# RACGP *STANDARDS FOR GENERAL PRACTICES*

# 5th EDITION

## DRAFT 1

## February 2016

The content of this draft edition may change
after the RACGP collects and considers feedback from stakeholders.

# Contents

# Preface to this draft

## Reading this draft edition

Areas of this draft edition that are shaded orange are included to help you review this draft and compare it to the 4th edition Standards. These shaded areas (including this preface) will be removed before we issue the final version of the 5th edition Standards.

## Preparation of this draft edition

The development of this draft of the 5th edition Standards began in February 2015, and was comprised of two phases:

- Initial Consultation Phase
  During this phase, the RACGP sought feedback on the 4th edition Standards and a number of ideas were proposed for the 5th edition Standards. The feedback was then consolidated and presented to the RACGP Expert Committee – Standards for General Practices (the Standards Committee) for consideration.
- Development Phase
  During this phase, the Standards Committee developed this draft edition, having:
  - reviewed all feedback
  - completed a comparative analysis of primary care standards from other countries
  - reviewed available evidence and recommended guidance from the International Society for Quality in Healthcare (ISQua)[1].

This draft edition has now been distributed for a second round of stakeholder consultation.

## Developing the final edition

1. The Standards Committee will prepare a second draft of the Standards, based on consideration of all feedback received on this draft edition.
2. In May 2016, the second draft will be issued to stakeholders for further feedback. These stakeholders will include accreditation surveyors who will make sure they can use them to

[1] ISQua promotes and support continuous improvement in the quality and safely of healthcare through their international accreditation programs. ISQua is responsible for assessing standards of organisations such as the RACGP and accrediting accreditation programs. The RACGP's *Standards for general practices* (4th edition) is ISQua-accredited, which means the Standards have been rigorously assessed and are recognised as meeting international standards of quality and safety.

easily and accurately assess practices, and selected practices across Australia, who will pilot the new Standards to check that they are workable and realistic.

3. The Standards Committee will review feedback from stakeholders, pilot sites and accreditation surveyors and use this information to develop a final version.
4. In 2017, the 5th edition Standards will be published on line on the RACGP's website.

## Send us your feedback

The RACGP's Standards Committee welcomes feedback on the draft Standards.

Forward your comments to:

Chair
RACGP Expert Committee - Standards for General Practices
RACGP
100 Wellington Parade
East Melbourne, Victoria 3002

Telephone 03 9998 8630
Facsimile 03 8699 0400
Email standards@racgp.org.au
Website www.racgp.org.au/standardsdevelopment

If you would like to discuss your comments, contact the RACGP Standards Unit on 03 9998 8630.

# Introduction to the Standards 5th edition

RACGP *Standards for general practices* (5th edition):
A benchmark for quality care and risk management in Australian general practices.

The purpose of the RACGP's *Standards for general practices* (5th edition) is to protect patients from harm and to improve the quality and safety of health services. They also provide practices with a way of identifying and addressing any gaps they have in their systems and processes.

## Development of this edition

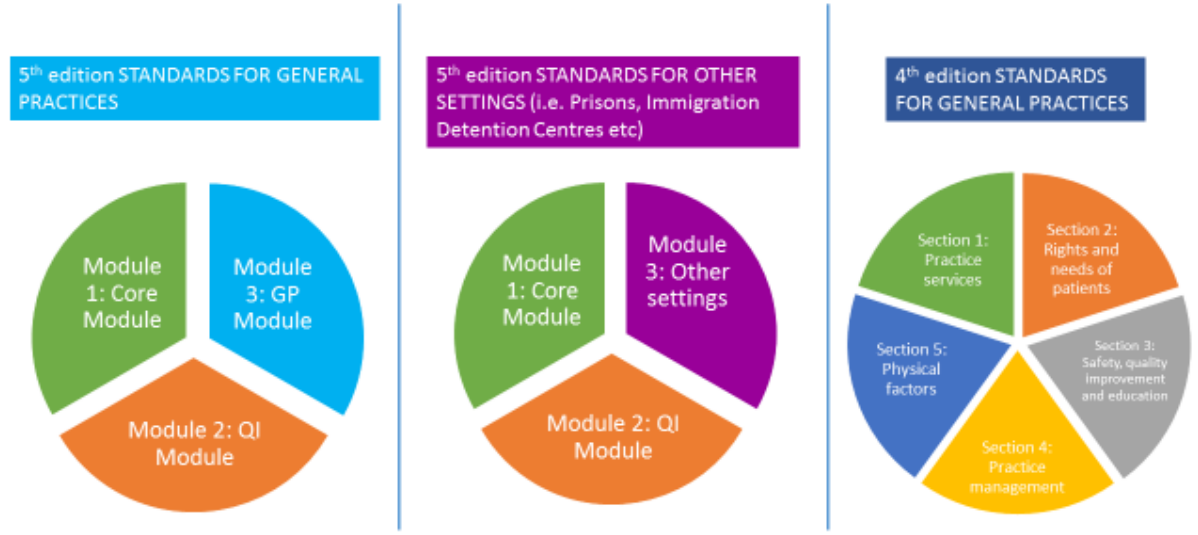
The RACGP's *Standards for general practices* (5th edition) (hereafter "the Standards") was developed by the RACGP in consultation with general practitioners, practice managers, practice nurses, consumers, technical experts, and many other stakeholders.

## Changes from previous edition

### 1. Revised structure

The 4th edition Standards has five sections that accreditation surveyors use to assess general practices. This edition of the Standards is comprised of three modules that address the same areas as the 4th edition Standards within a different structure. A modular structure allows us to update the modules separately, and adapt the Standards for other healthcare settings such as prisons and immigration detention centres. For example, the first two modules (Core Module and Quality Improvement Module) are relevant in all healthcare settings, but the third module needs to be specific to each healthcare setting. Figure 1 illustrates this modular approach.

Figure 1: RACGP Standards modular structure



## 2. Indicators that focus on outcomes and patients

The Standards' Indicators are written with a focus on outcomes and patients, where appropriate, instead of prescribed processes.

By focusing on outcomes, a practice can develop systems and processes that reflect their preferred ways of working and choose how to demonstrate that they meet the intent of the Indicator. This will give the practice's team greater ownership of their processes and systems, and embed those processes and systems before, during and after accreditation.

Focusing on patients means that the patient and what the patient receives is the emphasis of the Indicator rather than what the practice does. For example:

| Process focused indicator | Patient-focused indicator |
|---|---|
| Our practice team can demonstrate how we receive and return telephone, text, and email messages from patients. | Our patients can contact the practice and their GP by telephone, text, and email messages when required. |

## 3. Fewer Indicators

There are 18 fewer Indicators than there were in the 4th edition. This was achieved by:

- removing duplication
- merging Indicators that shared a similar theme.

## 4. Restructured explanatory notes

The explanatory notes for each Criterion now include two sections:

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

This change was made as a direct result of stakeholder feedback collected in the Initial Consultation Phase.

## 5. Plain English

In response to stakeholder feedback, this edition is written in plain English, eliminating ambiguity and minimising the use of technical language. As a result, readers should be able to understand everything the first time they read or hear it.

### 6. References to legislation removed

Most references to legislation have been removed because general practices are responsible for ensuring that they comply with relevant legislation, and because federal, state or territory, and local legislation overrides any non-legislative standards.

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

## Evidence-based standards

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

This evidence is based on two sources:

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

## Accreditation

Practices that wish to be accredited against the Standards must be formally assessed by an accreditation agency and demonstrate that they meet 100% of the mandatory Indicators in this document.

### Requirements for accreditation bodies in order to use the Standards

The RACGP has developed a number of requirements that accrediting bodies must meet in order to be granted permission to use the RACGP *Standards for general practices* (5th edition) for accreditation.

The RACGP considers that the peer surveyor model is paramount to continue to foster genuine collaboration and sharing of expertise amongst peers. In addition, the RACGP supports accreditation as a voluntary scheme.

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

- an in depth understanding of:
    - the Standards
    - the nature of general practice in Australia
    - requirements for training and vocational registration of GPs

- the capacity to efficiently accredit general practices across Australia
- a governance and advisory structure that includes GPs with considerable experience in general practice, and
- that applications from any practice that meets the RACGP definition of a general practice (regardless of location or size) for the purposes of accreditation, will not be financially or otherwise discriminated against, or refused accreditation because of size or remoteness.

In addition to the requirements set out for accrediting bodies, the RACGP requires that surveyor team must demonstrate the following:

- surveyor teams include at least two surveyors, of which one must be an appropriately qualified, trained and approved GP surveyor
- all surveyors must demonstrate a good understanding of confidentiality issues relating to general practice and personal health information and patient privacy
- GP and non-GP surveyors meet previous and recent experience requirements prior to being permitted to conduct survey visits
- GP surveyors shall be a vocationally registered GP and from 1 January 2016 all new surveyors will hold general practice Fellowship
- GP surveyors have at least five years full time or equivalent part time experience as a vocationally registered GP or Fellow, working as a GP in a practice (defined as a general practice for the purposes of accreditation by the RACGP), including recent experience in active general practice within the last two years. Active general practice is defined as working for at least two sessions a week in face-to-face patient contact in an accredited general practice
- GP surveyors participate in, and meet College requirements for quality assurance and continuing medical education
- all surveyors complete appropriate training and maintain their competence demonstrating their knowledge of the Standards.

RACGP considers that these requirements are paramount to fostering genuine collaboration and sharing of experience amongst peers. In addition, these requirements support increased rigour and accountability of the general practice accreditation model now and into the future.

## Mandatory ► and optional Indicators

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

Indicators that are not marked with the mandatory symbol are optional recommended Indicators. We encourage all practices to meet the recommended Indicators, but this is not essential for accreditation.

## The assessment process

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

Accreditation assessments are to be based on common sense: the accreditation agencies will not seek to penalise or exclude a practice from accreditation against the Standards on the basis of technicalities.

## Demonstrating compliance

Previous editions of the Standards dictated how practices should demonstrate compliance with the Standards (e.g. interview, document review, observation), and the 4th edition Standards focused on process measures. However, because this edition of the Standards is outcomes-focused, practices can choose how they demonstrate that they meet the intent of each Indicator and, provided that the practice team can explain this to the surveyor, the practice will be assessed as having met the Indicator. This approach gives practices greater scope to set up systems and processes that reflect the working arrangements in their practice and will be easier to maintain after their accreditation assessment.

## Guidance for assessment

For each Criterion, the information under the heading *Meeting this Criterion* provides examples of how a practice might choose to demonstrate compliance with one or more Indicators and/or the Criterion

# Module 1: Core module

# Preface to draft of Standard 1: Practice governance and management

## Indicators in this Standard

This Standard includes:

- Indicators from different sections of the 4th edition Standards relating to Practice Governance and Management, that address the overall structures, systems and processes that help practices provide high quality, safe care
- new Indicators filling some gaps in the 4th edition Standards, that focus on a whole-of-team approach.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 1.1 ► A | Setting a strategy and goals for improving services. | Included in response to feedback from the International Society for Quality in Health Care (ISQua) - who assess the Standards against their accreditation requirements – who identified this as a gap in the previous edition. |
| 1.1 ► B | This Indicator relates to 1.1 A. As well as setting a strategy, practices need to evaluate their progress towards achieving the strategy. | Included in response to feedback from the International Society for Quality in Health Care (ISQua) who identified this as a gap in the 4th edition Standards. |
| 1.1 ► C | Relating to clinical risk management, this Indicator accommodates the fact that risk management in general practice is broader than clinical risk. | Included in response to feedback from the International Society for Quality in Health Care (ISQua) who identified this as a gap in the 4th edition Standards. |
| 1.2 ► B | This Indicator supports practice team members to reflect on their performance and receive constructive feedback. | This Indicator was not mandatory in the 4th edition Standards, but now is. |
| 1.4 A | Having an open disclosure process promotes effective communication with patients when things go wrong, and supports the patient and their carer and/or family to achieve closure. Open disclosure can also improve the safety | This was identified as a gap in the 4th edition Standards. |

| | | |
|---|---|---|
| | and quality of the services the practice provides to patients. | |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 1.1 – Business risk management systems | ► A. Our practice has a strategy for planning and setting goals aimed at improving our services. | New Indicator |
| | ► B. Our practice evaluates its progress towards achieving its goals. | New Indicator |
| | ► C. Our practice has a business risk management system that identifies, monitors, and mitigates risks in the practice. | New Indicator |
| | ► D. Our practice inducts new staff and familiarises them with our systems and processes. | 4.1.1 ► B |
| | ► E. Our practice team discusses administrative matters with the principal practitioners, practice directors or owners when necessary. | 4.1.1 ► E |
| | ► F. Our practice encourages involvement and input from members of the practice team. | 4.1.1 ► F |
| 1.2 – Accountability and responsibility | ► A. All members of our practice team understand their role in the practice. | 4.1.1 ► A |
| | ► B. Our practice reviews each team member's performance. | 4.1.1 G |
| | ► C. Our practice has a complaints resolution process. | 2.1.2 ► B |
| | ► D. Our practice has a team member who has the primary responsibility for leading risk management systems and processes. | 4.1.1 ► C<br>3.1.3 ► A |
| | ► E. Our practice has a team member who coordinates the resolution of administrative and/or other complaints. | 4.1.1 ► D |
| 1.3 – Clinical communication | ► A. Our clinical team discusses the practice's clinical issues and support systems. | 1.4.1 ► C |
| 1.4 – Open disclosure | A. Our practice has an open disclosure process based on the national Open Disclosure Framework. | New Indicator |
| 1.5 – Work health and safety | ► A. Our practice supports the safety, health, and wellbeing of the practice team. | 4.1.2 ► B |
| | ► B. Our practice team is offered NHMRC recommended immunisations, as appropriate to their duties. | 5.3.3 ► H |
| | ► C. Subject to the informed consent of our practice team members, the natural immunity to their vaccine-preventable diseases or immunisation status is known. | 5.3.3 ► H |
| 1.6 – Research | ► A. Our practice ensures that all research is approved by the ethics committee and is indemnified. | 4.2.1 ► H |

# Standard 1: Practice governance and management

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

Practice governance relates to the principles, methods and processes that clinicians and health service managers follow to provide patient safety and quality care. It also provides a framework that practices can use to set, measure, and achieve their social, fiscal, legal, and human resources objectives.

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

- participatory
- consensus-oriented
- accountable
- transparent
- responsive
- effective and efficient
- equitable and inclusive
- compliant with legislation[1]

With good management and leadership that includes fostering a culture of openness and mutual respect, the entire practice team will be committed to achieving excellence in all areas of the practice and will participate in just and open discussions about how the practice can improve.

## Criterion 1.1 – Business risk management systems

### Indicators

► A. Our practice has a strategy for planning and setting goals aimed at improving our services.

Stakeholder question: does this terminology, 'a strategy for planning' make sense to general practices?

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

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

► D. Our practice inducts new staff and familiarises them with our systems and processes.

► E. Our practice team discusses administrative matters with the principal practitioners, practice directors or owners when necessary.

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

### Why this is important

*Practice strategy*

Strategy in practice management is the long-term plan to achieve one or more business outcomes, with consideration of the practice's current capabilities and the environment in which it operates. For example, what are the clinical resources? Are staff members willing to work evenings and weekends? What are the local conditions?

Having systems in place helps to get the team working together towards a common goal, and helps the practice to achieve consistency, quality, the ability to evaluate progress, and continuous quality improvement.

To operate a business successfully, strategic thinking and planning is as essential as financial budgeting and reporting. A documented business plan (that is linked to your strategy and includes how it will be implemented) is an effective way of measuring your progress, and increasing the likelihood of achieving your practice's objectives.

*Risk management*

Managing safety and risk is part of quality assurance, and therefore a significant part of practice management. Clinical risks clearly need to be managed, but so too do business risks, because if the business fails, the practice will not be able to provide clinical care. A risk management process helps you to consistently identify, document, and manage clinical and business risks.

*Induction program*

Your practice needs to have an induction program so that new staff (practitioners and other staff) understand:

- the day-to-day operations of the practice
- key occupational health and safety issues, such as infection control
- the processes for maintaining the privacy and confidentiality of patients' health information.

*Teamwork*

Research in Australia and the USA confirms that effective teamwork helps organisations to successfully implement safety initiatives[2]. So, while your practice needs to cultivate a just, open and supportive culture that preserves and values individual accountability and integrity, it also needs to foster a whole-of-team approach to the quality of patient care. For example, regular discussions where all staff are encouraged to contribute their ideas and observations can help to build a high performing team.

## Meeting this Criterion

*Practice strategy*

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

- the practice's mission, vision, ethics (or code of behaviour) and values
- how you plan to make efficient use of resources, including the level of staffing and skill mix required
- environmental factors
- financial factors
- human resource management, including effective recruitment, selection, appointment, management, retention, separation, and support systems.

If you have a smaller practice (e.g. with fewer than 10 staff), it may be sufficient to document your ethics and values.

*Risk management*

You could develop a risk management strategy that identifies, analyses, evaluates, and explains how you have managed risks.

Risks that might be identified in a practice include:

- poor record keeping
- failure to check a patient's history when writing scripts
- lack of documentation of the consent process
- equipment that is not maintained in accordance with the manufacturer's recommendations
- inadequate number of practice staff on during busy times.

A risk matrix could be developed to help you define the level of each identified risk (e.g. Low, Moderate, High, Extreme), based on a combination of the likelihood of an event and the severity of its impact if it was to occur.

A risk register is a helpful way to record problems that could result in a risk becoming a reality, so that you can identify potential risks and take action to reduce the likelihood or severity.

You could schedule regular risk management meetings and/or include risk management as a standing agenda item on team meetings so identified risks are reviewed, updated, and minimised.

*Induction program*

The following information could be included in your induction program:

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

*Teamwork*

The most common way for practices to build teamwork is to schedule regular staff meetings where everyone is encouraged to contribute to discussions. For small practices, this can be an informal discussion at regular intervals, such as at the end of every week.

It is a good idea to document the decisions made at staff meetings and the names of those responsible for implementing related actions.

Provide all members of the practice team with the opportunity to discuss administrative issues with the practice directors and/or owners when necessary. When the practice owner is not a member of the practice, then practitioners and other staff could develop systems for discussing administrative matters with the owner. Although these discussions do not necessarily need to occur as a formal staff meeting, this is recommended, particularly for medium and large practices.

Good communication between the manager/employer and the employees will help to create an efficient and productive workplace where there are positive working relationships. This will result in long-term benefits for the practice, the employees, and the patients.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Develop a mission and vision statement.

- Develop and maintain an organisational chart.
- Keep accurate and up-to-date staff employment files.
- Include an explanation of the human resource system in recruitment interviews.
- Document and define your recruitment process.
- Develop and use templates and checklists for staff inductions.
- Create and encourage the use of accessible communication channels, such as regular staff meetings.
- Maintain a human resources policy and procedure manual.
- Keep minutes of staff, clinical and other meetings.

## Criterion 1.2 – Accountability and responsibility

### Indicators

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

► B. Our practice reviews each team member's performance.

► C. Our practice has a complaints resolution process.

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

► E. Our practice has a team member who coordinates the resolution of administrative and/or other complaints.

### Why this is important

*Roles and responsibilities*

Having systems that have clear lines of accountability and responsibility are elements of good governance and encourage continuous improvement in safety and patient care.

When specific roles and responsibilities are documented (for example, in the practice policy document) and agreed to:

- the practice can monitor each staff member's performance against their role's requirements and determine whether any support and training is required
- each team member knows who they are reporting to for each duty or responsibility
- each team member knows who is responsible for various aspects of the practice's operations.

*Performance monitoring*

The objectives of a performance management system are to assess the performance of an individual and to determine how staff would benefit from further training and development.

*Managing complaints*

Consumer and patient complaints provide practices with a valuable source of information. Open discussions about patients' needs and their concerns about the quality of care will help your practice understand potential problems and identify how you can improve your services[3].

### Meeting this Criterion

*Roles and responsibilities*

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

- performance evaluation

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

Have each employee sign their position description to indicate that they accept and understand their roles and responsibilities.

If your practice engages commercial cleaners for environmental cleaning, create a written contract that outlines a cleaning schedule, suitable cleaning products to be used, and areas to be cleaned, and have the cleaners sign this contract. You could also consider having the cleaners record their work in a cleaning log.

*Performance monitoring*

One way managers can monitor a staff member's performance is to have regular weekly meetings, so that issues can be raised and addressed quickly. This is particularly useful in smaller practices where informal processes generally work better than formal processes.

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

The performance management system should cover:

- setting standards for performance
- assessing performance against the standards
- providing and receiving feedback about job performance
- agreeing on actions to further improve performance.

Whether you use formal or informal processes, managers need to document the performance discussions, agreed actions, and ongoing development needs.

*Managing complaints*

Practices should adopt a receptive attitude to patient feedback and complaints, and consider displaying notices that state that the practice will always try to resolve complaints directly.

Develop a system to record, review, and manage complaints, including how you will advise patients of the progress and outcome of their complaint.

If you receive a patient complaint, try to resolve the issue without involving any other parties. If necessary, contact your medical defence organisation to seek advice on resolving a complaint before

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

- acknowledging the patient's right to complain
- working with the patient to resolve the issue, where possible
- providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology
- ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another practitioner
- complying with laws, policies and procedures relating to complaints.

If the matter cannot be resolved, you or the patient can contact your state's Health Complaints Commissioner for advice and possible mediation.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain position descriptions that clearly explain responsibilities and lines of accountability.
- Have regular meetings with staff.
- Create a contract with your cleaning company and have them sign it.
- Maintain a HR policy and procedures manual.
- Keep a complaints ledger.

## Criterion 1.3 – Clinical communication

### Indicator

► A. Our clinical team discusses the practice's clinical issues and support systems.

### Why this is important

Having clinical guidelines and appropriate support systems that facilitate discussions helps to identify and address clinical issues and deliver consistent and quality care.

### Meeting this Criterion

Good communication between members of the clinical team can be achieved with face-to-face meetings. Communication tools such as message systems and notice boards can be used to record clinical issues and ideas that people have.

Clinical staff may find it valuable to have access to up-to-date resources about a range of clinical issues, to improve the treatment of patients and for their own professional development.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Keep meeting agendas and minutes, including those of clinical staff meetings.

## Criterion 1.4 – Open disclosure

### Indicator

A. Our practice has an open disclosure process based on the national Open Disclosure Framework.

### Why this is important

Health professionals have an obligation to:

- explain to patients when things go wrong
- offer a genuine apology (if warranted)
- explain what steps have been taken to ensure that the mistake is not repeated.

The RACGP has endorsed the Open Disclosure Framework developed by the Australian Commission on Safety and Quality in Healthcare. The Open Disclosure Standard is available at www.safetyandquality.gov.au/wp-content/uploads/2012/01/OD-Standard-2008.pdf

Open disclosure is defined as:

> *"an open discussion with a patient about one or more incidents that resulted in harm to the patient while they were receiving health care."*

Communicating openly and honestly helps the patient to:

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

In addition, if the patient receives a genuine explanation and apology, they are less likely to pursue litigation.

### Meeting this Criterion

Open disclosure includes:

- an apology or expression of regret (including the word "sorry")
- a factual explanation of what happened
- an opportunity for the patient to relate their experience
- an explanation of the steps being taken to manage the event and prevent recurrence.

Open disclosure is a discussion and an exchange of information that may take place over several meetings.

Contact your medical defence organisation for further guidance and advice about incidents when you may need to participate in open disclosure.

The Open Disclosure Framework for small practices is available at www.safetyandquality.gov.au/publications/implementing-the-australian-open-disclosure-framework-in-small-practices/ .

## Criterion 1.5 - Work health and safety

### Indicators

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

► B. Our practice team is offered NHMRC recommended immunisations, as appropriate to their duties.

► C. Subject to the informed consent of our practice team members, the natural immunity to their vaccine-preventable disease or immunisation status is known.

### Why this is important

Each practice owner/manager is responsible for ensuring that they provide a safe working environment. This includes being genuinely concerned for the health, safety and wellbeing of all employees, and meeting the practice's responsibilities as an employer by adhering to relevant state/territory and federal occupational health and safety (OH&S) legislation.

In particular, practices should offer staff immunisation in order to protect them from being infected with vaccine-preventable infectious diseases and from transmitting such infections to patients. The exact requirements will depend on the risk presented by the type of practice and each staff member's duties.

### Meeting this Criterion

*Safety of your practice team*

Consider having at least two staff members present during normal practice hours, so that telephone calls can be answered promptly, appointments can be made accurately and according to urgency, and medical emergencies can be managed appropriately.

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

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

Ensure that the layout of the facility complies with OH&S requirements, and consider how individual desks are configured so that staff members have the full range of movement required to do their job, and can move without strain or injury. One way to do this is to have a professional conduct an ergonomic assessment of each desk and workspace.

*Health and wellbeing of your practice team*

Practices can support the health and wellbeing of employees in many ways. For example:

- regular breaks for practitioners during consulting time can reduce fatigue as well as enhance the quality of patient care. Fatigue and related factors (sometimes called 'human factors') are associated with increased risks of harm to patients
- a plan for re-allocating patient appointments if a practitioner is unexpectedly absent from the practice can minimise the burden on the other practitioners
- making information about support services available to practitioners and other employees can help them identify and deal with pressures and stressors. This is particularly important in geographical areas where there is a shortage of practitioners or other employees.

*Dealing with violence*

Because patient-initiated violence in healthcare settings unfortunately continues to be an issue, your practice should develop a risk management strategy that protects practitioners and practice staff if a violent incident occurs or it looks like one might occur. Typically, such strategies include:

- a zero tolerance policy towards violence
- displaying signs that indicate the zero tolerance policy
- detailed steps to take when dealing with violence.

You could also take the following specific actions.

- As a practitioner has the right to discontinue the care of a patient who has behaved in a violent or threatening manner, a practitioner may choose to end the professional relationship during a consultation or by letter or telephone, depending on safety considerations. The practice should keep a record of the process, and any subsequent contact that the patient has with the practice.
- Set up a duress alarm system that employees can use if a patient is threatening or violent.

*Staff immunisation*

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

The following immunisations can be considered for office-based health professionals:

- hepatitis B
- influenza
- pertussis
- MMR (if non-immune)
- varicella (if seronegative).

An employee's refusal to be vaccinated should be recorded in the employee's personnel folder along with any natural immunity to disease or any post-immunisation immunity. As it cannot be assumed that staff will seroconvert post immunisation (e.g. hepatitis B), it is recommended that post-immunisation status is serologically confirmed wherever possible and that further vaccinations are provided as required.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a policy and procedure manual.
- Include work health and safety in recruitment interviews and employee inductions.
- Develop and adhere to appropriate staff rosters.
- Maintain an OH&S policy and procedure.
- Include OH&S as a standing agenda item on team meeting agendas.
- Maintain an appointment book that shows scheduled breaks.
- Create appropriate building, workstation, and desk designs and layouts.
- Provide staff with access to support services.

## Criterion 1.6 - Research

### Indicator

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

### Why this is important

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

When conducting research, you must ensure that the collection, use and disclosure of data complies with the legislative requirements relating to privacy. Even if your practice is using de-identified patient health information, there are still some situations that require that you obtain informed patient consent (other situations do not required informed patient consent). A Human Research Ethics Committee will decide on the requirements for consent when you are using de-identified data.

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

### Meeting this Criterion

Practice staff must be familiar with the NHMRC Code when participating in research.

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

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

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a research policy and ethics approval guidelines.
- Document ethics approval for all research conducted by staff of the health service that involves health service patients.

# Preface to draft of Standard 2: Communication with patients

## Indicators in this Standard

Indicators in this Standard relate to communication with patients. The new Indicators in this Standard build on Indicators in the 4th edition Standards.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| Last dot point of 2.1 ► A | Providing information on the range of services a practice provides | This was included in the explanatory notes of the 4th edition. Including this as an additional dot point to the Indicator will ensure that practices provide comprehensive information to their patients. |
| 2.4 C | Accessing translated resources | This was identified as a gap in the 4th edition Standards during the Initial Consultation Phase. |
| 2.5 ► A and ► B | Informing patients of out-of-pocket costs provided within your practice, and potential out-of-pocket costs relating to referred services. | Criterion 1.2.4 in the 4th edition did not have Indicators. These Indicators have been created in the 5th edition. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 2.1 – Practice information | ► A. Our patients can access up to date information about the practice. At a minimum, this information contains:<br>• our practice address and telephone numbers<br>• our consulting hours and details of arrangements for care outside normal opening hours<br>• our practice's billing principles<br>• our practice's communication policy, including receiving and returning telephone calls and electronic communication | 1.2.1 ► A.<br>(Last dot point is new) |

| | | |
|---|---|---|
| | • our practice's policy for managing patient health information (or its principles and how full details can be obtained from the practice)<br>• the process for the follow up of results<br>• how to provide feedback or make a complaint to the practice, including contact details of the local, state or territory health complaints conciliation body<br>• information on the range of services we provide. | |
| 2.2 – Telephone and electronic communications | ► A. Our practice manages telephone and electronic messages from patients. | 1.1.2 ► A |
| 2.3 – Informed patient decisions | ► A. Our patients can access information from the clinical team about proposed investigations, referrals and treatments, including the purpose, importance, benefits, and risks. | 1.2.2 ► A |
| | ► B. Our patients receive information to support the diagnosis, treatment and management of conditions. | 1.2.2 ► B |
| 2.4 – Interpreter and other communication services | ► A. Our practice uses an interpreter and other communication services with patients who do not speak the primary language of our staff, excluding exceptional circumstances. | 1.2.3 ► A |
| | ► B. Our practice uses appropriate communication services to communicate with patients who have a communication impairment, excluding exceptional circumstances. | 1.2.3 ► B |
| | C. Our patients can access resources translated into a language in which they are fluent. | New Indicator |
| 2.5 – Costs associated with care initiated by the practice | ► A. Our patients are informed of the out-of-pocket expenses for health care they receive at our practice. | 1.2.4 New Indicator |
| | ► B. Our patients are informed that there are potential out-of-pocket expenses for referred services. | 1.2.4 New Indicator |

# Standard 2: Communication with patients

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

Communication with patients includes:

- communication that occurs before the consultation, during the consultation, and after the consultation
- verbal and written communication, and the use of interpreters, including sign language interpreters
- communication between the patient and the practitioner, and communication between the patient and the practice team, and communication between the patient and other clinicians within the practice.

Communication should be patient-centred, which means that employees always consider and respond to the patient's values, needs and preferences, and give the patient ample opportunities to provide input and participate actively in decisions regarding their healthcare[4].

## Criterion 2.1 - Practice information

### Indicators

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

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

### Why this is important

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

### Meeting this Criterion

*Format of the information*

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

If your practice serves defined ethnic communities, provide written information in the languages most commonly used by your patients, and consider using interpreters.

*Advertisements in your practice information*

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

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Create and maintain an up-to-date, website that contains all the required information about the practice in language that is clear and easily understood.
- Create and maintain an up-to-date, information sheet that contains all the required information in language that is clear and easily understood.
- Alternative ways to provide the information to patients who are unable to read or understand the information sheet. For example, pictures and versions in languages other than English.
- Brochures and/or signs in the waiting room, written in languages other than English, explaining:
  - the practice's policy regarding its collection, storage, use, and disclosure of personal and health information
  - the costs and fees of the practice
  - available services
  - after-hours services.
- Display a list of names of the staff members on duty.
- Place a suggestion box in the waiting room, and regularly review suggestions.
- Establish and follow a process for dealing with suggestions and complaints.
- Make contact details of interpreters available.
- Train staff so that they can use the interpreter service.

## Criterion 2.2: Telephone and electronic communications

### Indicator

► A. Our practice manages telephone and electronic messages from patients.

### Why this is important

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

- patients can contact the practice when they need to
- patients can make appointments and receive other information in a timely fashion
- urgent enquiries are directed to appropriate emergency services.

### Meeting this Criterion

*Communicating by telephone*

When an employee provides information (such as the results of investigations) to a patient by telephone, the employee must make sure that recipient of the information is correctly identified so that patient confidentiality is not compromised. To do this, they must obtain three approved patient identifiers, which are items of information that are accepted for use to identify a patient. These include:

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

A Medicare number is not an approved identifier because it is not unique, and because some people have more than one Medicare number because they are members of more than one family and are on multiple cards. Also, some Australian residents and visitors may not have a Medicare number[5].

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

*Communicating by electronic means*

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

- inform patients that their privacy and confidentiality may be compromised when communicating by email without encryption

- clearly stipulate what content can and cannot be sent using electronic communication. For example, you may decide that sensitive information such as HIV status or pregnancy results can only be communicated via telephone or face-to-face
- obtain written consent from the patient before communicating health information electronically
- verify that the information is being sent to the correct email address or phone number before any information is sent.

You can choose not to communicate electronically with your patients.

*Online appointments*

If you choose to give patients the option of making appointments online:

- select the technology and system that best suits your practice's requirements
- decide which appointments are appropriate for online bookings. For example, many practices offer this option only for routine, non-urgent appointments.

*Referring important communications to clinical staff*

Guidelines about the following situations when communicating with patients via telephone or electronically will ensure that privacy is respected and maintained and that information is correctly and appropriately conveyed:

- which messages should and should not be conveyed to practitioners
- how messages are to be recorded (e.g. for privacy reasons, it may be unacceptable to record them on a sticky note)
- how to ensure a message is given to the intended person
- what to do if the intended recipient of the communication is absent
- how to ensure that practitioners can return messages in a timely manner.

*Communicating with patients with special needs*

Some patients (e.g. those with disability and those not fluent in English) need access to alternative means of communication.

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

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*Emergency message*

- Have a recording that advises patients placed on hold to hang up and call 000 in the case of an emergency.

*Messages from patients*

- Keep a policy, procedure, or flow chart showing how to deal with messages from patients.
- Maintain a paper or electronic (e.g. email, SMS, voicemail) messaging system.
- Ensure that reception staff know which messages need to be transferred to clinical staff.
- Have an appointment system that includes time for the clinical team to return messages to patients.
- Establish a notes system that shows when patients contacted the practice, the reason for the contact, and advice and information they were given.

*Giving information to patients*

- Document what information and advice can and cannot be given to patients over the phone or electronically.
- Implement a method for identifying patients over the phone that guarantees that information is being provided to the right person.

*Emails to and from patients*

- Have an automatic response that provides the practice's telephone number if emails are received when the practice cannot respond to them.
- Establish a process so that patients are advised of the practice's policy for checking, responding to, and sending emails.

*Recording when clinical staff have contacted a patient*

- On each patient's health record, record entries of when clinical staff have contacted the patient.

## Criterion 2.3 - Informed patient decisions

### Indicators

► A. Our patients can access information from the clinical team about proposed investigations, referrals and treatments, including the purpose, importance, benefits, and risks.

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

### Why this is important

Patients have the right to make informed decisions about their health, medical treatments, referrals and procedures, and therefore practices need to provide information that the patient can understand, tailored according to their individual needs and circumstances.

### Meeting this Criterion

*Providing appropriate and sufficient information*

Information provided to patients can be paper-based or online (e.g. leaflets, brochures, links to reputable websites). The information needs to be delivered in an appropriate language and format, which means using simple language, minimising jargon and complicated terms, and using clear diagrams.

Consideration also needs to be given to:

- the patient's physical, visual and cognitive capacities, which may affect their ability to understand the information, make decisions, or provide consent
- the way potentially sensitive information is communicated (e.g. sexually transmitted infections, blood borne viruses, and pregnancy results)
- the patient's cultural and linguistic background (e.g. you may need to use an interpreter to check that the patient understands everything that you have told them)
- situations where patients are dependent on a third party for their ongoing care, as the carer needs to receive and understand all appropriate information.

*Information about interventions*

Providing information about tests and treatments (including medicines and medicine safety) may help patients to make informed decisions about their health care. For this reason, practitioners can consider:

- offering to discuss any issues about a patient's condition, proposed treatment and medicines that could be confusing
- directing patients to reliable health and medicine websites where they can find further information

- advising patients to seek further advice about their medicines from their pharmacist.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*During the consultation*

- Use diagrams or flip charts in consultations to help explain health problems to patients.
- Obtain permission for a third party (e.g. interpreter or carer) to be included in consultations when the patient needs help to understand.

*Providing written and visual information to patients*

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

*Record relevant details in the patient's health record*

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

## Criterion 2.4 - Interpreter and other communication services

### Indicators

► A. Our practice uses an interpreter and other communication services with patients who do not speak the primary language of our staff, excluding exceptional circumstances.

► B. Our practice uses appropriate communication services to communicate with patients who have a communication impairment, excluding exceptional circumstances.

C. Our patients can access resources translated into a language in which they are fluent.

### Why this is important

Practitioners have a professional obligation to communicate effectively and understand their patients' health concerns. Patients have a right to understand the information and recommendations provided by their practitioners[6].

### Meeting this Criterion

*Communication with patients*

Qualified medical interpreters should be the preferred choice, other than in exceptional circumstances such as medical emergencies.

Interpreters can be accessed free of charge under some circumstances. For example, the Doctors Priority Line is a free telephone interpreting service that helps medical practitioners quickly connect to an interpreter so that they can communicate with a non-English speaking patient. Further information about this service is available at www.tisnational.gov.au .

Using a family member or friend as an interpreter is not recommended as it may potentially upset the friendship dynamics and family relationships[7], and incorrect or inadequate information about the patient's diagnosis may not be translated effectively and may lead to harm to the patient. This is demonstrated in a case where a patient's daughter was used in place of a translator: a Medical Board complaint alleged failure to use an interpreter, resulting in the death of the patient[8].

Consider writing a policy that explains how employees can communicate with patients who have low English proficiency. For example, the policy could include:

- how to identify that a patient requires an interpreter or communication service (e.g. placing a specific sticker on the patient's file)
- how to use the practice telephones when using interpreting services (e.g. setting up a three-way conversation or using speakerphones)
- that the national interpreter symbol is to be displayed in the reception area where patients can easily see it

- what information (such as the need for an interpreter, the patient's preferred language, and gender and cultural sensitivities) is to be recorded on a patient's health record and referral letters
- the training that employees receive on engaging credentialed interpreters.

Information on how the practice can communicate with patients who have communication impairments is available at www.dhs.vic.gov.au and www.caus.com.au/www/home/ .

*Translated resources*

Consider having a directory of resources, services, online tools and websites that facilitate or provide resources that translate information into languages other than English.

For example, the Health Translations Directory provides access to translated health information to health practitioners working with culturally and linguistically diverse communities. Further information can be found at //www.healthinfotranslations.org/ .

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Staff know how to contact and use the translating and interpreter services, including Auslan services for patients who are deaf.
- Staff have a list of contact details for interpreter and other communication services.
- Contact details for interpreter and other communication services are kept in reception and in consultation rooms.

## Criterion 2.5 - Costs associated with care initiated by the practice

### Indicator

► A. Our patients are informed of the out-of-pocket expenses for health care they receive at our practice.

► B. Our patients are informed that there are potential out-of-pocket expenses for referred services.

### Why this is important

For some patients, the cost of treatment or investigations is a barrier to care, so providing information in advance about costs they will or might incur (including costs in addition to consultation fees) is one way you can help patients make an informed decision about their own healthcare.

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

### Meeting this Criterion

Clearly communicating with patients about unexpected developments can help the patient to understand the need for additional costs. You should inform patients of the possible cost of additional treatments or procedures before beginning the treatment or procedure.

Consider:

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

While it is not necessary for you to know or provide the exact costs of referred and recommended services, you do need to tell patients of the potential for out-of-pocket costs before you make a referral, or recommend services such as pathology, imaging, and specialist or allied health.

If a patient requires exact information about the costs of such services, encourage them to make their own enquiries.

# Preface to draft of Standard 3: Rights and responsibilities of patients

## Indicators in this Standard

The Indicators in this Standard address delivery of respectful and culturally appropriate care, the presence of a third party during a consultation, and access to services.

## New Indicator

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 3.1 ► F | Considering ethical dilemmas | This was identified as a gap in the 4th edition Standards during the Initial Consultation Phase. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and indicator |
|---|---|---|
| 3.1 – Respectful and culturally appropriate care | ► A. Our practice considers the healthcare and cultural beliefs of our patients. | 2.1.1 ► A |
| | B. Our practice is aware of identified cultural groups of our patient population. | 2.1.1 G |
| | ► C. Our patients receive information from the clinical team about the risks resulting from refusing a specific treatment, advice, or procedure. | 2.1.1 ► B |
| | ► D. Our practice acknowledges a patient's right to seek further clinical opinions. | 2.1.1 ► C |
| | ► E. Our patients are provided with privacy. | 2.1.1 ► F |
| | ► F. Our clinical team considers ethical dilemmas. | New Indicator |
| 3.2 – Presence of a third party during a consultation | ► A. Our practice team obtains and documents the prior consent of a patient to have a third party present during the consultation. | 2.1.3 ► A |
| 3.3 – Access to care | ► A. Our patients with disabilities or special needs can access our services. | 5.1.3 ► B |

# Standard 3: Rights and responsibilities of patients

*Our practice respects the rights and needs of patients.*

The ACSQHC Charter of Healthcare Rights aims to facilitate a common understanding of the rights of people receiving health care. It is available at: www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

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

## Criterion 3.1 - Respectful and culturally appropriate care

### Indicators

► A. Our practice considers the healthcare and cultural beliefs of our patients.

B. Our practice is aware of identified cultural groups of our patient population.

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

► D. Our practice acknowledges a patient's right to seek further clinical opinions.

► E. Our patients are provided with privacy.

► F. Our clinical team considers ethical dilemmas.

### Why this is important

The ideal patient-clinician partnership is a collaboration based on mutual respect and a mutual responsibility for the health of the patient. The clinician's duty of care is to explain the benefits and potential harm of specific medical treatments and to clearly and unambiguously explain the consequences of the patient not following a recommended management plan.

*Respectful and culturally appropriate care*

Patients have the right to respectful care that considers their cultural beliefs and promotes their dignity, privacy, and safety. All members of the practice team need to have appropriate interpersonal skills so they can successfully work and interact with patients and colleagues.

Demonstrating respect for patients is required in all interactions with the patient, and extends to recording, storing, using and disclosing health and other information about a patient.

Patients have a corresponding responsibility to be respectful and considerate towards their practitioners and other practice staff.

*Consequences of disrespectful care*

Making or recording derogatory, prejudiced, prejudicial, or irrelevant statements about patients can result in serious consequences relating to treatment, because such statements (whether verbal or written) can be misinterpreted by other practitioners which may result in different treatment for the patient. In addition, because the Federal Disability Discrimination Act (1992) and state and territory Disability Services Acts and Equal Opportunity Acts prohibit discriminatory treatment based on someone's personal characteristics (including gender, religion, sexual preference, marital status, race, and political opinions), such statements may be illegal and can result in serious legal consequences, including legal action such as claims for compensation.

*Refusal of treatment and second opinions*

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

*Ethical dilemmas*

Practitioners often need to negotiate ethical issues in primary healthcare, and situations that can present ethical dilemmas are varied, range from bioethics dilemmas (including end of life care and pregnancy termination) to receiving gifts from patients.

In particular, ethical dilemmas may arise when considering:

- decisions not to treat
- decisions to withdraw or discontinue treatment
- decision to provide treatment against the patient's wishes.

Practices need to have a process to resolve ethical dilemmas in a timely way.

## Meeting this Criterion

*Respectful and culturally appropriate care*

Practitioners have a responsibility to ensure that, when taking a history from a patient and developing management plans, they fully understand the discussion that takes place and that the patient fully understands the proposed management and treatment. This may require the use of translating services. Practitioners must ensure there is clear and effective communication in the clinician-patient relationship so that practitioners can effectively manage the patient's healthcare.

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

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

*Managing health inequalities*

If choices need to be made about the allocation of limited resources, practices can choose to provide targeted and culturally appropriate care to people and communities whose needs for comprehensive primary care are high. This can address the health inequalities of some individuals, families and communities, such as refugees, asylum seekers, prisoners, people who identify as an Aboriginal or Torres Strait Islander, or people from other cultural backgrounds associated with known health risk factors.

Practices who do this need to have policies and procedures to deal with requests for care by patients outside the target population.

*Refusal of treatment or advice*

When a patient has refused the practitioner's recommended advice, procedure or treatment (including referrals to other care providers), practices may manage the associated risks by, for example, recording the refusal in the patient's health record, and recording an explanation of the action taken.

Consider documenting in the patient's health record any indication that the patient intends to seek another clinical opinion, and encourage patients to notify their practitioner when they are choosing to follow another healthcare provider's management advice so that the practitioner can discuss any potential risks of this decision.

*Deciding to no longer treat a patient*

If a practitioner no longer considers it appropriate to treat a particular patient, the steps taken to assist the patient with receiving ongoing care need to be recorded in the patient's health record.

*Second opinions*

If a patient seeks another clinical opinion, document the decision in the patient's health record, along with the actions taken by the practitioner and any referrals to other care providers.

*Dealing with distressed patients*

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

*Ethical dilemmas*

Practices need a system to document situations that present ethical dilemmas and the actions taken.

Practices may also provide ongoing training to support practitioners, and encourage staff to participate in reflective discussions about situations that present ethical dilemmas.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*Policies and procedures*

- Maintain a cultural safety policy so that your practice team knows they are required to provide care that is respectful of a person's culture and beliefs, and that is free from discrimination.
- Maintain a patient rights policy.
- Maintain a policy about ceasing a patient's care.

- Maintain policies and processes relating to patient records.
- Maintain an anti-discrimination policy.
- Maintain a policy and procedure manual.

*Additional services and facilities*

- Provide a transport service for patients who are otherwise unable to travel to the practice.
- Have separate entry and waiting rooms for men and women, if culturally appropriate.
- Provide a room where distressed patients have privacy.
- Provide gender-appropriate staff members to act as chaperones.

*Patient responses*

- Keep appropriate documentation in the patient's notes (e.g. refusal of treatment, choosing to seek other opinions).
- Record patient feedback, including complaints.
- Provide referrals to other healthcare providers.

*Staff*

- Discuss cultural safety in recruitment interviews.
- Provide cultural safety training for staff members and keep records of the training in the staff training register.

*Community consultation*

- Record community consultation that you participate in.

## Criterion 3.2 - Presence of a third party during a consultation

### Indicator

► A. Our practice team obtains and documents the prior consent of a patient to have a third party present during the consultation.

Stakeholder question: the requirement to document the present of a third party is a change from the 4th edition. What are stakeholders' views?

### Why this is important

Ensuring that prior consent for the presence of a third during a consultation is obtained means that the practice is complying with privacy legislation. Documenting the presence of a third party in the patient health record also means that there is an accurate record of events.

### Meeting this Criterion

*Prior consent to the presence of a third party arranged by the practice*

Before the consultation commences, patients must be asked to provide consent to have a third party present during the consultation. Third parties can be interpreters, carers, relatives, friends, medical, allied health or nursing students on placement, registrars, and chaperones.

If a patient has previously given prior consent to have a third party present, it is good practice to check that the consent remains valid at the beginning of the consultation.

If an undergraduate student, practice nurse or other health professional is to be present during the consultation (whether they are going to observe, interview, or examine), the practice must seek the patient's permission when the patient makes an appointment, or, failing that, when they arrive at reception.

It is not acceptable to ask permission in the consulting room, as some patients may feel pressured in the presence of the third party, and agree even if they would prefer not to. Even when prior consent has been given, the practitioner should confirm at the beginning of the consultation that the patient has consented to the presence of any third party.

Practitioners should record the patient's consent and the name of the third party in the consultation notes. It may be sufficient to record the initials of a medical student in the notes, if the practice can later provide the student's full name.

*Chaperones*

In some circumstances, the patient or practitioner may feel more comfortable if there is a chaperone present during an examination. If the practitioner requests the presence of a third party for this purpose, they must obtain prior consent from the patient.

*Third parties who accompany the patient*

Even when a patient is accompanied to the practice by a third person (such as a family member or carer), you must receive the patient's consent to the presence of that person in the consultation, and record this consent and the name of the third party in the consultation notes.

*Patients not able to provide consent*

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

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a policy about the presence of a third party in consultations.
- Include information about the third-party policy in the staff induction manual.
- Place signs in the waiting room when medical or nursing students are at the practice and observing consultations.
- Document a patient's verbal consent in the patient's health records.

## Criterion 3.3 - Access to services

### Indicator

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

### Why this is important

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

### Meeting this Criterion

*Good physical access is important*

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

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

*Accessible parking*

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

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Through the use of direct observation.

# Preface to draft of Standard 4: Health promotion and preventive activities

## Indicator in this Standard

The Criterion in the 4th edition Standards that covers Health Promotion was not mandatory, but it is in this edition.

## New Indicator

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 4.1 ► A | Practices are required to provide information on health promotion, illness prevention and preventive | Criterion 1.3.1 in the 4th edition did not have Indicators. This Indicator has been created in the 5th edition. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 4.1 – Health promotion and preventive care | ► A. Our patients receive information on health promotion, illness prevention, and preventive care. | Criterion 1.3.1 |

# Standard 4: Health promotion and preventive activities

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

Health promotion is the process of enabling people to increase their control over, and improve their health. It extends beyond influencing an individual's behaviour to include a wide range of social and environmental interventions[9], such as education programs, and changes to legislation and policies.

Health promotion is distinct from the education and information that practitioners use to support their diagnosis and choice of treatment.

Health professionals can deliver health promotion and can reinforce this in various ways, such as in written materials, in the practice's 'on-hold' telephone messages, and in education clinics that help people self-manage their chronic diseases.

For most Australians, general practices are the primary entry point to healthcare, and therefore have a crucial role in promoting health, illness prevention, and preventive care. For example, a patient can visit their practitioner to have regular check-ups, be screened for specific diseases, identify risk factors for disease, and discuss ways of achieving a healthy lifestyle.

Preventive healthcare consists of measures taken to prevent diseases, as opposed to treating them[10], based on relevant current clinical and other guidelines. According to 2013 data from the Australian Institute of Health and Welfare, the leading cause of preventable deaths in Australia is coronary heart disease[11].

An holistic approach to care encourages a practice to consider and respond to each patient's individual circumstances when providing health promotion, preventive care, early detection and intervention.

Practices can also coordinate with other health professionals and agencies to undertake health promotion and achieve preventive care objectives.

## Criterion 4.1 - Health promotion and preventive care

### Indicator

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

### Why this is important

Health promotion focuses on:

- prevention, promotion and protection rather than on treatment
- populations rather than individuals
- factors and behaviours that cause illness and injury rather than the illness and injury itself[12].

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

### Meeting this Criterion

*Providing information to patients*

Practitioners can verbally provide education about health promotion and preventive care during a consultation.

By providing information in documents such as brochures and fact sheets (paper-based and on your website), and referring patients to other reliable websites, you will encourage patients to select information on health issues that may affect or interest them.

You can also tailor information so that it caters for your patient population[13]. For example:

- you can modify or add to the information in documents, such as brochures and pamphlets, that you receive from health departments, non-government organisations, health promotion programs, and local community organisations and support and self-help groups
- you can provide information in other languages and other formats for patients with low English proficiency (e.g. in plain English, in pictures, in videos)
- you can provide culturally appropriate material (e.g. for Aboriginal and Torres Strait Islander patients).

*Providing a systematic approach to preventive care*

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

- conducting patient prevention surveys
- maintaining a disease register
- establishing a recall and reminder system

- maintaining a directory of local services that offer programs to help patients modify their lifestyle.

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

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

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

*Managing patient information to support preventive care*

When you collect information about a patient's health, including for example the patient's family's medical history, record the information in the patient's health summary and health record. A complete health summary that includes the patient's main health issues means you can provide better care and pass on appropriate information when patients seek care from other health professionals.

Some information may also be transferred to national state-based registers (e.g. immunisation data, cervical screening, and familial cancer registries) in order to improve care. If your practice participates in national registers, you need to:

- obtain consent from each patient to have their health information sent to a register
- inform patients that they can opt out of such registers
- remind patients when they need to have another screening, and not rely on patients receiving reminders from these registries.

# Preface to draft of Standard 5: Clinical management of health issues

## Indicators in this Standard

The Criterion in the 4th edition Standards that covers Diagnosis and Management of Health Issues was not mandatory, but in recognition of the importance of clinical autonomy, the new Indicator is mandatory.

## New Indicator

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 5.2 ► A | A practice can exercise clinical autonomy in decisions that affect clinical care | This was not mandatory in the 4th edition Standards, but now is mandatory. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 5.1 – Diagnosis and management of health issues | ► A. Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients. | 1.4.1 ► A |
| | ► B. Our clinical team supports consistency of diagnosis and management of our patients. | 1.4.1 ► B |
| 5.2 – Clinical autonomy for practitioners | ► A. Our clinical team can exercise autonomy in decisions that affect clinical care. | Criterion 1.4.2 |

# Standard 5: Clinical management of health issues

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

Contemporary practice is based on the best available evidence from Australia's current primary healthcare systems. This recognises that, in the absence of properly conducted clinical trials or other evidence of equal or greater reliability, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at the time.

It is important that practitioners can exercise clinical autonomy in decisions that affect clinical care. It is important that practices provide access to up to date clinical information and have appropriate support processes in place.

## Criterion 5.1 - Diagnosis and management of health issues

### Indicators

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

► B. Our clinical team supports consistent diagnosis and management of our patients.

### Why this is important

Clinical practice guidelines provide important recommendations for clinical care and should be accessible when providing healthcare, so that your practice can achieve consistent and tailored health care, according to community and patient demographics.

Consistently applying clinical guidelines helps to:

- provide consistency in diagnosis and management of health issues and minimise variation of care between clinicians
- provide continuity of care for each patient
- give the patient clear and consistent messages about their health issues and treatment.

In addition, patients value consistency in the quality of treatment and advice given by different practitioners in your practice.

### Meeting this Criterion

Practices need to make sure that clinical practices guidelines are current and accessible, whether online or paper-based.

Good communication between members of the clinical team can help to ensure a consistent approach to clinical care. While face-to-face meetings of the clinical team are preferred, communication tools such as message systems and notice boards can be useful to raise and address clinical issues.

### Examples of how a practice might choose to meet this Criterion:

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*Health records*

- Keep well-documented health records, treatment and care plans in each patient's health records.
- Update electronic health record software so that you always have the latest version.

*Clinical team meetings*

- Have regular clinical team meetings and document the topics of discussion, and the decisions made.
- Keep records of clinical team meetings where you discuss the use of clinical guidelines.

*Practice team's access to information*

- Have current clinical guidelines available in electronic and/or hard copy for staff to access.
- Ensure that staff members can find and use resources and guidelines.
- Ensure that staff members know what evidence-based resources and guidelines they use regularly.
- Establish and maintain a system that staff members can use to pass on messages to other staff members (e.g. a communication book, internal mail, and an email system).
- Ensure that staff members know how to discuss the care of patients with other staff members, while maintaining patient confidentiality.

*Culturally safe care*

- Ensure that staff members know how to help patients feel culturally safe in the service.
- Ensure that clinical staff members know what specific clinical guidelines the practice uses for patients who identify as an Aboriginal or Torres Strait Islander person, how to access them and how to use them to support evidence-based practice, including in the prevention and management of chronic diseases.

## Criterion 5.2 - Clinical autonomy for practitioners

### Indicator

► A. Our clinical team can exercise autonomy in decisions that affect clinical care.

### Why this is important

Professional autonomy and clinical independence are essential components of high quality care where clinically appropriate recommendations are in the best interests of the patient.

The intent of this Criterion is that, instead of having decisions imposed on them, the practitioner is free to provide the best level of care for each individual patient, based on their clinical judgement and current clinical and other guidelines.

All members of the clinical team must (within the boundaries of their knowledge, skills and competence) comply with the professional and ethical obligations required by law, their relevant professional organisation, and their practice. Further information on relevant codes of conduct is available at www.ahpra.gov.au/ . Regular and ongoing professional development helps to maintain a practitioner's clinical knowledge, skills and competence.

### Meeting this Criterion

Practitioners are free, within the parameters of evidence-based care and their credentials, to determine:

- the appropriate clinical care of each patient
- the specialists and other health professionals to whom they refer patients
- the pathology, diagnostic imaging, or other investigations they order and the provider they use
- how and when to schedule follow-up appointments with each patient.

# Preface to draft of Standard 6: Continuity of care

## Indicators in this Standard

The Standard on Continuity of Care contains very similar information to the 4th edition Standards. There have been no substantial changes.

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 6.1 – Requesting a preferred practitioner | ► A. Our patients can request their preferred practitioner. | 1.5.1 ► A |
| 6.2 – Clinical handover | ► A. Our practice manages the handover of patient care. | 1.5.2 ► A |
| 6.3 – Continuity of care and the therapeutic relationship | ► A. Our practice team transfers care to another practitioner (in our practice or in another practice) when a patient wants to cease receiving care from the practitioner or the practice. | 2.1.1 ► D |
| | ► B. Our practice facilitates the transfer of care of a patient when there has been a breakdown in the practitioner-patient relationship. | 2.1.1 ► E |
| 6.4 – Contingency plan | ► A. Our practice has a contingency plan for adverse and unexpected events, such as natural disasters, pandemic diseases, or an unplanned absence of clinical staff. | 3.1.2 ► E |

# Standard 6: Continuity of care

*Our practice provides continuity of care for its patients.*

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

There are three types of continuity:

- **informational continuity** (the flow of information from one healthcare event/consultation to others, particularly via documentation, handovers, and reviews of notes from previous consultations)
- **management continuity** (the consistency of care provided by multiple people involved in a patient's care)
- **relational continuity** (the sense of connection between the patient and their practitioner[14]).

Continuity of care is achieved when there is:

- a stable care environment
- good communication that builds a responsible practitioner-patient relationship
- a shared goal of achieving an improvement in the patient's overall health[15].

## Criterion 6.1 - Requesting a preferred practitioner

### Indicators

► A. Our patients can request their preferred practitioner.

### Why this is important

Consistently seeing the same professional has been shown to reduce visits to emergency departments and preventable hospital admissions[16].

Research also shows that continuity of care contributes to an overall lowering of costs, increased patient satisfaction and greater efficiency in investigating health problems[17].

### Meeting this Criterion

Keep patient health records that show patients attending the practice over time.

Have a system for ensuring that patients can see the practitioner of their choice, even if you do not have a formal, written appointment.

If you are providing Aboriginal and Torres Strait Islander medical services, continuity of care may involve a wider set of relationships, extending from the patient to the practitioner, Aboriginal health workers, and practice nurses.

*Courtesy notifications*

When a practitioner leaves a practice, it is courtesy to notify the practitioner's regular patients and, if appropriate, inform them about how they can access their health information if required.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Have individual appointment books for practitioners, nurses, allied health and Aboriginal health workers.
- Ensure that health records show ongoing care provided by a particular practitioner, where possible.
- If a practitioner is on leave, display notices in the waiting room that include the date the practitioner is due to return.

## Criterion 6.2 - Clinical handover

### Indicator

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

### Why this is important

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

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

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

It can also result in legal action.

### Meeting this Criterion

Clinical handover needs to occur whenever there is a crossover of care by different providers. For example, when:

- a practitioner is covering for a fellow practitioner who is on leave or is unexpectedly absent
- a practitioner is covering for a part-time colleague
- a practitioner is handing over care to another health professional, such as a practice nurse, physiotherapist, podiatrist, or psychologist
- a practitioner is referring a patient to a service outside the practice
- there is a shared care arrangement (eg, a team is caring for a patient with mental health problems).

Whenever clinical handovers occur due to the absence of a patient's regular practitioner, practices should ensure that, whether the handover is external or internal, the patient is:

- involved in the decision, particularly when they consult with more than one practitioner in the practice or a specialist or other care provider
- aware of who will take over their care.

Clinical handovers can be effectively completed face-to-face, via written information, via telephone and by electronic means, such as emails.

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

- the safe clinical handover when practices use eHealth solutions. For example, the use of healthcare identifiers that uniquely identify the individual throughout their time as a patient at the practice
- the process for giving and receiving information relating to home visits, after-hours services, hospital discharges, and care provided by other healthcare professionals such as specialists
- how to record the clinical handover in the consultation notes
- how to report near misses, errors and failures in clinical handover procedures.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*Referral letters*

- Use a clinical software program to generate referral letters that are automatically populated with necessary information.
- Keep copies of referral letters to allied health services, other practitioners, specialists and ambulance staff in the patient's health files.

*Handovers*

- Have a written policy explaining how to conduct internal and external handovers, including handovers to locum practitioners.
- Aim for face-to-face handovers, where possible.
- Have a standard form to be used for ambulance transfers.

*Formal arrangements*

- Maintain service-level agreements with medical deputising services and after-hours cooperative arrangements, clearly setting out the responsibilities of all parties.
- Have a shared-care arrangement where appropriate (for example, for a patient with mental health problems).

*Lapses and mistakes*

- Keep a register of handover lapses and mistakes.

- Keep records documenting any breakdowns in the clinical handover system that were identified and addressed.

## Criterion 6.3 - Continuity of care and the practitioner-patient relationship

### Indicators

► A. Our practice team transfers care to another practitioner (in our practice or in another practice) when a patient wants to cease receiving care from the practitioner or the practice.

► B. Our practice facilitates the transfer of care of a patient when there has been a breakdown in the practitioner-patient relationship.

### Why this is important

Healthcare systems that focus on primary healthcare have lower use of hospitals and better health outcomes, compared to systems that focus on specialist care[18].

Whether the patient chooses to see another practitioner at your practice or another practice, you need to have a system that ensures that the patient receives continuous and coordinated primary care.

### Meeting this Criterion

*Patient requests for transfer of care*

When a patient requests to be transferred to the care of a practitioner in another practice:

- a copy of the patient's health information must be transferred to the other practice in a timely manner
- your practice must comply with all requirements of the state or territory legislation governing the transfer of patient health information.

*Practitioner requests for transfer of care*

Practitioners have the right to discontinue treatment of a patient, especially when the practitioner thinks they can no longer give the patient optimal care, or when practitioner no longer considers it appropriate to treat the patient, (e.g. when a patient has behaved in a threatening or violent manner, or where there has been a significant breakdown in the practitioner-patient relationship).

When this happens, the practice should have a documented process to be followed by practice staff if the patient makes any subsequent contact with the practice.

However, there is still a professional and ethical obligation to provide emergency care to that patient, and in rural and remote areas, it may be difficult for a practice to uphold a decision to discontinue the treatment of a patient.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a policy about ceasing a patient's care.
- In the patient's notes, record details of the patient's or practitioner's decision to cease receiving or providing care, and action taken.
- Provide referrals to other healthcare providers

## Criterion 6.4 - Contingency plan

### Indicator

► A. Our practice has a contingency plan for adverse and unexpected events, such as natural disasters, pandemic diseases, or an unplanned absence of clinical staff.

### Why this is important

In an emergency, the demand for healthcare services generally increases, especially in the event of a pandemic[19], so it is crucial that your practice can continue to provide services during this time.

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

### Meeting this Criterion

In an emergency, practices may experience:

*Patients*

- increased demand for services
- increased number of patients presenting with injuries or highly infectious symptoms.

*Infrastructure and systems*

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

*Supplies and services*

- loss of critical equipment and supplies
- loss of or disruption to power supply
- loss or contamination of water supply.

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

- documenting an emergency response plan
- appointing an emergency management coordinator

- undertaking local and other research to identify, for example, local emergency services, the local geography, and previous events that have affected the community
- providing staff with relevant education and training
- testing components of the plan once a year
- reviewing, monitoring and updating the plan every three months
- keeping the emergency kit fully stocked.

The emergency response plan could contain:

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

# Preface to draft of Standard 7: Information management

## Indicators in this Standard

Indicators that relate to Information Management and appeared in different sections of the 4th edition Standards have been brought together. These Indicators address the structures, systems and processes to support how practices manage patient information.

## New Indicator

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 7.4 ► H | Practices are increasingly using electronic forms of communication to convey information about their services to the public and their patients, and therefore need an email and social media policy. | During the Initial Consultation Period, this was identified as a gap in the 4th edition Standards. |

## Mapping to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 7.1 – Patient identification | ► A. Our practice uses three approved patient identifiers to correctly identify patients and their clinical information. | 3.1.4 ► A |
| 7.2 – Medical record systems | ► A. Where our practice is using an active hybrid medical record system, a record of each consultation/interaction is made in each system, and that record includes where the clinical notes are recorded. | 1.7.1 ► B |
| 7.3 – Confidentiality and privacy of health information | ► A. Our patients are informed of how our practice manages their confidentiality and personal health information. | 4.2.1 ► D |
| | ► B. Only appropriate team members can access our patient health records. | 4.2.1 ► B |
| | ► C. Our patients are informed of the processes we follow to provide them with access to their health information. | 4.2.1 ► C |
| | ► D. In response to valid requests, our practice transfers relevant patient health information in a timely, authorised secure manner. | 4.2.1 ► E<br>4.2.1 ► F |
| | ► E. Our practice transfers identified patient health information to a third party only after we receive informed patient consent. | 4.2.1 ► G |

| | | |
|---|---|---|
| 7.4 – Information security | ► A. Our practice has a team member who has primary responsibility for the electronic systems and computer security. | 4.2.2 ► D |
| | ► B. Our practice does not store or temporarily leave the personal health information of patients where members of the public could sight or access that information. | 4.2.2 ► A |
| | ► C. Our practice's computers are accessible only via individual passwords that give access to information according to the person's level of authorisation. | 4.2.2 ► B |
| | ► D. Our practice has a business continuity plan relating to the storage of patient health information. | 4.2.2 ► C |
| | ► E. Our practice securely transfers electronic patient health information. | 4.2.2 ► F |
| | ► F. Our practice has appropriate procedures for the storage, retention and destruction of records. | 4.2.2 ► G |
| | ► G. Only authorised people can access prescription pads, letterhead, administrative records, and other official documents. | 5.1.1 ► E |
| | ► H. Our practice has a policy on the use of email and social media. | New Indicator |

# Standard 7: Information management

*Our practice has an effective system for managing patient information.*

Information management refers to the management, storage and disposal of electronic records, and the technology used to do this. Practices are required to comply with the relevant state and federal legislation relating to the collection, storage, use, disclosure, and disposal of patient's health and personal details.

## Criterion 7.1 – Patient identification

### Indicator

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

### Why this is important

Correct patient identification maintains patient safety and confidentiality. Not identifying a patient correctly can have serious, potentially life threatening consequences for the patient.

Using three approved patient identifiers minimises the risks of misidentifying patients and ensures that a practitioner has the correct patient health record for each consultation. For further information about the importance of correctly identifying patients, go to http://www.rand.org/pubs/monographs/MG753.html .

### Meeting this Criterion

Correct patient identification is necessary when:

- a patient makes an appointment
- a patient presents to the practice for their appointment
- communicating with a patient over the telephone or electronically
- a patient telephones asking for a repeat of a prescription
- collecting and managing information (e.g. scanned documents, x-rays) about a patient that the practice receives.

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

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

A Medicare number is not an approved identifier because it is not unique, and because some people have more than one Medicare number because they are members of more than one family and are on multiple cards. Also, some Australian residents and visitors may not have a Medicare number[5].

*Asking for patient identifiers*

When asking for patient identifiers, practice team members should ask the patient to state their name, date of birth, and address, while remaining mindful of privacy and confidentiality issues. For example, it is not a good idea to repeat the information back to the patient if other patients can hear the details.

A patient could also hand over a form of identification such as their drivers licence so the practice staff can confirm their identity.

It is not appropriate for staff to state the relevant patient identifier information and then ask the patient to confirm it, as it is easy for errors to occur, particularly if the patient is nervous, over-obliging, or has impaired hearing.

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

Communicating clinical information to patients electronically (e.g. via text messages and emails) increases the risk of giving private information to the wrong person, and breaching patient confidentiality.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Use approved patient identifiers.
- Maintain appropriate reception processes to ensure that patients are always correctly identified.
- Use patient health files.
- Keep a prompt sheet at reception to remind staff to ask for approved patient identifiers.

## Criterion 7.2 - Medical record systems

### Indicator

► A. Where our practice is using an active hybrid medical record system, a record of each consultation/interaction is made in each system, and that record includes where the clinical notes are recorded.

### Why this is important

Using an active hybrid medical record system to record patient health information can result in some information being recorded on one system (e.g. a medicines list on a computer) and some information being recorded on another system (e.g. past medical history on hand-written notes).

### Meeting this Criterion

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

If you have an active hybrid medical record system:

- all practitioners in your practice, including locums, must know that there is an active hybrid medical record system
- any practitioner who sees a patient, including locums, must know to look at both systems in order to access all relevant information
- information in both systems must be readily available at all times
- information does not need to be duplicated in both systems, but there must be a clearly visible note in both systems stating that the practice uses a hybrid medical record system and that information is recorded in both files
- you should work towards the electronic recording of at least allergies and medications.

## Criterion 7.3 - Confidentiality and privacy of health information

### Indicators

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

► B. Only appropriate team members can access our patient health records.

► C. Our patients are informed of the processes we follow to provide them with access to their health information.

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

► E. Our practice transfers identified patient health information to a third party only after we receive informed patient consent.

### Why this is important

Privacy of health information is a legislative requirement under *The Privacy Act 1988*.

Practices must collect personal health information and safeguard its confidentiality and privacy in accordance with Australian Privacy Principles (APPs).

Practices are subject to stringent privacy obligations because they provide health services and hold health information. Health information is a subset of personal information and can include any information collected in order to provide a health service, such as:

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

Sometimes details about a person's medical history or other information (such as details of an appointment) can identify the person, even if there is no name attached to that information. This is still considered health information and therefore must be protected in accordance with the *Privacy Act 1988*.

### Meeting this Criterion

Consider and address privacy requirements, how to manage your own and staff member's responsibilities, and the risks associated with keeping health records. This would include reviewing and developing policies about your practice's use of:

- computer systems and IT security
- systems that automatically generate letters

- email to communicate patient information
- social media
- file sharing applications[20].

Your medical defence organisation can provide information and advice about developing strategies to manage these risks.

*A privacy policy*

Document a privacy policy for the management of patient health information, and inform patients of the policy. Your privacy policy, which must address certain legislative requirements, may include:

- the definition of a medical and patient health record
- how the practice collects, uses, and discloses personal information
- how patients can access and correct their health information
- how patients can complain about breaches of privacy, and how the practice will handle the complaint
- whether health information is likely to be disclosed overseas and, if so, where
- how the practice discloses or provides access to patient health records to people or organisations outside the practice
- how the practice uses document automation technologies, particularly to ensure that only the relevant medical information is included in referral letters, particularly when automatically generated
- the processes the practice has regarding direct marketing.

For further information, visit www.oaic.gov.au/ .

*Familiarity with requirements*

As well as being familiar with the APPs, team members need to be familiar with the relevant state/territory privacy and health records legislation. For more information, visit www.oaic.gov.au and your state equivalent.

*The physical layout of your practice*

A carefully designed layout can help to maintain patient privacy and confidentiality. For example, consider:

- Is there adequate sound proofing between internal walls?
- Are there private areas where private conversations can be held?
- Are the computer screens in reception hidden from the view of patients and other visitors?
- Can private and confidential discussions in the reception area be overheard?

**Examples of how a practice might choose to meet this Criterion:**

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a privacy policy and related procedures.
- Maintain a patient health information management policy.
- Maintain a patient health records policy.
- Have staff sign confidentiality agreements and store them in the staff files.

## Criterion 7.4 - Information security

### Indicators

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

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

► C. Our practice's computers are accessible only via individual passwords that give access to information according to the person's level of authorisation.

► D. Our practice has a business continuity plan relating to the storage of patient health information.

► E. Our practice securely transfers electronic patient health information.

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

► G. Only authorised people can access prescription pads, letterhead, administrative records, and other official documents.

► H. Our practice has a policy on the use of email and social media.

### Why this is important

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

If unauthorised people have access to prescription pads, letterhead, administrative records, and other official documents, they can misuse these documents, particularly to gain access to un-prescribed medication.

### Meeting this Criterion

The current edition of the RACGP's *Computer and information security standards* (CISS) contains:

- information about security issues
- recommendations to protect against potential loss of sensitive data
- templates you can use to create a policies and procedures relating to information security and the use of computers.

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

*Designated staff member*

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

- knowing who and when to call for expert advice

- giving contact details of any external expert used by the practice to other relevant staff
- educating staff about data security
- ensuring that staff follow security protocols and policies.

*Restricting access to information, equipment, and stationery*

Patient health records and computer screens should be positioned so that only appropriate members of the practice team can see confidential information. Automated privacy protection tools (such as screen savers) should be used to prevent unauthorised access to computers when they are left unattended (e.g. when a practitioner leaves the consultation room to collect equipment, medication or information).

Install and regularly update antivirus software and appropriate hardware/software firewalls to protect computers and the information stored on them.

Laptops and other portable devices (e.g. personal digital assistants and mobile phones) and the information stored or accessed on them need to be as secure as your practice's desk-top computers and network, particularly because they are potentially more accessible to people outside the practice.

If you have assigned different levels of access to patient health information to different staff members:

- document who has what access
- make sure that people understand the need to keep their computer passwords private.

Securely store all practice stationery so that patients and other non-authorised persons cannot access it.

*Business continuity plan*

If your practice uses computers to store patient health information, you must have a reliable backup system and a contingency plan as part of the business continuity plan to protect information in the event of an adverse incident, such as a system crash or power failure.

The practice's business continuity plan needs to include:

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

*Transfer of health information*

Follow the processes in the APPs to correctly transfer patient health information to others (e.g. other health service providers, or in response to third party requests).

Contact your insurers if you have any concerns about third party requests for the transfer of patient health information.

*Replacing IT equipment*

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

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

*Destroying information*

In line with relevant state and territory legislation covering the retention of patient health information, you may consider destroying out-dated test results that no longer have clinical relevance.

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

You may also want to consult your medical defence organisation when determining the practice's policy regarding destruction of out-dated test results.

*Email and social media policy*

If your practice uses email and social media, you should have an email and social media policy. Staff must be familiar with the policy, comply with the policy, and understand the risks associated with using email and social media. The policy may include information about:

- maintaining passwords and keeping them secure
- processes to verify and update email addresses
- obtaining patient consent to communicate with them via email.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

*Policies and procedures, and training*

- Maintain a privacy and confidentiality policy and related procedures.

- Maintain an email and social media policy and related procedures.
- Maintain an information technology policy and related procedures.
- Undertake regular privacy and eHealth system training.

*Restrict access to information*

- Have a physical layout that means patient health information is kept from the view of members of the public.
- Ensure appropriate access is provided to each role, based on job descriptions.
- Maintain security of individual staff passwords.
- Use screensavers.
- Maintain data encryption via a public key infrastructure.
- Operate secure messaging so that only nominated people can access the communication.
- Use a shredder and/or have a secure document-shredding agreement with a reputable provider.

*Ensure business continuity*

- Operate a server backup log.
- Store backups offsite in a secure location.
- Maintain up-to-date antivirus protection and hardware/software firewalls.
- Maintain and test a business continuity plan for information recovery.
- Maintain an emergency generator.

*Protect mobile devices and the information stored on them*

- Maintain a logout register for laptops and mobile phones.
- Maintain a secure area for storage of portable devices.

# Preface to draft of Standard 8: Patient health records

## Indicators in this Standard

The Standard on Patient Health Records contains very similar information to the corresponding section in the 4th edition Standards. There have been no substantial changes.

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 8.1 – Patient health records | ► A. Our practice has an individual patient health record for each patient containing all health information held by our practice. | 1.7.1 ► A |
| | ► B. Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact information. | 1.7.1 ► C |
| | | 1.7.1 ► D |
| | ► C. Our patient health records include records of consultations (including consultations outside normal opening hours, and home or other visits), and telephone and electronic communications. | 1.7.3 ► A |
| | ► D. Our practice records clinical related communications in our patient health records. | 1.1.2 ► B |
| | ► E. Our patient health records show evidence that problems raised in previous consultations are followed up. | 1.7.3 ► B |
| | ► F. Our practice routinely records the Aboriginal and Torres Strait Islander status of our patients in their patient health record. | 1.7.1 ► E |
| | G. Our practice routinely records the cultural backgrounds of our patients in their patient health record. | 1.7.1 F |
| | ►H. Our patient health records contain each patient's lifestyle risk factors. | 1.7.3 ► C |

# Standard 8: Patient health records

*Our patient health records contain an accurate and comprehensive record of all interactions with our patients.*

Maintaining accurate and comprehensive patient health records is crucial in providing patients with continuity of high quality and safe care.

The patient health record is information held about a patient, in 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
- legal and occupational health and safety reports[14].

## Criterion 8.1 - Patient health records

### Indicators

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

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

► C. Our patient health records include records of consultations (including consultations outside normal opening hours, and home or other visits), and telephone and electronic communications.

► D. Our practice records clinical related communications in our patient health records.

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

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

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

►H. Our patient health records contain each patient's lifestyle risk factors.

### Why this is important

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

### Meeting this Criterion

*System to store patient health information*

Practices need to have an effective system to store patient's health information in a dedicated patient health record. In addition to containing clinical information, the patient health record may also contain other relevant information, such as details of personal injury insurance claims, and legal reports.

*Patient identification*

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

*Collecting information from patients*

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

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

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

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

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

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

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

You can collect this information as part of a patient questionnaire.

*Collecting information over time*

Because information about a patient is gathered over more than one consultation, it is important that information about clinically significant, separate events in a patient's life and the care provided are recorded and managed so that the information is readily accessible.

One way of doing this is to regularly update each patient's health summary.

Clinically significant information may include the patient's health needs and goals, preventive health activities, medical conditions, and their preferences and values. Having this information contributes to your ability to provide care that is tailored to the patient's needs and circumstances.

*Content of the patient health record*

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

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

Use consistent coding of diagnoses, when available, in the consultation notes to support continuous improvement of clinical care and patient outcomes.

Routinely record patients' height, weight and blood pressure at intervals of their choosing. This is particularly useful to identify significant or unexplained weight loss or gain that may indicate a disease, and to assess children's growth and development.

Because many people now take complementary and over-the-counter medicines that may react adversely with conventional medicines, you should document the use of complementary medicines (whether prescribed by a member of the clinical team or self-reported by the patient) as you would other medicines.

Consultation notes can contain the following information:

- date of consultation

- who conducted the consultation (e.g. by initial in the notes, or by audit trail in an electronic record)
- method of communication (e.g. face-to-face, email, telephone or other electronic means)
- the presence of a third party (e.g. an interpreter, carer, medical student)
- patient's reason for consultation
- relevant clinical findings
- diagnosis
- recommended management plan and, where appropriate, expected process of review
- any medicines prescribed for the patient (include the name, strength, directions for use, dose frequency, number of repeats, and date on which the patient started/ceased/changed the medication)
- complementary medicines the patient takes
- any relevant preventive care information collected, such as currency of immunisations, blood pressure, height and weight (body mass index)
- any relevant lifestyle risk factors such as smoking, nutrition, alcohol, and physical activity
- any referrals to other healthcare providers or health services
- any special advice or other instructions given to the patient.

*Retaining health records of active and inactive patients*

Your practice must keep and securely store health records of active and inactive patients. An inactive patient is generally defined as a patient who has not attended the practice/service more than twice in the past two years.

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

To protect against the possibility of superseded versions of medical software not being able to run properly on more modern hardware and operating systems, consider updating software regularly (so that files do not become incompatible), and retaining older hardware and operating systems so that you can store and retrieve older records.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain individual health records for each patient.
- Ensure handwritten records are legible.
- Ensure documents scanned into electronic health records are clear and can be easily read.

- Ensure patient health records show
  - the patient's preferred emergency contact (who may or may not be the patient's next of kin)
  - identification of Aboriginal and/or Torres Strait Islander status for all patients.
- Maintain up-to-date new and current patient forms.
- During staff inductions, cover policies and processed relating to patient health records.
- Maintain one or more policy and procedures manuals.
- Include a copy of any emails sent to a patient in their patient health record.

# Preface to draft of Standard 9: Education and training of practice staff

## Indicators in this Standard

Based on feedback from stakeholders from the Initial Consultation Phase, the Indicators in this Standard have changed significantly from the 4th edition. Some the Indicators in the 4th edition have been merged to make it easier for practices to demonstrate that they are meeting the intent of the Criterion.

## New Indicator

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 9.1 ► B | Ensuring the practice team is trained to safely use the practice's equipment. | Included in response to feedback from the International Society for Quality in Health Care (ISQua) who identified this as a gap in the previous edition. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition and Indicator |
|---|---|---|
| 9.1 – Qualifications and training of healthcare practitioners | ► A. Members of our clinical team:<br>▪ have current national registration where applicable<br>▪ have appropriate credentialing and competence<br>▪ actively participate in continuing professional development (CPD) relevant to their position in accordance with their legal and/or professional organisation's requirements<br>▪ have undertaken training in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of their professional organisation or at least every 3 years. | 3.2.1 ► A<br>3.2.1 ► B<br>3.2.1 ► C<br>3.2.1 ► D |
| | ► B. Our clinical team is trained to use the practice's equipment. | New Indicator |
| 9.2 – Qualifications and training of | ► A. Our non-clinical staff undertake training appropriate to their role and our patient population. | 3.2.2 ► A<br>3.2.2 ► B<br>3.2.3 ► A |

| | | |
|---|---|---|
| non-clinical staff | ► B. Our non-clinical staff undertake CPR training at least every three years. | 3.2.2 ► C<br>3.2.3 ► B |

# Standard 9: Education and training of practice staff

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

This Standard focuses on the systems that the practice uses to:

- verify employees' qualifications
- ensure that employees receive continuing education and training that is appropriate for their role.

## Criterion 9.1 - Qualifications and training of healthcare practitioners

### Indicators

► A. Members of our clinical team:

- have current national registration where applicable
- have appropriate credentialing and competence
- actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and/or professional organisation's requirements
- have undertaken training in cardiopulmonary resuscitation (CPR), in accordance with the recommendations of their professional organisation, or at least every 3 years.

► B. Our clinical team is trained to use the practice's equipment.

### Why this is important

Ensuring that all healthcare practitioners are suitably qualified reduces the risk of medical errors and ensures that your practice provides patients with safe, high quality care.

All healthcare practitioners:

- must be suitably qualified and trained
- must maintain the necessary knowledge and skills that enable them to provide good clinical care
- are expected to comply with the professional development requirements of the relevant professional organisation, whether or not the individual is a member of the organisation
- are expected to comply with the code of conduct of the relevant professional organisation, whether or not the individual is a member of the organisation
- must work within their scope of practice and competencies.

### Meeting this Criterion

Training can be gained by participating in external courses or 'on the job' training at the practice.

*Cardiopulmonary resuscitation training*

All healthcare practitioners should be trained in CPR so that they can help in emergency situations.

CPR training may be conducted by medical staff, preferably medical staff who have a current CPR instructor's certificate that complies with Australian Resuscitation Council (ARC) guidelines on instructor competencies. CPR training can also be conducted by an accredited training provider.

CPR training that is completed solely online does not meet the requirements of the Australian Resuscitation Council (ARC) that trainees physically demonstrate their skills at the completion of the CPR course.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Annually update employee files for each practitioner with current registration records.
- Keep continuous professional development (CPD) records.
- Conduct annual performance planning and store documents that identify training needs and training completed.
- Keep training logs that record training that practitioners have completed.
- Keep a training and development calendar.

## Criterion 9.2 – Qualifications and training of non-clinical staff

### Indicators

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

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

### Why this is important

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

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

### Meeting this Criterion

*Training relevant to the role*

Training may include formal courses in areas such as:

- practice procedure
- use of technology (hardware, systems, and software)
- first aid
- medical terminology
- medical practice reception
- Aboriginal and Torres Strait Islander health
- cross-cultural engagement
- safe operation of specific equipment.

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

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

*Cardiopulmonary resuscitation training*

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

CPR training for administrative staff may be conducted by medical staff or other clinical staff who feel competent to train colleagues, preferably medical or other clinical staff who have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies. CPR training for administrative staff can also be conducted by an accredited training provider.

CPR training that is completed solely online does not meet ARC requirements that trainees physically demonstrate their skills at the completion of the CPR course.

**Examples of how a practice might choose to meet this Criterion:**

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Record staff qualifications in employee files.
- Conduct annual performance planning and store documents that identify training needs and training completed.
- Keep training logs that record training that non-clinical staff have completed.
- Keep a training and development calendar.
- Mention required staff qualifications in job descriptions.

# Preface to draft of Standard 10: Practice facilities

## Indicators in this Standard

This contains very similar information to the corresponding Standard in the 4th edition Standards.

There have been no substantial changes.

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 10.1 – Practice facilities | ► A. Our practice facilities are fit for purpose. | 5.1.1 ► A |
| | | 5.1.3 ► A |
| | ► B. Our practice ensures that all patient consultations take place in a dedicated consultation or examination space. | 5.1.1 ► B |
| | ► C. Our consultation spaces permit patient privacy and confidentiality. | 5.1.2 ► A |
| | | 5.1.2 ► B |
| | ► D. Our practice has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time. | 5.1.1 ► C |
| | | 5.1.1 H |
| | ► E. Our practice has accessible toilets and hand-cleaning facilities. | 5.1.1 ► D |
| | ► F. Our practice is visibly clean. | 5.3.3 ► E |

# Standard 10: Practice facilities

*Our practice facilities are fit for purpose.*

A practice facility is the environment in which the practice operates, and includes the building and the equipment the practice uses to provide clinical care to patients.

## Criterion 10.1 - Practice facilities

### Indicators

► A. Our practice facilities are fit for purpose.

► B. Our practice ensures that all patient consultations take place in a dedicated consultation or examination space.

► C. Our consultation spaces permit patient privacy and confidentiality.

► D. Our practice has a waiting area that accommodates the usual number of patients and other people who would be waiting at any given time.

► E. Our practice has accessible toilets and hand-cleaning facilities.

► F. Our practice is visibly clean.

### Why this is important

Without appropriate practice facilities, patient care can be compromised and patient safety may be put at risk. Therefore, facilities must provide an environment that enables staff to perform their duties safely and effectively.

### Meeting this Criterion

*Design and layout*

The facilities need to be fit for purpose, and satisfy requirements relating to privacy, security, design and layout, consultation spaces, and access to facilities such as toilets.

The layout of the practice should give reception staff clear sight of the waiting areas so that they can:

- see and monitor waiting patients
- identify medical emergencies and reprioritise appointments accordingly.

Consultation rooms should be maintained at a temperature that is comfortable for a patient who needs to undress for an examination.

*Privacy and patient dignity*

The dignity of the patient should be protected by the use of appropriate visual and auditory privacy.

Visual privacy ensures that others cannot see the patient during the consultation and that they can undress in private, and be covered as much as possible during an examination. This can be achieved by:

- practitioners using a gown or sheet to cover patients,
- practitioners leaving the room while a patient is undressing and dressing, or providing an adequate curtain or screen.

Auditory privacy ensures that other people cannot overhear a consultation. This can be achieved by:

- having solid doors (instead of doors with paper cores)
- using ‘draught-proofing’ tape around door frames and a draught excluder at the base of doors
- playing appropriate background music to mask conversations between staff members and between staff and patients.

In areas of a practice where auditory privacy is not possible, such as nurses’ treatment bays, the facility should provide a private room for confidential conversations.

*Location of toilets and hand-cleaning facilities*

Ideally, toilets should be located within the practice, but if this is not possible, they must be very close to the practice. Toilets need to be easily accessible and well signposted.

There should be separate toilets for staff and patients.

Washbasins need to be close to the toilets to minimise the possible spread of infection and practitioners, other staff and patients need to be able to access them easily.

*Environmental cleaning*

Your practice should appoint one member of staff who has the primary responsibility for ensuring that appropriate cleaning processes are in place.

If you engage cleaning contractors, you need a written agreement that specifies the cleaning schedule, suitable cleaning products, and areas to be cleaned.

You could also consider having the cleaners record their work in a cleaning log.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- The physical layout includes consulting rooms, toilets, and hand-cleaning facilities.
- Maintain a reliable heating and cooling system.
- Have patient privacy screens.
- Have adequate signage to indicate the location of toilets and other facilities.
- Provide children’s furniture and play equipment.
- Use a written agreement with commercial cleaners.
- Use a cleaning log.

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# Module 2: Quality improvement module

# Preface to draft of Standard 1: Quality improvement

## Indicators in this Standard

Each of the areas covered by these Indicators are all directly related to the implementation of quality improvement activities within the practice, including ensuring that the practice team is engaged with this process.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 1.1 ► C | Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute. | This was included in the explanatory notes of the 4th edition but there was no Indicator. This Indicator has been included in response to that identified gap in the 4th edition Standards. |
| 1.3 B | Quality improvement can encompass activities specifically designed to improve clinical care | This was included in the explanatory notes of the 4th edition but there was no Indicator. This Indicator has been included in response to that identified gap in the 4th edition Standards. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 1.1 – Quality improvement activities | ► A. Our practice has a team member who has the primary responsibility for leading our quality improvement systems and processes. | 4.1.1 ► C<br>3.1.3 ► A |
| | ► B. Our practice team internally shares information about quality improvement and patient safety. | 3.1.3 ► B |
| | ► C. Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems. | New Indicator |
| | ► D. Our practice team can describe areas of our practice that we have improved in the past three years. | 3.1.1 ► A |
| 1.2 – Patient feedback | ► A. Our practice undertakes a formal process at least once every three years to seek and respond to feedback from patients in accordance with the RACGP's *Patient Feedback Guide*. | 2.1.2 ► C |

| | | |
|---|---|---|
| | ► B. In addition to the formal feedback process, our practice seeks and responds to feedback collected from patients, carers and other relevant parties on an ongoing basis. | 2.1.2 ► A |
| | ► C. Our practice can demonstrate how we have analysed and responded to feedback. | 2.1.2 ► D |
| | ► D. Our practice promotes how we have responded to feedback. | 2.1.2 E |
| 1.3 – Improving clinical care | A. Our practice team uses documented standardised clinical terminology. | 1.7.2 C |
| | B. Our practice team undertakes activities aimed at improving clinical practice. | New Indicator |

# Standard 1: Quality improvement

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

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

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

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

All practice staff need to have the opportunity to contribute to the practice's quality improvement activities.

## Criterion 1.1 - Quality improvement activities

### Indicators

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

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

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

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

### Why this is important?

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

Ensuring that practice staff are engaged with the practice's safety and quality systems helps the practice to implement its quality improvement activities.

### Meeting this Criterion

Quality improvement can relate to many areas of a practice, so the collaborative effort of the entire practice team is necessary if improvements in the quality and safety of the care are to be achieved.

Practices should use relevant patient and practice data to determine where quality improvements can be made (e.g. to patient access, to management of chronic disease, to preventive health).

These improvements can be in response to:

- feedback from patients
- feedback from members of the practice team
- an audit of clinical databases
- an analysis of near misses and mistakes.

Quality improvement activities can include:

- changes to the day-to-day operations of the practice, such as changes to
  - scheduling of appointments
  - normal opening hours
  - record keeping practices,
  - how patient complaints are handled
  - systems and processes
- activities specifically designed to improve clinical care or the health of the entire practice population, such as changes to

- rates of immunisation
- how the practice cares for patients with diabetes or hypertension
- the systems used to identify risk factors for illnesses that are particularly prevalent in the practice's local community (such as cardiovascular disease).

For example, your practice could complete an internal assessment of your clinical handover processes by checking with randomly selected referral recipients to determine whether the practice's clinical handover processes are consistently satisfactory, and then make appropriate changes based on the feedback you receive.

*Engaging the practice team*

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

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Identify the team member with responsibility for quality improvement activities in the practice.
- Set aside time during each team meeting to discuss quality improvement systems with your practice team.
- Maintain a quality improvement plan based on a clinical audit completed by staff.
- Keep agenda and minutes for planning meetings where quality improvement activities are discussed.

## Criterion 1.2 - Patient feedback

### Indicators

► A. Our practice undertakes a formal process at least once every three years to seek and respond to feedback from patients in accordance with the RACGP's *Patient Feedback Guide*.

► B. In addition to the formal feedback process, our practice seeks and responds to feedback collected from patients, carers and other relevant parties on an ongoing basis.

► C. Our practice can demonstrate how we have analysed and responded to feedback.

► D. Our practice promotes how we have responded to feedback.

### Why this is important

Collecting and responding to feedback about patient experiences has been shown to improve:

- clinical effectiveness and patient safety
- adherence to recommended medication and treatments
- preventative care such as the use of screening services and immunisations[21].

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

### Meeting this Criterion

You should regularly and rigorously collect feedback from patients so that your response to the feedback leads to meaningful quality improvement.

*Formal scheduled feedback*

At least once every three years, collect formal feedback from patients about their experience of accessing health care at your practice.

You can collect feedback using any of the following methods:

- a questionnaire developed by a commercial company
- a questionnaire developed in accordance with the RACGP's *Toolkit for developing patient feedback questionnaires*
- a practice-specific method that your practice decides upon (e.g. focus groups, interviews) that meets the requirements of the RACGP's *Patient Feedback Guide.*

*Ongoing feedback*

You must also seek feedback from patients on an ongoing basis. For example, you could:

- have short questionnaires focusing on specific areas of interest (e.g. a new service, a change to the waiting areas) available for patients to complete (these could be completed on paper,

via an electronic tablets available at the practice, on-line using a tools such as Survey Monkey)

- send an SMS to patients asking for their thoughts on a specific issue
- keep a suggestion box in the waiting room
- maintain a complaints register
- hold patient forums and information days
- have an electronic tablet at the practice door so patients could quickly rate their visit out of 5 as they leave.

*Encouraging patients to raise concerns*

Encourage patients to raise any concerns with the practice team directly, and attempt to resolve the concerns from within the practice.

*Using patient feedback*

Not every suggestion made by patients will be practical, feasible, or desired. It is up to the practice to decide what feedback will be used, and to prioritise activities based on the feedback.

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

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

Because patients value knowing that their feedback has been respectfully considered and implemented where possible, inform patients of the quality improvement activities that you will implement as a result of the feedback you have received. For example, you could display posters in the waiting area, include relevant information on the practice's website and in your newsletter, and send letters directly to patients.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Use the RACGP patient feedback tool at least once every 3 years to conduct patient surveys and reports

- Provide evidence that you address and discuss issues raised by patients at team meetings, annual planning days and/or strategic planning agendas.
- Communicate how you have responded patient feedback/complaint issues on the practice's website, and/or notice board
- Provide information about how the practice has improved services in response to patient feedback to the local media, where appropriate.

## Criterion 1.3 – Improving clinical care

### Indicators

A. Our practice team uses documented standardised clinical terminology.

B. Our practice team undertakes activities aimed at improving clinical practice.

### Why this is important

Using documented standardised clinical terminology helps practices to collect data that can be used to review clinical practices, which ultimately supports improvements in quality and safety.

Collecting clinical data can help to improve patient care because it can be undertaken as part of quality improvement activities such as: practice audits, Plan, Do, Study, Act (PDSA) cycles; and processes to identify patients with particular medical conditions (e.g. registers for chronic diseases such as diabetes).

### Meeting this Criterion

*Consistent terminology*

Using a nationally recognised coding system is an effective way of making sure that the practice uses clinical terminology consistently, and can be used in chronic disease registers. You can also use a software system that uses drop down boxes so that only pre-defined selections can be made.

Both methods avoid confusion that can result from entering 'free text' descriptions in a patient's medical history.

Coding does not necessarily need to replace details in past medical histories that have been recorded in free text, but can be a useful addition to a past medical history, particularly when there are important details in a patient's past medical history that may be difficult to formally code.

*Clinical audits*

You can undertake a clinical audit in order to improve your clinical practice.

A clinical audit is a planned medical education activity designed to help practitioners systematically review aspects of their own clinical performance against defined best practice guidelines. A clinical audit has two main components:

- an evaluation of the care that an individual practitioner provides
- a quality improvement process.

Research indicates[22] that "audit and feedback is widely used as a strategy to improve professional practice, either on its own or as a component of multifaceted quality improvement interventions", and that "audit and feedback generally leads to small but potentially important improvements in professional practice".

*PDSA cycles*

You could also choose to complete a PDSA cycle. PDSA cycles encourage the individual practitioner or the practice team to implement a planned improvement by breaking it down into small manageable stages, and testing each small change to make sure that things are improving and no effort is wasted before moving to the next stage. It emphasises starting on a small scale and reflecting and building on learning that occurs during each stage. It can be used to quickly and easily test suggested improvements, based on existing ideas and research, or implement practical ideas that have been proven to work elsewhere.

It is a cyclical model because the planned-for benefit is not always achieved after just one stage, so the process can be refined and the cycle repeated.

A PDSA cycle can be undertaken by an individual practitioner, a group of health professionals, and/or a multidisciplinary team. An individual practitioner can complete a PDSA cycle to improve their individual clinical knowledge and skills.

Further information on clinical audits and PDSA cycles is available in the RACGP's *QI&CPD 2014-16 triennium handbook* at https://www.racgp.org.au/download/Documents/QICPD/QICPD-Handbook-updated-April-2014.pdf .

*Other sources of information*

To improve the targeting and use of your prevention activities (e.g. smoking cessation, weight management), you may wish to collect data from other sources, such as:

- your clinical software or paper-based systems about, for example, smoking status
- diabetes register
- private pathology providers that provide, for example, diabetes screening and cervical screening.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Use patient management software to code patient health information.
- Use coded patient health information to audit patient records and compare clinical practice.
- Keep clinical data and reports, including rates of childhood vaccinations, completed adult health checks and updated risk factors.
- Maintain a continuous improvement register.

- Conduct an improvement activity such as a PDSA or clinical audit at least once every three years

# Preface to draft of Standard 2: Clinical indicators

## Indicators in this Standard

Each of these Indicators relate to areas that help practitioners to provide high quality clinical care to their patients.

## Mapping the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 2.1 – Health summaries | ► A. Our active patient health records contain a record of known allergies | 1.7.2 ► A |
| | ► B. Our active patient health records have a current health summary that includes, where appropriate:<br>▪ adverse drug reactions<br>▪ current medicines list<br>▪ current health problems<br>▪ relevant past health history<br>▪ health risk factors (e.g. smoking, nutrition, alcohol and physical activity)<br>▪ immunisations<br>▪ relevant family history<br>▪ relevant social history including cultural background where clinically relevant. | 1.7.2 ► B |
| 2.2 - Safe and quality use of medicines | ► A. Our patients are informed about the purpose, importance, benefits and risks of their medicines. | 5.3.1 ► A |
| | ► B. Our patients are made aware of their own responsibility to comply with treatment plans. | 5.3.1 ► A |
| | ► C. Our clinical team accesses current information on medicines and reviews our prescribing patterns in accordance with best available evidence. | 5.3.1 ► B |
| | ► D. Our clinical team ensures patients and other health providers to whom we refer receive an accurate and current medicines list. | 5.3.1 ► C |
| | ► E. Our clinical team ensures that medicines, samples, and medical consumables are acquired, stored, administered, supplied, and disposed of in accordance with manufacturers' directions and legislative requirements. | 5.3.1 ► D |

# Standard 2: Clinical indicators

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

Having accurate and up-to-date information about patients helps your practice provide safe, high-quality care, and ensure that other healthcare providers to which you refer a patient also provide a suitable standard of care.

Health summaries reduce the risk of inappropriate management, including medicine interactions and adverse side effects (particularly when allergies are recorded).

Having accurate and up-to-date information on medicines enables best practice prescribing.

## Criterion 2.1 - Health summaries

### Indicators

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

► B. Our active patient health records have a current health summary that includes, where appropriate:

- adverse drug reactions
- current medicines list
- current health problems
- relevant past health history
- health risk factors (e.g. smoking, nutrition, alcohol and physical activity)
- immunisations
- relevant family history
- relevant social history, including cultural background where clinically relevant.

### Why this is important

Maintaining clear and accurate medical records is essential if your practice is to provide high quality care[23]. A good health summary helps practitioners, locums, registrars and students to rapidly obtain an overview of all components of the patient's care in order to continue to provide safe and effective care for the patient.

Health summaries:

- reduce the risk of inappropriate management, including medicine interactions and side effects (particularly when allergies are recorded)
- provide a social and family overview that is vital to whole-patient care
- highlight lifestyle problems and risk factors (e.g. smoking, alcohol, nutrition, physical activity status) that can help practitioners with health promotion
- help prevent disease by tracking immunisation and other preventive measures.

### Meeting this Criterion

A patient's health summary should give a practitioner sufficient information to enable them to safely and effectively provide care for the patient.

If a patient has no known allergies, a practitioner should check this with the patient, and then record 'no known allergies' in the patient's health record. If your practice uses a hybrid health record system, you must record the patient's allergy status in the same system that is used for prescription writing.

You may also record:

- aspects of a patient's social history if this might increase their risk of health issues. For example, you might record a patient's Aboriginal or Torres Strait Islander status, refugee status, where they live (e.g. urban, rural, remote), sexuality and gender identity
- recent important events in a patient's life that could affect the patient's preferences, values and the context of the care they require. For example, changes in accommodation, family structure, and employment.

When recording information in a patient's health record, always consider the patient's right to privacy.

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Show active patient health records that include records of known allergies.
- Show active patient health records that include a current health summary.

## Criterion 2.2 - Safe and quality use of medicines

### Indicators

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

► B. Our patients are made aware of their own responsibility to comply with treatment plans.

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

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

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

### Why this is important

Patients must not use medicines, samples, and medical consumables after their expiry dates.

Patients need to understand the rationale for taking medications, and the benefits and risks associated with particular medicines so that they can make informed decisions about their treatment and will be more likely to follow the recommended treatment plan.

Having access to current information about medicines enables practitioners to engage in best practice prescribing.

### Meeting this Criterion

Practitioners need to regularly review the list of a patient's current medications to ensure that the list is up-to-date and that errors are not made when prescribing or referring.

A practitioner should:

- confirm a patient's current medicines list and known allergies at every patient contact and before prescribing or changing treatment.
- remove single use medications, including antibiotics, from a patient's records when they are no longer required.
- use the review of the patient's medicines list to assess the patient's compliance with their medication regime, and identify the need for any further education/support.

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

Practitioners need to be aware of the any complementary medicines the patient is taking, and the potential for side effects and drug interactions with conventional medicines. This information should be noted on letters of referral, including those for hospital admissions.

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

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

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

- Use videos, brochures and posters to inform patients about medicines.
- Keep medicines review documentation in patient health files including information given regarding purpose, importance, benefits, and risks of their medicines.
- Include evidence in patient records that clinical staff have informed patients of their own responsibility to comply with treatment plans.
- Use a current clinical software program (where computers are being used).
- Use current best evidence medicine guidelines in electronic and/or in hardcopy format.
- Keep a current medicines list and referral letters in patient health files.
- Show that medicines, samples, and medical consumables are acquired, stored, administered, supplied, and disposed of in accordance with manufacturers' directions and legislative requirements.
- Maintain an S8 medicines register.

# Preface to draft of Standard 3: Clinical risk management

## Indicators in this Standard

Each of the areas covered in these Indicators supports a practice's implementation of an appropriate clinical risk management system, in order to ensure that quality care continues to be provided.

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 3.1 – Clinical risk management systems | ► A. Our practice monitors, identifies and reports near misses and mistakes in clinical care | 3.1.2 ► B |
| | ► B. Our practice team makes improvements to our clinical risk management systems to prevent near misses and mistakes in clinical care. | 3.1.2 ► C |
| | | 3.1.2 ► D |

# Standard 3: Clinical risk management

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

Practices need to foster a just, open, and supportive culture when considering how to minimise and respond to adverse events and errors. While individual accountability and integrity should be preserved, blaming individual practitioners is not necessarily going to help in identifying problems with systems and processes. A more effective response to errors is to be thoughtful and supportive.

Members of the practice team must know how and to whom to report a near miss, mistake, or unanticipated adverse outcome. Mistakes are errors or adverse events that result in harm, and near misses are incidents that did not cause harm but could have.

All members of the practice team, no matter how junior, should feel empowered to recognise and report these events without fear of recrimination, so that the practice can take necessary action to reduce or eliminate the possibility of a similar event occurring again.

## Criterion 3.1 - Clinical risk management systems

### Indicators

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

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

### Why this is important

Near misses and mistakes in clinical care occur in all health settings.

Systems that practices can use to recognise and analyse near misses and mistakes means they can identify, implement and test solutions to prevent their reoccurrence.

If the practice does not make improvements after identifying a near miss or mistake, patients may be exposed to avoidable adverse outcomes, and practice staff may be exposed to an increased risk of medico-legal action.

### Meeting this Criterion

Most practitioners and practices already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent near misses and mistakes.

You can:

- establish a system so that practitioners talk to trusted peers or supervisors for advice
- use a more formal process that includes conducting practice discussions about what went wrong and how to reduce the likelihood of it happening again
- use structured techniques to analyse the causes of an error and reduce the likelihood of its reoccurrence
- establish a system so that members of the practice team know how and to whom to report a near miss, mistake or unanticipated adverse outcome, and that they can do so without fear of recrimination
- implement a clinical governance framework to help achieve a balance of ‘find it, fix it and confirm it’ functions in relation to improving the quality and safety of care...
    - Find it: use tools such as clinical audits and performance indicators to identify where quality improvement programs could affect the quality of care delivered and improve patient health outcomes
    - Fix it: once the gaps in quality care have been identified, you can implement strategies to address the issue
    - Confirm it: measure the improvement using an effective evaluation process.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Implement and maintain a clinical risk-management policy.
- Implement and maintain an incident or event register.
- Show that you conduct clinical audits demonstrating changes to clinical care that have reduced risk.
- Keep minutes of team and planning meetings where risks are discussed.
- Record revisions to policies and procedures that have been shown to reduce risk.

# References

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# Module 3: General Practice module

# Preface to draft of Standard 1: Comprehensive care

## Indicators in this Standard

Indicators from different sections of the 4th edition Standards that relate to Comprehensive Care have been brought together into this Standard. These Indicators specify the care that general practices and clinicians need to directly provide to their patients, as well as the systems that support patient care.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 1.3 ► C | Practices need to manage urgent results that are identified after-hours | This was included in the explanatory notes of the 4th edition but there was no Indicator. This Indicator has been included in response to that identified gap in the 4th edition Standards. |
| 1.5 ► D | Practices need to have a reminder system | This was included in the explanatory notes of the 4th edition but there was no Indicator. This Indicator has been included in response to that identified gap in the 4th edition Standards. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 1.1 – Responsive system for patient care | ► A. Our practice provides different consultation types to accommodate patients' needs. | 1.1.1 ► B |
| | ► B. Our practice has a triage system. | 1.1.1 ► A |
| | ► C. Our 'on hold message' advises patients to call 000 in case of an emergency (applicable only if the practice has an on-hold message). | 1.1.2 C |
| 1.2 – Home and other visits | ► A. Our patients can access home and other visits, both within and outside normal opening hours, when safe and reasonable. | 1.1.3 ► A |
| 1.3 – Care outside normal opening hours | ► A. Our patients can access after-hours care. | 1.1.4 ► A |
| | ► B. Our patients are alerted to processes to access after-hours care. | 1.1.4 ► B |
| | ► C. Time-critical results identified outside normal opening hours are managed by our practice. | New Indicator |

| | | |
|---|---|---|
| 1.4 – Continuous and comprehensive care | ► A. Our practice provides continuity of care and comprehensive care. | 1.5.1 ► B |
| 1.5 – Follow up systems | ► A. Pathology results, imaging reports, investigation reports and clinical correspondence received by our practice are:<br>▪ reviewed<br>▪ signed or initialed (or the electronic equivalent)<br>▪ acted on where required<br>▪ incorporated into the patient health record. | 1.5.3 ► C |
| | ► B. Our practice recalls patients with clinically significant results. | 1.5.3 ► E |
| | ► C. Our patients are advised of the process for follow-up of tests and results. | 1.5.3 ► D |
| | ► D. Our practice initiates and manages patient reminders. | New Indicator |
| 1.6 – Engaging with other services | ► A. Our practice coordinates comprehensive care with other health services. | 1.6.1 ► A |
| | ► B. Our practice's referral letters are legible and contain all required information. | 1.6.2 ► A |

# Standard 1: Comprehensive care

*Our practice provides comprehensive care to our patients.*

The scope of general practice is not limited by age, gender, body system, disease process, or service site, and as such, it spans:

- prevention
- health promotion
- early intervention for those at risk
- the management of acute, chronic, and complex conditions
- the entire practice population whether in the practice, patients' homes, health service facilities, outreach clinics, hospitals and other community facilities and spaces.

This Standard includes Criteria that relate to:

- providing comprehensive care in a general practice context, covering
  - scheduling of appointments
  - the triage of patients so that the most appropriate care is provided
  - the ability for the practice to conduct home and other visits and care after-hours.
- the coordination of care outside of the practice
- the system the practice has for recalls and reminders.

## Criterion 1.1 – Responsive system for patient care

### Indicators

► A. Our practice provides different consultation types to accommodate patients' needs.

► B. Our practice has a triage system.

► C. Our 'on hold message' advises patients to call 000 in case of an emergency (applicable only if the practice has an on-hold message).

### Why this is important

Practice staff need to be able to identify patients' needs and provide care in order to treat patients effectively. Patients need to be referred to the right clinician to receive the right level of care within an appropriate period. Those patients with urgent needs must be seen quickly. When patients call the practice in the case of an emergency and are put on hold, they should know that they need to ring 000.

### Meeting this Criterion

*Consultations accommodate different patients' needs*

Patients should be able to access care that is flexible and recognises different patient needs.

Practices should provide different types of consultation (e.g. long or short), different types of care (e.g. complex care, preventive care), and different levels of access (e.g. appointment systems or walk-in service) based on patients' needs.

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

- long appointments
- short appointments
- walk-in appointments
- recall appointments
- reserved appointment times for urgent appointments on the day.

Members of the practice team should assess the length of consultation a patient requires based on their needs, and sensitively suggest a longer consultation if, for example, the patient is attending for multiple or complex problems, chronic disease management or procedures. Longer consultations may also be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if the patient's carer or a translator will be present. Some patients may always need longer appointments.

When there is an emergency, staff members need to:

- update the patient waiting list

- explain to waiting patients that there has been an emergency and that this may increase their waiting time
- notify other patients who have not yet arrived that their appointment may be later than scheduled.

Your practice does not have to have a formal appointment system to meet this Criterion. For example, some practices do not take appointments but accept patients on a walk-in basis. Provided that the practice prioritises patients according to urgency of need, and adequately informs patients of anticipated waiting times, this system is accommodating patients' needs.

*Triage*

All members of the practice team should be able to describe:

- how the practice identifies patients with an urgent medical need
- the procedures for seeking urgent medical assistance from a clinical staff member
- how the practice deals with patients who have urgent medical needs when the practice is fully booked.

Training should be provided so that administrative staff and members of the clinical team can identify patients in need of urgent care. This training can be delivered in-house by a practice member or by an external training provider.

Although administrative staff do not usually have access to patient health records, they do need a way informing clinical staff of triage responses.

*Telephone triage*

Telephone triage enables patients to immediately share their health concerns with practice staff.

Patients often contact general practices by telephone to make an appointment, and it may sometimes be necessary for administrative staff to assess the urgency of the need for care: in other words, to triage patients. Before putting a caller on hold, the staff member should ask 'Is the matter urgent or may I put you on hold?'

Reception staff need to know which telephone calls they should transfer to clinical staff.

*Technology-based consultations*

Practices can conduct technology-based patient consultations in place of face-to-face consultations. Practitioners should:

- confirm the identity of the patient using three patient identifiers.
- advise patients of the security risks associated with unencrypted email.
- obtain the patient's prior written consent if possible before the consultation takes place.

*The Medical Board of Australia Guidelines: Technology-based patient consultations*[24] provides further information that you may find useful. You may also wish to obtain advice from your medical defence organisation about the suitability of providing advice by telephone or electronic means.

*Managing cross infection through triage*

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

Effective telephone triage can identify the risk of infection before patients present at the practice.

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

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

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Keep an appointment book (paper or electronic) showing a variety of appointment types, including:
    - long appointments
    - short appointments
    - walk-in appointments
    - recall appointments
    - reserved appointment times for urgent appointments on the day.
- Show evidence that staff members update the patient waiting list if there has been an emergency and that they explain to patients that this may increase their waiting time to see the doctor and other clinical staff.

- Display a sign in the patient waiting area explaining short, standard, and long appointments.
- Have triage guidelines at reception area.
- Make a triage flowchart available for reception and clinical staff to refer to.
- Display a sign on the front of the clinic giving contact details for patients requiring urgent care outside normal opening hours.
- Display a sign in the waiting area to advise patients with high-risk or condition deteriorating symptoms to let reception know.
- Ensure your service's health records show documentation of care plans, reviews and up-to-date health summaries.

## Criterion 1.2 - Home and other visits

### Indicators

► A. Our patients can access home and other visits, both within and outside normal opening hours, when safe and reasonable.

### Why this is important

Patients value an ongoing relationship with their GP, even when their needs change.

Your regular patients who are in residential aged care facilities, residential care facilities, or hospitals also need to be able to access care from your practice.

### Meeting this Criterion

You need to consider how to provide continuity of care to patients who are not able to physically attend the practice.

*Who can perform home or other visits?*

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

Visits may also be performed on behalf of your practice (for example by services that provide care outside normal opening hours). When this occurs, there needs to be a direct and continuing relationship between your practice's GP/s and the clinicians who perform the home or other visits on their behalf. This includes arrangements to exchange clinical details about the patient's care and any concerns your practice may have about the safety of a visiting clinician.

*Process for home and other visits*

Patients may be visited at home or in another setting, instead of coming into the practice, when:

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

Your practice should have policies relating to home and other visits that specify:

- factors that the practice considers make home and other visits safe and reasonable
- geographical limits for home and other visits
- personal circumstances and health concerns that necessitate a home visit
- possible alternative arrangements if a home or other visit is not available.

General practitioners and other members of the practice team need to know the conditions under which a home or other visit is deemed appropriate based on the practice's policy.

*Defining 'safe and reasonable' in the local context*

Your practice needs to decide what is 'safe and reasonable' in your local context and considering your practice's location and patient population. One measure is to consider what your peers (particularly those in the same area) would agree is safe and reasonable.

*Access to alternative sources of care*

When a home or other visit is neither safe nor reasonable, your practice needs to be able to describe an alternative system of care that these patients can access, such as GP telephone advice lines or access to other after-hours services. When determining alternative systems of care, you may wish to consider what other practices in your area do when a home or other visit is neither safe nor reasonable. Your practice should obtain documentary evidence from the alternative system that they are in principle able and willing to provide care for your patients when a home or other visit is neither safe nor reasonable, and documentation regarding the care they have provided to any of your patients.

Another option is to conduct video consultation. The practice needs to decide whether the practice will offer video consultation services as an alternative to face-to-face consultations by considering:

- patient safety
- clinical needs of patients
- clinical effectiveness
- patient preference
- location of the practice
- availability of telehealth facilities
- the conditions of your professional indemnity insurance.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Keep health records showing entries of when staff members have provided home and other visits and the time they occurred.
- Keep Medicare billings with item numbers showing home and other visits occurring.
- Keep a policy on circumstances when home visits are deemed safe and reasonable.

## Criterion 1.3 – Care outside normal opening hours

### Indicators

► A. Our patients can access after-hours care.

► B. Our patients are alerted to processes to access after-hours care.

► C. Time-critical results identified outside normal opening hours are managed by our practice.

### Why this is important

Sometimes patients require medical care outside normal opening hours. Patients value an ongoing relationship with a practice or GP who provides medical care on a 24-7 basis. Research indicates that patients who have better access to their primary care physician after-hours have significantly fewer emergency department visits[25]. If your practice is not able to provide after-hours care for your patients, you need to have arrangements so that other services can manage your patients' needs after-hours.

### Meeting this Criterion

*After-hours care*

Provide evidence that your practice is aware of the ways your patients can access care after-hours through another providers. This could include:

- clearly informing patients about local healthcare providers that operate outside your normal opening hours
- having formal arrangements in place with other providers, such as a medical deputising service (MDS), to deliver after-hours care
- participating in cooperative arrangements to deliver after-hours care, during sociable hours or unsociable hours.
- delivering your own after-hours care for their patients, either during sociable hours or for the full after-hours period

If your practice uses other services to provide care, such as the local hospital, a medical deputising service (MDS), or GP cooperative, you need to have evidence showing:

- details of the arrangements
- how and when you receive information about care provided to your patients outside normal opening hours
- how the providers of after-hours care can contact the practice in an emergency or when there are exceptional circumstances.

Regardless of how your practice ensures that your patients can access care outside normal opening hours, your patient health records should contain reports or notes of consultations of after-hours care that is provided by, or on behalf of, your practice.

If you have arrangements with any after-hours providers, give them after-hours contact details of one or more GPs from your practice, so that they can access important information about the patient, when required, particularly in an emergency.

*Informing patients about care outside normal opening hours*

Your practice should inform patients of your normal opening hours and the arrangements for care outside normal opening hours.

Inform your patients of the out-of-hours arrangements using one or more of the following:

- an out-of-hours message on the practice's telephone
- relevant information on your website and in your practice's collateral, including leaflets, newsletters and new patient information pack
- a clearly visible sign visible outside the practice.

*Follow up of seriously abnormal and life-threatening results*

Your practice needs to have procedures that ensure timely receipt of seriously abnormal and life-threatening results identified outside normal opening hours, so that you can provide prompt and adequate follow-up.

You need to explain what you expect of deputising doctors who receive urgent and life threatening results for one of your patients, as they have a responsibility to contact the general practice in exceptional circumstances. Ideally, this will be explained in a formal agreement between your practice and the service providing after-hours care.

If your practice uses another service to provide after-hours care (e.g. a GP cooperative, an MDS or a local hospital), you should have a defined and reliable system for the deputising practitioner to access patient health information in exceptional circumstances.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Ensure staff members are able to explain how your patients can access care after hours.
- Do one of the following:
    - Maintain an after-hours roster showing which staff are on call for after hours. OR
    - Maintain a formal after-hours agreement with another health service that shows how after-hours care is shared. OR

    - Maintain an agreement with a local hospital, which explains that your patients can access after-hours care for urgent presentations.

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

## Criterion 1.4 – Continuous and comprehensive care

### Indicators

► A. Our practice provides continuity of care and comprehensive care.

### Why this is important

*Continuity of care*

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

Continuity of care:

- supports the provision of quality patient care[2]
- reduces the use of emergency departments and preventable hospital admissions[26, 27]
- contributes to an overall lowering of costs, increased patient satisfaction, and greater efficiency[28].

There are three types of continuity:

- **informational continuity** - the flow of information from one healthcare event/consultation to others, particularly via documentation, handovers, and reviews of notes from previous consultations
- **management continuity** - the consistency of care provided by multiple people involved in a patient's care
- **relational continuity** - the sense of connection between the patient and their doctor[14].

*Comprehensive care*

Providing comprehensive care is central to providing quality healthcare.

Communities benefit considerably from having local general practices that offer a range of health and medical services, including aged care in the community, preventive care, palliative care, immunisation, women's health, men's health, children's health, after-hours services, home care, and hospital-in-the-home.

If patients are able to access a comprehensive range of services from a primary health provider in their community, it reduces demand for more complex and expensive services in the secondary and tertiary health sectors[27].

The provision of comprehensive care is particularly important in rural, remote, and socially disadvantaged areas, where patients may have reduced access to other healthcare services.

## Meeting this Criterion

*Continuity of care within general practice*

Maintain patient health records that show patients attending the practice over time, and the management planning, preventive health interventions, referrals, and receipt of reviews from other participants for long-term patients, especially those with complex or chronic health problems.

*Comprehensive Care*

Demonstrate that you provide comprehensive care by providing the list of services offered. For example:

- providing care to infants, children and elderly
- chronic disease management
- infectious disease management
- mental health care
- travel medicine
- preventative health care
- working with other health professionals such as practice nurses, mental health nurses, allied health professionals and Aboriginal health workers.

This can be demonstrated with patient health records that show patients receiving these services.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Ensure that health records for ongoing or long-term patients (2 years or more) show that they have been coming to the service, demonstrating their preference for the health service.
- Implement and maintain a recall and reminder system.
- Document management plans in patient health files, especially for those with complex or chronic health problems.
- Implement and maintain a clinical handover system for when clinicians are away or on leave.

## Criterion 1.5 – Follow up systems

### Indicators

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

- reviewed
- signed or initialled (or the electronic equivalent)
- acted on where required
- incorporated into the patient health record.

► B. Our practice recalls patients with clinically significant results.

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

► D. Our practice initiates and manages patient reminders.

### Why this is important

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

Ideally, practices should inform patients of clinically significant results face-to-face, so that the patient can ask questions and receive advice from the GP.

Using recalls and reminders information to proactively contact patients about their care means patients will be more likely to, for example, come back to the practice to discuss a test result or undergo a preventive activity, such as cancer screening. Failure to recall a patient may result in an adverse patient health outcome and the responsible practitioner may face medico-legal action.

### Meeting this Criterion

*Timely review and action on tests and results*

After a GP has explained and advised a patient of tests or other action required, and the patient has understood this advice, it is up to the patient to decide whether or not to follow the recommendations[29]. Some patients do not follow recommendations due to, for example, their particular circumstances, fear, ignorance, personality traits, expectations, beliefs, or cultural backgrounds.

Your practice should have safeguards that ensure that potentially clinically significant information does not get 'lost in the system'. For example, you could prepare a clearly expressed document for patients to sign indicating that they agree they are responsible for having the recommended tests performed and for obtaining the results.

General practitioners are obliged to ensure that all test results they receive are recorded and appropriately followed up with their patients[30]. This includes pathology and diagnostic test results ordered by another specialist or other health professional that are copied back to the GP.

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

*Clinical significance of results*

The follow-up system needs to accommodate different levels of follow up depending on the patient's needs and clinical significance of the case.

Consider the following factors to determine if a result is clinically significant and therefore requires action:

- the probability that the patient will be harmed
- the likely seriousness of the harm
- the burden of taking steps to avoid the risk of harm.

The clinical significance of a test or result should be considered in the context of the patient's history and presenting problems. "Clinically significant" does not necessarily mean only 'abnormal' results. Clinically significant is a judgement made by the GP that information is clinically important for a particular patient in the context of that patient's healthcare. While a GP will generally decide that an abnormal result is clinically important and requires further action, they may also decide that a normal result requires further action. For example, a normal mammogram in a woman with a breast lump, or a normal electrocardiogram in a patient with chest pain, does not eliminate the need for further consultation, investigation, and management.

*Recalling patients*

A recall occurs when a GP decides that a patient needs to be reviewed within a specified period. For example, you might recall a patient:

- when you receive a clinically significant test result
- after they have seen a psychologist or psychiatrist for a mental health assessment.

Develop a written policy for staff to follow, setting out a process for recall of patients with clinically significant results. The policy could include:

- a definition of clinically significant results
- a statement that responsibility for reviewing and identifying results as clinically significant rests with the GP

- how to recall a patient, clearly outlining the roles and responsibilities of different staff members, including what information different staff members can convey, and how to convey it. For example, if reception staff are responsible for contacting patients with significant results to make an appointment, explain how they could do this (e.g. 'Your doctor wants you to make an appointment this week to discuss the results of your recent tests')
- guidelines about what information needs to be recorded (clinical discussions and outcomes) in patient health records
- standard forms and letters for recalling patients
- guidelines that ensure that tests and results are reviewed and acted upon in a timely manner.

Your practice can also choose to document your recall system, including who is responsible for monitoring and follow-up of recalls.

Your staff induction should cover the recall system.

Record attempts to contact and recall patients about clinically significant tests and results in the patient's health files.

*Using technology to recall and remind patients*

Some software allows you to flag recall appointments so if the patient does not return as expected, you will be prompted to follow up.

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

Consider using your information system to automatically generate SMSs, emails, or letters for your practice to issue recalls and reminders.

*Communicating tests and results to patients*

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

Your practice needs to be able to identify unexpected significant results when they are received, particularly if the significance of such results was not discussed with the patient during the consultation. In these circumstances, practices need to consider how to sensitively inform the patient, who may not anticipate or understand the significance of the result.

When explaining test results to the patient, make sure your explanation is clear and that the patient understands what you are telling them. A patient who makes a decision based on insufficient or unclear information is not making an informed decision. When the patient fully understands the

information, they can give legally effective informed consent, or exercise their right to a legally effective informed refusal.

*Reminders*

A reminder occurs when a patient is added to a recommended preventive activity list that is managed on a periodic basis. Reminders are used to help manage preventive care, and can be set up before or during a consultation by noting in a patient's health record when the patient is due to return to the clinic for a routine check. Reminders help to ensure that patients have preventive health checks. For example, your practice could send a letter or SMS to:

- patients in the high-risk age bracket for flu prompting them to come in and have a flu shot before the start of the flu season
- patients who are due for a routine pap smear or breast screening test

Some medical software will display a prompt when a patient's health record is opened, so that the practitioner is informed that the patient is due for a preventive or clinical activity.

If you practice sends a reminder to a patient, and the patient does not make an appointment, the practice is not obliged to follow up, but should record the reminder in the patient's medical notes.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Ensure that pathology results in patient health files show evidence of review by GPs as required.
- Ensure patient health files show a record of attempts to contact and recall patients in relation to clinically significant tests and results.
- Ensure patient health files show when follow-up has occurred and treatment, if any, required.
- Ensure patient health files show when reminders have been initiated and acted upon.
- Document the review and recall system, including who is responsible for monitoring and follow-up of recalls.
- Maintain templates within a clinical software program to trigger recalls and reminders.
- Maintain a policy and procedure manual.

## Criterion 1.6 – Engaging with other services

### Indicators

► A. Our practice coordinates comprehensive care with other health services.

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

### Why this is important

By engaging and working cooperatively with other healthcare providers and other services, such as allied health and pharmacy services, diagnostic services, hospitals, and social, disability, and Indigenous health and community services, practices can provide optimal care to patients whose health needs require integration with other services.

Because coordination of care for individuals, families and communities is part of a GP's accepted role, and is associated with improved health outcomes for patients[31], engaging with other services is an important feature of high quality healthcare.

### Meeting this Criterion

*Coordinating comprehensive care with other services*

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

Your practice should have a register of these services (particularly useful for new members of the practice team) and foster good working relationships with these service providers so that you can achieve good collaborative care.

Your practice needs to be understand the different referral arrangements for public and private providers.

*Referral information*

Referral letters are critical in integrating the care of patients with external healthcare providers.

Referral letters must:

- be on appropriate practice stationery
- be legible
- include the patient name and date of birth and at least one other patient identifier
- explain the purpose of the referral
- contain enough information (the relevant history, examination findings, and current management) so that the other healthcare provider can provide appropriate care to the patient, but not include sensitive patient health information that is not relevant to the referral

- include a list of known allergies, adverse drug reactions, and current medicines
- identify the doctor making the referral and the healthcare setting from which the referral has been made (e.g. the general practice)
- identify the healthcare setting to where the referral is being made (e.g. the specialist consultancy)
- identify the healthcare provider to whom the referral is being made if known
- include any culturally appropriate information to facilitate culturally safe practices by other health service providers (for example, the need for an interpreter).

*Patient information in referrals*

Most of the information needed for a referral may be found in the patient's health summary. Many practices routinely incorporate a copy of the patient health summary into a referral letter or attach the summary as a separate document.

However, only clinically relevant patient health information should be provided in a referral letter. Information is clinically relevant if it is required by the healthcare practitioner to diagnose and treat the patient. For example, a patient's previous termination of pregnancy or STI is unlikely to be of clinical relevance to a physiotherapist, but probably would be to an obstetrician or gynaecologist.

Only pass on irrelevant or sensitive patient health information if you have gained the patient's consent. You may consider offering patients the opportunity to read a referral letter before it is sent.

General practices must consider their obligations under the Privacy Act before they use or disclose any health information[32]. As the Privacy Act does not prescribe *how* a healthcare organisation should communicate health information, you may use any method of communication as long as you take reasonable steps to protect the information and the privacy of the patient.

*Referrals sent electronically*

Unless the patient has provided their consent (preferably written) to do otherwise, all referrals forwarded by email should be encrypted[33]. The practice should comply with standards for the secure transmission of health information to avoid breaching patient confidentiality[32].

*Telephone referrals*

In the case of emergency or other unusual circumstances, a telephone referral may be appropriate. All telephone referrals must be recorded in the patient's health record.

*Keep copies of referrals*

For both medico-legal and clinical reasons:

- make a note in the patient health record of every referral made for that patient

- keep copies of important (non-routine) referral letters (ie new referrals or those for serious conditions) in the patient's health record (it is up to the GP to decide the significance of a referral).

### Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Keep an electronic or hard-copy register of service providers and organisations for patient referrals.
- Update the register regularly and document the date of update within the register.
- Keep an easily accessible list of pharmacies including the roster of on-call pharmacies.
- Maintain a policy on referral documents that includes using at least three patient identifiers.
- Maintain a standard referral template that includes all relevant details.
- Show that patient health records include discharge letters that are acted upon appropriately.

# Preface to draft of Standard 2: Infection prevention and control in the practice

## Indicators in this Standard

The Indicators in this Standard are similar to those in the 4th edition Standards.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 2.1 F | Tracking and tracing of reusable medical devices. | This was identified as a gap in the 4th edition Standards during the Initial Consultation Phase. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 2.1 - Infection prevention and control, including sterilisation | ► A. Our practice has a team member who has primary responsibility for coordinating infection control and sterilisation processes, including, where relevant:<br>• provision of an adequate range of sterile reprocessed or disposable equipment<br>• procedures for having instruments sterilised off site, including documentary evidence of a validated process<br>• procedures for on-site sterilisation of equipment, including monitoring the integrity of the whole sterilisation process, validation of the sterilisation process and steriliser maintenance<br>• safe storage and stock rotation of sterile products<br>• waste management. | 5.3.3 ► A |
| | ► B. Our practice has a team member who has primary responsibility for providing staff education on infection control. | 5.3.3 ► G |
| | ► C. All members of our practice team manage risks of potential cross-infection within our practice including:<br>▪ hand hygiene<br>▪ the use of personal protective equipment (PPE)<br>▪ triage of patients with potential communicable disease | 5.3.3 ► D |

| | | |
|---|---|---|
| | ▪ safe storage and disposal of clinical waste including sharps<br>▪ managing blood and body fluid spills. | |
| | ► D. Our patients are informed about respiratory etiquette, hand hygiene and precautionary techniques to prevent the transmission of communicable diseases. | 5.3.3 ► I |
| | E. Our practice tracks and logs the patients on which reusable medical instruments have been used. | New Indicator |

# Standard 2: Infection prevention and control in the practice

*Our practice has systems that reduce the risk of healthcare associated infections.*

Infection prevention and control is critical in general practice. Primary healthcare is increasingly delivered by teams that include doctors, practice nurses, and other health professionals, and all members of the practice team are responsible for preventing and controlling infection in the practice. Staff must be educated and competent in effective infection prevention and control in order to reduce the risk of cross-infection and transmission of disease.

Sterilisation is one important element of infection prevention and control. It includes:

- sterilising items
- prior cleaning of reusable medical devices and equipment
- cycle monitoring[34] and storage
- all aspects of equipment reprocessing
- staff education
- logging, tracking, and tracing reusable medical devices.

## Criterion 2.1 – Infection prevention and control, including sterilisation

### Indicators

► A. Our practice has a team member who has primary responsibility for coordinating infection control and sterilisation processes, including, where relevant:

- provision of an adequate range of sterile reprocessed or disposable equipment
- procedures for having instruments sterilised off site, including documentary evidence of a validated process
- procedures for on-site sterilisation of equipment, including monitoring the integrity of the whole sterilisation process, validation of the sterilisation process and steriliser maintenance
- safe storage and stock rotation of sterile products
- waste management.

► B. Our practice has a team member who has primary responsibility for providing staff education on infection control.

► C. All members of our practice team manage risks of potential cross-infection within our practice including:

- hand hygiene
- the use of personal protective equipment (PPE)
- triage of patients with potential communicable diseases
- safe storage and disposal of clinical waste including sharps
- managing blood and body fluid spills.

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

E. Our practice tracks and logs the patients on which reusable medical instruments have been used.

### Why this is important

Having systems that have clear lines of accountability and responsibility is part of good governance and encourages improvement in safety and quality care for patients.

It is important to keep patients of the practice and practice staff safe from infection. Infection prevention and control reduces the risk of infection travelling from patient to patient, or patient to practice staff.

## Meeting this Criterion

*Infection prevention and control*

Your practice should appoint one member of the clinical team who has primary responsibility for processes to prevent and control infection, including infection control processes, sterilisation process, environmental cleaning, spills management, staff immunisation, and staff education. These responsibilities must be documented, and staff must be understand and comply with these processes.

All members of the practice team must understand how infection can spread within the practice, and their role in infection prevention and control in the practice. Implementing policies and procedures that include triage protocols, and developing tools such as checklists, will help to ensure that all members of staff understand their own and others' roles and responsibilities relating to infection.

*Staff education*

To reduce the risk of infection, all staff must be educated on infection control processes. Practices are responsible for ensuring that they comply with state/territory and local government regulations relating to waste management.

Staff education about effective infection control must begin during staff induction, and continue throughout their employment. Education must be relevant to each person's particular role.

Refer to Chapter 1 of the RACGP's *Infection prevention and control standards for general practices and other office-based and community-based practices* (5th edition) that provides guidance on recording staff education and evaluating a staff member's competency in this area.

All practice staff must have easy access to personal protective equipment (e.g. face masks, gloves, gowns, eye protective wear) and receive education about its proper use. Staff must have a clear understanding of the purpose of this equipment and how to apply, remove and dispose of it appropriately.

*Managing cross-infection within the practice*

Risks of infection within the practice must be minimised.

Staff must be familiar with the use of standard and special precautions, spills management and environmental cleaning.

Refer to and adhere to the applicable sections of the RACGP's *Infection prevention and control standards for general practices and other office-based and community-based practices* (5th edition). It recommends the use of hand hygiene, Personal Protective Equipment (PPE) (including heavy duty protective gloves, gowns, plastic aprons, masks and eye protection), or other protective barriers when cleaning, performing procedures, dealing with spills, and handling waste.

Standard precautions must be applied to work practices, assuming that all blood and body substances, including respiratory droplet contamination, are potentially infectious.

Transmission-based precautions must be applied when patients are known to be, or suspected to be, infected with highly transmissible infectious agents (e.g. influenza). You can minimise exposure to other patients and staff by:

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

The practice must advise patients on how they can reduce the spread of infection while at the practice. For example, you can display signs in the waiting room and have tissues, rubbish bins, and antimicrobial hand sanitiser available.

*Ensuring sterile procedures are undertaken*

Develop policies, procedures, and tools such as checklists to ensure that adequate steps are taken for the complete sterilisation process. You could have an infection control policy, which contains:

- the name of the team member/s responsible for infection control and sterilisation processes
- immunisation that staff should receive, in accordance with recommendations in the current *Australian Immunisation Handbook*
- the appropriate use and application of standard and transmission-based precautions
- management of sharps injury
- management of blood and body substance spills
- hand hygiene
- environmental cleaning of clinical and nonclinical areas of the practice
- aseptic and sterile procedures for disposable instruments and/or instruments sterilised on site or off site. If sterilisation is performed on site, you must have a procedure for instrument reprocessing, sterilisation, and the validation process. If sterilisation is performed off site, you must have a validation process and appropriate and safe transport arrangements
- waste management, including the safe storage and disposal of clinical waste and sharps
- where patients and staff access personal protective equipment (PPE)
- how and when staff are educated on the appropriate application, removal and disposal of PPE
- details of pathology testing done within the practice.

*Sterilisation processes*

The clinical team member who has primary responsibility for infection prevention and control processes must ensure that the level of processing of equipment is appropriate to the risk of infection posed by their reuse. The Spaulding classification must be used as a general basis for the risk assessment[34], and the site of use (e.g. skin, mucous membranes, and wounds) must also be used to determine the risk to the patient.

If you use an accredited offsite sterilisation facility (e.g. an accredited general practice or Australian Council on Healthcare Standards accredited hospital), you must have a copy of the facility's accreditation certificate.

If you use an offsite sterilisation facility that is not accredited, you must:

- be sure that the facility would satisfy accreditation requirements for sterilisation
- have copies of the facility's relevant documents, including
  - reprocessing
  - sterilisation policies and procedures
  - monitoring of the sterilisation process and sterilisation equipment maintenance if applicable
  - annual validation records if applicable.

Have a documented agreement between your practice and the offsite sterilisation facility, detailing the arrangements and responsibilities of each party (e.g. responsibility for washing and packaging used equipment, expected turnaround time, responsible contact personnel in the practice and the offsite sterilisation facility and contingencies for process failure).

*Waste management*

Refer to and adhere to the applicable sections of the RACGP's *Infection prevention and control standards* (5th edition) (the Infection Control Standards), which provides guidance on waste management that practices may consider when developing an infection prevention and control policy.

*Tracking the sterility of reusable medical instruments and tracing patients*

The need to track reusable medical devices or trace patients on whom they have been used will not be necessary if the validated sterilisation process is strictly adhered to and monitored. Nonetheless, your practice needs to be able to trace patients and track reusable medical devices in case there is a failure to follow the sterilisation process or there is a medico-legal issue relating to sterilisation in the practice. You need to assess the risk to your practice and decide on the extent of tracking and tracing activities your practice requires.

You should be able to 'look back' at the details of the sterilisation process in any individual case to prove that the reusable medical instruments were sterile at the time of use if medico-legal issues

arise. To make sure that you can trace the process, you must record the sterilisation load number from the sterile barrier system that the reusable medical devices was contained in, either:

- in the patient's medical record
- on a label that you place into a paper record.

If an issue arises later, you can use this load number to refer back to the sterilisation log (and corresponding printout if retained) to recheck the results of that particular cycle.

If a process failure is identified after the release of items for use, you need to be able to trace all patients on whom those items were used. To make sure that you can do this, record patient identifiers (e.g. name and/or record number or date of birth) for each patient next to each item or pack listed in the load details in the steriliser log.

*Staying up-to-date*

Keep up-to-date with changes in legislation and guidelines for infection control and implement them promptly. Have systems for monitoring and obtaining information about national and local infection outbreaks and public health alerts, such as pandemic influenza, measles and pertussis outbreaks.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Demonstrate the team member with responsibility for infection prevention and control and education in their job description/s.
- The team member with responsibility for infection control and sterilisation can describe their role.
- Maintain a policy and procedure manual on infection control.
- Maintain a cleaning policy.
- Maintain a cleaning log.
- Show that you cover infection control in induction and ongoing staff education programs.
- Show that you discuss any changes to legislation and guidelines for infection control and any local outbreaks and public health alters at staff meetings.
- Include an education component in the infection-control policy.
- Make brochures or posters available at reception on respiratory etiquette and hand hygiene processes.
- Direct observation of safe sharps storage and disposal and safe clinical waste disposal.

# Preface to draft of Standard 3: Practice equipment

## Indicators in this Standard

This Standard explains the equipment that practices are required to have to provide general practice services. Some parts of the practice facilities Standard in the 4th edition have now been included in this Standard, as these Indicators can be assessed together.

## New Indicators

| New Indicator | Description and explanation | Other comments |
|---|---|---|
| 3.1 ► C | Our practice team is aware of the risks associated with equipment use | This was identified as a gap in the 4th edition Standards during the Initial Consultation Period and has now been included. |
| 3.1 G | Our practice has a defibrillator | A number of stakeholders suggested that defibrillators be included in this edition of the Standards. This new Indicator is not mandatory. |

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 3.1 - Practice equipment | ► A. Our practice has equipment for comprehensive primary care and emergency resuscitation including:<br>• auriscope<br>• blood glucose monitoring equipment<br>• disposable syringes and needles<br>• equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask), IV access, and emergency medicines<br>• examination light<br>• eye examination equipment (e.g. fluorescein staining)<br>• gloves (sterile and non-sterile)<br>• height measurement device<br>• measuring tape<br>• monofilament for sensation testing | 5.2.1 ► A |

| | | |
|---|---|---|
| | • ophthalmoscope<br>• oxygen<br>• patella hammer<br>• peak flow meter<br>• pulse oximeter<br>• scales<br>• spacer for inhaler<br>• specimen collection equipment<br>• sphygmomanometer with small, medium and large cuffs<br>• stethoscope<br>• surgical masks<br>• thermometer<br>• torch<br>• tourniquet<br>• urine testing strips, including pregnancy testing strips<br>• vaginal specula<br>• visual acuity charts<br>• x-ray viewing facilities. | |
| | ► B. Our practice maintains our equipment | 5.2.1 ► D |
| | ► C. Our practice team is aware of the risks associated with equipment use. | New Indicator |
| | ► D. Our practice has one or more height adjustable beds. | 5.1.1 ► G |
| | ► E. Our practice has timely access to a spirometer and electrocardiograph. | 5.2.1 ► B |
| | F. Our practice has a defibrillator. | New Indicator |
| 3.2 - Doctor's Bag | ► A. Each of our GPs has access to a fully equipped doctor's bag for routine visits and emergency care containing:<br>▪ auriscope<br>▪ disposable gloves<br>▪ equipment for maintain an airway in both adults and children<br>▪ in-date medicines for medical emergencies<br>▪ practice stationery (including prescription pads and letterhead)<br>▪ sharps container | 5.2.2 ► A |

| | | | |
|---|---|---|---|
| | | ▪ sphygmomanometer<br>▪ stethoscope<br>▪ syringes and needles in a range of sizes<br>▪ thermometer<br>▪ tongue depressors<br>▪ torch. | |

# Standard 3: Medical equipment in the practice

*Our practice provides medical equipment that is maintained and appropriate for comprehensive patient care.*

Practices must ensure that GPs and other clinical staff have access to the medical equipment they need to provide comprehensive primary care to their patient population, whether in the practice's rooms or elsewhere (where GPs will need to use a fully stocked doctor's bag).

## Criterion 3.1 – Practice equipment

### Indicators

► A. Our practice has equipment for comprehensive primary care and emergency resuscitation including:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask), IV access, and emergency medicines
- examination light
- eye examination equipment (e.g. fluorescein staining)
- gloves (sterile and non-sterile)
- height measurement device
- measuring tape
- monofilament for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- pulse oximeter
- scales
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer with small, medium and large cuffs
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet

- urine testing strips, including pregnancy testing strips
- vaginal specula
- visual acuity charts
- x-ray viewing facilities.

► B. Our practice maintains our equipment.

► C. Our practice team is aware of the risks associated with equipment use.

► D. Our practice has one or more height adjustable beds.

► E. Our practice has timely access to a spirometer and electrocardiograph.

F. Our practice has a defibrillator.

Stakeholder question: this new Indicator requires that practices consider whether they need an automated external defibrillator (AED) in their practice. What are stakeholders' views?

**Why this is important**

Practices need to have equipment that enables them to provide comprehensive primary care and emergency resuscitation as required.

Equipment needs to be maintained to ensure that it is in good working order when required.

Research shows that pulse oximeters are useful in a general practice to diagnose and assess hypoxia[35].

Other research shows that (despite the efforts of medical practitioners, policy makers and consumer advocates), people with disability continue to experience poorer health outcomes in a range of areas compared to the broader population[36]. One reason has been the lack of height adjustable examination beds in general practices, resulting in fewer opportunities for them to have thorough and dignified clinical examinations. Using height adjustable beds will also reduce workplace injuries because it will reduce the need for practitioners to help patients onto an examination bed that is too high.

Having an automated external defibrillator (AED) in your practice can reduce the risk of fatality from cardiac arrest[37].Although sudden cardiac arrest is rare in general practice facilities, when it does occur, a GP needs to be able to have a lead role in resuscitation[38]. Most cases of sudden cardiac arrest are due to ventricular fibrillation that can be returned to a normal sinus rhythm with the use of an AED. Using an AED is easy and can cause no harm as AEDs analyse the cardiac rhythm and will only deliver a shock if it is necessary. Survival rates after sudden cardiac arrest drop 7-10% for every minute without defibrillation. CPR alone has a 5% survival rate but CPR combined with early defibrillation increases the survival rate to 50%[39].

## Meeting this Criterion

*Range of equipment*

Your practice must have all the equipment necessary to provide services that meet local needs and support the procedures the practice performs, including equipment that is relevant to their location or patient population.

*Maintaining equipment*

Your practice must ensure that all equipment is in working order at all times. You could maintain a register that lists all equipment in the practice and schedules for servicing and maintenance.

Equipment that requires calibration or that is electrically or battery powered (e.g. electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales, and defibrillators) must be serviced regularly in accordance with the manufacturer's instructions to ensure it remains in good working order. You could keep receipts from any external equipment testing and calibration companies to schedule regular maintenance checks. You may also choose to maintain a checklist of equipment used in your consultation rooms to record dates of servicing and to conduct regular checks that maintenance is up to date.

*Storing hazardous materials*

You must store all hazardous materials, including liquid nitrogen and oxygen, securely.

*Height adjustable beds*

Follow the guidelines provided by disability advocacy groups when purchasing height adjustable beds:

- preferred minimum range of height adjustment: 45-95 cm
- preferred minimum weight capacity: 175 kg
- preferred minimum width of table: 71 cm
- preferred minimum length: 193 cm
- number of sections: two sections, allowing the head section to be raised.

You may also consider purchasing other features and equipment for your height adjustable beds, such as stirrups for gynaecological examinations.

*Electrocardiograph and spirometer*

You must have timely access to an electrocardiograph and a spirometer. You can purchase this equipment or make arrangements to have timely access to the equipment (e.g. with a pathology service or nearby local hospital).

If you have an electrocardiograph or spirometer on site, staff must be properly trained to:

- use and maintain the equipment
- analyse results.

You must determine what "timely access" means for your practice, based on clinical need and what peers would consider an acceptable timeframe.

*Automated external defibrillator (AED)*

Decide whether your practice needs to install an AED, based on the risks of harm from cardiac arrest, by considering:

- the location of your practice in relation to an AED, hospitals or other emergency services
- the number and composition of practice staff, patients and other persons who visit your practice (an AED is useful in workplaces where there are large numbers of members of the public[39])
- records of injuries, illnesses and near misses.

If you have an AED:

- it must be maintained according to the manufacturer's specifications
- staff must be properly trained to use and maintain the equipment
- it must be placed where it is clearly visible and accessible, and not exposed to extreme temperatures
- it must be clearly signed.

*Consulting with staff*

In accordance with Safe Work Australia recommendations[40], consider consulting with staff before making decisions on health and safety matters and deciding what new facilities the practice needs.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Maintain a checklist for consultation room equipment.
- Maintain an equipment register, including all of the required equipment.
- Keep a maintenance log including receipts from any external equipment testing and calibration companies.
- Direct observation of all required equipment.

## Criterion 3.2 – Doctor's bag

### Indicator

► A. Each of our GPs has access to a fully equipped doctor's bag for routine visits and emergency care, containing:

- auriscope
- disposable gloves
- equipment for maintaining an airway in adults and children
- in-date medicines for medical emergencies
- practice stationery (including prescription pads and letterhead)
- sharps container
- sphygmomanometer
- stethoscope
- syringes and needles in a range of sizes
- thermometer
- tongue depressors
- torch.

### Why this is important

GPs must be prepared to undertake home and other visits and must be available at short notice to help in emergencies. Therefore, they need to have immediate access to core equipment, medications, and stationery so that they can provide the necessary care. The doctor's bag is used these situations.

### Meeting this Criterion

*Equipping doctors' bags*

All GPs in your practice must have ready access to a doctor's bag that contains core equipment, medications and stationery, and to which they can add equipment in regular use (e.g. auriscope, ophthalmoscope or stethoscope) to make the bag ready for use.

If you are a small practice, you may have only one bag that is shared by your GPs.

If you are a medium or large practice, you may have multiple bags so that more than one GP can simultaneously use a bag when required.

*Storing doctors' bags*

You must store the bag/s securely, and in accordance with state and territory legislation.

*Medicines in doctors' bags*

Decide what general medicines you need to keep in your practice's doctors' bags based on:

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

Suggested emergency medicines that the practice could include are:

- adrenaline
- aspirin
- atropine sulphate
- benztropine mesylate
- benzylpenicillin
- chlorpromazine or haloperidol
- diazepam
- ergotamine maleate
- frusemide
- glucose 50% and/or glucagon
- glyceryl trinitrate spray or tablets
- hydrocortisone sodium succinate or dexamethasone
- metoclopramide hydrochloride
- morphine sulphate or appropriate analgesic agent
- naloxone hydrochloride
- promethazine hydrochloride
- salbutamol aerosol.

You must have:

- an up-to-date logbook that lists the emergency drug stocks in the doctor's bag
- a system for checking expiry dates and replacing drugs that have expired.

*PBS emergency drugs for doctors' bags*

Through the Pharmaceutical Benefits Scheme (PBS), certain medications are provided to prescribers without charge, so that, in emergencies, you can supply these medications free to patients.

A list of these medications available for doctors' bags is available at www.pbs.gov.au/browse/doctorsbag , and the Emergency Drug (doctor's bag) Order Form is available from Medicare for eligible prescribers.

When deciding which ones to include in a doctor's bag, consider:

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

*Emergency drugs for children*

Paediatric emergency drugs and dosages can be found in the Royal Children's Hospital *Pharmacopoeia*, available at http://www.rch.org.au/pharmacy/business_development/Paediatric_Pharmacopoeia/ .

When deciding which ones to include in a doctor's bag, consider the same factors listed under the heading *PBS emergency drugs for doctors' bags* on page **Error! Bookmark not defined.**.

*GPs' knowledge of medicines in doctors' bags*

All GPs must be familiar with the medicines that are in their doctor's bag, including the general usage, suggested dosage and possible side effects.

It is recommended that GPs seek appropriate and ongoing education on these medicines as required.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Direct observation of doctor's bag including all required equipment and medications.
- Maintain a doctor's bag contents checklist to ensure that bag is stored correctly and all medicines and stock are in date.

# Preface to draft of Standard 4: Vaccine Potency

## Indicators in this Standard

The Standard on Vaccine Potency contains very similar information to the 4th edition Standards. There have been no substantial changes.

## Mapping of the 5th edition to the 4th edition Standards

| 5th edition Criterion | 5th edition Indicator | 4th edition Criterion and Indicator |
|---|---|---|
| 4.1 - Maintaining vaccine potency | ► A. Our practice has a team member who has primary responsibility for cold chain management in the practice. | 5.3.2 ► A |
| | ► B. The team member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the National Vaccine Storage Guidelines. | 5.3.2 ► B |
| | ► C. The team member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:<br>• ordering and stock rotation protocols<br>• maintenance of equipment<br>• annual audit of our vaccine storage procedures<br>• continuity of the cold chain, including the handover process between designated members of the practice team<br>• accuracy of our digital vaccine refrigerator thermometer. | 5.3.2 ► C |

# Standard 4: Vaccine potency

*Our practice maintains the potency of vaccines.*

Being delicate biological substances, vaccines can become less effective or destroyed if they are not kept within an optimal temperature range or if they are exposed to direct UV light.

You must therefore maintain the potency of your vaccines to ensure they are effective in improving immunity against disease.

A cold chain is a series of storage and distribution activities (a supply chain) where the temperature is controlled. An unbroken cold chain is a supply chain that maintain a given temperature range. A cold chain is used to help extend and maintain the shelf life of vaccines as well as maintain the vaccine's potency.

Your practice must appoint a team member to be responsible for managing the cold chain within the practice.

## Criterion 4.1 – Maintaining vaccine potency

### Indicators

► A. Our practice has a team member who has primary responsibility for cold chain management in the practice.

► B. The team member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the National Vaccine Storage Guidelines.

► C. The team member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:

- ordering and stock rotation protocols
- maintenance of equipment
- annual audit of our vaccine storage procedures
- continuity of the cold chain, including the handover process between designated members of the practice team
- accuracy of our digital vaccine refrigerator thermometer.

### Why this is important

The success of any vaccination program depends on the potency of vaccines when they are administered to patients. To maintain their potency, vaccines need to be transported and stored within the safe temperature range of +2°C to +8°C. Being delicate biological products, if vaccines are not transported and stored within this temperature range, they become ineffective.

### Meeting this Criterion

*Nominating a person with primary responsibility*

Your practice must nominate a member of the clinical team to take responsibility for cold chain management and to achieve compliance with cold chain management guidelines.

The team member responsible for cold chain management must be trained so that they have the knowledge and skills required to ensure that vaccines remain potent.

All practice staff must know which team member has primary responsibility for cold chain so that they can seek advice and support from this person, in order to ensure vaccine potency.

Your practice must have a process for this person to hand over to another designated and trained member of the clinical team when they are unavailable.

Your practice's quality assurance and risk-management processes must include regular and routine self-auditing of your practice's cold chain management.

*Choosing a refrigerator*

Your practice must store vaccines in a reliable refrigerator that is capable of maintaining a stable temperature and is large enough to store sufficient number of vaccines to meet your practice's needs (with consideration of frequency and size of orders).

Do not use cyclic defrost and bar refrigerators because their internal temperatures fluctuate widely.

If your practice is using a domestic refrigerator, you must make certain modifications to reduce the risk of affecting the potency of the vaccines. You should:

- place a digital thermometer probe in the vicinity of stored vaccines to monitor the maximum and minimum refrigerator temperature
- store vaccines in their original packaging in a set of sliding plastic drawers or enclosed plastic containers to increase insulation (never in the door of the refrigerator)
- place bottles of salt water or unfrozen ice packs/gel packs in unused areas (e.g. refrigerator door or identified colder areas of the refrigerator) to help stabilise the temperature
- place temperature data loggers in different parts of the refrigerator to measure temperatures and identify temperature fluctuations.

*Monitoring the refrigerator's temperature*

Your practice must:

- at least twice a day on each day that the practice is open (ideally at the beginning and end of the day), monitor and record the minimum and maximum temperature of refrigerators in which any vaccine is stored
- view and consider (but not record) the current temperature every time a refrigerator storing a vaccine is opened.

*Data loggers in refrigerators*

Your practice can use data loggers to verify the efficacy of your cold chain efficacy and to conduct quality control checks of the temperature of refrigerators storing vaccines. Data loggers are small electronic devices that continuously measure temperatures. The data is uploaded to computer software so you can view and monitor the results. Some vaccine refrigerators come with inbuilt data loggers, and you can also purchase external data loggers.

Data loggers will help you determine and record:

- the accuracy of the refrigerator thermometer
- temperature fluctuations inside the refrigerator and the duration of the fluctuations
- areas in the refrigerator that are potentially too cool or too warm to store vaccines.

*Cold chain management*

To be confident of the potency of vaccines that your practice stores, your practice must:

- document and follow routine processes to maintain the cold chain, which may include risks to the potency of vaccines, and appropriate strategies to manage this risk
- ensure that all staff who handle vaccines receive ongoing education (as part of their professional development and training) that is appropriate to their level of responsibility
- know what action to take (including reporting and documentation) if the temperature of the refrigerator has been outside 2–8ºC
- self-audit your cold chain management as part of your routine quality assurance and risk management process, to ensure that vaccines being administered are potent. An example of a self-audit is contained in the appendix of the *National Vaccine Storage Guidelines: Strive for 5*.

## Examples of how a practice might choose to meet this Criterion

The following list contains some of the ways you might choose to demonstrate how your practice meets the requirements of this Criterion. Your practice may choose other forms of evidence to demonstrate how you meet the Criterion.

The following examples may not be suitable for all practices and contexts.

- Demonstrate that there is a team member with responsibility for sterilisation, cold chain management and education in their job description/s.
- Maintain a policy and procedure manual, that adheres to *Strive for 5*.
- Maintain a vaccine refrigerator temperature log.
- Include education around sterilisation, infection prevention and control and cold chain management in staff induction and ongoing training.

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# Glossary

This glossary contains the definition for terms used in this document.

| Term | Definition |
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| Aboriginal and Torres Strait Islander Status | A way of recording and identifying a patient's response when the practice asked them the standard Indigenous Australian status question: 'Are you of Aboriginal or Torres Strait Islander origin?' |
| Aboriginal health worker | A member of the Indigenous health workforce. Roles include:<br>▪ providing clinical functions<br>▪ liaison and cultural brokerage<br>▪ health promotion<br>▪ environmental health<br>▪ community care<br>▪ administration<br>▪ management and control<br>▪ policy development<br>▪ program planning.<br>They are often the first point of contact with the health workforce, particularly in remote parts of the country, |
| Access | The ability of patients to obtain services from the practice. |
| Accreditation | A formal process to assess a practice's delivery of healthcare against the RACGP's *Standards for general practices*. |
| Active hybrid medical record system | A combination of paper-based or electronic systems used by one or more practitioners to enter patient information. |
| Active patient | A patient who has attended the practice/service three or more times in the past two years. |
| Active patient health record | The health record of an active patient. |
| Administrative staff | Staff employed by the practice who provide clerical or administrative services and who do not perform any clinical tasks with patients. |
| Adverse drug reaction | See *Adverse medicines event*. |
| Adverse event | An incident that results in harm (e.g. disease, injury, suffering, disability, death) to a patient. |
| Adverse medicines event | An adverse event caused by a medicine. This includes harm that results from the medicine itself (an adverse drug reaction) and potential or actual patient harm that comes |

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| | from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident). |
| After-hours service | A service that provides care outside the normal opening hours of a general practice, whether or not that service deputises for other general practices, and whether or not the care is provided within or outside of the clinic. |
| Allied health professional | A health professional who collaborates with doctors and nurses to provide optimal healthcare for patients (e.g. physiotherapists, dieticians, podiatrists). |
| Alternative medicine | Health care practices in Australia that are not part of Australia's traditional or dominant health care system. The term is used interchangeably with the term "complementary medicine" and sometimes the term "traditional medicine" in some countries. |
| Antivirus software | Software that protects a computer or network from programs that can adversely affect how the computer or network operates. For example, viruses can corrupt other programs, destroy or modify data, affect how the computer or network operates. |
| Appointment system | The system that a practice uses to assign consultations to patients and practitioners. |
| Backup | A copy of all the files stored on a computer's or server's hard drive made onto another device such as a portable drive or an off-site server. |
| Business continuity plan | A plan that specifies how a practice will continue providing services if it is affected by disasters of various levels of severity. |
| CALD | Culturally and linguistically diverse. |
| Care outside normal opening hours | Clinical care that is provided to the practice's patients when the practice is normally closed. (Different practices can have different opening and closing hours.) |
| Carer | Someone who provides care and support to a family member or friend who is frail, or has a disability, mental illness, chronic condition, or terminal illness. |
| Chaperone | An impartial observer to a consultation between a practitioner and a patient. |
| Clinical-based care | Care that is provided when a patient attends a general practice, in contrast to care provided at another location, such as their home, school, or workplace, or a public space. |

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| Clinical governance | The policies, along with the implementation and monitoring of them, that make clinicians and health service managers jointly accountable for patient safety and the quality of care patients receive. |
| Clinical handover | The transfer, from one professional person or group to another, of professional responsibility and accountability for some or all aspects of a patient's care. |
| Clinical indicator | A measure, process, or outcome used to assess a particular clinical situation against the Standards, and determine whether the care delivered was appropriate. |
| Clinical management area | A physical space in the practice where clinical care is delivered. |
| Clinical risk management system | A system to manage the risk of errors and adverse events in the provision of healthcare. |
| Clinical significance | A way of referring to an assessment of:<br>▪ the probability that a patient will be harmed if further medical advice, treatment or other diagnostics are not obtained, and<br>▪ the likely seriousness of the harm. |
| Clinical team | The members of a practice team who have health qualifications that qualify them to perform clinical functions. |
| Clinical team member | An individual member of the practice team who has health qualifications that qualify them to perform clinical functions. |
| Code of Conduct | A set of principles that characterise good practice and explicitly state the standards of ethical and professional conduct that professional peers and the community expect of members of the practice team. |
| Cold chain management | The system of transporting and storing vaccines from the place of manufacture to the point of administration, that keeps the vaccines within the temperature range of 2–8°C. |
| Communicable disease | An infectious disease that is transmissible from one person to another or from an animal to a person by:<br>▪ direct contact with an affected person<br>▪ direct contact with an affected person's discharges<br>▪ indirect means. |
| Complaint | An verbal or written expression of dissatisfaction or concern with an aspect of the general practice. A complaint may be made using, for example, a complaints process, consumer surveys, or focus groups. |
| Complementary medicine | See *Alternative medicine*. |

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| Confidentiality | The act of keeping information secure and/or private, so that it is only ever disclosed to an authorised person. |
| Consequence | The effect that an event had, has, would have, on one or more of the practice's objectives. |
| Consultation note | A note in a patient's health record, made during or after a consultation, that contains relevant information about the consultation. |
| Continuity of care | The degree to which a patient experiences a series of discrete healthcare events as coherent, connected and consistent with their medical needs and personal circumstances. |
| Cooperative | A group of general practices that have an arrangement to work together to provide care to patients outside the normal opening hours of their practices. |
| Credentialing | The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners in order to form a view about their competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments. |
| Cultural background | Details of a patient's ethnic or cultural heritage that the practice has collected and recorded. |
| Cultural safety | The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs.<br>Health service organisations have a responsibility to "develop and sustain healthcare services that are free from discrimination and delivered in a manner that shows respect for patients and consumers" (quoted from Roles in Realising the Australian Charter of Healthcare Rights released by the Australian Health Ministers in 2008). |
| Cycle monitoring | Monitoring of the sterilisation cycle to ensure that the correct temperature, pressure, and time have been achieved for each cycle. |
| Disability | Disability is an umbrella term for any or all of the following components:<br>• impairments resulting in problems in body function or structure<br>• activity limitations resulting in difficulties in executing activities |

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| | • participation restrictions resulting in problems an individual may experience in involvement in life situations. |
| Disaster recovery plan | A documented plan of the actions the practice will take to retain and restore patient health information in the case of an event (such as a power failure) that would otherwise mean that some or all of the information would be unavailable. |
| Discrimination | Differential treatment or consideration of a patient based on particular characteristics (such as gender, age, ethnicity, religion). Positive discrimination enhances the care given to the patient, and negative discrimination is to the detriment of the patient's care. |
| Documented standardised clinical terminology | The structured vocabulary clinical practices use to accurately and consistently describe the care and treatment of patients. |
| Duty of care | The legal obligation to safeguard others from harm while they are in your care, or using your services, or exposed to your activities in any other way. |
| Early detection and intervention | The detection of early stages of a disease and the prompt and effective intervention to prevent the progression of the disease. |
| Electronic communication | The transfer of information (including but not limited to patient health information) within or outside the practice using email, internet communications, SMS, or facsimiles. |
| Emergency contact | The contact person who a patient has nominated to be contacted in an emergency. |
| Encryption | The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity. |
| Enrolled nurse | A nurse who works under the direction and supervision of a registered nurse as stipulated by the relevant nurse registering authority, but remains responsible for his/her actions and accountable for the delegated nursing care s/he provides. |
| Environmental cleaning | The process of removing all visible dust, soils, and other material from a surface. |
| Ergonomic assessment | The process of evaluating the extent to which an employee's workstation is designed to minimise the risk of injury and to maximise productivity. This is also referred to as a workstation assessment. |
| Ethical dilemma | The need to choose between two courses of action, both of which will result in an ethical principle being compromised. |

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| Ethics (or code of behaviour) | The principles adopted by an organisation to ensure that all its decisions and actions conform to normal and professional principles of conduct. |
| Error | An occasion when an activity or a planned sequence of mental or physical activities fails to achieve its intended outcome, and when this failure cannot be attributed to chance. |
| Firewall | Security software that prevents unauthorised (and usually external) access to information stored on a private network, and controls the flow of data according to specific rules defined by the practice. |
| Follow up | Activities that are the logical and responsible step/s to take after taking earlier related actions. For example:<br>▪ making a phone call to find out the status of tests and results that are expected but not yet been received<br>▪ contacting a patient to discuss a report, test or results. |
| Gender | A classification based on socially constructed differences between men and women that result in roles and expectations being assigned according to whether someone identifies (or is identified) as male or female. (The word 'sex' refers to the biological and physiological characteristics that define men and women.) |
| General practice | General practice is the provision of patient-centred, continuing, comprehensive, coordinated primary care to individuals, families, and communities. |
| General practitioner | A registered medical practitioner who:<br>▪ is qualified and competent for general practice anywhere in Australia<br>▪ has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities<br>▪ maintains professional competence in general practice. |
| Hardware | The physical components of a computer, including monitors, hard drives, and central processing units. |
| Health information | A subset of a patient's personal information that is collected in connection with the provision of a health service. It includes information or opinions about the health or disability of an individual, and a patient's wishes about future healthcare and health services. |

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| Health outcome | The health status of an individual, a group of people or a population which is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals, such as nurses and specialists. |
| Health promotion | The process of enabling people to increase their control over, and improve their health. It extends beyond influencing an individual's behaviour to include a wide range of social and environmental interventions. |
| Health summary | Documentation usually included in a patient health record that provides an overview of all components of the patient's healthcare. For example, current medications, relevant past health history, relevant family history, allergies, and adverse drug reactions. |
| Home visit | A general practice consultation conducted in the patient's (or someone else's) home. |
| Human Research Ethics Committee (HREC) | A committee constituted according to National Health and Medical Research Council requirements that reviews applications from people or organisations undertaking research projects involving human subjects. |
| Human resources | Employees and others who work in an organisation.<br>An area of business management that addresses the recruitment, training, and management of employees. |
| Incident | An event or situation that resulted, or could have resulted, in:<br>▪ unintended and/or unnecessary harm to a person<br>▪ a complaint, loss, damage, or claim for compensation. |
| Individual Healthcare Identifier | A patient's unique 16-digit number allocated by the Department of Human Services. An Individual Healthcare Identifier is allocated to each eligible Australian patient who seeks healthcare. |
| Induction program | Training provided to a new staff member to introduce them to the practice and its systems, processes and structures. |
| Infection | The invasion and reproduction of pathogenic (disease-causing) organisms inside the body that can cause tissue injury and progress to disease. |
| Infection control<br>Infection control measures | Actions to prevent the spread of pathogens between people in a healthcare setting. |
| Information management | The policies, processes, and systems that govern the creation, use, and storage of information. |

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| Information security | The protection of the confidentiality, integrity, and availability of information. |
| Informed consent | The written or verbal consent that a patient gives to the proposed investigation, proposed treatment, or invitation to participate in research, when they understand the relevant purpose, importance, benefits, and risks. For consent to be valid, a number of factors need to be satisfied, including:<br>▪ the patient has received and understood sufficient and appropriate information and is aware of the material risks<br>▪ the patient has the mental and legal competence to give consent. |
| Informed refusal | A patient's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment. |
| Interpreter service | A service that provides trained language interpretation or translation, either face-to-face or by telephone. |
| Issue | A relevant event that was not planned and requires action. An issue could be a problem, query, concern, or risk. |
| Known allergy | A hypersensitive reaction to a medicine or other substance that is made known to a GP (see also *Adverse drug reaction*). |
| Lifestyle risk factors | Habits or behaviours that people choose to engage in that, if changed, can directly affect some medical risk factors by reducing the likelihood of developing disease. |
| Medical consumable | A medical product used for a therapeutic purpose that is not pharmaceutical and is not re-usable. For example, a syringe. |
| Medical deputising service | A service that arranges for, or facilitates, the provision of medical services to a patient by a medical practitioner (deputising doctor) during the absence of, and at the request of, the patient's GP (principal doctor). |
| Medication history | An accurate recording of a patient's medications, comprising:<br>▪ a list of all current medicines including prescription and non-prescription medicines, complementary healthcare products and medicines used intermittently<br>▪ recent changes to the medication list<br>▪ past history of adverse drug reactions including allergies<br>▪ past history of recreational drug use. |

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| Medicine | A drug or other preparation for the treatment or prevention of disease. |
| Mission | The overall function of an organisation. |
| Mistake | An error or adverse event that results in harm. |
| Natural immunity | Immunity to a particular infection that is not the result of vaccination or previous infection but is inherent in the genetic make-up of an individual, species, family, etc. |
| Near miss | An incident that did not cause harm but could have. |
| Need<br>(As used in this document in phrases such as 'a practice needs to', and 'you need to'.) | Must if determined reasonable.<br>When interpreting and complying with these Standards, determine what 'needs' to be done by considering what is reasonable, given all relevant circumstances of the situation. |
| Network | A group of connected computers and peripheral devices used to store and share information sharing communicate electronically. |
| Next of kin | The person's closest living relative or relatives, as identified by the person. |
| Normal opening hours | The advertised opening hours of the practice. |
| Nurse | A registered nurse who can demonstrate competence in the provision of nursing care. A registered nurse practices independently and interdependently, and has accountability and responsibility for their own actions and the delegation of care to enrolled nurses and other healthcare workers. |
| Nurse practitioner | A registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role where their scope of practice is determined by the context in which they are authorised to practice. |
| Open disclosure | The way in which clinicians should communicate with and support patients, and their family and carers who have experienced harm during health care. |
| Organisational chart | A description (often presented visually) of an organisation's structure, which includes areas (e.g. departments, division, properties), hierarchies, roles, responsibilities, and professional relationships between individuals. |
| Other visit | A general practice consultation conducted in a facility other than the general practice or the patient's home (e.g. residential aged care facility). |
| Outcomes indicators | Ways of measuring the effects of care on patients and communities. |

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| Outside normal opening hours | The hours other than the practice's normal opening hours. |
| Over-the-counter medicine | Medicines that members can purchase from retailers (such as pharmacies, supermarkets, and health food stores) for self-treatment. |
| Patient | A person who is seeking or receiving healthcare. In relevant circumstances, the term also refers to a carer. |
| Patient health information | A patient's name, address, account details, Medicare number and any information (including opinions) about the patient's health. |
| Patient health record | Information, in paper or electronic form, held about a patient, which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information, legal information and reports, and occupational health and safety reports. |
| Performance management system | A formal and structured process used to evaluate and document an employee's performance in their role. |
| Personal Protective Equipment (PPE) | Equipment used as to prevent and control infection. PPE include appropriate gloves, waterproof gowns, goggles, face shields, masks, and footwear. |
| Physical facilities | The building/s and equipment used to provide clinical care to patients. |
| Policy and procedures manual | A document containing the practice's policies and procedures. |
| Position description | A document describing an employee's role, responsibilities, and conditions of employment. |
| Practice information sheet | A document that contains information patients need to know about the services the practice provides, and how to access those services. It should not be hand-written. |
| Practice management | The strategic planning, reviewing, and implementation of processes that increase a practice's efficiency and contribute to 'excellence in healthcare'. |
| Practice team | Staff who provide care within the practice (e.g. GPs, receptionists, practice managers, general practice nurses, allied health professionals). |
| Practice team member | An individual member of the practice team who provides care within the practice (e.g. GP, receptionist, practice manager, general practice nurse, allied health professional). |
| Practitioner or clinician (see also *Clinical team*) | A member of the practice team who has health qualifications that qualify them to perform clinical functions. |

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| Primary health care nurse | A nurse who works in primary care where primary care nurse is not a formally identified profession. |
| Privacy of health information | The protection of personal and health information to prevent unauthorised access, use, and dissemination. |
| Process indicators | Ways of identifying and evaluating the processes used to give and receive care. |
| Qualified | Holding the educational or other qualifications required to perform a specific activity (e.g. administer first aid) or hold a specific role (e.g. general practitioner, registered nurse). |
| Quality assurance | The maintenance of a desired level of quality in a service or product, especially by attending to every stage of the process of delivery or production. |
| Quality improvement | One or more activities undertaken within a practice to monitor, evaluate, or improve the quality of healthcare delivered by the practice. |
| QI&CPD<br>Quality improvement and continuing professional development | Educational activities endorsed by the RACGP that lead to quality improvement in clinical care. |
| Recall | The process of requesting a patient to attend a consultation to receive further medical advice on matters of clinical significance. |
| Referral | The process of sending or directing a patient to another practitioner. |
| Relevant family history | Information about a patient's family history that the practitioner considers important in order to provide appropriate clinical care to the patient. |
| Relevant social history | Information about a patient's social history (including employment, accommodation, family structure) that the practitioner considers important in order to provide clinical appropriate care to the patient. |
| Risk | An event or set of events that, if they occurred, would adversely affect the achievement of objectives. |
| Risk management | Systematic application of principles, approaches, and processes to:<br>▪ identify, assess, and minimise risks<br>▪ plan appropriate responses<br>▪ implement appropriate responses when required. |
| Risk matrix | A matrix used to categorise risks according to their probability and severity of the effects they would cause. |

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| Risk register | A document used to record problems and issues that could result in a risk becoming a reality, and the steps taken to minimise the likelihood or effect of the risk. |
| Safe and reasonable | A desired description of the outcome of a clinical care decision made by a practice that was based on relevant factors (e.g. the practice's location and patient population) and an understanding of what their peers (or practices in the same area) would agree was safe and reasonable. |
| Safety | The condition that means that potential risks and unintended results are avoided or minimised. |
| Schedule 8 medicines | Drugs that have a recognised therapeutic need and are legally available only by prescription because they are drugs of dependence and therefore have a higher risk of misuse, abuse, and dependence. |
| Screensaver | A software program that displays constantly changing images or dims the brightness of a display screen. It is used to:<br>▪ protect the screen from having an image etched onto its surface<br>▪ restrict unauthorised access to the computer or the information currently displayed on the screen. |
| Seronegative | Giving a negative result in a blood serum test (for example for the presence of a virus). |
| Server | A computer that provides services to users connected to the network running the server. Services can include printing, access to files and software applications, central storage of data). |
| SNAP | An acronym of four major risk factors to a patient's health: Smoking history, Nutrition, Alcohol consumption, and Physical activity. |
| Sociable hours | The after-hours period between 6 pm and 11 pm on weeknights. |
| Spaulding classification | A system that categorises medical devices according to the risk of infection involved with their use. |
| Standard clinical practice | Practice that might reasonably be expected by the public or professional peers. |
| Standard precautions | Methods and practices that health professionals use to prevent infection of themselves and others, based on the assumption that all blood and body fluids are potentially infectious. |
| Strategy | A method or plan for an organisation to achieve its short, medium, and long-term goals. |

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| Structure indicator | A measure, process, or outcome used to assess material resources, facilities, equipment and the range of services provided at a general practice. |
| Technology-based patient consultations | Consultations that use any form of technology to communicate (such as video-conferencing, internet and telephone), instead of face-to-face interactions. |
| Telephone triage | A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care. |
| Timely | Within an appropriate period of time for the given situation, as might reasonably be expected by professional peers. |
| Tracking and tracing | Part of a sterilisation process that refers to batch control identification of instruments used for a procedure on a patient. |
| Transmission-based precautions | Methods and practices that health professional use to prevent infection of themselves and others, when a patient is known or suspected to be infected with a highly transmissible infection such as influenza and when standard precautions may not be sufficient to prevent infection. Transmission-based precautions include droplet precautions, airborne precautions, and contact precautions and involve the use of triage, personal protective equipment, isolation, and other measures. |
| Triage | The assignment of degrees of urgency to wounds or illnesses in order to appropriately prioritise the treatment of a large number of patients or casualties. |
| Unsociable hours | The following after hours periods:<br>▪ 11 pm to 8 am weekdays<br>▪ before 8 am and after 12 noon on Saturdays<br>▪ any time on Sundays and public holidays |
| Urgent | Requiring immediate action or attention. |
| Values | Principles that stipulate how the organisation and staff are expected to behave. |
| Vision | A declaration of an organisation's objectives. |