Standards for health services in Australian prisons

1st edition
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Prepared by The Royal Australian College of General Practitioners National Expert Committee on Standards for General Practices

Disclaimer

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Acknowledgments

The RACGP Standards for health services in Australian prisons (the Standards) are based on the RACGP Standards for general practices (3rd edition). The Standards have been customised for use by health services in Australian prisons.

For their contribution to the Standards for health services in Australian prisons, the RACGP would like to thank the following.

Members of the National Expert Committee on Standards for General Practices (NECSGP), whose deep commitment to standards of quality and safety has resulted in this final document:

- Dr Lynton Hudson (Chair)
- Mrs Julianne Badenoch
- Dr Michael Civil
- Dr Karen Douglas
- Dr Glynn Kelly
- Dr Craig Lilienthal
- Ms Angela Mason
- Dr Chris Mitchell
- Ms Robin Toohey AM
- Dr Noela Whitby AM.

Dr Stephen Hampton and Dr Cameron Loy from the RACGP Network for Custodial Health, and all the general practitioners, staff and other health professionals working in health services in Australian prisons who provided comment on the revisions required to make these Standards applicable and appropriate for use by these services.

Members of the various organisations and government departments involved in the administration of healthcare in Australia’s corrections system who provided advice during the development of these Standards including representatives from:

- Australian Capital Territory Health
- Australian Medical Association
- Australian Psychological Society
- Commonwealth Ombudsman
- International Health and Medical Services
- Justice Action
- Mental Health Council of Australia
- New South Wales Justice Health
Acknowledgments

• Public Health Association of Australia
• Royal Australian and New Zealand College of Psychiatrists
• South Australia Prison Health Service
• The Royal Australian College of General Practitioners
• Victoria Police
• Western Australia Corrective Services.

Australian General Practice Accreditation Limited, who conducted a field test of the RACGP Standards for health services in Australian immigration detention centres at both a private and public centre in Western Australia, and provided advice on how these Standards could be adapted for corrective services in Australia.

The staff of Acacia and Eastern Goldfields regional prisons that participated in the pilot accreditation visits.

The Standards for health services in Australian prisons were principally authored by Dr Ronelle Hutchinson and Mr Ian Watts on behalf of the NECSGP.
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Foreword

People incarcerated in Australian prisons or detained in custody often face complex problems with their health and wellbeing. These problems can stem from a myriad of sources including the individual’s cultural, religious and sociopolitical background, as well as their understanding of health and illness and any previous experience of the prison system.

It is acknowledged that health services in Australian prisons are run by the relevant state or territory department of health or department of justice (Victoria only). However, the RACGP Standards for health services in Australian prisons (the Standards) are designed to support general practitioners working to achieve better health outcomes for people incarcerated in Australian prisons or detained in custody.

Following the release of the RACGP Standards for health services in Australian immigration detention centres, GPs working in the area of custodial health recommended that the College develop a comparable set of standards to accommodate the special circumstances and challenges facing health services in Australian prisons.

The RACGP NECSGP worked collaboratively with a network of GPs with a specific interest in custodial health to customise the RACGP Standards for general practices (3rd edition) and to publish the RACGP Standards for health services in Australian prisons.

General practitioners providing healthcare in prisons face the usual challenges of general practice in addition to a range of complex issues such as the need to balance privacy and confidentiality with safety and security and patients at risk of self destructive behaviour.

It is envisaged that these Standards will evolve as more research is undertaken into this complex domain of primary healthcare.

The NECSGP thanks all those individuals and organisations who have contributed to this project. Your collective contributions have enabled the RACGP to deliver this first edition of Standards for health services in Australian prisons.

Dr Lynton Hudson  
Chair  
National Expert Committee on Standards for General Practices  
The Royal Australian College of General Practitioners

Professor Claire Jackson  
President  
The Royal Australian College of General Practitioners
Preamble

Why are these Standards necessary?

The prison environment presents a significant challenge for the delivery of high quality primary healthcare.

The Standard guidelines for corrections in Australia,\(^1\) which are endorsed by all state and territory governments, provide a basic framework for the delivery of health services to people incarcerated in Australian prisons.

The RACGP, acting on a recommendation by GPs working in the area of custodial health, has developed the Standards for health services in Australian prisons to provide a more complete framework for the delivery of safe, high quality healthcare to prisoners, and to engage health professionals working in prisons in comprehensive quality improvement initiatives (see Appendix A). It is acknowledged that health services in Australian prisons are run by the relevant state or territory department of health or department of justice (Victoria only). However, the RACGP Standards for health services in Australian prisons are designed to support GPs who are working to achieve better health outcomes for people incarcerated in Australian prisons or detained in custody.

The RACGP Standards for health services in Australian prisons are intended to cover health services provided to prisoners and remand prisoners. Health services provided to offenders (people subject to community corrections orders outside of prisons) lie outside the scope of these Standards as it is assumed this cohort of patients will be able to access primary healthcare from general practices in the wider community, for which the RACGP Standards for general practices will apply.

Any assessment against the RACGP Standards needs to be based on common sense and should not seek to penalise or exclude health services on the basis of technicalities.

The challenges behind the Standards

The Standard guidelines for corrections in Australia\(^2\) stipulate that each prisoner is to have access to evidence based health services, provided by a registered and competent health professional, providing a standard of care comparable to that which they would receive in the general community.

This requirement poses special challenges for health professionals on three key fronts.

First, the closed environment of prisons means that prisoners necessarily have restricted access to the broad range of healthcare available in the wider community. In addition, health professionals often need to balance a patient’s right to privacy and confidentiality against a need for safety and security.

Second, the patient population in prisons is generally characterised by complex clinical needs making it more difficult for health professionals to achieve good health outcomes. Studies that investigate the health status of incarcerated people both in Australia and internationally, identify consistent patterns of disease that
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are significantly higher than the same disease representation in the general community. Communicable diseases, such as hepatitis B and C, HIV/AIDS and tuberculosis are prevalent at higher rates in prisons than found in the general community. The higher incidence of some communicable diseases can be attributed to high risk behaviour such as the sharing of needles for intravenous drug use, prison tattooing and unprotected sexual activity.

Illicit drug use and abuse is a problem. Prison entrants are five times more likely than those in the general population to have used illicit drugs (71% compared to 13%). In many jurisdictions some drug treatment programs are restricted to prisoners who were on the treatment program in the community before entering prison.

The mental health problems of incarcerated people include a high prevalence of anxiety and depression as well as post-traumatic stress disorder, psychosis, suicidal thoughts, suicide attempts and other self harming behaviours. The Australian Institute of Health and Welfare (AIHW) reports a higher incidence of mental health problems in the Australian prison population than in the general population, with similar statistics found internationally. The AIHW reports that in a census week in mid-2009, 37% of prison entrants reported having a mental health disorder at some time, and a history of mental health problems was more common among female prison entrants (57%) than male entrants (35%).

The Australian Bureau of Statistics (ABS) documents the incarceration rate of Aboriginal and Torres Strait Islander people as 21 times more likely than that of non-Indigenous Australians. This significant representation highlights the need to incorporate appropriate cultural practices within healthcare delivery, including appropriate training of health service staff.

Why are the Standards important to our health service?

Striving for standards of excellence is important for a number of reasons.

- The Standards provide a framework for safe, high quality healthcare in the prison setting comparable to healthcare available in the general community
- The Standards provide a structured way for your health service to self assess quality and safety systems before considering what changes may need to be made
- Achieving the Standards is an indication that your health service is providing safe, high quality care
- Using the Standards to undertake quality improvement initiatives creates opportunities for collaborative teamwork and for assessing whether intended outcomes have been achieved
- Engaging in quality improvement and meeting the Standards demonstrates to the prison community that your health service is serious about providing safe, high quality healthcare.
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How can our health service use the Standards?

Your health service can self assess against the Standards as part of your quality improvement process, or you might collaborate with other health services to assess each other.

The chart below shows the hierarchical relationship between standards, criteria, indicators and explanations.

Each standard describes an element of the health service’s activity that is critical to quality and safety.

Each standard has a number of specific criteria that separate the standard into several components. Each criterion describes a process that your health service can use to meet the standard.

Each criterion has explanation notes to provide assistance to your health service in meeting the criterion. The explanations provide further detail, definitions of terms, and assistance for your health service in considering ways in which you might be able to demonstrate achievement of the criterion. The explanations provide a detailed description of the RACGP’s position on related issues and are the authoritative view on the interpretation of the criterion.

Each criterion is followed by a number of indicators that provide ways for your health service to demonstrate that it has achieved that criterion. There are indicators that require demonstration of the processes used to meet the criterion; indicators that require your staff to be aware of those processes; indicators that require documentation of your processes; and indicators that ask for a feedback
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mechanism to ensure the process is working properly.

The indicators seek to focus on principles of quality and safety. For example, the indicator on scheduling care does not specifically require an ‘appointment book’ to be used, rather it requires ‘effective scheduling of care’. This approach allows health services to focus on achieving timely access to care based on clinical need, rather than on the particular mechanism used for booking appointments.

The advantages and disadvantages of structure, process and outcome measures have been reviewed.9 Most process measures require less risk adjustment for patient illness than do most outcome measures.10 This is important in a context such as corrections, where the population of people incarcerated may change rapidly and frequently. Where the determinants of the outcome are beyond the control of the health service provider, process indicators are preferable.11,12 As a result, the RACGP decided to focus on process indicators that are in the direct control of health services. Although in many instances, outcome indicators are the ideal measure of quality, consideration needs to be given to causality, and to whether there are intervening variables affecting the outcome that are beyond the control of the health service under assessment, in which case pragmatism is required.

The Standards are written as an integrated whole. For example, you will see that indicators relating to privacy appear in more than one place in the Standards. This indicates that your health service should consider a number of different systems that collectively contribute to the protection of patient privacy, for example:

- the way in which your health service uses recall and reminder systems (Criterion 1.3.1)
- how your health service stores patient health information (Criterion 1.7.1)
- how your information technology provides protection from unauthorised access (Criterion 4.2.2)
- whether your health service provides screens, curtains, gowns or sheets to protect the privacy of patients when they undress (Criterion 5.1.1)
- how the physical structure of your health service protects privacy during consultations (Criterion 5.1.2).

You can assess your health service against each criterion and related indicators to determine whether you have achieved a particular standard. At times your health service may find some indicators are not applicable to you. If this is the case, it is important to consider why they do not apply and whether your peers would agree.

Your health service can use the following ways to demonstrate how you achieve the standards, criteria and indicators:

- interviews with all staff (medical, clinical, allied health and administrative)
- interviews with the medical staff (doctors) in your health service
- interviews with other staff who provide clinical care (eg. nurses or allied health staff)
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- interviews with administrative staff in your health service (eg. receptionists)
- direct observation of your health service
- reviewing your patient health records
- reviewing your documentation (eg. your policy and procedures manual, patient information sheet, continuing professional development data or appointment schedule).

The use of different sources of information allows ‘triangulation’ of the information – allowing a more robust assessment of whether your health service is meeting the Standards.

Are some criteria and indicators in the Standards more important than others?

Some indicators are of central importance to quality and safety. These key or mandatory indicators are marked with a flag symbol next to the indicator. Flagged indicators assist your health service to determine whether you have achieved the critical aspects of a criterion. Indicators that do not have flags are still important (though not mandatory) and provide guidance to your health service about other ways you might demonstrate quality and safety.

Providing healthcare to incarcerated people presents unique challenges. Some clinical risks may be magnified in this setting. As such, there is a range of systems/processes in the Standards where extra vigilance is needed to ensure the provision of high quality and safe care to patients within prisons. These criteria include the following.

- Informed patient decisions (Criterion 1.2.2)
- Interpreter services (Criterion 1.2.3)
- Clinical autonomy for medical, clinical and allied health staff (Criterion 1.4.2)
- Continuity of comprehensive care (Criterion 1.5.1)
- Continuity of the therapeutic relationship (Criterion 1.5.2)
- Engaging with other services (Criterion 1.6.1)
- Respectful and culturally appropriate care (Criterion 2.1.1)
- Confidentiality and privacy of health information (Criterion 4.2.1)
- Transfer of health information (Criterion 4.2.3).

How do the Standards help reduce risk?

Every system in a health service is vulnerable to errors (eg. equipment, policies and procedures, clinical performance). Not all vulnerabilities in a health service have an adverse impact on patient care but if vulnerabilities ‘line up’ in sequence they can combine to produce an error or an adverse event. Safeguards
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therefore need to be put in place in each system to reduce the likelihood of an error occurring.\textsuperscript{13}

The Standards provide ways of checking for vulnerabilities in systems that are important to safety and quality. Meeting each of the integrated criteria establishes a form of safeguard for patients and health services by closing the ‘holes’ in the system.

It is essential that your health service meet all the standards and criteria to be confident you have minimised the chance of an error occurring and have increased the safety and quality of the care your service provides. When assessing your health service against these Standards, you might wish to identify areas in which you could improve. You may wish to prioritise these improvements if you want to make a number of changes. Some improvements may take a period of time to implement and evaluate. The important issue is that your health service actively works toward those improvements.

What is the value of peer review in our health service?

If your health service is undertaking a self assessment against the Standards, you might consider discussing the assessment informally with a trusted colleague. A ‘fresh set of eyes’ over your systems can assist in identifying areas that your health service does really well and those that require improvements. Peers can make judgments that take into account all factors and provide feedback on innovative ways to improve your health service.

Does meeting the Standards protect our health service legally?

During the review of the Standards for general practices (2nd edition), the RACGP commissioned a legal opinion on a number of areas of the Standards. In addition, all medical defence organisations in Australia were consulted on the priority areas they thought needed to be included. The RACGP considered these views and weighed the medicolegal risk, the benefits to patient safety and the feasibility of health services implementing these systems. In issues of high medicolegal concern, such as the follow up of tests and results in Criterion 1.5.4: System for follow up of tests and results, the RACGP has endeavoured to prepare standards that reflect what would reasonably be expected of a health service in a prison and a general practice within the community. Health services are encouraged to seek further advice from their doctor’s medical defence organisation, relevant professional indemnity insurer and the relevant government departments within each state or territory if they have concerns about a particular issue.

The Standards concentrate on principles of quality and safety in the delivery of healthcare, however health services should be aware of relevant and changing state, territory or federal legislation that may impact on the way they work.
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We welcome your feedback

The RACGP NECGP welcomes feedback regarding possible improvements to these Standards. Any comments or ideas about the RACGP Standards for health services in Australian prisons can be forwarded to:

Chair, National Expert Committee on Standards for General Practices
The Royal Australian College of General Practitioners
1 Palmerston Crescent
South Melbourne Victoria 3205
Telephone 03 8699 0414
Facsimile 03 8699 0400
Email standards@racgp.org.au
Website www.racgp.org.au/standards

This symbol means a particular indicator is ‘flagged’ or mandatory; indicators which are not ‘flagged’ are discretionary.
Section 1
Services

Standard 1.1
Access to care
Our service provides timely care and advice.

Standard 1.2
Information about the health service
Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Standard 1.3
Health promotion and prevention of disease
Our service provides health promotion and illness prevention services that are based on best available evidence.

Standard 1.4
Diagnosis and management of specific health problems
Our service provides patient care that is effective, and in broad agreement with best available evidence.

Standard 1.5
Continuity of care
Our service provides continuity of care for our patients.

Standard 1.6
Coordination of care
Our service engages with a range of relevant external services to improve patient care.

Standard 1.7
Content of patient health records
Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.
Standard 1.1
Access to care
Our service provides timely care and advice.

Criterion 1.1.1
Scheduling care in opening hours
Our service has a flexible system that enables us to accommodate patients with urgent, nonurgent, complex, planned chronic care, and preventive health needs.

Indicators

- A. There is evidence that our service has a flexible system to accommodate patients with urgent, nonurgent, complex, planned chronic care, and preventive health needs (document review).
- B. Our staff can describe the way in which they identify urgent medical matters and their procedures for obtaining urgent medical attention (interview).
- C. Our service has a written policy for dealing with urgent medical matters (document review).
- D. Our service can demonstrate that patients can directly access the health service by telephone, written request, in person or other direct method during normal opening hours (direct observation).

Explanation
The needs of patients vary widely and health services need to have flexible systems that can accommodate urgent, nonurgent, complex, planned chronic care and preventive health needs during normal opening hours.

There are times when patients need urgent access to primary medical care, and health services need to have systems that anticipate this need (e.g., an appointment system could include reserving unbooked appointment times for patients with urgent medical needs). Patients also value the opportunity to see a GP or another member of the clinical team within a reasonable time for nonurgent and preventive health matters.

Health services need to be able to identify patients who have an urgent health need and facilitate care for them appropriately. The system used to identify patients with urgent needs has to be efficient and prompt. Medical, clinical and administrative staff need to be able to describe the service’s policy and procedures for identifying patients with urgent medical matters and the procedures for seeking urgent medical assistance from a clinical staff member. Staff also need to be able to describe how the health service deals with patients who have urgent medical needs when the health service is operating at full capacity (e.g., when staff are fully occupied).
The *Standard guidelines for corrections in Australia* stipulate that a prisoner is to be medically examined by a suitably qualified health professional within 24 hours of being received into prison, and thereafter as necessary. This is a clinically important process (as opposed to a routine bureaucratic procedure) for determining whether the prisoner has health concerns (e.g., acute or chronic illness, ongoing medication requirements, potential detoxification issues or suicide risk) that require immediate medical attention and management. Where necessary, and when the prisoner is likely to continue to be in custody in the prison, a follow-up to the initial consultation in order to perform a comprehensive health assessment would be recommended within 48 hours of the prisoner’s arrival.

Length of individual consultations will vary according to clinical need. There is a body of evidence suggesting that longer consultation times are associated with better health outcomes and improved patient satisfaction. Much of the benefit is thought to arise from the improved communication between doctors and their patients that occurs in longer consultations. Research also suggests that preventive care, effective record keeping, patient satisfaction and patient participation in the consultation can be compromised when consultations are too short. Data from the Bettering the Evaluation and Care of Health (BEACH) study shows average consultation times in Australian general practice are around 14 minutes. Although there is no comparable data for consultation times within prison health services, it is noted that patients in prison are more likely to have chronic diseases and complex clinical needs necessitating longer consultation times.

The system for scheduling care needs to include longer consultations for people who have more complex clinical needs or if an interpreter is present. Staff need to have the skills and knowledge to assist in determining the most appropriate length and timing of consultations at the time of the request. Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that health services have systems that endeavour to predict and meet this need.

Thus, key indicators for whether consultation times are long enough are not only duration, but other factors such as the adequacy of patient health records. Whether a health service meets this criterion may need to be seen in the context of other indicators in the health service. Assessment of this criterion needs to take into account the specific circumstances of the health service.

Health services that do not have a formal appointment system can meet this criterion if there is adequate communication on anticipated waiting times and if the service prioritises patients according to urgency of need.
It is important that prisoners normally have direct access to the health service to make an appointment and do not routinely have to rely on others, such as prison staff within the facility, to mediate their request for access to healthcare or to identify medical needs. It is not appropriate for prison staff to triage patients who request medical attention. Triage by clinical staff allows for greater assurances of confidentiality and privacy for prisoners as well as minimising any medicolegal risk to the health service that may arise from relying on nonhealth professionals to identify medical needs.

It may not be possible for prisoners to contact a health service by telephone to make an appointment, and written requests for an appointment could prove difficult for prisoners with low levels of literacy. Health services may therefore need to devise special strategies for prisoners to request an appointment. A method currently used in one health service is for each prisoner to have a card containing their name or prisoner number that can be placed in an appointment box. It is important for health services to document in a patient’s health record any delay between a request for healthcare and the provision of that healthcare, including the reason for the delay.
Standard 1.1
Access to care
Our service provides timely care and advice.

Criterion 1.1.2
Visits to patient living quarters by appropriate clinical staff
Our medical or clinical staff members are able to visit a patient’s living quarters to provide urgent healthcare where such visits are deemed safe and reasonable.

Indicators

A. There is evidence that our service provides visits to patients’ living quarters for urgent healthcare (health records review, document review).

B. Our staff can describe our service’s policy on visits to living quarters and the situations in which a visit is deemed appropriate (interview).

C. Our service has a written policy on visits to living quarters (document review).

Explanation
Visits to patients in their living quarters in a prison need to be available if clinically required and if such visits are deemed safe and reasonable.

For people in prisons, their living quarters need to be seen as their home, and in that context it is reasonable that health services in prisons have the capacity to provide visits to patients in their living quarters if clinically necessary. The need for visits to patients’ living quarters is likely to occur infrequently but when such visits are required (eg. for an emergency response), health service nurses, escorted by prison security staff, are most likely to provide such consultations. There are security and safety considerations involved in visits to living quarters and accordingly patients are more likely to be brought to the health service for medical care. Indicator B requires the health service to have the capacity to provide visits to patients’ living quarters by an appropriate member of the clinical team where it is deemed safe and reasonable to do so. Both prison and health service staff need to understand the service’s policy for providing emergency care in living quarters and how this will be facilitated (eg. for patients requiring resuscitation).

Staff need to be able to describe the conditions under which a visit to living quarters is deemed appropriate (eg. the types of clinical problems that might necessitate such visits).

What is ‘safe and reasonable’ is not defined here as it is a decision that each health service needs to make in the local context (eg. with regard to the location of living quarters and the prisoner population). What is safe and reasonable also needs to be considered by the health service in light of what their peers would agree was safe and reasonable.
Standard 1.1
Access to care
Our service provides timely care and advice.

Criterion 1.1.3
Care outside normal opening hours
Our service ensures reasonable arrangements for healthcare for patients outside our normal opening hours.

Indicators
A. There is evidence of one (or a combination) of the following for our patients (document review):
   i. our staff provide care for patients outside normal opening hours of the service either individually or through a roster, or
   ii. formal arrangements for care outside the normal opening hours of our service exist through a cooperative of one or more local health services, or
   iii. formal arrangements exist with an accredited medical deputising service, or
   iv. formal arrangements exist with an appropriately accredited local hospital or an after hours facility in circumstances where we do not use an accredited medical deputising service or cooperative or provide the services ourselves.

   Where a health service is providing care as indicated by Aii, Aiii, or Aiv, the documentation of the arrangement must include:
   • reference to the timely reporting of the care provided back to the health service, and
   • a defined means of access for the deputising practitioner to patient health information and to our medical staff in exceptional circumstances, and
   • assessment by our service that the care outside normal opening hours will be provided by appropriately qualified health professionals.

B. Patient health records contain reports or notes of consultations that occur outside normal opening hours by or on behalf of our service (health records review).

C. Our service has a written policy for the provision of healthcare outside normal opening hours (document review).

D. A notice in all living quarters of the prison provides multilingual information on how to obtain care from the health service both within and outside normal opening hours (document review).
Explanation

Sometimes patients require healthcare outside the normal opening hours of the health service. Health services are required to make reasonable arrangements for access to primary medical care services for their patients outside their normal opening hours. Arrangements need to be in place so that patients can be triaged (as commonly done by telephone) and a decision made about their clinical care by a clinically trained professional. This may be done by a health service staff member (eg. a doctor or a nurse), another health professional on behalf of the service (eg. a medical deputising service) or through a documented agreement with another healthcare provider such as a hospital.

It is important that people are able to access appropriate primary and emergency care when the health service is not normally open. The nature of incarceration means that the ability of patients to contact and use mainstream primary health and emergency services is restricted. As such, it is important that health services in prisons make arrangements for the timely and appropriate provision of healthcare to all people incarcerated in the facility at all times.

It may be necessary for health services to consider the quality and sustainability of potential options and to make judgments about which will provide the highest quality of care while maintaining the safety of patients and staff. It may be that telephone triage in the first instance is an appropriate arrangement for care when the health service in the prison is closed.

Regardless of the arrangements used to provide care outside normal opening hours, there needs to be documentary evidence of the system the health service uses to provide such care. If the health service uses other doctors to provide care, such as a medical deputising service or medical cooperative, the health service needs to have evidence of how and when it receives information about any care provided to their patients outside normal opening hours, and also how external contractors providing care can contact the health service in an emergency or in the case of exceptional circumstances for clarification or help regarding background information relating to that patient.

Where medical care outside normal opening hours is provided by a GP, then the GP should be a recognised GP (either a Fellow of the RACGP or vocationally recognised). In some facilities it may not be possible to recruit recognised GPs. In such circumstances, doctors who provide general practice care outside normal opening hours, and who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the patient population. Doctors performing general practice care who are not recognised GPs need to have been assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP (as outlined in Criterion 3.2.1: Medical staff qualifications and training).
When the health service’s own medical or clinical staff cannot safely or reasonably deliver care outside normal opening hours, the health service must be able to clearly document the alternative system of care that is available for patients at those times. Assessment of this criterion needs to take into account the approach of health services in other prisons. The care should be appropriate to the needs of the patient, timely and reliable (i.e. what is claimed to be available is provided). What is ‘safe and reasonable’ is not defined here as it is a decision that each health service needs to make in their local context (e.g. with regard to location, and the patient population). What is safe and reasonable needs to be considered by the health service in light of what their peers would agree was safe and reasonable.

Arrangements for healthcare outside normal opening hours need to be communicated clearly to prisoners, prison staff and patients of the health service.
**Standard 1.2**

*Information about the health service*

Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

**Criterion 1.2.1**

*Health service information*

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

**Indicators**

- **A.** Our health service information sheet or familiarisation process is available to prisoners and includes (document review):
  - a feature that distinguishes any written material as belonging to the health service
  - only family names not first names of staff providing clinical care (if our health service deems it appropriate to include the names of staff on the information sheet)
  - our consulting hours and arrangements for care outside our service’s normal opening hours
  - an explanation of how individuals can contact the health service directly to make an appointment
  - an explanation of the arrangements in place for interpreters
  - an explanation of the relationship between the health service and the prison’s management company and/or the relevant government department
  - an explanation of how to provide feedback or complain to the health service
  - the health service’s policy on the use of patient health information.

- **B.** Our health service information sheet is prepared and provided to individuals by our health service staff (document review, interview).

- **C.** Our staff can describe how essential information is provided to patients who are unable to read or understand our written information sheet (interview).
Explanation

Providing written information about the health service informs patients of the range of services provided by the health service. It is important that the information sheet is clearly marked as relating to the health service (as opposed to the prison) through the use of logos or other branding symbols. Health service staff should establish alternative communication mechanisms for patients who have limited literacy skills or a visual impairment. The best time for providing information about the health service should be considered by health service staff (eg. doing so immediately at reception into the prison may lead to information overload particularly for those being incarcerated for the first time).

Health services may decide that their information sheet should include only family names (not first names) of staff providing clinical care. Issues relating to the security level of the prison may determine the way in which the names of staff are presented to patients. Referring to staff by title (eg ‘doctor’ or ‘nurse’) may be one way of ensuring formality and maintaining professional boundaries between staff and patients in the prison.

It is important that patients are encouraged to provide feedback to the health service and an explanation in the information sheet about how they can do this signifies the health service welcomes feedback.

Because there are a number of parties involved in the healthcare of people in prisons, it is important that the health service be transparent about the relationship between the service and other parties (eg. the relevant government department). This will assist in increasing trust between patients and staff in the health service. This parallels the situation in general practice, where there needs to be transparency between general practices and any other service with which the practice has contractual agreements (eg. pathology and imaging services).

Where a health service serves defined ethnic communities, it is appropriate to make written information available in the most common languages used by the health service population – this is one way in which the health service can provide healthcare in a culturally appropriate manner (see Criterion 2.1.1: Respectful and culturally appropriate care). This is particularly important for health services in prisons where patients come from culturally and linguistically diverse backgrounds, and where there are patients who may be unfamiliar with the way healthcare is provided in Australian prisons.

Privacy of patient health information is particularly important for health services in prisons. Patients need to be informed that their health information will be treated as private and confidential and – subject to disclosures required or authorised by law – will only be released to third parties on a ‘need to know’ basis:

- with the consent of the prisoner, or
- in the interest of the prisoner’s welfare, or
- where maintaining confidentiality may jeopardise the safety of others or the good order and security of the prison.15
Standard 1.2
Information about the health service

Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Criterion 1.2.2
Informed patient decisions

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

Indicators

A. Our medical and other clinical staff can describe how they inform patients about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments (interview).

B. Our medical and other clinical staff can describe how they use written information to support their explanation of the diagnosis and management of conditions when appropriate (interview).

C. Our medical and other clinical staff can describe how they provide information (printed or otherwise) about medicines and medicine safety to patients (interview).

D. Our medical and other clinical staff can describe how patients are advised of any potential costs when they are referred for investigations, or for consultations with a medical specialist or allied health professional, including the cost of transport and any prison staff chaperone that may be associated with the referral (interview).

Explanation

It is important that patients have sufficient information to make appropriate decisions about their own healthcare. Information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments needs to be tailored to the individual patient’s needs. This information needs to be delivered in appropriate language and be appropriate to the patient’s cultural and socioeconomic understanding of health and illness and where necessary include clear diagrams and written information. Consideration also needs to be given to the patient’s physical, visual and/or cognitive capacities, which may impact on their ability to understand the information, make decisions or provide consent. Consideration needs to be given to the way in which information is communicated in relation to potentially sensitive investigations or tests (eg. sexually transmissible infections or blood borne viruses). If working cross culturally, special care is needed to ensure there is a shared understanding between the health professional and the patient about the information provided.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) encourages patients to actively discuss with their healthcare provider the purpose, importance, benefits and risks associated with their healthcare. The publication 10 tips for safer healthcare (available at www.racgp.org.au/safety) provides further detail. Health services may find it useful to refer patients to this information to help create an understanding of shared responsibility between the patient and the health service. Mutual understanding is an important component to the follow up of investigations that have taken place in order to achieve and maintain positive health outcomes.
The provision of information about medicines and medicine safety, including Consumer Medicines Information (CMI), may assist patients to make informed decisions about their medicines. Health professionals need to be confident that patients understand any reasons for changes to their medication and if a particular medication is not available, the implications of using alternative medication. Consumer Medicines Information provides an online version of leaflets produced by pharmaceutical companies for the general public and is available at www.nps.org.au/search_by_medicine_name. When it is not possible for a patient to continue using the same medication as they had been taking before incarceration, then it is important that the reasons for this be explained to the patient to encourage trust and compliance with a new medication regimen.

Should a patient decide not to follow the advice of a GP or other health professional after receiving sufficient information to make an informed decision about their care, their refusal and their awareness of its implications should be documented in the patient health record and an attempt made to provide alternative care.

Some people in prisons may be susceptible to self destructive or self harming behaviour (e.g. over or under medicating or a hunger strike). Where a patient is known to be considering, or has embarked on self destructive or self harming behaviour, a GP may need to make judgments about the competence of the person to form an unimpaired and rational judgment concerning the consequences of such behaviour.

The cost of primary healthcare provided to patients in prisons is not charged to patients. To ensure there is certainty about this fact, it should be made clear to patients that they will not be charged for primary healthcare provided by the health service.

Where additional healthcare is required, it is the responsibility of other medical specialists and healthcare providers (e.g. dentists) to give patients information about the cost of any treatment or investigations that will be charged to the patient. In the context of incarceration, these circumstances are relatively uncommon and usually arise where the care is elective.

Where elective investigations or treatments are required, the health service can help patients to make informed decisions about referrals to other specialists or healthcare providers by advising if there will be a cost involved. Costs may include charges beyond the scope of the health related investigations (e.g. requiring a prison staff chaperone or associated transportation charges). It is suggested that health services seek information about these related additional costs to help patients make informed decisions about offsite medical treatment. Health service staff are not required to know the fee for a referred test or treatment, but they do need to indicate to patients that a fee may be incurred.

When medical or other clinical staff refer patients to institutions or services in which the staff member has a direct financial interest, the staff member needs to provide full disclosure of such interest to the patient. Medical staff are referred to the Medical Board of Australia publication Good medical practice: a code of conduct for doctors in Australia. Available at www.medicalboard.gov.au/codes-and-guidelines.aspx.
Standard 1.2

Information about the health service

Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Criterion 1.2.3

Interpreter services

Our service has policies and procedures for communicating with patients who are not proficient in the primary language of our medical staff.

Indicators

A. Our medical and other clinical staff can describe how they communicate with patients who do not speak the primary language of our medical staff (interview).

B. Our health service has a list of contact numbers for interpreter services (document review).

Explanation

Healthcare professionals have a professional obligation to ensure they understand their patients’ problems, and that their patients understand medical information and recommendations they are given. The use of interpreters can be challenging and time consuming. In some situations however, the use of interpreters is essential for providing safe, high quality healthcare. This means health service staff need to know that interpreter services exist and how to access them.

It is important to protect the privacy and confidentiality of a patient when using interpreters for clinical care. In most circumstances the use of other prisoners or departmental staff to interpret on behalf of patients would be inappropriate. There may be exceptional circumstances where this would be required, but in general, it is considered unsuitable in good medical practice.

The Australian Government Translating and Interpreting Service (TIS) can assist health services in providing quality care to patients. Further information about TIS can be found by calling 131 450 or visiting www.immi.gov.au/tis.

The Australian Government also funds an interpreting service for patients who are deaf and use Australian Sign Language (AUSLAN). Information about this free AUSLAN interpreting service is available at www.nabs.org.au.

Due to the high incarceration rates of Indigenous Australians, health service staff need to know how to access relevant interpreter services for their region. Further information regarding access interpreter services for Indigenous Australian languages can be found at www.ngapartji.org/content/view/22/52 or www.naati.com.au/index.asp.

All reasonable efforts need to be made to access an interpreter with a compatible dialect and of an acceptable ethnic group or gender. Inadequate access to appropriate interpreters may discourage patients from seeking care from the health service. Multilingual prompt cards can be displayed in consulting rooms to help the health service engage the most appropriate interpreter for the patient.
Standard 1.3
Health promotion and prevention of disease
Our service provides health promotion and illness prevention services that are based on best available evidence.

Criterion 1.3.1
Health promotion and preventive care
Our service provides health promotion and illness prevention services that are based on best available evidence.

Indicators

A. There is evidence that our service provides multilingual information about health promotion and illness prevention to patients (health records review, document review).

B. There is a range of multilingual posters, leaflets, and brochures about health issues available or on display in the waiting area or consulting areas (direct observation).

C. Our medical and other clinical staff can describe how they provide information to patients on issues relating to health promotion and illness prevention, including issues relevant to common patient presentations (interview).

D. Our health service uses one or more of the following (health records review, document review):
   - flagging of patient health records for opportunistic preventive activities
   - paper or electronic system showing due dates for preventive activities (subject to informed patient consent)
   - paper or electronic reminder system with appropriate informed patient consent.

E. Our health service participates in national state or territory reminder systems/registers (subject to informed patient consent) (document review).

Explanation
Health services in prisons need a systematic approach to health promotion, preventive care and early detection and intervention. Health services have the potential to coordinate with other health professionals and key agencies where appropriate, to achieve health promotion and preventive care objectives. This holistic approach to care allows for each patient’s individual circumstances to be considered when providing health promotion, preventive care, early detection and intervention.

Health services are encouraged to provide patients with information about health promotion and illness prevention. Health promotion activities may also be an avenue to help the patient develop confidence in their ability to participate in their own healthcare. Health promotion is distinct from the education and information that medical and other clinical staff use to support their diagnosis and choice of treatment. Such prevention, education and health promotion may be delivered by doctors, nurses or allied health professionals within the health service and reinforced through the use of written materials and resources.
It is useful for patients to self-select information on a range of health issues that may affect or interest them. Providing written material is recommended as patients remember only 3–4 key messages from a consultation. This criterion refers to the many health pamphlets and brochures available from sources such as departments of health, nongovernment organisations, health promotion programs, local community organisations, and support and self help groups. Many of these organisations provide health promotion information at no cost. Some educational materials are also produced in audiovisual format, which may complement the written material in the health service. Health services are encouraged to be selective about the leaflets, brochures and pamphlets they make available as they may vary considerably in quality and reliability.

Prisons should seek to address health challenges that are more prevalent among prisoner populations than the wider community (eg. safe injecting procedures and blood borne virus transmission).

The use of the internet as a source of information about health issues is becoming more common. Health services need to consider the quality of information available on internet sites before using them. Health services are encouraged to use the checklist in the current edition of the RACGP Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting (the “green book”)17 (available at www.racgp.org.au/guidelines/greenbook) to help determine whether patient education materials are of suitable quality.

HealthInsite at www.healthinsite.gov.au provides useful information. The Australian Psychological Society has health promotion resources for use by psychologists (www.psychology.org.au) and the Multicultural Mental Health Australia website has health promotion materials in a range of languages (www.mmha.org.au). The Healthy for Life website has specific information for people of Aboriginal and Torres Strait Islander background (www.health.gov.au/healthyforlife).

This criterion also requires health services to have a systematic process for providing preventive care to patients. This may be through the use of formal preventive activities such as patient prevention surveys, or the use of disease registers and recall and reminder systems. It may also be through using patient presentations at the health service as an opportunity to provide health promotion and illness prevention activities in addition to the specific reason for the patient’s visit. Preventive activities need to be based on the best available evidence. Reminder systems need to operate in such a way as to protect the privacy and confidentiality of patient health information. Health services also need to consider their responsibility if they discharge a prisoner or if the prisoner is released from prison or transferred to another prison.

Health services within prisons have a unique opportunity to undertake important health promotion activities. Determinants that contribute to higher morbidity patterns and negative health status in prisons include socioeconomic status,
education, social influence and high risk behaviour\textsuperscript{18,19} and these are all issues that health services in prisons would need to take into account.

Individuals in prisons may have never had the opportunity to access information relevant to improving their health outcomes. Raising awareness of health issues could therefore improve the overall health status of prisoners in the prison. Where patients are able to make informed decisions, the result may have long term positive repercussions, particularly when a patient is released.\textsuperscript{20}

Targeted health promotion activities within the prison (eg. safe injecting education aimed at reducing the incidence of blood borne viruses) can be facilitated by health service staff. Other clinical staff, such as nurses, can be utilised to develop and disseminate information and health promotion activities at no additional cost to the health service.

Some patient health information may also be transferred to national registers (eg. immunisation data) or state and territory based registers (eg. cervical screening or familial cancer registries) in order to improve care. Health services are encouraged to use these registers subject to the patient’s consent. To ensure continuity of preventive care beyond the period of incarceration, discharge planning for a patient should include updating relevant health registers and transferring health information to the health professional who will continue care of the patient, all subject to the patient’s consent.

Health services might also use data collected in clinical software or paper based systems to improve their targeting of prevention activities among patients in prisons (eg. smoking cessation, sexually transmissible infections). Health services may also use information transferred from private pathology providers (eg. diabetes screening, cervical cancer screening) to design and implement preventive activities. This is not only a quality improvement activity (see Criterion 3.1.1: Quality improvement activities) but it also provides a check that the health service is identifying all relevant patients for their health promotion and preventive care activities.

Further information regarding health promotion and preventive activities is available in the current editions of the RACGP Guidelines for preventive activities in general practice (the ‘red book’),\textsuperscript{21} the RACGP green book,\textsuperscript{22} and the RACGP Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practice.\textsuperscript{23} (All guidelines available at www.racgp.org.au/guidelines.)
Standard 1.4
Diagnosis and management of specific health problems
Our service provides patient care that is effective, and in broad agreement with best available evidence.

Criterion 1.4.1
Evidence based practice
Our health service ensures that our approaches to common and serious conditions are consistent with best available evidence.

Indicators
A. Our health service can demonstrate that we have ready access to a range of current references relevant to primary care (including mental healthcare, drug withdrawal and opiate management guidelines and blood borne virus management) (direct observation).
B. There is evidence in our patient health records that our health service provides care of common and serious conditions that is consistent with clinical practice based on best available evidence (health records review).
C. Our medical and other clinical staff can describe how they ensure their approaches to common and serious conditions are broadly consistent with clinical practice based on best available evidence (interview).
D. Our medical and other clinical staff can describe and access clinical practice guidelines used to assist in the management of serious and common conditions (interview).
E. Our health service staff can explain how they access guidelines for the specific clinical care of patients who are identified as Aboriginal or Torres Strait Islander (interview).

Explanation
Contemporary practice is based on best available evidence in the current Australian context. This criterion recognises that, in the absence of well conducted clinical trials or other higher order evidence, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at that time. Health service staff may consider conducting research to increase the evidence relevant to patient health status and outcomes in the prison setting.

Clinical practice guidelines must be up-to-date and may include recommendations from sources such as:
- Australian Medicines Handbook (www.amh.net.au)
- Australian Prescriber (www.australianprescriber.com)
- Australian Psychological Society resources (www.psychology.org.au)
- Central Australian Rural Practitioners Association treatment and reference manuals (www.carpa.org.au)
- Cochrane Database (www.acc.cochrane.org)
- Safety Every Time – Our General Practice Checklist (a checklist to reduce the risk of errors in medical procedures) (www.racgp.org.au/publications/tools#)
Multicultural Mental Health Australia (www.mmha.org.au)
National Health and Medical Research Council (www.nhmrc.gov.au)
National Prescribing Service (www.nps.org.au)
RACGP Medical care of older persons in residential aged care facilities (‘silver book’)28 (www.racgp.org.au/guidelines/silverbook)
Regaining Trust after an Adverse Event – an education module on managing adverse events in general practice (www.racgp.org.au/Content/NavigationMenu/PracticeSupport/Runningappractice/Patientsafetyinitiatives/currentprojects/RegainingTrustWorkbook.pdf)
Therapeutic Guidelines (www.tg.com.au)
Victorian Transcultural Psychiatry Unit for culturally sensitive evidence based guidelines (www.vtpu.org.au)
Infectious Disease Information (www.healthinsite.gov.au/topics/Infectious_Diseases)
The Australasian Society of Infectious Disease (www.asid.net.au)
Register of Australian Drug and Alcohol Research (www.radar.org.au).

It may be helpful for medical staff – especially those undertaking procedural work and minor surgery – to use the Safety Every Time – Our General Practice Checklist (www.racgp.org.au/safety) or an equivalent protocol that incorporates the five safety steps. Compliance with the protocol reduces the risk of error for medical staff who perform procedures.

Medical and other clinical staff will find it valuable – both for treating patients and for their professional development – to have access to resources about a range of clinical issues, including care provided to patients in prisons. These resources may include paper based resources (eg. text books and peer reviewed journals) as well as electronic resources (eg. access via the internet or CD-ROM). Useful resources may relate to clinical matters (eg. infectious diseases or mental health), information about cultural beliefs, health practices of various cultural groups, and might not be limited to what the profession would generally consider to be references on ‘evidence based practice’.

This criterion does not necessarily require access to the most recent editions of texts, materials or publications, nor does it require those resources to be in electronic format. However, resources need to contain information that is consistent with current practice and not recommend management that is no longer applicable.
Standard 1.4

Diagnosis and management of specific health problems

Our service provides patient care that is effective, and in broad agreement with best available evidence.

Criterion 1.4.2

Clinical autonomy for medical and other clinical staff

Our health service ensures that all medical and other clinical staff in our service can exercise autonomy in decisions that affect clinical care.

Indicators

- **A.** Our medical and other clinical staff are free to determine (interview):
  - investigations relevant to diagnosing a patient’s health status
  - how and when to schedule follow up appointments with individual patients.

- **B.** Our medical and other clinical staff are consulted about:
  - the scheduling of appointments
  - the equipment and supplies that our health service uses (interview).

- **C.** Our health service has a written policy that confirms our medical and other clinical staff can exercise autonomy in decisions that affect clinical care, within the parameters of evidence based medicine (document review).

- **D.** Our medical and other clinical staff can describe the notification process to be used if they believe a third party is restricting their ability to provide or coordinate safe, high quality healthcare (interview).

- **E.** Our health service has a documented protocol for the notification of concerns regarding the provision of safe, high quality healthcare (document review).

Explanation

The intent of this criterion is that medical and other clinical staff are free – within the parameters of evidence based care – to make decisions that affect the clinical care they provide, rather than having these decisions imposed upon them. The Australian Medical Association (AMA) Code of Ethics (revised in 2006), which has been endorsed by the RACGP, argues that in order to provide high quality healthcare, clinical independence and professional integrity must be safeguarded from increased demands from society, third parties, individual patients and governments (www.ama.com.au).

Clinical staff need to be free to care for their patients without obligations or pressures placed on them by a third party, which may challenge the independence of their professional judgment. There are international guidelines for health professional practice in such circumstances.
This criterion also means that the health service needs to discuss with medical and other clinical staff their individual preferences for the systems the health service uses to provide clinical care (including investigation options, appointment scheduling, patient load, equipment, length of counselling sessions) rather than requiring staff to use systems that may affect their ability to provide care with clinical autonomy.

This criterion is not intended to conflict with Criterion 1.4.1: Evidence based practice, and does not preclude adherence to valid guidelines for the clinical care of an individual patient based on best available evidence.

Some organisations have developed codes of practice so that health service systems do not restrict the ability of medical and other clinical staff to exercise autonomous judgment in providing clinical care. For example, there is a code of conduct for corporations who provide management and administrative services in medical facilities in Australia\textsuperscript{32} that emphasises the importance of doctors having professional independence and outlines processes for complaints about such matters.

Some health services in prisons may not have free choice in the engagement of ancillary services. For example, there may be existing corporate level agreements about the provision of services such as pathology. Where this is the case, medical and other clinical staff need to have clear avenues to raise any concerns about the quality of such services and their desire to use alternatives (see Criterion 3.1.2: Clinical risk management system).

Health services in prisons need to have clear protocol for the formal notification of any concerns about impediments to clinical autonomy or the quality of ancillary services. Such notification would be made to the relevant service provider, the relevant government department and if needed, the Australian Human Rights Commission or Commonwealth Ombudsman. The process of notification and escalation of concerns needs to be understood by all staff in the health service. In the event that a notification occurs, this needs to be documented in the relevant patient health records.
Standard 1.5
Continuity of care
Our service provides continuity of care for our patients.

Criterion 1.5.1
Continuity of comprehensive care
Our health service facilitates continuity of comprehensive care to patients.

Indicator
A. Our health service has strategies or policies that support continuity of comprehensive care (interview, document review).

Explanation
Health services in prisons provide patient centred, continuing, comprehensive and coordinated primary care (including mental health and dental healthcare) and it is important that patients have the opportunity to develop an ongoing relationship with the service while they are in the prison. Continuity is the degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected, and consistent with the patient’s medical needs and personal context. Continuity of care is distinguished from other attributes of care by two core elements – care over time and the focus on individual patients.

Continuity of care begins when a prisoner is received into the prison and screened for current medications, chronic health concerns and other events critical to the management of their healthcare. The processes and procedures the health service has in place to monitor and record relevant health information for each patient is an important factor in maintaining continuity of care.

The Standard guidelines for corrections in Australia\(^3\) stipulate that a prisoner is to be medically examined by a suitably qualified health professional within 24 hours of being received into the prison. If a prisoner has a pre-existing plan for the management of a particular condition, health service staff are encouraged to maintain the established care plan until such a time that a full assessment can be conducted.

Decisions need to be made on a case-by-case basis as to the appropriateness of requesting records from external health providers to assist in the ongoing care of a patient while they are in the prison. Bearing in mind that some patients will not want external health providers to know of their imprisonment, the patient needs to provide consent for such requests to be made.

In general, subject to the patient’s consent, it is advisable for a medical practitioner to confirm medications prescribed by a colleague in the community before the medications are prescribed again within the prison setting.
Prisoners may be frequently and rapidly transferred to alternative locations, compromising the continuity of care received from a single health service. To ensure continuity of care across health services in different prisons, health service staff need to develop a routine procedure for the way in which health information is transferred to a new location.

Discharge planning protocols should be organised by the health service and discharge plans should be documented in the patient health record at the time a patient leaves the facility whether by transfer to an alternative prison or on release into the community.

There are a number of types of continuity.34

- The sense of affiliation between the patient and their health professional (‘my doctor’ ‘my nurse’, ‘my psychologist’ ‘my dentist’ or ‘my patient’), sometimes called ‘relational continuity’, which is the focus of Criterion 1.5.2: Continuity of the therapeutic relationship

- Consistency of care by the various people involved in a patient’s care (ie. not working at ‘cross purposes’), sometimes called ‘management continuity’, which is the focus of Criterion 1.5.3: Consistent approach

- Continuity of information across healthcare events, particularly through documentation, handover and review of notes from previous consultations, sometimes called ‘informational continuity’, which is the focus of Criterion 1.5.4: System for follow up of tests and results.

For people incarcerated in Australian prisons, health services act as coordinators of all healthcare services and as patient advocates. Patients in prisons have a restricted capacity to choose healthcare providers and are reliant on a health service to provide or coordinate their healthcare including mental healthcare, specialist healthcare, dental healthcare, allied healthcare and emergency healthcare. As such, coordination and continuity of comprehensive care for these patients is critical.
Standard 1.5

Continuity of care

Our service provides continuity of care for our patients.

Criterion 1.5.2

Continuity of the therapeutic relationship

Patients attending our health service are able to see an appropriate member of our clinical team.

Indicators

A. Our staff can describe how patients can request access to an appropriate member of the clinical team when making an appointment or attending our health service (interview).

B. A sample of patient health records indicates that where possible and practicable, patients see the same doctor or other member of the clinical team (health records review).

C. Members of our clinical team can identify the person who coordinates clinical care where this is required for a particular patient (interview).

Explanation

Relational continuity is a sustained relationship between a single practitioner and a patient (or sometimes more than one practitioner and a patient) that extends beyond individual consultations or episodes of illness. This can be described as a sense of affiliation between a patient and their doctor (‘my doctor’, ‘my health service’, ‘my psychologist’ or ‘my patient’). It is often viewed as the basis for continuity of care. Health services in prisons may need to consider the ways in which they can build trust and confidence with patients, particularly where patients may not have access to the practitioner of their choice due to the nature of the setting. Therapeutic continuity is particularly challenging to achieve where there is a high volume of patient movement to other locations (a feature of prisons) and where it is difficult to attract or fund permanent staff.

It is acknowledged that some health services do not have formal, written appointment schedules by which patients are booked to see a doctor or another member of the clinical team. However, health services need to be able to demonstrate that they have a system or rationale for determining how patients may see an appropriate health professional.

Many health services employ doctors, nurses and allied health professionals as part of the clinical team. In general, the RACGP Standards protect a patient’s right to see their preferred doctor or another member of the clinical team such as a nurse or allied health professional. However, the RACGP acknowledges this may not be feasible in the prison setting.

Where practicable, the health service needs to make reasonable efforts to enable patients to see a health professional of their own gender, where a patient has specifically requested this.

Coordination of care is a critical issue in providing safe, high quality care to patients in Australian prisons. Coordination is a particularly significant factor where several health professionals are providing episodic and isolated care. In this scenario, the health service needs to identify a particular person (GP or otherwise) who coordinates the clinical care for an individual patient.
Standard 1.5
Continuity of care
Our service provides continuity of care for our patients.

Criterion 1.5.3
Consistent approach

Within our health service there is a consistent approach to diagnosing and managing common and serious conditions of individual patients.

Indicators

- A. Members of our clinical team can describe how they ensure consistency of diagnosis and management of common and serious conditions (within the parameters of evidence based care) within our health service (interview).
- B. Our health service has regular meetings to discuss clinical care (interview, document review).
- C. Members of our clinical team can describe how they hand over or transfer the care of individual patients to colleagues within our health service, to health services in other prisons and to health professionals continuing a patient’s care in the community (interview).

Explanation

A consistent approach to diagnosis and management across the various people involved in the clinical care of an individual patient is an important aspect of continuity of care and ensures that clinicians are not working at cross purposes. Patients value consistency in the quality of treatment they receive from a health service and expect that treatment and advice given by different health professionals within a health service will not be in conflict. If a health service employs nurses, psychologists or allied health professionals, patients expect advice provided by these professionals to be consistent with the diagnosis and management approach of the treating doctor. Providing consistency in the diagnosis and management of health issues across a multidisciplinary team assists in ensuring that the health service provides continuity of care for patients (Criterion 1.5.1: Continuity of comprehensive care).

Consistency is just as important in a small health service as it is in large health services with numerous clinical and allied health staff. In prisons where staff rosters and rotations may vary, health services need to ensure that documentation of consultation notes is comprehensive, clear and concise in order to maintain consistency of clinical care. This is also of particular importance in a setting in which patients are frequently and rapidly transferred to alternative correctional locations. Ensuring the timely transfer of patient health information to a new location or to a community based practitioner, ensures consistent management of ongoing care.
Health services can enhance the consistency of care by ensuring that clinical care is based on the best available evidence (see Criterion 1.4.1: Evidence based practice). For example, doctors and psychologists treating a patient with depression should provide consistent information and advice to the patient about their treatment and ongoing care. Management continuity is particularly important for people with chronic or complex diseases and may involve having a plan for the patient’s overall care that is shared by all the people providing care.

Another way of ensuring a consistent approach within the parameters of evidence based practice is by discussing clinical issues at regular meetings of the clinical team.
Standard 1.5
Continuity of care
Our service provides continuity of care for our patients.

Criterion 1.5.4
System for follow up of tests and results
Our health service has a system to review and follow up tests and results.

Indicators

A. Our patient health records contain evidence that pathology results, imaging reports, investigation reports and clinical correspondence received by our health service have been (health records review):
   • reviewed by a GP
   • initialled, and
   • where appropriate, acted upon in a timely manner.

B. Our staff can describe the system by which pathology results, imaging reports, investigation reports, and clinical correspondence received by our health service are (interview):
   • reviewed
   • signed or initialled (or the electronic equivalent)
   • acted on in a timely manner, and
   • incorporated into the patient health record.

C. Our health service has a written policy describing the review and management of pathology results, imaging reports, investigation reports and clinical correspondence received by our service (document review).

D. Our staff can describe how patients are advised of the process for following up results (interview).

E. Our staff can describe the procedure for follow up and recall of patients with clinically significant tests and results (interview).

F. Our health service has a system to recall patients with clinically significant tests and results (document review).

G. Our health service has a written policy to follow up and recall patients with clinically significant tests and results (document review).

Explanation
This criterion focuses on the systems that health services need to use to follow up tests and results as part of their duty of care to patients.

The information gained from tests and results can have considerable impact on the choices patients and health professionals make in patient care.

‘Follow up’ can have several meanings:

• following up the information – following up on tests and results that are expected to be, but have not yet been, received by the health service

• following up the patient – chasing or tracing the patient to discuss the report, test or results after they have been received by the health service and reviewed, or if the patient did not present for a test as expected.
The relationship between a health professional and a patient is characterised by trust and by the health professional having special knowledge and skills that the patient generally does not have. While health services are not expected to follow up every test ordered or to contact patients with the results of every test or investigation undertaken, there may be considerable risk in not following up clinically significant tests and results.

During the review of the RACGP Standards for general practices (2nd edition), members of the general practice profession expressed concern about the way in which the RACGP would reflect the profession’s standards in the area of follow up. Some members of the profession felt the courts had inappropriately shifted patient responsibilities on to doctors. Others commented that the decisions of the courts were less important to them than the emotional consequences of missing clinically significant results. In response, the RACGP commissioned a legal opinion on the issue which was taken into consideration along with the views of the profession when preparing the Standards. The RACGP decided to provide lengthy detail in this explanation to assist in clarifying these issues.

Medical and other clinical staff are not necessarily legally responsible for everything that goes wrong in a health service. Other people or entities (eg. a patient or a third party provider such as a pathology company) may be legally responsible for an adverse event instead of or together with a doctor or other health professional.

In some circumstances, people incarcerated in prisons will require the assistance of departmental staff to assist in the provision of their care (eg. arrange transport to attend offsite services). Health services in prisons will need to have a system in place to follow up such assistance, as it represents a link in the chain of care which may be broken and interrupt the continuity of care (eg. transport for an appointment may be overlooked if the prison management is busy or if resources required to facilitate the transfer of a patient are reallocated). Cooperation with the relevant government department may be particularly important in situations involving a clinically significant test result being received after a patient has been released from the prison.

The health service needs a system that is designed to ensure that:

- all test results and clinical correspondence (eg. reports from other healthcare providers) relating to a patient’s clinical care are reviewed
- clinically significant tests and results are followed up
- individual cases receive appropriate follow up depending on the clinical significance of the case.

The nature and extent of responsibility for following up tests and results will depend on what is reasonable in the circumstances. Overall, the following factors are important in determining whether something is clinically significant and therefore requires follow up:
• the probability that a patient will be harmed if adequate follow up does not occur
• the likely seriousness of any potential harm
• the burden of taking steps to avoid the risk of harm.

The clinical significance of a test or result needs to be considered within the context of the patient’s history and presenting problems. Clinically significant results do not only arise from abnormal test results. For example, a normal mammogram in a woman with a breast lump or a normal electrocardiogram in a patient with chest pain does not preclude the need for further consultation, investigation and management. A result is deemed clinically significant when a GP or another member of the clinical team judges that something is clinically important for that particular patient in the context of that patient’s healthcare. The judgment may be that an abnormal result is clinically important and requires further action. On the other hand, the result may be normal but further action may still be required.

The persistence with which a health service needs to facilitate further investigations will depend on the likelihood (as judged by a health professional) that the investigation, test or referral will be clinically significant and the degree of urgent action required.

The health service needs to have a working system for follow up – even if the system is as basic as a simple diary entry, or logbook containing ‘worrying’ or ‘high risk’ cases – so that where there is a concern about the significance of a test or result, a reminder occurs. Medical and other clinical staff do not necessarily need to supervise the follow up system directly, but it needs to operate consistently and a GP or another member of the clinical team need to be responsible for identifying worrying cases.

The health service needs to be able to identify unexpected significant results when they occur, particularly if the significance of such results was not raised in the consultation. In these circumstances health services need to alert the patient, who may not anticipate or understand the significance of the result.

Problems in follow up can be avoided or minimised through interventions at earlier points in patient care. The relationship between a health professional and patient is a special one that is based on trust and communication. While the patient is the ultimate decision maker, it is important for the patient to be well informed in order to be in a position to make good decisions. Decisions need to be based on information that doctors and other clinical staff have a duty to provide. Health staff need to convey such information to patients in a way that helps patients to understand it. A patient who makes a decision based on insufficient information is not making an informed decision. Once the patient is properly informed there can be legally effective informed consent, and there can also be legally effective informed refusal.

Patients too have responsibility for their own healthcare, including seeking their own results. It is important to have follow up systems in the health service that:
• are meaningful for patients
• create a shared understanding of what is going to happen
• define who is responsible for follow up
• encourage patients to discuss how they can help manage their own health.

These systems might include outlining the health service’s policy for follow up in the patient information sheet, and having GPs and other clinical staff routinely describe the health service’s system for follow up to patients when requests for pathology or imaging tests are made. The standards for ensuring that patients have the information they need to make informed decisions are covered in Criterion 1.2.2: Informed patient decisions.

At an early stage in a patient’s care, the health service needs to reinforce the respective rights and responsibilities of patients and members of the health service team in following up tests and results. Developing this understanding with patients in a way that is easy for the patient to understand, reinforces to patients the need to think about the way in which they help to manage their own health. A brief and accurate note of these discussions is important to record in the patient’s file. In circumstances where the literacy of the patient is a problem, the health service would need to consider how to inform patients of their responsibility and follow up the results of recommended investigations.

Documentation of relevant clinical information is also required for health professionals who may require the records later. The standards for maintaining patient health records are covered in Criteria 1.7.1: Patient health records; 1.7.2: Health summaries and 1.7.3: Consultation notes.

Reliance on patient memory or motivation in place of an effective follow up system is not appropriate. Patients may not follow the recommendations provided by the health service because of their particular circumstances, fear, ignorance, personality, expectations, beliefs, cultural background or a range of other factors. Health services need to have systems that respond to situations where a particular patient is judged unlikely to go through with a test or follow up on the results.

In some instances, the results of investigations are sent to the health service rather than to the doctor who ordered the investigation. In such cases, the health service needs to have a follow up and recall system that identifies who in the service is responsible for the receipt, review and follow up of these results.

The location of the prison may also impact on the systems needed for follow up. For example, the proximity of consultant services to which patients can be referred may affect the way that investigations, tests and referrals are followed up in a system that is both appropriate and practicable.

Where a patient indicates they do not intend to take a recommended test, the health service needs to ensure the patient has received sufficient information to make an informed decision and to understand the consequences of their actions or inactions. This discussion needs to be recorded in the patient health record (see Criterion 1.2.2: Informed patient consent).
The review of results or reports needs to be completed in a timely manner. The speed with which results/reports are acted on, and the degree of effort taken to contact a patient to discuss the results, will depend on the health professional’s judgment of the clinical significance of the result/report, and the context, duration and longevity of the clinical relationship. If the health service needs to initiate follow up contact with a patient, it needs to do so in a reasonable manner. Attempts to contact a patient to follow up test results need to be documented in the patient’s health record.

A close analysis of how and when things go wrong in following up patients with clinically significant tests or results often shows it is due to a problem, or several problems, with the health service system including:

• the quality and content of discussions with the patient
• the recording of those discussions
• the recording of the clinical encounter
• the person to whom the results are returned (eg. the health service versus the treating clinician).

It is useful for health services to understand that protecting patients and health professionals from errors involves a series of safeguards within a well designed system that is routinely adhered to.

The RACGP recognises that information technology can be a useful tool in follow up but cautions health services to be aware of the limitations of clinical information systems.
**Standard 1.6**

*Coordination of care*

Our service engages with a range of relevant external services to improve patient care.

**Criterion 1.6.1**

Engaging with other services

Our health service engages with a range of services to plan and facilitate optimal patient care.

**Indicators**

- **A.** Our health service demonstrates how it engages with the following (document review, interview):
  - other medical services such as diagnostic services, hospitals and specialist consultant services
  - allied health and dental services which are provided within the prison or via providers external to the health service
  - disability and community services
  - health promotion and public health services and programs
  - the prison’s management company
  - the relevant state/territory departments responsible for primary medical care in prisons.

- **B.** There is evidence our health service refers patients to other health, community or disability services as required (health records review).

**Explanation**

Engaging other services (eg. diagnostic services, hospitals, specialists, dentists, allied health, mental health, social, disability and community services) can assist the health service to provide comprehensive care to patients. For health services in prisons, these other services also include the relevant government departments.

The health service needs to have readily accessible written or electronic information about local health, disability and community services and how to engage with them to plan and facilitate patient care. In general in prisons, such services will not be provided onsite.

How the health service engages with external providers may require sensitive consideration as some community based services may be reluctant to facilitate care for incarcerated patients.

Health services may also need to be aware of different referral arrangements for public and private healthcare providers.

Health services will need to engage with prison staff where the facility plays a role in matters such as facilitating travel, providing chaperoned access to offsite services, assisting with access to medication, meeting specific nutritional requirements or following up on medical instructions provided to patients. It may be useful for a health service to schedule regular briefing meetings to discuss the obligations of the health service in providing healthcare to patients, and invite relevant staff from the prison and the relevant government department to attend.
Standard 1.6
Coordination of care
Our service engages with a range of relevant external services to improve patient care.

Criterion 1.6.2
Referral documents
Our referral documents to other healthcare providers contain sufficient information to facilitate optimal patient care.

Indicator

A. Our health service can demonstrate that referral letters are legible, contain at least three approved patient identifiers, state the purpose of the referral and where appropriate (health records review):
- are on appropriate health service stationery
- include relevant history, examination findings and current management
- include a list of known allergies, adverse drug reactions and current medicines
- are documented in the patient’s health record.

Explanation
Referral documents are a key tool for integrating the care of patients between one health service and external healthcare providers. Referral documents therefore need to be legible (preferably typed) and contain sufficient current information to allow another healthcare provider to provide continuous and effective care to a patient. Most of the information needed for a referral may be found in the patient’s health summary (see Criterion 1.7.2: Health summaries). Unless the details of a patient’s offence/crime are relevant to the care provided by an external provider or the provider’s safety, then such details should not be included in prisoner referral documents. Patients need to be aware that their patient health information is being disclosed in referral documents and they need to provide consent for this to happen.

In the case of a medical emergency or other unusual circumstances, a telephone referral may be appropriate. This telephone referral needs to be documented in the patient’s health record.

For both medicolegal and clinical reasons, health services need to keep copies of important referral letters in the patient’s health record (eg. new referrals or those for serious conditions). Health services that do not retain any referral letters would have difficulty meeting this criterion.

In referring patients to external providers, it is important for the health service to emphasise the independence of the primary healthcare team within the prison to encourage good communication between external healthcare providers and the health service. Some external providers may be unclear about the relationship between the health service and the prison and be reluctant to provide information about a patient’s healthcare back to the prison health service if there is the belief it will not be treated confidentially. If this is a foreseeable problem
for the health service, members of the clinical team may consider explaining to external healthcare providers that patient confidentiality is assured. For example, it may be advisable to have a report specifically addressed to a clinician or case manager within the health service rather than confidential patient health information being addressed to the health service as an entity.

Correctly identifying patients is crucial when referring patients so that it is ensured the right patient receives the right treatment. Approved patient identifiers include:

- name
- address
- date of birth
- gender
- patient record number if it exists.

A Medicare number is not an approved patient identifier.

Clinicians should be alert to the common use of aliases by prisoners, to ensure the right patient receives the right treatment.
**Standard 1.7**

*Content of patient health records*

Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

**Criterion 1.7.1**

*Patient health records*

For each patient we have an individual patient health record containing all clinical information held by our health service relating to that patient.

**Indicators**

- **A.** There is evidence that each patient has an individual patient health record that contains all the health information held by our health service relating to that patient (health records review).
- **B.** Our patient health records are legible (health records review).
- **C.** Our active patient health records include (health records review):
  - the patient’s full name
  - date of birth
  - gender.
- **D.** Our health service can demonstrate that we are working toward recording the following information in our active patient health records (health records review):
  - cultural background (e.g. Aboriginal and Torres Strait Islander status)
  - the person the patient would like contacted in an emergency.

**Explanation**

Health services need to have an effective system whereby an individual patient’s health information is stored in a dedicated patient health record. Health records need to include:

- the patient’s contact details, name, date of birth and other demographic information
- medical history (including current medications)
- social history, family history
- consultation notes (including any care outside the normal opening hours of the health service and visits to a patient’s living quarters)
- letters received from hospitals or consultants, other clinical correspondence, investigations or referrals and results.

Besides clinical information, the patient health record may also contain other relevant information pertaining to the patient, such as relevant legal reports.

Medical errors and breaches of personal privacy can occur as the result of information being recorded in, or taken from, an incorrect patient health record. As a result, it is important to have an accepted protocol for ordering given and family names, as well as ways of distinguishing the files of patients that have similar or identical names.
For health services in prisons, a patient’s health record needs to be independent and separate from that person’s correctional record. The patient’s health information should remain private and confidential as outlined in section 2.42 of the *Standard guidelines for corrections in Australia* (see Criterion 4.2.1: Confidentiality and privacy of health information).

Patient health records may be solely electronic, solely paper based, or a hybrid (combination of paper and electronic records). If health information about a patient is kept in two sites (as in the case of hybrid records), health services need to have a system in place to ensure all the information is available and accessible when needed. This is important to ensure continuous and comprehensive care especially when a patient is relocated to another prison or to a community based practitioner (see Criterion 1.5.1: Continuity of comprehensive care).

Basic personal information that is required from each patient might be collected by health service staff, with new patients completing a generic form or being interviewed in a private environment before their consultation.

It is critical that patient health records are legible so that any other member of the health service team could take over the care of the patient if necessary. If the health service scans documents such as external reports for inclusion in a patient’s health record, the scanned copy needs to be of quality that reproduces the legibility of the original document.

Health services also need to be working toward routinely recording the person the patient would like contacted in an emergency, and the patient’s cultural background. Health services that have not been routinely recording this information already need to demonstrate how they are improving the consistency with which it is recorded in patient health records (see www.racgp.org.au/standards/fourthedition/factsheets).
Standard 1.7
Content of patient health records
Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

Criterion 1.7.2
Health summaries
Our health service incorporates health summaries into active patient health records.

Indicators
A. At least 90% of our active patient health records contain a record of allergies in the health summary (health records review).
B. At least 75% of our active patient health records contain a health summary. A satisfactory summary includes where appropriate (health records review):
- adverse medicines events
- current medicines list
- current health problems
- past health history
- risk factors
- immunisations
- relevant family history
- relevant social history.
C. Our patient health records show evidence that health summaries are updated to reflect recent important life events (health records review).
D. If our health service uses both an electronic and paper based system for recording a patient’s health summary, our service can demonstrate how the patient’s health information is accessible when required (interview).

Explanation
A vital component of a quality health record is a health summary. All active records should contain an up-to-date health summary. A good health summary assists GPs, nurses, other doctors, allied health staff and other members of the clinical team in the health service to obtain an accurate overview of all the components of a patient’s care. Health summaries reduce the risk of inappropriate management including medicine interactions and side effects (particularly when known allergies are recorded). Health summaries provide the social and family overview vital to patient centred care. A health summary will assist with health promotion by highlighting lifestyle problems and risk factors (eg. smoking, alcohol, nutrition, physical activity status). Health summaries also help disease prevention by tracking immunisation and other preventative measures. An up-to-date health summary is critical for the smooth transfer of care from one practitioner to another (either within the health service or at another prison or community based service). Because health summaries are such an important component of safe, high quality care, the requirement that at least 75% of all patient health records contain a health summary has been included in these Standards.
While it is important to record all known allergies in health summaries, it is particularly important to record known allergies to medicines as this facilitates safer prescribing and reduces the likelihood of adverse patient outcomes. If a patient has no known allergies, it is important to record this and not leave it as an assumption in the absence of recorded allergies.

While a health summary would normally include a list of current medicines, in general, subject to the patient’s consent, it is advisable for a medical practitioner to confirm medications prescribed by a colleague in the community before the medications are prescribed again within the prison setting.

Recording recent important life events covers a wide range of social events of importance to the patient, which may include changes in accommodation, family structure (eg. death of family members) and/or important events relating to the person’s incarceration. Recent important life events can alter a patient’s preferences, values and the context of their care.

Where a health service does not meet the 75% minimum level in one or more of the elements of a health summary (eg. risk factors), the health service needs to explain how it is attempting to improve the completeness of the health summary in regards to that element. A health service that shows a deficiency in the recording of any information needs to have a plan for improvement.

This criterion applies to active patient health records only. In the case of health services in prisons, an active health record is the record of a patient who is currently incarcerated in the prison.

The RACGP appreciates that family and social history especially should only be recorded in a health summary where it assists with patient care and does not impair a patient’s right to privacy and, as such, not all health summaries will include all the items listed in Indicator B. Recording details of a patient’s criminal history should only be included in a health record where it is required for facilitating patient care or maintaining the safety of health service staff.
Standard 1.7
Content of patient health records
Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.

Criterion 1.7.3
Consultation notes
Each of our patient health records contains sufficient information about each consultation to allow another health professional to carry on the management of the patient.

Indicators
A. Members of our clinical team document consultations including consultations outside normal opening hours and visits to living quarters in patient health records as follows (health records review):
- date of consultation
- patient reason for consultation
- relevant clinical findings
- diagnosis
- recommended management plan and where appropriate expected process of review
- any prescribed medicine (including medicine name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed)
- any relevant preventive care undertaken
- any referral to other healthcare providers or health services
- any special advice or other instructions
- identification of who conducted the consultation, eg. by initial in the notes, or audit trail in electronic record.

B. Our patient health records show evidence that problems raised in previous consultations are followed up (health records review).

Explanation
A consultation is an interaction related to the patient’s health issues that takes place between a health professional in the health service and a patient. A consultation may be with a doctor (GP or other specialist medical practitioner) or with another member of the clinical team who provides clinical care within the health service (eg. nurse or psychologist).

The quality of patient health information needs to be such that another health professional could read and understand the terminology and abbreviations used, and from the information provided be equipped to manage the care of the patient. Documentation of all the items in Indicator A will not be required for every individual consultation, such as consultations for repeat prescriptions.

Ideally, information about the consultation needs to be entered into the patient’s health record as soon as is practicable (eg. during or immediately after the consultation or as soon as information such as test results becomes available).
As part of the continuing care that health services in prisons provide, information concerning patients is gathered over more than one consultation. It is important there is a connecting process so that information about clinically significant, separate events in a patient’s life and in the care provided are not overlooked but are recorded and managed in a way that makes this information readily accessible. Regularly updated health summaries are one method of managing patient health information. Clinically significant information may include the patient’s health needs and goals, medical conditions, preferences and values. All this contributes to care that is responsive to a patient’s individual needs.

Medical defence organisations have identified lapses in following up on problems and issues raised previously by patients, as a considerable risk. This scenario can occur when earlier consultation notes are inadequate, or when patients are not seen by the usual member of the clinical team, although it can also occur when a staff member is busy or distracted. Therefore, to sustain safe and high quality patient care it is useful for health services to have systems, including systems for consultation notes, that reduce the risk of such lapses.

It is also important for health services in prisons to document in a patient’s health record if there is a delay (for whatever reason) between the patient requesting healthcare and the provision of that healthcare. It may be useful for medico-legal purposes to document the reason for the delay and the follow up that occurred as a result.
Section 2

Rights and needs of patients

Standard 2.1

Collaborating with patients

Our health service respects the rights and needs of patients.
Standard 2.1
Collaborating with patients
Our health service respects the rights and needs of patients.

Criterion 2.1.1
Respectful and culturally appropriate care
Our health service provides respectful and culturally appropriate care to patients.

Indicators

A. Our health service does not discriminate against patients on the basis of their gender, race, disability, indigenous status, age, sexual preference, beliefs, criminal convictions or medical condition (interview).

B. Members of our clinical team can describe how they provide care for a patient who refuses a specific treatment, advice or procedure (interview).

C. Members of our clinical team can describe how they transfer the care of a patient to another health professional within our health service or in another health service (interview).

D. Members of our clinical team can describe the arrangements for managing the transfer of a patient who they no longer wish to treat, to another health professional (interview).

E. Our staff can describe how our health service provides privacy and confidentiality for a patient without compromising the occupational health and safety of health service staff and other patients (interview).

F. Our staff can identify significant cultural groups within our health service (e.g. Aboriginal and Torres Strait Islanders) and outline the strategies we use to address their special needs (interview).

Explanation
Patients have the right to respectful care which promotes their dignity, privacy and safety. Patients have a corresponding responsibility to give respect and consideration to the staff and other patients of the health service. Staff need to have appropriate interpersonal skills to work with patients and others in the health service. This criterion requires that staff deal with patients in a respectful and polite manner.

Prisons present a challenging environment in which to provide healthcare. In this setting, transcultural awareness is central to a health professional being able to understand an individual patient’s perception of health and illness. This awareness requires an understanding of the multitude of cultural, religious, socioeconomic and linguistic backgrounds of patients as well as the social determinants of ill health. It is also important to foster cultural sensitivity regarding a patient’s past experiences (e.g. level of education, history of drug addiction, mental health concerns or previous experiences of the corrections system), which may influence their perception of the prison system and therefore their trust of healthcare workers. Due to the high incarceration rates of Indigenous Australians, health service staff should develop a working
understanding of this culture in order to be able to provide culturally appropriate healthcare. There are many useful resources available for improving health professionals’ understanding of culture and its impact on mental and physical health including:

- Indigenous Health Infonet (www.healthinfonet.ecu.edu.au)
- The Victorian Transcultural Psychiatry Unit (www.vtpu.org.au/links)
- World Medical Association Statement on Ethical Issues Concerning Patients with Mental Illness (www.wma.net/en/30publications/10policies/e11/index.html)
- Mood Gym Australian National University (http://moodgym.anu.edu.au/welcome)

Demonstrating respect for patients extends beyond the face-to-face interactions that occur between health service staff and patients to the recording of a patient’s health information. Making or recording derogatory, prejudiced, prejudicial, or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters, and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other health professionals and may result in inappropriate treatment of a patient.

Health service staff need to be aware that recording details of a patient’s criminal record is not appropriate unless it is directly relevant to the provision of the patient’s healthcare or the safety of health service staff. It is not appropriate for patients to be referred to in derogatory terms such as ‘crim’ in health records. Health services need to be aware that the Federal Disability Discrimination Act 1992, as well as the various state and territory disability services acts and the Human Rights and Equal Opportunities Commission Act 1986, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion) as well as discrimination on the basis of a person’s criminal convictions. Further information is provided by the Australian Human Rights Commission (www.humanrights.gov.au). This website has guides to the relevant legislation and links to state and territory agencies with similar responsibilities.

The ideal health professional-patient partnership is a collaboration based on mutual respect and a mutual responsibility for the health of the patient. The health professional’s duty of care is to explain the benefits and potential harm of specific treatments and to clearly and unambiguously explain the consequences of not adhering to a recommended management plan.
The use of interpreters should be considered in every consultation when the patient is known to have a non-English speaking background in order to avoid misunderstandings and to assist in developing trust between the patient and healthcare professional. It is important to protect the privacy and confidentiality of the patient when using interpreters for the facilitation of care within the health service. There may be exceptional circumstances where other prisoners, prison staff or departmental staff are required to act as interpreters. However, it is generally considered inappropriate to use such people in place of properly qualified interpreters.

Where patients refuse advice, procedures or treatments, an appropriate risk management strategy for health services needs to include recording such refusals in the patient’s health record, including referrals to other healthcare providers if arranged. This includes documenting any refusal of medical care where a patient is proposing to engage in self-destructive behaviour or is engaging in such behaviour (e.g., self-cutting) and the health professional’s assessment of the person’s competence to make such refusals. If a patient refuses to act on medical advice, the health service needs to consider whether the patient’s culture contributes to a perception of the suggested care being unsuitable. If so, attempts need to be made to provide care in a culturally appropriate context.

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

For patients in prisons it is important that the health service arranges the transfer of care to another healthcare practitioner when a patient is released from the prison or transferred into another prison. Subject to a patient’s consent, a comprehensive health summary needs to be provided to the health professional who will be coordinating the care of the patient outside the prison or to the patient, if no health professional has been identified by the time of the patient’s release. It is useful for the discharge planning process to be managed by the person in the health service who is identified as leading the care or having the greatest proportion of interaction with that patient (see Criterion 1.5.2: Continuity of the therapeutic relationship).
There may be patients who members of the clinical team no longer consider appropriate to treat due to a critical breakdown in the therapeutic relationship. Members of the clinical team have the right to discontinue the treatment of such patients, especially when they think they can no longer give the patient their best care. Where continuing with the treatment of a particular patient has adverse effects on health service staff, alternative arrangements need to be considered. Discussions with the relevant department of health/justice staff may be required to determine how future care will be provided.

The health service is encouraged to have a risk management strategy which details the steps that need to be taken to protect staff and to deal with these distressing situations, as well as the steps that need to be taken to assist patients with ongoing care, including referral to other healthcare providers where practicable. The convention of health service staff being ‘in sight and sound’ of prison staff is a risk management strategy currently utilised within Australian prisons to maintain a safe working environment. Health service and prison staff need to have a mutual understanding of the way in which the privacy and confidentiality of patient consultations and health information will be maintained in this context.

A patient in distress may feel more comfortable in a private area. Health services need to attempt to provide privacy for such patients without compromising the safety of staff. This does not mean a health service needs to have a room permanently set aside for such patients, but rather needs to have a plan that can be implemented as the need arises to ensure a distressed patient is treated respectfully.
Standard 2.1
Collaborating with patients
Our health service respects the rights and needs of patients.

Criterion 2.1.2
Patient feedback
Our health service seeks and responds to patient feedback.

Indicators

- A. Our health service has a process for receiving and responding to feedback and complaints from patients (document review).
- B. Our staff can describe the processes for receiving and responding to feedback and complaints from patients (interview).
- C. Our health service makes contact information for the Australian Human Rights Commission, Commonwealth Ombudsman and the relevant state/territory health complaints agency available to patients on request (interview, document review).
- D. Our health service can describe an improvement we have made in response to patient feedback or complaints (interview).
- E. Our process for seeking feedback from the patients of our health service gathers information on the following areas (document review):
  - whether patients are satisfied with the health service’s process of scheduling care
  - whether health service staff discuss health promotion and illness prevention
  - whether patients are treated with respect and in a culturally appropriate manner by health service staff
  - whether patients receive sufficient information about the purpose, importance, benefits and risks of investigations, referrals or treatments proposed by the health service staff to enable them to make informed decisions about their healthcare
  - whether patients are confident that any feedback or complaint to the health service will be handled properly and will not affect their ongoing healthcare
  - whether patients were asked for prior consent to allow a third person to be present during a consultation
  - whether patients are offered the use of an interpreter
  - whether patients find it is easy to contact the health service
  - whether patients are satisfied with the facilities in the consultation area
  - whether patients understand the separation between the health service and the prison and think the health service makes adequate provision for their privacy and confidentiality.
Explanation

Unique information about patient needs and the quality of care provided by a health service can be gained from patients. Discussing patient feedback openly helps staff to understand strengths in their health service, potential problems, and how to improve. It is helpful to know what patients think about a health service and what they are likely to tell other people. The more feedback a health service receives, whether it be complaints, compliments or suggestions, the better it will be able to provide safe, high quality and cost efficient healthcare.

The ‘Turning wrongs into rights: learning from consumer reported incidents’ project,37 a national project funded under the auspices of the ACSQHC, has undertaken research on complaints management in Australian healthcare organisations and has developed guidelines on complaints management in healthcare.

The importance and value of effective complaints management was expressed by the ACSQHC in its publication Better practice guidelines on complaints management for healthcare services.38

Consumers (including patients and carers) have a unique expertise in relation to their own health and their perspective on how care is actually provided. Consumer complaints are therefore a unique source of information for healthcare services on how and why adverse events occur and how to prevent them. As well as reducing future harm to patients, better management of complaints should restore trust and reduce the risk of litigation, through open communication and a commitment to learn from the problem and prevent its recurrence.

The complex challenge of providing healthcare to patients in prisons means it is important that health services be transparent about their relationships with other parties including the prison (see Criterion 1.2.1: Health service information).

It may be of benefit for a health service to declare that feedback being sought from patients is only for the quality improvement of the health service. The health service needs to explicitly encourage and support patients to provide feedback or make a complaint. To this end, it is suggested that patients who wish to make a complaint to the health service are encouraged to do so with the assistance of independent advocates who may be able to clarify the nature of the complaint and work to find a resolution. In some prisons, there are prisoner committees that may act as patient advocates. It needs to be made clear by the health service that anonymous feedback can be provided, or complaints can be made without fear of negative repercussions for a patient’s healthcare.

It is important that a health service have some kind of structured mechanism to gain feedback from patients. It is recognised that gaining feedback from patients in prisons can be challenging. However, health services need to determine the most appropriate way of gaining meaningful feedback about the health service for their patient population. This might be through the use of a patient survey about the health service, or it could be through the use of focus group discussions where patients are invited to come together to discuss their views on the health service. Given the challenges in gaining feedback from incarcerated people, at the very least, health services need to be able to demonstrate they are working toward a mechanism for seeking patient feedback that can drive quality improvement.
**Standard 2.1**
**Collaborating with patients**
Our health service respects the rights and needs of patients.

**Criterion 2.1.3**
**Presence of a third party**
Subject to safety and security considerations, the presence of a third party observing or being involved in clinical care during a consultation occurs only with the permission of the patient being given before the consultation.

**Indicators**
- A. Our staff can describe how and when they obtain prior consent from a patient for the presence of a third party during a consultation, subject to safety and security considerations (interview).
- B. Our health service has a policy about the presence of third parties in consultations (documents review).

**Explanation**
The privacy and confidentiality of therapeutic treatment is generally accepted by health professionals as a patient’s right and is explicitly supported within these Standards. Compromising on this aspect of a patient’s rights may affect the trust they have in the health service and may reinforce power imbalances that are detrimental to a patient’s health and wellbeing.

In some circumstances, a member of the clinical team may feel more comfortable if there is a third party present during an examination. Appropriate consent needs to be obtained from the patient where the health professional requests the presence of a third party and the patient’s permission needs to be sought before the consultation occurs. It is not acceptable to ask permission in the consulting room, as some patients may feel ambushed and unable to refuse. The presence of a third party in the consultation (including interpreters) should be documented in the patient’s health record.

There may be tension between the need to respect the privacy and confidentiality of a patient and the need to manage any security or safety risks that the patient may pose to health professionals during a consultation. For health services in prisons, a policy for managing these potentially conflicting needs may need to be negotiated with the relevant government department and prison management. The policy would need to outline the circumstances in which third parties such as a prison officer need to be present during a consultation for safety or security purposes, and the way in which disclosure of personal health information to the third party would be minimised.

At maximum security facilities, having prison staff in the consultation room may be part of the standard operating procedure and if this is the case health service staff will have to accommodate this in the way they provide care. In facilities with other security classifications, the convention of ‘within sight and sound’ may be sufficient to maintain appropriate security levels as well as the privacy of the patient. Health service staff should consult with the relevant government department and the prison’s management company to determine what is required in relation to a third party presence, and incorporate such provisions into the way they deliver healthcare to ensure the best possible security as well as patient privacy and confidentiality.
Section 3

Safety, quality improvement and education

Standard 3.1
Safety and quality
Our health service is committed to quality improvement.

Standard 3.2
Education and training
Our health service supports quality improvement through education and training.
Standard 3.1
Safety and quality
Our health service is committed to quality improvement.

Criterion 3.1.1
Quality improvement activities
Our health service engages in quality improvement activities.

Indicators
- A. Our staff can describe an aspect of our health service that we have improved in the past 3 years (interview).
- B. Our health service uses data about the service or our patient population for quality improvement initiatives (interview or document review).

Explanation
Health services that engage in quality improvement activities review the health service’s structures, systems and processes to discover opportunities to make changes that will increase the quality and safety of patient healthcare. It is critical that the health service also has a plan for carrying out any improvements it has identified as being necessary.

Quality improvement activities can vary from activities designed to improve the day-to-day operations of the health service (eg. improving patient health record keeping) to those specifically designed to improve the health of the service’s wider population (eg. improving rates of immunisation or improving the care of patients with diabetes). Quality improvement is not restricted to clinical areas and may include improvements made in response to feedback from patients about factors such as the service’s physical facilities or equipment (see Criterion 2.1.2: Patient feedback).

Quality improvement activities are underpinned by effective information management techniques that allow health services to collect and analyse data and make decisions about service improvements based on practice specific information.

Quality improvement tools and other resources
RACGP Oxygen: Intelligence in practice provides a suite of integrated products and services to improve the way patient information can be used to better inform decisions in both clinical and business settings. These include:

- The PCS Clinical Audit Tool® (CAT®), a software application used within the general practice that allows analysis of identifiable practice information
- The Clinical Health Improvement Portal® (CHIP®) a secure web based data warehouse that builds on the clinical and business improvement opportunities available via CAT® and allow analysis of de-identified practice information against GP-agreed clinical indicators.
More information about Oxygen products and services is available at www.racgp.org.au/ehealth.

Engaging in quality improvement activities is an opportunity for staff members to come together as a team to work on areas that will improve the safety or quality of patient healthcare. Achieving desired improvements may require the collaborative effort of the whole health service team.
Standard 3.1

Safety and quality

Our health service is committed to quality improvement.

Criterion 3.1.2

Clinical risk management system

Our health service has a clinical risk management system to enhance the quality and safety of our patient care.

Indicators

A. Our medical and other clinical staff can describe the process for identifying and reporting a near miss or mistake in clinical care (interview).

B. Our medical and other clinical staff can describe an improvement we have made to prevent a near miss or mistake in clinical care from reoccurring (interview).

Explanation

Near misses and mistakes in clinical care that might harm patients occur in all health services. One review of studies about near misses and mistakes suggests that the frequency with which a GP will be involved in an incident in which an error occurred will be between 5 and 80 times per 100,000 consultations. The evidence about the frequency of near misses and mistakes varies but the better constructed studies suggest even higher rates of occurrence.

Most health services already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent mistakes. Some health professionals talk to other trusted peers or supervisors about ways to manage risk. Some health services have formal processes such as team discussions or structured techniques to analyse the causes of a near miss or mistake and work out how to reduce the likelihood of its recurrence.

The same mistake can have different causes on different occasions. Part of the quality improvement process (see Criterion 3.1.1: Quality improvement activities) is having a consistent clinical risk management system so that the causes of near misses and mistakes are identified and the related processes are improved to reduce the likelihood of them occurring again.

If a health service does not make improvements after identifying a near miss or mistake then patients may be exposed to an increased risk of adverse outcomes and health service staff may be exposed to an increased risk of medicolegal action. For example, if a clinically significant test result is not communicated to the patient or adequately followed up and if the health service knows this has happened yet fails to improve their systems for following up test results, then the service may be exposed to an increased risk of medicolegal action. A similar risk of medicolegal action may apply where an important detail in a previous consultation is not considered by a GP at the patient’s next consultation, resulting in a significant clinical problem being overlooked and the health service knows this has happened yet fails to improve
their system for record keeping. This second example may be more likely with the use of certain electronic based record systems that do not show the previous consultation record when a patient’s health record is opened.

The vast majority of incidents do not lead to patient harm. They are deemed ‘near misses’ that are caught before any harm to a patient occurs. For example, a doctor may prescribe a medicine for a patient who then tells the doctor they are allergic to that medicine and so the doctor changes the prescription. Similarly, a doctor may notice that a nurse has prepared an incorrect vaccine for a patient and advises the nurse accordingly, who then replaces it with the correct vaccine. These ‘near misses’ can provide important opportunities for quality improvement within a health service.

The health service needs to have a process in place whereby health service staff know how to notify a near miss or mistake or an unanticipated adverse outcome. A recent study suggests that staff members who are able to hold discussions about difficult subjects such as disrespect, micromanagement, competence and error are likely to be involved with better patient health outcomes, remain longer in their positions, and be more satisfied with their work.40

Health services will have very different systems in place to identify and reduce clinical risk. It is important however, for health services to be able to demonstrate how and why they have made changes within the health service to reduce risk and improve clinical care.

There are a number of parties involved in caring for people who are incarcerated in prisons. Health service staff need to know how to report a concern that the actions of another party (e.g., government department or prison management) may compromise the quality or safety of healthcare provided by the health service. It is critical that health services are able to make direct contact with the relevant government department in the event that an administrative, management or other criminal justice process is likely to cause a clinical mistake or pose a risk to patient safety (see Criterion 1.4.2: Clinical autonomy for medical and other clinical staff).

The RACGP recommends that medical and other clinical staff notify their medical defence organisations of all events or circumstances that they perceive might give rise to a claim.
**Standard 3.2**

*Education and training*

Our health service supports quality improvement through education and training.

**Criterion 3.2.1**

**Medical staff qualifications and training**

All medical staff in our health service are appropriately qualified and trained, have current Australian registration, and participate in continuing professional development.

**Indicators**

- **A.** All the doctors in our health service can provide evidence of current Australian registration (document review).
- **B.** Our health service can demonstrate that all our doctors are recognised Fellows of the relevant medical colleges OR Where the recruitment of Fellows of the relevant medical colleges has been unsuccessful, our health service can demonstrate that doctors have the qualifications and training necessary to meet the needs of our patients (interview, document review).
- **C.** For each doctor in our health service, we can provide evidence of satisfactory participation in the continuing professional development program of the relevant medical college (document review).
- **D.** Our doctors have undertaken training in CPR in accordance with RACGP QI&CPD recommendations (document review).
- **E.** Our doctors can describe how to use our automated external defibrillator (interview).

**Explanation**

The *Standard guidelines for corrections in Australia*\(^4\) stipulate that each prisoner is to have access to evidence based health services, provided by a registered and competent health professional, who is providing a standard of care comparable to that which they would receive in the general community.

This requirement poses special challenges for health professionals on two key fronts.

First, the closed environment of prisons means that prisoners necessarily have restricted access to the broad range of healthcare that is available in the wider community. Second, the patient population in prisons is generally characterised by complex clinical needs, making it more difficult for health professionals to achieve good health outcomes.

These factors mean it is imperative that medical staff working in prisons are appropriately qualified and experienced.

All doctors in the health service need to meet the standards of the relevant Australian specialist medical college, in terms of their vocational training and their continuing professional development.
General practice is a distinct discipline in medicine and requires specific training. Doctors providing general practice care need to be appropriately trained and qualified in the discipline of general practice, and be either vocationally recognised or have Fellowship of the Royal Australian College of General Practitioners (FRACGP). The RACGP defines a GP as a registered medical practitioner who is qualified and competent for general practice in Australia, has the skills and experience to provide patient centred, comprehensive, coordinated and continuing medical care, and who maintains professional competence for general practice through continuing professional development.42

In some areas it may be impossible to recruit vocationally recognised GPs. In such circumstances, doctors who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the patient population. Doctors who have not yet met the equivalent of the RACGP Fellowship need to be assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP. Adequate professional and personal support for doctors working in health services in prisons is critically important.

Doctors providing general practice care who are not participating in the RACGP Quality Improvement and Continuing Professional Development (QI&CPD Program triennium need to demonstrate recent and continuing participation in activities equivalent to Category 1 activities of the QI&CPD Program. The RACGP QI&CPD Program is based on adult learning principles (ie. knowledge is more likely to be gained when the adult undertaking the learning recognises a need to know, goes looking for the knowledge, and reviews what has been learnt) and requires GPs to undertake a minimum of two Category 1 activities in each triennium (eg. small group learning or clinical audits). Further information about the RACGP QI&CPD Program is available at http://qicpd.racgp.org.au.

The RACGP recognises that cardiopulmonary resuscitation (CPR) skills are used infrequently and there is evidence that these skills diminish without use. There may be additional medicolegal risk for a medical practitioner who is perceived not to have assisted a patient by providing CPR. Although Indicator D does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

The nature of incarceration means that patients have restricted ability to directly contact and use mainstream primary health and emergency services. As a consequence, health services in prisons need to have appropriate equipment for emergency care and resuscitation including an automated external defibrillator. All members of the clinical team should be trained in resuscitation techniques (CPR) and the use of the defibrillator.
Standard 3.2

Education and training

Our health service supports quality improvement through education and training.

Criterion 3.2.2

Qualifications and training of other staff with clinical roles

All other staff with clinical roles are appropriately trained for their role in our health service.

Indicators

- **A.** Our other clinical staff (clinicians other than doctors) have appropriate training, qualifications and current registration, and participate in continuing professional development relevant to their profession (interview, document review).

- **B.** Other staff who are involved in clinical care have appropriate training and qualifications, and participate in continuing education relevant to their role (interview, document review).

- **C.** All our staff involved in clinical care have undertaken training in CPR in accordance with the requirements of the relevant registration act or professional organisation or at least every 3 years (document review).

- **D.** All our staff involved in clinical care can describe how to use our automated external defibrillator (interview).

Explanation

Staff other than doctors who are involved in clinical care may include nursing staff, psychologists, allied health professionals or other members of the health service team who provide clinical care. All nonmedical staff involved in clinical care need to be appropriately trained for their roles, including the use of any clinical equipment and tests required for their role (e.g., electrocardiograph, spirometer, steriliser, psychological screening or testing). Training may be gained through participation in external courses or on-the-job training at the health service.

The RACGP recognises that CPR skills are used infrequently and there is evidence that these skills diminish without use. Although Indicator C does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

The nature of incarceration means that patients have restricted ability to directly contact and use mainstream primary health and emergency services. As a consequence, health services in prisons need to have appropriate equipment for emergency care and resuscitation including an automated external defibrillator. All members of the clinical team should be trained in resuscitation techniques (CPR) and the use of the automated external defibrillator.
Standard 3.2

Education and training

Our health service supports quality improvement through education and training.

Criterion 3.2.3

Training of staff with nonclinical roles

The administrative staff in our health service participate in training.

Indicators

A. Our administrative staff can describe training undertaken within the past 3 years that is relevant to their role in our health service (interview).

B. There is evidence that our administrative staff have undertaken training within the past 3 years that is relevant to their role in our health service (document review).

C. Our administrative staff have undertaken training in CPR at least every 3 years (interview, document review).

Explanation

Administrative staff of the health service (such as receptionists and health service managers who do not provide clinical care) also need training to be successful in their roles. This may include formal training (e.g., a computer course, training in the use of software programs, training in first aid, management, medical terminology, medical reception, cross cultural training) or on-the-job training provided by staff in the health service (e.g., making appointments, recognising urgent situations, confidentiality requirements, familiarisation with the policy and procedures manual). Where health services work collaboratively with the relevant government department, the health service staff may wish to invite prison staff to attend relevant training provided by the health service to support the health status of prisoners.

The RACGP supports cardiopulmonary resuscitation (CPR) training for all members of the community because this has been shown to improve patient outcomes. The RACGP recognises that CPR skills are used infrequently and there is evidence that these skills diminish without use. Although Indicator C does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

The nature of incarceration means that patients have restricted ability to directly contact and use mainstream primary health and emergency services. As a consequence of this restriction, health services in prisons need to have appropriate equipment for emergency care and resuscitation including an automated external defibrillator. Administrative staff should be trained in resuscitation techniques (CPR) and the use of the automated external defibrillator.
Section 4

Health service management

Standard 4.1
Health service systems
Our health service demonstrates effective human resource management processes.

Standard 4.2
Management of health information
Our health service has an effective system for managing patient information.
Standard 4.1

Health service systems

Our health service demonstrates effective human resource management processes.

Criterion 4.1.1

Human resource system

Our health service has a system to manage its human resources.

Indicators

- A. Our staff can describe their roles within our health service (interview).
- B. Our health service can identify the person who coordinates seeking patient feedback and investigating and resolving complaints (interview).
- C. Our health service can identify the health professional who leads clinical improvement (interview).
- D. Our health service can identify the health professional who leads our clinical care (interview).
- E. Our staff are able to discuss administrative matters with the health service managers and/or owners when necessary (interview).
- F. Our health service has an induction program for new staff (document review).
- G. Our staff have position statements/job descriptions (document review).
- H. Our health service has regular staff meetings (interview or document review).

Explanation

Research from both general practice and other industries supports the importance of effective human resource management.

For example, research in Australia and the United States of America confirms that teamwork is important to the quality of care. The research literature identifies teamwork as an important success factor in a number of safety initiatives across different industries. The alignment of role, competence and (where required) licensing, was also identified by the authors of a study of high performing clinical teams as a common element.43

Staff need to have position descriptions that outline their roles, responsibilities and conditions of employment. A position description establishes the role of the employee within the organisation, documents the parameters of the responsibilities and duties associated with that position, and forms the basis for evaluation and lines of accountability. Recruitment, training and development, performance evaluation, remuneration management and succession planning can all be based on the measure of an individual against their position description.
It is important for health services to have an induction program for new medical staff (including registrars and locums) as well as other clinical staff and administrative staff. Official visitors to the health service will also need an induction for special procedures such as a lock down which may occur in the prison. Such inductions should be designed to improve the safety of visitors while they are in the prison.

New staff need to understand the day-to-day operations of the health service including occupational health and safety issues (e.g., security and infection control policies) relevant to their roles, as well as the processes by which the privacy and confidentiality of patient health information is maintained, including what information can be released to the relevant government department and in what circumstances. Medical and other clinical staff in particular need to be aware of key public health regulations (e.g., reporting requirements for communicable diseases) that will affect how they work. Medical and other clinical staff also need to be made aware of local health and community services (e.g., pathology and local hospitals) they are likely to refer to in the course of routine consulting. All members of the staff team need to understand the role of the Commonwealth Ombudsman and the role of local state/territory health complaints bodies. An induction program that covers these issues as well as the specific operational processes of the health service is essential to assist new staff to perform their roles properly.

It is important for health services in prisons to provide specific information to new staff members relevant to the correctional environment. In particular, it is suggested that any induction program include the following.

- The rights and obligations of people who are incarcerated particularly relating to healthcare access
- Processes for engaging with the prison management
- Processes for engaging with the relevant government department (see Criterion 1.6.1: Engaging with other services)
- The protocol for the notification of concerns regarding the provision of healthcare (see Criterion 1.4.2: Clinical autonomy for medical and other clinical staff)
- Payment arrangements for the health service’s clinical services and arrangements for payments to external health providers, and associated access costs
- Information about particular cultural groups within the patient population.

Health services that have not employed new staff in the past 3 years are not required to have an induction program already developed. However, these health services need to be able to describe what they plan to do when employing a new staff member.
It is important that the health service team has identified leaders in areas such as clinical care and improvement, information management, complaints/feedback, and human resources. In the clinical care area, leadership might include convening a health service meeting to review the quality of care provided to a patient, or the mentoring of new staff. In the clinical improvement area, leadership might mean instigating a plan to monitor the management of patients on particular treatments (e.g., methadone treatment programs or mental health management) with a view to improving the way the health service manages these patients. Sometimes, the person who leads clinical care may not lead the clinical improvement strategy within a health service, though both are important and it is assumed both would be led by a health professional.

In order to respond to patient feedback and make related improvements, health services need to identify a team member responsible for examining issues raised by patients and facilitating improvements in the health service.

It is possible for a single individual within the health service to assume all these leadership responsibilities. In some health services however, different members of the health service team will undertake leadership in these areas. In this case, a structured opportunity to discuss and agree on clinical matters is needed in order to meet the Standards.

It is important that staff have the opportunity to discuss administrative issues with the health service managers and/or correctional administrators when necessary. When a person or corporate body other than the practising medical staff own the health service, medical and other clinical staff need to have defined avenues for discussing health service administrative matters with the owners.

Further information about human resource issues can be obtained from:

- a range of resources from the Australian Medical Association (www.ama.com.au)
Standard 4.1
Health service systems
Our health service demonstrates effective human resource management processes.

Criterion 4.1.2
Occupational health and safety
Our health service implements strategies to ensure the occupational health and safety of our staff.

Indicators
- A. Our health service and office equipment is appropriate for its purpose (direct observation).
- B. At least one staff member, in addition to a GP or another member of the clinical team is present when our health service is open for routine consulting (interview).
- C. Our staff can explain how our health service supports their health and wellbeing (interview).
- D. Our health service has a documented occupational health and safety policy (document review).
- E. Our staff have mechanisms to immediately alert others of a risk to their safety (direct observation).

Explanation
The occupational health and safety of health service staff is governed by occupational health and safety (OH&S) legislation which may vary from state to state. Health services need to consider how they ensure the service is a safe working environment for all staff.

To support occupational health, safety and wellbeing, during normal opening hours health services need to be staffed by at least one additional person who is trained to take telephone calls, make appointments and assist with medical emergencies and CPR. Normal opening hours are defined as those hours the health service advertises as its regular hours of opening for routine consultations.

The health and wellbeing of all staff is an important occupational health and safety issue and health services might find the following resources useful.

- Australian Association of Practice Managers (www.aapm.org.au)
- General Practice Registrars Australia (http://gpra.com.au)
- Australian General Practice Network (www.agpn.com.au)
- NSW Rural Doctors Network (www.nswrdn.com.au)
- Doctors Health Advisory Services for states and territories (www.dhas.org.au/content/view/1/21)
Health services can support the health and wellbeing of staff in many ways. For example, scheduling regular breaks in consulting time may reduce fatigue and support the health and wellbeing of the medical and clinical staff as well as enhance the quality of patient care. Fatigue and related factors, sometimes called human factors, are associated with increased risk of harm to patients.

Health services can make information available to staff about support services in their state or territory. Another possible strategy is to have a plan for reallocating work flow if a GP or another member of the clinical team is unexpectedly absent from the health service.

Supporting the psychological health and wellbeing of staff is an issue that has been of growing concern to the medical community. Providing healthcare to people in Australian prisons may be emotionally and professionally challenging for health professionals. Systems of professional support for medical and other clinical staff working in such services (eg. clinical supervision, employee welfare programs and grievance processes) are important for health and wellbeing and also for retaining good staff.

Indicator D requires a health service to have a documented occupational health and safety policy. Given the risks to the safety and security of health service staff posed by some patients, the OH&S policy needs to be explicit about safety and security. The security component of the policy will need to be negotiated with the relevant government department and the prison management company. The health service should have its own occupational health and safety policy that is consistent with, but does not rely on the prison management company’s OH&S policy. However, the prison management company is likely to be an expert source of appropriate OH&S procedures for a correctional context.

Providing healthcare to patients who are incarcerated means safety and security issues need to be considered carefully. Staff should have mechanisms for immediately alerting others to risk. For example, there may be a duress alarm in consultation rooms or personal duress alarms for individual staff. There is a cultural convention in prisons that necessitates prison staff being ‘within sight and sound’ of a patient. Health service staff need to liaise with prison management to determine under what circumstances a prison officer needs to be present during a consultation, and the mechanisms that will be used by the health service to maintain patient privacy and confidentiality. Where a third party is required in a consultation, the rationale for their presence needs to be explained to the patient (see Criterion 2.1.3: Presence of a third party).

Health services are referred to the information about safety for GPs and their practice teams on the RACGP’s website (www.racgp.org.au/gpandpracticeteamsafety/safety). Health services are advised to consider in advance what action will be taken in the event of a security breach.
Standard 4.2

Management of health information

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

Criterion 4.2.1

Confidentiality and privacy of health information

Our health service has a systematic approach to managing the confidentiality and privacy of patient health information.

Explanation

The patient health information held by health services within Australian prisons belongs to the relevant state or territory department of health or department of justice (Victoria only).

The Commonwealth Privacy Act 2001 states that a patient’s ‘personal health information’ includes a person’s name, address, account details and any health information (including medical or personal opinion) about the person. Sometimes details about a person’s medical history or other contextual information can identify them, even if no name is attached to that information and so this is still considered personal health information. Medical and other clinical staff have requirements relating to confidentiality in their professional registration and codes of conduct.

The RACGP Handbook for the management of health information in private medical practice (www.racgp.org.au) describes minimum safeguards and procedures that need to be followed in order to meet appropriate legal and ethical standards concerning the privacy and security of patient records and this information is also pertinent to health services in Australian prisons.

Health services are encouraged to become familiar with the relevant federal and state or territory privacy legislation as this will determine how health services manage patient health information. Further information is available from www.privacy.gov.au.
The health service needs to have a documented policy for managing patient health information. This policy needs to outline:

- procedures for informing new patients about privacy arrangements (including how patients are informed about the use of their information for quality assurance, research and professional development)
- the range of people (eg. doctors and other members of the clinical team) who may have access to patient health records and the scope of that access
- procedures for patients to gain access to their health information
- how the health service gains a patient’s consent before disclosing their personal health information to third parties
- the process for providing health information to another health professional should patients request that be done
- the way the health service addresses complaints about privacy related matters
- information on the retention of patient health records
- the exceptions to the usual obligations for using or disclosing patient health information (eg. uses or disclosures required or authorised by law or those necessary to prevent or lessen a serious or imminent threat to someone’s life, health or safety)
- how the confidentiality and privacy of patient health information can be maximised if a prison officer is required to be present during a consultation.

Section 2.42 of the Standard guidelines for corrections in Australia outlines principles designed to support the confidentiality and privacy of patient health information as follows:

The confidentiality of medical information shall be maintained to preserve each prisoner’s individual entitlement to privacy subject to disclosures required or authorised by law. However, medical information may be provided on a ‘need to know’ basis:

- with the consent of the prisoner, or
- in the interest of the prisoner’s welfare, or
- where to maintain confidentiality may jeopardise the safety of others or the good order and security of the prison.

There may be tension between the need to respect the privacy and confidentiality of a patient consultation and the need to manage any security or safety risks that the patient may pose to health professionals during a consultation. If third parties such as a prison officer need to be present during a consultation for safety or security purposes, health services need to make reasonable efforts to ensure the disclosure of personal health information to the third party is minimised (see Criterion 2.1.3: Presence of a third party).
Patients need to be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or on a ‘need to know’ basis in the interest of the prisoner’s welfare or where to maintain confidentiality may jeopardise the safety of others or the good order and security of the prison50 (see Criterion 1.2.1: Health service information). The health service, in conjunction with the relevant government department and/or prison management, needs to determine the types of risks or events that would warrant the transmission of confidential information without the consent of a patient. This may vary for different prisons depending on the prison population.

Patient consent is often provided at an early stage in the process of clinical care. This is a good time to ensure that patients develop a shared expectation about the use of their patient health information including the access that individual health service staff may have for the purpose of continuous and comprehensive care and the likelihood that such information will be used during quality improvement activities within the health service.

Research is an important component of general practice in Australia. Health services are encouraged to participate in research both within their own service and through reputable external bodies. Further information about research in health services, including the requirements for ethics approval, can be found in the NHMRC National statement on ethical conduct in human research51 (www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf).

The privacy and confidentiality of patient health information is equally important for health services that have paper based, hybrid (paper based and electronic), and solely electronic based systems of information management. Each system will pose different challenges to privacy and information security. Hybrid systems are more vulnerable to errors in information management as both the electronic and paper records need to be fully congruent.
Standard 4.2
Management of health information
Our health service has an effective system for managing patient information.

Criterion 4.2.2
Information security
The security of patient health information in our health service is maintained.

Indicators

► A. Our practice team can demonstrate that the personal health information of patients of our practice (including medication charts) is neither stored nor left visible, in areas where nonhealth service staff have unrestricted access or where constant staff supervision is not easily provided (interview, direct observation).

► B. Our practice ensures that our practice computers and servers comply with the RACGP computer security checklist and that (interview, direct observation):
  • computers are only accessible via individual password access to those in the practice team who have appropriate levels of authorisation
  • computers have screensavers or other automated privacy protection devices that are enabled to prevent unauthorised access to computers
  • servers are backed up and checked at frequent intervals, consistent with a documented information disaster recovery plan
  • back up information is stored in a secure offsite environment
  • computers are protected by antivirus software that is installed and updated regularly
  • computers connected to the internet are protected by appropriate hardware and software firewalls.

► C. If our practice uses computers to store personal health information, we have an information disaster recovery plan that has been developed, tested and documented (document review).

► D. Our practice has a designated person with primary responsibility for the practice’s electronic systems and computer security (interview).

► E. Our communication devices are accessible only to authorised staff (document review).
Explanation

The RACGP *Handbook for the management of health information in private medical practice* (www.racgp.org.au)\(^{52}\) and the RACGP *Computer security guidelines* (3rd edition)\(^{53}\) (www.racgp.org.au/ehealth/csg) provide information on the safeguards and procedures that need to be followed by general practices in order to meet appropriate legal and ethical standards concerning privacy and security of patient health information. These documents also contain suggestions for additional security procedures. The Commonwealth *Privacy Act 2001* states that a patient’s ‘personal health information’ includes a person’s name, address, account details and any health information (including medical or personal opinions) about the person. Sometimes details about a person’s medical history or other contextual information can identify them, even if no name is attached to that information and so this is still considered ‘personal health information’. Further information is available from www.privacy.gov.au\(^{54}\).

It is likely that health services will have different levels of access to patient health information for different staff members. For example, administrative staff may not have full access to patient health information. The type of staff who are authorised to access different levels of patient health information needs to be documented in the policy and procedure manual.

The health service must ensure that both active and inactive patient health records are kept and stored securely. Health records should not be accessible to staff of departmental staff or the prison’s management company. If a patient’s health record needs to be accessed in response to a third party request, health service staff should only provide access to information specific to the request, in accordance with the Commonwealth *Privacy Act 2001*\(^{55}\).

An inactive patient health record is generally considered to be the record of a patient who is no longer incarcerated in the prison. It is recommended that inactive patient health records are retained by the health service indefinitely or as stipulated by relevant state or territory legislative requirements for prisons.

Staff need to ensure the confidentiality and security of patient health information and any equipment used to record, store or communicate such information (eg. computers, memory sticks or paper files). The presence of an additional person during the normal opening hours of the health service (besides the GP or another member of the clinical team) should increase security and safety for patients and staff and reduce the risk of unauthorised access to patient health information (see Criterion 4.2.1: Confidentiality and privacy of health information).

When a health service uses computers to store patient health information, the health service needs to undertake regular back ups and have a documented information disaster recovery plan to protect and save electronic information in the event of an emergency (eg. power failure).

The RACGP *Computer security guidelines*\(^{56}\) provides a self assessment guide and security checklist, and has information about information disaster recovery plans (www.racgp.org.au/ehealth/csg).
**Standard 4.2**

**Management of health information**

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

**Criterion 4.2.3**

**Transfer of patient health information**

On request by a patient, our health service transfers a summary or a copy of the patient’s health record to the patient, another medical practitioner, health service provider or health service as applicable.

**Indicators**

- **A.** Our staff can describe the procedures for transferring patient health information to another health service provider or health service (interview).
- **B.** Our health service notes in the relevant patient health record any request by a patient or other authorised party to transfer patient health information. This note includes details of when and where the information was sent and who authorised the transfer (health records review).
- **C.** When we collect identifiable patient health information for continuing professional development activities, we only transfer it to a third party if the patient has provided consent (document review).
- **D.** Our electronic data transmission of patient health information over a public network is encrypted (document review).

**Explanation**

The personal health information of people held in prisons is regulated and protected by Federal and state or territory legislation. Health services need to ensure that patients develop a shared expectation about the use of their patient health information including the access that individual health service staff may have for the purpose of continuous and comprehensive care and the likelihood that such information will be used during quality improvement activities within the health service. The transfer of a prisoner’s personal health information outside the prison system should not take place without a patient’s consent unless there are exceptional circumstances (see Criterion 4.2.1: Confidentiality and privacy of health information).

Before any transfer of health information, the health service needs to consider whether other confidential information (e.g. staff rosters) may be embedded in the health information and how this should be managed to avoid a security risk for members of the health service team.

For a quality improvement activity undertaken within a health service, where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the health service, ethics approval is not required.

Clinical audits using a tool such as CAT® (see Criterion 3.1.1: Quality improvement activities) or ‘plan, do, study, act’ cycles undertaken within a health service as part of a quality improvement activity do not require ethics approval. For example, a practice wishing to determine how many of its patients are given advice on smoking cessation, or how
many patients with heart failure are prescribed angiotensin-converting enzyme inhibitors and beta-blockers, may complete an audit on their service data.

In general, a health service’s quality improvement or clinical audit activities for the purpose of seeking to improve the delivery of a particular treatment or service would be considered a directly related secondary purpose for information use or disclosure. In other words, in general, the health service would not need to seek specific consent for this use of patient health information.

To ensure patients understand and have reasonable expectations of quality improvement activities, practices are encouraged to include information about quality improvement activities and clinical audits in the practice policy on managing health information.

Patient health information that is transmitted electronically over a public network (eg, the internet) can pose significant privacy risks. It is technically possible for a third party to intercept and read emails, or for emails to be inadvertently sent to the wrong person. Encryption allows for the ‘scrambling’ of a message so that it can only be read by the intended person who verifies their identity using a unique identifying code (or key). The RACGP Computer security guidelines57 provide further information about security procedures including encryption such as public key infrastructure (PKI). Health services should not transfer patient health information via email unless it is encrypted.

For patients in prisons, it is important that the health service arranges the timely transfer of care to another healthcare practitioner or service when a patient is released from the facility or transferred to another prison. Prisoners can be frequently and rapidly moved to alternative prisons. In such instances, health service staff need to ensure that comprehensive transfer of patient health information is facilitated in a timely manner.

Where a prisoner is being released into the community, health services should be proactive in ensuring the patient’s health information is provided to the health professional or service that will continue the patient’s care outside the prison. Subject to the patient’s consent, a comprehensive health summary needs to be provided to the health professional who will be coordinating the care of the patient outside the prison or to the patient themself (if no health professional has been identified). It is useful for the transfer of care to be managed by the person within the health service who has led the care of that individual within the prison (see Criterion 1.5.2: Continuity of the therapeutic relationship).
**Standard 4.2**

Management of health information

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

**Criterion 4.2.4**

Retention of patient health information

Our health service has a system for the retention of patient health information.

### Indicators

- **A.** Our practice keeps individual patient health information until the patient has reached the age of 25 years or for a minimum of 7 years from the time of our last contact with the patient, whichever is longer (interview).
- **B.** Our health service has a process for identifying, storing and retrieving inactive patient health information (interview, direct observation).
- **C.** Our health service has an appropriate method of destroying (eg. shredding) any material containing patient health information before its disposal (interview, direct observation).

### Explanation

Health services need to be aware that there may be specific legislation in their state or territory requiring a minimum period of retention of health records. Such legislation normally recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer. The health service will need to clarify the state or territory legislative requirements relevant to the retention and destruction of health records for patients who are no longer incarcerated in the prison. Such requirements may vary from what is required for community based patient health information.

In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with patients’ future diagnosis and treatment.

Additionally, staff need to be aware of the positions taken by medical defence organisations (and any other professional indemnity insurers) with respect to the retention, storage and destruction of patient health information.

The health service must also ensure that inactive patient health records are kept and stored securely – an inactive patient health record is a record of a patient who is no longer detained in a prison.
Section 5

Physical factors

Standard 5.1
Facilities and access
Our health service provides a safe and effective working environment for our team.

Standard 5.2
Equipment for comprehensive care
Our health service provides medical equipment and other resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Standard 5.3
Clinical support processes
Our health service has processes in place that support the safety and quality of clinical care.
Standard 5.1
Facilities and access
Our health service provides a safe and effective working environment for our team.

Criterion 5.1.1
Health service facilities
Our health service facilities provide a safe and effective environment for patients and staff.

Indicators

► A. Our health service has at least one dedicated consulting room for the exclusive use of every GP and any other members of the clinical team working in our service at any given time (interview, direct observation).

► B. Each area or room used by our health service is clearly identified for exclusive use by the health service (direct observation).

► C. Each of our consultation rooms (which may include an attached examination or treatment room or area) (direct observation):
  • is free from excessive extraneous noise
  • has adequate lighting
  • is maintained at a comfortable ambient temperature
  • has an examination couch (for medical or clinical consultations only)
  • has facilities to protect patient privacy when patients need to undress for a clinical examination (eg. an adequate curtain or screen and gown or sheet).

► D. Our health service has a waiting area that can accommodate the usual number of patients and other people who would be waiting at any given time (direct observation).

► E. Our health service has an area that caters for the specific needs of patients who are at risk of self harm (direct observation).

► F. Our health service has toilets and hand cleaning facilities readily available for use by patients and staff (direct observation).

G. Where appropriate, our health service has heating and/or air conditioning (direct observation).

► H. Our health service has a dedicated telephone system with sufficient inward and outward call capacity (staff interview, direct observation).

► I. Our health service has the capacity for dedicated electronic communication by facsimile or email (direct observation).

► J. Prescription pads, letterhead, administrative records and other official documents stored in our health service are accessible only to authorised persons (direct observation).

► K. Our health service can demonstrate how we ensure there is no smoking in our service (interview, document review, direct observation).

► L. Our health service has security measures in place to prevent unauthorised access to our facilities and equipment (direct observation).
Explanation

Health service facilities need to be safe for staff and patients. Health and safety refers not just to requirements within consultation areas but also to other areas of the health service.

While this criterion discusses consultation rooms, it is acknowledged that some health services may have areas other than rooms where patients are treated. These consultation areas need to be appropriate for the health and safety of staff and patients.

To encourage a safe and effective therapeutic environment, consultation rooms need to be clearly marked as space associated with the health service, such as with a sign on the door. Consultation rooms should be for the exclusive use of the health service and should not be shared with non-health service parties (e.g., prison staff).

The consultation room temperature needs to be such that a patient who has undressed for a clinical examination remains comfortable.

The dignity of a patient can be protected and visual privacy maintained during clinical examinations by the use of a gown or sheet and an adequate curtain or screen positioned to maximise the privacy of the patient, particularly when the patient is required to undress for a clinical examination or procedure. This requirement is particularly important where there is a door opening to an area to which prison staff have access and where patients are required to undress or dress in the presence of the treating health professional. In instances where a third party such as a prison officer needs to be present for security and safety purposes, health services need to be careful to maintain the dignity of the patient when undressing or dressing is required.

Toilets for patient access should be located within the health service. Toilets not within the health service itself need to be within very close proximity and be easily accessible and well signposted. Washbasins need to be situated in close proximity to the toilets to minimise the possible spread of contamination. Washbasins need to be easily accessible to staff and patients. Separate staff and patient toilets are desirable.

For occupational health and safety reasons, there should be no smoking on the health service premises or in the environs.

All environments should satisfy the relevant state or territory and federal occupational health and safety laws.

The health service needs to have an area that caters for the specific needs of patients who are at risk of self harm. This safe room should be situated within or in close proximity to the health service to facilitate continual monitoring of the patient’s physical and mental health and allow for immediate intervention if needed. The room should be designed to minimise the potential for self harm (e.g., no hanging points).
Standard 5.1

Facilities and access
Our health service provides a safe and effective working environment for our team.

Criterion 5.1.2

Physical conditions conducive to confidentiality and privacy

The physical conditions in our health service support patient privacy and confidentiality.

Indicators

A. The physical facilities of our health service support patient confidentiality and privacy without compromising the occupational health and safety of health service staff or the safety of other patients (direct observation).

B. The visual and auditory privacy of consultations is ensured without compromising the occupational health and safety of health service staff or the safety of other patients (direct observation).

Explanation

The physical arrangements of the health service need to provide privacy and confidentiality for patients and their health information.

It is important that patients have confidence their health information is being treated respectfully, with consideration to privacy and confidentiality (see Criterion 4.2.1: Confidentiality and privacy of health information; and Criterion 4.2.2: Information security).

It is acknowledged that in prisons it may be difficult to preserve ideal levels of privacy and confidentiality for patients while maintaining the safety and security of health service staff. Nevertheless, health services need to find a satisfactory balance between patient privacy and confidentiality and the necessity to maintain appropriate safety and security for staff. Health service staff should be aware of areas where maintaining appropriate levels of privacy and confidentiality for patients is not achievable.

The layout of waiting areas can be designed to support patient privacy and confidentiality, especially when patients are discussing personal issues with staff.

Consultations need to be private and not able to be overheard by others. In cases where a prison officer needs to be within sight and sound of the consultation, attempts should be made to minimise the ability of the prison officer to hear details of the private discussion between a health professional and a patient.

Auditory privacy within the health service can be enhanced by the use of background music to mask conversations between staff members and between staff and patients.

Visual privacy for patients may be ensured by the use of a curtain or screen, and gown or sheet when a patient needs to undress for a clinical examination or procedure (see Criterion 5.1.1: Health service facilities). Where a patient is required to undress for their consultation, the observation requirements of prison staff may need to revert to within sound only to maintain patient privacy and dignity.
Standard 5.1
Facilities and access
Our health service provides a safe and effective working environment for our team.

Criterion 5.1.3
Physical access
Our health service provides appropriate physical access to our premises and clinical services, including access for people with disabilities.

Indicators
- A. There is wheelchair access to our health service and its facilities (direct observation)
  OR
  If physical access to our health service is limited, we provide visits to patients’ living quarters subject to suitable safety and security (interview).
- B. Our staff can describe how they facilitate access to our health service for patients with disabilities (interview).
- C. Our health service has a height adjustable bed.

Explanation
Good physical access to the health service’s facilities and clinical services is important for patients. Health services need to make all reasonable efforts to facilitate physical access to their premises and clinical services.

When considering what is reasonable in terms of access, health services should consider the needs of patients with a disability. The health service may take a range of steps to assist patients with a disability, such as having pictorial signage for patients who are illiterate; spaces in waiting areas, hallways and consultation rooms that are wide enough for patients in wheelchairs; and a unisex wheelchair accessible toilet for patients with disabilities.

The RACGP has been involved in ongoing discussions with consumer bodies, the disability sector and the Australian Human Rights Commission with respect to improving access to high quality healthcare for people with a disability.

Height adjustable beds are especially necessary for patients with limited mobility and the RACGP has therefore determined that each accredited health service must have one or more height adjustable beds.

Height adjustable beds may assist health service teams as follows:
- reduce the risks associated with patients getting on and off the examination couch especially for people with impaired mobility
- reduce the risk of misdiagnosis or nondetection of serious medical conditions through difficulty in conducting an examination that may occur if a patient is not able to be examined on a standard examination couch
• reduce the risk of health service staff injuring themselves when examining patients, or assisting patients on and off an examination couch

• reduce risks associated with the health service’s legal responsibilities under the Disability Discrimination Act 1992 to ensure people with a disability have equal access to the same range and quality of medical care as others.

Health services need to consider where a height adjustable bed may be best located (eg. in a treatment room rather than a consultation room).

In exceptional circumstances where physical space is limited and a height adjustable bed cannot be accommodated, the health service needs to be able to demonstrate why it cannot accommodate a height adjustable bed and how the health service safely manages examinations of patients with impaired mobility while protecting the occupational health and safety of clinical staff.

The disability sector has had experts review height adjustable beds available currently on the market to ensure they meet the needs of people with disabilities. Simple functional specifications for appropriate beds are available at www.racgp.org.au/standards/fourthedition/factsheets.

For more information relating to the Federal Disability Discrimination Act 1992 and legislation regarding the right to access primary healthcare, the website www.hreoc.gov.au is recommended.
Standard 5.2
Equipment for comprehensive care
Our health service provides medical equipment and other resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Criterion 5.2.1
Health service equipment
Our health service has access to medical equipment necessary for comprehensive primary care and resuscitation.

Indicators

A. Equipment for comprehensive primary care and resuscitation is available within our health service, including (direct observation):
- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway, equipment to assist ventilation (including bag and mask), intravenous access, and emergency medicines
- examination light
- eye examination equipment (eg. fluorescein staining)
- gloves (sterile and nonsterile)
- height measurement device
- measuring tape
- monofilament for sensation testing
- ophthalmoscope
- oxygen (and the means to administer it)
- patella hammer
- peak flow meter or spirometer
- scales
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer
- stethoscope
- thermometer
- torch
- tourniquet
- urine testing strips
- vaginal speculae
- visual acuity charts
- X-ray viewing facilities.

B. Our health service has timely access to the following equipment:
- spirometer
- electrocardiograph
- dental mirror (direct observation, interview).

C. Our medical and other clinical staff can describe the procedures commonly performed within our health service and can demonstrate that available equipment is safe and sufficient for these procedures (interview).

D. Our health service has a schedule for the maintenance of our clinical equipment (document review).

E. Our health service has an automated external defibrillator which staff can readily access in an emergency (direct observation).
Explanation

Health services in prisons need to have the necessary equipment for comprehensive primary care and resuscitation. To meet this criterion, the equipment must be present and in good working order.

There is a wide range of equipment that health services may need in order to provide comprehensive primary care, including emergency resuscitation, within a prison. Additional equipment may be required depending on the particular interests and requirements of medical and other clinical staff, the procedures the health service undertakes and the patient population. For example, it is likely that health services in correctional settings will need equipment and medicines to treat patients who are suffering from drug overdoses or drug withdrawal.

If a health service offers spirometry, it is not essential to also have a peak flow meter (as outlined in Indicator A). Health services need to have timely access to spirometers and electrocardiographs. Some health services will have these diagnostic devices on their premises, other health services will have ready access to this equipment but not own it. Health services that do not have an electrocardiograph or spirometer on their premises need to be able to describe their arrangements for accessing this equipment when necessary on the day of a consultation. Similarly, if the health service does not provide dental care on its premises, the arrangements for accessing a dental mirror or dental care by an external provider need to be demonstrated.

Equipment that requires calibration or that is electric or battery powered (eg. electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales, defibrillators) needs to be serviced on a regular basis to ensure it is maintained in good working order. To ensure equipment operates safely, effectively and accurately, manufacturers’ guidelines should be used to determine maintenance schedules for health service equipment.

There is evidence both internationally and in Australia to suggest that immediate defibrillation significantly improves the chance of a patient’s survival after cardiac arrest. Although cardiac arrest in primary care situations is a very rare event, the difference in outcomes between early defibrillation and later defibrillation is significant (10% increase in mortality for each minute from the time of the arrest).58 The ability of patients in prisons to directly access mainstream emergency care is restricted. Health services in prisons therefore need to have equipment for emergency care and resuscitation including an automated external defibrillator. As the health service is unlikely to be staffed 24 hours per day, it is recommended that the defibrillator be placed in an area where prison staff can access it in case an emergency arises outside the service’s normal opening hours (eg. outside the main door to the health service).
Standard 5.2
Equipment for comprehensive care
Our health service provides medical equipment and other resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Criterion 5.2.2
Doctor’s bag or emergency trolley
Our health service ensures that our medical and other clinical staff have access to a doctor’s bag or an emergency trolley.

Indicators
- A. Our health service has an accessible doctor’s bag or emergency trolley (interview, direct observation).
- B. When in use, our doctor’s bag or emergency trolley contains (direct observation):
  - auriscope
  - disposable gloves
  - equipment for maintaining an airway in adults
  - health service stationery (including prescription pads and letterhead)
  - in date medicines for medical emergencies
  - ophthalmoscope
  - sharps container
  - sphygmomanometer
  - stethoscope
  - syringes and needles in a range of sizes
  - thermometer
  - tongue depressors
  - torch.

Explanation
All GPs in the practice require ready access to an emergency trolley or a doctor’s bag. Bags should always contain core equipment, medications and stationery so when they are required the GP can simply add equipment in regular use (e.g. auriscope, ophthalmoscope or stethoscope) to make the bag ready for use. The health service is not required to maintain two separate sets of equipment, but rather the necessary items can be placed in the doctor’s bag or on the emergency trolley when attending a consultation in a patient’s living quarters or an emergency as the case may be.

More than one health professional in the health service can share the use of a doctor’s bag or emergency trolley. Large health services need to consider whether more than one doctor’s bag or emergency trolley is needed to ensure that doctors and other health professionals have ready access to essential equipment when required. This is particularly important when a prison has more than one health service in different locations within the facility.
Health services need to consider what medicines they keep in their doctor’s bag or emergency trolley. Consideration needs to be given to the health service location, the type of clinical conditions likely to be encountered in the prison, the expiry date and climatic vulnerability of medicines, and the cost and size of the doctor’s bag or emergency trolley.59

Doctors’ bags and emergency trolleys must be kept secure in accordance with state and territory legislation.
Standard 5.3
Clinical support processes
Our health service has processes in place that support safety and the quality of clinical care.

Criterion 5.3.1
Medicines
Our health service ensures that all medicines (including Schedule 4 and Schedule 8 medicines) are stored securely and are only accessed by authorised personnel.

Indicators
- A. Our health service ensures that all our medicines are securely stored (direct observation).
- B. The acquisition, storage, use, transfer and disposal of Schedule 4 and Schedule 8 medicines within our health service are appropriately documented (document review).

Explanation
All sensible security measures need to be taken to prevent unauthorised access to medicines. Due to the health service being located within a prison, health service staff need to ensure they have a particularly robust system for storing and dispensing medicines, making certain no unauthorised access occurs.

Enhanced security measures such as rigorous record keeping or an additional locked cabinet may be needed for equipment associated with the administration of medicines (e.g. needles or tourniquets).

Health services need to be familiar with their state or territory legislation regarding the storage of Schedule 8 medicines. State and territory legislation generally requires that Schedule 8 medicines be stored in a locked cabinet or safe that is fixed to an immovable structure.

The use of Schedule 8 medicines must be correctly recorded in accordance with state and territory legislation, and appropriate documentation is needed in relation to:
- the date of administration
- details of patient
- quantity of medicines coming in
- quantity of medicines going out
- quantity of medicines still held
- comments about conditions prevailing (e.g. breakages)
- the signature of the person/people entering the data and administering the medicine.

Some states and territories also have specific legislation relating to the storage, use and disposal of Schedule 4 medicines and health services need to be familiar with these requirements as well.
Standard 5.3
Clinical support processes
Our health service has processes in place that support safety and the quality of clinical care.

Criterion 5.3.2
Vaccine potency
Our health service has appropriate processes to maintain the potency of vaccines.

Indicators
- A. Our health service can demonstrate how our cold chain management processes conform to the current published edition of the NHMRC National Vaccine Storage Guidelines (direct observation).
- B. Our staff can describe how the process our health service uses for cold chain management conforms to the current published edition of the NHMRC National Vaccine Storage Guidelines (interview).
- C. Our health service has a documented policy for cold chain management procedures that conforms to the current published edition of the NHMRC National Vaccine Storage Guidelines (document review).

Explanation
The success of any vaccination program depends on the potency of vaccines when they are administered. The essential references for this criterion are the current published edition of the NHMRC Australian Immunisation Handbook and the National Vaccine Storage Guidelines which outline exactly what a health service needs to do in relation to cold chain management. It is important that health services follow established protocols for cold chain management and monitoring during the storage, use, transfer and disposal of vaccines. These references are available online at www.immunise.health.gov.au.

The most common problems faced in maintaining the potency of vaccines are:
- on a daily basis when the health service is open, monitoring the maximum and minimum temperature of refrigerators in which vaccines are stored
- knowing what to do if the temperature of the refrigerator falls below or exceeds the acceptable range.

Vaccines should be stored in an appropriate refrigerator. Safe vaccine storage may be achieved using domestic refrigerators if appropriate safeguards are in place, such as a combination of the following:
- a temperature probe placed in the vicinity of stored vaccines
- staff taking the correct action when out of range temperatures are recorded
- the use of trays for storing vaccines.

Although standards relating to cold chain management change from time to time and there are a number of bodies that make recommendations on this process, the NHMRC recommendations are seen as the authoritative advice.
Standard 5.3

Clinical support processes
Our health service has processes in place that support safety and the quality of clinical care.

Criterion 5.3.3

Perishable materials
Perishable materials held by our health service (e.g. medicines, vaccines and other healthcare products) are not kept or used beyond their expiry dates.

Indicators

A. Our health service does not hold or use perishable medicines, vaccines or other healthcare products beyond their expiry date (direct observation).
B. The relevant staff in our health service can describe our procedure for checking the expiry dates of perishable materials and for disposing of such materials where necessary (interview).
C. Our health service has a written procedure for checking the expiry dates of perishable materials and for disposing of such materials where necessary (document review).

Explanation

To promote the safe and effective use of perishable materials such as medicines (including sample medicines), vaccines and other healthcare products, health services need to ensure they do not keep perishable materials beyond their expiry dates. This includes perishable materials held in a doctor’s bag or on an emergency trolley.

It is also important to ensure that perishable materials held by a health service are stored and secured appropriately.
Standard 5.3

Clinical support processes

Our health service has processes in place that support safety and the quality of clinical care.

Criterion 5.3.4

Infection control

Our health service manages the risk of cross infection in accordance with the current edition of the RACGP Infection control standards for office based practices.

Indicators

A. Our staff can describe how our health service ensures that, where necessary, sterile equipment is used in clinical procedures (interview).

B. Our staff members with designated responsibility for sterilisation procedures can describe in detail how the use of sterile equipment is assured, including where relevant (interview, direct observation):
   - provision of an adequate range of disposable equipment
   - procedures for having instruments sterilised offsite
   - procedures for onsite equipment sterilisation
   - monitoring the integrity and validation of the entire sterilisation process and steriliser maintenance
   - procedures for safe storage and stock rotation
   - education and training of the relevant staff.

C. Our staff can describe how risks of potential cross infection are managed within our health service, including procedures for (interview, direct observation):
   - hand hygiene
   - managing a sharps injury
   - safe storage and disposal of clinical waste including sharps
   - managing blood and body fluid spills
   - monitoring ongoing adherence to our infection control processes.

D. Our staff can describe (interview):
   - the routine used by our health service for cleaning, disinfecting and decontaminating the clinical and nonclinical areas of our service
   - standard precautions
   - additional precautions.

E. Our health service has a written policy that outlines our service’s infection control procedures (document review).

F. Subject to their informed consent, the immunisation status of our staff is known to our health service and staff members are offered immunisation appropriate to their roles (document review, interview).

G. The induction of new staff to our health service ensures they are familiar with standard precautions against infection and related issues appropriate to their roles (document review, interview).
**Explanation**

Infection control has a number of aspects. These concern the sterility of clinical equipment, the occupational health and safety of staff, and managing the risk of cross infection in the health service environment.

The health service needs to have a written policy on infection control processes within their service. This written policy needs to include:

- sharps injury management
- blood and body fluid spills management
- hand hygiene
- a regular cleaning schedule describing the frequency of cleaning as well as cleaning products and procedures for clinical and nonclinical areas of the health service
- the provision of sterile instruments whether by the use of disposables, or by onsite or offsite sterilisation of reusable instruments
- procedures for all aspects of the sterilisation process if instruments are sterilised onsite. For instruments sterilised offsite, procedures covering both sterilisation and transport. There should be procedures for validating or obtaining evidence of validation for all onsite and offsite aspects of sterilisation
- procedures for waste management including the safe storage and disposal of clinical waste (including sharps)
- the appropriate use of standard and additional precautions
- prevention of disease in the workplace by serology and immunisation.

In terms of the sterilisation of equipment, the RACGP *Infection control standards for office based practices* (4th edition) describe sterilisation as the preferred process for the reprocessing all reusable instruments and equipment (noncritical, semicritical, and critical) that can withstand this process regardless of their intended use. If disinfection is used, disinfection can be achieved by thermal (hot water) systems and chemical disinfectants. Disinfecting is not a sterilising process. However, sterilisation is one form of disinfection.

Health services that sterilise onsite need to demonstrate the correct use and maintenance of sterilising equipment.

Where a health service uses offsite sterilisation facilities, the health service needs to document procedures for the safe transport of instruments to and from the health service, and demonstrate that the offsite facility performs the sterilisation correctly and validates its processes (e.g. by providing evidence that the facility is accredited by the Australian Council on Healthcare Standards).

Where a health service employs single use disposable instruments, the health service needs to be able to demonstrate that the packaging of instruments is not compromised and the instruments have remained sterile until their use.
In relation to waste management within the health service, the RACGP *Infection control standards for office based practices* define three categories of waste produced by healthcare industries and outline the appropriate disposal mechanism for each.

- **Clinical waste** – includes discarded sharps; laboratory and associated waste directly involved in specimen processing; human tissues (but excluding hair, teeth, urine and faeces); materials or solutions containing free flowing or expressible blood and animal tissues or carcasses used in research.
- **Related waste** – includes cytotoxic waste, pharmaceutical waste, chemical waste and radioactive waste.
- **General waste** – includes all waste materials that do not fall into the clinical or related waste categories. General waste contaminated with blood or body substances (though not to such an extent that it would be considered clinical waste, ie. not contaminated with expressible blood) may be disposed of through the general waste processes of the health service. Gauze that has blood on it (but which cannot be expressed), used disposable vaginal speculae, cervical spatulae and brushes, and tongue depressors are likely to be the most common items in this category.

The disposal of clinical waste can be achieved as follows.

- For most clinical waste – into a safely located yellow, leak proof container displaying a biohazard symbol.
- For sharps – into a safely located yellow, leak proof and puncture resistant container displaying a biohazard symbol (eg. mounted on a wall or on a bench) in all areas where sharps are generated.

Disposal of general waste can be achieved as follows.

- Via a small bin lined with plastic, mounted on the wall or on a bench (to hold contaminated general waste that is not clinical waste) (eg. cervical spatulae, tongue depressors, disposable speculae). It can then be disposed of through the general waste stream.
- The usual waste paper bin under the desk can be used for waste not contaminated by blood or body fluids.

Health services need to be aware of any local or state or territory regulations that may require alternative disposal of waste from health services.

Potential infection risks to staff need to be reduced. In this context, it is important for health services to ensure that all staff are familiar with infection control procedures within the health service (including standard and additional precautions, spills management, environmental cleaning), for the health service to know the immunisation status of their staff, and for the health service to ensure that staff are offered appropriate immunisation for their roles.
Standard precautions apply to work practices that assume all blood and body substances are potentially infectious. The NHMRC recommends the use of personal protective equipment including heavy duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste (Indicator D).

Additional precautions are used for patients known or suspected to be infected with highly transmissible pathogens. This may be achieved by minimising the length of time such patients are exposed to other patients and staff through the use of masks, by isolating the patient in a separate room or by fast-tracking the patient’s care (Indicator D).

For more information on infection control (including standard precautions, hand cleaning, staff immunisation, sharps injury, sharps and waste management) refer to the current edition of the RACGP Infection control standards for office based practices and the Commonwealth Department of Health and Ageing publication Infection control guidelines for the prevention of transmission of infectious diseases in the healthcare setting.

It is important that health services remain alert to changes to guidelines for infection control, and be in a position to implement them promptly. Health services should also have systems for monitoring and obtaining information about national and local infection outbreaks and emerging new risks of cross infection such as the advent of Avian flu, severe acute respiratory syndrome (SARS) and pandemic influenza. This is particularly important for health services in prisons, as this setting increases the risk of exposure to infection and the spread of infectious diseases.

Healthcare services in prisons need to be aware of the risk of infectious diseases from people recently arrived at the facility and also containment processes for the prison as a whole. Staff need to be familiar with their responsibilities to monitor and report disease outbreaks to the relevant state or territory authorities and to respond by implementing appropriate precautions. Appropriate infection control measures need to be instituted to prevent the spread of infectious disease to the wider population in a prison. Furthermore, there needs to be a system in place that allows for the monitoring of threatened outbreaks (eg. varicella, measles, lyssavirus, Hendravirus) and emerging disease (eg. SARS, avian influenza or community associated methicillin resistant Staphylococcus aureus).

Further information about infection control is available in the RACGP Infection control standards for office based practices (www.racgp.org.au/publications/standards).
Appendix A

The principles of quality and safety in the Standards for health services in Australian prisons

Indicators of quality can be developed for a range of stakeholders with different, sometimes overlapping or conflicting perspectives, who emphasise different priorities, and who may wish to use indicators in different ways. The legitimacy and utility of indicators of quality and safety depends on their acceptability to the stakeholders they affect, including those who use them.

Different levels of the healthcare system (patient, practitioner, whole organisation, region or country) can be the focus of standards, as the creation of latent conditions for error and harm can occur at all these levels.

In primary care, process factors are pervasive, contributing causes of medical error. Therefore, there is sound reason to focus on the setting and process of healthcare to analyse issues of safety and quality.

Quality and safety in healthcare depends on more than the performance of each health professional working in isolation. Efforts to assess and enhance quality need to include attention to the structure and organisation of health services.

In recent years, there has been a growing recognition of the role of healthcare systems (both small and large scale systems) as a precursor to safety and quality. Service structures and processes were therefore considered within the scope of the Standards together with informal aspects of an organisation such as the safety culture and safety related behaviours. Indicators of processes and structures that support a safety culture are needed. For example, it is important that infection control processes are documented in a way that is meaningful (eg. a written policy). However, it is arguably more important that the relevant staff members understand and utilise suitable infection control processes.

Viewing and analysing healthcare as a system has practical implications. First, improvements in the quality of healthcare delivery are unlikely without changes to the systems: working harder within the same system is unlikely to result in improvements. Second, change in a system is more likely to be successful if it is first undertaken on a small scale. It is then possible to determine whether the change achieves its intended outcome and whether any unintended consequences also result.

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

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

• Process relates to what is done in giving and receiving care (eg. the consultation, ordering tests or prescribing)
Appendix A

- Outcomes relate to the effects of care on patients and communities (e.g. immunisation coverage rates, diabetes management, or cervical screening).

Structure, process and outcomes are important in defining quality in primary healthcare. Most of the content of these Standards refers to structure and process issues within a health service, as these are within the direct control of each health service. Some outcomes are also included.

These Standards cannot address everything that impacts on the health and wellbeing of people incarcerated in Australian prisons. Some issues (e.g. blood borne virus, substance abuse, mental health concerns) are beyond the scope of these Standards and will need to be addressed by government departments and the companies contracted to manage the day-to-day operations of prisons.
Glossary

Access: The ability of prisoners to directly approach and obtain services from the health service

Active patient: A patient who is incarcerated in a prison

Active patient health record: The record of a patient who is incarcerated in a prison

Administrative staff: Staff employed by the health service who provide clerical or administrative services and who do not perform any clinical tasks

Adverse event: An incident in which unintended harm results to a person receiving healthcare

Antivirus software: A software program that protects the computer or network from a virus program that can create copies of itself on the same computer and on others, and corrupt programs

Allied health professional: Health professionals who work alongside doctors and nurses to provide optimal healthcare for all Australians (eg. physiotherapists, dieticians, podiatrists)

Appointment system: The system a health service uses to assign consultations between patients and GPs or other staff members who provide clinical care

At risk prisoner: A prisoner who is considered to be at risk of self harm or at risk of assault from other prisoners or one who has a potentially harmful medical condition

CALD: People from culturally and linguistically diverse backgrounds

Care outside normal opening hours: Clinical care that is provided to patients of the health service at a time when the service is normally closed. Each health service will have different opening and closing hours

CD-ROM: A 'compact disc – read only memory' for storing electronic information

Clinical management area: Areas in the health service where clinical care is delivered

Clinical risk management system: A system or process the health service has put in place that is directed toward effective management of potential opportunities for error and adverse effects

Clinically significant: A judgment made by a health professional that something is clinically important for that particular patient in the context of that patient’s healthcare. The judgment may be that something is abnormal and therefore clinically important for that particular patient, or it could be something that is normal but is clinically important for that particular patient

Clinical team: The members of the health service team who have qualifications related to health and perform clinical functions
Glossary

Community corrections centre: Any building, enclosure, place or class of places established to meet the statutory requirements for the supervision of people who are under a legal supervision, development, or work order

Complaint: An expression of dissatisfaction or concern with an aspect of the health service. Complaints may be expressed verbally or in writing and may be made through a formal complaints process, consumer surveys or focus groups

Confidentiality: The nondisclosure of information except to another authorised person, or the act of keeping information secure and/or private

Consumer Medicines Information: Written information produced by pharmaceutical companies to inform consumers about prescription and pharmacy-only medicines

Continuity of care: The degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected and consistent with the patient’s medical needs and personal context. Three aspects of continuity have been defined in the literature:

- informational continuity is the flow of information across healthcare events/consultations, particularly through documentation, handover and review of notes from previous consultations
- management continuity is the consistency of care by the various people involved in a patient’s care
- relational continuity is the sense of affiliation between the patient and their doctor

Continuing professional development (CPD): Educational activities designed to lead to quality improvement in clinical care

Cultural background: Patients identified as being of a particular ethnic or cultural background or heritage

De-identified information: Information from which individual patients cannot be identified

Disability: Any type of impairment of body structure or function, activity limitation and/or restriction of participation in society

Discrimination: Providing differential treatment or consideration based on characteristics of the patient. Discrimination can be positive (providing differential treatment to enhance care to the patient) or negative (providing differential treatment to the detriment of the patient’s care, or neglecting to provide treatment)

Early detection and intervention: The detection of early stages of disease and prompt and effective intervention to prevent disease progression

Electronic communication: The transfer of information (not necessarily patient health information) within or outside the health service through email, internet communications, SMS or facsimiles
Glossary

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

**Error**: A generic term to encompass all occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some chance agency

**Fellowship of the RACGP (FRACGP)**: Fellowship of the RACGP is granted to GPs who have demonstrated that they have reached the standard required for unsupervised general practice in Australia

**Firewall**: In information technology, a gateway or barrier between a private network and an outside or unsecured network (i.e. the internet) to provide added security. A firewall can be used to filter the flow of data through the gateway according to specific rules

**Full back up**: A copy of all files that reside on a computer or server hard drive. The files are marked as having been ‘backed up’

**General practice**: General practice is the provision of patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities

**General practitioner (GP)**: A registered medical practitioner who is qualified and competent for general practice anywhere in Australia; has the skills and experience to provide patient centred, continuing comprehensive, coordinated primary care to individuals, families and communities; and maintains professional competence for general practice

**Hardware**: The physical components of a computer such as a monitor, hard drive or central processing unit

**Health promotion**: Preventive health activities that reduce the likelihood of disease occurring

**Human research ethics committee**: A committee that reviews applications from people or investigators/institutions undertaking research projects involving human subjects. The committee needs to be constituted according to National Health and Medical Research Council requirements

**Human resources**: Relating to the field of personnel recruitment, training and management

**Identifiable information**: Patient health information from which a patient can be identified

**Inactive patient health record**: The record of a patient who is no longer incarcerated in the prison

**Induction program**: A form of training provided to new staff members or GPs to introduce them to the health service’s systems, processes and structures
Glossary

Information disaster recovery plan: A documented plan of the actions the health service needs to take to retain and restore patient health information in the event of a ‘disaster’ (normally a power failure or other such event)

Information sheet: A photocopied, typed or electronically generated information sheet that includes essential information for patients about services and methods of access to those services

Informed consent: Consent by a patient (either written or verbal) to a proposed investigation, treatment or invitation to participate in research after achieving an understanding of the relevant purpose, importance, benefits, and associated risks. For consent to be valid, a number of factors need to be satisfied, including the patient receiving sufficient and appropriate information and being made aware of the material risks. The patient must have the mental and legal competence to give consent

Interpreter service: A service that provides trained language translation either face-to-face or by telephone

Medical deputising services: Services that arrange for or facilitate the provision of medical services to patients of GPs (principals) by other medical practitioners (deputising doctors) during the absence of, and at the request of, the GPs

Medical staff: Staff who have Australian medical registration

Mistake: An error or adverse event that results in harm

Must: Used where there is strong documentary evidence of a risk of harm to patients if the direction is not followed

Near miss: An incident that did not cause harm but could have

Need: Where these Standards use the phrase ‘a health service needs...’, the RACGP’s position is that what ‘needs’ to be done in any situation is determined by what is reasonable in all the circumstances. In interpreting the Standards, care must be taken to be sensitive to the often highly variable circumstances of any particular situation

Network: A collection of connected computers and peripheral devices used for information sharing and electronic communication

Normal opening hours: The advertised opening hours of the health service

Outcomes indicators: Indicators that relate to the effects of care on patients and communities

Outside normal opening hours: The hours not covered by normal opening hours

Patient: A person receiving healthcare. In relevant circumstances, the term is also intended to include a carer
Glossary

**Patient health information**: A patient’s health information includes their name, address, account details and Medicare number and any health information (including opinion) about the person.

**Patient health record**: Information held about a patient in hard or soft form, which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information and legal and occupational health and safety reports.

**Physical facilities**: The building and equipment used to provide clinical care to patients.

**Policy and procedures manual**: A resource document containing written information about the health service’s policies and procedures.

**Position description**: A document describing an employee’s role, responsibilities and conditions of employment.

**Prison**: Any building, enclosure or place legally declared to be a prison for the lawful custody of people committed by lawful authority.

**Prisoner**: A person sentenced by the court to a term of imprisonment, or ordered by the court to be detained in a prison. This includes a person placed in the custody of the administering department in accordance with a lawful order for the purpose of undergoing special treatment while under restrictive custody.

**Privacy of health information**: The protection of personal and health information to prevent unauthorised access, use and dissemination.

**Process indicators**: Indicators that relate to what is done in giving and receiving care.

**Public key infrastructure (PKI)**: PKI is a secure method of transmitting information electronically to provide authentication and confidentiality; PKI is used to transfer information between GPs and other healthcare providers.

**Remand prisoner**: Any person charged with a criminal offence who has been ordered by the court to be detained in custody while awaiting trial or sentencing.

**Referral**: Directing a patient to another practitioner.

**Relevant family history**: Information about the patient’s family history that the GP considers to be important for the purposes of providing clinical care to the patient.

**Relevant social history**: Information about the patient’s social history (including employment, accommodation, family structure) that the GP considers important for the purposes of providing clinical care to the patient.

**Risk management**: The culture, processes and structures that are directed toward effective management of potential opportunities for adverse events.
**Glossary**

**Safe and reasonable**: A decision that each health service needs to make in light of factors that affect their service (e.g. location, patient population) in providing clinical care. What is deemed safe and reasonable needs to be considered in light of what peers (or similar health services) would agree was safe and reasonable.

**Safety**: The degree to which potential risk and unintended results are avoided or minimised.

**Screensavers**: A software program that displays constantly changing images or dims the brightness of a display screen to protect the screen from having an image etched onto its surface or being read.

**Server**: Typically a computer in a network that provides services to users connected to the network (or ‘clients’), such as printing, accessing files and running software applications. A server can be used as a central data repository for users of the network.

**Should**: Indicates best practice by primary care experts and is a recommendation.

**Software**: A program (or group of programs) which perform specific functions such as word processing or spreadsheets.

**Staff**: All staff working within the health service.

**Staff involved in clinical care**: Staff employed by the health service who perform any clinical tasks with patients.

**Structure indicators**: Indicators that relate to material resources, facilities, equipment and the range of services provided at the health service.

**System**: An organised and coordinated method or procedure.

**Team**: Staff members who as a group provide care within the health service (e.g. doctors, receptionists, managers, psychologists or other mental health experts, nurses, allied health professionals).

**Timely**: A length of time which might reasonably be expected by professional peers for a defined situation.

**Urgent**: A health need that requires immediate action or attention.

**Visits to patient living quarters**: A consultation conducted in the patient’s living quarters within the prison.

**Vocationally recognised general practitioner**: A GP on the RACGP Fellows list or the Vocational Register (grandparented) with Medicare, or a GP on the Australian College of Rural and Remote Medicine Fellows List with Medicare.
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