieval bag(s), emergency retrievals/evacuations, drug cupboard content, access and dispensing process.

Team work, including cross-disciplinary teamwork, is encouraged, and efforts are made to bring staff from different areas together so that they can work collaboratively on an issue or task. Time is allowed for team meetings every fortnight.

Managers of all areas have management and leadership skills training.

Showing how you meet Criterion 4.1.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how you meet the criterion.

- Keep up-to-date staff employment files.
- Show that you cover the human resource system in staff interviews.
- Maintain an organisational chart.
- Document and define the recruitment process.
- Use induction templates/checklists.
- Maintain position descriptions with defined accountability and responsibilities.
- Keep a complaints ledger.
- Maintain accessible communication channels, such as regular staff meetings.
- Show that you maintain a policy and procedure manual outlining human resources matters.
- Keep minutes of staff, clinical and OH&S meetings.

Related RACGP criteria

Criterion 3.1.3 Clinical governance

Criterion 4.1.2: Occupational health and safety

Our practice implements strategies to ensure the occupational health and safety of our GPs and other members of the practice team.

In a nutshell

Occupational or workplace health and safety is a legal obligation to ensure a safe working environment for staff. It requires your health service to follow relevant state/territory and federal laws, which may vary between states. Health and safety extends to staff wellbeing, so your health service is advised to have systems in place that protect both the physical safety and general wellbeing of your staff, both in and outside of normal opening hours. Additionally, your service could encourage health and wellbeing through healthy practices such as taking breaks to reduce fatigue and its associated risks to patient safety.

Key team members

- CEO/director
- Health service manager
- Human resources manager
- OH&S officer
- All staff members

Key organisational functions

- Occupational/workplace health and safety policies and protocols
- Staff rostering
- Risk management and control
- Staff wellbeing and safety

Indicators and what they mean

Table 4.2 explains each of the indicators for this criterion. Refer to page 90 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 4.2
Criterion 4.1.2 Occupational health and safety

Indicators	What this means and handy hints
<p>► A. At least two members of the practice team are present during normal opening hours.</p>	<p>Your health service needs to have at least two members of staff present during normal opening hours so that health professionals can concentrate on their clinical work. This means that when there is a health professional seeing patients, there is at least one other staff member present who has the skills to take telephone calls, make appointments, assess the urgency of appointment requests and assist with medical emergencies.</p>
<p>► B. Our practice team can describe how our practice supports their safety, health and wellbeing.</p>	<p>The safety, health and wellbeing of your staff is important, not only in its own right but because this contributes to the level of care and service they are able to provide to patients.</p> <p>Having processes to support safety, health and wellbeing contributes to a supportive workplace culture and can enhance staff retention. It is also important because of concerns about violence in general practice, where there have been deaths of, and assaults on, clinical staff. Your health service can support staff safety, health and wellbeing in many ways, such as:</p> <ul style="list-style-type: none"> • scheduling regular breaks in consulting time to reduce fatigue • having plans or protocols for re-allocating patient appointments when a doctor is unexpectedly absent • providing readily available information for doctors and other staff about support services in the area (for example, counselling services or crisis counselling) and providing access to these services • providing a risk-management strategy, known to all staff, with details of steps to be taken in situations of violence, or the threat of violence or distress to any staff member • having a discontinuance of care policy and process for doctors who wish to end a doctor–patient relationship in any circumstance, and particularly in circumstances of violence or threat of violence • having building and layout designs that support safety.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that it has effective OH&S processes for its staff. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

There is a specific OH&S policy and procedure manual that is updated at least every 3 years or if a change in legislation occurs. Each updated version is dated and staff are notified if an update has occurred.

The health service has an OH&S committee that meets regularly. Copies of the minutes are emailed to all staff members as well as a hard copy being placed in a file in the staff tearoom.

The service obtains rebates for health service equipment relating to occupational health and safety through its state jurisdiction where applicable. Through the state WorkSafe website it also obtains guidance material – including codes of practice, guidance notes and alerts on specific hazards, and solutions as well as advice on processes and actions required to meet legal obligations or prevent injuries.

The appointment book ensures that regular breaks for clinicians are scheduled. The service is receptive to proposals for part-time or job sharing where it is possible.

Many processes are in place to support staff and to recognise their contribution. For instance, specific achievements (such as promotions) and routine occurrences (such as birthdays) are regularly celebrated. Staff participate in leisure activities and competitions after hours. A culture of mutual trust and caring is encouraged by leadership example. Staff have ready access to support services as required.

The layout of consulting rooms is designed so that staff members are not trapped behind desks and unable to get to the door in case of emergency.

All consulting rooms have a duress alarm in place.

In the smaller remote clinic the service has included a safe room for staff members, which is a secure, lockable room that contains a toilet, telephone for emergency calls and access to water.

Showing how you meet Criterion 4.1.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how you meet the criterion.

- Maintain a policy and procedure manual.
- Show that you cover occupational health and safety in staff interviews and inductions.
- Ensure appropriate use of staff rosters.
- Maintain an OH&S policy and procedure.
- Cover OH&S in staff interviews.
- Maintain an appointment book showing scheduled breaks.
- Ensure the service has suitable building and layout designs.
- Show that staff have access to support services.

Related RACGP criteria

Criterion 5.3.3 Healthcare-associated infections

Other information for this Standard

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 4.1 Practice systems:

- 1.3 Human resources
- 1.8 Legal and regulatory compliance

The ISO *Standards* include the following sections that are relevant to Standard 4.1 Practice Systems:

- 6 Resource management

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The Australian Association of Practice Managers' publication *The guide: AAPM business manual for healthcare* is available for purchase at:

- www.aapm.org.au

RACGP members who are registered GPs can access a range of services to support their wellbeing, through the GP Support Program:

- www.racgp.org.au/yourracgp/membership/extrabenefits/wellbeing/gpsupport

The CRANApplus Bush Support Services program understands the particular mental health needs of both Indigenous and non-Indigenous remote health workers, and offers personalised care via a bush support line: 1800 805 391. For more details visit:

- <https://crana.org.au/support>

The RACGP self-care guidebook for GPs *Keeping the doctor alive: a self care guidebook for medical practitioners* provides medical practitioners with information and resources on strategies for self care as an essential element of their professional life. The RACGP's *Rebirth of a clinic* is a guide on building and layout designs for safety. For more details on both books visit:

- www.racgp.org.au/publications/tools

See the Doctor's Health Advisory Service for details of doctors' health advisory services in each state and territory:

- www.dhas.org.au

The Australian Association of Practice Managers offers plenty of support.:

- www.aapm.org.au

Read the AMA position statement *Personal safety and privacy for doctors*:

- <https://ama.com.au/position-statement/personal-safety-and-privacy-doctors-2005>

Standard 4.2

Management of health information

Our practice has an effective system of managing patient information.

Overview of this Standard

This Standard concerns the management of health information collected from and for patients, which needs to comply with Australian Privacy Principles and relevant health information legislation. Patient health records (and other personal health information) need to be collected, held, used and disclosed in accordance with legal requirements to ensure the [confidentiality](#), privacy and security of this information. This can be assisted by ensuring that a privacy policy and information security policy is put in place, implemented and updated as required. Confidentiality in the ACCHS context is very important in order to ensure community confidence in accessing your service and developing relationships with health professionals.



Criterion 4.2.1: Confidentiality and privacy of health information

Our practice collects personal health information and safeguards its confidentiality and **privacy** in accordance with Australian Privacy Principles.

In a nutshell

The law requires your health service to maintain the confidentiality and privacy of personal health information in relation to the way it collects, holds, uses and discloses this information. This criterion requires your service to have in place a documented privacy policy in line with Australian Privacy Principles, and to make sure patients are aware of the policy. See pages 94–95 of the *Standards for general practices* for more information about what the privacy policy should cover.

Further information regarding the Australian Privacy Principles is available from the Office of the Australian Information Commissioner at www.oaic.gov.au

Key team members

- CEO/directors
- Health service manager
- All staff

Key organisational functions

- Patient communication and informed choice
- Patient complaints policy and process
- Patient confidentiality and privacy policy
- Patient consent policy
- Patient health information management policy
- Patient health records policy
- Patient informed consent policy
- Patient records management system
- Patient records policy and processes
- Patient rights policy
- Patient telephone and electronic communications policy
- Research policy
- Ethics approval guidelines

Indicators and what they mean

Table 4.3 explains each of the indicators for this criterion. Refer to page 93 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 4.3

Criterion 4.2.1: Confidentiality and privacy of health information

Indicators	What this means and handy hints
<p>► A. Our practice team can describe how we ensure the confidentiality of patient health records.</p>	<p>A patient confidentiality and privacy policy is advised. It should clearly describe how patient information is collected, recorded, stored and used. Your policy could outline:</p> <ul style="list-style-type: none"> • what information is collected • why information is collected • how the information is recorded and stored • how your health service maintains the confidentiality of information it holds. <p>Staff must clearly understand how they need to apply relevant elements of the policy or process to protect patient confidentiality. These elements would include that patients have individual health records and only authorised staff have access to those records, and that patient health information is not transferred to a third party – including another healthcare provider – without the patient's consent.</p>
<p>► B. Our practice team can demonstrate how patient health records can be accessed by an appropriate team member when required.</p>	<p>Your service has a documented health service privacy policy and staff can describe how particular elements of the policy are applied to give nominated members of the team specified access to health records. Patient health information is collected for the purposes of delivering health services, and should only be accessed, when needed, by an appropriate staff member. This means that not every staff member should or could access patient information. The health service's privacy policy could outline:</p> <ul style="list-style-type: none"> • the people (for example, doctors, nurses or AHWs) with full access to patient health records • the people with limited access to patient health records <ul style="list-style-type: none"> – the scope of that access; that is, what kind of information they can access, when and for what purposes. For example, administrative staff may be authorised to access name, address and date of birth for patient identification purposes and for keeping patient contact information up to date when patients present to the health service • the people with no access at all to patient health records. <p>Generally speaking, access to patient health information will be authorised for treating clinicians, but not for other staff.</p> <p>For clinicians who are relatives of a patient at the health service, accessing patient health information would need to be considered on the same basis; that is, if the relative is a treating clinician, access would be authorised. However your health service would need to consider an additional caveat in deciding whether such access would be fully appropriate. See section 3.14 from the Australian Medical Council code of conduct:</p> <p>Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues.</p> <p>See www.amc.org.au/images/Final_Code.pdf</p>

Table 4.3 (continued)

Indicators	What this means and handy hints
► C. Our practice team can describe the processes we use to provide patients with access to their health information.	<p>Your service has a documented health service privacy policy and staff can describe how particular elements of the policy are applied to meet patients' rights to request access to their own health information. The policy could outline how patients can request access to their health information (for example, by submitting a form) and how your health service would normally make information available (for example, a copy of the health summary is normally provided and an administration fee normally applies for copies of reports).</p> <p>Note that there may be situations where doctors withhold patient health information (such as where access to that information will pose a serious threat to the life or health of any individual). Where doctors are concerned about providing information to their patients, they are strongly advised to talk to their medical indemnity insurers. This scenario could be outlined in the privacy policy.</p>
► D. Our practice team can demonstrate how patients are informed about our practice's policy regarding management of their personal health information.	<p>There are two compulsory components to communicating with patients about your health service's privacy policy.</p> <ol style="list-style-type: none"> 1. You are required to provide a copy of your privacy policy upon request. You can also satisfy this requirement by making your policy available on your website or on a sign at reception. 2. You are required to provide a collection statement that sets out information about: <ul style="list-style-type: none"> (a) the identity of your health service and how it can be contacted (b) how patients can access their own health information on request (c) the purpose for which information is collected (d) other organisations to whom your health service usually discloses patient health information (e) any laws that require particular information to be collected (f) the main consequences for the patient if important health information is not provided. <p>An important aspect of communicating these requirements for ACCHSs is the need to provide the information in an easily understood format due to language and cultural barriers. This is particularly the case where there may be perceived cultural sensitivities. It is highly recommended that the design and provision of this information be made in consultation with the relevant local community or cultural advisors.</p>
► E. Our practice team can describe the procedures for transferring relevant patient health information to another service provider.	<p>It is important that the provision of patient health information to third parties or other service providers is made in accordance with written policies and processes. The relevant policy and procedures could include:</p> <ul style="list-style-type: none"> • how your health service gains patient consent before disclosing their personal information to third parties • the process of providing health information to another service provider • how your health service informs patients of the processes in place (for example, through a brochure or your service website).

Table 4.3 (continued)

Indicators	What this means and handy hints
<p>► F. Our practice team can demonstrate how we facilitate the timely, authorised and secure transfer of patient health information in relation to valid requests.</p>	<p>Section 2.3 Use and disclosure with consent of the <i>Privacy in the private health sector</i> (see Useful resources on page 175) sets out the correct process for transferring patient health information to others, such as other health service providers or in response to third-party requests. Keep in mind that these guidelines were developed for private sector and non-government health service organisations. It is strongly advised that your health service establishes a written document that sets out clear processes for your clinical team to ensure timely, authorised and secure transfer of patient health information. It is suggested that this policy includes:</p> <ul style="list-style-type: none"> • a definition of valid requests, providing examples of what would constitute valid and non-valid requests • a procedure that promotes timely responses to requests, and timely transfer of documents • provision for resourcing of clinical team members concerned about third-party requests (such as information and/or contacts of relevant insurers) • procedures for managing complaints about patients' requests for access to their own health information.
<p>► G. When we collect patient health information for quality improvement or professional development activities, we only transfer identified patient health information to a third party once informed patient consent has been obtained.</p> <p><i>Amended in May 2013.</i></p>	<p>Health services are encouraged to use patient health information for internal quality improvement or professional development activities that seek to improve a particular treatment or service offered by the health service. But it is important that no patient can be identified from this information.</p> <p>Where de-identified and aggregated patient health information is being used by your health service for such quality improvement activities, then additional patient consent for the use of their health information is not necessary.</p> <p>Where a practice is providing patient health information or data to a third party for research purposes, there are some situations where informed consent is required, and there are some situations where informed consent is not required. The requirement for consent when using de-identified data will be decided by a Human Research Ethics Committee.</p> <p><i>Amended in May 2013.</i></p> <p>To ensure patients understand how their (de-identified and aggregated) health information may be used for internal quality improvement purposes it is recommended that this is explained in your health service's privacy policy.</p> <p>This indicator was reviewed by the RACGP in May 2013. See www.racgp.org.au for updates.</p>

Table 4.3 (continued)

Indicators	What this means and handy hints
<p>► H. Whenever any member of our practice team is conducting research involving our patients, we can demonstrate that the research has appropriate approval from an ethics committee.</p>	<p>If your health service, or any of its staff, conducts research about its patients, the service needs to obtain human research ethics approval from an independent ethics committee.</p> <p>Information about research in general practice, including requirements for ethics approval, can be found in the NHMRC's <i>National statement on ethical conduct in research involving humans</i> (see Useful resources on page 175).</p> <p>Obtaining ethics approval for research about patients is important because it helps your health service to ensure that:</p> <ul style="list-style-type: none"> • the research will have potential benefits for patients, your health service itself and/or the local community • the research avoids the over-researched syndrome experienced by some Aboriginal and Torres Strait Islander communities • the research is planned and conducted with the full involvement of the community ('Not about us without us') • patient rights are protected • there is compliance with special cultural and ethical issues in research involving people from Aboriginal or Torres Strait Islander background. <p>There are separate ethical considerations regarding research with Indigenous and vulnerable peoples that may not come into play when researching other populations. These include differing world views and approaches to research, recognition of Indigenous vulnerability, and Indigenous knowledge. Additionally, there are recognised characteristics of Indigeneity that impact on research; these characteristics include ecological ties, human encounters, autonomy and self-determination.</p> <p>There are some well-established protocols in researching Aboriginal and Torres Strait Islander peoples that take into account cultural and ethical issues. See the Useful resources section on page 175 for these.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that it has an effective system for managing patient information. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service has a documented privacy policy that reflects key legislation and is written in plain English and other community languages so that all staff and patients clearly understand what it says. The policy clearly defines confidentiality and privacy in relation to health information and documents procedures for the management of patient information.

The confidentiality and privacy policy and procedure manual includes:

- procedures for informing new and existing patients about privacy arrangements in relation to health information in the service
- details about which staff members may have access to patient health records and to what level they can access this information – for example, reception staff can only access demographic information but doctors have full access
- details about how patients can request access to their own health information
- processes for sharing patient health information with third parties in an authorised, secure and timely way – for example, the transfer of health records or referral to a specialist
- information on how the service maintains privacy of patient health information in relation to other uses – for example, for quality improvement and professional development
- information on how the service deals with complaints about privacy in relation to health information
- details about how privacy is maintained when using patient data for quality improvement activities or when conducting research.

Staff position descriptions clearly state their roles and responsibilities in relation to confidentiality and privacy, and these are appropriate for their job.

When they start employment, staff and volunteers are required to sign a confidentiality agreement in relation to health information; this is kept in their file. Privacy and confidentiality in relation to health information is clearly emphasised at orientation and in ongoing staff training. The policy emphasises that breaches are viewed as grounds for termination of employment.

The privacy policy in relation to health information includes a clause stating that any research activities involving patients of the health service require Human Research Ethics Committee approval, which will decide if informed patient consent is required.

Amended in May 2013.

A research-specific consent form is used to clearly identify the difference between consent for treatment or a procedure and consent for research. Any issues or changes that arise in relation to confidentiality and privacy are discussed at staff meetings and documented in the policy and procedures if necessary.

A privacy notice is displayed in the waiting room detailing how the service collects, uses and shares patient health information.

De-identified patient information is used by the service for internal quality improvement processes, preventive health activities and health-promotion planning. This information is not used for any other purpose.

The service uses a community engagement process (through the board) to identify priorities for research about patients, the health service itself or the community.

Showing how you meet Criterion 4.2.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Maintain a privacy policy and procedures.
- Maintain confidentiality agreements in staff contracts and staff files.
- Show that you utilise staff orientation and induction.
- Show that you utilise staff interviews.
- Maintain a patient health information management policy.
- Maintain a patient health records policy.
- Maintain a patient rights and responsibilities document as for Criterion 2.1.1.
- Maintain a research policy and ethics approval guidelines.
- Document ethics approval for all research conducted by staff of the health service that involves health service patients.

Related RACGP criteria

Criterion 3.1.1 Quality improvement activities

Criterion 4.2.2: Information security

Our practice ensures the security of our [patient health information](#).

In a nutshell

Privacy and security of patient health information held in hard copy or electronic form by your health service is a legal requirement. Computer security is an important aspect of patients' health information security. It includes not only the storage of patient health information, but also the availability and integrity of, and designated access to, this information.

In addition to appropriate measures to maintain information security, a computerised practice needs a contingency plan to cover information recovery situations such as computer crashes. Designating a staff member with primary responsibility for electronic systems and computer security is vital.

Key team members

- Health service manager
- Computer information technology manager

Key organisational functions

- Electronic communications policies
- Electronic records policy
- Patient health records policy
- Privacy and confidentiality policy and processes
- Culling policy

Indicators and what they mean

Table 4.4 explains each of the indicators for this criterion. Refer to page 97 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 4.4

Criterion 4.2.2 Information security

Indicators	What this means and handy hints
<p>► A. Our practice team can demonstrate that the personal health information of patients of our practice is neither stored, nor left visible, in areas where members of the public have unrestricted access or where constant staff supervision is not easily provided.</p>	<p>Your service's privacy policy (and procedures) identifies and addresses every possible risk that members of the public might be able to view hard or electronic copies of personal health information, in any location at which your service provides services and programs.</p> <p>Your health service may also have an information technology policy that sets out the conditions in which information technology is used to store, access and retrieve patient health records. The policy could clearly set out:</p> <ul style="list-style-type: none"> • the provision of passwords and levels of security and access to patient health records • the conditions of storage of health record information, such as data entry in non-public areas • that the visibility and design of furniture and equipment to ensure privacy and confidentiality of patient information is maximised • the safe and secure use of portable equipment. <p>Your computer security policy/manual could provide that:</p> <ul style="list-style-type: none"> • computers are only accessible via individual password to those in the health service team who have appropriate levels of authorisation • computers have screensavers or other automated privacy protection devices enabled to prevent unauthorised access to computers.

Table 4.4 (continued)	
Indicators	What this means and handy hints
<p>► B. Our practice ensures that our practice computers and servers comply with the RACGP computer security checklist and that:</p> <ul style="list-style-type: none"> • computers are only accessible via individual password access to those in the practice team who have appropriate levels of authorisation • computers have screensavers or other automated privacy protection devices enabled to prevent unauthorised access to computers • servers are backed up and checked at frequent intervals, consistent with a documented business continuity plan • backup information is stored in a secure off-site environment • computers are protected by antivirus software that is installed and updated regularly • computers connected to the internet are protected by appropriate hardware/software firewalls. 	<p>There are two ways practices can meet Criterion 4.2.2 of the RACGP Standards for general practices (4th edition) (the Standards). Practices need to comply with either:</p> <ul style="list-style-type: none"> • Minimum compliance requirements: the RACGP <i>Computer security guidelines: A self assessment guide and checklist for general practice</i> (3rd edition)(the Guidelines) <p>OR</p> <ul style="list-style-type: none"> • Recommended compliance requirements: the RACGP <i>Computer and information security standards for general practices and other office-based practices</i> (2nd edition) (the CISS 2nd edition) <p>By complying with either the Guidelines or the CISS 2nd edition, practices will meet Criterion 4.2.2 of the Standards for accreditation purposes.</p> <p>For practices that choose to use the Guidelines for accreditation purposes, the RACGP strongly recommends that practices familiarise and work towards meeting the requirements set out in the CISS 2nd edition as part of the practice's continuous quality improvement program.</p> <p>Please note: practices that are participating in the national eHealth records system – which includes the personally controlled electronic health record (PCEHR) – are required to develop, maintain, enforce and communicate to staff written policies that ensure that the practice's use of the eHealth record system is secure, responsible and accountable. Compliance with the RACGP <i>Computer and information security standards for general practices and other office-based practices</i> (2nd edition) (the CISS 2nd edition) will assist practices to meet these professional and legal obligations. This is a separate requirement to accreditation.</p>

<p>► C. If our practice uses computers to store personal health information, we have a business continuity plan that has been developed, tested and documented.</p>	<p>If your health service uses computers to store personal health information, you need to have a backup system that provides for situations of computer crashes or power failure. This will ensure that in these situations, critical areas of your service – such as making appointments, billing patients and patients' health information – are protected. The plan needs to be tested on a regular basis, to make sure that the backup protocol for information recovery works properly.</p> <p>Additionally, if your service uses portable equipment (such as laptops, mobile phones or tablets), the physical security of this equipment will need to be monitored.</p>
Table 4.4 (continued)	
Indicators	What this means and handy hints
<p>► D. Our practice has a designated person with primary responsibility for the practice's electronic systems and computer security.</p>	<p>Your health service needs to designate a staff member to be responsible for computer security and for updating and maintaining the computer security policy and procedure manual. This staff member is responsible for contacting the relevant expert advisor, educating staff on data security and ensuring that security protocols are being followed. All relevant staff members could also be provided with details of any external experts used by your health service.</p>
<p>► E. Our communication devices are accessible only to authorised staff.</p>	<p>Where your health service provides electronic communication devices such as laptops, tablets or phones, it is important to ensure that only authorised staff have access to them. You can do this by providing appropriate levels of security, such as password access and guidelines for use. This could be documented in an electronics devices policy and/or manual.</p>
<p>► F. Electronic data transmission of patient health information from our practice is in a secure format.</p>	<p>It is vital that your health service provides the necessary level of software/hardware protection in your electronic devices and computers for the secure transmission of encrypted patient health information. Access by staff members would similarly only be made available after the necessary levels of protections (such as passwords).</p>

<p>► G. Our practice has an appropriate method of destroying health record systems before disposal (e.g. shredding of paper records, removal and reformatting of hard drives).</p>	<p style="text-align: center;">Case study</p> <p>Your health service could develop a policy on the destruction and disposal of health records that sets out steps for safe disposal and compliance with privacy requirements, to ensure that:</p> <ul style="list-style-type: none"> • physical documents are shredded or similarly destroyed • computer hardware/software upgrades or changes provide for removal and deletion of information or appropriate clearance of data prior to disposal • hard-drive memories of electronic equipment (including faxes and photocopiers) and devices are cleared prior to disposal • guidelines are available for the secure destruction and disposal of patient health records. <p>When patient records become inactive, it is recommended that they be retained indefinitely or as stipulated by the relevant national, state or territory legislation. It is also recommended that your service consult medical defence organisations when deciding on your policy with respect to retention of health records.</p>
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Below is a description of the ways in which an Aboriginal community controlled health service can ensure the security of its patient health information. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The paper-based patient health records that the service still has are stored in a lockable room to which patients do not have access.

The staff induction process and on-the-job training informs staff members of the process for computer security and continuity of work practices if the computers fail.

Staff members have individual computer passwords that are automatically scheduled to be changed every 60 days. All laptops are password protected and used in accordance with the service's security protocols.

Each computer is set to automatically display a screensaver when the computer has not been used for a set period of time.

Staff members are required to logout when they have finished entering patient information and then log back in when using any laptops or portable equipment that may contain patient health records.

Staff access to patient health information varies according to their role – for example, finance staff do not have access to patient health files but do have access to the accounting and Medicare billing software; doctors have full access to health

files; and reception staff have access to patient demographics and the appointment book.

The service has a business continuity plan with protocols for levels of staff access, retrieval of electronic patient health records and other important information – such as patient appointments and billing – in the event of an adverse incident, such as a system crash or power failure. The plan is tested on a regular basis to ensure backup protocols work properly and information can be recovered. See also: case study for Criterion 1.7 1.

The service has specific security protocols to address:

- email use – no confidential information is provided by email; do not reply to [spam](#) mail
- access to the internet, usage limits and the process to gain authorisation to blocked sites
- type of antivirus software, subscription details and how often it is automatically updated
- how incremental and full backups of the server and other computers occur, and when

- software and hardware firewall installation to assist in prevention of intrusion by hackers
- asset register of all computers, laptops, printers and other devices
- the [network](#) diagram
- the processes for continuing business if the computers are no longer functioning. This includes the use of a manual appointment book, manual billing, use of paper-based scripts, pathology, radiology and referrals. It also directs staff members to a register of contacts and allied health professionals located in reception.

The practice manager runs a Medicare billings report and a patient data report each month the afternoon before backup and again the following morning to check that the information is identical. If there are any differences the practice manager contacts the IT provider to check the backup.

All health service computers are fitted with an uninterrupted power supply that allows approximately 2 hours of computer usage if the power supply is temporarily lost. Its smaller remote service has a backup generator in place to maintain electricity to the computer system. This allows time for clinical care to continue and backup and closure of non-essential computers if the usual power supply is interrupted.

There is a designated staff member responsible for computer and information security and liaison with the external IT provider. The health service has a formal service level agreement in place with the external IT provider, including a confidentiality agreement.

The health service has a contract with a licensed, secure, shredding company as well as shredders at each of its clinics to ensure destruction of any patient health information or confidential business information.

The health service ensures that all information, including patient health information, is removed from any computers or other equipment with hard-drive memory (such as photocopiers and fax machines) prior to the disposal/replacement of the equipment.

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how you meet the criterion.

- Maintain a privacy and confidentiality policy and procedures.
- Maintain an information technology policy and procedures.
- Ensure a physical layout showing ways in which patient health information is kept from the view of members of the public.
- Show that you maintain individual staff passwords.
- Show that you operate screensavers.
- Operate a server backup log.
- Show that you maintain offsite storage of backup.
- Show that you maintain up-to-date antivirus protection.
- Show that you maintain hardware/software firewalls.
- Show that you maintain a tested business continuity plan for information recovery.
- Show that you maintain an emergency generator.
- Show that you utilise job descriptions.
- Maintain a logout register for laptops and mobile phones.
- Show that you maintain a secure area for storage of portable devices.
- Show that you maintain data encryption via public key infrastructure.
- Show that you operate secure messaging.
- Maintain a shredder and/or show that you maintain secure document-shredding agreement with recognised provider.

Showing how you meet Criterion 4.2.2

Other information for this Standard

What these words mean

Aggregated

Grouped together.

Backup

Full backup is a backup of all files residing on the computer/server hard drive. The files are marked as having been backed up.

Incremental backup is a type of backup that only includes files that have been modified or added since the previous full or incremental backup. The files are marked as having been backed up.

Confidentiality

(from the *Standards'* glossary)

The nondisclosure of information except to another authorised person, or the act of keeping information secure and/or private.

De-identified

The removal of identifying information – patient name, medical record number, birthdate, social security number – from medical records, to protect patient privacy. Information is de-identified when it is not possible to reasonably ascertain the identity of a person from that data.

Firewall

A firewall is used to provide added security by acting as a gateway or barrier between a private network and an outside or unsecured network (for example, the internet).

Network

This is a collection of connected computers and [peripheral devices](#) used for information sharing and electronic communication.

Patient health information

(from the *Standards'* glossary)

A patient's health information includes their name, address, account details, Medicare number and any health information (including opinion) about the person.

Peripheral device

This is a device attached to a network or a computer such as a printer or a modem.

Personal information

(adapted from the *Standards'* glossary, and in relation to personal information that constitutes patient health information)

The Privacy Act definition of personal information (Section 6 *Privacy Act 1988* (Cwth)) is:

information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

Privacy

(from the *Standards'* glossary, in relation to health information)

The protection of personal and health information to prevent unauthorised access, use and dissemination.

Server

(adapted from the *Standards'* glossary)

This is typically a computer in a network environment that provides services to users connected to the network. These services include printing, accessing files and running software applications. A server can be used as a central data storage for users of the network.

Spam

Unsolicited email. Often it is simply nuisance email, but it may entice you to provide confidential personal information – for example, bank passwords.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 4.2 Management of health information:

- 1.6 Knowledge management
- 2.4 Consumer rights

The ISO *Standards* include the following sections that are relevant to Standard 4.2 Management of health information:

- 6 Resource management
- 7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources – including a fact sheet on information security – on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

GPA ACCREDITATION *plus* also has a template, *Feedback on transfer of medical records*, for obtaining information on why the request for transfer was made and practice performance:

- www2.gpa.net.au/files/factsheets/AP_154.doc

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The *Privacy Amendment (Private Sector) Act 2000* extends the 1988 legislation to cover the private health sector throughout Australia. Ten national privacy principles form part of the legislation and promote greater openness between health service providers and consumers in relation to the handling of health information. *Privacy in the private health sector* (2001), published by the Office of the Federal Privacy Commissioner, is a set of guidelines that aims to help health service providers comply with the national privacy principles. Section 2, Use and disclosure, sets out the correct process for transferring patient health information to others, such as other health service providers or in response to third-party requests.

- www.privacy.gov.au/materials/types/guidelines/view/6517

The RACGP *Handbook for the management of health information in private medical practice* sets out minimum safeguards and procedures to be followed to meet appropriate legal and ethical standards concerning privacy and security of patient records:

- www.racgp.org.au/your-practice/business/tools/safetyprivacy/privacy/

Relevant state and territory privacy legislation is available at:

- www.privacy.gov.au

The Aboriginal Health and Medical Research Council's Ethics Committee has published its *Guidelines for research into Aboriginal health – key principles*:

- www.ahmrc.org.au/index.php?option=com_docman&task=doc_download&gid=14&Itemid=45

The NSW *Aboriginal health information guidelines* were published to ensure consistency and good practice in the management of health and health-related information about Aboriginal peoples in NSW:

- www.ahmrc.org.au/index.php?option=com_docman&task=doc_download&gid=15&Itemid=45

The NHMRC website has a downloadable publication, *National statement on ethical conduct in human research* (2007, updated 2009):

- www.nhmrc.gov.au/guidelines/publications/e72

The NHMRC publication *Keeping research on track: a guide for Aboriginal and Torres Strait Islander peoples about health research ethics* is a resource document for Aboriginal and Torres Strait Islander peoples to refer to when making decisions about health research in their communities:

- www.nhmrc.gov.au/guidelines/publications/e65

Services with AGPAL accreditation can access a range of resources on information security at:

- www.agpal.com.au/resources/

The RACGP *Computer and information security standards and workbook* is available at:

- www.racgp.org.au/your-practice/standards/ciss

Section 5

Physical factors

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Standard 5.2

Equipment for comprehensive care

Our practice provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Overview of this Standard

This Standard is about ensuring that the facilities at your health service meet OH&S requirements, and promote safety and security for your staff and patients. Your health service's physical environment needs to enable staff to protect patient confidentiality and privacy. It is also about taking reasonable steps to assist patients with disabilities and special needs to physically access your health service.



Criterion 5.1.1 Practice facilities

Our practice facilities are appropriate for a safe and effective environment for patients and the practice team.

In a nutshell

Your health service facilities need to meet OH&S requirements and ensure an appropriate environment where staff can provide effective patient care. Your facilities also need to afford safety, and auditory and visual privacy, for patients.

Key team members

- Health service manager
- Reception staff
- Clinical staff

Key organisational functions

- Occupational health and safety
- Patient confidentiality and privacy
- Quality and safe clinical practice

Indicators and what they mean

Table 5.1 explains each of the indicators for this criterion. Refer to page 101 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.1
Criterion 5.1.1 Practice facilities

Indicators	What this means and handy hints
<p>► A. Our practice has at least one dedicated consulting/examination room for every member of our clinical team working in our practice at any time.</p>	<p>There is at least one separate consulting or examination room, or area, for each member of your health service team providing patient consultations at any given time.</p>
<p>► B. Each of our consultation rooms (which may include an attached examination room/area):</p> <ul style="list-style-type: none"> • is free from excessive noise • has adequate lighting • has an examination couch • is maintained at a comfortable ambient temperature • ensures patient privacy when the patient needs to undress for a clinical examination (e.g. by the use of adequate curtains or screens and gowns or sheets). 	<p>Your health service's consultation or examination rooms need to be comfortable for your patients and to allow your clinical staff to provide appropriate healthcare. The rooms also need to afford audio and visual privacy for patients, and to ensure that their right to confidentiality and privacy in healthcare is maintained.</p> <p>When a member of your clinical team consults or examines patients, patients need access to a room or area that ensures dignity and confidentiality.</p>
<p>► C. Our practice has a waiting area sufficient to accommodate the usual number of patients and other people who would be waiting at any given time.</p>	<p>The layout at reception needs to be sufficiently large to accommodate the usual number of patients and any other people who may be waiting at any given time. It should also allow reception staff to easily monitor the area and identify medical emergencies and re-prioritise appointments as the need arises.</p>
<p>► D. Our practice has toilets and hand-cleaning facilities readily accessible for use by both patients and staff.</p>	<p>Ideally, toilets would be placed within your health service. They would be readily accessible and well signposted. Where possible, toilets would be designed and placed with cultural and kinship protocols in mind to minimise breaches of your community's cultural practices. Separate staff and patient toilets are also desirable.</p> <p>Where toilets are not within the health service, they need to be within close proximity to the service, readily accessible and well signposted. There should be a safe and secure pathway from the main health service to the toilets. As with toilets within the health service, they should be designed and placed with cultural and kinship protocols in mind.</p> <p>Washbasins and hand-cleaning facilities need to be situated in close proximity to the toilets to minimise spread of infection. They should also be easily accessible to doctors, other staff and patients.</p>

Table 5.1 (continued)

Indicators	What this means and handy hints
► E. Prescription pads, letterhead, administrative records and other official documents are accessible only to authorised persons.	Secure facilities, such as locked cabinets, need to be used to store prescription pads, letterheads, administrative records and other official documents. They should only be accessible to authorised staff members and kept secured and locked as required.
► F. Our practice and office equipment is appropriate to its purpose.	<p>In accordance with OH&S regulations and to support the delivery of safe and effective healthcare, office and clinic equipment should be 'fit for purpose', meaning that it should be the right equipment for what you want to use it for.</p> <p>This means that your service needs to make sure it purchases the right equipment, and that it maintains and repairs or replaces that equipment, so that it continues to serve its purpose.</p>
► G. Our practice has one or more height-adjustable beds.	<p>Height-adjustable beds are especially necessary for patients with limited mobility and this criterion requires that each health service has one or more height-adjustable beds.</p> <p>See page 102 of the <i>Standards for general practices</i> for a summary of the various risks that can be minimised by the use of height-adjustable beds.</p> <p>In exceptional circumstances where the physical space at the health service is too small to accommodate a height-adjustable bed, the service needs to be able to demonstrate how it manages examinations for people with impaired mobility, and how it protects staff safety while doing so.</p> <p>Rebates for health service equipment that relate to occupational health and safety may be available through government and other jurisdictions. It is highly recommended that your health service check the relevant WorkSafe websites of your state or territory for information on rebates that could apply.</p>
H. Our practice waiting area caters for the specific needs of children.	The specific needs of children who are in the waiting room need to be adequately catered for. This could include the provision of children's sized furniture and equipment, toys and other quiet activities.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can provide facilities that are appropriate for a safe and effective environment for its patients and staff. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The service matches its clinical staff recruitment practices and roster (including for visiting specialists) with the availability of consultation rooms, so each of its clinical staff members has access to a separate, properly equipped consulting room when required.

Because its community is expanding and patient numbers are increasing, the service is already finding that consultation space is tight. It is now developing plans to expand the service facilities, including adding at least one more consultation room, to continue to ensure one fully equipped consultation room for each clinician at any given time.

Any time it plans to introduce new or additional services or programs, the service thinks about what space and equipment will be required, to make sure no existing clinical equipment or facilities are negatively affected.

The health service's consulting rooms and areas have privacy screens for patients to undress for examinations and a privacy sheet or gown is provided for patients to cover themselves. There are examination lights and examination tables in each of the consulting rooms.

The service has a fully equipped mobile caravan to visit outlying areas and provide healthcare to patients who find it difficult to visit the service. This is rostered so that only one GP uses the consultation area in the caravan at any one time.

The service has at least one height-adjustable bed in all its locations, including in the caravan. Because of the many people of childbearing age in its community the service has chosen a model with a side rail that can be moved up and down and stirrups for gynaecological examinations when required. This is in addition to the basic RACGP requirement.

The waiting areas in all service locations provide items for children, such as wall-mounted interactive play panels (which are easily cleaned and do not have loose pieces that could cause hazards to children) and child-sized tables and chairs. The service has also worked with other ACCHSs to develop a number of waiting room activities for children. These include videos and colouring books

featuring a variety of child-specific health promotion designed pages or quizzes about healthy lifestyles. The waiting areas also include both an inside and outside waiting area, for patients who prefer to wait outdoors.

The service has male and female patient toilets, including a disabled toilet located off the waiting room to cater for its many patients with a physical disability. All of the toilets have access to hand-washing facilities. The service equipment in its clinical area includes wheelchairs, patient slides and lift/walker belts for its patients, if required.

There are separate staff toilets with hand-washing facilities located within the building, to which patients do not have access.

The service has its electrical equipment inspected and tagged annually by an independent contractor.

All fire equipment is checked and tagged annually by an independent contractor.

Showing how you meet Criterion 5.1.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Ensure the physical layout of the service includes consulting rooms, toilets and hand-cleaning facilities.
- Maintain a heating and cooling system.
- Have patient privacy screens.
- Have adequate signage.
- Maintain at least one height-adjustable bed.
- Provide children's furniture and play equipment.

Related RACGP criteria

Criterion 5.1.3 Physical access

Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy

The physical conditions in our practice support patient privacy and confidentiality.

In a nutshell

Patient privacy and confidentiality is protected by the physical layout and facilities of your health service.

Key team members

- Health service manager
- All clinical and reception staff

Key organisational functions

- Culturally safe and competent clinical practice
- Documentation and storage of patient health records
- Electronic records policy
- Patient health information policy
- Patient health records policy
- Patient confidentiality and privacy policy

Indicators and what they mean

Table 5.2 explains each of the indicators for this criterion. Refer to page 104 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.2

Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy

Indicators	What this means and handy hints
<p>► A. The physical facilities of our practice support patient privacy and confidentiality.</p>	<p>Your patients' privacy and confidentiality is protected at two levels. At each of these levels, the physical facilities of your health service need to support staff activities to ensure they can maintain patient privacy and confidentiality.</p> <ol style="list-style-type: none"> 1. During patient and staff interaction: physical facilities must provide for patients' audio and visual privacy. Visual privacy can be aided by the use of gowns, curtains and screens. Audio privacy can be ensured when discussions and conversations between staff and between staff and patients are masked by background music, or held in a private room. 2. When documenting and using patient health information: patient health information must only be visible to the GP (and, if they choose, their patient) but not to any unauthorised person. The positioning of computers and computer screens and the use of screen savers should be carefully considered to hide information from the view of the general public.
<p>► B. Visual and auditory privacy of consultations and treatments is supported.</p>	<p>Visual privacy during consultations shows respect for patients. For example, if a patient needs to undress, they should be offered a gown or sheet to wear and an adequate curtain or screen behind which to undress.</p> <p>Members of the clinical team need to be sensitive to patient dignity when patients are required to undress/dress in the presence of the doctor, nurse or health worker. Different patients may respond differently to these situations, and sometimes gender differences matter, so health professionals need to be sensitive to varying patient needs.</p> <p>Auditory privacy means that conversations with patients or conversations with other staff about patient health information cannot be overheard by others. Consultation rooms can be made private with solid doors, the use of draught-proof taping around doorframes or draught excluders at the base of doors. Background music may also assist in masking conversations.</p> <p>A patient should never be put in the situation where discussions about their health situation can be overheard by others. If there is the risk that this will happen during consultations, the patient needs to be offered a private room or space.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can provide physical conditions that are conducive to confidentiality and privacy. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

All the health service's physical facilities are managed to ensure that patients' visual privacy is maintained, whether they are in a consultation room, in the waiting room or in another service location. If the doctors go out in the mobile van, it is checked before departure to make sure there are enough clean gowns for the number of patients they will see. The mobile van has a curtain to ensure privacy for times when patients have to undress. When visiting outstations, the doctors make sure there is a private area where they can conduct patient consultations.

Staff members position computer screens so they are not visible from the waiting room or from corridors to which patients have access. Any paper-based patient information is not left visible on the desks in the reception area. The service's facsimile machine, to which patient pathology results are on occasions sent, is located in an area to which patients do not have access.

The waiting room has either a radio playing or a television on to mask conversations that are held at the reception counter. If more private conversation is required with a patient, the staff member will take the patient to a free consulting room or office to continue the conversation. If there is no free room or office, they will take the patient to a place that is outside the hearing range of other patients or staff.

Staff use a low voice tone when talking with patients in the consultation room. Doors to consultation rooms are always kept closed when they are being used. If someone visits with the patient, they will be asked to leave the consultation room during patient consultations, procedures or treatments – unless they have the patient's permission to be there. At no time do any staff members talk about patients with each other in a way that can be heard by people in the waiting room or anywhere in the service. When having

phone conversations with patients or other staff, staff members make sure that nothing they say can identify the patient or reveal anything about them.

The mobile van is sound insulated so that no passer-by can overhear what is being discussed. Doctors doing home or other visits are especially careful to maintain auditory privacy, so that other family members cannot overhear what is being discussed. They make sure that if a person wants to be present at the consultation, this is only allowed with the prior consent of the patient. If the patient does not agree, the doctor will politely but firmly make sure that the other person is not present, or will make an appointment for the patient to come to the health service.

Showing how you meet Criterion 5.1.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Through the use of direct observation.
- Through the use of staff interviews.

Related RACGP criteria

Criterion 5.1.1 Practice facilities

Criterion 4.2.2 Information security

Criterion 5.1.3 Physical access

Our practice provides appropriate physical access to our premises and services including access for people with disabilities or special needs.

In a nutshell

You need to make reasonable efforts to assist patients who have limited capacity to physically access your health service, including those who have limited mobility or a disability.

Key team members

- Health service manager
- Aboriginal health worker
- Driver

Key organisational functions

- Service and program planning
- Outreach services
- Home and other visits policy and procedures
- Servicing patients with a disability

Indicators and what they mean

Table 5.3 explains each of the indicators for this criterion. Refer to page 106 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.3

Criterion 5.1.3 Physical access

Indicators	What this means and handy hints
<p>► A. There is wheelchair access to our practice and its facilities, or if physical access is limited, our practice provides home or other visits to patients with disabilities or special needs.</p>	<p>Your health service needs to make reasonable efforts to assist patients with limited mobility, other disabilities or special needs to physically access your health service. This includes the provision of wheelchair access at the entrance, pathways, hallways, consultation areas and toilets.</p> <p>Home or other visits might be provided for patients who are unable to come to the health service because it may be too difficult to physically attend.</p>
<p>► B. Our GPs and other practice staff can describe how they facilitate access to our practice for patients with disabilities or special needs.</p>	<p>In addition to physical aids such as ramps and railings, your health service could improve physical access for patients with disabilities by providing services or information in different ways such as those described below. All staff need to know about and be able to describe these practices. They could include:</p> <ul style="list-style-type: none"> • the use of pictorial signage to assist patients with an intellectual disability or visual impairment • the provision of a transport service accompanied by a health worker or nurse to assist patients with no means of getting to your health service, due to distance or other transport issues • a disability car park area that is close to the entrance and is specifically marked and reserved for disability parking. It also needs to be sufficiently wide to accommodate loading and unloading wheelchairs.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can provide appropriate physical access, including for people with disabilities or special needs. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

Note that it is well recognised that many Aboriginal and Torres Strait Islander patients face barriers to accessing primary healthcare services. These barriers include financial, geographical, cultural and race-related issues, as well as the physical access issues covered in this criterion. ACCHSs have been developed to address many of these access barriers, but some barriers are outside their direct control. This criterion covers only the provision of physical access for patients with disabilities or special needs.

The health service has wheelchair access for clients and it also has wheelchairs available for patient use. The doors within the service are wide enough to accommodate wheelchairs. There is a designated disabled car space in the car park. The service contains pictorial signage for the toilets.

The clinic provides a transport service with a designated transport driver to assist those patients who

have difficulty accessing the service because of lack of transport. The service also provides outreach clinics to isolated communities on a regular basis, including use of a mobile van. Its Aboriginal health workers and registered nurses provide home visits to patients where it is deemed safe and reasonable to do so.

Review of the service's Medicare billing item numbers will show evidence of home and other visits.

Showing how you meet Criterion 5.1.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Through the use of direct observation.
- Through the use of staff interviews.
- Maintain a policy and procedure manual.
- Use patient information sheets.

Related RACGP Standards and criteria

Criterion 5.1.1 Physical facilities

Other information for this Standard

What these words mean

Ambient

The temperature of the room or surrounding environment.

Auditory privacy

Auditory privacy is maintained when nothing that is spoken about or to the patient can be heard by someone who is not supposed to hear it.

Visual privacy

Visual privacy is maintained when:

- nothing about the patient that has been written or recorded in visual form (for example, an X-ray) can be seen by someone who is not supposed to see it
- appropriate covering (gowns, sheets, curtains or screens) is used when the patient needs to undress/dress in the presence of a GP or other health professional.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 5.1 Facilities and access:

- 1.8 Legal and regulatory compliance
- 2.4 Consumer rights
- 1.4 Physical resources

The ISO *Standards* include the following sections that are relevant to Standard 5.1 Facilities and access:

- 6 Resource management
- 7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The *Disability (access to premises – buildings) standards* for new buildings and renovations came into operation on 1 May 2011 and will apply to buildings where building approval is lodged on or after that date. A fact sheet can be obtained from:

- www.hreoc.gov.au/disability_rights/standards/PSguide.html

Standard 5.2

Equipment for comprehensive care

Our practice provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Overview of this Standard

This Standard is about ensuring that your health service has the right equipment (including resuscitation equipment) to provide healthcare services to its community, and that your clinical staff have timely access to the equipment. Where appropriate, this equipment needs to be well maintained, serviced and calibrated.



Criterion 5.2.1 Practice equipment

Our practice has access to the medical equipment necessary for comprehensive primary care including emergency resuscitation.

In a nutshell

Your health service needs to have the necessary equipment to provide comprehensive primary care to its community and to perform emergency resuscitation when required. The equipment that is necessary for your health service will partly depend on the health profile of your local community, and would include equipment to provide chronic and acute care. See Table 5.4 on page 192 for a list of the equipment that all health services should have. Equipment that requires calibration or is electronically operated needs to be serviced regularly and in accordance with the manufacturer's instructions.

Key team members

- Health service manager
- Clinic manager

Key organisational functions

- Service and program planning
- Equipment register
- Equipment maintenance records/schedules

Indicators and what they mean

Table 5.4 explains each of the indicators for this criterion. Refer to page 108 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.4
Criterion 5.2.1 Practice equipment

Indicators	What this means and handy hints
<p>► A. Our practice has equipment for comprehensive primary care and emergency resuscitation including:</p> <ul style="list-style-type: none"> • 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), IV access, and emergency medicines • examination light • eye examination equipment (e.g. fluorescein staining) • gloves (sterile and non-sterile) • height measurement device • measuring tape • monofilament for sensation testing • ophthalmoscope • oxygen • patella hammer • peak flow meter • scales • spacer for inhaler • specimen collection equipment • sphygmomanometer with small, medium and large cuffs • stethoscope • surgical masks • thermometer • torch • tourniquet • urine testing strips • vaginal specula • visual acuity charts • X-ray viewing facilities. 	<p>Equipment required for comprehensive primary care and emergency resuscitation needs to include everything listed for this indicator. In addition, it needs to be stocked in accordance with community needs, and to support the procedures that are regularly performed at your health service.</p> <p>This means, for example, that in communities with high incidence of chronic diseases, equipment at the health service will be different from communities with high incidence of tropical diseases. Communities close to hospitals will have different needs compared to remote communities in terms of the type of emergency equipment and medication.</p> <p>Similarly, equipment may vary between seasons (wet and dry) and therefore may need to be stored and maintained differently at different times of the year (for example, high humidity may affect certain equipment like the HemoCue®).</p> <p>It is important that your health service understands the needs of its community and plans appropriately in terms of health service equipment for comprehensive primary care and emergency care.</p>

Table 5.4 (continued)

Indicators	What this means and handy hints
► B. Our practice has timely access to a spirometer and electrocardiograph.	<p>Timely access to ECGs and spirometry is important for the appropriate diagnosis and management of certain conditions. Although not all clinics need on-site access to this equipment, all clinics need timely access to it.</p> <p>If your health service chooses to have an ECG and spirometry machine, your staff will need training on how to use it and maintain it and, of course, to analyse the results.</p> <p>Rural and remote health services may need to have this equipment on site for appropriate emergency, acute and ongoing care.</p>
► C. Our practice can demonstrate that the equipment we use is sufficient for the procedures we commonly perform.	<p>The healthcare needs of Aboriginal and Torres Strait Islander peoples are different to those of other patient populations. Factors such as remoteness and cultural background have a huge influence on patient presentation and the types of conditions and problems managed in ACCHSs.</p> <p>As a result, ACCHSs may regularly perform procedures that are not common in other areas of general practice. Your health service therefore needs to demonstrate that the equipment it uses is adequate for the diagnosis and treatment of its patients and their conditions.</p>
► D. Our practice can demonstrate how we maintain our key equipment, according to a documented schedule.	<p>All equipment needs to be in good working order and serviced on a regular basis.</p> <p>It is highly recommended that your health service maintain a register of equipment. The register can then be used to document the service and maintenance schedules for each item.</p> <p>It is important that this register is regularly updated and maintained to ensure that manufacturers' instructions are followed, and equipment can be kept in good working order at all times.</p>
E. Our practice has a pulse oximeter.	<p>Your health service should have a pulse oximeter, and keep it in good working order. Relevant staff need to know how to use it properly.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure access to medical equipment necessary for comprehensive primary care including emergency resuscitation. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The clinic has all the equipment listed on page 192 available for comprehensive primary healthcare, as well as emergency resuscitation equipment.

In addition, the clinic regularly conducts community health research, using external reports and databases as well as local data obtained from clinical audits and community consultations, to better understand the present and future health issues of the community. Consequently, it makes sure that it is planning ahead to ensure it has the necessary equipment to provide regular primary healthcare services for projected needs and to manage health emergencies. For example, because presentations to the GPs include a high number of cases of diabetes, as well as otitis media and anaemia in patients under 5 years, the service has tympanometry, HemoCue® and/or HbA1c machines to improve the care and follow up of patients with these conditions.

Because of its strong focus on preventive health, the service makes sure it has the necessary equipment to screen for chronic conditions common to its community and for preventive care.

The service's resuscitation equipment is checked weekly by the nurses and recorded in a log. The equipment is restocked immediately after use. In addition the remote clinic has emergency equipment in the ambulance and grab packs for obstetric and other emergencies, such as traffic accidents.

The visual acuity charts are both in pictorial and standard letter format, with the pictorial format being used for children and adults who have difficulty reading.

Clinics have access to both an electrocardiograph and a spirometer. They have adult and child pulse oximeters available for use by staff members.

Equipment is maintained according to a documented maintenance log, which includes when the equipment is due for service or calibration. It has a task list for the checking of oxygen cylinders and calibration of the electrocardiograph.

Staff are trained in the proper use of medical equipment and the analysis of results. When interviewed, the service's staff members can describe the commonly performed procedures and the special equipment (in addition to that in the standard list) that is used.

Showing how you meet Criterion 5.2.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Through the use of direct observation.
- Maintain a checklist for consultation room equipment.
- Through the use of staff interviews.
- Maintain an equipment register.
- Keep a maintenance log.
- Maintain a task list.
- Keep receipts from any external equipment testing and calibration companies.

Criterion 5.2.2 Doctor's bag

Our practice ensures that each GP has access to a doctor's bag.

In a nutshell

A doctor's bag should be available at any time, to each GP, fully equipped and stored securely. In remote settings, a doctor's bag may be interpreted as a combination of the special packs in common use in ACCHSs.

Key team members

- Health service manager
- Clinic manager

Key organisational functions

- Equipment register
- Doctor's bag

Indicators and what they mean

Table 5.5 explains each of the indicators for this criterion. Refer to page 111 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.5
Criterion 5.2.2 Doctor's bag

Indicators	What this means and handy hints
<p>► A. Each of our GPs has access to a fully equipped doctor's bag for emergency care and routine visits and the bag contains:</p> <ul style="list-style-type: none"> • auriscope • disposable gloves • equipment for maintaining an airway in both adults and children • in-date medicines for medical emergencies • ophthalmoscope • practice stationery (including prescription pads and letterhead) • sharps container • sphygmomanometer • stethoscope • syringes and needles in a range of sizes • thermometer • tongue depressors • torch. 	<p>Each of your health service doctors has access to a doctor's bag, fully equipped with the contents listed, for emergency situations and routine out-of-clinic visits. The bag should be kept secure, and in accordance with each state and territory's legislative requirements.</p> <p>In remote settings, a doctor's bag may be interpreted as a combination of the special packs in common use in ACCHSs, together with any additional pieces of equipment that make up the full complement of equipment described in this criterion.</p> <p>Different communities' health needs mean that the medicines kept in the doctor's bag would reflect those needs.</p> <p>The shelf life and climatic vulnerabilities of medicines need also be taken into account when deciding how your health service stores the medicines required for the doctor's bag.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that each of its GP has access to a doctor's bag. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service has a doctor's bag (or a combination of packs and any additional equipment) containing the required equipment, and the doctor's bag is readily accessible to the doctors. It contains the necessary medicines to enable doctors to treat patients appropriately wherever they are.

The doctor's bag is kept in a locked cupboard and is checked weekly at the same time that the equipment is checked, and these checks are recorded in a log.

Health services should ensure that GPs are familiar with the medicines contained in their doctor's bag, including the general usage, suggested dosage and possible side effects.

It is recommended that GPs seek appropriate and ongoing education on the medicines contained in their doctor's bag.

Amended in May 2013.

Showing how you meet Criterion 5.2.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the RACGP *Standards*. Please use the following as examples only, because your service may choose different forms of evidence to show how you meet the criterion that may be just as good or better.

- Through the use of direct observation.
- Maintain a doctor's bag contents checklist.

Other information for this Standard

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the QIC *Health and community services standards* (6th edition) and the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 5.2 Equipment for comprehensive care:

1.4 Physical resources

The ISO *Standards* include the following sections that are relevant to Standard 5.2 Equipment for comprehensive care:

- 6 Resource management
- 7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

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The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

Andrew Baird's *Australian Prescriber* (2007;30:143–6) article 'Drugs for the doctor's bag' provides a useful explanation of PBS and other medicines for the doctor's bag:

- www.australianprescriber.com/magazine/30/6/143/6

In regards to PBS emergency drugs for doctors' bags, certain pharmaceutical scheme medications are provided without charge to prescribers who in turn can supply them free to patients for use. An up-to-date list of PBS medications for doctors' bags is available at:

- www.pbs.gov.au/browse/doctorsbag

In regards to emergency drugs for children, paediatric emergency drugs and dosages can be found in the Royal Children's Hospital Pharmacopoeia:

- www.rch.org.au/pharmacy/dev/index.cfm?doc_id=11341

An *Emergency drug (doctor's bag)* order form is available from Medicare.

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Overview of this Standard

This Standard is about your health service having the key requirements to support the safety and quality of clinical care for its patients, staff and the community. This requires policies and practices that govern how your health service provides for:

- the safe and quality use of medicines by patients
- potent vaccines maintained through an effective cold chain management system
- the management of healthcare-associated infections through a documented infection-control policy that outlines infection-control processes.

These clinical support processes contribute to the broader risk-management systems that your health service has in place.



Criterion 5.3.1 Safe and quality use of medicines

Our clinical team prescribes, dispenses and administers appropriate medicines safely to informed patients.

In a nutshell

Many Aboriginal community controlled health services face particular challenges in relation to this criterion. Transporting and storing temperature-sensitive medicines is a challenge for some remote services. In addition, for financial, cultural or other reasons patients may be reluctant to fill their prescriptions or to take their medication as recommended. A range of government and other initiatives has been developed to try to address these factors.

Your health service needs to also ensure that it maintains a shame-free environment, where patients feel comfortable and safe discussing issues related to the prescription and use of medicines.

Key team members

- Health service manager
- Clinic staff
- Designated clinic team member responsible for storage and security of drugs

Key organisational functions

- Patient communication policy
- Patient information and education
- Drug storage and security
- Safe and quality use of medicines policy
- Translation service
- Drug and medicines information and tools

Indicators and what they mean

Table 5.6 explains each of the indicators for this criterion. Refer to page 113 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.6

Criterion 5.3.1 Safe and quality use of medicines

Indicators	What this means and handy hints
<p>► A. Our clinical team can demonstrate how our patients are informed about the purpose, importance, benefits and risks of their medicines and how patients are made aware of their own responsibility to comply with the recommended treatment plan.</p>	<p>It is vital that patients understand the reasons for taking medicines, how important it might be that they take them as prescribed and the benefits and risks involved. When patients understand the ‘why’ and ‘what if’ of their medicines, they are more likely to take them and to adhere to the recommended treatment plans.</p> <p>Effective, open and culturally appropriate communication, sometimes about the patient’s life situation, is critically important in promoting treatment uptake. When prescribing medicine, your doctors need to provide clear advice to minimise risk and maximise medicine safety. Information about medicines can be communicated to patients via:</p> <ul style="list-style-type: none"> • clear, culturally appropriate, two-way verbal communication • written information (in English or the patient’s or carer’s language) • pictorial media and other visual tools • translators, Aboriginal health workers and/or cultural brokers/consultants • access to Consumer Medicines Information (CMI) and their tools. <p>Exploring any issues that patients might have in obtaining and taking the medicine is another important part of GP–patient communication.</p> <p>Documenting the above process is also important, and can be done using tools such as:</p> <ul style="list-style-type: none"> • checklists • file notes • electronic prescribing tools • information resources for consumers (CMI, list of information resources) • patient information materials • patient treatment plans. <p>A good relationship between your health service and a pharmacist can also help patients feel more comfortable about taking the medication.</p>

Table 5.6 (continued)

Indicators	What this means and handy hints
<p>► B. Our clinical team can demonstrate how we access current information on medicines and review our prescribing patterns in accordance with best available evidence.</p>	<p>Immediate and quick access to resources that help doctors to keep up to date with current information on medicines, and to review their prescribing patterns in accordance with best available evidence, is important to achieving the safe and quality use of medicines. Your health service is advised to make these resources available to doctors when they see patients.</p> <p>It is now considered standard practice to use the <i>Therapeutic guidelines</i>, which are available online (see Useful resources on page 217). Relevant therapeutic guidelines available to support best-practice prescribing include:</p> <ul style="list-style-type: none"> • analgesic guidelines • antibiotic guidelines • cardiovascular guidelines • dermatology guidelines • respiratory guidelines. <p>A number of computer-based clinical decision-support tools are becoming more widely available. These provide an electronic platform that can host a range of products which can be selected to suit your health service's needs. This includes the use of the <i>Australian medicines handbook</i> online. Such tools have an interactive and searchable format, enabling doctors to access independent, evidence-based drug information during the consultation.</p>
<p>► C. Our clinical team can demonstrate how we ensure patients and other health providers to whom we refer receive an accurate and current medicines list.</p>	<p>Medicine lists are lists of patients' current medication and should be accurate and regularly updated. This means that medicines that are single-use need to be deleted from the list when they are no longer required.</p> <p>It is recommended that your doctors:</p> <ul style="list-style-type: none"> • regularly review medicine lists with patients; this gives them an opportunity to also determine whether patients are taking up the treatment, and whether further education or support is required. Many doctors do this routinely and prior to prescribing or changing treatment. It is highly recommended that doctors do this at every patient contact • provide patients with new medicine lists when medicines are changed • include prescription and non-prescription medicines, as well as complementary and traditional medicines • attach medicine lists to referral letters to other health providers and explain to the patient why they are doing this.

Table 5.6 (continued)

Indicators	What this means and handy hints
► D. Our clinical team can demonstrate how we ensure that medicines (including samples and medical consumables) are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and jurisdictional requirements.	It is recommended that a designated person takes primary responsibility for the proper storage and security of medicines, vaccines and other health products. This person needs to have good reading and writing skills and be familiar with the legal requirements of Schedule 4 and Schedule 8 medicines regarding their acquisition, storage and disposal. A policy and procedure manual and register relating to the storage and security of medicines is recommended, to assist with jurisdiction requirements and manufacturers' directions.

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure it has a safe and quality use of medicines. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

The health service understands that there are some important issues it needs to get right if it is to ensure it prescribes and manages medicines safely and appropriately for its patients. These issues include:

- effective two-way communication with patients (including where patients speak English as a second or third language) to ensure full understanding of medicines and their use
- patient understanding of medical terminology
- patient understanding and acceptance of the Western medical model and use of medicines and other treatments, including the benefits and risks associated with not taking prescribed medicines
- financial and other barriers to accessing medicines
- the importance of a trusting and respectful relationship between GPs and their patients
- the development of health literacy amongst the patient population, to encourage patients' active participation in the healthcare process.

Consequently the service takes its responsibilities with regards to prescribing, dispensing and administering medicines very seriously. Its GPs and other health professionals are responsible for ensuring that appropriate patient communication and education processes are in place to ensure

informed choice and consent occurs. This is seen as particularly important for patients who are used to taking traditional medicines.

GPs take time when talking about prescribing new medicines to a patient in order to explain carefully and in clear, plain language the reasons for prescribing this medicine, its benefits and any side effects, and the importance of taking it as prescribed. They also take time to check whether their patients fully understand what has just been said, and encourage them to talk about how they feel about getting the medicine and taking it in accordance with the prescription. This can mean that patients will tell GPs important and relevant things that they might not otherwise say.

Importantly, GPs listen to what their patients have to say and show understanding of any concerns or problems that they raise. They then work with patients to try to resolve any issues getting in the way of them taking the necessary medicines. Where necessary GPs will include an interpreter in these consultations, or an Aboriginal health worker from the same community as the patient. The receptionist often plays a role in this by encouraging patients to think about any questions they might have before they go in to see a GP.

All patients are encouraged to contact the service if they have any questions or concerns about their

medications and an appointment will be made for a review of their medicines if required. At the next visit, GPs will ask patients how they are going with their new medicine, carefully listens to their response and work through any issues or concerns that patients raise.

GPs select formulations that are appropriate for their patients and tailor drug regimens to their needs (for example, appropriate dosing intervals and drug combinations). Dose administration aids are recommended, where appropriate. Because of the risk of frequent power cuts affecting refrigeration and storage facilities, where possible preparations appropriate for an environment with limited storage conditions are selected.

The doctors review current medicines, including complementary and traditional medicines, at each consultation and remove medicines that are not currently prescribed or were short term and are now completed – for example, antibiotics. Patients are given updated medicines lists when changes have been made in their treatment. The doctors explain carefully to patients why these changes have been made.

Nurses and Aboriginal health workers provide instruction, education and demonstration on how to use inhalers. Aboriginal health workers are often involved with some consultations and medicine reviews, because they can assist communication and can also interact with pharmacists to ensure an appropriate two-way information exchange.

The health service has a good relationship with the local pharmacists and maintains regular communication with them, including the two-way provision of feedback if problems arise.

The waiting room contains a looping video and posters and brochures on the safe use of medicines – for example, not giving one person's medicines to another person.

Staff members can demonstrate how they access medicines information in the clinical software program, *Therapeutic guidelines* and the CARPA manual and how they review their prescribing patterns in accordance with best available evidence.

Patient referral letters to external health providers contain a list of medications that is current on the day the referral was made.

Medicines are kept in a secure, locked area that is not accessible to patients. Before any medicines are stored, designated staff members check the expiry date and recommended storage options. Staff members rotate the older stock forward according to expiry date when storing new stock.

Staff check expiry dates of all medicines each month and document them in a log book. There is a system in place where different coloured stickers are used for different years of expiry – for example, medicines due to expire in 2013 have a yellow sticker, 2014 have a blue sticker, 2015 have a green sticker. This method means that staff members only need to check the medicines with the coloured sticker of the current year; this saves a considerable amount of time.

Schedule 8 medicines are kept in a locked safe and all of these drugs are checked every month and documented in the Schedule 8 drug book according to state or territory legislation.

Showing how you meet Criterion 5.3.1

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Use videos, brochures and posters.
- Keeps medicines review documentation in patient health files.
- Maintain instructions on how to use inhalers.
- Use a current clinical software program.
- Use the *Therapeutic guidelines* – electronic and hardcopy format.
- Keep a current medicines list and referral letters in patient health files.
- Show that you securely store S8 medicines.
- Maintain an S8 medicines register.

Criterion 5.3.2 Vaccine potency

Our practice maintains the potency of vaccines.

In a nutshell

Vaccine potency is dependent on an effective cold chain management system for transportation and storing of vaccines. A member of your health service team needs to have primary responsibility for cold chain management, and to ensure that self-auditing becomes a routine part of quality assurance and risk-management processes. Relevant clinical and administrative staff need to understand and be able to explain how the service ensures the potency of vaccine stock.

See page 117 of the *Standards for general practices* for the two essential references for this criterion.

Also see the Useful resources section on page 217 for resources on cold chain management for remote health services.

Key team members

- Staff member designated with primary responsibility for cold chain management
- Clinic manager
- Health service manager
- Clinic staff

Key organisational functions

- Cold chain management system, including cold chain management policy and procedures
- Quality assurance and risk-management processes
- Quality and safe clinical practice
- Safe and quality use of medicines

Indicators and what they mean

Table 5.7 explains each of the indicators for this criterion. Refer to page 117 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion.

Table 5.7
Criterion 5.3.2 Vaccine potency

Indicators	What this means and handy hints
<p>► A. Our practice team can identify the person with primary responsibility for cold chain management within the practice.</p>	<p>A staff member needs to be designated with specific responsibility for cold chain management in your health service. This staff member should be well known to all clinic staff and be able to support clinic staff in maintaining the potency of vaccines used by the health service.</p>
<p>► B. The person with primary responsibility for cold chain management has this responsibility defined in their position description and can describe how the process used for cold chain management complies with the current edition of the <i>National vaccine storage guidelines</i>.</p>	<p>The person with primary responsibility for cold chain management would have their role and responsibilities clearly defined in their position description and receive training appropriate to this responsibility.</p> <p>The person needs to be familiar with the processes explained in the essential references for this criterion and describe how the health service's process complies with:</p> <ul style="list-style-type: none"> the current edition of the <i>National vaccine storage guidelines: Strive for 5</i> the current edition of the NHMRC <i>Australian immunisation handbook</i>. <p>Your health service's designated person should be familiar with the requirements for general practice in relation to cold chain management. It is recommended that a policy and procedure manual ensure compliance with the <i>National vaccine storage guidelines</i>.</p> <p>At least one other person should be nominated to deputise for the above person if they are away at any time. This person should be properly trained and authorised for cold chain management responsibilities.</p>
<p>► C. Our practice can demonstrate how we review the following processes to ensure potency of our vaccine stock:</p> <ul style="list-style-type: none"> ordering and stock rotation protocols maintenance of equipment annual audit of our vaccine storage procedures continuum of cold chain management, including the handover process between designated members of the practice team accuracy of our digital vaccine refrigerator thermometer. 	<p>This indicator is important for ACCHSs, because preventive health programs for the community and services for patients involving vaccinations are only as effective as the potency of vaccines that are administered to patients. Therefore the identified processes to ensure potency of vaccine stock are vital.</p> <p>Routine internal auditing helps to ensure that potent vaccines are being administered. For an example of a self-audit, please refer to the appendix to the <i>National vaccine storage guidelines: Strive for 5</i>.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can maintain the potency of its vaccines. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

A staff member at each clinic has designated responsibility for cold chain management and this is documented in their job description. Each health service clinic has a backup staff member who is able to manage the cold chain of vaccines if the designated staff member is ill or on leave.

The staff induction process includes cold chain management and staff training logs show records of cold chain in-service training. When interviewed, the designated staff members are able to demonstrate the procedures of cold chain management, from stock ordering to the accuracy of the digital thermometer in the refrigerator used to store vaccines.

The service has the latest edition of the *Australian immunisation handbook* and *National vaccine storage guidelines: Strive for 5* available for staff reference.

Staff members are aware of the importance of promptly notifying the designated staff member when a vaccine delivery arrives.

Each clinic has purpose-built vaccine refrigerators, which are serviced on a regular basis and in response to unacceptable variations in temperature outside the recommended range.

The smaller clinic, which suffers from power interruptions, has a backup generator for maintaining electricity to the vaccine refrigerator.

The service's policy and procedure manual details the processes for:

- ordering and receiving vaccines
- monitoring and recording the temperature of the vaccine refrigerator, at a minimum daily
- rotating stock so that vaccines with the shortest expiry date are used first
- monitoring and adjusting equipment such as the [data logger](#), thermometer and thermostat
- equipment maintenance – for example, changing batteries in the thermometer, checking the accuracy of the thermometer

- action to take if the refrigerator temperature goes outside the recommended range, including what to do and how to prevent it happening again – for example, to report to the appropriate state or territory health department and document the incident
- how to pack a cooler for outreach clinics
- how to manage a power failure.

Designated staff members provide induction to new staff members and in-service to other staff members on the importance of the vaccine deliveries and what to do if they hear the vaccine refrigerator alarm going. They also check the vaccine refrigerator seals monthly for perishing or any damage.

A self-audit is conducted by designated staff members every six months, to determine:

- current staff members' knowledge of the cold chain process and whether they know that the vaccine refrigerator is not to be unplugged and no food or drinks are to be stored in it
- if a record is available to show that the temperature has been checked each working day
- whether there is a valid documented reason if monitoring has been missed
- whether all deviations of temperature outside the acceptable range were reported to the appropriate state or territory health department
- if there is an appropriate gap between the vaccines and the walls of the refrigerator
- whether vaccines are stored in their original packaging in a set of plastic drawers or enclosed plastic containers to increase insulation
- if the refrigerator can continue to store the volume of vaccines safely as required by the service.

Showing how you meet Criterion 5.3.2

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Through the use of staff interviews.
- Use job descriptions.
- Maintain a policy and procedure manual.
- Maintain a vaccine refrigerator temperature log.
- Maintain a staff training log.

Criterion 5.3.3 Healthcare-associated infections

Our practice has systems that minimise the risk of healthcare-associated infections.

In a nutshell

Infection control is crucially important to minimising healthcare-associated infections within your health service. This requires the appointment of a team member with primary responsibility for coordinating infection-control processes, supported by a written infection-control policy and ongoing education. There are nine indicators for this criterion, all of which must be met for accreditation against the *Standards*. Review these important requirements on page 120 of the *Standards for general practices*.

See the Useful resources section on page 218 of this guide for resources on infection control and waste management for remote health services in the Northern Territory.

Healthcare-associated infections can be minimised when:

- procedures and systems are put in place to ensure compliance with regulatory requirements and standards
- staff are educated, equipped (for example, through immunisation) and have easy access to appropriate personal protective equipment to sustain effective infection control
- compliance is evidenced through documentation of procedures and systems and regular monitoring and updating of processes and policies.

Key team members

- Staff member responsible for [infection control](#)
- Clinic manager
- Health service manager
- All staff

Key organisational functions

- Clinical risk-management practices
- Clinical staff personal safety (immunisation)
- Infection-control policies and processes – for example, hand hygiene
- Environmental cleaning policy and processes
- Sterilisation policy and processes
- Human resources management (staff personal files and records)
- Occupational health and safety (infection control)
- Staff ongoing education and training
- Staff orientation process and package

Indicators and what they mean

Table 5.8 explains each of the indicators for this criterion. Refer to page 117 of the *Standards for general practices* for more information and explanations of some of the concepts referred to in this criterion. See also the list of resources and guidelines on page 125 of the *Standards*, including for infection control, pandemic resources, hand hygiene and immunisation.

Because waste management is a more complicated process for remote services, more specific guidelines are available in Appendix A.

Table 5.8
Criterion 5.3.3 Healthcare associated infections

Indicators	What this means and handy hints
<p>► A. Our practice team can identify the person with primary responsibility for coordinating infection-control processes within our practice and this person has such responsibility defined in their position description.</p>	<p>Your health service needs to appoint a team member with primary responsibility for coordinating infection control. Specific areas of responsibility can be delegated to other nominated members of the clinic team. It is advised that all those delegated with this responsibility have it documented in their relevant position descriptions. These responsibilities could include:</p> <ul style="list-style-type: none"> • infection-control processes • sterilisation processes • environmental cleaning • staff immunisation • staff education • waste management.

Table 5.8 (continued)	
Indicators	What this means and handy hints
<p>► B. Our practice has a written, practice-specific policy that outlines our infection-control processes.</p>	<p>Your health service needs to have a written infection-control policy that is specific to how things are done in your service. This policy could include:</p> <ul style="list-style-type: none"> • immunisation for staff working within the health service, in accordance with recommendations in the current <i>Australian immunisation handbook</i> • appropriate use and application of standard and transmission-based precautions • sharps injury management • blood and body substance spills management • hand hygiene • environmental cleaning of both clinical and non-clinical areas of the health service • aseptic and sterile procedures for disposable instruments and/or instruments sterilised on site or off site • procedures for instrument reprocessing, sterilisation and the validation process, if sterilisation is performed on site • validation process and appropriate and safe transport arrangements if the sterilisation is performed off site • waste management, including the safe storage and disposal of clinical waste and sharps • access for patients and staff to personal protective equipment (PPE) and evidence of education on the appropriate application, removal and disposal of PPE • pathology testing conducted within the health service. <p>The infection-control policy could set out procedures in relation to each of these aspects and the staff member or members responsible.</p> <p>In addition to infection control, it is highly recommended that your health service have written policies and/or processes that deal with:</p> <ul style="list-style-type: none"> • ongoing education and training in infection control to each staff member, including a description of how your health service assesses staff competency in infection-control procedures • cold chain monitoring (see Criterion 5.3.2) • monitoring of the sterilisation process and maintenance of sterilisation equipment if applicable (for health services that perform on-site sterilisation) • annual validation records if practicable (for health services that perform on- or off-site sterilisation) • staff immunisation records.

Table 5.8 (continued)

Indicators	What this means and handy hints
<p>► C. The practice team member with delegated responsibility for the sterilisation process can describe in detail how sterile procedures are undertaken, including, where relevant:</p> <ul style="list-style-type: none"> • provision of an adequate range of sterile reprocessed or disposable equipment • procedures for having instruments sterilised off site, including documentary evidence of a validated process • procedures for on-site sterilisation of equipment, including monitoring the integrity of the whole sterilisation process, validation of the sterilisation process and steriliser maintenance • safe storage and stock rotation of sterile products. 	<p>Sterilisation processes and equipment need to be coordinated by a team member (for example an infection-control officer) who has been delegated with responsibility for sterilisation and received the necessary training for the role. It is highly recommended that the staff member allocated these responsibilities has them recorded in their job description.</p> <p>When required, the staff member can describe in detail how sterile procedures are undertaken, including, where relevant, those outlined in this indicator.</p> <p>The use of policy, procedures and other tools such as checklists is a good way of ensuring that adequate steps have been taken for the complete sterilisation process.</p>
<p>► D. All members of our practice team can demonstrate how risks of potential cross-infection within our practice are managed (as appropriate) including procedures for:</p> <ul style="list-style-type: none"> • hand hygiene • the use of personal protective equipment • triage of patients with potential communicable disease • safe storage and disposal of clinical waste including sharps • managing blood and body fluid spills. 	<p>An important component of infection control is the education and training of staff to ensure that the potential for cross-infection is minimised. This means that all staff need to be familiar with different policies, protocols and procedures that your health service has in place around infection control. These include the infection-control policy and triage protocols.</p> <p>See page 121 of the <i>Standards for general practices</i> for more information on waste control.</p> <p>It is the role of the infection-control officer to coordinate the different policies that relate to infection control. This includes the use and knowledge of standard and special precautions, spills management and environmental cleaning.</p>
<p>► E. Our practice is visibly clean.</p>	<p>Your health service looks clean, everywhere, all the time.</p>

Table 5.8 (continued)

Indicators	What this means and handy hints
<p>► F. The practice team member with delegated responsibility for environmental cleaning can describe the process for the routine cleaning of all areas of the practice and can provide documentation on the practice's cleaning policy.</p>	<p>Your health service is advised to have a cleaning policy that sets out a schedule and responsibilities for cleaning all areas of the service. Also refer to chapters 2–5 of the RACGP <i>Infection control standards for office-based practices</i> (4th edition).</p> <p>If your health service pays for commercial cleaners, a written contract is advised, to outline a cleaning schedule, suitable cleaning products and the area to be cleaned. A cleaning log would be most useful.</p> <p>Environmental cleaning needs to be coordinated by a team member who has been delegated with this responsibility. It is highly recommended that this team member's responsibilities are recorded in their job description. When required, this team member can describe in detail how environmental cleaning has been undertaken, and provide documentation as evidence (such as your policy or the cleaning log).</p>
<p>► G. The practice team member with delegated responsibility for staff education on infection control can describe how the induction program for new staff covers our infection-control policy as relevant to their role, and the requirements for providing ongoing staff education and assessing staff competency.</p>	<p>It is recommended that your health service has a staff education and training policy specific to infection control.</p> <p>It is the obligation of the team member delegated with responsibility for staff education on infection control to ensure that staff are adequately trained and educated on infection-control procedures. It is also highly recommended that this team member's responsibilities are recorded in their job description.</p> <p>When required, this team member can describe how:</p> <ul style="list-style-type: none"> • your health service's orientation and induction process covers the infection-control policy, so that all new staff members are aware of their roles and responsibilities around infection control, and who they need to go to for questions about this matter • your health service's infection-control policy provides for ongoing education and training in infection control as relevant to each staff member • your health service records staff members' ongoing training and education around infection control • your health service assesses staff competency in infection-control procedures.

Table 5.8 (continued)

Indicators	What this means and handy hints
<p>► H. Subject to the informed consent of individual practice team members:</p> <ul style="list-style-type: none"> • the natural immunity to vaccine-preventable diseases or immunisation status of practice team members is known • staff members are offered NHMRC-recommended immunisations, as appropriate to their duties. 	<p>Your health service has an OH&S responsibility to protect staff from exposure to harmful substances. In a healthcare setting, this includes the provision of immunisation to all staff members, as appropriate to their duties. Exact requirements may vary, and need to be assessed according to the risk presented by the type of health service and the duties performed by the staff members.</p> <p>It is highly recommended that you consult the <i>Australian immunisation handbook</i> on recommended vaccinations for healthcare workers (see Useful resources section on page 217). The following immunisations can be considered for office-based health professionals:</p> <ul style="list-style-type: none"> • hepatitis B • influenza • pertussis • MMR (if non-immune) • varicella (if seronegative). <p>Whether staff have been vaccinated, have refused vaccination or have any natural immunity, this should be recorded in each staff member's personal file. It cannot be assumed that staff will seroconvert post immunisation (for example, hepatitis B). It is therefore recommended that post-immunisation status is serologically confirmed where possible, and further vaccination provided as required. Post-immunisation immunity, where known, should also be documented in staff personal files.</p>
<p>► I. Our practice team can explain how patients are educated in respiratory etiquette, hand hygiene and precautionary techniques to prevent the transmission of communicable diseases.</p>	<p>Your health service's clinic team can explain how they educate or show patients how they can minimise healthcare-associated infections, such as:</p> <ul style="list-style-type: none"> • respiratory etiquette (for example, blowing your nose and covering your mouth when you sneeze) • hand hygiene (for example, handwashing after toileting and before food preparation) • precautionary techniques to prevent transmission of communicable diseases. <p>If your health service caters to multi-lingual people and cultures, the use of pictures and diagrams is very effective. These can be strategically placed in the waiting rooms, consultation rooms and toilets. Staff may also need to be trained in cultural awareness and sensitivity when communicating these messages to patients and visitors. Alternatively, the use of health workers and cultural liaison officers in developing education materials and tools can also be effective.</p>

Case study

Below is a description of the ways in which an Aboriginal community controlled health service can ensure that the risk of healthcare-associated infections is minimised. Not all of these good practices are required by the *Standards*, but they illustrate the many practical and creative things that ACCHSs can do to ensure they deliver services of high safety and quality to their community.

Each of the service's clinics has a designated staff member who is responsible for infection-control processes and this responsibility is documented in their job descriptions. The staff induction manual includes infection-control procedures and responsibilities of individual staff members, both clinical and non-clinical. These procedures and responsibilities include sharps injury, staff immunisation, hand hygiene, spills-kit use and location, environmental cleaning and waste management.

Staff induction and ongoing staff training, developed by a staff training needs assessment, is conducted to sustain effective infection control, and is recorded in line with Chapter 1 of the RACGP's *Infection control standards for office-based practices* (4th edition). This is reinforced with memory prompts such as checklists.

Hand hygiene and cough-etiquette posters are displayed in the waiting room, reception, consulting rooms, staff offices, patient and staff toilets, staff kitchen and storerooms. Hand rubs and masks are available throughout the service for patients and staff members. Reception staff are aware of the need to place patients who may have an infection (cough, rash, diarrhoea and vomiting or obvious bleeding) in a separate room to the waiting room.

The health service has a written infection-control policy that includes:

- immunisation for staff working in the service and how to document refusal
- the appropriate use of standard and transmission-based precautions
- sharps injury management, which includes the process for documenting a staff injury and who to report this to
- blood and body-substance spills management
- hand hygiene
- environmental cleaning of clinical and non-clinical areas of the service

- waste management (see Appendix A)
- aseptic and sterile procedures for disposable instruments and/or instruments sterilised on site
- a procedure for instrument processing, sterilisation and the servicing and validation of sterilisers
- how to use personal protective equipment for both staff and patients.

If there are sterilisers on site, they are validated annually and the challenge load used in the validation is photographed and placed above the steriliser, with instructions that this is the maximum load that can be placed in the steriliser and guaranteed to be sterile after processing. There is both a clean and dirty sink in the steriliser area.

The staff members who use sterile equipment can explain how they ensure that it is still sterile – for example, intact packaging, expiry date.

Staff members are aware of how to dispose of clinical and general waste. There is a documented contract with a licensed contractor to dispose of clinical waste.

The consulting rooms have sharps bins attached to the walls, out of reach of children. They also have clinical waste bins clearly identified with a biohazard symbol, also positioned out of reach of children.

There is a cleaning log for both clinical and non-clinical areas, detailing which cleaning products are to be used and which areas are to be cleaned by external contractors.

The health service receives regular publications from the public health unit of the state health service and also receives urgent notifications of national and local infection outbreaks and public health alerts.

Showing how you meet Criterion 5.3.3

Below are some of the ways in which an Aboriginal community controlled health service might choose to demonstrate how it meets the requirements of this criterion for accreditation against the *Standards*. Please use the following as examples only, because your service may choose other, better-suited, forms of evidence to show how it meets the criterion.

- Use job descriptions.
- Maintain a policy and procedure manual.
- Maintain guidelines in designated areas.
- Through the use of direct observation.
- Maintain a cleaning policy.
- Maintain a cleaning log.
- Show that you cover infection control in ongoing staff education programs.
- Ensure there's an education component in the infection-control policy.
- Utilise staff files.
- Make available brochures.
- Have posters at reception.

Related RACGP criteria

Criterion 3.1.3 Clinical governance.

Other information for this Standard

What these words mean

Cold chain

(adapted from the *Standards'* glossary)

This is the system of transporting and storing vaccines within the safe temperature range of +2C to +8C. The cold chain begins from the time the vaccine is manufactured, moves through to the state or territory vaccine distribution centres and ends when the vaccine is administered.

Data logger

This is a small electronic device that measures the temperature of a vaccine refrigerator and keeps a record of the results over a period of time.

Infection control

(adapted from the *Standards'* glossary)

Actions to prevent the spread of pathogens (something that causes disease) between people in a healthcare setting. Examples of infection-control measures include targeted healthcare-associated infection surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.

Policies and procedures are used to minimise the risk of spreading infections, especially in hospitals and other human or animal healthcare facilities. The purpose of infection control is to reduce the occurrence of infectious diseases. These diseases are usually caused by bacteria or viruses and can be spread by human-to-human contact, animal-to-human contact, human contact with an infected surface, airborne transmission through tiny droplets of infectious agents suspended in the air, and, finally, by such common vehicles as food or water.

Standard precautions

These are work practices required for the basic level of infection control, and are recommended for the treatment and care of all patients. They include:

- hygienic practices, particularly washing and drying hands before and after patient contact
- use of protective barriers when necessary, which may include gloves, gowns, plastic aprons, masks, eye shields or goggles
- appropriate handling and disposal of sharps and other contaminated or clinical waste

- appropriate reprocessing of reusable equipment and instruments
- use of aseptic technique
- use of environmental controls.

Transmission-based precautions

These are used when standard precautions may not be enough to prevent transmission of infection. Transmission-based precautions (airborne precautions, droplet precautions and contact precautions) are recommended to provide additional precautions beyond standard precautions.

Transmission-based precautions can be used for patients who are known, or suspected, to be infected or colonised with epidemiologically important pathogens that can be transmitted by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. These precautions should be used in addition to standard precautions:

- airborne precautions used for infections spread in small particles in the air, such as chicken pox
- droplet precautions used for infections spread in large droplets by coughing, talking or sneezing, such as influenza
- contact precautions used for infections spread by skin-to-skin contact or contact with other surfaces, such as herpes simplex virus.

Vaccine

A product often made from extracts of killed viruses or bacteria, or from live, weakened strains of viruses or bacteria; the vaccine is capable of stimulating an immune response that protects against natural (wild) infection. Vaccines can become less effective or destroyed if they are frozen, allowed to get too hot or exposed to direct sunlight or fluorescent light.

Validation process

This refers to the process or steps that have been taken to make sure that a specified purpose has been achieved. For example, validation of sterilisation processes requires that your health service shows the steps you have taken to make sure that sterilisation has actually occurred.

Related external standards

Some of the standards and criteria in the *Standards for general practices* are similar to those in broader organisational standards – specifically the *QIC Health and community services standards* (6th edition) and

the International Organization for Standardization's *ISO 9001:2008 (E)* (4th edition). Where these similarities occur they are identified. This may reduce the amount of work undertaken to achieve accreditation for both sets of standards.

Be aware, though, that each set of standards has a different purpose and scope. This means that you will need to be familiar with both sets of standards, and their similarities and differences, so that you respond appropriately as well as efficiently to the requirements of each.

The QIC *Standards* include the following standards that are relevant to Standard 5.3 Clinical support processes:

2.2 Focusing on positive outcomes

The ISO *Standards* include the following sections that are relevant to Standard 5.3 Clinical support processes:

- 6 Resource management
- 7 Product realisation

Useful resources

The *Standards for general practices* includes specific resources for each criterion. The following additional resources may be useful if you wish to enhance your understanding of this Standard or identify any gaps in your service's policies, processes and procedures. Some of these resources will contain sample policies or templates that have been developed by other health services or support organisations, which you could customise to suit your particular circumstances.

The RACGP *Infection control standards for office-based practices* (4th edition) is a must-have resource. It can be purchased from the RACGP using the publications order form:

- www.racgp.org.au

Your state or territory NACCHO affiliate or Medicare Local may provide support and training for health services and general practices seeking accreditation against the *Standards*.

AGPAL and GPA ACCREDITATION *plus* have some useful tools and resources on their websites:

- www.agpal.com.au/resources/
- www.gpa.net.au/index.php/resources-4th-edition/fact-sheets

The South Eastern Health Providers Association has a very useful set of resources for health services and general practices freely available on its website. These include a *Policy and procedure manual* (2011), designed to align with the *Standards for general practices*:

- sehpa.com.au/policy-procedure-manual

The QUMAX section of the NACCHO website is a valuable resource:

- www.naccho.org.au/promote-health/qumax

The North Carolina Program on Health Literacy toolkit provides resources to help develop patient health literacy:

- <http://nchealthliteracy.org/toolkit/>

The website of Therapeutic Guidelines Australia, an independent, not-for-profit organisation, contains guidelines for a number of topics:

- www.tg.org.au/index.php?sectionid=1

National vaccine storage guidelines: Strive for 5 can be downloaded at:

- www.health.gov.au/internet/immunise/publishing.nsf/content/provider-store

The *Australian immunisation handbook* 9th edition:

- www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-home

There are a couple of useful resources for information on cold chain management for remote services:

- http://remotehealthatlas.nt.gov.au/cold_chain.pdf
- <https://www.racgp.org.au/afp/200810/200810page.pdf>

Infection-control guidelines for the prevention of transmission of infectious diseases in the healthcare setting (Department of Health and Ageing):

- www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm

The National Health and Medical Research Council's *Australian guidelines for the prevention and control of infection in healthcare* (2010):

- www.nhmrc.gov.au/guidelines/publications/cd33

Blue book – Guidelines for the control of infectious diseases is published by the Communicable Disease Prevention and Control Unit of the Victorian Department of Health, to assist public health practitioners in the prevention and control of infectious diseases:

- <http://ideas.health.vic.gov.au/bluebook.asp>

A comprehensive 215-page administration template for Aboriginal community controlled health services in rural New South Wales was developed by NSW Rural Doctors Network and the Aboriginal Health and Medical Research Council. It is available at the AH&MRC:

- www.ahmrc.org.au/index.php?option=com_docman&task=cat_view&gid=28&Itemid=45

Each state and territory would have its own guidelines, in accordance with laws and regulations, for the investigation, control and prevention of infectious diseases in a healthcare setting. Please refer to the relevant infectious control units in your state or territory for more information.

Information on infection control for remote services in the Northern Territory can be found at the following websites – but check to ensure the advice is current:

- www.nretas.nt.gov.au/__data/assets/pdf_file/0016/14029/waste_management_small_communities.pdf
- http://health.nt.gov.au/Remote_Health_Atlas/Contents/Infection_Control/index.aspx

The Remote Health Best Practice Group's *Best practice communique* 10–08: Turbo burners:

- http://remotehealthatlas.nt.gov.au/1008_turbo_burners_communique.pdf

Appendices

Appendix A

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Appendix B

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Appendix C

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Appendix A

Tips to help you prepare for accreditation

This section is a compilation of some tips and hints that may assist you, both in preparing for accreditation and on the day the surveyors visit your service. Note that it is not a definitive summary.

On the day of the visit

Remember that your surveyors also go through the process of accreditation in their own health services and know how stressful and anxious staff can be.

Make sure that the surveyors know where they can park to avoid getting a parking ticket.

Put a notice up letting patients know that there are visitors to the service and that you are having your survey visit today.

Have the surveyors sign a confidentiality agreement after arrival if this is your service's policy.

A rough guide for the survey visit (which will usually take a minimum of four hours) could include:

- entry meeting
- guided tour of the health service
- formal interviews, as scheduled in advance
- informal interviews, as requested
- review of relevant documents and records
- observation/inspection
- exit meeting and summation.

Some tips for interviewees to remember about interviews:

- be well prepared
- relax, be honest and provide as much relevant information as possible
- if you do not understand the question, ask the surveyor to rephrase and/or explain further
- if asked a question that is outside the scope of your role, advise the surveyor
- remember, it's the system being assessed – not you personally!

Policies

It would be helpful to have your relevant key policies on hand, such as:

- after-hours visits
- pathology results
- vaccine potency
- infection control
- communication
- incident management
- patient identification
- privacy.

Care outside normal opening hours (Criterion 1.1.4)

Make sure your service has in place a formal agreement for the provision of care outside normal opening hours and that a copy of that agreement is available for the surveyors on the day, if applicable.

If your service has an agreement to participate in an after-hours roster with other health services, have the agreement and a copy of the roster ready for the surveyors.

Check that your answering machine is working and that the message is clear and current – the surveyors will be phoning after hours to check on this.

Check that you have a means of knowing that the other health services with which you share after-hours care, or the medical deputising service you use, have appropriately qualified doctors on staff.

Qualifications of staff (Criterion 3.2.1, 3.2.2, 3.2.3)

Check that your service has current professional registration details for general practitioners, practice nurses, dentists, dietitians, physiotherapists and other allied health professionals.

Check that you have in place a system for making sure you update the professional registration of staff members in their employee records.

Staff training (Standard 3.2)

Ensure that your service has in place documented training records/logs for staff members.

Make sure you have available for the surveyors copies of the GPs' continuing medical education triennial points.

Ensure you have evidence that all staff have had CPR training in the previous 3 years.

Job descriptions and staff issues (Criterion 4.1.1)

Check that all staff members have documented, current job descriptions.

Verify that the job descriptions include who is responsible for cold chain management, information technology, cleaning, vaccine management, sterilisation, quality improvements, risk-management systems, infection control, privacy and complaints handling. This could also be shown on a list in staff common areas.

Check that your staff members know what their roles are.

Check that your records show that staff have been offered immunisation, and the outcome.

If you have documented minutes of staff and clinical meetings, make them available for surveyors to look at.

If you use a communication book or equivalent, have this available for the surveyors as well.

Vaccines (Criterion 5.3.2)

The *National vaccine storage guidelines: Strive for 5* is now the benchmark reference and a copy should be available in your service.

A 'don't switch off' sign on the power point is a good idea.

Do not overcrowd the fridge.

Have a protocol for when the temperature range is NOT between 2–8°C: who is to be notified and what action is to be taken.

Ensure a copy of data logging is available for surveyors.

Ensure that there is no food or drink in the refrigerator.

S8 drugs summary of requirements (Criterion 5.3.1)

If your service does not stock S8 drugs your GPs need to be able to explain to the surveyor the alternatives to injectable S8 drugs that are used to provide analgesia (pain relief) to patients.

Have your S8 drug register available for the surveyor to look at.

Check the relevant state or territory website (or other publication) to ensure your service's requirements are current:

ACT: *Drugs of Dependence Act 1989*:

- www.legislation.act.gov.au/a/alt_a1989-11co/default.asp

NSW: Poisons and Therapeutic Goods Regulations:

- www.legislation.nsw.gov.au/fullhtml/-inforce/subordleg+392+2008
- Northern Territory: *Poisons and Dangerous Drugs Act 2012*:
<http://notes.nt.gov.au/dcm/legislat/legislat.nsf/linkreference/poisons%20and%20dangerous%20drugs%20act?opendocument>

Queensland: Health (Drugs and Poisons) Regulation 1996, appendix 6:

- <http://www.legislation.qld.gov.au/LEGISLTN/SLS/1996/96SL414.pdf>

See, also, appendix C of *What doctors need to know*, published by Queensland Government Environmental Health Branch:

- http://gpcore.ochsner.org/SoM/week1/supplementary/Enviro_Health_2008.pdf

South Australia: Code of Practice for the Storage and Transport of Drugs of Dependence:

- www.dassa.sa.gov.au/webdata/resources/files/CS_ActCode_DOD_storage_trans.pdf

Tasmania: Schedule 8 Medicine Summary by GPA Assist *plus*:

- <http://www.gpa.net.au/resources/factsheets/GPA%20Schedule%208%20Medicine%20Summary%20TAS.pdf>

Victoria: Drugs, Poisons and Controlled Substances Regulations 2006:

- www.health.vic.gov.au/dpu/reqhealth.htm

WA: Requirements for the prescribing of Schedule 4 and Schedule 8 medicines in Western Australia:

- www.public.health.wa.gov.au/cproot/3554/2/Prescribing_S4_S8_080825.pdf

Sterilisation (Criterion 5.3.3)

Ensure that the person who is responsible for sterilisation has had appropriate training and that they are well prepared to explain your service's processes to the surveyor.

Check whether your clinical staff know how to ensure the equipment and consumables they are using are sterile.

If your service sterilises its own instruments, check whether you have a steriliser validation certificate that has been done in the last 12 months. This needs to be available for the surveyors.

Make sure your staff are aware of the maximum load that can be processed and ensure sterilisation of instruments is the 'challenge pack' load that was used and documented by the technician when they performed the validation. Any load exceeding this 'challenge pack' load is not considered to be sterile.

Appendix B

Continuous quality improvement

This additional section has been included to provide a brief overview of continuous quality improvement (CQI). We recommend that you read this in conjunction with the relevant sections of the *Standards* and the RACGP QI&CPD program.

The section gives a general description of CQI and then provides examples for the provision of clinical services. If, through the process of obtaining accreditation against the *Standards*, you identify any omissions, gaps or even patches of mediocrity in the processes of your health service, it may be appropriate to use a CQI process to address these.

For more information, refer to the Useful resources section of Standard 3.1 Safety and quality. In particular, GPs and other health professionals participating in the RACGP QI&CPD program should refer to the section on quality improvement at <http://qicpd.racgp.org.au/program/overview/quality-improvement>

What is continuous quality improvement?

Most of us choose to work in healthcare to improve quality of life for the members of our community. How can we be sure that we are making a difference?

The glossary in the *Standards for general practices* defines quality improvement as:

An activity undertaken within a general practice, where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the practice. Ethics approval is not required for quality improvement activities, including clinical audits using a tool such as CAT or 'plan, do, study, act' cycles, undertaken within a general practice.

Continuous quality improvement is the process through which we can, on a regular basis, look at our health service and demonstrate that we are making a difference. Best practice is constantly changing and CQI systems enable us to ensure that we are providing the most effective service possible and that our work is impacting on the community positively.

We cannot call ourselves effective health professionals unless we take part in CQI to continually improve the delivery of those health services.

The RACGP Standards

Continuous quality improvement is illustrated by Criterion 3.1.1 in the *Standards for general practices*, which looks for evidence of quality improvement in a practice. Auditing, which is one of the components of CQI, is also recognised as a category 1 QI&CPD activity, with points awarded.

Blame-free culture

The days of finding someone to blame following a significant event are a thing of the past. CQI is not a tool to affix blame. Our training ensures that our practices are safe and ethical. Nevertheless, keeping up with the pace of continually evolving evidence-based medicine means that we all, at some point, will be practicing medicine that is out of synch with the latest evidence. Such is the nature of healthcare work. It is therefore vital that we understand this and appreciate the benefits of CQI as a learning tool.

Whose responsibility?

CQI is the responsibility of all clinical and non-clinical staff, although this needs to be driven by a CQI plan. The process is continuous and relies on everyone contributing.

Putting the theory into practice

There are many ways of evaluating the service provided. Health services need to ensure that staff have adequate time during work hours to do this.

The next section explains some of the ways in which the theory of CQI could be put into practice for clinical services.

A pre-requisite to good CQI is consistent coding

See also the RACGP publication *Clinical indicators and the RACGP* (2010) at www.racgp.org.au/your-practice/business/tools/standards/indicators

If health services do not use standardised coding then searching the database for information on the presentations you wish to study is going to be a difficult task.

Coding chronic obstructive pulmonary disease (COPD) as wheezing, bronchitis, emphysema, asthma etc. will make running a search for individuals with COPD very difficult. It is therefore important that you consistently use internationally accepted standard codes.

The cornerstone of CQI is good records. If the data entered in your health service's electronic records system is poor quality, the information that you extract will be useless. Brief note keeping might appear to save you time, but in the long run it will cost you time and quality.

Clinical audit

A clinical audit is the gold-standard way of assessing and improving clinical services. It should be an on-going process that is relatively quick and easy to perform. The aim of an audit is to see how your service compares to nationally accepted evidence-based standards.

Choosing a topic for a CQI project

You need to choose a topic that is relevant to your community. This can be identified by looking at your chronic disease registers, from issues raised in your staff meetings, or from other sources such as patient feedback data. Several independent bodies also provide suitable audit topics for general practice. These bodies include:

- RACGP QI&CPD program: <http://qicpd.racgp.org.au/program/overview>
- One 21 Seventy: www.one21seventy.org.au
- Australian Primary Care Collaboratives program: www.apcc.org.au
- National Prescribing Service: www.nps.org.au

Criteria for comparison

Once you have chosen a suitable clinical topic, appropriate criteria need to be selected for comparison with nationally accepted standards. For example, if the topic you have chosen is the quality of asthma management, a criterion that could be used for comparison could be: people above the age of 7 with asthma should be offered spirometry at diagnosis.

You can choose your criteria by reviewing the current evidence. In the case of asthma, the easiest way of doing this is by looking at the guidelines published by the National Asthma Council of Australia or the second edition of the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*. This resource was developed by the

RACGP and NACCHO and provides guidelines for the prevention and management of a broad range of chronic diseases in the Aboriginal and Torres Strait Islander population.

Similarly, depending on what the audit topic is, you may choose to review the guidelines published, for example, by:

- National Prescribing Service
- One 21 Seventy
- Diabetes Australia
- Kidney Health Australia
- National Heart Foundation.

Such guidelines can help you to choose your audit criteria.

Standards for benchmarking

Once the criteria have been selected, a benchmark needs to be set. Continuing with the example of asthma, the benchmark used might look something like this: at least 80% of adults with asthma have been offered spirometry.

The benchmark selected may be arbitrary, or a comparison can be made with other health services in the area. For example, if another health service in the area has demonstrated that 90% of their asthma patients have had spirometry, you can use 90% as your standard.

Using the National Asthma Council to set the criteria, the initial stages of your audit may, therefore, look like this:

- topic: adults with asthma
- criteria:
 - adults with asthma who have had spirometry at diagnosis
 - smoking status has been documented
 - inhaler technique education has been documented in the notes
- the standards against which to benchmark could be set at 80% for each of the above criteria.

Data collection

Ideally, an audit would include all patients who fit the selection criteria. In the example above, this would include all adult patients at your service with asthma. However, this would be very cumbersome and doing this regularly would be time-consuming. An alternative and more effective way of looking at your data is by randomly sampling 20–40 patients who fit the selection criteria. You then need to look at each person's notes to see if they have had spirometry at diagnosis, smoking status documented and inhaler technique documented as having been discussed. The results may look something like this:

- number of adult patients with asthma randomly selected: 30
- criterion 1: spirometry done at diagnosis 15/30 (50%)
- criterion 2: smoking status documented 27/30 (90%)
- criterion 3: inhaler technique documented as discussed 3/30 (10%).

Analysis

For criterion 2, consistency with best-practice guidelines is clearly demonstrated; however, the health service could be doing better in criteria 1 and 3.

How can the service improve care in these areas? This needs to be discussed in your service meeting; just being aware of the issues might result in more spirometry and more education. Additionally, the answer might be better documentation, or the service may feel that it would benefit from a dedicated nurse-led asthma clinic, which could focus on carrying out more spirometry as well as providing patient education.

Analysis of the audit data is service-specific. What works in one service may not necessarily work in another.

Re-audit

Once changes to clinical practice have been implemented, their effectiveness needs to be demonstrated by performing a re-audit. This is usually done 6–12 months after the changes are implemented, but time frames can vary depending on the nature of the changes made.

Other continuous quality improvement activities

Significant event analysis (SEA)

SEA is a tool for recording unexpected events and attempting to minimise their risk of occurring again. Such events need to be recorded in a way that preserves the anonymity of the individuals involved, and an analysis needs to be conducted on what went well and what could have been done better. SEA links in with auditing and quite often identifies further areas that require auditing. SEA is particularly good at highlighting issues for improvement that you might have not otherwise thought about. For example:

You receive a letter from the hospital stating that a patient who attends your service has been discharged following an overdose of benzodiazepines. You note that the patient was seen the day before with insomnia and was prescribed benzodiazepines but suicide risk was not assessed. As a consequence of the analysis your health service may decide that the guidelines on benzodiazepine prescribing and suicide-risk assessment need to be reviewed and incorporated into practice. An audit could then demonstrate that the change in practice has indeed improved outcomes.

Remember that the application of SEA is not just limited to clinical issues. It can be used for any unexpected event in the practice.

Inter-service visit

The aim of a national health system is to improve outcomes for the population. Individual services are not in competition but should work in harmony to improve health outcomes. If an area for improvement has been identified by your CQI program, you may want to see how another health service deals with the same problem. This could then be implemented by your service. The RACGP CQI website provides guidance on organising an inter-service visit.

Other activities

CQI can also include collecting and using patient feedback, video analysis of consultations, participation in accredited learning activities, journal clubs and many other activities.

Appendix C

Focus groups

Introduction

This section is included to provide guidance about running focus groups as a means of obtaining patient feedback on their experience of your health service (Criterion 2.1.2). The RACGP publication *Patient feedback guide: learning from our patients* should be closely studied to ensure that you align your focus group methodology with RACGP requirements for this criterion. This is obtainable from www.racgp.org.au/your-practice/business/tools/standards/patient-feedback

Remember that any practice-specific patient feedback methods used for the purpose of gaining accreditation against the *Standards* need RACGP approval before they are used. For more information or to obtain an application form, contact standards@racgp.org.au. Application fees apply.

Remember, too, that if you are planning to use an RACGP-approved focus group for accreditation purposes, questions should cover the six categories of the patient experience:

- access and availability of care in your practice
- information provision to patients
- privacy and confidentiality of care in your practice
- continuity of care
- communication skills of clinical staff
- interpersonal skills of clinical staff.

Again, see the *Patient feedback guide* for more information.

What is a focus group?

A focus group is a small group of people, led by a facilitator in a group-interview format, and brought together to discuss a particular topic or issue. Focus groups provide a forum for health services to discuss issues and explore selected matters with their clients. These issues could include expectations, attitudes and feelings about various aspects of the health service, and experiences of services or programs.

Key characteristics

Focus groups are usually:

- held with a group of about 10 to 12 people
 - participants are generally chosen because they share some common characteristics. For example, they are all parents of young children, or are participating in a behaviour modification program, such as smoking cessation
- led by a facilitator (usually two) in a group-interview format. The facilitator should be in a position where they can be neutral or impartial about the comments given by participants. It is best not to have the manager of the services or programs under discussion as facilitator
- of 1½ to 2 hours in duration
- used when largely qualitative information is required.

Focus groups tend to:

- produce qualitative data – the goal is not to reach a consensus, solve a problem or make a decision
- seek to obtain insights into attitudes, perceptions, beliefs and feelings of participants
- use a questioning approach that uses predetermined, sequenced, open-ended questions.

Frequently a brief questionnaire is used during the focus group interview as a method of structuring feedback and of obtaining more precise data, such as priorities and preferences.

Purposes

Focus groups are appropriate methods to use for:

- identifying client needs and expectations
- obtaining regular snap shots of your service
- testing attitudes to proposed service enhancements or new methods of delivery
- probing for perceptions and experiences relating to a particular service or service feature
- obtaining feedback on a recently introduced initiative
- getting feedback for improvement
- understanding how clients think
- obtaining more detail about service gaps identified in quantitative research.

Advantages of focus groups

Some of the advantages of using the focus group method are:

- they allow probing for more in-depth responses and opinions
- clarification can be obtained if statements are ambiguous or obscure
- they are flexible and offer the opportunity to go in different directions if desired
- group discussion allows respondents to build on each other's responses
- they provide real-life data in a social environment
- their flexibility allows changes to be made to future focus groups
- they provide high face validity
- they can generate speedy results
- they can be of low cost, especially if the service already has an experienced facilitator to gain sound feedback data.

Disadvantages of focus groups

Some of the disadvantages of using the focus group method are:

- they don't provide a representative view of the whole population
- they don't provide quantitative information of statistical significance
- they are mainly subjective and qualitative information is obtained
- unless managed well, the discussion can go in directions that are unproductive
- more articulate individuals may dominate the discussion
- personal bias – of the facilitator and of the participants – may distort the data

- some participants may feel inhibited in expressing their opinion
- they take time to conduct, write up and analyse
- groups can vary considerably
- groups can be difficult to assemble
- the environment needs to be conducive to discussion
- facilitators require special skills
- data can be difficult to analyse.

Planning focus groups

Focus groups require a lot of planning, especially if more than one group will be conducted. These are the steps that need to be followed:

Determine your purpose in holding a client focus group

- Keep your attention to one general purpose.
- Ensure that focus groups are the best method for addressing this purpose.
- Choose appropriate participants for that purpose.
- Restrict your focus of enquiry to issues that can be addressed in about 1 to 1½ hours.

Determine the focus group scope and process

- Aim for a sampling process, particularly for a large client population.
 - This may mean more than one focus group or interview, to obtain the full spectrum of input.
- Arrange separate focus groups for sub-groups within a larger, more diverse client group. Ensure that each group has reasonably similar membership, so that all people feel they have the opportunity to contribute.
- Determine other elements of the process – such as the exact issues to be addressed, how they will be addressed and the specific nature of the questions to be asked. It is useful to review previous patient feedback data, as well as CQI actions and results, to help you determine the appropriate areas to concentrate on.
- Use a standard format so that the findings can be reliably interpreted.
- Develop a discussion guide or interview schedule, so that this standard format can be followed.
- Plan and design the means by which the results need to be recorded, collated, presented, analysed and communicated.
- Choose facilitators who are of sufficient experience and seniority to have the respect of participants.
 - It is best not to have a service manager facilitate a focus group on the services they are responsible for delivering. It is difficult for them to be impartial and participants may feel reluctant to give honest feedback in their presence. Your state or territory NACCHO affiliate may be able to offer some assistance here.
 - At the same time, make sure they are people who are reasonably familiar with the service, who can interpret feedback accurately and clear up any misunderstandings.
 - It goes without saying that your preference should be for people with good communication and people skills.
- Aim to have two facilitators in a focus group; this has the advantage of allowing you to choose

facilitators according to the above criteria. Also, one can conduct the discussion while the other takes notes and acts as backup. For remote services it is preferable to have male facilitators for a men's focus group, and female facilitators for a women's focus group.

Consider using a structured questionnaire

You may choose to ask participants to complete a short questionnaire to obtain certain kinds of data and to use as an interview tool. This can:

- provide opportunities for everyone to participate
- ensure that you cover all areas, even if some don't come up in discussion
- allow for more private views to be aired
- provide some structure
- allow for more quantifiable information to be collected, through the use of measurement devices such as rating scales.

Generally the administration of a questionnaire would occupy a small amount of the total interview time (say 5 to 10 minutes), and the facilitator would supervise the completion of the forms. Questionnaires should be well designed and administered, to ensure the results are valid and not distorted by poor design or undue influence of the focus group facilitator.

Determine how many and which clients are to be invited to a focus group

- Aim to invite people who can give you the highest quality information for the topic you are addressing.
- Consider who is likely to obtain most from the interview; they are the people who are most likely to respond to your invitation (for example, people who frequently use your service are more likely to attend than infrequent users; people who have problems with your service are also more likely to attend).
- Be aware that results can be distorted because of sampling bias (for example, there may be some people who will want to participate because they have a particular line to push or represent a particular interest group; this may not be the best forum for them to have their say, as there is the risk that they may dominate).
- Involve your health service staff and managers in the selection process, as they will have the best ideas on appropriate focus group membership.
- You will need to invite more people than the numbers you want – at least twice as many; sometimes more. Even so, be prepared for fewer or greater numbers than you plan for.
- If large groups are involved, you will need to use a sampling approach; consider calling in external experts.

Determine the times, dates and locations of the focus groups

- Choose a time and venue that are likely to be attractive and appealing for your invitees.
- Make sure your arrangements are as convenient as possible for prospective participants, even if they are at some inconvenience to you.
- Remember that these people are going out of their way already in giving up their time to assist you.
- If participants need to travel, it is appropriate to reimburse their travel costs and to provide adequate refreshments and accommodation, if required.
- Generally refreshments are offered on arrival in all focus groups, but do make sure this doesn't occupy too much time.

Invite focus group participants

- Agree a method for inviting focus group participants. This could be by community visits or notices in the health service or public areas, or by telephone and confirmed by mail or email.
- Ensure invited participants have a clear understanding of the purpose of the focus group and the use to which the findings will be put.
 - Ensure consent is freely given, based on that understanding.
- Also advise participants how issues of confidentiality will be handled (see section on ethical issues).
- If you plan to audio or video record the focus group, advise prospective participants of this so their consent to participate is given with this knowledge.
- Always make sure there is some phone contact, preferably initiated by someone known to the participant, to remind people of the details and to answer any questions.
- Be aware that many of your clients may not have participated in focus groups and may want some information about what is involved – and particularly what their role is expected to be – before they will agree to participate.
- Sometimes an incentive – such as an opportunity to have lunch afterwards with the board, a free nutrition class or a movie voucher – may need to be offered in order to encourage participation.

Conducting focus groups

The actual conduct of focus groups generally follows the sequence outlined below.

Preparation

- Ensure the room is comfortable and that the seating allows participants to see and interact with each other.
- Select two people to conduct each focus group.
- Agree who will take the lead interviewing role and who will take notes and keep time.
- Provide refreshments on arrival, but make it brief.
- Bring with you a copy of any correspondence to the participants, the interview schedule, copies of any questionnaire used and writing paper.
- The RACGP requirements for patient feedback are that six categories of the patient experience are covered (for more information on these categories see the RACGP *Patient feedback guide*, downloadable from www.racgp.org.au/your-practice/business/tools/standards/patient-feedback):
 - access and availability
 - information provision
 - privacy and confidentiality
 - continuity of care
 - communication skills of clinical staff
 - interpersonal skills of clinical staff.

Conducting the focus group

General discussion

- Greet each participant and start the session with introductions.
- Open by thanking the group for their time.
- Introduce yourselves and group members – quickly!
- Restate the purpose of the focus group, the beginning and ending times, and the respective roles of the two facilitators – in other words, one to manage the discussion and one to take notes.
- Outline any ground rules of the session.
- Make a clear statement about the confidentiality of the information provided by participants: no statement made will be attributed to a particular person and no identifying details – about participants or any people referred to – will be disclosed.
- Ask participants to respect confidentiality too.
- Ask if they have any questions before you start. Keep further explanation brief and to the point.
- Remind them of the main purpose of the focus group: to collect information about the issue, not to have a gripe session or to solve problems.
- Explain what will be done with the information after it is collected, including the opportunity to review the focus group transcript.
- Work through your general questions with the group. Encourage discussion but keep the pace moving, to be sure you cover the areas you wish to cover.
- Encourage all members to participate, especially about more complex issues. Encourage those who talk less to share their thoughts and don't allow one or two members to dominate the sessions.
- Ensure all participants have reasonable airspace; invite quiet members to comment.
- If there are criticisms of your service, probe for information to better understand the issue and ask how it could be done better.
- If necessary explain (briefly) why problems may have occurred and perhaps apologise briefly but don't become defensive, as this will stifle further criticism.
- Ensure the discussion is focused on key elements of the service under discussion. If your interview is concluded without having learned about the most important aspects from your client's point of view, it has failed to achieve its purpose. Don't concentrate on one topic at the expense of others.
- If there is specific positive feedback, record it to pass on to the people involved.
- If there is a specific problem aired, take notes and follow up later.
- If you begin to run out of time, there are several options, and you will need to be sensitive to the atmosphere in order to propose the best option:
 - ask if you can extend the current focus group time
 - work quickly through the key questions in the remaining time
 - finish before having all your questions answered
 - allow for follow-up feedback to be given – for example, by telephone or email.

Recording and note-taking

- Consider the value of having the focus group audio or video recorded, or using a live scribe pen with a recorder, with participants' prior permission.
- Both facilitators may take brief notes, but one needs to have primary responsibility for note taking.
- Notes should summarise the key points being made by focus group participants.
- Try to record the comments legibly and in the appropriate order, so that minimal sorting has to be done later.
- Avoid bias; ensure comments are recorded accurately and objectively.
- Where there is agreement between several group members on an issue, just tick the comment by the number of people who agreed (even nonverbally) to it.
- Record good quotes verbatim, as they can provide a flavour to the report.

Closure

- Summarise the key issue raised and key points made.
- Explain that the focus group records will be returned to the participants to check for accuracy.
- Repeat what actions will be taken as a result of participants' feedback, and how this will be communicated.
- Thank the group for their time and input.

Follow up

- Clean up and clarify your interview records immediately so that they can be understood at the report writing and collating stage.

Responsibilities of the focus group facilitator

The focus group facilitator is clearly the most critical factor influencing the effectiveness and usefulness of focus groups. They conduct the whole session, and guide the flow of group discussion across the specific topics selected. It goes without saying that focus group facilitators need to have particular skills and characteristics. Key amongst these are experience in handling small groups, cultural awareness, enthusiasm, self-organisation, energy and open-mindedness.

Key tasks of focus group facilitators are to:

- be clear about the nature and purpose of the focus group they are running
- prepare well, so that the topics and issues are understood before the focus group begins
- establish rapport with the group, and set the scene for productive discussion
- achieve a good balance between encouraging lively discussion and maintaining a focus on the topics to be discussed
- stay alert to group dynamics, to recognise threats to productive group discussion
- manage group dynamics so that discussion flows smoothly and people feel comfortable sharing their thoughts
- stay open-minded themselves so that preconceptions about the topic and the participants are minimised
- prepare a report that accurately captures the responses of the group
- maintain confidentiality.

Ethical Issues

There are a number of ethical issues that focus group facilitators need to be aware of and to address appropriately. The most important are:

- the voluntary nature of focus groups
- the need to respect confidentiality and anonymity.

Consent

No person should be compelled to participate in a focus group, nor should they be made to remain if they want to leave. Consent (in most cases, verbal consent is sufficient) should be obtained from each participant prior to the focus group, and a clear statement of the purpose of the focus group should be provided, to allow prospective participants to make an informed decision. No use should be made of the information provided in a focus group other than for the purpose for which consent was given.

Confidentiality

People who participate in focus groups need to be assured that no information will be revealed that can identify them, and that comments they make are not reported (either verbally or in writing) in such a way that specific people or incidents can be identified. People will either not participate in a focus group if they are not given that assurance, or they may distort or suppress information if they feel it is going to be used for other purposes.

In addition to these two key issues, the actual conduct of focus groups requires attention to more subtle matters of ethics. In conducting a focus group, facilitators need to:

- avoid judging focus group participants by their appearance or other known characteristics
- treat all people and the comments they make with respect
- avoid influencing a response by asking leading questions
- observe confidentiality with focus group discussions so that minimal information is revealed that could be used to identify personal details of focus group participants or any people to whom they refer.

Communication skills

There is a set of communication skills that need to be employed in focus groups. The facilitator needs to judge when particular skills are needed.

Nonverbal skills

- Adopt a relaxed, open posture.
- Listen with your eyes as well as your ears – look at the speaker.
- Listen for basic fact and main ideas.
- Listen for attitudes, opinions, or beliefs.
- Do not interrupt the speaker.
- Use positive, non-verbal communication to prompt the speaker.
- Be aware of the speaker's non-verbal communication.

Active listening

Active listening is a valuable but underused skill. It basically consists of summarising your understanding of what the other person is trying to say by:

- repeating key phrases: 'more specific information ...'
- summarising messages: 'So, what you're wanting to see here is...'
- showing empathy: 'It must have been really frustrating ...'

You can also use active listening to:

- repeat your understanding of their comments in your own words
- ask the speaker if that is correct and for any clarifications
- make sure key points by the speaker are captured
- ask as a check to verify understanding.

Use active listening when:

- the person isn't being clear
- you are reacting defensively to what is being discussed
- you want to demonstrate that you understand
- you want to defuse the situation
- you want to sum up what has been said
- you want to elicit more information
- you want to move on.

Probing questions

In order to gain additional insight into the process, use some of the following types of probing questions.

- Open probe: questions that begin with how, what, which, when and who. Effective to encourage responsiveness and reduce defensiveness.
- Compare and contrast: questions that ask the other person to look for and discuss similarities or differences. These kinds of questions help the responder to develop and express ideas while allowing the interviewer to steer the direction of the interview.
- Extension: a question that builds on information already provided.
- Clarification: questions designed to get further explanation about something already said.
- Laundry list: techniques where the interviewer provides a list of choice options to the interviewee. This encourages the other person to see beyond a single choice and to state a preference

Assertion skills and tactics

Assertion skills

Assertion skills – being clear, firm and respectful – may be called for when a focus group is not going in the desired direction. Key assertion skills the facilitator requires include:

- active listening
- selective ignoring, where you ignore an unhelpful or provocative comment (don't overuse this)

Assertion tactics

Key assertion tactics the facilitator requires include:

- Knowing when to use I statements – 'I'd like to move on...'
- using appropriate muscle level if you are concerned that a participant may derail the focus group, perhaps by dominating the discussion, demanding a solution to a problem, or provoking conflict with other participants. Appropriate muscle level means ensuring that your first intervention is mild ('Let's hear what other people have to say'), moving to a higher muscle level if they fail to respond ('Perhaps we can make an appointment to talk about this another time. What I would like to do now is invite other people to contribute so that we can hear everyone's opinions')
- addressing the process, not just the content – 'We're going off the track here'.



How we react to criticism

Generally we react to criticism by becoming defensive – a natural response to perceived attack. Focus group participants may criticise us, our service or our organisation in ways that make us feel defensive. As a result we react by:

- giving reasons as to why things are the way they are (frequently seen as excuses)
- not listening
- reacting angrily.

Handling criticism

- Get sufficient information to report the criticism accurately.
- Understand the nature of the problem – use open questions, clarifying questions, active listening.
- Understand the extent of the problem.
- Show concern, empathy.
- Indicate willingness to ensure it is addressed.
- Don't attempt to problem-solve.

Aim for balance between questions as planned and unexpected directions, remembering at all times:

- an individual's desire to tell their story and the need of the group to fully participate in the discussion
- positive and negative feedback. If an individual has a horror story to tell, you may need to see whether there are more positive stories of the same service
- emotions (your own feeling response to what is being said) and reason (your professional responsibility to manage the discussion)
- empathy with a participant and bias that prevents you from seeing the situation from another point of view

Remember, if the going gets tough:

- use your own judgement
- tune into the atmosphere of the group
- two heads are better than one
- use a combination of listening skills and assertion skills.

Preparing a focus group report

Just as it is best not to have the manager of the services or programs being discussed as the facilitator of the focus group, it is also wise not to have them prepare the focus group report. It is a common human characteristic to become defensive when faced with criticism, and this can influence the content of the focus group report. However, it is quite appropriate – and indeed necessary – to invite the manager and their staff to comment on the focus group report before actions are agreed.

Organise input

More qualitative information, such as that obtained from interviews and focus groups, can be difficult to organise. However, it is important that feedback is documented and presented in a digestible form, otherwise the purpose in holding the discussion has been lost.

The feedback from your focus groups should be collated, aggregated (if you conducted any structured questionnaires) and presented in such a form as to make decision-making reasonably straightforward.

Keep in mind that information obtained from focus groups can go through various filters, depending on how carefully you listened to what was said, how accurately you recorded it, how promptly you developed a more detailed focus group report, and how carefully you then collated all your focus group findings.

Generally a focus group report will consist of summaries of key points or themes made in response to each question. These need to be as objective as possible, and should try to capture the mood or response of the whole group, or the majority of its members. If divergent views were expressed, this could be reflected in the report too. Frequently quotations will help illuminate the general meaning of what was said, though quotes should only be used when they reflect a widely held view. The report could be seriously distorted, otherwise.

Remember that focus group results are qualitative and not perfectly representative of the general population. Care needs to be exercised in constructing a report for readers and decision-makers who were not there to pick up nuances or differing views.

Once again, the objectives of the focus group project would determine how and for whom the information needs to be reported. As a general rule, numbers and percentages are not appropriate for focus group research and are not to be included in report. Reporting is more descriptive and presents the meaning of the data as opposed to a summary of data.

- Report participants' words but do not identify them by name.
- Describe main participant characteristics. The RACGP advises that demographic information (such as age, gender, ethnicity, educational achievement, socioeconomic information and whether any participant has been diagnosed with a chronic disease) should be collected for each participant.
- Use descriptive phrases or words used by participants as they discussed the key question.
- Identify themes in the responses to the key questions.
- Identify sub-themes indicating a point of view held by participants with common characteristics.
- Include a description of participant enthusiasm or other group characteristics if relevant.
- If there was inconsistency between participant comments and their reported behaviors, record this.
- Suggest new avenues of questioning that could be considered in future: should questions be revised, eliminated, added, etc.
- Summarise the overall mood of discussion.
- In giving meaning to the descriptions, be careful about your own biases in interpretation.

Communicate your findings

Communicate the results – even an executive summary – to the relevant groups, keeping in mind that the clients who participated in the focus groups should be at the top of your list.

Final comments

The above guidelines for using focus groups as a means of obtaining patient feedback are suggestions only. They cannot cover every possible situation that might arise, and may offer advice that is not appropriate to a particular circumstance. Draw from the guidelines judiciously, discuss issues and approaches with other staff, and, most importantly, ensure that you are familiar with relevant guidelines in the RACGP *Patient feedback guide*.

Acronyms and abbreviations

4WD	four-wheel drive	NACCHO	National Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal community controlled health service	NAIDOC	National Aborigines and Islanders Day Observance Committee
AGPAL	Australian General Practice Accreditation Limited	NHMRC	National Health and Medical Research Council
AH&MRC	Aboriginal Health & Medical Research Council of NSW	nKPIs	national key performance indicators
AHCSA	Aboriginal Health Council of South Australia	PBS	Pharmaceutical Benefits Scheme
AHCWA	Aboriginal Health Council of Western Australia	PIP	Practice Incentives Program
AHMAC	Australian Health Ministers' Advisory Council	PPE	personal protective equipment
AHPRA	Australian Health Practitioner Regulation Agency	OATSIH	Office for Aboriginal and Torres Strait Islander Health
AHW	Aboriginal health worker	OH&S	occupational health and safety
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory	QI&CPD	Quality Improvement & Continuing Professional Development program
ARC	Australian Resuscitation Council	QIC	Quality Improvement Council
CARPA	Central Australian Rural Practitioners Association	QAIHC	Queensland Aboriginal and Islander Health Council
CAT	clinical audit tool	QUMAX	Quality Use of Medicines Maximised in Aboriginal and Torres Strait Islander peoples program
CMI	Consumer Medicines Information	RACGP	Royal Australian College of General Practitioners
COAG	Council of Australian Governments	VACCHO	Victorian Aboriginal Community Controlled Health Organisation
COPD	chronic obstructive pulmonary disease		
CPD	continuing professional development		
CPR	cardiopulmonary resuscitation		
CQI	continuous quality improvement		
DMO	district medical officer		
ECG	Electrocardiogram		
GP	general practitioner		
GPA	General Practice Australia		
HPOS	Health Professional Online Services		
HR	human resources		
ISO	International Organization for Standardization		
MBA	Medical Board of Australia		
MOU	memorandum of understanding		





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