RACGP

Standards for general practices (6th edition)

Draft

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Glossary

* Terms marked with an asterisk relate to the Point-of-care testing (PoCT) standard.

Term	Definition
Aboriginal or Torres Strait Islander status	A way of recording and identifying a patient's response when the practice asks them, 'Are you of Aboriginal and/or Torres Strait Islander origin?' The standard response options should be provided either verbally or in written form: • No • Yes, Aboriginal • Yes, Torres Strait Islander For people of both Aboriginal and Torres Strait Islander origin, both 'Yes' boxes should be marked when in written form.
Aboriginal and Torres Strait Islander health worker/practitioner	A member of the Aboriginal and Torres Strait Islander health workforce. Roles include, but are not limited to: • providing clinical functions • liaison and cultural brokerage • health promotion • environmental health • community care • administration • management and control • policy development • program planning An Aboriginal and Torres Strait Islander health worker/practitioner is often an Aboriginal and Torres Strait Islander person's first point of contact with the health workforce, particularly in remote parts of the country
Access	The ability of consumers to obtain services, care and treatment from the practice
Accreditation	A formal process to assess a practice's delivery of healthcare against the RACGP's *Standards for general practices*
Accuracy*	Measure of how close the results of a test come to the true value.
Active patient	A patient who has attended the practice/service three or more times in the past two years
Active patient health record	The health record of an active patient
Administrative staff	Members of the practice team who provide clerical or administrative services and who do not perform any clinical tasks with patients

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>Adverse event</td><td>An adverse event, or incident, is any event or circumstance arising during care that could have or did lead to unexpected actual harm, loss or damage. Incidents include near misses, sentinel events and unsafe acts.</td></tr>
<tr><td>Adverse medicines event</td><td>An adverse event caused by a medicine; this includes harm that results from the medicine itself (an adverse drug reaction) and potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident)</td></tr>
<tr><td>After-hours service</td><td>A service that provides care in the after-hours period as defined by Services Australia, whether or not that service deputises for other general practices, and whether or not the care is provided physically in or outside of the clinic.

Services Australia defines the after-hours periods as follows:

<table><tr><th>Day</th><th>Normal hours</th><th>Sociable after-hours</th><th>Unsociable after-hours</th></tr><tr><td>Weekdays</td><td>8.00 am – 6.00</td><td>6.00–11.00 pm</td><td>11.00 pm – 8.00 am</td></tr><tr><td>Saturdays</td><td>8.00 am – 12.00 pm</td><td>None</td><td>Before 8.00 am; after 12.00 pm</td></tr><tr><td>Sundays and public holidays</td><td>None</td><td>None</td><td>All day</td></tr></table></td></tr>
<tr><td>Allied health professional</td><td>A health professional who collaborates with doctors and nurses to provide optimal healthcare for patients, for example physiotherapist, dietitian, podiatrist</td></tr>
<tr><td>Analyte*</td><td>A chemical substance in a fluid or other specimen from the body that is undergoing analysis.</td></tr>
<tr><td>Analytical performance*</td><td>The ability of a Point of Care Testing system to detect and/or measure its intended analyte(s).</td></tr>
<tr><td>Appointment system</td><td>The system that a practice uses to assign consultations to patients and practitioners</td></tr>
<tr><td>Artificial intelligence (AI)</td><td>Artificial intelligence (AI) describes the machine simulation of human cognitive capabilities such as learning, reasoning or problem-solving, and self-correction(1). It encompasses a range of technologies, such as machine learning, deep learning, natural language processing, robotics, chatbots, image recognition and machine vision, and voice recognition(2).</td></tr>
</table>

Term	Definition
Artificial intelligence (AI) scribe	A tool that can automate parts of the clinical documentation process for a medical practitioner. AI scribes can convert a conversation with a patient into a clinical note, summary, or letter that can be incorporated into the patient's health record. Also referred to as: digital scribes, virtual scribes, ambient AI scribes, AI documentation assistants, and digital/virtual/smart clinical assistants.
Backup	A copy of all the files stored on a computer's or server's hard drive made onto another device such as a portable drive or an offsite server
Bias*	A quantitative measure of inaccuracy or systematic departure from accuracy under specified conditions of analysis.
Buddy system	A system that enables a 'buddy' to follow up results and correspondence or continue the care of patients on behalf of an absent colleague
Calibration*	The process of testing and adjustment of an instrument, kit or test system, to provide a known relationship between the measurement response and the value of the substance being measured by the test procedure.
Care outside of normal opening hours	Clinical care that is provided to the practice's patients when the practice is normally closed
Carer	People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged[3].
Chaperone	An impartial observer to a consultation between a practitioner and a patient
Clinical decision limits*	Specific cut-off points or limits for decision about diagnosis or well-defined specific actions, based on guidelines from expert groups.
Clinical governance	A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of a patient's care, from one professional person or group to another
Clinical indicator	A measure, process, or outcome used to assess a particular clinical situation against the RACGP's *Standards for general practices*, and determine whether the care delivered was appropriate

Term	Definition
Clinical information system	Software used in general practice to perform a range of clinical and administrative functions including the management of patients' personal details, histories, recalls and reminders, medications and prescriptions, referrals and reports, diagnostic correspondence and clinical decision support. They also assist with quality improvement by facilitating clinical audits.
Clinical information	This relates to all information the practice receives regarding their patients. It could include (but is not limited to) pathology results, imaging reports, investigation reports, discharge summaries and letters received from other doctors and all other clinical correspondence. It could be delivered via email, phone call, encrypted message and mail, among other forms of communication.
Clinical risk management system	A system to manage the risk of errors and adverse events in the provision of healthcare
Clinical significance	A way of referring to an assessment of: • the probability that a patient will be harmed if they do not receive further medical advice, treatment or other diagnostics • the likely seriousness of the harm
Clinical team	All members of the practice team who have health qualifications that qualify them to perform clinical functions (including doctors, nurses, workers, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and allied health care professionals)
Code of conduct	A set of principles that characterise good practice and explicitly state the standards of ethical and professional conduct that professional peers and the community expect of members of the practice team
Cold chain management	The system of transporting and storing vaccines from the place of manufacture to the point of administration to keep the vaccines within the temperature range of 2–8°C
Communicable disease	An infectious disease that is transmissible from one person to another, or from an animal to a person, by: • direct contact with an infected person • direct contact with an infected person’s discharges • indirect means
Complaint	Any verbal or written expression of dissatisfaction or concern with an aspect of the general practice. A complaint may be made using, for example, a complaints process, consumer surveys or focus groups

Term	Definition
Comprehensive care/ Comprehensiveness[a]	The coordinated delivery of the total health care required or requested by a patient. 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. Comprehensiveness ensures services are not limited by body system, disease process or service site. [a] This use of 'comprehensiveness' in this definition is not intended to change the requirements for general practice as a speciality or for training purposes. This definition is to be used for practice accreditation. For training and achieving Fellowship the definition of Comprehensive Australian general practice must be used.
Confidentiality	The act of keeping information secure and/or private, so that it is only ever disclosed to an authorised person
Consequence	The effect that an event had, has, or would have, on one or more of the practice's objectives
Consultation note	A note in a patient's health record, made during or after a consultation, that contains relevant information about the consultation
Consumables*	Products required to perform a test, such as cartridges, reagents, calibrators.
Consumer	A person who uses a health service, or someone who provides support for a person using a health services. Consumers can be patients, carers, family members or other support people. As a collective, consumers are referred to as a community.
Consumer engagement	When consumers, are meaningfully involved in decision-making about health service design, care and treatment.
Consumer representative	A consumer who has taken up a specific role to provide advice on behalf of consumers, with the overall aim of improving health care[4]
Continuing Professional Development (CPD)	Educational activities endorsed by the RACGP that lead to improved quality of clinical care
Continuous care / Continuity of care	When a patient experiences a series of discrete healthcare events and/or services that are coherent, connected and consistent with their medical needs and personal circumstances

Term	Definition
Contracted members of the practice team (Contractors)	Individuals who: • provide specific services at the practice but are not directly employed by it • typically work under a service or consulting contract and have autonomy in managing their work • do not receive paid leave entitlements from the practice that employed members do, for example leave entitlements, superannuation. They may be independent contractors, freelancers, or part of an external service provider.
Controls*	The material used to perform quality control testing.
Cooperative	A group of general practices that have an arrangement to work together to provide care to patients outside the normal opening hours of their practices
Cultural background	Details of a patient's cultural heritage that the practice has collected and recorded
Cultural safety	The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs
Current, evidence-based guidelines and standards	Guidelines and standards that use a broad evidence base, are peer reviewed and endorsed by the general medical sector, for example research and tertiary education institutions, peak bodies such as medical colleges and government agencies.
Cyber	Relating to or characteristic of the culture of computers, information technology, and virtual reality.
Cybersecurity incident	A cybersecurity incident is a malicious ICT event that can involve an attempt to steal data, money, intellectual property, destroy data, or prevent computers or networks from operating. General practices hold valuable data and so are particularly vulnerable to cybersecurity attacks and are a target for cybercriminals
Demographic	A particular sector of a population
Digital communications	The electronic exchange of information using digital technologies. Digital communications include, but are not limited to, the practice's use of email, SMS and electronic messaging apps, electronic health records, patient portals, mobile health apps, and remote patient monitoring.

Term	Definition
Digital health technologies	The use of digital technologies and platforms to deliver healthcare services remotely or enhance in-person care, such as telehealth, mobile health apps, patient portals, remote monitoring devices, and secure messaging platforms.
Disability	Term for any or all of the following components: • Impairments resulting in problems in body function or structure • Activity limitations resulting in difficulties in executing activities • Participation restrictions resulting in problems in involvement in life situations
Discrimination	Different treatment or consideration of a patient based on particular characteristics (such as gender, age, ethnicity or religion). Positive discrimination enhances the care given to the patient, and negative discrimination potentially reduces, or does reduce, the quality of that patient's care
Duty of care	The legal obligation to safeguard others from harm while they are in the care of clinicians, using practice services, or otherwise exposed to the practice's activities
Electronic communication	The transfer of information (including, but not limited to, patient health information) within or outside the practice using clinical information systems, email, internet communications, text message or facsimiles
Emergency	A serious, unexpected, and often dangerous situation requiring immediate action, including natural, public health and patient emergencies
Emergency contact	The person whom a patient has nominated to be contacted in an emergency
Employed members of the practice team (Employees)	Individuals who work directly for the practice under a formal employment agreement. They receive wages, benefits, and are generally subject to the practice's management and policies, with their working hours and responsibilities directly controlled by the practice.
Encryption	The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity
Enrolled nurse	A nurse who works under the direction and supervision of a registered nurse as stipulated by the relevant nurse registering authority, but remains responsible for their own actions and accountable for the delegated nursing care they provide
Environmental cleaning	The process of removing all visible dust, soils and other material from a surface

Term	Definition
Environmental-impact metrics	Methods for assessing environmental impact, such as observations, routine practices, and periodic reviews. These may include identifying areas of high energy use, adopting energy-saving habits, and discussing efficiency improvements with staff
Ergonomic assessment	The process of evaluating the extent to which a workstation and workspace is designed to minimise the risk of injury and to maximise productivity. This is also referred to as a workstation assessment
Ethical dilemma	The need to choose between two courses of action, both of which will result in an ethical principle being compromised
Ethics (or code of ethics)	The principles adopted by an organisation to ensure that all its decisions and actions conform to normal and professional principles of conduct
External quality assurance program*	An external program enabling a practice to compare Point of Care test results with a reference sample.
Ethnicity	Details of a patient's ethnicity that the practice has collected and recorded
Firewall	Security software that prevents unauthorised (and usually external) access to information stored on a private network, and controls the flow of data according to specific rules defined by the practice
Follow up	Activities that are the logical and responsible steps to take after taking earlier related actions, including: • making a phone call to find out the status of tests and results that are expected but not yet been received • contacting a patient to discuss a report, test or results
Gender	Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. 'Non-binary' is an umbrella term describing gender identities that are not exclusively male or female
General practice	The provision of GP-led, comprehensive, patient-centred, whole-person and continuous primary care to individuals, families and communities

Term	Definition
General practitioner (GP)	A registered medical practitioner who: • is qualified and competent to provide general practice anywhere in Australia • has the skills and experience to provide comprehensive, patient-centred, whole-person and continuous primary care to individuals, families and communities • maintains professional competence in general practice
GP-led	GP-led care refers to primary healthcare services: • that are clinically governed primarily by one or more GPs • have GPs who are physically present and provide patient consultations in person on a regular and ongoing basis.
Hard copy	A physically printed or written document, including records, information, or data.
Hardware	The physical components of a computer, including monitors, hard drives and central processing units
Harm	A damaging effect on a person, such as disease, injury, suffering, disability or death. Harm may be physical, social or psychological
Health information	A subset of a patient's personal information that is collected in connection with the provision of a health service. It includes information or opinions about the health or disability of an individual, and a patient's wishes about future healthcare and health services
Health outcome	The health status of an individual, group of people or specific population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals, for example nurses and specialists
Health promotion	The process of enabling people to improve and increase their control over their health. As well as influencing an individual's behaviour, it also encompasses a wide range of social and environmental interventions
Health summary	Documentation usually included in a patient's health record that provides an overview of all components of the patient's healthcare, for example current medications, relevant past health history, relevant family history, allergies and adverse drug reactions
High-risk results	Clinical test results that are seriously abnormal and life-threatening and need to be communicated in an appropriately timely manner

Term	Definition
Home visit	A general practice consultation conducted in the patient's (or someone else's) home
Human research ethics committee (HREC)	A committee constituted according to National Health and Medical Research Council requirements that reviews applications from people or organisations undertaking research projects involving human subjects
Human resources	People who work in an organisation OR An area of business management that addresses the recruitment, training and management of the people who work in an organisation
Hybrid patient health record	A combination of digital clinical information systems used by one or more practitioners to enter patient information
Incident	An event or situation that resulted, or could have resulted, in: • unintended and/or unnecessary harm to a person • a complaint, loss, damage or claim for compensation
Inactive patient	A patient who has not attended the practice/service on three or more occasions in the past two years
Indemnity	Provides security or protection against a loss or other financial burden. Medical indemnity insurance is a compulsory condition of registration for all medical practitioners in Australia
Individual healthcare identifier	A patient's unique 16-digit number allocated by the Department of Human Services (each eligible Australian patient who seeks healthcare is allocated one)
Induction program	A structured process designed to welcome and orient members of the practice team and introduce them to the practice's systems, processes and structures
Infection	The invasion and reproduction of pathogenic (disease-causing) organisms inside the body that can cause tissue injury and can lead to disease
Infection control measures	Actions to prevent the spread of pathogens between people in a healthcare setting
Information and Communication Technology (ICT)	Technological tools and systems used to transmit, store, create, share, and access information, encompassing both computer hardware and software, as well as telecommunication networks, enabling effective communication and information exchange across various platforms

Term	Definition
Information management	The policies, processes and systems that govern the creation, use and storage of information
Information security	The protection of the confidentiality, integrity and availability of information
Instrument*	A testing platform, system or device
Interpreter service	A service that provides trained language interpretation or translation, either face to face or by telephone or digital communication
Informed consent	The written or verbal consent that a patient gives to the proposed investigation, proposed treatment, or invitation to participate in research, when they understand the relevant purpose, importance, benefits and risks. For consent to be valid, several criteria need to be satisfied, including the: • patient having received and understood sufficient and appropriate information, and being aware of the material risks • patient having the mental and legal competence to give consent
Informed refusal	A patient's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment
Innate variations of sex characteristics	'Variations of sex characteristics' refers to people with innate genetic, hormonal or physical sex characteristics that do not conform to medical norms for female or male bodies. It refers to a wide spectrum of variations to genitals, hormones, chromosomes and/or reproductive organs. Other umbrella terms used to describe being born with variations of sex characteristics are 'intersex' or 'differences/disorders of sex development'
In-person consultation	a physical consultation between a medical practitioner and a patient. This could be conducted at the general practice premises, via a home visit, at a hospital or aged care facility.
Intersex	People who are born with genetic, hormonal or physical sex characteristics that are not typically male or female
Intravenous consumables	The equipment used to administer fluid or medications intravenously. For the purposes of the practice equipment and doctor's bag, these include cannulas or butterflies, bungs, film dressing or tape, but does not necessarily include fluids.
In vitro*	Outside the body; in a clinical or research laboratory; in an artificial environment such as a test tube or petri dish

Term	Definition
In vitro diagnostic medical device (IVD)*	A medical device (including a reagent, calibrator, control material, kit, specimen receptacle, software, instrument, apparatus, equipment or system) used in vitro (whether alone or in combination with other diagnostic goods) to examine specimens from a human body
Issue	A relevant event that was not planned, such as a problem, query, concern or risk, and requires action
LGBTIQA+	Initialism for lesbian, gay, bisexual, transgender, intersex, queer and asexual, or other gender and sexual diversities
Lifestyle risk factors	Habits or behaviours that people choose to engage in that, if changed, can directly affect some medical risk factors by reducing the likelihood of developing disease
Medical consumable	A medical product used for a therapeutic purpose that is not pharmaceutical and is not re-usable, for example a syringe
Medical deputising service	A service that arranges for, or facilitates, the provision of medical services to a patient by a medical practitioner (deputising doctor) during the absence of, and at the request of, the patient's GP (principal doctor)
Medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered[5].
Member of the clinical team	An individual member of the practice team who has health qualifications that qualify them to perform clinical functions (including doctors, nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, and allied health care professionals) See clinical team
Member of the practice team	An individual member of the practice team See practice team
Mission	The fundamental purpose of an organisation that sets the direction for daily operations

Term	Definition
Natural disaster / emergency	A situation caused by natural events, like floods or fire, which significantly disrupts normal operations and poses a threat to the safety of patients, members of the practice team, and/or the practice.
Natural immunity	Immunity to a particular infection that is not the result of vaccination or previous infection but is inherent in the genetic make-up of an individual, family, etc
Near miss	An incident that did not cause harm, but could have
Network	A group of connected computers and peripheral devices used to store and share information electronically
Next of kin	A person's closest living relative or relatives, as identified by that person
Non-conformance*	Departures from standard procedures, or instances where the process or system does not comply with the predetermined specifications
Normal opening hours	The advertised opening hours of a practice
Nurse	A registered nurse with competence in the provision of nursing care; a registered nurse practices independently and interdependently, and has accountability and responsibility for their own actions and the delegation of care to enrolled nurses and other healthcare professionals
Nurse practitioner	A registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role where their scope of practice is determined by the context in which they are authorised to practice
Open disclosure	An open discussion with a patient and carer about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence.
Operational plan	A plan that sets operational objectives, detailing specific actions and steps necessary to achieve goals strategic goals. An operational plan translates strategic goals into day-to-day activities
Operational objective	Specific, precise actions or steps taken to achieve a goal. Objectives break down goals into manageable parts

Term	Definition
Organisational chart	A description (often presented visually) of an organisation's structure, which includes areas such as departments, division, properties, hierarchies, roles, responsibilities and professional relationships between individuals
Other visit	A general practice consultation in a facility other than the general practice or the patient's home, for example residential aged care facility
Outside of normal opening hours	The hours other than the practice's normal opening hours
Over-the-counter medicine	Medicines that people can purchase from retailers (such as pharmacies, supermarkets and health food stores) for self-treatment
Patient	A person who is seeking or receiving healthcare
Patient centredness	Patient-centeredness places the patient's needs, values and preferences at the forefront of medical decision-making, empowering patients to take an active role in their own healthcare. Patient-centeredness is reflected in a general practice team's understanding that health, illness and disease are ultimately personal experiences, and that the role of the team is to collaborate with patients to support their healthcare.
Patient emergency	Any urgent medical situation experienced by a patient that necessitates immediate assessment and treatment to prevent serious harm or deterioration in health
Patient health information	A patient's name, address, Medicare number and any information (including opinions) about the patient's health. Examples include but are not limited to clinical results, referrals, care plans, incoming and outgoing correspondence and hospital discharge summaries.
Patient health record	Information, held about a patient, in paper form or electronic form, which may include: • contact and demographic information • medical history • notes on treatment • observations • correspondence • investigations • test results photographs • prescription records • medication charts • insurance information • legal information and reports • work health and safety reports

Term	Definition
Performance monitoring	A formal and structured process used to monitor and document an employed member of the practice team's performance in their role
Personal protective equipment (PPE)	Equipment used as an infection prevention and control measure. Includes the use of gloves, waterproof gown, goggles/face shield, mask and appropriate footwear
Point-of-care testing (PoCT)*	Pathology testing performed at the point or time of care that helps healthcare practitioners make immediate and informed decisions about a patient's care
Point-of-care testing practitioners (PoCT practitioners) *	Members of the practice team (including any employee, contractor and practice nurse) who performs PoCT who: • have undertaken training • participate in training and education updates
Policy	A documented guideline that outlines the practice's principles and rules for specific activities or behaviours, for example infection control. Policies need to be documented in either paper or electronic form and be easily accessible by all members of the practice team.
Position description	A document describing an employed member of the practice team's role, responsibilities and conditions of employment
Post-analytical*	Post-testing processes, such as reporting
Practice environment	The facilities or area used for practice operations and providing care to patients. This could include, but is not limited to, a clinic, vehicle or home office.
Practice leadership	This relates to members of the general practice leadership team and could include the practice owner, practice manager or clinical leads.
Practice management	The strategic planning, reviewing and implementation of processes that increase a practice's efficiency and contribute to 'excellence in healthcare'
Practice team	All people who work or provide care within the practice, including employees and contractors
Practitioner/clinician (refer to *Clinical team*)	A member of the practice team who has health qualifications that qualify them to perform clinical functions (including doctors, nurses, Aboriginal health workers, and allied health care professionals)

Term	Definition
Pre-analytical*	Pre-testing processes, such as test requests
Precision*	The measure of the closeness of results obtained after analysing the same sample more than once
Privacy policy	A document formulated by each practice that communicates how they manage patient health information in compliance with the requirements of the Australian Privacy Principes (APPs)
Public health emergency	A widespread threat to public health, often caused by infectious diseases or other hazards, requiring coordinated efforts to control and mitigate its impact on the community
Qualified	Holding the educational or other qualifications required to perform a specific activity, for example to administer first aid, or hold a specific role such as GP or registered nurse
Quality assurance	The maintenance of a desired level of quality in a service or product, especially by attending to every stage of the process of delivery or production
Quality control (QC)*	The set of procedures designed to monitor the test method and the results to assure test system performance. These procedures include testing control materials, charting the results and analysing them to identify sources of error, and evaluating and documenting any remedial action taken as a result of this analysis
Quality improvement	One or more activities undertaken by a practice to monitor, evaluate, or improve the quality of healthcare it delivers
Reagent*	A substance that produces a chemical reaction in a sample that allows an analyte to be detected and measured
Recall	The process of requesting a patient to attend a consultation to receive further medical advice on matters of clinical significance
Reference interval*	The reference interval or range for a particular test is expressed as the average value for the ‘normal’ population group together with the variation around that value (plus or minus two standard deviations from the average). In this way, ranges quoted represent the values found in 95% of individuals in the chosen non-diseased or ‘reference’ group
Referral	The process of sending or directing a patient to another practitioner

Term	Definition
Relevant family history	Information about a patient's family history that the practitioner considers important to provide appropriate clinical care to the patient
Reminder	A prompt to remind patients to visit their general practice or carry out routine or important tasks related to their health
Research	The process of creating new knowledge and / or using existing knowledge in a new or creative way to generate new concepts, methodologies, inventions and understandings. Research in general practice could involve: • direct patient involvement, for example through clinical trials, observational activities, interviews or focus groups • indirect patient involvement, for example through the collection of deidentified patient data.
Respiratory etiquette	Public health measures used to reduce the spread of respiratory infections, such as encouraging people to cover their mouth or nose when coughing or sneezing, use tissues to blow their nose, dispose of used tissues, and wash their hands after touching their nose
Response plan	A plan that specifies how a practice will continue providing services if it is affected by unexpected events that disrupt the continuity of its services, including disruptions to business as usual and emergencies (natural disaster, health emergency, cyber emergency)
Risk	An event or set of events that, if they occurred, would adversely affect the achievement of objectives
Risk management	Systematic application of principles, approaches and processes to: • identify, assess and minimise risks • plan appropriate responses • implement appropriate responses when required
Risk matrix	A matrix used to categorise risks according to their probability and the severity of the effects they would cause
Risk register	A document used to record problems and issues that could result in a risk becoming a reality, and the steps taken to minimise the likelihood or effect of the risk
Safe and reasonable	A desired description of the outcome of a clinical care decision made by a practice that was based on relevant factors, for example the practice's location and patient population, and an understanding of what their peers (or practices in the same area) would agree was safe and reasonable

Term	Definition
Safety	The condition that means potential risks and unintended results are avoided or minimised
Schedule 8 medicines	Drugs that have a recognised therapeutic need and are legally available only by prescription because they are drugs of dependence and therefore have a higher risk of misuse and abuse
Screen*	The examination of asymptomatic people to classify them as likely or unlikely to have a disease
Screensaver	A software program that displays constantly changing images or dims the brightness of a display screen. It is used to: • protect the screen from having an image etched onto its surface • restrict unauthorised access to the computer, and the information displayed on the screen before the screensaver begins
Security	The administrative, technical and physical safeguards in an information system that protect it and its information against unauthorised disclosure, and limit access to authorised users in accordance with an established policy
Server	A computer that provides services to users connected to the network running the server. Services can include printing, access to files and software applications, and central storage of data
Sex	A person's assigned sex at birth, determined by sex characteristics observed at birth or infancy. A person's sex can change over the course of their lifetime and may differ from their assigned sex at birth
Sex characteristics	A person's chromosomal, gonadal and anatomical characteristics associated with sex
Shared decision making	A consultation process whereby the clinician and patient collaborate to make health decisions following discussions about the evidence-base, benefits and harms, and consideration of the patient's preferences, values and circumstances[6].
Significant clinical incident	Any event or circumstance arising during the provision of healthcare, or lack of care, that could have or did lead to unexpected actual harm. Incidents include near misses, sentinel events and unsafe acts.
Sociable hours	The after-hours period from 6.00–11.00 pm on weeknights

Term	Definition
Social media	Online social networks used to disseminate information through online interaction
Standard precautions	Methods and practices that health professionals use to prevent infection of themselves and others, based on the assumption that all blood and body fluids are potentially infectious
Sterile	A condition characterised by the absence of protozoa, spores, mycobacteria, fungi, Gram-positive and Gram-negative bacteria, chlamydia, Rickettsia, mycoplasma and viruses
Sterile barrier system	The packaging for items placed in a steriliser
Sterilisation	A validated process used to render a product free from all forms of viable microorganisms (the nature of microbial death is described by an exponential function, and although the probability that all microbes have died can be reduced to a very low number, it can never be reduced to zero)
Strategic plan	A plan that sets specific goals and the actions needed to achieve those goals. A strategic plan answers the question: "How will we achieve our mission?"
Strategic goals	Overarching goals designed to guide the practice towards its desired future state, which serve as a roadmap for decision-making and resource allocation, helping the practice prioritise actions and align efforts towards achieving its long-term mission
Strategy	A method or plan for an organisation to achieve its short-term, medium-term, and long-term goals
Synchronous care	Care delivered to consumers in real-time that could include telehealth services or face-to-face.
Technology infrastructure	The underlying framework and components that support the functioning of a general practice's telehealth services and other technological needs. This may include hardware like computers, tablets, and medical devices, as well as software for communication, electronic health records, and security protocols. Additionally, it encompasses networking systems, internet connectivity, and data storage solutions to facilitate telehealth consultations and overall operational efficiency

Term	Definition
Telehealth	The use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance. Telehealth services use information and communications technologies to deliver health services and transmit health information over both long and short distances. It is about transmitting voice, data, images and information
Telephone triage	A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care
Test method*	A method or procedure that produces a test result
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers
Tracking and tracing	Part of a sterilisation process that refers to batch control identification of instruments used for a procedure on a patient
Trans and cis	'Trans' and 'cis' are terms that describe the experience or modality of gender (and are used as prefixes to gender, ie transgender and cisgender), rather than a gender label itself. The trans experience occurs when an individual's gender differs from that presumed for them at birth. The cis experience occurs when an individual's gender is the same as what was presumed for them at birth
Transcription errors*	Data entry errors that usually occur because of typographical mistakes when transferring data and results
Transition of care	Transitions of care occur when all or part of a person's health care is transferred between health providers or services, whether temporary or long term.
Transmission-based precautions	Methods and practices that health professionals use to prevent infection of themselves and others, when a patient is known or suspected to be infected with a highly transmissible infection such as influenza and when standard precautions may not be sufficient to prevent infection. Transmission-based precautions include droplet precautions, airborne precautions and contact precautions, and involve the use of appropriate measures such as triage, PPE and isolation
Triage	Patient prioritisation based on where resources can be best used or are most needed
Unique individual identification	A method used to verify a person's identity by ensuring they are uniquely distinguishable from others. This can include passwords, multi-factor authentication, or biometric methods such as fingerprint recognition, voice recognition, or retinal screening

Term	Definition
Unsociable hours	The following after-hours periods: • Weekdays – 11.00 pm – 8.00 am • Saturdays – before 8.00 am and after 12.00 pm • Sundays and public holidays – any time
Urgent	Requiring immediate action or attention
Values	Aspirations and goals for an organisation, which can guide decision making and engage members of the practice team to work toward common goals
Whole-person care	Holistic care is reflected in the interplay between bio-psycho-social contributors to health, and which leads to a deep understanding of the whole person, and the ability to manage complex conditions and circumstances. A general practitioner (GP) functions as a physician, counsellor, advocate and agent of change for individuals, families and their communities.

Preamble

Introduction

The Royal Australian College of General Practitioners (RACGP) has developed the *Standards for general practices* 6th edition (the Standards) to promote a high standard of general practice care by improving the quality and safety of general practices.

Standards of quality and safety are implemented globally to foster excellence in service delivery.

Accreditation against standards seeks to:

- improve patient safety[7],[8],[9]
- promote patient-centredness, including support for patients and inclusion in decision-making[10]
- improve the quality of healthcare[8]
- foster continuous quality improvement[8]
- foster practice safety culture[8],[7]

The Standards support general practices to identify, develop and implement sound and contemporary systems and processes that also provide a framework for continuous quality improvement.

Consumer and practice team experiences and outcomes are central to the Standards.

Evidence-based standards

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

Development of the Standards has drawn on the following sources:

- A comprehensive literature review of current evidence
- Level IV evidence (where studies are not available). Level IV evidence is otherwise known as evidence from a panel of experts. So that this Level IV evidence is as robust as possible, the Standards have been tested by Australian general practices and consumers, overseen by an expert committee consisting of GPs, academic GPs, nurses, practice managers, and consumer representatives
- The Quintuple Aim for health care improvement[11]
- The International Society for Quality in Health Care (ISQua) Guidelines and principles for the development of health and social care standards (6th edition)
- The Department of Health and Aged Care Accreditation arrangements review (2021) and Gap Analysis of barriers to general practice accreditation (2024)
- Feedback from the general practice profession via consultation and piloting of the Standards.

Reflecting the quintuple aim for health care improvement in the Standards

The quintuple aims of healthcare (improving the patient experience, population health outcomes, cost-efficiency of healthcare, provider wellbeing and health equity) provide an evidence-based approach for healthcare improvement. The quintuple aim was foundational to the development of these Standards.

All five elements of the quintuple aim are reflected throughout the Standards.

Patient experience

The Standards reflect that patient experience is upfront in the definition of a general practice for the purpose of accreditation, via the inclusion of patient-centred care. The Standards put patients' needs, values and preferences at the forefront of care to empower them to take an active role in their own healthcare. Criteria related to accessing services, communication with the practice, feedback mechanisms, and practice environment further address patient experience in the Standards.

Population health

The Standards promote preventive care and access to evidence-based services, advocating the use of primary care in communities. A digital and data-based approach to collecting health information as reflected in the Standards helps practices to understand and manage the health of the practice's community, as well as informing continuous quality improvement. Criteria related to health promotion and preventative care and environmental sustainability further address population health in the Standards.

Reducing costs

The Standards aim for a reduction of costs in primary care by encouraging general practices to continuously improve, identify inefficiencies, reduce waste, and effectively allocate resources. By promoting and facilitating the uptake of these Standards across general practices, the Standards help to lessen the burden on the broader healthcare system. The resulting cost savings can be reinvested to enhance patient care and outcomes.

Care team wellbeing

The Standards promote care team wellbeing throughout themes of collaboration and communication, patient care and safety, efficiency and productivity, training and continued professional development. The Standards have practices encourage involvement and input from all members of the practice team and foster a positive culture by supporting their safety, health, and wellbeing. Induction, training and development are ways care team wellbeing is further addressed in the Standards.

Health equity

The Standards promote equitable healthcare through the provision of culturally appropriate care, continued quality improvement principles, promotion of accessible healthcare and optimal management of patient health data. The Standards require cultural competence among practice teams and the recognition and respect for the diversity and individual choices of patients. They also require patient access to the practice and the provision of accessible information and consultation types.

Environmental sustainability in the Standards

Environmentally sustainable measures in a practice safeguard public health, uphold ethical responsibilities and ensure long-term viability. Measures such as reducing energy consumption, minimising waste and promoting environmentally aware practices not only mitigate the practice's impact on the environment but also contribute to improved patient wellbeing and satisfaction.

Environmental sustainability is embedded throughout the Standards. Together with a suite of RACGP resources, the Standards support general practices to implement environmentally sustainable measures. To foster a workplace culture of sustainability, practices should integrate sustainable principles into daily operations and empower staff through clear communication and individual responsibility. Practice change occurs with the involvement of the whole practice team and when the changes are easily understood.

Point-of-care testing in the Standards

The Point-of-care testing (updated 6th edition) standard aims to:

- improve the quality and safety of point-of-care testing (PoCT) performed by health services
- help services identify and address any gaps they have in their systems and processes.

The PoCT standard is included as an appendix to the National Pathology Accreditation Advisory Council (NPAAC) *Requirements for point of care testing (Second Edition 2021).* The Requirements for Point of Care Testing 3rd edition is in development and will refer to the RACGP PoCT standard for general practices (updated 6th edition).

Definition and benefits of PoCT

Point-of-care testing (PoCT) is defined as testing performed outside the laboratory environment, near to or at the side of the patient, which is not done under the supervision of a trained laboratory professional[12]. *

The potential benefits of PoCT in general practice are:

* It is not necessary for a practice to be accredited against the Standards for PoCT to claim simple basic pathology tests (MBS Group P9) with the exception of MBS items 73812 or 73826.

- healthcare practitioners' ability to make immediate and informed decisions about a patient's care, together with the patient, which may result in improved clinical management
- greater patient compliance with pathology requests, especially in at-risk patients
- greater convenience and satisfaction for patients because of the speed of diagnosis, management and treatment decisions
- more equitable access to pathology, regardless of where patients live
- more opportunities for patients to engage with the practice team[13, 14].

Why do we need the PoCT standard?

The sophistication and reliability of the technology for PoCT systems and instruments, make PoCT more accessible for general practices[15]. Fit-for-purpose standards relating to the use of PoCT in general practices aim to ensure that PoCT contributes to the overall safety and quality of care provided in the practice.

Structure of the Standards

Standards, criteria and sub-criteria

- There five standards in the sixth edition. Each standard is assigned a prefix code:
  - F for Foundations of general practice
  - CG for Clinical governance
  - PP for Patient participation
  - CQI for Continuous quality improvement
  - PoCT for Point-of-care testing
- Within each standard, criteria are numbered according to their position in each section and identified with an alphanumeric code. For example, F1.A refers to the first criterion (A) under 'Defining and planning for the practice' in the Foundations of general practice standard.
- Criteria are supported by one or more sub-criteria that describe the key activities, processes or practices associated with that criterion.

Consumer expectation statements

The RACGP has partnered with consumers to create and embed consumer expectation statements to capture consumers experiences of each criterion. Consumer experiences and outcomes are central to the Standards for general practices. Consumer engagement is linked with better patient health outcomes and safer care. The consumer expectation statements guide general practices about what consumers value, need, prefer and expect of them and help ensure decision-making in general practices is patient centred. These statements sit at the beginning of each criterion.

Focus on outcomes and patients

The criteria in the Standards are written with a focus on outcomes and patients.

Patient-centred care is emphasised throughout the Standards by addressing key areas such as recognition and respect for diversity and individual choices, supporting timely and effective care/partnerships, patient access and safety, preventive health measures, and privacy.

By focusing on outcomes, practices can develop systems and processes that reflect their preferred ways of working. This outcome-driven approach fosters greater ownership among the practice team, encouraging consistent adherence to these processes, not just during accreditation assessments, but as an integral part of daily operations.

Structure of explanatory notes

The explanatory notes for each criterion have the following sections:

- *Criteria*
  These are activities the practice needs to complete, or evidence it needs to present.
- *Why this is important*
  This section explains why criteria and sub-criteria are important from a quality and safety perspective.
- *Meeting these criteria*
  This section sets out ways that the practice can choose to meet the relevant criteria and associated sub-criteria.

Terminology

Use of 'patient' and 'consumer'

The Standards refer to either or both patients and consumers throughout criteria and explanatory notes, depending on the intent. The terms 'patient' and 'consumer' are used as follows:

- **'Patient'** is a person who is seeking or receiving healthcare
- **'Consumer'** is a person who uses a health service, or someone who provides support for a person using a health service. Consumers can be patients, carers, family members or other support people
- **'Consumer representative'** is a consumer who has taken up a specific role to provide advice on behalf of consumers, with the overall aim of improving health care.

Use of 'employed' and 'contracted' members of the practice team

The Standards refer to members of the practice team in various ways, at times distinguishing whether criteria or explanatory notes apply to all members of the practice team, employed members only or contracted members only. These terms are used as follows:

- **'Employed members of the practice team (Employees)'** are individuals who work directly for the practice under a formal employment agreement. They receive wages, benefits, and are generally subject to the practice's management and policies, with their working hours and responsibilities directly controlled by the practice.

- 'Contracted members of the practice team (Contractors)' are individuals who:

  - provide specific services at the practice but are not directly employed by it
  - typically work under a service or consulting contract and have autonomy in managing their work
  - do not receive paid leave entitlements from the practice that employed members do, for example leave entitlements, superannuation.

- Contractors may be independent contractors, freelancers, or part of an external service provider.

A member of the clinical team may be an employed or contracted member of the practice team.

Facilitating patient health records

Criteria relating to patient health records may apply to both employed and contracted members of the practice team who engage with the practice under any contractual arrangement. Seek appropriate legal advice if you have any questions or concerns about the applicability of the contractual arrangements between the practice and the clinicians for record keeping and the privacy of patient personal and sensitive information in connection with these criteria.

Reduced citation of federal, state or territory legislation

Legislation is referenced in the Standards only where it is particularly relevant to specific aspects of general practice. However, this document is not intended to comprehensively address legislative obligations. Practices are responsible for identifying and complying with all applicable federal, state, territory, and local laws. While accreditation against the Standards may assist in meeting some legislative requirements, it is not intended to guarantee compliance with all legal obligations.

Required and aspirational criteria

All criteria in the Standards need to be met to achieve accreditation, unless they are marked as aspirational.

The RACGP encourages practices to meet aspirational criteria, but they are not essential to achieve accreditation.

Accompanying resources

Supplementary resources that will help the practice meet criteria are provided in the resource tab of each criterion.

Accreditation

The RACGP supports accreditation as a voluntary scheme.

If a practice wants to be accredited against the Standards, it needs to be formally assessed by an accrediting agency approved under the Australian Commission on Safety and Quality in Health Care (ACSQHC) National General practice Accreditation Scheme (the NGPA Scheme), which commenced on 1 January 2017.

The practice first needs to meet the definition of a general practice for the purpose of accreditation before being assessed against the Standards.

Definition of a general practice for the purpose of accreditation

For a practice or health service to seek accreditation:

- it needs to provide comprehensive, patient-centred, whole-person and continuous care; and
- its services are predominantly* of a general practice nature.

* More than 50% of the practice's general practitioners' clinical time (ie collectively), and more than 50% of services for which Medicare benefits are claimed or could be claimed (from that practice) are in general practice.

The above definition exists solely to identify services eligible to be assessed as a general practice against the RACGP *Standards for general practices* (the Standards) by an accreditation agency approved under the NGPA Scheme. This definition is for the assessment of the environment and systems of quality and safety. There will be some services that are eligible to be accredited against the Standards but that may not be appropriate as training practice locations or eligible for entry into a training program.

The general practice, once acknowledged as meeting the definition, needs to then meet all required criteria in the Standards to be accredited.

GP-led care

Accredited practices need to be General Practitioner (GP) led. GP-led care refers to primary healthcare services:

- that are clinically governed primarily by one or more GPs
- have GPs who are physically present and provide patient consultations in person on a regular and ongoing basis.

To be considered GP-led, GPs need to be involved in the clinical governance of the practice.

It is recognised that in certain practice models or contexts, such as in remote or multi-site services, physical presence may not be feasible at all times. GP-led practices maintain continuous shared care with GPs during times the GPs are not physically present.

Comprehensive care

Comprehensive care is the coordinated delivery and/or facilitation of the total health care required or requested by a patient. 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. Comprehensiveness means services are not limited by body system, disease process or service site.

This use of 'comprehensiveness' in the definition of a general practice for the purpose of accreditation is not intended to change the requirements for general practice as a speciality or for training purposes. This definition is to be used for practice accreditation. For training and achieving Fellowship the definition of Comprehensive Australian general practice is used.

Effective comprehensive care provided in the practice setting can reduce the need for more expensive care provided in hospitals or by other specialists[16],[17]. It is associated with slower growth in health expenditure, as well as better system quality, equity and efficiency[18].

Comprehensive care in the general practice context usually takes the form of a multidisciplinary team of care providers who are wholly accountable for the primary healthcare requirements of the patient[19]. Members of GP-led teams can vary significantly depending on community need, and often include nurses, allied health professionals, practice management and administrative staff[20].

Patient-centredness

Patient-centredness places the patient's needs, values and preferences at the forefront of medical decision-making, empowering patients to take an active role in their own healthcare. Patients are provided the information and health

literacy to help them generate well-informed needs and preferences that are likely to improve health outcomes. Patient-centredness is reflected in a general practice team's understanding that health, illness and disease are ultimately personal experiences, and that the role of the team is to collaborate with patients to support their healthcare.

Whole-person care

Whole-person care is reflected in the interplay between bio-psycho-social contributors to health, and which leads to a deep understanding of the whole person, and the ability to manage complex conditions and circumstances. A general practitioner (GP) functions as a physician, counsellor, advocate and agent of change for individuals, families and their communities.

Continuous care

Continuity of care is when a patient experiences a series of discrete healthcare events and/or services that are coherent, connected and consistent with their medical needs and personal circumstances. Continuity of care is distinguished from other attributes of care because of two key characteristics: it refers to care that takes place over time and focuses on individual patients.

When patients visit the same GP over time, they develop a patient–practitioner relationship, which has been shown to reduce visits to emergency departments and preventable hospital admissions[21].

Patients who have continuity of care with a regular GP:

- report high levels of satisfaction with their experience of care[22]
- have lower rates of hospitalisation and emergency department attendances[23]
- have lower mortality rates[19]
- are more likely to receive appropriate and patient-centred care.

The assessment process

If you want your general practice to be accredited, you must select an approved accreditation agency from the list of agencies available at www.safetyandquality.gov.au/our-work/generalpractice-accreditation

Each accreditation agency has trained surveyors who assess general practices. The agency you select will work with your practice to help you prepare for the accreditation process. They will also appoint a team of surveyors who visit each location from which your practice operates to assess your practice against the Standards.

Surveyor teams

Surveyor teams are comprised of at least two surveyors, one of whom must be an appropriately qualified GP surveyor and one of whom must be an appropriately qualified nurse, practice manager, allied health professional or Aboriginal and Torres Strait Islander health worker/health practitioner with relevant experience in general practice.

Surveyor teams may include a third person, such as a non-health practitioner or consumer who has been appropriately trained in the Standards.

Fair and independent assessments

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

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

Requirements for accreditation agencies and surveyors

The RACGP has developed requirements that accrediting agencies and surveyors must meet in order to be granted permission to use the Standards to assess general practices, as outlined below.

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

Accrediting agencies

To use the Standards, accrediting agencies must have an active license agreement co-signed by the RACGP and agency, and are required to demonstrate the following to the RACGP:

- An in-depth understanding of
  - the Standards
  - the nature of general practice in Australia
  - requirements for training and vocational registration of GPs
- An accreditation assessment framework that includes a single onsite assessment that is conducted once every three years at each location that the practice operates from
- The capacity to efficiently accredit general practices across Australia
- A governance and advisory structure that includes GPs with considerable experience in general practice
- A commitment not to refuse an application for accreditation from a practice that meets the RACGP's definition of a general practice, regardless of location or size
- A commitment not to financially or otherwise discriminate against a practice because of location or size

All surveyors

Surveyors must:

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

GP surveyors

GP surveyors must:

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

Non-GP surveyors

Non-GP surveyors:

- can be an appropriately qualified nurse, practice manager, allied health professional or Aboriginal and Torres Strait Islander health worker or health practitioner
- must have at least five years' full-time equivalent experience, and
  - must be working at least 16 hours a week in an accredited general practice, and have done so for the last two years
  - or
  - have worked at least 16 hours a week in an accredited general practice for at least two years, and not more than two years ago.

Accreditation of a general practice that performs point-of-care testing

To be accredited against the point-of-care (PoCT) standard, a practice needs to:

- meet all required criteria in the PoCT standard in addition to all other criteria in the Standards (The RACGP encourages practices to meet aspirational criteria, but they are not essential)
- be formally assessed against the PoCT standard by an accrediting agency approved under the National General Practice Accreditation Scheme (the Scheme), which commenced on 1 January 2017.

The PoCT accreditation visit can occur concurrently with or after the general practice accreditation visit.

Surveyor teams for the assessment of the PoCT standard

A surveyor team will conduct accreditation visits to assess the practice against the PoCT standard. At least one member of the surveyor team must be trained in applying the PoCT standard in general practice.

PoCT and the Australian Register of Therapeutic Goods

In Australia, PoCT devices and systems are categorised as *in-vitro* diagnostic medical devices (IVDs) and are therefore regulated as a subset of medical devices by the *Therapeutic Goods Administration*.

The *Australian Register of Therapeutic Goods* (ARTG) lists therapeutic goods that can be legally imported into Australia, or supplied for use in Australia, or exported from Australia.

Unless a specific exemption has been granted, it is a criminal offence under the *Therapeutic Goods Act 1989* to import into, supply in or export from Australia a medical device that is not listed on the ARTG.

The PoCT standard assumes that a practice's PoCT devices or systems, including but not limited to consumables, reagents, controls and software, are listed on the ARTG.

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Foundations of general practice standard

The Foundations of general practice standard encompasses the fundamental principles and structures necessary for the effective operation and management of a general practice. This includes defining strategic objectives and goal setting, managing clinical risks, ensuring continuity of services, minimising environmental impact, and implementing IT continuity and security measures. The standard seeks to promote a culture of team involvement, supporting practice team roles and training. These elements form the cornerstone for a well-functioning, viable, and sustainable general practice.

F1 – Defining and planning for the practice

Consumer expectation statement: I expect that this practice has defined mission and values and monitors its progress towards achieving them supported by appropriate and current policies and procedures.

F1.A The practice defines and monitors its mission and values.

The practice:

- defines and documents its mission and values
- has at least one member of the practice team who has primary responsibility for defining the practice's mission and values
- communicates its mission and values to the practice team and consumers
- monitors how its mission and values are reflected in the practice's operation and quality improvement activities.

F1.B The practice maintains a strategic plan and measures progress toward achieving its goals.

The practice:

- documents a strategic plan that includes defined goals and reviews the plan every two years
- has at least one member of the practice team who has primary responsibility for the practice's strategic plan and financial management
- measures its progress toward achieving the defined goals in the practice's strategic plan.

F1.C The practice maintains an operational plan and measures progress toward delivering its objectives.

The practice:

- has a documented operational plan that includes defined objectives
- has at least one member of the practice team who has primary responsibility for the practice's operational plan
- measures its progress toward achieving the defined objectives and how its mission and values are being addressed in the operational plan.

F1.D The practice has a strategic approach to the safe provision of healthcare.

The practice:

- incorporates a strategic approach to safety
- assesses the practice's safety culture using feedback from team members or other appropriate methods.

F1.E The practice's policies, procedures, and operational documents are current, accurate, and accessible.

The practice:

- maintains currency, accuracy and accessibility of policies, procedures, and operational documents
- reviews all policies, procedures and operational documents for currency at least every two years, or as circumstances require
- has a document version control process that assigns responsibility for sign-off and review of documents.

F1.F The practice has processes to consider, reflect on and respond to ethical issues.

The practice:

- facilitates one or more processes for the practice team to consider, reflect on and respond to ethical issues.

Why this is important

Defining a practice's mission and values ensures a consistent culture and purpose, guiding decision-making and aligning strategic and operational plans with core principles.

Clear mission and values statements help prioritise efforts, while a strategic plan ensures intentional, sustainable improvements in care and staff development. Meanwhile, operational plans help embed best practices into daily workflows, fostering efficiency, accountability, and a high standard of care.

By aligning strategy and operations with core values, practices can create an environment where patient needs are consistently met, members of the practice team work cohesively towards shared goals, and decisions are made with clarity and purpose.

Meeting these criteria

Mission and values

Values are lived experiences and actions that reflect a practice's commitment to its stated mission. These could include how the practice embeds:

- a culture of continuous quality improvement
- its code of ethics, outlining the core principles and beliefs that guide the practice and set the tone for its culture
- patient and consumer empowerment
- cultural competence
- the adoption of innovation in healthcare delivery
- empathy and compassion
- engagement and collaboration with members of the practice team, consumers, and the community.

Promoting the practice's mission and values to the practice team is important for alignment, motivation, and productivity. To do so, the practice could:

- communicate the practice's strategic goals and objectives through regular channels, such as team meetings, emails, internal memos, and digital discussion groups such as WhatsApp, and invite input from the practice team to support alignment and engagement
- for employed members of the practice team, assess how well those members reflect the practice's values and ethics in their performance evaluations
- provide ongoing training to help the practice team understand the practice's goals and objectives and encourage the practice team to participate in reflective discussions to further inform these.

Strategic plan

The practice's strategic plan could address at a high level the plans for the practice in terms of service development, financial goals, outcome goals, and delivery of safe and high-quality care. The practice's strategic plan is an operational document and needs to be reviewed for currency every two years.

To develop a strategic plan, the practice could:

- assess its current operational and financial performance
- identify and document key areas where improvements are needed
- set goals that are specific, measurable, achievable, relevant and time-bound
- determine a timeframe to review and refresh its goals.

To measure progress toward the goals set in the strategic plan, the practice could:

- define and track measurable key performance indicators related to its goals
- use benchmarking data to identify areas of improvement in the practice
- conduct strategy review meetings with relevant members of the practice team
- collect and assess feedback from the practice team and consumers.

Operational plan

To measure progress toward the objectives set in the operational plan, the practice could:

- monitor key performance indicators to see how its day-to-day activities align with operational objectives
- set and track the completion of milestones within objectives
- implement performance dashboards that can give real-time updates on operational metrics, and use these to identify areas for attention
- include discussion of operational objectives at team meetings
- audit key processes for efficiency and effectiveness.

Including interdependencies with external organisations, for example public health units, PHNs, in the operational plan can streamline referrals and access to resources. Incorporating communication strategies also helps align the team with operational goals.

The practice's operational plan is an operational document and needs to be reviewed for currency every two years. It may not require major changes when reviewed but needs to be updated when relevant changes are identified.

Strategic approach to safety

Embedding safety into the practice strategy plan supports a proactive practice-wide focus on the safe, high-quality care. Strategies that address safety as a core element of the practice's planning, leadership and culture could include:

- assigning clear responsibilities for safety leadership
- setting safety-related goals
- outlining workforce training needs
- identifying indicators for monitoring safety performance.

Assessing safety culture

Assessing the safety culture of the practice helps leaders understand how well safety is supported by team behaviours, values, and attitudes. Safety culture assessments could involve:

- members of the practice leadership team observing how members of the practice team implement safety strategies in their daily activities, for example risk mitigation, infection prevention and control, privacy measures
- conducting surveys or focus groups with the practice team regarding their confidence in the practice's:
  - general safety processes, for example in infection prevention and control, privacy, information technology
  - risk management and reporting systems
  - incident management and reporting systems
  - protocols for supporting team members to provide safe care.

Currency, accuracy and accessibility of policies, procedures, and operational documents

The document control process needs to include naming conventions, versioning, and clear responsibility for review and sign-off.

Reviewing for currency needs to happen every two years or as circumstances require.

The practice could:

- implement centralised document storage, for example using a digital folder such as Google Drive, SharePoint, or a practice management system, inducting staff on where to find the latest versions. Such systems allow a practice to allocate access to authorised members of the practice team
- use clear naming conventions for documents that includes the document name, version number, date of last update, assigned reviewer and next review date
- setup reminders to prompt review of documentation
- discuss key documents and required updates at team meetings.

Ethical issues

Processes for the practice team to consider, reflect on and respond to ethical issues that arise could include:

- how to maintain professional boundaries. Examples include where members of the practice team know patients outside of the practice, or when offered gifts by patient

- how to manage confidentiality in the waiting room
- how legal obligations are performed ethically, for example, release of notes to child protection agencies
- staff requests for appointments, including for workplace injuries.

While a formal mechanism for considering ethical issues is not required, the following approaches could be implemented:

- Encourage open communication – Fostering a culture where members of the practice team feel supported in raising and discussing ethical concerns, through clear practice policies.
- Provide education and support – Offering training on ethical decision-making, including case-based discussions and reflective practice sessions.
- Facilitate ethical discussions – Incorporating ethical considerations into team meetings or clinical case reviews to address challenges proactively.
- Establish ethical guidelines – Developing clear policies that provide guidance on managing ethical dilemmas, such as patients who are also staff or known to practice members.
- Develop and maintain ethical issues register – Recording ethical issues that arise in practice, along with actions taken, to support reflection, transparency, and continuous learning.
- Seek external expertise – Consulting medical defence organisations or ethics advisory services when complex ethical issues arise.

Resources

- The RACGP *General Practice Business Toolkit* includes various modules that guide establishment, management and enhancement of general practices.
- Business.gov.au provides details and a template to develop a business plan.
- Business.gov.au provides guidance to manage risks, detailing aspects of insurance, health and safety laws and cyber security.
- Ahpra's *Good medical practice: a code of conduct for doctors in Australia* addresses the observation and practise of ethical conduct principles.

F2 – Response planning

Consumer expectation statement: I expect that this practice has appropriate response planning in place to coordinate ongoing high quality and safe care during emergencies and unexpected events.

F2.A The practice has a tested response plan for disruption to the continuity of its services, including from unexpected events, emergencies, and interruptions to business as usual.

The practice:

- documents its processes for how it prepares for, responds to and recovers from unexpected events
- has at least one member of the practice team who has primary responsibility for its response and emergency processes
- makes the practice team aware of plans for preparedness and response to unexpected events
- has a process for the clinical team to continue delivering care, if feasible and only as a backup process in the event of an emergency if information and communication technology (ICT) is not functioning
- tests its response plan.

Why this is important

Just as clinical risks need to be managed, so too do risks related to running a practice. If a practice is unable to operate due to a disruption to business as usual or emergency, it will not be able to provide clinical care.

Practice preparedness for disruptions to regular operation will help to provide effective continuity of care for patients, and to permit the business to continue to operate as smoothly as possible.

Meeting these criteria

Response planning

The practice could adopt an all-hazards risk-based approach to response planning, specific to its location and what it considers to be unexpected events. This may include:

- clinically related emergencies
- infrastructure
- information technology
- equipment and power failures
- cyber attacks
- interruptions in communications
- loss of access to the practice
- staff shortages.

Rather than creating detailed plans for every scenario, practices could focus on building core capabilities and systems that enhance their overall readiness, both for everyday disruptions and larger emergencies.

Delivery of care during unexpected ICT outages

If an unexpected ICT outage occurs, the practice needs to have a process so that the clinical team can continue delivering care to patients without reliance on digital systems and tools. This process could include:

- a manual appointment and documentation process, for example, the temporary use of paper-based clinical notes, prescriptions and referrals that can be scanned or transcribed when ICT is functioning
- alternative communication methods, such as backup phone lines or mobile devices for internal and external communication
- a hard copy emergency contact list for IT support, vendors, and relevant members of the practice team.
- using local backup systems that allow data to be accessed offline, if necessary
- training members of the practice team on procedures for handling ICT outages and document retrieval.

Emergency planning

Emergencies may include natural disasters, health crises, patient emergencies, and critical incidents. Examples include fire, floods, pandemics, anaphylaxis, death of a team member. Each practice needs to tailor its planning to its local environment and risks.

Refer to Part B – Emergency planning and response, in *Managing emergencies in general practice*, for detailed guidance on preparing an emergency response plan.

Testing response plans

The practice needs to regularly test its plans for effectiveness. This could involve:

- running mock scenarios, for example ICT outages, pandemic response
- conducting emergency drills, for example fire, clinical emergencies
- testing ICT resilience, for example simulating cyberattacks or access issues
- reviewing responses to real disruptions to identify strengths and areas for improvement.

Review of response plan

The practice's response plan is an operational document and needs to be reviewed for currency every two years (see criterion F1.E).

Resources

- The Emergency Response Planning Tool (ERPT) – A subscription-based tool to support planning and recovery from emergencies and pandemics.
- RACGP *Managing pandemics in general practice* – Guidance and templates for pandemic planning and response.
- RACGP *Disaster resources for general practice* – Factsheets on different disaster types and how to manage them.
- RACGP *Information for GPs in disaster-affected areas* – Support, financial assistance, self-care, accreditation, and community resources. The RACGP also provides evacuation centre resources.
- AJGP published *Situation report: Australian general practitioners in disaster health management*[24] – Overview of how GPs integrate into broader disaster response systems, with examples of PHN-led initiatives.

F3 – Environmental sustainability and responsibility

Consumer expectation statement: I expect that this practice is aware of its environmental impact and is focussed on minimising this.

F3.A The practice is aware of and takes steps to minimise its environmental impact.

The practice:

- documents strategies aimed at improving its environmental impact and to reduce direct and indirect carbon greenhouse gas emissions.

F3.B The practice has at least one member of the practice team who has primary responsibility for environmental sustainability in the practice.

The practice:

- has at least one member of the practice team who has primary responsibility for engaging in and promoting the environmental sustainability of the practice.

Why this is important

Climate change is a key public health issue and poses risks to healthcare infrastructure and service delivery[25, 26]. Environmentally sustainable measures in a practice can safeguard public health, improve patient wellbeing and satisfaction, uphold ethical responsibilities, reduce operational costs, and protect the long-term viability of a practice.

Embedding sustainability and personal agency within relevant aspects of the practice and clearly communicating this to the practice team fosters a workplace culture of sustainability.

Meeting these criteria

Environmental sustainability

The practice team can support existing sustainability measures and actively contribute to minimising the practice's environmental footprint. Practice change occurs when the whole practice is involved, and changes are understood and easily implemented.

General energy use makes up the largest component of the non-clinical carbon footprint of general practice. There are many ways the practice might avoid unnecessary energy use and increase efficiency. These actions can save the practice money.

When considering the practice's policy outlining measures to address its environmental impact, some key areas of focus and examples of practical measures to address environmental impact are included in **Tables 1 and 2** below. **These examples are provided as suggestions for ways the practice could meet criterion F3.A**. They have been adapted from the RACGP's *Greening up: Environmental sustainability in general practice*, which can be referred to for further detail.

Table 1 contains suggestions any general practice can undertake, many of which focus on behavioural, operational, or team-based actions that do not require building ownership.

Table 2 contains suggestions relevant to owner-occupied practices, or practices with significant control over their premises. These include actions related to building upgrades, energy sourcing, and water systems, which may not be feasible for tenants without landlord cooperation.

Table 1 Key non-clinical actions for an environmentally sustainable general practice

Sustainability component	Possible actions
Workplace culture	• Promote effective leadership on sustainability and encourage behavioural change by appointing 'climate champions' or a 'green team' • Educate and support consumers using digital posters, which help alert them to the effects of climate change on physical and mental health.
Energy: Heating, ventilation and cooling (HVAC)	• Adjust the practice's thermostat for the season, aiming to meet the recommended heating, ventilation, and air conditioning (HVAC) settings for maintaining acceptable comfort conditions with reasonable energy efficiency (for winter 20–22°C and for summer 24–26°C). • Consider the best times for HVAC so that appropriate temperatures are reached when employees and consumers arrive and leave the practice (based on the season).
Energy: Appliances and lighting	• Review the energy rating of all appliances and prioritise energy efficiency when purchasing appliances. • Install timers or motion sensors for lighting and other power outlets (such as instant hot water in the kitchen), where possible and safe to do so. • Turn off computers and screens when not in use; turn off standby power at the end of each day by turning off all appliances at the wall or power board. • Embed energy-saving processes either manually through work protocols or via building management systems. • Change globes to LEDs (these use up to 75% less energy than halogen globes).
Travel	• Encourage members of the practice team and consumers (when appropriate) to use methods of transport other than cars, such as walking, public transport or cycling. • Encourage cycling by providing bike racks and change facilities. • Provide patients with public transport options, routes and timetables. • Ask members of the practice team to consider alternative/active transport and explore car-pooling. • Be a role model by using alternative/active transport. • Have a dedicated 'green team' to promote active and alternative transport. • Lobby local governments to provide electric vehicle charging stations.
Professional services	• Choose services – phones, computers, IT support, finance, accountancy, payroll, insurance, etc. – with a smaller environmental footprint.
Minimise e-waste	• Avoid purchasing new electronic products that can't be reused or recycled. • Reduce the consumption of electronic devices by repairing broken equipment before purchasing new items. • Re-use electronic devices by donating items to charity, friends or family. • Discard e-waste responsibly, including by engaging a recycling company to collect various types of e-waste for recycling or dropping off e-waste at organisations that offer recycling free of charge. • Develop an e-waste recycling policy using the RACGP template.
Reducing paper usage	• Move to e-prescribing, where practical for patients. • Use recycled paper. • Reduce junk mail by putting a 'No junk mail' sticker on the practice's mailbox. • Replace printed material with digital alternatives.

	• Subscribe to online editions of journals rather than ordering printed copies. • Discourage laminating materials.
Carbon offsets	• After reducing all possible emissions, consider purchasing carbon offsets to achieve net-zero emissions – many companies offer carbon offsets with a range of validation and verification standards.
Water efficiency	• Use products (such as dishwashers and fridges) with a high water-efficiency rating. • Only run the dishwasher when it is full.
Recycling	• Place recycling bins, including for food waste, either in each room or in a common area. • Make sure recycling bins aren't contaminated with non-recyclable waste, perhaps by displaying informational posters from local council. • Use recycled products, such as paper, toilet tissue and toner cartridges, as much as possible. • Do not fill medical waste bins with materials that could be recycled or disposed of in regular waste because disposing of medical waste is costly and resource intensive. • Consider what other items can be recycled, for example batteries, light globes and soft plastics.
Waste management	*Note that from an infection prevention and control perspective, waste management is addressed at criterion CG9 – Infection prevention and control, including reprocessing, which requires practices to maintain an up-to-date practice-specific infection control policy that contains waste management and includes the following options:* • Consider choosing reusable items over single-use plastics and packaging to reduce waste generation • Reuse materials where possible • Engage in responsible disposal, which includes: – disposing of hazardous waste correctly – using recycling services for specific materials. This could include using recycling companies that specialise in processing materials like electronics, textiles, and metals. • Implement a workplace recycling policy, establishing guidelines for recycling using templates from local environmental agencies. • Inform members of the practice team about programs on waste management and sustainability.
Business planning	• Embed sustainability in business planning and incorporate sustainability goals in financial objectives. • Perform an audit of energy/carbon emissions to set a benchmark and establish a framework to reduce emissions based on data. Use a free online carbon-footprint calculator. Professional audits can be expensive and are unlikely to be cost effective for smaller practices. • Include sustainability as a standing item at practice meetings.
Disaster management	• Prepare for potential disasters by assessing and planning for threats related to climate change, such as extreme heat, flooding or bushfires. The RACGP has resources and guides to help manage, prevent, prepare for, response to and recovery from emergencies and pandemics.

Table 2 Key non-clinical actions for an environmentally sustainable general practice – Owner-occupied practices

Sustainability component	Possible actions
Energy: Heating, ventilation and cooling (HVAC)	• Regularly clean and maintain the HVAC for maximum efficiency, including regularly cleaning filters). • Consider methods for reducing demand of HVAC, including: – improved building insulation – high-performance window glazing – natural ventilation – external window shading – appropriate window coverings • Consider an upgrade if the HVAC system is more than 10 years old.
Energy: Sourcing renewables	• Consider changing energy source to 100% renewables (or at least some percentage if cost is inhibitive). See green-energy providers on the GreenPower website. • Consider converting from use of gas to electricity. • If the practice owns its premises, consider installing rooftop solar.
Water efficiency	• If the practice has a garden, plant sustainable and drought-resistant plants. • Install rainwater tanks or grey-water systems. • Install low-water-use toilets. • Promptly repair water leaks.

F4 – Induction, training and supporting performance

Consumer expectation statement: I expect that the team at this practice has a clear understanding of their roles and are appropriately managed and trained.

F4.A The practice inducts members of the practice team.

The practice:

- has a system to induct members of the practice team
- has at least one member of the practice team who has primary responsibility for inducting members of the practice team.

F4.B Employed members of the practice team are trained to perform their role in the practice.

The practice:

- trains employed members of the practice team about their role when they start working at the practice and provides ongoing training to address continued competency and adaptation to changes
- trains employed members of the practice team so that they work within the scope of their role
- confirms that employed members of the practice team have completed training appropriate to their role and the practice's patient population.

F4.C The practice discusses professional development with each employed member of the practice team.

The practice:

- supports employed members of the practice team via discussions about professional development
- documents discussions about professional development, agreed actions and ongoing development needs.

F4.D Members of the practice team are certified at least once every three years to perform cardiopulmonary resuscitation (CPR).

The practice:

- has evidence that members of the practice team complete CPR training at least once every three years.

Why this is important

Induction program

All employed staff and contractors must undergo a routine induction when they commence work to understand:

- the practice's mission, values, and strategic and operational plans
- day-to-day operations, including systems, policies, and procedures
- workplace health and safety (WHS) requirements
- privacy and confidentiality at the practice
- use of practice equipment and ICT for clinical and non-clinical team members
- recall and reminder systems
- key public health regulations
- local health and community services, for example pathology, hospitals, referral networks.

Discussing performance

Performance discussions:

- offer a valuable opportunity for employees and managers to provide feedback, set goals, and align on expectations, which can lead to improved performance and personal development
- help to identify strengths and areas for improvement, fostering better communication and understanding within the team.

Meeting these criteria

Roles and responsibilities

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

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

Staff could sign their position description to indicate that they understand their role and responsibilities. Position descriptions could be reviewed regularly to keep them up to date and to make sure employed members of the practice team understand their role and responsibilities.

While induction is needed for contracted members of the clinical team, they are not required to sign position descriptions.

Induction and training

Induction and training equip members of the practice team with essential knowledge and skills. Training is a continuous process. Regular training is needed to achieve competency in changes in the practice processes, systems, and equipment.

Professional development

A strong professional development culture enhances employee growth, satisfaction, and capability.

Effective professional development includes:

- having a clear framework with scheduled discussions and defined objectives
- setting realistic goals aligned with individual and practice needs
- tracking progress and recognising achievements
- having mechanisms for two-way feedback and open dialogue
- identifying learning opportunities, such as training and mentoring.

Managers need to document key discussions, actions, and development needs. These conversations are collaborative and separate from salary reviews.

Training in responding to abuse and violence

Training the practice team to recognise and respond to issues like domestic and family violence, child abuse and neglect, and sexual assault is essential for compassionate and effective patient care. It builds confidence and supports a coordinated response.

The practice could:

- arrange training and education with experts in domestic violence, child protection, and trauma-informed care
- develop guidelines, referral pathways, or response frameworks
- encourage open discussion across clinical and non-clinical members of the practice team for shared understanding.

Many HealthPathways portals provide response protocols, referral contacts, and decision support tools for training in these areas. Additional resources are included in Resources.

Cardiopulmonary resuscitation (CPR) training

CPR training needs to:

- be conducted by an accredited training provider who holds a current CPR instructor's certificate that complies with Australian Resuscitation Council (ARC) guidelines on instructor competencies

- comply with ARC guidelines
- include the operation of an automated external defibrillator (AED) according to manufacturer's instructions
- require trainees to physically demonstrate their skills and competency at the completion of the CPR course.

A whole-of-practice approach to CPR training can build team confidence and readiness.

CPR training that is completed solely online does not meet this requirement.

Various other professional bodies may set requirements for the frequency of CPR certification that differ from the Standards, however the RACGP requirement for is at least once every three years.

Resources

- RACGP *Abuse and violence: working with our patients in general practice*, 5th edition (the White Book) – Practical guidance for abuse and violence in general practice
- Blue Knot Foundation – Training on complex trauma for health professionals
- Phoenix Australia – Trauma-informed care education
- 1800RESPECT – Resources for responding to family and sexual violence
- Our Watch – Training and resources on preventing violence against women
- Safer Families – Programs to build family violence response capabilities in primary care
- Australian Institute of Family Studies – Information on child abuse and mandatory reporting
- National Association for Prevention of Child Abuse and Neglect – Resources for child abuse prevention and professional development

F5 – Registration and qualifications of practitioners

Consumer expectation statement: I expect the care I receive is always provided by, or supervised by, suitably qualified practitioners.

F5.A Members of the clinical team have current national registration and accreditation/certification with their relevant professional association.

The practice:

- ensures that each practitioner has current national registration and accreditation/certification.

F5.B Every GP who provides general practice services in the practice is one or more of the following:

- **a specialist GP**
- **a medical practitioner on a pathway to general practice Fellowship**
- **a GP registrar under appropriate supervision from a qualified specialist GP**
- **working under an approved workforce program.**

When the recruitment of recognised specialist GPs or doctors on a pathway to Fellowship has been unsuccessful, the practice ensures doctors who are recruited have the qualifications and training necessary to meet the needs of patients.

Why this is important

Ensuring practitioners who provide care at a practice are suitably qualified supports high standards of safe, quality care and professional competence.

Meeting these criteria

Registration and credentialing

Practitioners are responsible for maintaining current national registration and providing evidence of their credentialing. This includes meeting ongoing continuing professional development (CPD) requirements relevant to their scope of practice.

General practice is a specialist discipline

Doctors in general practices need to be appropriately trained and qualified in the discipline of general practice and be either:

- be vocationally recognised
- have Fellowship of the RACGP (FRACGP) or ACRRM (FACRRM)
- be otherwise recognised as a specialist GP by the Australian Health Practitioner Regulation Agency (Ahpra).

Where specialist GPs and doctors on a pathway to Fellowship are unavailable

Although it may not be possible to recruit specialist GPs in some areas, practice doctors who are not recognised specialist GPs need to be appropriately trained, supervised and supported through continual professional development to meet the needs of the local community.

F6 – Clinical autonomy of practitioners

Consumer expectation statement: I expect practitioners at this practice to make clinically independent recommendations to me about my care based on their expertise and knowledge.

F6.A Members of the clinical team can exercise autonomy, to the full scope of their practice, skills and knowledge, when making decisions that affect clinical care.

The practice:

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

Why this is important

Professional autonomy and clinical independence are essential components of high-quality care.

Meeting these criteria

Practitioners are free, within their scope of care, to determine:

- the appropriate clinical care they provide for each patient
- the specialists and other health professionals to whom they refer patients
- the pathology, diagnostic imaging, or other investigations they order, and the provider of these services
- the clinically appropriate appointment type available for each consultation, including telehealth
- how and when to schedule follow-up appointments with each patient.

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

The aspects of clinical autonomy described in this criterion do not override requirements bound by training or registration. For instance, a GP registrar may have limitations on duration and scheduling of appointments imposed by their training requirements.

F7 – Practice team culture, safety and involvement

Consumer expectation statement: I expect that this practice fosters a culture that supports the health, safety and wellbeing of the practice team and consumers and enables open communication for the team to work together effectively.

F7.A The practice fosters a positive culture by supporting the safety, health, and wellbeing of the practice team.

The practice:

- has a work health and safety policy
- has processes to manage occupational exposures
- supports the practice team during emergencies or other traumatic events
- supports staff involved in significant clinical incidents, including patient safety incidents
- educates the practice team in its work safety, health and wellbeing requirements
- has systems in place to protect members of the practice team from violence and aggression
- monitors and adjusts the workload of members of the practice team to support their wellbeing.

F7.B The practice leadership group actively seeks the involvement and input from all members of the practice team.

The practice leadership group:

- actively seeks input from all members of the practice team
- maintains a process for members of the practice team to escalate and resolve issues
- has processes for the practice team to discuss administrative matters.

Why this is important

Supporting the safety, health and wellbeing of the practice team

Practice owners and managers are responsible for creating a safe, healthy, and supportive working environment, in line with the quintuple aims of:

- advancing population health
- enhancing people's healthcare experience
- supporting healthcare providers' work life
- promoting health equity
- reducing healthcare costs[11].

Supporting staff involved in clinical and patient safety incidents strengthens psychological wellbeing, reinforces team trust. By offering structured debriefs, access to mental health resources, and opportunities to contribute to system improvements, practices can build team resilience and promote shared responsibility for safety.

The practice owner/manager is obliged to meet their responsibilities as an employer by adhering to relevant federal and state/territory workplace health and safety (WHS) laws.

Practice team involvement and input

Actively seeking input from all members of the practice team helps embed safety and wellbeing initiatives into daily operations. Encouraging open communication and shared decision-making supports:

- effective two-way communication
- shared responsibility for improvements
- collaborative identification and resolution of issues
- alignment with practice values and goals
- continuous quality improvement through team feedback.

Practice culture and wellbeing

A cohesive, positive and strong team culture:

- fosters the wellbeing of the practice team, open communication, collaboration and mutual respect promotes provider and consumer satisfaction
- is crucial for providing high-quality patient care and ensuring patient safety.

When members of the practice team have a strong sense of belonging and shared goals, they are more likely to:

- work together seamlessly
- make informed decisions collectively
- deliver consistent and coordinated care.

Meeting these criteria

Safety, health and wellbeing of the practice team

Table 3 provides areas of focus and accompanying strategies that the practice could adopt.

Table 3 Strategies to support the safety, health and wellbeing of the practice team

Theme	Focus area	Actions
Safety	Safety features in the practice	• Install adequate external lighting around pathways, entrances, and carparks. • Establish clear emergency contacts and protocols for all team members. • Install duress alarms or security cameras to monitor and respond to threats. • Develop and regularly review emergency exit plans. • Prioritise safety-focused room design when planning renovations or fit-outs.
	Patient aggression and patient-initiated violence	• Have a clear, visible zero-tolerance policy (on signs, websites, phone systems). • Facilitate staff training in de-escalation and incident response (including knowing when it is appropriate to discontinue care for a violent patient). Whole of practice training could be used to facilitate a collective approach to the prevention, identification and early response to violence and harassment. • Record incidents for review and risk assessment. • Know when it is appropriate to discontinue care for a violent patient. The RACGP *Preventing and managing patient aggression and violence* provides detailed guidance on dealing with violence and aggression.
Health	Healthy workload	• Encourage regular breaks during consulting time. • Support team members attending GP appointments and preventative care. • Provide access to support services for workplace stress. • Offer flexible work arrangements during crises or emergencies. • Provide access to changing rooms, showers, staff toilets, and bike racks.
	Healthy lifestyle	• Provide smoking cessation programs.

		• Participate in health awareness events, for example Close the Gap, Crazy Socks 4 Docs, International Nurses Day and RUOK Day). • Organise walking meetings or lunchtime walks. • Partner with local gyms or initiate team health challenges. • Register as an RACGP parkrun practice. • Choose healthy catering options for events and meetings.
	Healthy physical environment	• Maximise natural lighting and introduce green spaces, plants or natural design elements to boost mood and productivity. • Encourage sustainable transportation options, such as biking or walking, to improve staff fitness and mental health. • Reduce the use of harmful chemicals and promote eco-friendly alternatives.
Wellbeing	Wellbeing and inclusion	• Facilitate training on topics such as unconscious bias, cultural sensitivity, and diversity. • Provide access to gender-neutral bathrooms. • Foster a culture that celebrates diversity and open dialogue. • Use software/tools compatible with assistive technology. • Offer career support for staff on parental leave. • Designate clean, private spaces for breastfeeding or pumping.
	Cohesive, positive and strong team culture	• Display the practice values and ethics electronically and physically. • Provide opportunities for learning and professional development. • Have regular team discussions or check-ins (formal or informal, individual or as a team). • Celebrate achievements, positive feedback and milestones. • Host social activities and informal gatherings.
	Supporting staff in emergencies or after traumatic events	• Debrief as a team after a traumatic event. • Use support services like: – Employee Assistance Programs (EAP) – the GP Support Program – a free service for RACGP members that provides access to professional advice on personal and work-related issues – the Nurse and Midwife Support Service – a support service for nurses that provides access to confidential advice and referral – services offered by the local Primary Health Network.
	Supporting staff involved in significant clinical incidents, including patient safety incidents	• Acknowledge that clinical incidents, including patient safety incidents can be distressing and may affect the emotional wellbeing of team members involved.

		• Use support services (as listed above). • Apply a fair and just approach to incident reviews that avoids individual blame and focuses on system improvement. • Involve affected members of the practice team in reflective discussions and in identifying changes to prevent recurrence. • Foster a culture of openness and trust where members of the practice team feel safe, supported, and encouraged to speak up about incidents and contribute to understanding what happened, why it happened, and how the practice can improve systems and processes to prevent similar issues in the future.

Mental health

A culture of open communication, regular workload review, and access to mental health resources support members of the practice team. Professional organisations that offer support include:

- the RACGP's *self-care and mental health resources*, including the GP support program
- DRS4DRS, which provides coordinated access to mental health and wellbeing resources
- the Nurse and midwife support helpline
- the AAPM Member Assistance Program.

Practice team involvement and input

To foster a culture that values individual contributions and promotes whole-of-team involvement in decision-making the practice could:

- use communication tools, such as digital message systems, notice boards, to collect feedback, ideas, or concerns
- maintain clear processes for escalating and addressing issues raised by team members
- invite all team members to participate and contribute to regular meetings or discussions (including informal discussions in small practices)
- keep and share records of meetings to ensure transparency and follow-up
- communicate during recruitment and induction that all staff are encouraged and expected to provide input on how the practice operates.

Resources

- RACGP *Self-care and mental health resources* – Self-care and mental health resources to support the wellbeing of GPs and practice teams.

F8 – Information security

Consumer expectation statement: I expect that my information is securely managed to protect my privacy.

F8.A The practice has an information and communication technology (ICT) continuity, protection, and recovery plan.

The practice:

- maintains, documents, and regularly tests an ICT continuity, protection, and recovery plan that includes a cyber security incident response plan
- has a backup log operated by the practice or contracted provider
- maintains up-to-date antivirus protection and hardware/software firewalls
- has secure retention and backup of information in offsite or cloud storage locations and the ability to restore information from chosen backup locations
- has procedures to inform patients of any instance where there has been a data breach affecting their personal information.

F8.B The practice has secure electronic systems and ICT.

The practice:

- has at least one person (a member of the practice team or contracted ICT professional) with primary responsibility for the security of the practice's electronic systems and ICT
  - if the above person is an external contractor, the practice has at least one member of the practice team who has primary responsibility for digital governance
- documents its policies for the storage of, and access to, health information in the practice's privacy policy, including remote access if applicable.

F8.C The practice uses digital communications in a way that protects the privacy of patients and the practice team.

The practice:

- uses digital communications in a way that protects the privacy of patients and the practice team.

F8.D The practice uses social media in a way that protects the privacy of patients and the practice team.

The practice:

- uses social media in a way that protects the privacy of patients and the practice team.

F8.E The practice has procedures for the storage, retention, and destruction of records.

The practice:

- documents procedures for the storage, retention, and destruction of records, both digital and hard copy (physical).

Aspirational criterion

F8.F The practice informs patients about the digital communication tools it uses to support their care.

The practice:

- informs patients about any communication products or platforms used for communication between the practice and patients to support the delivery of care.

Why this is important

Maintaining a secure, functional, and reliable ICT system is critical for general practices to deliver safe, continuous patient care. Robust planning around ICT continuity, information protection, and recovery allows the practice to respond quickly to disruptions such as cyberattacks, hardware failures, or natural disasters. Similarly, clear procedures for data storage, retention, destruction, and communication protect patient privacy, support compliance with legal obligations, and strengthen patient trust.

Meeting these criteria

Information and communication technology (ICT) continuity, information protection and recovery

Table 3 describes the components that are to be included in the practice's ICT continuity, protection, and recovery plan.

Table 4 What to include in the practice ICT continuity, protection, and recovery plan

Component	Description	
Cyber security incident response plan	A cyber security incident response plan outlines how the practice will respond to and manage a data breach, including the following steps:	
	Detection and analysis	• Measure the scope of data breaches • Engage ICT providers or forensic specialists
	Containment and eradication	• Respond to threat actors, for example individuals or groups deliberately causing harm • Isolate affected systems (implied through engagement of ICT/forensic teams)
	Recovery	• Access essential systems and information to continue providing care
	Communication to patients/service users	• Notify patients and stakeholders • Notify relevant authorities
	Post-incident analysis	• Review the incident and implement necessary improvements.
Daily backup procedures	Daily (or more frequent) backups of critical operational data, for example appointments, billing, patient health info, ideally automated.	
Backup testing schedule	Regular tests to confirm that backups are correctly created, accessible, and readable.	
Secure offsite/cloud backup	Use of secure offsite or cloud-based storage with verified ability to restore data when needed.	
Third party provider agreements	Standard letters of agreement signed by ICT providers to clarify their obligations around security.	
Malicious software protection	Active and updated antivirus/malware protection on all systems.	
Email security	The process for scanning incoming emails and their attachments for potentially malicious software or links to potentially malicious websites	

Automatic updates	Processes to ensure timely and automatic updates of antivirus signature files and software patches.
Staff training	Ongoing training for team members on cyber safety, malware prevention, and incident reporting procedures.
Software updates and maintenance	Updates and installations, preferably outside of practice hours to minimise disruption.
Remote access	If the practice allows remote access to its systems for clinicians and other users, its policies will document remote access. Refer to the RACGP's *Information security in general practice* for further information on remote access.

Relevant authorities in cybersecurity

The practice needs to:

- know its legal obligations in the event of a cyber security incident
- be aware of the authorities that govern cybersecurity in Australia and know who to contact in the event of a cybersecurity emergency. Relevant bodies include:
  - the Australian Signals Directorate
  - Police (state and federal)
  - Department of Home Affairs.

Designated member of the practice team

The practice needs to have at least one person who has primary responsibility for the security of its electronic systems and ICT. This person may be a qualified member of the practice team or a contracted ICT professional. If the person with primary responsibility is an external contractor, the practice has at least one member of the practice team with primary responsibility for digital governance who:

- know when and how to escalate ICT issues
- distribute contact details of external experts to relevant members of the practice team
- educate the practice team on data security
- monitor the compliance of the practice team with security policies
- oversee procurement and maintenance of ICT systems
- align ICT practices with the overall strategic plan.

The designated member of the practice team could facilitate education and training regarding the practice's ICT continuity, protection, and recovery plan, or whole practice training for mutual learning and identification of barriers.

Engaging third party ICT providers

When contracting external ICT providers, the practice confirms that:

- contractors understand and comply with the practice's data security policies
- contracts specify obligations, including for remote access
- providers are experienced in handling sensitive health data.

The RACGP's *Information security in general practice* provides advice on which factors to consider when developing a contractual agreement with a technical service provider or cloud service provider.

Storage of health information and other data

Wherever possible, store health information and other data (including backups) in Australia. Doing so will help the practice to avoid burdensome legal and regulatory issues associated with overseas storage. Data stored in Australia is subject to protections afforded by the *Privacy Act 1988* and the Australian Privacy Principles (APPs). If the practice stores data outside of Australia, its privacy policy will include relevant details and informs patients that their health information is stored overseas.

Retaining health records of active and inactive patients

The practice must keep and securely store and dispose of health records of active and inactive patients in accordance with legal obligations imposed by the Privacy Act 1988 and the Australian Privacy Principles (APPs).

Destroying information

The practice needs to:

- retain health information as required and in accordance with the applicable laws. This includes both digital and hard copy (physical) records
- appropriately destroy or permanently de-identify health information following the expiry of the relevant periods
- have processes for the disposal of hard drives and other storage media whether this is internal or contracted externally. Wipe all information off hard drives and paper-based technology such as faxes, printers and photocopiers before recycling or disposing of them as legally permitted.

The *Privacy Act 1988* requires health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or disclosure. However, the ACT, NSW and Victoria require medical records to be retained until a young person turns 25, and for adults, for seven years from the date of the provision of the last health service. This overrides the *Privacy Act 1988*.

Under some state and territory legislation, the destruction of any medical record is prevented when the record is likely to be involved in legal proceedings. It is recommended the practice seek advice on the current limitation periods that apply in its jurisdiction.

Resources

- RACGP *Information security in general practice* 'Cybersecurity attacks and how to respond' and the *Responding to a cybersecurity incident* factsheet – Guidance on preparing for cybersecurity attacks.
- Australian Digital Health Agency *Cloud services: Considerations for healthcare organisations* – Key considerations for healthcare organisations when assessing and implementing cloud services, including security, privacy, and compliance requirements.
- RACGP *Using email in general practice – Guiding principles* – Guide to using email securely and effectively, with a focus on privacy, consent, and clinical safety.
- RACGP *Social media in general practice* – Guide to the safe and professional use of social media, including a template for a social media policy (which complies with Ahpra's social media policy).
- Section 4.4 of Ahpra's Good medical practice: a code of conduct for medical practitioners –Guidance on social media use.
- RACGP *Information security in general practice* 'Secure destruction and de-identification' – Guidance on secure destruction and de-identification of records, including hardware.

F9 – Confidentiality and privacy of health and other information

Consumer expectation statement: I expect that my health information held by this practice is secure and confidential and I am promptly notified if a data breach occurs.

F9.A The practice manages health information securely and confidentially.

The practice:

- informs patients how their personal health information is managed, including security, confidentiality and access
- has at least one member of the practice team who has primary responsibility for privacy related matters
- maintains a privacy policy consistent with the Australian Privacy Principles and communicate it to patients
- confirms that the practice team understands and implements its privacy policy
- protects patient privacy when communicating electronically with or about patients by using a secure message system or other method of encryption, unless the patient has provided informed consent to their information being sent without such protection
- informs patients of its data breach protocols.

F9.B The practice has a policy and procedure so that only authorised members of the practice team can access its clinical information system, prescription forms, and other official documents.

The practice:

- only allows authorised members of the practice team to access its clinical information system via unique individual identification and according to the person's level of authorisation
- describes in its privacy policy how members of the practice team access patient information
- securely stores all official documents, including prescription forms, administrative records, templates and letterhead.

Why this is important

Protecting the security and confidentiality of health and other information is critical for consumer privacy and safety.

Meeting these criteria

Management of patient health information

The practice needs to collect personal health information and then safeguard its confidentiality and privacy in accordance with:

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

The practice is subject to stringent privacy obligations because it holds health information, which is a subset of personal information. Sensitive personal information requires more rigorous protection than non-sensitive information. Personal information can include any information collected to provide a health service, including a person's:

- name and address
- bank account details
- Medicare number
- health information
- demographic and identity-related details.

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

The RACGP's *Privacy and managing health information in general practice* explains the safeguards and procedures that general practices need to implement to meet legal and ethical standards relating to privacy and security. The practice's medical defence organisation can also provide information and advice about developing relevant strategies.

A privacy policy

The practice's documented privacy policy needs to address the management of patient health information, and the practice needs to inform patients of the policy. The privacy policy needs to be in plain English, specify a review date, and address certain legal requirements, which include:

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

Refer to the RACGP's privacy policy template available at the resources page on the RACGP website.

For further information about privacy, visit the Office of the Australian Information Commissioner's (OAIC's) website.

Consumers need to have access to the practice's privacy policy. This could be on the practice's website or reception staff could provide a copy when a consumer asks for one, for example via QR code or hard copy). See PP1 – Information about the practice for more information on making information such as this accessible to patients.

Disclosure of patient health information to a responsible person

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

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

If a carer is seeking access to a patient's health information, it is a recommended that the practice seeks advice from its medical defence organisation before a decision is made to give the carer access to the information or not.

Familiarity with requirements

The practice needs to confirm that members of the practice team understand and implement its privacy policy. As well as being familiar with the APPs, members of the practice team could:

- familiarise themselves with the relevant state/territory laws about privacy and health records (for more information about privacy laws in each jurisdiction, visit the OAIC website)
- undertake regular privacy training to maintain familiarity with privacy requirements.

Appropriate access to systems, platforms and other information

Members of the practice team only require access to the systems, platforms and other information they need to undertake their roles. Members of the practice team have a responsibility to use patient information only for its intended purpose and for the benefit of the patients. Access could include, but is not limited to:

- the practice's clinical information system/s
- online identity verification and authentication systems (ie for secure access to government online services including Medicare)
- digital health record platforms, including My Health Record
- correspondence (letters and emails) from consumers or external clinicians.

Keeping health information concealed

Consider what physical factors need to be addressed so that health information is concealed from unauthorised sight and access. Some practical considerations include:

- positioning computer screens to prevent unauthorised viewing
- using automated privacy tools, such as screensavers, when devices are unattended
- securing mobile phones, tablets, laptops, and other portable devices to the same standard as desktop computers.

F10 – Digital health technologies

Consumer expectation statement: I expect that digital health technologies provided by this practice are easy to access and use; secure and regularly assessed; and my consent is obtained prior to use.

F10.A The practice uses digital health technologies safely and securely.

The practice:

- facilitates processes for members of the clinical team to obtain informed consent from patients when using digital health technologies
- has a documented process for assessing, implementing and managing digital health technologies, including consideration of their potential impacts on the practice, members of the practice team and patients
- provides members of the practice team with access to technical expertise for the digital health technologies it uses.

Why this is important

'Digital health technologies' encompasses the use of digital technologies and platforms to deliver healthcare services remotely, or enhance in-person care, such as telehealth, mobile health apps, patient portals, remote monitoring devices, and secure messaging platforms. The use of digital health technologies aims to increase accessibility, continuity, and efficiency in patient care.

Having processes for clinicians to obtain informed consent when using digital health technologies facilitates transparency, builds trust and promotes patient-centred care.

Adherence to a documented data governance policy for the use of digital health technologies is needed to maintain the integrity and security of patient information.

Meeting these criteria

Safe and secure digital health technology

The practice needs to support, via relevant processes, policy and systems, safe and secure use of digital health technologies. This includes the practice's ICT, ensuring that:

- the practice has a reliable internet connection
- equipment and connectivity needed for digital health technologies can deliver sound and image quality suitable for clinical purposes
- each proposed new technology includes a systematic, operational assessment of its impact prior to its implementation. These could be workflow changes, readiness of the team, resource requirements, or consumer experience
- all hardware and software are tested for ongoing reliability
- if members of the practice team work off site, the practice has:
  - communication systems to and from the practice (email, telephone, fax, secure messaging)
  - remote access to clinical records
  - 'read and write' options for the practice's clinical information system
  - access to My Health Record if applicable.

Refer to the RACGP's *Guide to providing telephone and video consultations in general practice* for more information on ways to use digital health technologies safely and securely.

Discussing implementation of digital health technologies

There are various ways the practice can seek input from members of the practice team when implementing new digital health technologies. Their feedback could inform decision making and training needs.

The practice could:

- seek input from the practice team in the initial stages of implementing a new digital health technology

- highlight the benefits and expected outcomes to the practice team
- address training and support needs
- encourage ongoing feedback from the practice team to support assessment and evaluation.

F11 – Artificial intelligence (AI)

If the practice does not use artificial intelligence, criteria F11.A and F11.B are not applicable.

Consumer expectation statement: I expect that this practice asks for my consent to use artificial intelligence, explains how it will be used to provide me with care and ensures my safety and privacy.

F11.A Where the practice uses artificial intelligence, it does so safely and securely and consistent with existing standards.

The practice:

- facilitates processes for members of the clinical team to obtain and document informed consent from patients when aspects of care will be delivered using AI
- clearly defines that clinicians are accountable for care decisions supported by AI tools, and documents processes to support their clinical oversight
- facilitates data deidentification/anonymisation when using AI tools that process patient data
- discusses the implementation and use of AI with members of the practice team to identify practical implications and training needs.

F11.B The practice assesses and evaluates its use of artificial intelligence.

The practice:

- has a process to assess and evaluate the use of AI, including risk mitigation.

Why this is important

Artificial intelligence (AI) describes the machine simulation of human cognitive capabilities such as learning, reasoning or problem-solving, and self-correction(1). It encompasses a range of technologies, such as machine learning, deep learning, natural language processing, robotics, chatbots, image recognition and machine vision, and voice recognition(2). An AI scribe is a tool that can automate parts of the clinical documentation process for a medical practitioner. AI scribes can convert a conversation with a patient into a clinical note, summary, or letter that can be incorporated into the patient's health record.

Having a strategy for the implementation of AI tools in a practice is intended to focus on how its adoption enhances patient care, rather than adding unnecessary complexity or risk. While AI can bring significant benefits to healthcare (like faster workflows, more accurate diagnoses, and more effective treatments), using it without thoughtful planning could lead to unintended consequences, for example misdiagnosis, privacy breaches, or ethical and legal issues.

Ensuring AI systems operate within a structured governance framework helps safeguard patient safety by providing clinicians with reliable tools while maintaining transparency and oversight. By embedding clinical supervision and accountability into AI governance, general practices can strengthen trust in these tools and uphold high standards of quality and ethical responsibility.

Facilitating informed consent helps maintain patient trust and autonomy by ensuring they understand how AI is being used in their care. This aligns with ethical healthcare practices and transparency principles.

Open discussions with the practice team and clear lines of support aim to build confidence, knowledge, and readiness among the practice team to effectively integrate AI in their work. Including diverse perspectives from the practice team aims to minimise the risk of missing important considerations only noticeable by some members. Implementing regular evaluation checks that AI systems are operating as intended, helps to mitigate risks and prompts the identification of performance improvements.

Meeting these criteria

Informed consent and transparency

If the practice uses AI tools, it needs to inform patients of how these tools use their health information, for instance, what is collected and where it is stored. Tools used to transcribe consultations may need to access patient health records or listen to the consultation to generate notes for the GP, which could have implications for data security if not done in ways that comply with Australian privacy legislation. See PP4 – Informed consent for further advice on obtaining informed consent.

Artificial intelligence in general practice

If the practice uses AI tools, it must consider how to meet its obligations under the *Australian Privacy Act 1988* and the *Australian Privacy Principles* (APPs). Legal advice may be useful, particularly when evaluating the following:

- Does the AI vendor confirm compliance with the Privacy Act and APPs?
- Can collected data be used or sold for secondary purposes?
- How is patient data encrypted, stored, and destroyed?
- How is personal information managed and de-identified?
- Can clinicians review and confirm AI outputs before use?

Accountability for AI output

The practice needs to ensure that AI systems used in clinical care operate within a framework that supports clinical supervision of, intervention in, and accountability for any AI output. This includes establishing:

- governance structures
- risk management processes
- safeguards to support clinicians in making informed decisions.

Practitioners have professional obligations for the use and review of AI tools used for clinical care. Ahpra provides advice meeting professional obligations and potential challenges facing clinicians.

Assessment, evaluation and the ability to question AI output

AI systems need to be evaluated to confirm they perform as intended and that risks are actively managed. Given the potential for significant impact on patients or practice operations, practices need to provide:

- a timely and accessible process for patients, consumers, and the practice team to question or challenge AI outputs
- transparent processes for responding to AI-related issues
- clinical autonomy for practitioners, including the ability to review and override AI outputs using clinical judgement
- access to information about how its AI systems work so that patients, consumers and members of the practice team can properly question its output if needed.

Practices need to be particularly mindful of the potential disproportionate impact of AI on vulnerable populations. Vulnerable populations (including people with disabilities, older adults, people from culturally and linguistically diverse backgrounds, and those experiencing disadvantage) may be more at risk of harm from AI systems. This could be due to biases in the data the AI was trained on, a lack of transparency about how decisions are made, or barriers to understanding or contesting AI-driven decisions. Practices should take extra care to assess and manage these risks when using AI.

Practices can strengthen their approach to AI evaluation by implementing additional assessment activities. Examples of activities a practice could undertake include:

- collecting structured feedback from members of the practice team on their experiences with AI systems, including effectiveness and usability
- auditing outcomes from AI-generated recommendations, for example checking for over-diagnosis or missed diagnosis when AI tools are used for interpretation or triage
- monitoring consumer feedback and complaints related to the use of AI in their care, to identify safety concerns or opportunities for improvement

- tracking the number and nature of technical support requests or issues raised about AI system performance
- collecting data on how often AI is used in clinical decision-making or administrative processes, compared to clinician-only approaches.

Resources

RACGP resources

The RACGP has developed resources that practices can use to guide implementation of digital health technologies and/or AI in their practice:

- *Artificial intelligence (AI) scribes*: This resource describes AI scribe tools that can automate parts of the clinical documentation process for a medical practitioner, and explores their potential benefits and risks, as well as relevant considerations.
- Artificial intelligence in primary care position statement: This resource can help the practice understand the advantages and risks of AI in general practice.
- *Privacy and managing health information in general practice*: This resource aims to help the practice understand relevant privacy laws, patient consent and information management and security and adapt these to digital health technology and AI.

AI ethics

The federal Department of Industry, Science and Resources has published eight voluntary AI ethics principles which can assist the practice in providing safe healthcare when using AI. These principles encourage businesses to use AI in ways that:

- benefit individuals, society and the environment
- respect human rights, diversity and individuals' autonomy
- are inclusive and minimise discrimination
- uphold rights to privacy
- operate in accordance with their intended purpose
- are transparent and easily understood
- allow a person, community, group or environment to easily contest the uses or outcomes of the AI system
- allow accountability and human oversight.

Medical defence organisations provide advice on medico-legal issues such as privacy, consent, accuracy and quality.

Clinical governance standard

The Clinical governance standard incorporates the systems that practices use to manage risk and protect the safety of patients and members of the practice team. These systems include maintaining patient health records systems, the use of current, evidence-based guidelines and standards, transitions of care, infection prevention and control, practice environment and equipment, and research. The standard aims to foster an open and transparent general practice culture and to promote the digitisation of patient health records.

CG1 – Clinical information systems

Consumer expectation statement: I expect my digital health information is managed, kept up-to-date and available when my care provider needs it, or I request it.

CG1.A The practice uses a digital clinical information system to manage its patient health information.

The practice:

- has a digital clinical information system to manage patient health information
- maintains, if more than one digital clinical information system is used:
  - up to date patient health summaries in the patient health records of each system
  - records of each consultation or interaction in each patient health record, which includes where the clinical notes are recorded.

Why this is important

Digital clinical information systems

Using digital clinical information systems to manage patient health information helps to support communication, clinical decision-making and quality improvement processes in general practices.

Using multiple digital clinical information systems

The practice uses multiple digital clinical information systems if one or more of the practice's practitioners enter patient information into more than one digital clinical information system that relate to patients of the practice.

Meeting these criteria

The practice has a digital clinical information system that suits the needs of the practice.

Using multiple digital clinical information systems

If the practice uses multiple digital clinical information systems, the complete details of all patient consultations do not need to be duplicated in both systems, but each system needs to include:

- up to date health patient health summaries, such as the same in each record. This ensures that all pertinent information, including allergies and medications, are available in any system at any time. See CG3 – Facilitating complete patient health records for further information
- records of each consultation or interaction in each patient health record, which includes where the clinical notes are recorded.

If the practice uses more than one digital clinical information system, the record of each consultation or interaction could include:

- a note in the practice's clinical information system, notifying users that a consultation or interaction has occurred, and where to find the full details of the consultation or interaction
- a billing record to show where a consultation has occurred.

The practice could also develop a policy or process regarding the use of multiple digital clinical information systems, how information is stored in each system and where to find relevant information.

It is good practice to:

- inform all practitioners in the practice, including locums, that multiple digital clinical information systems are being used and that they need to look at both systems in order to access all relevant information
- ensure the required information in both systems is readily available at all times
- include a clearly visible note stating that the practice uses a hybrid digital patient health record system and where information is recorded.

Resources

- RACGP General practice toolkit: *Clinical information system*

CG2 – Patient identification

Consumer expectation statement: I expect I am correctly identified by this practice.

CG2.A The practice uses a minimum of two approved patient identifiers to correctly match each patient to their patient health record.

The practice:

- uses a minimum of two of the following approved patient identifiers to confirm a patient's identity each time they engage with the practice:
  - name (family and given names together are one identifier)
  - date of birth
  - address
  - individual phone number.

Why this is important

Verifying a patient's identity

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

Correctly identifying patients using a minimum of two identifiers is in line with World Health Organization recommendations[27] and ensures that practitioners have the correct patient health record for each consultation.

Meeting these criteria

Correct patient identification is necessary when:

- a patient makes an appointment
- a patient presents to the practice for their appointment
- the practice communicates with a patient over the telephone or electronically
- a patient telephones asking for a repeat of a prescription
- a patient sees more than one member of the clinical team during a visit
- a patient record is accessed
- the practice collects and manages information about a patient – for example, scanned documents, X-rays.

A patient's Medicare number is not an approved patient identifier, as some Australian residents and visitors do not have a Medicare number[28] and others may share numbers if they belong to the same family.

When conducting telehealth consultations over the phone or via video, members of the clinical team still need to confirm the patient's identity using a minimum of two identifiers. It is recommended that confirmation of a patient's identity be documented in the medical record for each telehealth encounter.

Asking for patient identifiers

When matching patients to their health record, members of the practice team need to:

- be mindful of privacy and confidentiality
- not compromise the safety of the patient
- ensure the correct patient is matched to their health record, particularly if they have a common or duplicated name
- seek identifying information from patients rather than providing the information to the patient and asking them to confirm it is correct.

The practice could keep a prompt sheet at reception to remind reception staff to ask patients to identify themselves. To help maintain patient privacy by minimising information given verbally at reception, the practice could:

- identify patients via official documents such as driver's licence or passport. Medicare cards cannot be used as a stand-alone patient identifier as they do not include a photo of the patient. However, a current Medicare card could be used as a secondary identifier with an approved patient identifier that has photo identification such as a current driver's licence or passport.
- use multi-factor authentication if using an online check-in system to identify patients presenting for an appointment, for example via a tablet in the waiting room, or via the patient's mobile phone.

It is not advisable to retain photos of patient identification documents in patient health records, particularly if the practice's clinical information system does not allow information to be permanently deleted. This is a data security risk and could result in identity theft if there is a cybersecurity incident at the practice. This could be covered by the practice's privacy policy.

Patients who wish to remain anonymous

In line with the APPs, wherever it is lawful and practicable, patients need to be able to remain anonymous when receiving care from the practice and when practicable to do so[29]. Patients may choose to receive services anonymously if, for example, sensitive issues arise or they feel they may be at risk, such as in domestic violence situations or difficult relationships. In these circumstances, the use of an alias or 'disguised identity' may be the most appropriate approach. The Office of the Australian Information Commissioner (OAIC) provides information on the differences between anonymity and pseudonymity, as well situations where it may be lawful to identify patients, for example when prescribing medications, referring to diagnostic services, or accessing benefits such as Medicare. The practice could:

- obtain legal advice regarding situations where it is lawful for patients to maintain anonymity or pseudonymity
- use mechanisms within the clinical information system to enhance patient privacy in sensitive situations, for example by restricting access within the patient's health record to the patient's regular GP.

Cultural considerations for Aboriginal and Torres Strait Islander peoples

Following the death of an Aboriginal or Torres Strait Islander person, some communities have cultural protocols for the avoidance of naming deceased people, which may influence the ways the practice identifies patients. As protocols differ throughout the country, the practice could check with the local Aboriginal or Torres Strait Islander community for correct procedures, avoidance names, time periods for avoidance and the use of images and naming of deceased people. The practice may find the RACGP's resource, *An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives* useful; however, it is always important to discuss protocols with local Aboriginal and Torres Strait Islander community members, or where possible, family members[30].

Entering patients' phone number into their health record

When recording patients' phone numbers in their health record, the practice could check with the patient whether the phone number is unique to the patient and note this in the record. There are many situations where patients wish to keep their health information private, for example patients under 18 accessing healthcare without their parents' knowledge, or in cases of family violence.

Resources

- RACGP: *An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives*
- Office of the Australian Information Commissioner:
  - Healthcare identifiers
  - APPs chapter 2: Anonymity and pseudonymity
- World Health Organization: *Patient identification*.

CG3 – Facilitating complete patient health records

Consumer expectation statement: I expect that this practice has processes to involve me in shared decision-making about my care and that my health records are complete, correct and up to date, to ensure I receive the right care at the right time.

CG3.A The active patient health records contain all required demographic and identification details for each active patient in codable fields.

The practice:

- Codes, for each active patient:
  - identification details
  - contact details
  - next of kin
  - emergency contact information.

CG3.B The practice routinely records the Aboriginal and Torres Strait Islander status of patients in a codable field.

The practice:

- documents the patient's Aboriginal and/or Torres Strait Islander status in a codable field.

CG3.C The practice has a patient health records system that allows clinicians to record their patient consultations and clinical related communications.

The practice:

- has a patient health record system that allows clinicians to record all consultations and clinical related communications.

CG3.D The patient health records contain sufficient information that documents consultations and clinical related communications.

Members of the clinical team:

- document sufficient information for consultations and clinical related communications
- document matters that have been followed up from previous consultations.

CG3.E The practice's clinical information system facilitates the recording of details of each patient's current health summary in codable fields.

The practice:

- uses a clinical information system that facilitates coding of patient health information
- ensures the clinical information system facilitates active patient health records in which clinicians can code in the patient's health summary:
  - adverse drug reactions
  - current health problems
  - family history
  - health/lifestyle risk factors, such as smoking, nutrition, alcohol, physical activity
  - immunisations
  - known allergies
  - past health history
  - social history
- ensures that all (100%) of the active patient health records document known allergies or indicate that the patient has no known allergies in a codable field.

CG3.F Members of the clinical team keep an accurate and current medicines list in each patient health record.

Members of the clinical team:

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

CG3.G The practice supports members of the clinical team to involve patients in shared decisions about their care.

The practice:

- provides members of the clinical team with shared decision-making information and resources to use when discussing treatment and care options with patients.

Members of the clinical team:

- identify and respect patients' preferences or choices
- document shared decision making in the patient's health record.

CG3.H Members of the clinical team discuss, document and provide information to patients regarding the purpose, importance, benefits, risks and side effects of:

- **proposed investigations**
- **referrals**
- **diagnosis**
- **treatment options**
- **management of their conditions**
- **a patient's refusal to follow significant clinician advice**
- **the process implemented when a patient has refused a treatment, advice or procedure.**

CG3.I The patient health records system allows the practice team to record all communications with patients.

The practice:

- has a system that allows members of the practice team to:
  - record when members of the practice team have attempted to contact or have successfully contacted the patient
  - record when a patient contacts the practice, the reason for the contact, and the advice and/or information given to the patient
  - record when a translation service was used for a patient, including contact details of that service.

Aspirational criterion

CG3.J The active patient health record facilitates the collection, where relevant, of the following demographic details in codable fields:

- **ethnicity**
- **birth sex**
- **gender**
- **preferred pronouns.**

Why this is important

Patient health records

Accurate patient health records improve patient safety and wellbeing as they support clinical decision making, help to manage clinical risks and comply with privacy laws. For example, an accurate patient health record assists members of the clinical team to easily access information on a patient's allergies or the patient's medical history. The RACGP has developed the *Improving health record quality in general practice* guide to help practices maintain high quality and consistent patient records, share patient health information, and quality improvement.

Using codable fields

Using a nationally recognised medical vocabulary within codable fields helps the practice collect structured data that can be used by members of the practice team to improve quality and safety.

Collecting structured clinical data allows:

- tracking of care over time for both individuals and across the patient population
- quality improvement activities
- collecting benchmarking data for comparison with other practices.

Providing appropriate and sufficient health information

Patients have the right to make informed decisions about their health, medical treatments, referrals and procedures, including refusal of advice given to them.

The practice has a duty to provide relevant information about preventive health and illness prevention that patients can understand and that is tailored to their needs. Members of the clinical team need to document relevant discussions or activities undertaken relating to preventative care, illness prevention and health promotion in the patient's health record, including where the patient has refused to follow advise provided.

Meeting these criteria

Privacy Laws

Members of the practice team are legally required to collect, handle, store and share all patient personal and sensitive information in accordance with applicable privacy laws.

Professional obligations of the clinical team

Members of the clinical team have their own professional obligations for care and treatment decisions. The *Good medical practice: a code of conduct for doctors in Australia* outlines how practitioners are required to work with their patients and other healthcare professionals in coordinating patient care.

Collecting information from patients

When collecting information from a new patient, the practice could:

- clearly define how information is collected, for example personal information could be collected via the patient registration form while clinical information could be collected during the consultation. This could include definitions around which information is, or is not obtained in public areas
- collect information using a generic form, on paper or electronically, or by privately interviewing patients before the first consultation
- clarify information in a private space, preferably away from the waiting area
- consider the sensitivity of details being collected to determine whether a member of the clinical team is best suited to ask the patient for that information.

It is important for patient details (including the contact details of their emergency contact) to be up to date. The practice could do this by:

- having a prompt sheet for members of the practice team to ask patients whether their details have changed each time they contact the practice or book an appointment
- using automated systems such as a patient portal to prompt patients to update their information.

Collecting sufficient information regarding consultations and communications

Patient health records need to contain a sufficient amount of information that documents consultations and clinical related communications. 'Sufficient information' is to be maintained in a form that can be understood by other health practitioners and includes information that allows another health practitioner to continue the care of that patient. This could include:

- details of clinical history
- clinical findings
- investigations
- diagnosis/es and information that supports diagnosis/es
- information given to patients
- medication
- reason for visit
- referral and other management
- information that promotes continuity of care, or explains the care, treatment and services provided.

Collecting patient demographic information

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

The practice needs to identify and record the Aboriginal or Torres Strait Islander status and cultural background of all patients, as this information can be an important indicator of clinical risk factors and therefore help practitioners to provide relevant care. Consistent recording of Aboriginal and Torres Strait Islander status helps improve clinical care by allowing for:

- a better understanding of the patient's potential experiences and beliefs, including questions such as: are they a member of the stolen generation, do they have particular cultural obligations or participate in cultural activities that are part of their wellbeing?
- access to care co-ordination services locally
- correct immunisations to be recommended
- different preventive health care interventions to be recommended
- participation in the Closing the Gap Pharmaceutical Benefits Scheme (PBS) co-payment measure
- access to particular medications on the PBS
- access to particular MBS item numbers and subsequent follow up by practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and allied health services.

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

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

All patients have the right to respond to this question as they see fit. If a patient indicates that they do not wish to answer the question, record 'Not stated/inadequately described'. The patient's response needs to be received without question or comment, and the response recorded without any amendments or annotations[31]. However, if the patient does not answer this question when it is on a form, follow up immediately in case they missed it by mistake, rather than assume that the patient has refused to answer.

Collecting information about a patient's cultural heritage before a consultation can help the practice to provide the most appropriate care. This could be done by using a new patient form.

Providing patient-centred care

The practice could record each patient's ethnicity, as well as their country of birth if relevant to their care. In some circumstances, there may be direct genetic health risks or religious beliefs that impact on health decisions. For further information on providing culturally safe care for Aboriginal and Torres Strait Islander patients, as well as respectful care to diverse populations, see PP3 – Respectful, culturally appropriate and culturally safe care.

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

The practice could record patients' birth sex, gender and preferred pronouns. Refer to the RACGP's fact sheet for guidance on collecting and recording information about patient sex, gender, variations of sex characteristics and sexual orientation.

The practice could do the following to respect patient privacy when collecting this information from patients:

- ensure all members of the practice team understand the importance and reasoning behind the sensitive collection of information about sex and gender
- clearly explain why questions are being asked and how answers will be used in the patient registration form
- use forms that allow patients an option from multiple fields (formats for preferred question and answer options can be found in the RACGP factsheet).
- document patient preferred pronouns throughout transitions of care, with the patient's permission
- have a policy or process regarding the collection, storage and disposal of information about sex, gender, sex characteristics and preferred pronouns that includes how this information is collected, and which members of the practice team are best placed to request and discuss this information with patients.

Keeping a current and accurate medicines list

In line with professional obligations, members of the clinical team need to keep an accurate and current medicines list in each patient's health record and include this information in patient referral letters.

Shared decision making

Shared decision making is a consultation process whereby the clinician and patient collaborate to make health decisions following discussions about the evidence base, benefits and harms, and consideration of the patient's preferences, values and circumstances[6]. Shared decision making can be applicable to most situations; however, it is particularly important in situations where evidence does not clearly support a particular option, or where a preference-sensitive decision is involved, such as where the decision is heavily influenced by the patient's preferences and values[6].

Discussing and providing information about the purpose, importance, benefits, risks and side effects of actions

When providing information on the purpose, importance, benefits, risks and side effects of actions to a patient, their carer, family member or other support person, it is recommended that the member of the clinical team considers the patient's physical, visual and cognitive capacities and health literacy and:

- use plain English
- tailor information
- provide online or paper-based resources, including factsheets or brochures from trusted and accessible sources
- use tools and resources to help present information, for example visual resources and decision support tools
- check understanding of information using tools like the teach-back method
- encourage and provide opportunities for questions.
- the member of the clinical team could also document the information resource that has been given to the patient, for example by pasting the resource's URL into the patient health record.

Refusal of treatment or advice

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

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

Resources

- RACGP: *Improving health record quality in general practice*
- RACGP: *Collecting and recording information about patient sex, gender, variations of sex characteristics and sexual orientation*
- Australian Institute of Health and Welfare: *National best practice guidelines for collecting Indigenous status in health data sets*
- Medical Board of Australia: *Good medical practice: a code of conduct for doctors in Australia*
- Australian Commission on Safety and Quality in Health Care:
  - *Shared decision making*
  - *Decision support tools for specific conditions*.
  - *Risk communication module*
- Medical Journal of Australia: *Shared decision making: what do clinicians need to know and why should they bother?*
- Agency for Clinical Innovation:
  - *Shared decision making*
  - *Yarning to make health decisions together*
- EBSCO: *My Health Decisions*: a collection of shared decision-making aids
- Orygen: *Shared decision making for mental health, evidence summary*
- AskShareKnow: AskShareKnow decision making tool
- healthdirect
- Better Health Channel.

CG4 – Provision of clinical and medicines guidelines

Consumer expectation statement: I expect this practice provides and ensures access to current information and evidence-based guidelines to the clinical team to facilitate best practice healthcare.

CG4.A The practice ensures the clinical team has access to current, evidence-based medicines information.

The practice:

- ensures members of the clinical team have access to current evidence-based information relating to medicines, including information about the purpose, importance, benefits and risks of medicines.

CG4.B The practice ensures the clinical team has access to current, evidence-based clinical and emergency guidelines that help diagnose and manage patients.

The practice:

- ensures members of the clinical team have access to current, evidence-based clinical and emergency care guidelines.

CG4.C The practice supports members of the clinical team to adopt environmentally sustainable clinical practices.

The practice:

- provides members of the practice team with access to information, resources and/or strategies for the implementation of environmentally sustainable clinical practices.

CG4.D The practice supports members of the clinical team and patients to reduce inappropriate antibiotic prescribing.

The practice:

- provides members of the clinical team with access to information and resources to reduce inappropriate antibiotic prescribing
- provides patients with access to information and resources to reduce inappropriate antibiotic use.

Why this is important

Current medicines information and clinical and emergency care guidelines

Having access to current, evidence-based medicines information and clinical and emergency care guidelines enables practitioners to undertake best practice prescribing of medicines based on community and patient demographics. Emergency guidelines allow the clinical team quick access to information regarding acute presentations and are often available through state health departments.

Adopting environmentally sustainable clinical practices

The healthcare sector is a significant contributor to carbon emissions, medical waste, and resource consumption. Encouraging sustainable practices helps reduce this impact while maintaining high-quality patient care. Choosing required treatments wisely and reducing the number of unnecessary tests and procedures are essential steps in reducing carbon footprint in general practice.

Antimicrobial stewardship

Antimicrobial resistance is a significant and growing global health issue that needs to be addressed in a unified and strategic manner.

Meeting these criteria

Access to medicines information and clinical and emergency guidelines

The practice could choose to meet this requirement by subscribing to guidelines and standards, or by ensuring members of the clinical team have access to free services. The practice could also maintain a current version of clinical software databases that include drug guides, medical dictionaries, coding classifications, and information about consumer medicine.

Supporting members of the clinical team to adopt environmentally sustainable clinical practices

The practice can support members of the clinical team to adopt environmentally sustainable clinical practices without imposing requirements on the clinical team. The practice could:

- provide evidence-based, non-prescriptive resources that incorporate sustainability principles
- provide evidence-based comparisons of therapeutic goods to the clinical team for consideration
- provide checklists or quick guides for common clinical scenarios, for example when to use reusable vs. single-use PPE, or ways to reduce waste when prescribing
- promote environmental sustainability topics in existing professional development or CPD activities, or within team discussions
- adopt prescribing software with default options that prioritise sustainability where clinically appropriate, for example using e-scripts instead of paper.

Educating patients on safe antimicrobial use

Providing the clinical team and patients with information and resources to reduce inappropriate antibiotic prescribing can help to maintain the effectiveness of antibiotics, prevent the emergence of antimicrobial resistance and decrease preventable healthcare-associated infection.

The practice could:

- support practitioners to use shared decision making with patients during consultations to reduce the inappropriate prescribing of antibiotics (see CG3 – Facilitating complete patient health records for information on shared decision making)
- promote information on antimicrobial resistance and the appropriate prescribing of antibiotics and other drugs, for example on the practice's website, digital display or social media pages (which may include posts from other healthcare organisations)
- display QR codes to link patients to this information
- consider how the practice can support GPs to reflect on their own patterns of prescribing and patient care and compare these with other GPs in their practice
- encourage the practice's clinical team to use consumer fact sheets to facilitate shared decision making on whether to use antibiotics.

Resources

Medicines information includes:

- *Therapeutic guidelines*
- the *Australian medicines handbook* (jointly owned by the RACGP, the Pharmaceutical Society of Australia, and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists [ASCEPT])
- the *Medicines Advice Initiative Australia* develops educational interventions to target specific health care problems and are intended for use by audiences including GPs, Aboriginal Community Controlled Health Organisations, pharmacists, hospitals and other health services
- the *National medicines policy* is a federal framework promoting the safe and quality use of medicines for all Australians
- the *National Medicines Policy resources collection* comprises resources related to the National medicines policy

Clinical guidelines include:

- Key RACGP guidelines (including the *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people*, *Guidelines for preventive activities in general practice (the Red Book)* and *Handbook of non-drug interventions (HANDI)* among others)
- The Royal Children's Hospital Melbourne: *Clinical practice guidelines*
- Australian Commission on Safety and Quality in Health Care:
  - *Access to therapeutic guidelines*
  - *Clinical care standards*
- Health Pathways (available free of charge to general practice teams via local primary health networks)
- *UpToDate* decision support subscription.

Emergency guidelines include:

- The Agency for Clinical Innovation (NSW): *Emergency care institute*
- Australian and New Zealand Committee on Resuscitation (ANZCOR): guidelines.

Environmental sustainability resources:

- RACGP:
  - Environmental sustainability in general practice – *Reducing the Carbon footprint of inhalers: Climate and clinical implications*
  - *Greening up – Environmental sustainability in general practice*
- Doctors for the Environment Australia: *Sustainable healthcare resources*

The following resources could help promote antimicrobial stewardship:

- AJGP article: *How can general practitioners reduce antibiotic prescribing in collaboration with their patients?*
- RACGP: *First do no harm, Antibiotic use for acute otitis media in children*
- Australian Commission on Safety and Quality in Health Care:
  - AMS resources and links
  - *Do I really need antibiotics?*
  - *Decision support tools for specific conditions*.
- Therapeutic guidelines: *Antibiotic*.

CG5 – Transitions of care

Consumer expectation statement: I expect that this practice communicates with other healthcare services and that my health information is securely transferred in a timely way when requested or authorised by me.

CG5.A The practice has processes that facilitate timely transitions of care.

The practice:

- supports consumers when coordinating care with other health services
- collaborates and communicates with internal and external practitioners and services throughout transitions of care
- documents and shares patient health information to allow continuity of care in accordance with the Australian Privacy Principles (APPs)
- provides templates that allow the clinical team to write referral letters containing all required information outlined in the RACGP guidance document
- has a process for handover of care in the event of expected or unexpected leave by a member of the clinical team.

Members of the clinical team:

- keep copies of referrals to other services that are legible and contain all required information.

CG5.B In response to authorised, valid requests, the practice transfers relevant patient health information in a timely and secure manner.

The practice:

- facilitates the transfer of care when requested by the patient, authorised caregiver or a general practitioner in the practice
- obtains patient consent for the health information being transferred to another practitioner or service
- has a privacy policy that addresses the timely, authorised, and secure transferral of patient health information.

Why this is important

Timely transitions of care

Transitions of care occur frequently in general practices and includes clinical handover of care. Inadequate handover of care is a major risk to patient safety and could result in:

- delayed treatment
- delayed follow-up of significant test results
- unnecessary repeating of investigations
- medication errors
- adverse events
- legal action.

The Australian Commission on Safety and Quality in Health Care has published best practice guidance on optimal transitions of care, which includes:

- care that is person-centred
- multidisciplinary collaboration
- documenting and accessing information via a comprehensive and secure record system
- ongoing continuity and coordination of care.

Transitions of care occur whenever there is a transfer of care from one provider to another. For example, when:

- a practitioner is covering for a fellow practitioner who is on leave or is unexpectedly absent
- a practitioner is covering for a part-time colleague
- a solo practitioner is handing over to a locum GP
- a practitioner is handing over care to another health professional, such as a nurse, physiotherapist, podiatrist or psychologist
- a practitioner is referring a patient to a service outside the practice
- there is a shared-care arrangement
- there is an emergency, such as handover to and from hospitals, mental health inpatient facility or ambulance
- a person is discharged from a hospital or mental health inpatient facility back to their GP
- the patient makes a request, for example to transfer their health records to a different general practice.

Meeting these criteria

Whenever a transition of care occurs, clinical handover could be facilitated by:

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

Transitions of care during acute health emergency situations

Transitions of care during an acute health emergency can present higher risks of harm to patients, particularly if the health service is not well prepared for such an event. Acute emergency situations in general practice could include (but are not limited to) acute medical episodes such as a heart attack, mental health event, asthma attack, convulsions, head injury or other trauma or pregnancy related events such as premature delivery.

The practice could implement processes addressing transitions of care during emergency health situations, for example:

- incorporating the concept of ISBAR (Identify, Situation, Background, Assessment and Recommendation) into transitions of care
- outlining how to communicate all relevant health information to the practitioner or service taking over the patient's care (which could include providing physical documentation)
- reviewing whether the patient's medical record (which could include My Health Record, with the patient's consent) is current and accessible to responsible services and/or clinicians.

If the practice is aware that a patient has been admitted to hospital or other facility (either while attending the general practice or in the community), it is good practice to have follow-up protocols once they have been discharged, including processes to review and follow-up up discharge summaries and other documentation, including those received electronically, if needed.

The practice could document processes to follow during handover, including:

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

Emailing referrals

The RACGP has developed a resource that shows the risk associated with emailing certain types of information to patients or other healthcare providers, depending on the practice's policies and processes.

Although the Privacy Act 1988 does not prescribe the method of communication a healthcare organisation uses to pass on health information to patients or third parties, it does require that the practice takes reasonable steps to protect the information and the patient's privacy.

Unless the patient has consented otherwise, the practice needs to protect patients' privacy when communicating electronically with or about them, via a secure messaging system or other method of encryption. See F9 – Confidentiality and privacy of health and other information for further advice.

Responding to requests for patient health information

A patient's health information may be requested by the patient, another practice, or third party. For example, a patient's new practice may request a copy of the patient's health record. The practice's privacy policy needs to address the timely, authorised, and secure transferral of patient health information in response to such valid requests.

When transferring patient health information to others, for example to patients, other health service providers, or in response to third-party requests, follow the relevant processes in the Australian privacy principles (APPs) and all requirements of relevant state or territory laws.

In line with F9 – Confidentiality and privacy of health and other information, practices need to transfer patient health information securely. If the practice chooses to send patient health information via email, security measures are required to protect patient health information.

Contact the practice's medical indemnity insurer or medical defence organisation (MDO) with concerns about third-party requests for the transfer of patient health information.

Additional ways to facilitate timely transitions of care

To further facilitate timely transitions of care, the practice could:

- keep records of any breakdowns in a clinical handover system that were identified and addressed
- have a policy explaining how to conduct internal and external handovers, including to locum practitioners
- have a shared-care arrangement when appropriate
- create and document a buddy system
- use internal messaging or internal email for members of the clinical team to communicate with each other
- use a clinical information system that enables the practice to upload a patient's shared health summary/record or event summary to the patient's national shared electronic health record when the patient requests it
- have a policy or process that addresses how the practice acts upon all correspondence (including paper and electronic communication) in a timely and appropriate manner
- inform patients of any potential costs associated with the transfer of their health information and consider whether a cost would impede the safe transfer of care.

Resources

- RACGP:
  - *A guide for ensuring good referral outcomes for your patients*
  - *Managing external requests for patient information*
  - *Information security in general practice*
  - *Patient communication via electronic media – including email*
  - *Electronic sharing of information*
  - *Internet and email use*
  - *Using email in general practice*.

- The RACGP and Advanced Pharmacies Australia have developed the following resources to help practices manage medications during transitions of care:
  - *Medication management at transitions of care*
  - *Safe medication management at transitions of care*
  - *Consumer guide: Medication safety when moving between the community and hospital*.

- Australian Commission on Safety and Quality in Health Care:
  - *Principles for safe and high-quality transitions of care*
  - *Transitions of care*.

- Services Australia: *Refer or request Medicare services*
- National disability insurance scheme (NDIS) website
- NDIS: *Information for GPs and health professionals*
- Office of the Australian Information Commissioner (OAIC): *Guide to securing personal information*
- Avant: *Email communication with patients: privacy and patient safety*.

CG6 – Follow-up systems

Consumer expectation statement: I expect that this practice has systems in place to notify me of results. This includes quick and effective communication of high-risk results, so I know what action is recommended.

CG6.A The practice acts on all clinical information received regarding its patients in a timely manner.

The practice:

- has a system for GPs to review, notate, act upon and incorporate clinical information which is received by the practice into the patient health record
- has follow-up systems for recalling and documenting interactions with patients who have clinically significant results, which include documenting in the patient's health record each attempt to contact and recall patients with clinically significant results
- has a process to follow-up results and investigations when they have not been provided to the GP
- has a process for the initiation, management and documentation of patient reminders
- educates members of the practice team so they can inform patients about the practice's processes for receiving and advising results.

Members of the clinical team:

- ensure that pathology results, imaging reports, investigation reports and clinical correspondence received are:
  - reviewed
  - electronically notated, or, if on paper, signed or initialled
  - acted on where required
  - incorporated into the patient health record.

CG6.B The practice has a system to manage high-risk (seriously abnormal and life-threatening) results identified outside normal opening hours.

The practice:

- has a policy that outlines the process for the practice's management for high-risk results identified outside of normal opening hours
- provides its main diagnostic services with the contact details of the practitioner responsible for results outside normal opening hours, such as the practitioner who ordered the investigation or delegated practitioner or after-hours service.

Why this is important

Acting on correspondence

The information obtained from investigations can affect the choices that a patient, the GP, and other clinicians make about the patient's care. Clinically significant results need to be communicated quickly and appropriately so suitable action can be taken to reduce the likelihood of an adverse patient outcome. GPs are well placed to understand the context around significant results, for example, medication changes that might need additional monitoring in a particular patient.

Managing patient results

Recall refers to the process of requesting a patient to attend a consultation regarding significant clinical matter/s. Failure to recall a patient may result in an adverse outcome and the responsible practitioner may face medico-legal action.

Reminders are proactive prompts given to patients to visit their practice for routine or important tasks related to their health. Using reminders will mean that patients are more likely to, for example, come back to the practice to undergo a preventive activity such as cancer screening.

Meeting these criteria

Recalling patients

A recall occurs when a patient needs to be reviewed within a specified period. For example, the practice might recall a patient on behalf of a member of the clinical team:

- to discuss a clinically significant investigation result
- to discuss a report received from a specialist
- after diagnosis of a significant condition
- for medication management, particularly where missing a review could have a significant consequence, for example with a long-term injectable medication.

Clinical team roles and responsibilities

The practice could implement the following processes to help ensure that clinical information is appropriately reviewed, notated, acted on and documented in the patient's health record:

- provide clinicians with remote access to the clinical software
- use secure electronic platforms to facilitate the communication of recalls with patients.

Recall process

The practice's recall process could include:

- a policy or other document outlining how patients are followed up regarding recalls, including:
  - the roles and responsibilities of different members of the practice team
  - how results and recalls are communicated to patients such as via phone call or text message
  - the number, frequency and nature of the attempts the practice will make to contact the patient
  - for example, it may be useful to make up to three telephone calls at different times of the day and then attempt to contact the patient via email, text or mail. This process will depend on the practice setting and the processes used for recalls. The practice could begin with electronic notifications followed by a phone call or letter.
  - what information different members of the practice team can convey and how to convey it, for example if reception staff are responsible for contacting patients with clinically significant results to make an appointment, explain the best type of language to use in such a conversation
  - how to consistently document the contact with the patient in their patient health record
  - the actions the practice will take if the patient:
    - does not respond to recall notifications
    - is not notified of an outstanding result during a consultation regarding an unrelated matter
- recommendations about what information needs to be recorded, such as clinical discussions and outcomes, in patient health records
- how the practice ensures tests and results are reviewed and acted upon in a timely manner.

Reminders

Reminders are used to help manage preventive care and can be set up before or during a consultation by noting in a patient's health record when the patient is due to return to the clinic for a routine check. For example, the practice could send an email, letter or text message to patients on behalf of a clinical team member who are:

- in high-risk cohorts for vaccine preventable diseases (including children, patients who are immune-compromised and older people)
- eligible for national cancer screening programs.

The practice's process regarding non-clinically significant patient reminders could address how (or whether) they are followed up or recorded if the patient does not respond.

The practice could:

- appoint a member of the practice team to be responsible for managing recalls and reminders
- have reminders sent through the clinical information system
- maintain templates in the clinical information system to send out standard correspondence when a reminder is triggered, such as via text or email
- educate members of the practice team so they can tell patients about the process of sending out reminders
- publish the process the practice uses to send reminders to patients.

Follow-up of high-risk (seriously abnormal and life-threatening) results identified outside of normal opening hours

The practice needs to have a policy to describe its management of high-risk results that are identified outside of normal opening hours. This includes advising its main diagnostic services of appropriate contact details to communicate high-risk results back to the referring GP or their delegate outside of normal opening hours. This contact information includes the requesting GP's phone number or the after-hours and medical deputising service (AHMDS) contact information.

If the practice engages an AHMDS, it is recommended that the practice explains to deputising doctors what is expected of them if they receive urgent and life-threatening results for one of the practice's patients. The deputising doctor has a responsibility to contact the patient outside normal opening hours if necessary and inform the general practice the following day. See criterion AHS1.6 – Follow-up systems of the *RACGP Standards for after-hours and medical deputising services* for further information).

Resources

- RACGP Information security in general practice:
  - *Patient communication via electronic media – including email*
  - *Electronic sharing of information*
  - *Internet and email use*
  - *Using email in general practice*
- Office of the Australian Information Commissioner (OAIC): *Guide to securing personal information*
- Avant: *Email communication with patients: privacy and patient safety*.

CG7 – Managing clinical risks and incidents

Consumer expectation statement: I expect that clinical risks are properly reported, investigated and documented, and that improvements are made to reduce risk.

CG7.A The practice has a clinical risk management system that identifies, monitors, mitigates and evaluates clinical risks in the practice.

The practice:

- has a documented process for clinical risk management
- develops procedures to mitigate clinical risks
- maintains a clinical risk register
- reports results of risk identification, management and mitigation, including lessons learnt, to the practice's leadership
- has appropriate systems in place to receive and share relevant public health notifications to relevant members of the practice team in a timely manner.

CG7.B The practice monitors, identifies, responds to, reports on, and improves its processes related to significant clinical incidents and near misses, including patient safety incidents.

The practice:

- maintains a clinical incident or event register
- informs members of the practice team how and to whom to report a near miss or significant clinical incidents, and that they can do so without fear of recrimination
- investigates and analyses the causes of near misses and significant clinical incidents to reduce the likelihood of recurrence
- implements improvements when learning from significant clinical incidents and near misses including recording, reporting and sharing actions and learnings.

Why this is important

Mitigating clinical risk

Mitigating clinical risk improves the quality of patient care. A clinical risk register identifies and records potential risks so that the practice can take action to reduce the likelihood of the risk occurring or recurring.

Managing patient safety incidents

Patient safety incidents in clinical care occur in all health settings. Incidents that cause harm are referred to as 'significant clinical incidents'. Those that had the potential to cause harm, but did not, are referred to as 'near misses'.

A system to record and analyse near misses and significant clinical incidents helps practices identify, implement, and test solutions to reduce the likelihood of recurrence.

It is good practice to share learnings from significant clinical incidents and near misses with the practice team. This could include learnings from positive experiences, such as where an existing system has prevented a significant clinical incident.

Information regarding reporting incidents through the Australian open disclosure process can be found at PP7 – Open disclosure and complaints.

Meeting these criteria

Clinical risk register

The clinical risk register could be a simple system such as a table or spreadsheet to identify, monitor and document clinical risk. Once clinical risks have been identified, the practice could develop a risk matrix to assess and define the level of each identified risk, for example low, moderate, high, extreme, based on a combination of the:

- nature of the harm that could be caused by a particular risk
- likelihood of an event
- severity of its impact if it were to occur.

To proactively identify, assess, and mitigate risk further, the practice could:

- schedule regular risk management meetings and/or include risk management as a standing agenda item for clinical meetings
- implement continuous quality improvement processes that directly address risk, including those identified in the risk register, to make improvements to care, such as via audits, peer review, clinical guideline review
- foster a strong safety culture, for example by promoting open communication among the practice team that encourages members of the practice team to report risks
- maintain a clinical governance framework that ensures accountability, transparency, and quality in clinical practice
- provide ongoing risk management training and education to members of the practice team.

Managing significant clinical incidents

A 'just culture' recognises significant clinical incidents as opportunities to understand causation rather than immediately assign blame[32]. It enables members of the practice team to voice concerns and learn when something goes wrong without fear of blame or retribution.

To promote a 'just culture' and reduce near misses and significant clinical incidents, the practice could:

- develop mechanisms for practitioners to talk to trusted peers and supervisors for advice and support
- implement 'Plan, do, study, act' (PDSA) cycles to improve the quality and safety of care
- have the practice's medical defence or medical indemnity insurer check and approve the process for recording and responding to near misses and adverse events.

Resources

- Medical Board of Australia: *Good medical practice: a code of conduct for doctors in Australia*.

CG8 – Immunisations

Please note that the RACGP is currently obtaining further legal advice regarding CG8 – Immunisations.

Consumer expectation statement: I expect members of this practice team to be immunised according to guidelines to reduce risk to the health of the team and consumers.

CG8.A Employed members of the practice team and independent members of the clinical team have recommended immunisations based on the risks associated with their respective role.

The practice:

- has a process so all employed and contracting members of the practice team, and independent members of the clinical team, have up-to-date immunisation against infective diseases as mandated by the local state or territory
- communicates, recommends and offers employed and contracted members of the practice team, and independent members of the clinical team, immunisations recommended in the *Australian immunisation handbook*, as appropriate to their duties
- records the natural immunity to vaccine-preventable diseases or immunisation status of employed and contracted members of the practice team, and members of the clinical team engaged by the practice, (with their consent)
- has processes to protect members of the practice team who cannot receive vaccinations against specific infectious diseases due to health conditions.

Why this is important

Ensuring that employed and contracted staff have up-to-date immunisations protects all persons attending the practice premises from preventable infectious diseases. Having a structured process for recording and monitoring immunisation status assists the practice to adhere to local legal requirements.

Meeting these criteria

Practice team immunisation

Employed members of the practice team need to have immunisations as mandated in the local state or territory to protect the team from serious illness due to vaccine-preventable infectious diseases and from their transmitting such infections to patients. The practice also needs to communicate, recommend and offer employed or contracted members of the practice team any additional recommended immunisations, as appropriate to their duties.

The exact immunisation requirements and recommendations will depend on the risk of infection based on the practice's location, patient population and the duties of each member of the practice team. The practice could conduct a risk assessment regarding the types of immunisations each practice team member needs to have based on their role. Please see the *RACGP Infection prevention and control guidelines*, the *Australian immunisation handbook* and CG 9 – Infection prevention and control, including reprocessing for more information.

The practice could include in their contracts with members of the clinical team a requirement to have recommended immunisations based on the risks of their role and as mandated by the local state or territory.

In situations where a practice team member chooses not to have recommended or mandated immunisations, the practice needs to review relevant state / territory legislation or obtain legal advice to ensure they continue to comply with workplace protections.

The practice could provide members of the practice team the option to either receive required vaccinations at the practice or from their own GP or immunisation service. If a member of the practice team cannot receive vaccines, this needs to be documented so the member of staff can be allocated appropriate alternative duties in the event of an infectious disease outbreak.

Employed members of the practice team need to receive the vaccines they require before starting or within the first few weeks of working at the practice, and as recommended by the local state or territory health department.

Resources

- RACGP: *Immunisation resources*
- Department of Health and Aged Care:
  - *Australian immunisation handbook*
  - *Questions about vaccination*
  - *Immunisation resources*
- National Centre for Immunisation Research and Surveillance Australia: *Factsheets, FAQs and other resources*
- Australian Academy of Science: *The science of immunisation*.

CG9 – Infection prevention and control, including reprocessing

Consumer expectation statement: I expect that this practice uses current evidence-based Australian systems to protect me from infections.

CG9.A The practice has a written, practice-specific policy that outlines its infection control processes.

The practice:

- maintains an up-to-date practice-specific infection control policy that is based on current, evidence-based Australian guidelines and standards (specific requirements are outlined in the *explanatory materials*)
- communicates the policy with patients
- ensures all members of the practice team are aware of and implement the policy.

CG9.B The practice has at least one member of the clinical team with the roles and responsibilities of infection prevention and control coordinator.

The practice:

- has at least one member of the clinical team who has primary responsibility for infection control and the use of sterile equipment (their responsibilities are outlined in the *IPC Guidelines*)
- documents the responsibilities of the practice's infection prevention and control coordinator in their job description
- ensures all members of the practice team are aware of who is the practice's infection prevention and control coordinator and their responsibilities.

CG9.C All members of the practice team manage risks of cross-infection in the practice in line with current, evidence-based Australian guidelines and standards.

The practice:

- manages risk of cross-infection in the practice team, in line with current, evidence-based Australian guidelines and standards (the practice team's responsibilities are outlined in the *explanatory materials*)
- ensures the practice team understands all aspects of standard and transmission-based precautions, in line with current, evidence-based Australian guidelines and standards
- ensures the practice team has access to PPE
- safely stores and disposes of sharps and clinical waste.

CG9.D The practice's patients are informed about appropriate precautionary techniques to prevent the transmission of communicable diseases.

The practice:

- informs patients about appropriate techniques to prevent the transmission of communicable diseases, including respiratory hygiene
- provides patients with access to alcohol-based hand sanitiser and tissues
- provides patients who have respiratory symptoms with access to masks
- provides patients with access to soap and water after using the toilet.

CG9.E If the practice reprocesses reusable medical devices, it does so in accordance with the RACGP Infection prevention and control guidelines or another model that meets the current Australian standard.

The practice:

- includes in the practice-specific infection control policy details of risk assessment for reprocessing reusable medical devices
- reprocesses reusable medical devices in accordance with the RACGP *Infection prevention and control guidelines* or another model that meets the current Australian standard.

CG9.F The practice ensures that the record of sterilisation load numbers from the sterile barrier system can be traced to relevant patients.

The practice:

- has a process to record sterilisation load numbers for each patient when sterile items have been used.

Why this is important

Keeping patients and the practice team safe

Infection prevention and control reduces the risk of infection travelling from patient to patient, or between patients and members of the practice team.

Current, evidence-based Australian guidelines and standards

Using current, evidence-based Australian guidelines and standards helps maintain best-practice policies and procedures related to infection prevention and control. The RACGP's *Infection prevention and control guidelines* is recommended as it has been developed by GPs and nurses and uses an Australian evidence-base. Other Australian-based models the practice could consider include (but are not limited to):

- State-based infection prevention and control guidelines
- *Australian guidelines for the prevention and control of infection in healthcare (2019)*
- *Standards Australia guidelines for organisations on preventing, controlling and managing infectious diseases*
- *The Aged care infection prevention and control guide*

Accountability in infection prevention and control

Assigning responsibility for infection prevention and control to a member of the practice team is part of good governance and the delivery of safe and quality care to patients.

Risk-based approach for reprocessing reusable medical devices

By incorporating a risk-based approach and following the RACGP *Infection prevention and control guidelines* or another model that meets the current Australian standard for reprocessing reusable medical devices, the practice can systematically assess and mitigate potential hazards to protect patients from infection risks.

Meeting these criteria

Infection control policy

The practice's up-to-date practice-specific infection control policy contains:

- the role and position description responsible for infection control and sterilisation processes
- the appropriate use and application of standard and transmission-based precautions
- management of sharps injury
- management of blood and body-substance spills
- hand hygiene
- environmental cleaning of clinical and nonclinical areas of the practice
- use of aseptic and sterile procedures

- procedures for reprocessing (sterilising) instruments (if relevant) onsite or offsite, ensuring there is documented evidence this reprocessing is monitored and has been validated
- detail on managing occupational exposures, including steps for preventing, identifying, and managing exposure incidents
- waste management, including the safe storage and disposal of clinical waste and sharps
- where patients and the practice team can access PPE
- how and when members of the practice team are educated on the appropriate application, removal, and disposal of PPE
- the practice's process for managing potentially infected patients.

Review of infection control policy

The practice's infection control policy is an operational document and needs to be reviewed for currency every two years (see criterion F1.E).

Regularly reviewing and updating the infection control policy in line with current, evidence-based Australian guidelines and standards such as the RACGP's IPC Guidelines helps to:

- promote a culture of safety in the practice
- protect patients from emerging infectious diseases
- ensure the practice is implementing the most effective infection and control strategies
- address emerging risks such as disease outbreaks or pandemics
- maintain compliance with federal, state and territory regulations
- maintain a continuous quality improvement culture.

The practice could:

- conduct regular audits of the infection control policy, which could include observation of the practice team infection control practices, equipment maintenance and environmental cleaning
- request feedback from patients and members of the practice team regarding the effectiveness of the policy
- add 'infection control moments' to the standing agenda at practice team meetings.

Infection prevention and control coordinator

The responsibilities of the infection prevention and control (IPC) coordinator are outlined in the Risk assessment and planning section of the *IPC Guidelines*.

If the practice reprocesses sterile items onsite, the IPC coordinator is also responsible for the management of sterile items.

Educating the practice team

To reduce the risk of infection, all members of the practice team need to be competent in infection prevention and control processes, based on their role. This education could begin during induction and continue throughout their time at the practice.

Policies and procedures that include triage protocols and tools such as checklists will help all members of the practice team to understand their own and others' roles and responsibilities relating to infection.

Refer to section 1 of the current edition of the RACGP's *Infection prevention and control guidelines* (IPC Guidelines) for guidance about recording the education of members of the practice team and how to evaluate their competency in this area.

All members of the practice team need to:

- know who the practice's infection prevention and control coordinator is
- have easy access to PPE, for example masks, gloves, gowns, protective eye wear and hand sanitiser
- understand relevant infection risks and modes of transmission of common pathogens
- know when personal protective equipment is required and what type
- know who is responsible for ensuring that essential procedures are performed and be aware of the cleaning schedule
- know what to do if there is an accident or incident that risks exposure to infection

- know how to implement standard and transmission-based precautions, spills management and environmental cleaning (see below section on 'Managing the risks of cross-infection in the practice')
- be trained in the key components of education infection prevention and control, as outlined in the IPC Guidelines
- know how to perform hand hygiene
- educate patients on infection prevention and control activities.

Managing the risk of cross-infection in the practice

Refer to and follow the applicable sections of the *Infection prevention and control guidelines*, which recommend the use of standard and transmission-based precautions:

- during recognised periods of increased risk of transmission
- when interacting with potentially infectious patients
- when cleaning
- when performing procedures
- when dealing with spills and handling waste.

The practice could minimise exposure to other patients and members of the practice team by:

- conducting a risk assessment and identifying strategies to eliminate or minimise the risk of transmission, including the management of non-critical devices, for example, shared patient equipment
- implementing effective triage and appointment scheduling
- implementing distancing techniques, such as:
  - spacing patients in the practice in line with relevant health authority guidance
  - isolating the infected patient in a separate space
  - offering telehealth appointments to patients experiencing respiratory illness (if clinically appropriate)
  - considering whether home visits might be most appropriate for older or other vulnerable patients.

Educating patients about infection prevention and control

Patient education regarding appropriate precautionary techniques could involve:

- educating patients about how 'respiratory symptoms' present themselves, such as cough, sore throat, runny nose etc
- informing patients how they can reduce the spread of infection while at the practice, for example via the practice's website and social media, or by displaying signs in the waiting room
- displaying posters and/or brochures promoting good respiratory hygiene throughout the practice's premises
- running simple social media campaigns educating patients about respiratory hygiene and instances where telehealth appointments are most appropriate to prevent the spread of infection
- using the patient appointment booking system to remind patients about respiratory hygiene techniques, such as via an alert at the time of booking
- including reminders about respiratory hygiene on the practice's website, email signatures or telephone voicemail system
- directing patients towards state or territory advice and resources.

Isolation

Isolating infected patients can minimise the risk of infection transmission. Isolated patients need to receive appropriate medical care and observation while isolated and have access to bathroom facilities.

Isolation areas require additional cleaning, especially where there is a risk of multi-resistant organism transmission. The member of the clinical team responsible for coordinating prevention and control of infection need to collaborate with all relevant staff to minimise the risk of outbreak.

Risk-based approach for reprocessing reusable medical devices

The practice needs to develop its own risk assessment process for the reprocessing of reusable medical devices.

The RACGP *Infection prevention and control guidelines* provides advice regarding the reprocessing of reusable medical devices, including a template for general practice risk-based assessment for reprocessing reusable medical devices.

Clinical waste management

Refer to and follow Cleaning, laundry and waste management within the IPC Guidelines, which provides guidance on clinical waste management that could be used when developing an infection prevention and control policy.

Keeping up to date

Keep up to date with changes in laws and guidelines relating to infection prevention and control and implement them promptly. Establish:

- systems for monitoring and obtaining information about public health alerts for national and local infection outbreaks
- protocols for managing outbreaks of infectious disease, in line with local, state and national guidance.

Resources

- RACGP: *Infection prevention and control guidelines*
- Australian Commission on Safety and Quality in Health Care:
  - *Australian guidelines for the prevention and control of infection in healthcare (2019)*
  - *The Aged care infection prevention and control guide*
  - *Infection control signage posters*
  - *Resources for consumers*
  - *resources on environmental cleaning*
- National Health and Medical Research Council: Preventing infection
- Australasian College for Infection Prevention and Control: IPC for consumers
- *Standards Australia guidelines for organisations on preventing, controlling and managing infectious diseases*

CG10 – Practice environment

Consumer expectation statement: I expect that this practice provides my care in an environment that is clean, hygienic and ensures privacy.

CG10.A The practice environment accommodates the provision of safe, quality care.

The practice:

- ensures the practice environment maintains auditory and visual privacy during patient consultations
- ensures that consultation rooms have solid doors and provides adequate privacy screening around the examination couch/bed
- has a policy that describes the process for optimising patient privacy during consultations, if the practice does not have a physical practice environment
- has space that accommodates patients and caregivers in distress
- has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time, if the practice has a physical practice environment
- has a cleaning policy aligned with the RACGP *Infection prevention and control guidelines* or another relevant Australian standard
- ensures the practice team and patients have timely access to toilets, that have:
  - hand washing and drying facilities, including a sink and liquid hand soap
  - rubbish bins
  - sanitary bins or hygienic means to dispose of sanitary items
  - change table
  - exhaust fan/s or natural ventilation.

Why this is important

Practice environment

Without an appropriate practice environment, patient care can be compromised, and patient safety may be put at risk. The practice environment therefore needs to enable members of the practice team to perform their duties safely and effectively. Practice environment in this instance refers to practices that operate either with or without fixed physical premises.

Meeting these criteria

Privacy and patient dignity

The practice needs to protect the dignity of each patient by optimising both visual and auditory privacy. A consultation or examination space itself may not be able to guarantee complete audible privacy, but reasonable steps need to be taken to maintain privacy during patient consultations. The practice could consider whether:

- it is possible to have a spare consulting room or quiet area to provide privacy for patients in distress
- private conversations with or regarding patients can be held in quiet, separate areas
- computer screens are hidden from the view of patients and other visitors
- the layout, music and other features protect patient privacy during discussions, for example the protection of details such as phone number, address and medical information.

Visual privacy helps ensure that others cannot see the patient during the consultation, and that the patient can undress in private and be covered as much as possible during an examination.

This is achieved by:

- ensuring each consultation space has gowns or sheets to cover patients
- providing curtains around the examination couches

Auditory privacy helps to facilitate that other people cannot overhear a consultation. Where the practice has dedicated consultation rooms, the rooms need to have solid doors. Privacy could also be achieved by:

- using sound-proofing tape around door frames and a draught-excluder at the base of doors if applicable, noting this needs to be balanced with adequate heating, ventilation and air conditioning
- playing appropriate background music to mask conversations between members of the practice team and patients.

If a physical practice environment has areas where auditory privacy is not possible, such as nurses' treatment bays, there needs to be a private room available for confidential conversations.

Design and layout

The practice needs to maintain patient privacy during consultations regardless of where those consultations occur. If the practice has a physical practice, the layout of the practice will ideally provide reception staff clear sight of the waiting areas, so that they can see and monitor waiting patients.

A practice operating within a physical building can maintain privacy by using dedicated consultation rooms, while an outreach service consulting in the community may not have a dedicated space and may need to employ privacy strategies that suit its given setting.

The practice could also consider the cultural requirements of patients in areas such as the waiting room.

The practice could consider ways to keep consultation rooms at a comfortable temperature.

Ventilation and building design

Good ventilation is an important way to reduce the risks of airborne transmissions of microbial infections in enclosed spaces. The practice could do this by:

- conducting a risk assessment for the best type of ventilation for the practice based on factors such as practice layout, patient demographics and cost
- using natural airflow (such as keeping windows open provided patient privacy is not compromised)
- embedding it into the building design by engaging a ventilation engineer or occupational hygienist
- air cleaning by filtration, for example by using a properly installed HEPA filter
- other air-cleaning and disinfection technologies[33].

Privacy when providing consultations by telehealth

Patient privacy and confidentiality during telephone and video consultations rely on secure environmental/physical, audio and visual components. Refer to the RACGP's *Guide to providing telephone and video consultations in general practice* for guidance on how to maintain privacy and confidentiality when providing telephone and video consultations.

Location of toilets and hand-cleaning facilities

Ideally a practice has separate toilets for the practice team and for patients. However, if this is not possible, it may be necessary to ensure access to toilets that are very close by. For example, if the practice is located within a shopping centre.

Washbasins need to be in or close to the toilet cubicle to reduce the possible spread of infection.

As per the *IPC Guidelines*: *the use of alcohol-based handrub is now recommended for routine hand hygiene for dry, visibly clean hands, except after using the toilet, before handling or eating food/drink, or when norovirus or Clostridioides difficile is present or suspected – antimicrobial soap is recommended in these instances.*

Maintaining a clean practice environment

Practices need to have a current cleaning policy that identifies responsibilities, work health and safety issues, and procedures for routine scheduled cleaning, unscheduled cleaning, and monitoring of effectiveness. Refer to section 9 of the Infection prevention and control guidelines for details on what to include in a practice cleaning policy.

Practices need to regularly inspect, clean and maintain their practice equipment and environment to facilitate safe patient care. The Australian Commission on Safety and Quality in Health Care has resources on environmental cleaning which can help the practice (whether the practice has a physical premises or not) implement processes to maintain a clean and hygienic environment, including risk assessment, environmental cleaning audits, staff training, cleaning schedules and cleaning equipment and products. The RACGP's *IPC Guidelines* provide guidance on scheduled cleaning.

Resources

- RACGP General practice toolkit: *Layout*
- RACGP: *Guide to providing telephone and video consultations in general practice*

The following resources provide advice on optimising ventilation in the practice:

- RACGP's *Infection prevention and control guidelines*
- AusHFG (Australasian health facility guideline) part D: *Infection prevention and control*

CG11 – Practice equipment

Consumer expectation statement: I expect this practice has and maintains the equipment and medicines to provide the care I need, and the clinical team can use them safely.

CG11.A The practice has equipment that enables the provision of comprehensive primary care, emergency care and resuscitation.

The practice:

- has all required equipment listed below, ensuring each item is maintained, calibrated annually, and stored according to manufacturer's instructions, easily accessible and in working order at all times.

Required practice equipment:

- ability to view X-rays
- auriscope
- automated external defibrillator (AED) that is easily accessible, clearly sign-posted and not exposed to extreme temperatures
- basic minor procedural equipment (including suturing equipment, local anaesthetic)
- blood glucose monitoring equipment
- disposable gowns
- disposable syringes and needles
- doctor's bag (see below for list of required equipment)
- DRSABCDE and anaphylaxis charts
- electrocardiograph
- equipment for resuscitation, including equipment for maintaining an airway for adults, children and infants, and equipment to assist ventilation, including bag and mask
- equipment for sensation testing
- emergency medicines
- examination light
- eye examination equipment, including fluorescein drops or strips
- gloves (sterile and non-sterile)
- goggles
- height adjustable bed
- height measurement device
- intravenous access consumables
- infant weighing scales if appropriate to the patient population
- measuring tape
- ophthalmoscope
- oxygen
- reflex hammer
- pulse oximeter (adult and paediatric as required)
- razors for emergency management
- scales
- scissors
- sharps container
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer (with small, medium and large cuffs)
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips, including pregnancy testing kits
- vaginal specula
- visual acuity charts.

- **Doctor's bag:**

- auriscope
- blood glucose monitoring equipment
- disposable gloves
- equipment for maintaining an airway in adults and paediatrics
- flushes
- hand sanitiser
- in-date medicines for medical emergencies
- intravenous access consumables
- practice stationery (including prescription paper, letterhead and pen)
- pulse oximeter (adult and paediatric as required)
- ophthalmoscope
- sharps container
- sphygmomanometer
- spills kit, if required
- stethoscope
- PPE
- syringes and needles in a range of sizes
- thermometer
- tissues
- tongue depressors
- torch
- urine testing strips
- waste bags.

CG11.B Members of the clinical team can use the practice's clinical equipment safely and effectively.

The practice:

- documents that members of the clinical team have been provided with education on the safe use of the practice's clinical equipment that is relevant to their role.

CG11.C The practice has timely access to a spirometer.

The practice:

- has timely access to a spirometer.

CG11.D The practice ensures that medicines, samples and medical consumables are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and relevant laws.

The practice:

- acquires, stores, administers, supplies and disposes of medicines, samples and medical consumables according to manufacturers' directions and relevant laws.

Why this is important

Practice equipment

Having well maintained equipment that is in working order at all times enables the provision of safe comprehensive primary care and emergency resuscitation.

A fully equipped doctor's bag gives GPs immediate access to core equipment, medications and stationery so they can provide the necessary care when they make home and other visits or in the event of an emergency off site.

Educating of the clinical team

Providing the clinical team with appropriate education on how to use the practice's clinical equipment relevant to their role helps ensure safe and quality care, reduce adverse events and maintain workplace health and safety.

Storage of medicines, samples and medical consumables

Medicines, samples and medical consumables must be managed in accordance with legislation and manufacturers' directions.

Meeting these criteria

Maintaining clinical equipment

Equipment that requires calibration, has consumables with expiration dates, or which is electrical or battery-powered, for example electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales and defibrillators, needs to be serviced annually in accordance with the manufacturer's instructions so that it remains in good working order.

The practice needs to store all hazardous materials, including liquid nitrogen and oxygen, in accordance with work health and safety regulations.

The practice could:

- maintain a register that lists all clinical equipment in the practice, along with schedules for cleaning, servicing and maintenance
- keep documentation from companies that have provided external equipment testing and calibration so regular maintenance checks can be scheduled
- maintain a checklist of equipment used in consultation rooms so the practice can record dates of servicing and regularly check that maintenance is up to date
- consider maintenance, cleaning and servicing of practice equipment as part of the procurement processes.

Consider infection prevention and control when maintaining equipment in the practice (see CG9 – Infection prevention and control, including reprocessing). This could include implementing strategies for maintenance activities, for example:

- scheduling maintenance outside of patient visiting hours
- performing deep cleaning before and after maintenance
- isolating work area using barriers.

Range of equipment

The practice could:

- maintain a checklist of equipment that is needed in consultation rooms
- maintain an equipment register, including all the required equipment and contents of doctor's bag
- perform a regular audit of the practice's equipment, including doctor's bag
- educate members of the clinical team in equipping the doctor's bag, including information about the medicines within it.

Height adjustable beds

Every practice with a physical premises needs to have a height adjustable bed for patient and staff safety. It is recommended that the bed be turned off when not in use to prevent user safety incidents. Follow these guidelines when purchasing height-adjustable beds:

- Preferred minimum range of height adjustment: 45–95 cm
- Preferred maximum weight capacity: 175 kg
- Preferred minimum width of table: 71 cm
- Preferred minimum length: 193 cm
- Number of sections: two (so the head section can be raised).

Patient demographics

The practice could consider whether it is appropriate to have different equipment tailored to the patient population, for example:

- bariatric beds, seats and scales
- equipment to assist with mobility, for example grab bars, raised seats.

Storing a doctor's bag

The practice needs to store the bag securely and in accordance with state and territory laws.

Deciding what medications to include in a doctor's bag

Determine which medications need to be included in a doctor's bag based on the:

- location of the practice
- local community's health needs
- types of clinical conditions likely to be encountered
- shelf life and climatic vulnerability of each medicine.

Requirements relating to the acquisition, use, storage, and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation, with which the practice must comply.

Pharmaceutical Benefits Scheme emergency drugs for a doctor's bag

Certain medications are provided to prescribers without charge through the Pharmaceutical Benefits Scheme (PBS). A list of medications available for inclusion in the doctor's bag is available at the PBS website and the emergency drug (doctor's bag) order form is available at the Services Australia website.

Emergency drugs for children

The Royal Children's Hospital Melbourne has developed an emergency medication and resuscitation resources page and emergency drug dose calculator which may be used when considering which items to include in a doctor's bag.

Education of the clinical team on the safe and effective use of the practice's clinical equipment

Education requirements depend on the specific equipment at the practice, the equipment's relevance to the role of the member of the clinical team, and the identified need for education by each member of the clinical team. Each member of the clinical team will have completed different education and training and therefore will need to identify whether they are already competent and whether they need education regarding each type of clinical equipment. Education may need to be provided if the practice acquires a new piece or type of clinical equipment. All education and training need to be documented.

The practice could:

- conduct education as part of the induction process
- facilitate ongoing education as needed
- keep a calendar, showing when refreshers are needed.

Spirometer

The practice needs to have timely access to a spirometer. The practice could purchase this equipment, or GPs could refer to a local provider so there is timely access.

Storage of medicines

To ensure patients' safe use of medicines, vaccines and other healthcare products, store these products appropriately and securely, dispose of them in accordance with relevant local and federal laws and do not use or distribute them after their expiry dates. The practice could appoint a designated person to have primary responsibility for the proper storage, security and disposal of medicines, vaccines and other healthcare products.

Requirements relating to the acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation, and practices need to comply with these laws. Refer to the local department of health for further information on the requirements related to the safe management of schedule 4 and schedule 8 medicines.

Consumables available at the practice

When managing medical consumables, the practice could:

- schedule audits of expiry dates of medical consumables
- appoint a designated person to have primary responsibility for the management of medical consumables
- consider the placement of consumables to ensure they are used before their expiry such as hand hygiene products.

Resources

- Pharmaceutical benefit scheme (PBS) website
- Emergency drug (doctor's bag) order form: Services Australia
- Australian Commission on Safety and Quality in Health Care:

  - National Mixed-Case Lettering List
  - Principles for the safe selection and storage of medicines: Guidance on the principles and survey tool

- Royal Children's Hospital Melbourne:

  - emergency medication and resuscitation resources
  - emergency drug dose calculator.

The practice could refer to the following resources to assist with spirometry use:

- Australian Commission on Safety and Quality in Health Care: *Chronic obstructive pulmonary disease (COPD) clinical care standard*
- *Australian Asthma Handbook*
- *Lung Foundation Australia*.

CG12 – Maintaining vaccine potency

Consumer expectation statement: I expect that this practice stores and delivers vaccines safely and effectively in line with current guidelines.

CG12.A The practice has a written, practice-specific policy that outlines its cold chain processes.

The practice:

- maintains a cold chain management policy and procedure that is:
  - based on the current edition of the *National vaccine storage guidelines: Strive for 5*
  - communicated to patients and members of the practice team
  - implemented by all members of the practice team.
- has a record of all monitoring of vaccine refrigerators, including the temperature.

CG12.B The practice has at least one member of the practice team who has primary responsibility for cold chain management in the practice.

The practice:

- has a member of the practice with primary responsibility for cold chain management, which includes ensuring the practice complies with the current edition of the *National vaccine storage guidelines: Strive for 5*
- ensures the responsible member of the practice team has had appropriate training in cold chain management and understands their role
- informs members of the practice team who is responsible for cold chain management
- has a process to delegate cold chain management when the member of the practice team with primary responsibility is unavailable.

Why this is important

Vaccine potency

The success of any vaccination program depends on the potency of vaccines when they are administered to patients. To maintain their potency, vaccines need to be transported and stored within temperature ranges recommended within the *National vaccine storage guidelines: Strive for 5*. The practice maintains vaccine potency by having a current cold chain management policy and a person responsible for cold chain management.

Meeting these criteria

Maintaining a cold-chain policy

The practice's cold-chain policy needs to be based on the current edition of the *National vaccine storage guidelines: Strive for 5*. The practice could ensure their cold chain policy remains current by:

- subscribing to updates with federal, state or territory health departments regarding cold chain requirements and public health alerts
- conducting regular quality improvement activities related to cold chain management.

Review of cold chain management policy

The practice's cold chain management policy is an operational document and needs to be reviewed for currency every two years (see criterion F1.E).

Nominating a person with primary responsibility

The practice needs to nominate a member of the practice team to take responsibility, authority, and accountability for cold chain management in the practice.

All members of the practice need to know which member of the practice team has primary responsibility for cold chain management so they can seek advice and support from this person with any questions about vaccine storage and supply.

The responsible person could:

- discuss the cold chain management policy in team meetings
- create a template to make monitoring and recording of refrigerator temperatures easier
- create a roster for monitoring cold chain compliance
- include education about cold chain management in induction and ongoing training for the practice team
- conduct an audit of vaccine storage to determine whether it complies with the *National vaccine storage guidelines: Strive for 5*.

Resources

- Department of Health and Aged Care:
  - *National Vaccine Storage Guidelines 'Strive for 5'*
  - *National Vaccine Storage Guidelines resource collection*
- Primary Health Networks (PHNs) provide localised cold chain management advice.

CG13 – Research

If the practice or any members of the practice team (including GP contractors) participate in or conduct research, the practice meets all criteria within CG13 – Research.

If the practice has not participated in research, criteria within CG13 – Research are not appliable.

Consumer expectation statement: I expect that this practice asks for my consent for research, gives me the choice to opt out, and ensures all ethics and approvals are in place.

CG13.A Any research the practice and/or practice team participates in has been approved by an appropriate Human Research Ethics Committee.

For any research that involves patients of the practice, the practice:

- keeps evidence of ethics approval for research activities
- maintains records of any research activity conducted at the practice
- complies with the research protocol
- provides evidence of an agreement between the practice and the research institution.

CG13.B If the practice conducts research, it confirms that the appropriate indemnity is in place for research, based on the level of risk.

The practice:

- maintains records of appropriate indemnity for the practice and GPs based on research activity level of risk.

CG13.C The practice only shares identifiable patient health information for research purposes to a third party with patient consent or if required by legislation.

The practice:

- documents in the patient's health record the patient's consent for the practice to transfer their health information to a third party to conduct research
- informs patients that declining to participate in research will not affect the care they receive at the practice
- allows patients to refuse consent for identifiable data provision to a third-party
- specifies in the privacy policy how patient health information is used in research.

CG13.D The practice only shares deidentified patient health information for research purposes to a third party in accordance with its legal obligations and ethical responsibilities.

The practice:

- enters into a formal data sharing agreement or contract with external parties who intend to use its deidentified general practice data for research or other secondary purposes
- ensures all parties demonstrate compliance with data management best practice
- provides information on secondary use to patients
- provides patients an opportunity to opt out of providing data for secondary uses.

Why this is important

Responsible research involves good governance and management, compliance with relevant legislation and the procurement of ethics approval (if applicable to the practice's research). This will often be done in conjunction with a research institution; however, if the practice chooses to conduct its own research, the practice will need to comply with relevant legislation and other obligations.

Legislation and codes of conduct

There are various codes of conduct and responsibilities under federal legislation that practices that conduct human research need to adhere. These include:

- the *Australian code for the responsible conduct of research* (the Code), which was developed by the National Health and Medical Research Council (NHMRC) and promotes integrity of research and provides guidance about responsible research practices
- the *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research* (the AIATSIS Code), which was developed by the Australian Institute of Aboriginal and Torres Strait Islander Studies. The practice could refer to the AIATSIS Code if the patient sample includes Aboriginal and Torres Strait Islander peoples.

Privacy

Practices conducting or participating in research need to collect, use and disclose data in compliance with privacy laws. Even for practices using de-identified patient health information, there are situations where informed patient consent needs to be obtained.

Human research ethics committees

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

There are many HRECs operating in institutions and organisations across Australia. A list of HRECs registered with the NHMRC is available here.

Information about the RACGP National Research and Evaluation Ethics Committee (NREEC) can be found at the RACGP website.

Ethics approval is usually required in research studies involving general practices and their patients, but there are some exceptions. The institution conducting the research or their Human Research Ethics Committee (HREC) will be able to provide advice regarding situations where ethics approval may not be required, and the practice's role in this process.

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

Meeting these criteria

The NHMRC's Australian code for responsible conduct of research defines 'research' as follows:

> *The concept of research is broad and includes the creation of new knowledge and/or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies, inventions and understandings. This could include synthesis and analysis of previous research to the extent that it is new and creative*[34].

The practice team needs to be familiar with the NHMRC's Code when participating in research. In addition, the practice may wish to develop a policy in collaboration with the research institution leading the research (if applicable) that is commensurate to the practice's involvement in the research. The policy could include information about:

- selecting a specific group of patients for research, for example patients with depression
- the process and documentation of ethics approval
- whether a specific room/s will be needed to conduct the research
- data storage, record keeping and compliance with privacy laws
- relevant training for the practice team
- information provided to patients.

Research indemnity and risk

It is important to understand the potential risks that individual research activities may have on the practice and its patients. The practice needs to confirm that the appropriate indemnity is in place for research, based on the research project's level of risk.

The NHMRC *National statement on ethical conduct in human research 2023* (National Statement) gauges research by the amount of risk it may pose to people involved in the research. The NHMRC describes low risk and minimal risk research as follows.

> *Low risk research describes research, including some types of clinical trials, in which the only foreseeable risk is no greater than discomfort. Accordingly, research in which the risk for participants or others is greater than discomfort is not low risk research. Research in this category is considered higher risk research and carries risk of harm. Higher risk research requires review by an HREC.*
>
> *Institutions may choose to differentiate between levels of lower risk or between levels of higher risk for review or monitoring purposes. They may choose to develop review processes to accommodate these differentiations in level of risk, taking care to respect the principle of proportionate review when establishing any such review processes*[35].

Practices need to obtain their own advice about whether they require indemnity insurance for any research their practice is involved in.

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

An example of higher risk research is a clinical trial. If the practice is involved in a clinical trial, the practice will usually be indemnified by the sponsor such as a university or a drug company. The practice needs to make sure that the sponsor's indemnity covers the practice's liabilities. If it does not, the practice will need to get a separate insurance policy or indemnity.

If the research is not a clinical trial, it is recommended that the practice discuss all potential risks with the practice team and the lead external researcher, as well as the practice's insurance broker or indemnity insurer to determine whether extra insurance to indemnify the practice for research is required.

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

Formal data sharing arrangements

If the practice shares de-identified data for research or other purposes, the practice needs to enter a formal data sharing agreement or contract with the external party/ies that intend to use the practice's data. The RACGP's *Three key principles for the secondary use of general practice data by third parties* provides guidance on what to consider as part of the practice's data sharing agreement. The practice could also obtain advice from a lawyer or Medical Defence Organisation (MDO) on what needs to be included in the formal agreement.

Data management best practice

The practice needs to ensure it and the external parties with which the practice has a formal agreement comply with data management best practice. This includes:

- compliance with the *Privacy Act 1988* and the *Australian Privacy Principles*
- acting ethically with regard to general practice data
- only using the data for the agreed purposes
- ensuring data security
- special consideration for data linkage, which includes obtaining informed consent from the patient/s involved, such as bringing together data related to one individual, family, place or event from disparate sources.

Informing patients of secondary use of data

The practice needs to provide patients with information on the use of their health data by third party organisations and provide them with opportunities to opt out of providing their data for secondary use. Ensuring information transparency includes having processes or protocols in place to inform patients about how the data collected in the practice is protected in terms of privacy and ethical principles. The practice could use the following mechanisms to inform patients about how their data is collected and used, as well as how to opt out of data collection for research purposes:

- publishing information on the practice's website, social media channels and newsletters
- informing patients via the patient registration form about how their health information will be collected and shared, and how they can refuse consent to participate in research or opt out of data collection for research purposes
- posters throughout the practice.

In line with criteria at PP2 – Communication, the practice needs to provide information in ways that are understood by the practice's patients.

Sharing de-identified data

Many general practices share de-identified data as part of large research or public health data collection programs. If the practice shares de-identified data, it needs to be confident that re-identification cannot occur. To prevent re-identifying individual patients:

- identifiable demographic data needs to be separated from clinical data prior to linkage
- personnel involved in the linking of identifiable data do not have access to the clinical data
- personnel with access to clinical data are not involved in linking identifiable data.

Resources

- RACGP:
  - Australian General Practice Research
  - RACGP National Research and Evaluation Ethics Committee (NREEC)
  - *Three key principles for the secondary use of general practice data by third parties*
- National Health and Medical Research Council (NHMRC):
  - *Australian code for the responsible conduct of research*
  - *Human Research Ethics Committees*
  - *National statement on ethical conduct in human research 2023*
- Australian Institute of Aboriginal and Torres Strait Islander Studies: *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research*
- Office of the Australian Information Commissioner (OAIC):
  - *Privacy Act 1988*
  - *Australian Privacy Principles*

Patient participation standard

The Patient participation standard encompasses person-centred care – that general practices prioritise patient needs, values and preferences and empower patients to take an active role in their own healthcare. The standard emphasises that general practice teams understand that health, illness and disease are ultimately personal experiences, and that the team's role is to collaborate with patients to support their healthcare.

PP1 – Information about the practice

Consumer expectation statement: I expect that practice information is easy for me to access and understand and provided at the time I need it.

PP1.A Consumers can access up-to-date information they need about the practice.

The practice:

- makes practice information available to consumers. This includes, at a minimum, the following information:
  - the practice's address and telephone numbers
  - consulting hours and details of arrangements for care outside normal opening hours
  - appointment types
  - the practice's billing principles
  - a list of practitioners
  - the practice's communication policy, including when and how it receives and returns telephone calls and electronic communications
  - the practice's policy for managing patient health information (or its principles and how full details can be obtained from the practice)
  - the practice's policy for recalls and reminders
  - how to provide feedback or make a complaint to the practice
  - details on the range of services the practice provides.
- provides practice information:
  - in a timely manner
  - in formats that are accessible to consumers
  - in simple language that consumers understand
- updates practice information when there are any changes
- informs patients about out-of-pocket costs for healthcare they receive from the practice.

Why this is important

Accessing information

It is important that consumers can access the information they need and want about the practice, including the range and cost of services provided. This information needs to be accessible, correct, responsive and current.

Meeting these criteria

Acquiring the information that consumers need

The information that consumers need and how that information is presented will differ between practices based on patient population. Therefore, practices may determine what consumers need by engaging them and understanding their preferences. This could occur through:

- providing updates and responding to comments and queries on social media.
- routinely collecting patient feedback to identify what consumers need and concerns they may have.

If the practice serves specific ethnic communities, it could provide access to written information in the languages most used by these consumers. The practice can provide the information in many formats, such as:

- QR codes that link to websites
- on social media
- on the practice's website
- on printed information sheets.

Pictures and simple language versions help consumers who would otherwise be unable to read or understand the information. The practice could also display the languages spoken by the practice team on an information sheet or QR code on the practice website.

Appointment types

The information the practice provides to consumers about appointment types needs to detail whether in-person and/or telehealth appointments are available and in what circumstances. The practice could educate, and communicate with, consumers about the process and the benefits of an appointment type and length before they take place.

Costs

The practice could:

- place information about its billing policy on the practice website
- display billing information in waiting areas
- explain the billing policy in person to patients.

PP2 – Communications

Consumer expectation statement: I expect that this practice coordinates its communication with me so that I can access and understand the information I receive to support and enhance my care.

PP2.A Members of the practice team communicate with consumers in a manner that supports timely and effective care/partnerships.

The practice:

- facilitates communication between the practice team and consumers that supports timely and effective care/partnerships
- facilitates the use of interpreters when consumers do not speak the primary language of the practice team
- provides information in a format and language that is understood by the consumer
- informs the consumer about the forms of communication it allows such as telephone and electronic communication including email, and advise the consumer:
  - of specific phone numbers and email address(es) they can use
  - of how long they can expect to wait for a response
  - that they should not use email to contact the practice in an emergency.
- has procedures to manage:
  - how messages are communicated by the practice team– internal electronic messaging systems are preferable
  - how communication with the patient is recorded in the clinical information system
  - how a message is given to the intended person and what to do if the intended recipient is absent
  - how the practice team can respond to messages in a timely manner.

PP2.B The practice communication systems advise consumers to call 000 in case of an emergency.

The practice:

- has all practice communication systems inform consumers to call 000 if they have an emergency
- directs consumers who have called the practice to call 000 in the event of an emergency.

PP2.C The practice uses digital communication systems to enhance patient care.

The practice:

- uses digital communications in a way that enhances patient care.

PP2.D If the practice uses social media, it does so in a way that enhances patient care.

The practice:

- only uses social media in a way that enhances patient care.

Why this is important

Communication between members of the practice team and consumers results in effective partnerships and care. Consumers have a right to receive information about services, waiting times and costs and understand the information and recommendations they receive, including risks of different tests and treatments, and make informed decisions about their health, medical treatments, referrals and procedures[36].

Effective communication with consumers allows:

- consumers to contact the practice during opening hours
- consumers to make appointments and receive other information in a timely fashion

- an understanding of what to do in the event of a medical emergency
- urgent enquiries to be dealt with in a timely and medically appropriate way.

Meeting these criteria

Communicating in the event of an emergency

All communication systems at the practice should direct consumers to call 000 in case of an emergency. When receiving calls, reception staff should first ask if the matter is an emergency before putting the caller on hold. Where it is an emergency reception staff should direct the caller to contact 000.

Communicating by electronic means

For information about communicating with consumers electronically refer to the F8 – Information security

If the practice allows consumers to contact it by email or a website portal, inform them:

- of specific email address(es) or portal they can use
- of how long they can expect to wait for a response
- that they should not use email or the portal to contact the practice in an emergency.

Communicating with patients with specific communication requirements

For patients from culturally and linguistically diverse backgrounds or those with a specific communication requirement who need to use other forms of communication, use services such as:

- the National Relay Service (NRS) for patients who are deaf
- the Translation and Interpreter Service (TIS National) for patients who do not speak English or have limited English proficiency.

The practice team needs to know how to access the NRS for patients who are deaf or have a hearing or speech impairment.

Appropriately qualified medical interpreters are the preferred choice. The TIS National Service is free of charge for all private medical practitioners providing services eligible for Medicare rebates. Reception staff are also eligible to use this service for arranging appointments or providing results to patients.

Although Aboriginal and Torres Strait Islander peoples may appear comfortable with English, they may still benefit from being offered an appropriate interpreter or support person such as an Aboriginal and Torres Strait Islander Health Practitioner or Health Worker.

Consider the needs of patients who need assistance with communication due to hearing, speech or visual disability, or cognitive requirements. Augmentative and Alternative Communication (AAC) is when a person uses a different method of communication than speech[37]. They might use:

- body movement or gestures
- sign language
- a computer or other device
- communication books or other printed material[37]

The practice team could consider the following when communicating with a patient with a communication impairment:

- ask the patient about the best way to communicate if unsure
- speak directly to the patient, even if they are accompanied by a third party acting as a support person or advocate
- confirm the reason for their visit, their symptoms and other issues, and confirm that the patient has understood the information given to them
- use apps that allow voice activation translation or enable non-speaking people to communicate
- provide information in different formats such as audio and Easy Read[38] .

Further information about how the practice can communicate with patients who have communication impairments is available at Communication Rights Australia and at Novita Children's Services.

Patient refusal of interpreter

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

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

Translated and plain English resources

Consider having a directory of resources, services, online tools and websites that will help the practice to provide information in plain English and languages other than English. The Health Translations Directory provides health practitioners with access to translated health information if they are working with culturally and linguistically diverse communities.

Using digital communications and social media to enhance patient care

The practice needs to use digital communications and social media in a way that enhances patient care. Digital communications include, but are not limited to, the practice's use of email, SMS and electronic messaging apps, electronic health records, patient portals, mobile health apps, and remote patient monitoring. Social media encompasses any social media platforms used by the practice for the provision of patient care.

To raise patient awareness of the practice policies about the use of digital communications and social media, the practice could:

- put its digital communications and social media policies on its website and social media platforms
- have an automated response to digital communications from patients such as email or SMS that advises them of when they are likely to receive a response.

Resources

- Brisbane South PHN and North Western Melbourne PHN have education resources on communicating across cultures in primary healthcare.

PP3 – Respectful, culturally appropriate and culturally safe care

Consumer expectation statement: I expect to be treated in a respectful way that considers my cultural background and individual choices.

PP3.A The practice recognises and respects the diversity and individual choices of all patients.

The practice:

- facilitates culturally safe care for Aboriginal and Torres Strait Islander patients
- recognises diversity within the patient population and provides respectful and person-centred care.

Why this is important

Practices provide initial, continuing, comprehensive and coordinated care to the population they serve, tailored to the individuals in that population. Delivering respectful, culturally appropriate, culturally safe, and person-centred care requires respectful collaboration between patients and practitioners.

Patients' rights and responsibilities

All patients have the right to respectful and person-centred care that is accessible and considers and respects their identity, body diversity, religion and cultural beliefs. Respect for a patient means that care is available to anyone without bias or influence of one's own personal beliefs.

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

Understanding what culturally safe care is

Cultural safety is how a person experiences the practice including the practice environment, policies and procedures. When referring to Aboriginal and Torres Strait Islander peoples culturally safe practice is the *ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism*[39]. For Aboriginal and Torres Strait Islander peoples clinical and cultural safety are inextricably linked and cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities as recipients of care.

Culturally safe policies should aim to create *an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need, where there is shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening*[40] .

To promote culturally safe care that is free from bias and racism, the practice could facilitate the following for staff and contractors who are Ahpra registered and have an obligation as a registered professional:

- acknowledge the factors that impact individual and community health, including colonisation, systemic racism, social, cultural, behavioural and economic factors
- encourage the practice team to acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices
- recognise the importance of decision making, partnership and collaboration in healthcare which is self-determined by individuals, families and communities
- foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues[39].

Meeting these criteria

Culturally safe care

The practice team needs to understand the demographics and cultural backgrounds of the practice's patient population so that they can provide the most appropriate care. This could be achieved by using a clinical audit tool or census data to identify cultural groups in the patient population.

For the practice to provide culturally safe care for Aboriginal and Torres Strait Islander patients, the practice could:

- provide access to cultural awareness and cultural safety training for the practice team and keep records of the training in the practice's training register
- maintain a cultural safety policy for the practice team so that the practice team knows they are required to provide care that is respectful of a person's culture and beliefs, and that is free from discrimination
- regularly seek feedback from Aboriginal and Torres Strait Islander patients from the practice
- seek feedback from Elders in the local Aboriginal and Torres Strait Islander community
- collaborate with Aboriginal and Torres Strait Islander patients to co-design service at the practice
- have an Elders Council at the practice
- have members of the local Aboriginal and Torres Strait Islander Community act as cultural mentors to practice staff
- have an employment policy that employs Aboriginal and Torres Strait Islander staff
- make practice public areas welcoming to Aboriginal and Torres Strait Islander patients
- have culturally appropriate information that is available and accessible to Aboriginal and Torres Strait Islander patients
- allow practice staff to acknowledge and participate in significant events in the local Aboriginal and Torres Strait Islander calendar
- display signs acknowledging the traditional custodians of the land
- display Aboriginal or Torres Strait Islander art and flags.

Respectful and culturally appropriate care

To provide care that is respectful and recognises diversity, the practice could:

- maintain a policy about patients' rights and responsibilities
- educate the practice team on how to deliver care that is compassionate, person-centred and respects patients' rights
- maintain an anti-discrimination policy and ensure it complies with relevant discrimination laws
- have separate sections of the waiting room for men and women, if possible and culturally appropriate for the patient population
- hold meetings for the clinical team to discuss and identify the unique health needs of lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) patients and those of other gender and sexual diversities
- have a process where members of the clinical team ask patients about their cultural identity and beliefs
- display LGBTIQA+ symbols and/or flags
- have gender neutral toilets
- display organisational cultural protocols within the office, waiting areas and consultation rooms
- provide resources appropriate to the health literacy and cultural needs of patients
- consider having a patient representative or advocate that is invited to meetings with partners and managers when changes need to occur in the practice, or to consult on a new policy or initiative.

The practice could consider factors that may affect the provision of respectful and culturally appropriate care, including

- the patient's preference for a clinician of a specific gender
- the role of the patient's family
- the patient's right to not have family present
- the impact that the patient's culture has on their health beliefs
- history of traumatic events.

Refer to the *RACGP General Practice Patient Charter* for information about patient rights and responsibilities, including posters that can be used by the practice to make patients aware of these. The RACGP charter aligns with the *Australian Charter of Healthcare Rights*.

Resources

- The RACGP Aboriginal and Torres Strait Islander Health faculty has resources and guides to support practices. This includes Cultural awareness and cultural safety training and an Introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives that provides a guide to appropriate and respectful behaviour with Aboriginal and Torres Strait Islander Peoples and good practice tables support culturally responsive healthcare.
- The RACGP Aboriginal and Torres Strait Islander Cultural and Health Training Framework includes guiding principles and ways of working together with Aboriginal and Torres Strait Islander Peoples.
- The RACGP General Practice Patient Charter and guide for implementation supports the principle of a person-centred health system.
- PHNs can support general practices to provide culturally safe and appropriate care including training. Some examples include Hunter New England and Central Coast and Brisbane South PHN.
- Free online learning and resources can be found at NACCHO and Evolve Communities.

PP4 – Informed consent

Consumer expectation statements:

- I expect that the risks, benefits and alternatives of treatment are explained to me in a way I can understand and then choose to consent to or reject.
- I expect that this practice asks for my consent when an additional person is introduced into a consultation.

PP4.A The practice has processes to obtain and document informed consent for clinical procedures and treatments.

The practice:

- provides processes for clinicians to obtain informed consent for clinical procedures and treatments.

PP4.B The practice has processes to obtain and document informed consent for when a third-party is present.

The practice:

- facilitates the documentation of the patient's consent to the presence of a third party arranged by the practice.

Why this is important

Patients have a right to make informed decisions about their health and the healthcare they receive. A patient can only make an informed decision regarding a proposed treatment, procedure or care plan when they have been provided with sufficient information. Obtaining consent prior to the presence of a third party during a consultation, procedures or treatments undertaken means that the practice is complying with privacy laws and the patient's confidentiality rights.

Meeting these criteria

What constitutes valid informed consent?

Valid patient consent:

- is freely given without duress
- is given by someone who is legally capable (competent) of consenting
- is specific and covers the intervention or procedure to be performed[41].

A patient needs to have the legal capacity to be able to provide consent. For example, a person with cognitive impairment may not have such capacity. Where appropriate, a parent, legally appointed guardian or substitute decision-maker may provide consent on behalf of a patient. Where this is applicable, clinicians should identify the relevant person in the patient's health record and comply with the Australian Privacy Principles (APPs) in the *Privacy Act 1988* and other relevant state or territory law. Refer to F9 – Confidentiality and privacy of health and other information.

Inferred or express consent

Consent may be:

- express – when a patient signs or clearly articulates their agreement
- inferred (or 'implied') – where the circumstances are such to reasonably infer the patient has consented. For example when a patient cooperates with the healthcare professional's treatment or routine procedure, such as taking medication given, extending an arm for a blood sample, or attending a follow-up appointment to receive information or advice regarding the management of a condition[41].

Express consent needs to be sought wherever practical and/or where significant clinical risk is likely, for example, for a clinical or surgical procedure.

Documentation of expressed consent needs to refer to the information provided, the nature of the discussion (including a discussion of risks, potential harms and side effects) and the patient's response.

Consent to the presence of a third party arranged by the practice

Before the consultation commences, the patient needs to be asked if they consent to having a third party who is associated with the practice present during the consultation. Third parties can be interpreters, registrars, chaperones/observers, and medical, allied health or nursing students on placement.

If a student, nurse, or other health professional is to be present during the consultation (whether they are going to observe, interview or examine), the practice team is responsible for obtaining the patient's permission when the patient makes an appointment, or, failing that, when the patient arrives at reception. The practice could place signs in the waiting room when medical or nursing students are at the practice and observing consultations.

It is not acceptable that the first occasion where consent is sought is in the consulting room, as some patients may not feel comfortable refusing consent in the presence of the third party and therefore feel pressured into agreeing.

If a patient has previously given consent to have a third-party present, check that the consent remains valid prior to each consultation.

It may be necessary to later identify any third parties who were present during a consultation. For this reason, details of the third party need to be recorded so that they can be linked back to the consultation and subsequently identified if required. For example, the third party could beidentified by reference to their role, for example a nurse or medical student, or initials.

The practice could:

- maintain a policy about the presence of a third party during a consultation
- include information about the third-party policy in the induction manual for the practice team.

PP5 – Accessibility of services

Consumer expectation statement: I expect that I can access services that meet my needs, regardless of my abilities.

PP5.A All of the practice patients, including those with disability, can access services from the practice.

The practice:

- has infrastructure and processes that enable patients with disabilities or impairment to access its services.

Why this is important

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

Meeting these criteria

Access is important

All patients, including those with disability or impairment, need to be able to physically access the practice premises and services easily and safely. The practice could achieve this by:

- providing pathways, hallways, consultation areas and toilets that are wheelchair-friendly
- having a wheelchair that patients can use while they are at the practice
- installing appropriate ramps and railings
- using pictures, signs and other sources of information to help patients who have intellectual disability or vision impairment, or are not fluent in English
- having a transport service for patients who cannot otherwise get to the practice
- facilitate access where patients do not use or have access to digital health technologies, so they are not disadvantaged.

The practice could improve its non-physical access for patients with disability or impairment by:

- using existing and emerging technology to give patients access to telehealth consultations
- practitioners offering home visits, where appropriate.

Accessible parking

Where possible, inform consumers of the nearest disability parking to the practice.

PP6 – Health promotion and preventative care

Consumer expectation statement:

- I expect that this practice provides me with preventative health information and information on all issues relevant to my healthcare.
- I expect that this practice provides me with information about my health, treatment and care choices in a way I can understand to make decisions that are right for me.

PP6.A The practice provides patients with relevant information about preventative care, illness prevention and health promotion.

The practice:

- provides information about preventative care, illness prevention and health promotion.

Members of the clinical team:

- document in the patient's health record discussions or activities relating to preventative care, illness prevention and health promotion.

PP6.B The practice shares information with patients about environmental issues relevant to the healthcare they receive.

Why this is important

Health promotion, illness prevention and preventative care

Many health conditions can be avoided, or their impact can be reduced, by creating illness prevention and preventative care systems and environments[42]. Health promotion enables people to increase control over, and improve their health[43]

Sharing information about environmental issues with patients

The practice can help address environmental issues that contribute to health problems by sharing information about these with patients. This can support patients to make informed choices that support both the environment and overall health outcomes.

Meeting these criteria

Providing patients with relevant information about preventive care, illness prevention and health promotion

To provide patients with relevant information about health promotion, illness prevention and preventive care the practice could:

- review the practice's patient population and their healthcare needs, and provide relevant specific information
- include health promotion material in practice information, for example bowel screening, kidney health checks, diabetes or infectious diseases.
- provide a directory of local services that offer programs to help patients modify their lifestyle
- have culturally specific health information, for example Aboriginal and Torres Strait Islander health, in the practice.

Sharing information about environmental issues with patients

The practice needs to share information about environmental issues with patients by using resources that relate to their healthcare. The practice could:

- provide patients with information that explains the importance of reducing waste, conserving energy, and the benefits of using environmentally friendly products.
- inform patients about how to minimise the environmental impact of medications, such as returning unused drugs to a pharmacy to be destroyed.
- provide information to consumers about managing the impact of climate change on their health including extreme heat. For example posters in the waiting area such as the RACGP Climate change and health practice posters or links to digital resources.
- include sustainability-related topics when engaging patients.

For more information, see the RACGP's *Greening up: Environmental sustainability in general practice*

PP7 – Open disclosure and complaints

Consumer expectation statement: I expect that this practice manages and responds openly to complaints in a timely manner.

PP7.A The practice applies the Australian Open Disclosure Framework.

PP7.B The practice uses a complaints management process to respond to complaints in a timely way.

The practice:

- acknowledges receipt of each complaint to the complainant in a reasonable time
- maintains:
  - a complaints management process
  - a complaints register
  - practice information for consumers on how to escalate a complaint to the relevant complaints commissioner.

Why this is important

Open disclosure

Communicating openly and honestly following adverse events (including clinically significant incidents) shows compassion towards patients, improves the practice's relationship with its patients and allowing patients to be more engaged in their own care.

Managing complaints

Patients need to be able to raise concerns or complaints about the quality and safety of care at the practice.

Meeting these criteria

Open disclosure

Open disclosure is a discussion and exchange of information that may take place over several meetings. The practice has an obligation to facilitate the following for contractors and practice staff:

- respectfully explain to patients when things go wrong
- offer an expression of regret or genuine apology (if warranted)
- explain what steps have been taken so that the mistake is not repeated.

Incidents and near misses, including the discussion and any apology, can be recorded in the patient's record as per the *Australian open disclosure framework*.

To meet this criterion the practice could:

- maintain an open disclosure process, policy and guidelines
- educate and encourage the practice team to follow the process
- discuss open disclosure during induction of the practice team
- discuss open disclosure at practice team meetings
- introduce quality improvement initiatives based on incidents and near misses as part of the open disclosure process.

Disclosure to the patient following an incident that caused harm is beneficial to both the patient and the practice. Disclosure may also be appropriate where no harm appears to have been caused, especially if there is reasonable likelihood of harm resulting in the future because of the incident.

Contact the practice's medical defence organisation and insurer for further guidance and advice about when the practice may need to participate in open disclosure, and what kind of documentation the practice would require for risk management initiatives.

Managing complaints

If the practice receives a complaint, try to resolve the issue within the practice team in a reasonable amount of time. If the practice team cannot resolve the complaint, contact the practice's medical defence organisation for advice on resolving the complaint before any further action is taken.

The practice needs to:

- have a system to record, review and manage complaints
- maintain a complaints register
- advise consumers of the progress and outcome of their complaint
- inform consumers that the practice will always try to resolve complaints directly
- have information available at the practice or website for consumers on how they can escalate a complaint to the relevant state complaints commission.

The practice could:

- create a position description/s that include the responsibility for complaint resolution
- keep minutes or notes of practice or management meetings that where consumer complaints have been considered and discussed
- introduce quality improvement initiatives based on use complaints made to the practice.

Resources

- Australian Commission on Safety and Quality in Health Care has resources and information for clinicians and consumers on open disclosure, including implementing the Australian Open Disclosure Framework.
- Section 4 of the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia* provides advice about managing complaints at the practice level.

PP8 – Engaging consumers

Consumer expectation statement: I expect that this practice engages consumers in a proactive, ongoing and meaningful way to gain feedback on their experiences and uses these insights to improve care.

PP8.A The practice engages with consumers to monitor, review and improve care.

The practice:

- engages with consumers to improve care using formal and informal engagement

Why this is important

Engaging consumers in a proactive, ongoing and meaningful way to gain insights and feedback on consumer experience is linked with increased clinical effectiveness and patient safety, adherence to medication and the use of screening services[44].

Meeting these criteria

Engaging consumers

Engaging consumers is a term used when consumers (of a healthcare system) collaboratively work with health professionals or health service providers/organisations with the aim of ensuring that the care being received meets the needs of those consumers and is safe and of high quality[45]. Engaging consumers is an ongoing relationship that allows for planned and opportunistic engagement and implies two-way communication between parties.

Consumer engagement approaches

There are various levels (and approaches) that can be used to actively engage consumers in healthcare. Engagement approaches can be formal or informal.

Formal engagement is a structured and planned process that:

- seeks direct input from consumers or consumer representatives
- requires input from consumers at specific times
- is a combination of in-person and digital engagement[46].

Informal engagement uses instances of opportunistic engagement and:

- seeks wide input from consumers
- is more fluid and flexible in the engagement process
- allows for consumer input at any point in time
- may be online and digital in nature and where this is the case may be captured through digital analytics[46].

Applying formal consumer engagement approaches

Consumers of healthcare services can provide valuable insights for a practice. Practices can use various methods to collect either consumer outcome or experience data to help make ongoing improvements to services.

Patient-reported measures (PRMs) enable patients to share information about their healthcare experiences and the outcomes of their care[47]. PRMs can be collected across the care continuum, including general practices. There are standardised and validated tools to measure PRMs that specifically focus on either:

- patient-reported experience measures (PREMs) that capture the patient's perception of their experience with healthcare or services; or
- patient-reported outcome measures (PROMs) that help patients to report on outcomes relating to their health.

PROMs capture patient perspectives about how illness or care impacts on their health and wellbeing without interpretation of that perspective by a health care provider[48]. Insights from PROMs can be used to glean broader insights into health outcomes in the practice population if integrated with relevant clinical information[49].

The Australian Commission on Safety and Quality in Health Care has evidence on the use of PROMs, resources and information on the selection, use and implementation of validated PROMs, consumer information and case studies of successful implementation.

Table 4 outlines formal approaches practices could take to engage consumers[50].

Table 4 5 Mechanisms to formally engage consumer in general practice

Mechanism	Examples of how consumers could be engaging in general practice
Inform	• Social media and online platforms • Receive health information, practice news and results from consumer feedback through newsletters, emails and other media.
Consult	• Focus groups • Patient journey mapping • Follow up calls • Workshops and community events • Yarning circles for Aboriginal and Torres Strait Islander consumers • Use of technology for real-time feedback • Suggestion boxes
Involve	• Collect PREMs and PROMs • Speak at practice events of sessions on relevant topics • Participate in practice meetings on quality improvement activities or consumer feedback • Review practice materials or resources such as factsheets or website copy with a consumer lens
Collaborate	• Consumer advisory councils • Quality improvement committees
Empower	• Engage in the governance of the practice

Using consumer engagement to improve service provision

The practice could:

- create specific action plans to address areas for improvement raised by consumers
- plan annual processes such as flu vaccination based on previous years consumer feedback
- introduce a new service, healthcare provider or other changes based on consumer feedback and needs. For example, changes to reception, opening hours and/or days etc.

Resources

- The RACGP Aboriginal and Torres Strait Islander Health Introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives provides a guide on five levels of engagement with Aboriginal and Torres Strait Islander Peoples and considerations when planning to engage with Indigenous peoples.
- The Australian Commission on Safety and Quality in Health Care has developed a range of information and resources to support services to measure patient experience including a guide to implementing patient reported experience measures (PREMs).
- The Australian Commission on Safety and Quality in Health Care has a range of tools to support the implementation of patient reported outcome measures (PROMs) including the validated generic PROMs and specific high-burden conditions.
- The Agency for Clinical Innovation has resources for clinicians and patients to support the collection and use of PRMs, including how to use and select a patient survey, online training, research and evidence, and PREMs and PROMs survey's. Clinicians and patients in New South Wales can access the Health Outcome and Patient Experience (HOPE) platform to support the collection of PRMs
- Validated international PROMs that could be used depending on patient population or health condition include the Standard Sets of the International Consortium for Health Outcomes Measurement (ICHOM) and the Patient-Reported Outcomes Measurement Information System (PROMIS)
- The Insync's Patient Satisfaction Instrument (PSI) and the Consultation and Relational Empathy (CARE) are validated PREMs for primary care. Other tools that could be adapted include Practice Accreditation and Improvement Survey (PAIS), the Australian Hospital Patient Experience Questionnaire Set (AHPEQS) (available in Easy English and 20 languages), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
- The Centre for Culture, Ethnicity and Health (CEH) has consumer participation strategies to support engagement with consumers from culturally and linguistically diverse backgrounds. The Office of Multicultural Interests has Tips for engaging culturally and linguistically diverse communities and a guide for engaging CALD communities.

PP9 – Responsive system for patient care

Consumer expectation statement: I expect that this practice provides a variety of appointment types based on my current healthcare need.

PP9.A The practice has a triage system for prioritising patient care.

The practice:

- prioritises patients according to their urgency of need
- has a member of the clinical team who has primary responsibility for training the practice team in triage, including how to:
  - identify patients with an urgent medical need
  - identify emergency events and reprioritise appointments accordingly
  - seek urgent medical assistance from an appropriate member of the clinical team
  - manage patients with urgent medical needs when the practice is fully booked.

PP9.B Patients can access different consultation types to accommodate their needs.

The practice:

- provides a variety of consultation types
- provides information to patients about how they can access care when they are unable to attend in person.

Why this is important

Patients need to be able to access care that is flexible and recognises their needs. Members of the clinical team are required to be able to identify patients' needs and provide appropriate care to treat patients effectively. Patients need to be referred to the right clinician to receive the right level of care within an appropriate period.

Meeting these criteria

Consultations accommodate different patients' needs

The practice needs to provide different types of consultations, such as long and short consultations, and different levels of access such as appointment systems or walk-in services or telehealth, based on patients' needs. The practice needs to have a process to inform patients of different appointment types.

Triage training

The practice needs to have a member of the clinical team who has primary responsibility for training the practice team about triage, including how to:

- identify patients with an urgent medical need
- identify medical emergencies and reprioritises appointments accordingly
- seek urgent medical assistance from a member of the clinical team
- manage patients who have urgent medical needs when the practice is fully booked.

PP10 – Care when the practice is not open

Consumer expectation statement: I expect to find information about alternative ways to access care when this practice is closed.

PP10.A Consumers are informed how to access synchronous care that is provided by clinicians who meet Australian health professional obligations when the practice is not open.

The practice:

- informs consumers how to access synchronous care provided by clinicians who meet Australian professional obligations when the practice is not open.

Why this is important

Consumers need to be informed of how they can access care when the practice is not open. This includes when the practice is closed during an after-hours period and during periods that are not specifically 'after-hours'. This allows consumers to access appropriate healthcare when they need it and may decrease demand on hospital emergency departments. Synchronous care is care delivered to consumers in real-time. This could include telehealth services or face-to-face.

Meeting these criteria

Informing consumers about care outside of normal opening hours

To inform consumers about care outside normal opening hours, the practice could:

- use an out-of-hours message on the practice's afterhours phone number
- use its consumer information sources, for example on the practice website, email signatures, social media and posters
- display a clearly visible sign outside the practice of normal opening hours and arrangements for care outside of those hours.

Provision of after-hours care by the practice

For consumers to be able to access care after-hours, the practice could provide after-hours care directly, either during sociable after-hours or for the full after-hours period.

Provision of after-hours care by another provider

After-hours care may also be provided on behalf of the practice by another practice or provider, including urgent care clinics. If the practice uses a third-party provider (including telehealth), the third-party provider's clinicians need to meet requirements to practice in Australia.

Australian health practitioner obligations

If the practice does not provide care outside normal opening hours, the service to which the practice refers consumers must be provided by Ahpra registered doctors or nurses.

After-hours telehealth and arrangement with third-party providers

All after-hours telehealth consultations need to be synchronous (ie performed in real-time). If the practice engages with an after-hours telehealth provider or medical deputising service, a formal document with the provider could include details of the arrangements and:

- how and when the practice receives documentation and information about care provided to patients after-hours
- how the provider can contact the practice in an emergency or exceptional circumstances
- how the provider delivers safe and quality care that is patient-centred and culturally appropriate and meets its obligations under the Australian Privacy Principles
- the triage and escalation process for patients to consult with a clinician via telehealth after-hours
- how the provider will ensure patients requiring an in-person consultation will be seen either by a practice GP at a clinically appropriate time or referred to the local hospital or facility.

If the practice does not provide after-hours care, the practice could give the third-party the after-hours contact details of one or more GPs from the practice so they can access important information about the patient, particularly in an emergency.

Healthdirect

The practice could refer consumers to healthdirect (a national, 24-hour helpline provided by the Australian government), that can direct consumers to registered health professionals for health advice, including a GP or registered nurse call back or video call when the practice is closed.

Temporary closure periods

Examples of when a practice might be closed for a period that is not specifically 'after-hours' may include:

- staff absences
- holiday closures
- emergencies such as floods (See F2 – Response planning).

If the way the practice manages these instances differs from regular after-hours arrangements, the practice could consider a separate policy or procedure for this.

Resources

- RACGP Guide to providing telephone and video consultations in general practice.
- RACGP Telehealth and supervision: A guide for GPs in training and their supervisors.

Continuous quality improvement standard

The Continuous quality improvement (CQI) standard encourages general practices to continuously evaluate, monitor and improve the quality of their services to enhance patient care and experiences.

CQI1 – Continuous quality improvement activities

Consumer expectation statement: I expect that this practice continuously monitors the services and care provided and makes improvements to enhance patient care.

CQI1.A The practice team undertakes continuous quality improvement activities.

The practice:

- trains member/s of the practice team who have the primary responsibility for quality improvement activities in the practice about their role
- has a system to identify quality improvement activities
- undertakes at least one quality improvement activity every 12 months, one of which includes the use of coded clinical data
- keeps a record of feedback from the practice team about quality improvement systems
- documents quality improvements made to the practice or practice systems in response to feedback, complaints, or audits
- has processes to report performance data and quality improvement activities to the practice's leadership.

CQI1.B The practice assesses and acts on its environmental performance to track progress toward sustainability goals and compliance with its documented strategies to reduce direct and indirect carbon greenhouse gas emissions.

The practice:

- assesses progress toward sustainability goals and compliance and reports it to the practice's leadership
- implements actions based on the practice's assessment that reduce direct and indirect carbon greenhouse gas emissions.

Aspirational criterion

CQI1.C The practice measures environmental-impact metrics to assess and manage its overall environmental footprint.

The practice:

- assesses and manages its overall environmental footprint.

Why this is important

Continuous Quality Improvement (CQI) results in service improvements through continuous cycles of change led by the practice team. Using practice information and data to make quality improvements to practice structures, systems and clinical care will lead to improvements in patient safety and care.

Meeting these criteria

Roles and responsibilities

Having at least one member of the practice team who leads CQI in the practice establishes clear lines of accountability. The responsibilities of this role need to be agreed to and documented and need to be included in a position description or process document.

Engaging the practice team and leadership

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

- provide training for staff on quality improvement methodologies
- establish a quality improvement team that includes members from all parts of the practice that meets regularly to discuss practice and performance data, and leads improvements that are shared with the practice team
- include quality improvement as a standing agenda item at team meetings
- keep a record of quality improvement discussions at planning meetings

- provide virtual or physical noticeboards or suggestion boxes for the team to contribute their ideas
- have a system for developing, mandating, implementing and reviewing policies and procedures and keeping the team up to date with any changes
- create short surveys for the team to complete that are incorporated into a quality improvement plan.

The practice needs to report performance data and quality improvement activities to practice leadership teams which could include the practice owner, practice manager and clinical leads. These could be based on:

- structured or coded clinical data extracted from clinical software
- clinical audits of a particular treatment or service
- data reported to PHNs such as Practice Incentives Program (PIP) Quality Improvement (QI)
- activities undertaken by the practice quality improvement team.

Formal reporting of performance data and quality improvement to the practice leadership is not necessary to meet this criterion however the practice could:

- provide verbal updates in team meetings
- produce short summaries of data to share and discuss in team meetings
- include data and quality improvement as a standing item on the team meeting agenda.

Analysing and sharing data with the practice team and leaders helps build a culture of continuous quality improvement.

Continuous quality improvement activities

Improving care using clinical data

Analysis of coded data can be used to identity actions to improve clinical care for the practice's patient population. This could include:

- rates of immunisation
- chronic disease management and preventive health
- identifying patient population with health/lifestyle risks factors such as smoking, alcohol consumption, physical activity
- the use of antimicrobials in the practice.

The practice can promote the potential use of coded clinical data for clinicians' CPD and in practice team discussions. The RACGP's CPD activities in your practice provides information about how GPs could meet CPD requirements that can also support the requirements of criterion CQI1.A. Through this process the practice could also identify processes to improve data accuracy and completeness for example in patient health records.

Quality improvement activities that consider environmental performance and impact

Assessing environmental performance

The practice's quality improvement activities need to include assessment of environmental performance to track progress toward sustainability goals and strategies (as per the documented strategies aimed at improving the practice's environmental impact, see F3 – Environmental sustainability and responsibility).

To achieve this, the practice could:

- agree on measures to review the practice's environmental impact over time, such as energy consumption, waste generation, recycling practices, water usage
- set specific, measurable, and time-bound improvement targets for resource efficiency and environmental impact reduction
- inform patients about the practice's commitment to environmental responsibility and progress made
- review the environmental actions at regular intervals.

The practice needs to report its progress towards its sustainability goals to the practice leadership teams. This could also include making summaries of key environmental actions and outcomes standing agenda items at team meetings.

Aspirational – Measuring environmental-impact metrics

The practice could measure environmental-impact metrics so that the practice can assess and manage its overall environmental footprint (criterion CQI1.C is aspirational). This could include measurement over time of:

- water and electricity use
- waste reduction and recycling
- procurement choices
- the energy efficiency of practice equipment and appliances.

Many of the of the possible actions listed in Table 1 *Key non-clinical actions for an environmentally sustainable general practice* (See F3 – Environmental sustainability and responsibility) can be measured and assessed over time.

To achieve this, the practice could:

- define a set of performance indicators relevant to the practice, for instance, monitoring:
  - what materials and products the practice sources from sustainable suppliers
  - indoor air quality
  - the practice's generation and correct disposal of clinical waste
  - how much of the practice's energy consumption comes from renewable sources.
- use monitoring equipment to gather accurate and detailed information, for example energy and water meters
- review collected data to identify trends and areas where resource efficiency and sustainability can be improved
- communicate environmental metrics to staff and patients.

Introducing meaningful environmental sustainability improvements to the practice

Consider small changes that can be enhanced over time. Whether or not the practice premises are owned or leased, the practice could leverage what is already available, such as:

- requesting utility usage data from owners instead of setting up additional monitoring
- contributing to existing combined initiatives within the building (if sharing premises)
- leveraging existing property waste and recycling services.

Formal reporting of sustainable activities and results is not necessary to meet this criterion. The practice could produce summaries of key environmental actions and outcomes. These could become a standing agenda item at team meetings.

Resources

- Primary Health Networks provide useful quality improvement tools and resources for primary care. This includes using Practice Incentives Program (PIP) data to identify areas for improvement, how to use data extraction tools, quality improvement toolkits for specific conditions like asthma, cardiovascular disease, COPD, diabetes, and templates for QI activities like a plan-do-study-act (PDSA) cycle. Examples can be found at PHNs including Brisbane South PHN, Eastern Melbourne PHN, Hunter New England and Central Coast PHN, Nepean Blue Mountains PHN and South West Sydney PHN.
- The Clinical Excellence Commission has quality improvement resources including QI toolkits focusing on clinical areas where the risk of harm is well recognised including antimicrobial stewardship
- The Australian Commission on Safety and Quality in Health Care clinical care standards can be used as a tool to support quality improvement in specific conditions, treatments, procedures or clinical pathway to align with best practice.
- Business.gov.au offers further rationale and a template to develop a sustainability action plan, which can easily be adapted to practices for the purpose of meeting these criteria.

Point of care testing standard

The Point of care testing (PoCT) standard encompasses the systems that practices need to ensure PoCT supports patient safety and high-quality care. This includes effective clinical governance, appropriate education and training of PoCT practitioners, processes to ensure the successful implementation and performance of a PoCT program and systems to support quality outcomes.

PoCT1 – Clinical purpose

Consumer expectation statement: I expect that this practice follows evidence-based processes to ensure my safety when suggesting and performing point of care testing.

PoCT1.A The practice team can describe the clinical and diagnostic purposes of PoCT based on best practice evidence, and how it can be applied.

The practice:

- describes the clinical and diagnostic purposes for using PoCT
- ensures the clinical and diagnostic purposes of PoCT are evidence-based.

PoCT1.B The practice's specifications for the analytical performance of PoCT are determined by the relevant clinical and diagnostic purposes.

The practice:

- provides evidence that the analytical performance specifications of each test method are based on the clinical and diagnostic purposes for which they will be used
- demonstrates that the analytical performance of each test method has been evaluated upon commissioning and following major repairs.

PoCT1.C The practice team uses reference data that is based on best practice evidence to interpret test results.

The practice:

- demonstrates that the practice uses reference intervals and/or clinical decision limits for interpreting PoCT results
- demonstrates reference intervals and/or clinical decision limits are evidence-based.

PoCT1.D The practice team uses processes that minimise the risk to patients and improve the quality of PoCT.

The practice:

- records and addresses adverse and non-conformance events
- documents how it is reviewing adverse and non-conformance events, and documents the outcome of the review
- demonstrates that the practice can maintain continuity of care if PoCT is not available.

Why this is important

The purpose of PoCT is to help healthcare practitioners make immediate and informed decisions about a patient's care and management[51].

How PoCT is intended to be used

PoCT can improve the timeliness, efficiency and quality of care in some areas of clinical practice[52]. When deciding on the clinical and diagnostic purposes where PoCT may benefit patients, consider current best practice evidence.

Because PoCT can be used to diagnose, monitor, manage or screen, the practice needs to define its analytical performance requirements, based on its intended clinical and diagnostic purposes. For example, using PoCT to monitor a patient's diabetes may have different analytical requirements than to diagnose infections with public health implications[53].

Evaluation of PoCT systems

The quality of PoCT may be affected by many factors, including the storage of consumables, the knowledge and skills of PoCT practitioners, specimen quality and variability between instruments[54].

The practice needs to perform due diligence to ensure the PoCT device meets its needs. This may be through consulting literature or professional bodies. Evaluation of a PoCT system includes three aspects - Selection, Verification and quality procedures:

- Selection – PoCT devices should be evaluated and selected based on intended clinical use. These PoCT devices need to be assessed against the manufacturer's claimed specifications.
- Verification – the purpose of the verification process is to confirm (verify) that a particular PoCT system performs to and meets the manufacturer's stated specifications, and to validate the results against a known standard.
- Calibration, quality control and quality assurance – it is important that the use of calibration, quality control and quality assurance is assessed prior to implementation of a PoCT, to independently confirm appropriate and accurate performance of a POCT system.

Interpreting test results

The practice can interpret test results by using reference data obtained from various sources, including PoCT suppliers, pathology providers, international bodies and professional societies.

It is important that the practice:

- agrees on which reference intervals and clinical decision limits will be used to interpret PoCT results
- only uses reference intervals and clinical decision limits that are based on current best practice evidence.

Quality use of PoCT

Having a consistent approach to PoCT, which includes having agreed reference intervals and clinical decision limits, may help GPs to interpret test results.

Each GP needs to exercise clinical judgement when:

- deciding whether to use PoCT
- deciding whether to use results of PoCT to make decisions about patient management.

Safe and effective PoCT is possible only if:

- GPs have the required skills and receive appropriate training
- PoCT is undertaken often enough to maintain those skills
- the practice records, addresses and reviews non-conformance and adverse events.

Meeting these criteria

Sources of information and evidence

PoCT suppliers, pathology providers, international bodies, professional societies and other sources can provide evidence about the clinical and diagnostic purposes, analytical performance and reference data for PoCT. The practice does not have to generate its own evidence.

It is recommended that the practice:

- seek information from a validated source, relevant to the PoCT being carried out
- select information that is appropriate for the practice's clinical and diagnostic purposes and patient population.

Evaluating PoCT systems' analytical performance

It is important that the practice demonstrates how the analytical performance of a PoCT device has been verified to confirm that it performs to and meets the manufacturer's stated specifications:

- on commissioning
- following major repairs
- at other times as needed.

The Australian Point of Care Practitioner's Network (APPN) provides resources to help practices implement a PoCT program. This includes the resource *How to choose and evaluate a point-of-care testing instrument* that practices can refer to when evaluating a PoCT system's analytical performance.

Quality improvement and risk management

To improve quality of care and to minimise risks to patients:

- apply quality improvement and risk management processes to PoCT
- record and address adverse and non-conformance events in a timely manner
- notify the member of the clinical team with nominated responsibility for PoCT of adverse and non-conformance events. Adverse and non-conformance events could be included as an agenda item in team meetings.
- review adverse and non-conformance events, including how they are addressed

The practice could report adverse events to the TGA. The TGA has the following resources on reporting relevant adverse events related to the performance of PoCT devices: *Medical device Incident Reporting and Investigation Scheme (IRIS)*, and information on *reporting an adverse event or problem* for health professionals.

Continuity of care

In the event of unplanned loss of PoCT, the practice needs to demonstrate how it will ensure continuity of care for patients.

Resources

- Pathology Tests Explained has information on the advantages of PoCT and a resource on reference intervals and what they mean is available and a video resource.
- The Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has published analytical goals for point-of-care testing (PoCT) used for diabetes management.
- Scandinavian evaluation of laboratory equipment for primary health care (SKUP) evaluates PoCT instruments and publishes the reports.
- The Australian Point of Care Practitioner's Network (APPN) evaluates instruments and publishes the reports, available via login. This includes a template evaluation protocol endorsed by the Australasian Association of Clinical Biochemists (AACB) and IVD Australia.
- specimencare.com, sponsored and maintained by Becton, Dickinson and Company provides best practice resources for the pre-analytical phase of testing.
- Journal article by Julie LV Shaw explores Practical challenges related to PoCT.
- The Australasian Association of Clinical Biochemists (AACB) has published the Point of care testing implementation guide.

PoCT2 – Clinical responsibility

Consumer expectation statement: I expect that this practice takes responsibility for safe and quality delivery of point of care testing.

PoCT2.A The practice has at least one member of the clinical team who has primary responsibility for the quality of PoCT.

The practice:

- has at least one member of the clinical team who has overall primary responsibility for the implementation, conduct, quality and accreditation of PoCT within the practice
- has at least one member of the clinical team on duty when PoCT is being used who accepts the responsibility of running PoCT within the practice
- demonstrates that the responsible member of the clinical team is competent in using PoCT.

Why this is important

The successful implementation of PoCT requires skills, knowledge and time. To ensure results are of a uniformly high quality, the practice needs to properly manage relevant organisational and technical activities. This can be best achieved if one member of the clinical team is responsible for, and oversees, PoCT activities.

Effective clinical governance of PoCT ensures that:

- each member of the practice team takes ownership of PoCT processes, models good practice, and challenges poor practice
- each member of the practice team is jointly accountable for patient safety and quality care
- roles, responsibilities and accountabilities for achieving agreed outcomes are clearly allocated to and agreed to by members of the practice team, according to each person's scope of practice
- members of the practice team use what they have learnt to improve patient safety and quality of care.

Meeting these criteria

A designated member of the clinical team needs to have ultimate responsibility for PoCT undertaken by the practice. This person:

- needs to have an adequate understanding of PoCT, including
  - the diagnostic and technical applications and any limitations
  - the Standard for PoCT
  - the practice's PoCT policies and procedures
- needs to have competency in using PoCT. This may be through provision of evidence of appropriate PoCT training for example, external courses, in-house programs, 'on the job' training at the practice, that aligns with the practice's PoCT program or system
- can delegate their day-to-day PoCT responsibilities to an appropriately trained PoCT practitioner but needs to retain ultimate oversight of PoCT in the practice.

The practice could:

- maintain a clinical governance policy
- maintain a standing order for practice nurses to carry out a PoCT and to interpret the result according to their level of training and scope of practice.

PoCT3 – Qualifications, education and training of PoCT practitioners

Consumer expectation statement: I expect that practitioners at this practice understand their role and have up to date training to perform point of care testing.

PoCT3.A Members of the practice team who perform PoCT:

- **have successfully undertaken training**
- **participate in training and education updates.**

The practice:

- provides evidence that PoCT practitioners can demonstrate competency in PoCT
- provides evidence that PoCT practitioners receive regular training and education updates
- provides evidence that all PoCT practitioners receive training updates when:
  - significant changes to method(s) are introduced
  - new tests and/or instruments are introduced
- provides evidence that individual PoCT practitioners receive training updates when a competency issue with that practitioner has been identified.

Why this is important

Having PoCT practitioners who are trained reduces the risk of errors and safeguards the validity of results that inform clinical decision making, ensuring that the practice provides patients with safe, quality care.

The organisation responsible for providing the PoCT service needs to provide evidence that all PoCT practitioners:

- are suitably trained
- maintain the knowledge and skills that enable them to perform PoCT
- work within their scope of practice and competencies.

The quality of PoCT can be compromised by pre-analytical, analytical and post-analytical errors and issues, especially if performed by inadequately trained PoCT practitioners. This is why members of the practice team performing and managing PoCT require appropriate training and education and needs to be able to demonstrate competency when assessed[55].

Meeting these criteria

The practice needs to maintain records that clearly show that the training of PoCT practitioners is appropriate for the PoCT they perform.

All PoCT practitioners need to receive updated training if:

- significant changes to the PoCT method/s are introduced
- a new test and/or instrument is introduced

An individual PoCT practitioner needs to receive updated training if a competency issue with that practitioner has been identified.

Table 5 provides details of areas that training may cover.

Table 56 Point-of-care training in general practice

General	• The practice's policies • Overview of clinical purposes
PoCT system	• Basic principles of analysis, calibration, bias, precision, range, sensitivity, specificity, interferences, method evaluation and method comparison • Normal test performance according to the manufacturer's instructions • Recognition of malfunctions and appropriate actions • Error messages and actions

	• Storage of consumables • Care, maintenance and decontamination of the PoCT system.
Patients and specimens	• Appropriate information for patients – including what the test is, why it is being done and the cost to the patient • Patient preparation • Specimen collection techniques • Specimen identification and labelling • Specimen handling and stability • Recognition of unsuitable specimens • Patient and staff safety.
Results	• Recognition of abnormal, clinically urgent and erroneous results • Documentation of the testing episode • Data management.
Quality	• Principles and procedures of PoCT quality control testing and external quality assurance programs • Assessment of acceptable/unacceptable quality control testing and external quality assurance results, and appropriate actions.

The practice could:

- record each employee's qualifications in employment files
- keep a training calendar that lists PoCT professional development and training opportunities
- store documents that record training needs and training completed
- conduct annual performance reviews that identify learning and development goals
- keep training logs that record training that PoCT practitioners have completed.

Assessment of PoCT practitioners

Members of the practice team need to be assessed for competency in all aspects of their PoCT duties and responsibilities.

The Australian Point of Care Practitioner's Network (APPN)

The APPN is an online platform that provides professional development programs for all PoCT practitioners. PoCT practitioners can also maintain an electronic record of their continuing professional development (CPD) on the APPN's portal.

Resources

- The Australian Point of Care Practitioner's Network (APPN) is an online platform providing training, certification, quality assurance and professional development programs for PoCT practitioners.
- RMIT University offers a course on PoCT.
- Flinders University offers a Graduate Certificate in Global Point-of-Care Testing.

PoCT4 – Facilities for testing

Consumer expectation statement: I expect that this practice provides point of care testing in an environment that is clean, private and uses equipment and consumables in line with manufacturer's guidelines.

PoCT4.A The practice conducts testing in a safe environment that ensures patient privacy.

The practice:

- demonstrates that testing and result communication is performed in a safe area where patients' visual and auditory privacy is ensured.

PoCT4.B The practice ensures that instruments and consumables are located and managed to optimise performance.

The practice:

- has a testing area that has appropriate space, lighting, power, security and ambient temperature for sample/specimen handling, testing and documenting
- maintains a consumables inventory, including lot numbers and expiry dates
- stores the required quantity of within-date consumables as per the manufacturers' instructions
- disposes of expired consumables in accordance with local, state and federal requirements
- where temperature-sensitive consumables are stored as per the manufacturers' instructions, uses a minimum–maximum thermometer to monitor temperature, and keeps records of that monitoring
- has a documented contingency plan for continued operations in the event of equipment and other failures.

Why this is important

Optimising the operation and maintenance of PoCT instruments and consumables is important in delivering high-quality test results that clinicians can use when making clinical decisions.

Ensuring that PoCT is conducted in a safe environment is important in reducing the risk of infection for patients and the practice team. It is also important that the PoCT environment is considerate of patient privacy when conducting PoCT.

Meeting these criteria

When conducting PoCT, ensure the area has adequate space for instruments, consumables, documentation and waste disposal and does not compromise patient privacy.

Provided that patient privacy is maintained, the area does not need to be solely dedicated to performing PoCT. For example, a consultation or nurse's room may be suitable.

The practice could have a procedure document or log that includes recording of consumables, lot numbers, expiry dates and monitoring. This may also include a risk matrix for documenting contingency plans in the event of unexpected events.

Note that cleanliness and hygiene, including disposal of sharps, waste management and management of body fluid spills is covered in the Clinical Governance standard and the RACGP Infection prevention and control guidelines. Safe use of PoCT includes following these standards and guidelines in relation to equipment, consumables and the environment in which testing is performed and stored in.

PoCT5 – Performance of tests

Consumer expectation statement: I expect that this practice performs point of care testing in line with manufacturer's guidelines and results are communicated in an understandable and timely manner.

PoCT5.A The practice follows the manufacturers' instructions for PoCT.

The practice:

- demonstrates that it follows the manufacturer's instructions for each test method
- demonstrates that it checks the accuracy of transfers of data and transcription of results
- demonstrates that it records and investigates deviations appropriately.

PoCT5.B The practice records and communicates results appropriately.

The practice:

- demonstrates that the practice team records and communicates results to the responsible clinician and the patient in a timely manner
- demonstrates that results are acted upon appropriately.

PoCT5.C The practice identifies and reviews errors and deviations.

The practice:

- demonstrates that it records and investigates deviations appropriately.

PoCT5.D The practice ensures that specimens remain positively identified with patients throughout the testing process.

The practice:

- demonstrates that specimens remain positively identified with patients throughout the testing process
- clearly identifies patient specimens retained for any purpose.

PoCT5.E The practice has documented its requirements for PoCT technical support services.

The practice:

- demonstrates that it has ongoing arrangements with providers of technical support services.

PoCT5.F The practice commissions and maintains PoCT equipment in accordance with each manufacturer's instructions.

The practice:

- retains records of installation and commissioning
- ensures that maintenance is undertaken by appropriately trained operators
- retains records of maintenance in accordance with the manufacturers' instructions
- retains a log of failures and investigation performed.

Why this is important

The quality and safety of patient care depends on the result from PoCT being valid and reliable. To ensure that this is the case, the technology needs to be used in a standard way in accordance with the manufacturers' instructions, and errors need to be identified and acted upon.

Consistency is best achieved if the practice documents standard operating procedures and work instructions for all stages of testing and ensures that they are in accordance with the manufacturers' instructions.

To ensure continuity of PoCT, the practice could have an established arrangement with third-party suppliers of goods and services. Suppliers of essential PoCT support services are also responsible for providing:

- consumables (directly or via authorised supplier channels)
- technical support
- maintenance (in addition to the routine maintenance the practice completes)
- education to members of the practice team who use their devices.

Meeting these criteria

Standard operating procedures

The practice must follow the instructions published by the PoCT manufacturer as they are approved by the Therapeutic Goods Administration (TGA). However, it is best practice to also create and maintain standard operating procedures or work instructions for the practice as the manufacturer's instructions may not include some critical steps such as patient interactions and result management.

It is important to formally evaluate and approve any proposed changes to the standard operating procedures and work instructions before the practice uses them.

The practice could:

- maintain standard operating procedures for each test method, ensuring only the latest versions are used
- keep a copy of the relevant procedures/work instructions with each test instrument.

Communicating results

The practice needs to ensure that all PoC test results are recorded, understood, and acted upon in a timely and appropriate manner.

Deviations and errors

The practice needs to regularly review deviations and issues encountered during testing.

Avoiding transcription errors

Transcription errors are data entry errors that usually occur because of typographical mistakes when transferring data and results. To avoid transcription errors, it is strongly preferred that results are transferred electronically[56]. The practice could demonstrate how it recognises and avoids potential transcription errors.

Specimens

Although there is no requirement to label specimens that are to be used completely in the testing process:

- it is important that specimens remain positively identified with the patient throughout the testing process
- if specimens are retained following testing, they need to be clearly labelled and stored in accordance with relevant guidelines.

Technical services

When making arrangements with technical support services, consider the following:

- required response time for maintenance
- ownership or leasing arrangements of instruments
- required training of PoCT practitioners
- support for technical updates and troubleshooting
- written agreements with third parties who provide technical support services, if it is appropriate.

Consumables

When making arrangements with suppliers of consumables, consider:

- required frequency and volume of consumables
- required response time for urgent consumables.

Manufacturers' instructions

The practice needs to make records of preventative maintenance, service and calibration as per the manufacturers' instructions and keep these records as required by legislation. These requirements may vary from state to state, so consult with the practice's medical defence organisation or check legislative requirements to identify specific requirements the practice needs to fulfil.

Suppliers of routine maintenance need to provide the practice with a record of work and performance checks they undertake. If this is not possible, the practice needs to maintain its own records. This includes keeping a log of failures and investigations performed.

Resources

- specimencare.com, sponsored and maintained by Becton Dickenson Pty Ltd provides best practice resources for the pre-analytical phase of testing.
- The Clinical Excellence Commission has published a checklist for conducting root cause analysis.
- A review of ISO Standard ISO/TS 20658:2017(en) Medical Laboratories – Requirements for collection, transport, receipt, and handling of samples.

PoCT6 – Data management

Consumer expectation statement: I expect that my results from point of care testing are included in my health record.

PoCT6.A The practice records PoCT results in the patient's health records.

The practice:

- keeps PoCT records, including who performed the tests and the date.

Aspirational criterion

PoCT6.B The practice facilitates the recording of PoCT results using a nationally recognised coding system.

This criterion is aspirational. The practice could:

- use a clinical information system that facilitates coding of PoCT in patient health information.

Why this is important

Maintaining appropriate records is a way of managing risks. It allows for recording of results in the context of a patient's history and examination, allowing for a record of clinical decision making that is essential for safe and quality care. Records of PoCT results and associated processes need to be kept with the relevant patient's health information, in accordance with relevant legislation and guidelines.

The practice needs to demonstrate that it can readily retrieve from its health record systems all data related to a patient testing cycle.

Meeting these criteria

If the practice needs to investigate the reliability of a test result, it may need to:

- identify the PoCT practitioner who conducted the test
- identify the kit or batch of reagents used
- identify whether quality control results were within the acceptable range
- review the transcription so that errors and non-conformance events can be ruled out.

The practice should ensure the results are accessible for future consultations, trend determination and quality improvement activities by coding the information needed to record appropriately, rather than entering as free text in the patient record.

Resources

- The Australian Point of Care Practitioner's Network has developed a 'Data management' document for PoCT.

PoCT7 – Quality control procedures

Consumer expectation statement: I expect that this practice has processes in place to ensure the quality of all point of care testing.

PoCT7.A The practice uses quality control procedures to ensure the PoCT is functioning optimally.

The practice:

- demonstrates that all quality control procedures comply with manufacturers' recommendations and applicable regulations
- has standard operating procedures or work instructions that include the acceptable limits for quality control testing results and record actions taken in the event of an unacceptable result
- regularly reviews quality control results.

Why this is important

Quality control (QC) testing helps the practice to:

- be confident that its PoCT is functioning properly
- detect and manage sub-optimal performance.

Meeting these criteria

QC testing

QC testing is usually performed on artificial samples purchased from PoCT manufacturers or other commercial sources. The samples have different known levels of analytes to cover the range that practices might encounter clinically.

QC testing is conducted on the samples, QC results are recorded, then compared with the target range or acceptable window that the practice has been given:

- results falling within this range are considered acceptable
- results falling outside this range are unacceptable and may indicate a problem with the testing process.

The PoCT manufacturer can provide a simple quality control record sheet to enter, review and analyse QC results.

An acceptable window for QC results is usually determined when a PoCT device is first implemented. It is recommended that QC results fall within the manufacturer's specified limits and that practices can demonstrate that they have a system for ensuring appropriately timed QC.

Standard decision-making rules are used to determine whether to accept or reject the QC results. QC test results need to be recorded, and action needs to be taken should the QC result fall outside the acceptable range[57].

Reviewing quality control results

It is important that the member of the clinical team who is responsible for PoCT:

- regularly reviews QC results
- investigates unacceptable results or performance
- records any remedial actions taken.

The practice could compare PoCT results with local laboratory results on the same specimen on the same patient and document the outcome.

Resources

- The World Health Organization has a quality manual template for a laboratory quality management system that could be adapted for PoCT.
- The Australasian Association of Clinical Biochemists (AACB) has published the Point of care testing implementation guide and Position Statement.

PoCT8 – External quality assurance program

Consumer expectation statement: I expect that this practice participates in an external quality system to monitor point of care testing, detect issues early, and act if needed.

PoCT8.A The practice participates in an external quality assurance program.

The practice:

- enrols all test methods in an approved external quality assurance program
- keeps records of participation
- reviews reports from external quality assurance programs and keeps records of action taken if reports indicate poor performance.

Why this is important

External quality assurance programs deliver peer review of PoCT systems and monitor PoCT performance, making it more likely that issues that might otherwise go unnoticed are detected early[56].

Meeting these criteria

External quality assurance programs provide identical samples to all program participants who then each test the sample using their routine test method. The program collates the results and provides each participant with:

- the range of results achieved
- an indication of whether their method is producing results significantly different to those produced by a different practice using the same method
- details of the accuracy and precision of their results.

If the practice has unacceptable results or performance, it needs to:

- investigate the reasons for these results or performance
- record any remedial actions taken.

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