Standards for health services in Australian immigration detention centres
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Acknowledgments

This is the Royal Australian College of General Practitioners (RACGP) Standards for health services in Australian immigration detention centres. These Standards have been based on the RACGP Standards for general practices (3rd edition) and have been customised for use by health services in Australian immigration detention centres.

In developing the RACGP Standards for health services in Australian immigration detention centres, the RACGP would like to thank:

• the members of the National Expert Committee on Standards for General Practices (NECSGP), whose deep commitment to standards of quality and safety has resulted in this final publication:
  – Dr Lynton Hudson (Chair)
  – Dr Noela Whitby AM (previous Chair)
  – Dr John Aloizos AM
  – Dr Karen Douglas
  – Dr Chris Mitchell
  – Mr Gary Smith
  – Ms Robin Toohey AM
  – Dr Howard Watts OAM

• Dr Leanne Rowe, the RACGP’s nominee to the Detention Health Advisory Group (DeHAG) for the Department of Immigration and Citizenship (DIAC)

• the general practitioner experts in refugee health who provided comment on drafts of these Standards

• the members of the DeHAG who provided advice during the development of these Standards, including nominees from:
  – Australian Dental Association
  – Australian Medical Association
  – Australian Psychological Society
  – Commonwealth Ombudsman
  – Forum of Australian Services for Survivors of Torture and Trauma
  – Immigration Detention Advisory Group
  – Mental Health Council of Australia
  – Public Health Association of Australia
  – Royal Australian and New Zealand College of Psychiatrists
  – The Royal Australian College of General Practitioners
  – Royal College of Nursing, Australia
  – Victorian Healthcare Association

• the staff from Professional Support Services and International Health and Medical Services, who participated in a pilot of a draft version of these Standards at the Maribyrnong Immigration Detention Centre, and a subsequent focus group

• all the health professionals working in health services in Australian immigration detention centres who provided comment on the revisions required to make these Standards applicable and appropriate for use by these services.

The RACGP Standards for health services in Australian immigration detention centres were principally authored by Dr Ronelle Hutchinson and Mr Ian Watts on behalf of the NECSGP. Development work has been supported by the RACGP GP Advocacy and Support team.
I am pleased to introduce The Royal Australian College of General Practitioners (RACGP) Standards for health services in Australian immigration detention centres.

Appropriate health care is a basic human right in any civil society, and the RACGP has long advocated that all people living in Australia should have access to high quality general practice and primary health care.

For more than 10 years, the RACGP has been working with consumers, members of our profession and a wide range of stakeholders to articulate standards for the settings in which we work.

Two recent instances of the unlawful detention of Australian citizens within immigration detention centres and a report from the Human Rights and Equal Opportunity Commission have highlighted concerns about the provision of health care to people detained in these facilities. The recommendations from the Commonwealth Inquiry into the circumstances of the immigration detention of Cornelia Rau (‘the Palmer report’) and Inquiry into the circumstances of the Vivian Alvarez matter (‘the Comrie report’) provide valuable guidance in ensuring the quality and safety of primary health care for people detained in immigration detention centres.

Initially the RACGP proposed that its Standards for general practices (3rd edition) were applicable to immigration detention centres, and that the general practice profession could assist in ensuring that the standards of health care in these facilities meet the expectations of the Australian community.

In 2006, when the Australian Government Department of Immigration and Citizenship (DIAC) sought the RACGP’s assistance to work with health professionals, their employers and the DIAC to develop standards for use in health services in immigration detention centres, the RACGP was pleased to have the opportunity to assist.

The RACGP supports the reforms within the DIAC in response to the Palmer and Comrie reports. After consultation, customisation of the RACGP’s Standards for general practices (3rd edition) and pilot testing, the RACGP Standards for health services in Australian immigration detention centres have been finalised. These Standards mirror the quality and safety principles in the Standards for general practices (3rd edition).

As recently elected president of the RACGP, and a migrant to Australia, I commend these RACGP Standards to the people who care for patients in Australian immigration detention centres. I particularly want to acknowledge the commitment and advocacy of Dr Leanne Rowe and her peers in our college, including members of the National Expert Committee on Standards for General Practices and their colleagues on the DIAC Detention Health Advisory Group, and to pay tribute to their contribution to our shared professional ideals.

Dr Vasantha Preetham
President
April 2007
The Department of Immigration and Citizenship (DIAC) has a duty of care toward those whom it detains. A primary responsibility is to protect the health of people in immigration detention and, when health care is required, to provide health care services that are timely, appropriate and effective. The quality of care in immigration detention should be consistent with the quality of health service provision in the general Australian community.

The duration of detention depends on many factors and may be brief or prolonged. The population in immigration detention is characterised by cultural and linguistic diversity. The fact of detention and the experiences of some people before detention contribute to increased vulnerability to the development of health problems. The provision of high quality health care in the context of detention is a challenging undertaking. The ethical complexity of providing health care, particularly mental health care in a detention environment, has been extensively discussed. The major expansion of detention options that has occurred in recent times has substantially improved capacity for health service provision that is responsive to the individual health care needs of people in immigration detention.

These Standards represent a substantial advance in the capacity of the DIAC to discharge its duty of care to people in immigration detention. They are a clear statement of the department’s commitment to high quality health care and to openness and accountability in health service provision. The Standards are a valuable guide to practice for health service providers. The linkage of standards in immigration detention with general community standards is a welcome development.

The application of these Standards will result in improvement in the quality of health care in immigration detention and will contribute to the prevention of failures in health care such as those that have been the subject of multiple inquiries.

The Detention Health Advisory Group is pleased to have had the opportunity to work with the RACGP in the production of these Standards. We now look forward to the systematic implementation of the Standards and to evaluation of the impact of them on the quality of health service provision in immigration detention.

Harry Minas
Chair, Detention Health Advisory Group
April 2007
The RACGP is keen to support health professionals, their employer organisations and the Australian Government Department of Immigration and Citizenship (DIAC) through the Detention Health Advisory Group (DeHAG) in their endeavours to provide high quality health care to people detained in Australian immigration detention centres.

The development of health care standards for use in immigration detention centres falls within the responsibility of the Detention Health Advisory Group (DeHAG). In July 2006, DeHAG members agreed that DIAC should progress the development of health care standards based on the RACGP Standards of general practices. Members of the DeHAG have worked closely with the RACGP and the DIAC in the development of the RACGP Standards for health services in Australian immigration detention centres.

Who are these Standards for?

Indicators of quality can be developed for a variety of stakeholders with different, sometimes overlapping or conflicting perspectives who emphasise different priorities and who may wish to use indicators in different ways. Indicators of quality and safety are only legitimate and useful if they are accepted by the stakeholders they affect, including those who use such indicators.

Standards can focus on different levels of the health care system: the patient, the practitioner, the organisation, the region or the country. This is because the conditions for error and harm can occur at all levels.

With process factors being pervasive contributors to medical error in primary care, there is sound reason to focus on the setting and process of care as the unit of analysis.

These Standards have been written principally for the multidisciplinary teams of health professionals who provide care to people detained in Australian immigration detention centres. These services provide and coordinate initial, continuing, comprehensive and coordinated medical and allied health care (including mental health care) for individuals, families and communities within detention centres, and provide care which integrates biomedical, psychological, social and environmental understandings of health. Throughout the Standards, mental health professionals are referred to as ‘clinical staff members’ or ‘allied health staff members’ as appropriate. Please refer to the glossary for more information on how different types of health care professionals are defined in these Standards.

When detaining people in immigration detention centres, the Australian Government bears a special responsibility to provide adequate health care (including mental health care) through the health services in these centres. The government has committed itself to ensuring that people in detention are able to access timely and effective primary health care, including mental health services (including counselling) and dental health services, in a culturally responsive framework. Where a health condition cannot be managed within the centre, the government is committed to ensuring that care is facilitated by referral to external advice and/or treatment. The government requires that a person in detention who sustains serious injury or becomes seriously ill while in detention be provided with a level of care commensurate with their condition and with the health care that would be available to the Australian community.

In this context, the Australian Government and the employers of the health professionals in immigration detention centres are important secondary audiences for these Standards.

These Standards are based on the RACGP Standards for general practices (3rd edition), and the whole scope of those Standards are applicable to health services in immigration detention centres. The challenge for the RACGP has been to ensure that the Standards are appropriate to the particular
context in which care is provided and the particular patient populations for whom care is provided in immigration detention centres.

Health services within immigration detention centres provide health care in a unique and challenging environment. Some of these challenges include:

- the potential for language or cultural differences to create misunderstandings and misinterpretations during consultations
- the process of detaining individuals which may erode their trust in the health care system and make them hesitant to access care. This hesitancy needs to be recognised in the context of the individual’s cultural, religious and sociopolitical background
- an individual’s health and illness framework which may arise from a complex interaction of past experiences, and an individual’s religious, cultural and sociopolitical background and which needs to be understood if comprehensive health care is to be provided
- cultural awareness which is obviously paramount in these health care settings. ‘Culture’, however, is a complex issue and it is important to acknowledge that many individuals detained in immigration detention centres may belong to minority groups in their home countries and may have been persecuted for this reason. These individuals may not therefore be representative of the mainstream culture of their country of origin (see criterion 2.1.1).

An appreciation and understanding of how these complex issues impact on an individual’s perception of physical and psychological health is important in achieving good quality health care from a whole person perspective. The RACGP recognises that the people who are detained in these centres also have a critical stake in the Standards, and recognises that they are another important secondary audience.

What is the purpose of these Standards?

Indicators of quality can have a number of purposes: to provide accountability, to assist in quality improvement and to inform consumers to help them make wiser purchasing decisions.\(^7\)

The purpose of these Standards is to engage primary health care professionals in a comprehensive, continuous quality improvement process.

How do the Standards reflect the principles of quality and safety?

These Standards aim to address the quality and safety of the health care provided to people detained in Australian immigration detention centres. They are, in essence, the same Standards that apply to and are expected of general practice health care delivered to the Australian community.

Quality and safety in health care depends on more than the performance of individual health professionals working in isolation. Efforts to assess and enhance quality also need to consider how health services are structured and organised.\(^8\)

In recent years there has been a growing recognition of the role of the health care system (including both small and large scale systems) as a precursor to safety and quality. In focusing on the service as the unit of analysis, service structures and processes are considered to lie within the scope of the Standards.

Safety related behaviours are affected by informal aspects of an organisation (such as its attitudes to safety)\(^9\) and there is a need for indicators of processes and structures that support a safety culture. For example, it is important that infection control processes are documented in a meaningful way (e.g. a written policy), however it is arguably more important that the relevant staff members know and understand the infection control processes.
‘Viewing and analysing health care as a system has practical implications. Firstly, improvements in the quality of health care delivery are unlikely without changes to the systems: working harder within the same system is unlikely to result in improvements. Secondly, change in a system is more likely to be successful if it is first undertaken on a small scale. It is then possible to determine whether the change achieves its intended outcome and whether any unintended consequences also result.10

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

- structure relates to material resources, facilities, equipment and the range of services provided at the health service
- process relates to what is done in giving and receiving care (eg. the consultation, ordering tests or prescribing)
- outcomes relate to the effects of care on patients and communities (eg. immunisation coverage rates, diabetes management, or cervical screening).11

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

These Standards do not, and cannot, address all the impacts on the health and wellbeing of people detained in Australian immigration detention centres. A range of issues impact on health and wellbeing (such as housing, nutrition, physical activity) that reinforce the effects of high quality and safe health care provided by the health service. These issues are beyond the scope of these Standards and will need to be addressed by the Australian Government and the companies contracted to manage the day to day operations of immigration detention centres.

What are the Standards?

The RACGP Standards for health services in immigration detention centres outline the hallmarks of safe, high quality care. The Standards are based on the RACGP Standards for general practices (3rd edition), which are internationally accredited by the International Society for Quality in Health Care (ISQua) and have been used as the basis for development of standards for general practices in both New Zealand and Ireland. Furthermore, other health care sectors are looking to the RACGP Standards as a viable framework for quality improvement, and in recent years the Australian optometry profession has used the Standards as a basis for developing their own practice standards.

The RACGP Standards for health services in Australian immigration detention centres form one of the benchmarks of quality and safety in primary care and provide future directions for quality improvement. The Standards outline the aspects of a health service that support high quality and safe comprehensive care, including attention to the services that are provided, the rights and needs of patients, quality improvement and education processes, management, and the physical aspects of the health service.

The Standards reflect a move away from viewing one health care professional as being solely responsible for the structures, systems and processes that deliver quality and safety, and a move toward recognising that each member of the team – and the team as a whole – contributes to quality improvements within a health service.

The Standards concentrate on the principles of quality and safety rather than prescribing exactly how a health service should provide care. The Standards are written so as to apply to the diverse forms of health services in immigration detention centres. The Standards also recognise that
different patients have different health care needs, and that services may provide different types of care. The *Standards* do not focus on current government programs (such as health or immigration policies or programs) or require services to participate in such programs in order to meet the *Standards*.

Where possible, the *Standards* are based on evidence from clinical trials or large scale research into improvements in quality and safety in practice and patient care, and from current professional consensus where no other evidence is available. The *Standards* concentrate on those areas of a health service that are considered critical in supporting quality and safety.

There is limited information about the health care needs of people detained in immigration detention centres. There is some evidence that detention itself may impact on mental health and that the detention context, immigration administrative processes (eg. appeals processes) and associated stressors may exacerbate symptoms of psychological morbidity for people detained in immigration detention facilities.[12–14] There are several clinical observations published about asylum seekers who have been detained in Australian immigration detention centres, but more systematic or scientific studies are rare. A number of studies have demonstrated higher than average levels of mental illness and psychiatric morbidity including high rates of suicide, depression, hunger strikes, post-traumatic stress, anxiety and panic among asylum seeker populations worldwide.[15–18]

Legal advice sought by the RACGP during the preparation of the *Standards for general practices* (3rd edition) suggested that the indicators of quality in those *Standards* could potentially help identify a widely held, peer professional view (currently the tort law test for the standard of care in at least one Australian state).[19] As a result, the RACGP considered it critical that the indicators not unreasonably ‘raise the bar’ without proper regard to all the circumstances of the services being assessed. It was decided that the indicators should reflect the norm for good quality general practice in Australia – a principle that extends to the standards for health services in Australian immigration detention centres.

**Why are the *Standards* important to our health service?**

Striving for – and achieving – standards are important to health services for a number of reasons:

- all health professionals want to improve care and patient safety, and the *Standards* provide an overview of the important components of a health service that are central to these improvements
- the *Standards* provide a structured way for health services to assess themselves in relation to quality and safety, before considering what changes may need to be made
- achieving the *Standards* is an indication that a health service is providing high quality, safe and effective care
- engaging in a quality improvement cycle and periodically returning to the *Standards* can help health services keep their development on track and determine if quality improvement changes have achieved their intended outcomes
- using the *Standards* provides an opportunity for health service staff to come together as a team to consider quality improvement. The *Standards* cover many areas and achieving them requires the collaborative effort of the whole team
- engaging in quality improvement and meeting the RACGP *Standards* demonstrates to the community that the health service is serious about providing the highest quality and most comprehensive care possible.
**How does our service use the Standards?**

Services can self assess against the Standards as part of their quality improvement process, or they might collaborate with other services to assess each other. Services can also have an external party assess and certify the degree to which they meet the Standards.

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

Each standard describes an element of the health service’s activity that is critical to quality and safety, with specific criteria separating each standard into a number of components. Each criterion describes a process that health services can use to meet the standard and offers explanatory notes to assist health services in assessing against the criterion.

The explanatory notes provide detailed descriptions of the RACGP’s position on issues related to the criterion and are the authoritative view on how criterion should be interpreted.

Each criterion is followed by a number of indicators to help services demonstrate how they have achieved that criterion. There are indicators that require services to demonstrate the processes they have used to meet the criterion, indicators that require staff to be aware of those processes, indicators that require services to document their processes, and indicators that require services to demonstrate feedback mechanisms to ensure that processes are working properly.

The indicators seek to focus on principles of quality. For example, the indicator for scheduling care does not require the use of an ‘appointment book’; the indicator instead requires that care is scheduled effectively. This approach allows services to focus on achieving timely access to care based on clinical need, rather than on the mechanism of booking appointments.

There are advantages and disadvantages to using structure, process and outcome measures. Most process measures require less risk adjustment for patient illness than do most outcome measures. This is important in the immigration detention context, where the population of people in detention may change rapidly. Process indicators are preferable where the determinants of the outcome are beyond the control of the health provider, and the RACGP has decided to focus on process indicators that are within the direct control of health services in immigration detention centres. In many instances, outcome indicators are the ideal measures of quality, however consideration needs to be given to causality, and whether there are intervening variables affecting the outcome that are beyond the control of the setting under assessment.
The Standards are written as an integrated whole. For example, indicators relating to privacy appear in more than one place in the Standards. This indicates that services should consider a number of different systems that contribute to the protection of patient privacy, eg:

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

Services can assess themselves against each criterion and associated indicators to determine whether they have achieved the standard. At times, services may find that some indicators are not applicable; in these cases, services should consider why the indicators do not apply and if their peers would agree.

Health services can use the following means to demonstrate how they achieve the standards, criteria and indicators:

- interviews with all staff (medical, clinical, allied health and administrative)
- interviews with the medical staff (doctors) in the service
- interviews with staff who provide clinical care (such as nurses and allied health professionals)
- interviews with administrative staff in the service (such as receptionists)
- direct observation of the service
- reviewing patient health records
- reviewing documentation (such as policy and procedures manuals, information sheets, continuing professional development data or appointment schedules).

The use of different sources of information means that information can be ‘triangulated’, allowing more robust assessments of whether a service meets the Standards.

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

Some standards are easy to measure; and others are more difficult to assess. There is evidence that experienced health professionals can – and do – make accurate, relevant and informed judgments about those aspects of a service that are not easily measured or quantified. These might be important aspects of quality that could be improved in the health service.

Some indicators are of central importance to quality and safety. These ‘key’ indicators are marked with a flag symbol. This assists services to determine that they have achieved the critical aspects of the criterion. Indicators that are not flagged are still important, and provide guidance to services about other ways in which they might demonstrate quality and safety. These are often indicators that are important to include in the Standards, but which are more challenging for some health services to achieve.
The Palmer and Comrie reports suggest that some clinical risks are magnified when delivering health care to patients detained in immigration detention centres. As such, some of the criteria in these Standards relate to systems and processes that require extra attention to ensure the provision of high quality and safe care to patients within immigration detention centres. These include:

• informed patient decision (criterion 1.2.2)
• interpreter services (criterion 1.2.3)
• clinical autonomy for medical, clinical and allied health staff (criterion 1.4.2)
• continuity of comprehensive care (criterion 1.5.1)
• continuity of the therapeutic relationship (criterion 1.5.2)
• engaging with other services (criterion 1.6.1)
• respectful and culturally appropriate care (criterion 2.1.1)
• confidentiality and privacy of health information (criterion 4.2.1)
• transfer of health information (criterion 4.2.3).

How do Standards help reduce risk?

Every system in a health service is vulnerable to errors. Ideally, each system would operate perfectly. The reality, however, is that equipment, policies and procedures, external systems (such as other health professionals), patients, doctors and other staff are all vulnerable to mistakes, errors and ‘failures’. For example, the thermostat on the vaccine refrigerator may stop operating properly and cause the temperature of the vaccines stored in the refrigerator to decrease to freezing.

Not all vulnerabilities in a health service have an adverse impact on patient care. The vaccine in the example above may continue to be effective if the temperature did not decrease sufficiently to deactivate it. However, vulnerabilities can occur in sequence: the temperature of the vaccine refrigerator in the example above is not recorded when the thermostat became faulty, the potency of varicella vaccine is compromised due to the decrease in temperature, and the vaccine is administered to a patient who subsequently contracts chicken pox.

Such a sequence of vulnerabilities has been likened to the lining up of holes in Swiss cheese. Safeguards need to be put in place in each system to reduce the likelihood of an error occurring – the aim is to prevent the ‘holes’ from lining up.

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

It is essential that health services meet all the standards and criteria to be confident that they have minimised the chance of an error occurring and have increased the safety and quality of the care they provide. When assessing against these Standards, services might identify areas in which they could improve. Services may wish to prioritise these improvements if there are a number of changes they wish to make. Some improvements may take a period of time to implement and evaluate; the important issue is that services actively work toward those improvements.
What is the value of peer review in our service?

Services that undertake their own assessment against the Standards might consider discussing the assessment informally with trusted colleagues. A ‘fresh set of eyes’ can assist services in identifying areas in which they perform well, as well as areas where improvements are needed. Peers can make judgments that take into account all factors, and offer more than just the inspection of a checklist that could be conducted by a trained person. Peers can also provide feedback on innovative ways in which services can improve, and provide an opportunity to exchange ideas about what will work best in a particular environment. Most importantly, peers can provide feedback on quality improvement activities – they can help services identify whether changes have brought about the intended outcomes or if there are other things the service can do to improve quality.

Health services may be assessed against the Standards by a third party to gain formal ‘accreditation’ against the RACGP Standards. The only model of third party review supported by the RACGP for these Standards is by peers working in primary care. Any formal assessment process against the RACGP Standards needs to be based on common sense and shouldn’t seek to penalise or exclude health services on the basis of technicalities.

Does meeting the Standards protect our service legally?

During the review of the Standards for general practices (2nd edition), the RACGP commissioned a legal opinion on a number of areas of the Standards. In addition, all medical defence organisations in Australia were consulted as to the priority areas they thought needed to be included. The RACGP considered these views and weighed the medicolegal risk, the benefits to patient safety and the feasibility of services implementing these systems.

Regarding issues of high medicolegal concern (such as the follow up of tests and results in criterion 1.5.4), the RACGP has endeavoured to prepare standards that reflect what would reasonably be expected of a health service in an immigration detention centre and a general practice within the community. Health services that have concerns about a particular issue are encouraged to seek further advice from their doctor’s medical defence organisation, the relevant professional indemnity insurers and the DIAC.

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

The RACGP National Expert Committee on Standards for General Practices welcomes feedback regarding possible improvements to these Standards. Any comments or ideas about the RACGP Standards for health services in immigration detention centres can be forwarded to:

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section one
SERVICES

Standard 1.1 ACCESS TO CARE
Our service provides timely care and advice.

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

Standard 1.3 HEALTH PROMOTION AND PREVENTION OF DISEASE
Our service provides health promotion and illness prevention services that are based on best available evidence.

Standard 1.4 DIAGNOSIS AND MANAGEMENT OF SPECIFIC HEALTH PROBLEMS
Our service provides patient care that is effective, and in broad agreement with best available evidence.

Standard 1.5 CONTINUITY OF CARE
Our service provides continuity of care for our patients.

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

Standard 1.7 CONTENT OF PATIENT HEALTH RECORDS
Our patient health records contain sufficient information to identify the patient and to document the reason for visit, assessment, management, progress and outcomes.
CRITERION 1.1.1

Scheduling care in opening hours

Our service has a flexible system that enables us to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs.

Explanation

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

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

Health services need to be able to identify patients who have an urgent health need and facilitate care for them appropriately. The system used to identify patients with urgent matters needs to be efficient and prompt. Medical, clinical and administrative staff need to be able to describe the service’s policy and procedures for identifying patients with urgent medical matters and the procedures for seeking urgent medical assistance from a clinical staff member. Staff also need to be able to describe how the health service deals with patients who have urgent medical needs when the health service is operating at full capacity (eg. when staff are fully occupied).

Actual length of individual consultations will vary according to clinical need. There is a body of evidence suggesting that longer consultation times are associated with better health outcomes and improved patient satisfaction. Much of the benefit is thought to arise from the improved communication between doctors and their patients that occurs in longer consultations. Research also suggests that preventive care, effective record keeping, patient satisfaction and patient participation in the consultation can be compromised when consultations are too short. Data from the Bettering the Evaluation and Care of Health (BEACH) study shows that the average consultation time in Australian general practice is approximately 14 minutes. Similarly, consultations with mental health experts (such as psychologists) will vary according to clinical need.

The system for scheduling care needs to include consultations of appropriate length for patients with more complex needs. Longer consultations may be required if the patient has complex medical needs or if an interpreter is present. Patients need to be encouraged to ask for a longer consultation if they think it is necessary. Staff need to have the skills and knowledge to assist in determining the most appropriate length and timing of consultations at the time of the request. Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that health services have systems that endeavour to predict and meet this need.

* Where these Standards use phrases such as ‘a health service needs…’, the RACGP’s position is that what ‘needs’ to be done in any situation is determined by what is reasonable in all the circumstances. In interpreting the Standards, care must be taken to be sensitive to the often highly variable circumstances of any particular situation.
ACCESS TO CARE

**Standard 1.1**

Our service provides timely care and advice.

Key indicators for appropriate consultation length include not only the duration of the consultation, but other factors such as the adequacy of patient health records. Decision about whether a health service meets this criterion need to be made in the context of other indicators in the health service. Assessment of this criterion needs to take into account the specific circumstances of the health service.

Health services that do not have a formal appointment system can meet this criterion if there is adequate communication to patients on anticipated waiting times and if the service prioritises patients according to urgency of need.

It is important that patients have direct access to the health service to make an appointment and do not rely on other parties (such as the detention service provider) to mediate their request for access. Direct access allows for greater assurances of confidentiality and privacy for patients as well as minimising any medicolegal risk to the health service that may arise from relying on non-health staff to identify medical needs. Health services may need to make arrangements for both telephone and written access mechanisms if the health service staff do not speak a patient’s preferred language.

It is also important for health services to document in a patient’s health record if there is a delay between the patient requesting health care and the provision of that health care (for whatever reason). It may be useful (for medicolegal purposes) to document the reason for the delay and what follow up occurred as a result.

**Indicators**

- **A.** There is evidence that our service has a flexible system to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs (document review).
- **B.** Our staff can describe how they identify urgent medical matters and their procedures for obtaining urgent medical attention (interview).
- **C.** Our service has a written policy for dealing with urgent medical matters (document review).
- **D.** Our service can demonstrate that patients can directly access the health service by telephone and written request during normal opening hours (direct observation).
CRITERION 1.1.2
Visits to patient living quarters by appropriate clinical staff members

Patients of our service are able to obtain visits from a medical or clinical staff member in their living quarters where such visits are safe and reasonable.

Explanation

Visits to patients in their living quarters in the immigration detention centre need to be available where such visits are safe and reasonable.

People in immigration detention need to see their housing or rooms as their 'home', and in that context it is reasonable that health services in immigration detention centres have the capacity to provide visits to patients in their living quarters if necessary. It is recognised that because the service is located within the facility, the need for visits to patients’ rooms is likely to be infrequent. It is also recognised that there may be security and safety considerations involved in visiting living quarters of the centre. Indicator B requires that the service have the capacity to provide visits to patients’ living quarters by an appropriate clinical or medical staff member – where it is safe and reasonable – and that staff understand the policy for these 'home visits'.

Staff need to be able to describe the conditions under which a visit to a living quarters is deemed appropriate. Examples include deciding which types of problems that necessitate such visits. A definition of 'safe and reasonable' has not been provided here, as this is a decision that each health service needs to make in their local context (eg. with regard to location of living quarters, patient population) and in light of what peers would agree was safe and reasonable.

Indicators

A. There is evidence that patients of our service access visits in their living quarters (health records review, document review).

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

C. Our service has a written policy on visits to living quarters (document review).
CRITERION 1.1.3
Care outside normal opening hours

Our service ensures reasonable arrangements for medical care for patients outside our normal opening hours.

Explanation

Sometimes patients require medical care outside the normal opening hours of the detention centre’s health service. Health services are required to make and be able to demonstrate reasonable arrangements for access to primary medical care services for their patients at these times.

It is important that people can access appropriate primary and emergency care when the health service is not normally open. The nature of detention means that patients have a restricted ability to contact and use mainstream primary health and emergency services compared with people within the community, and it is important that health services in immigration detention centres make arrangements to provide timely and appropriate health care to all people detained in the centre at all times.

It may be necessary for health services to consider the quality and sustainability of these arrangements and to make judgments about which options will provide the highest quality of care while maintaining the safety of patients and staff. In these circumstances, medical staff may want to discuss how they balance these needs with peer surveyors in accreditation.

Regardless of the arrangements used to provide care outside normal opening hours, the service needs to provide documentary evidence of the system it uses to provide such care. If the health service uses other doctors to provide care (such as a medical deputising service or cooperative), the health service needs to have evidence of how and when it receives information about any care provided to their patients outside normal opening hours, and how the doctors providing care can contact the health service in an emergency or in exceptional circumstances. It may be of substantial benefit if the doctor providing care is able to contact a doctor within the health service for clarification or help regarding background information relating to that patient (especially in an emergency).

Care outside normal opening hours needs to be performed by a recognised general practitioner (either a Fellow of the RACGP or a vocationally recognised GP) where clinically necessary. In some areas it may not be possible to recruit recognised GPs. In such circumstances, doctors who provide general practice care outside normal opening hours and who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the health service community. Doctors performing general practice care who are not recognised GPs need to have been assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP (as outlined in criterion 3.2.1).

When the health service’s medical staff cannot safely or reasonably deliver care outside normal opening hours, the health service must be able to clearly document the alternative system of care that is available for patients at these times. Assessment of this criterion needs to take into account the approach of similar health services. It is necessary that the care is appropriate to the needs of the patient, that it is timely and reliable, and that any care that is claimed to be available is actually provided. A definition of ‘safe and reasonable’ has not been provided here, as this is a decision that each health service needs to make in their local context (eg. with regard to location, patient population) and in light of what peers would agree was safe and reasonable.
ACCESS TO CARE

**Standard 1.1**

Our service provides timely care and advice.

**Criterion 1.1.3 Care outside normal opening hours (continued)**

Arrangements for medical care outside normal opening hours need to be communicated clearly to patients of the health service.

Health services need to have after hours arrangements in place to allow abnormal and life threatening results identified by pathologists to be conveyed to a medical practitioner who will ensure that an informed appropriate medical decision is made and acted on promptly.

The Australian Competition and Consumer Commission has developed an information kit for the medical profession (see resources). This may be of assistance to health services who want to ensure that their arrangements comply with the *Trade Practices Act* (ie. are not anticompetitive as defined within the *Trade Practices Act*).

**Indicators**

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

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

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

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

- **D.** A notice in all living quarters of the immigration detention centre provides multilingual information to patients on how to obtain care from the health service (both within and outside normal opening hours) (document review).
CRITERION 1.2.1

Health service information

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

Explanation

Providing written information about the health service is useful to patients as it provides an opportunity to inform patients about the range of services the health service provides. It is important that the information sheet is clearly marked as relating to the health service (as opposed to the Department of Immigration and Citizenship [DIAC] or the detention service provider) through the use of logos or other branding symbols.

It is also important for patients to know the first names of the medical and clinical staff in the health service. For privacy reasons, health services may decide that their information sheet should include only first names (not surnames) of staff providing clinical care.

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

Because there are a number of parties involved in the health care and the detention of people in immigration detention centres, it is important that the health service be transparent about the relationship between the service and other parties (eg. detention service provider and the DIAC). This will build trust between patients and staff in the health service. This parallels the process in general practice, which requires transparency between general practices and any other services with which the practices have contractual agreements (eg. pathology and imaging services).

The health service needs to find alternative ways to provide or discuss health service information with patients who are unable to read or understand the information sheet (eg. people with literacy problems or with visual impairment).

It is appropriate for health services that deliver care to defined ethnic communities to make written information available in the most common languages within the health service population — this is one way in which the health service can provide health care in a culturally appropriate manner. This is particularly important for health services in immigration detention centres where patients come from culturally and linguistically diverse backgrounds and who will be unfamiliar with the health service and with the system of health care provision in Australia.

The information sheet needs to comply with the Australian Medical Association Code of ethics 2004 (see resources). This is distinct from other information services provided by the health service (eg. health promotion information or ‘tailor made’ health information magazines) which may contain local advertising.

Privacy of patient information is particularly important for health services in immigration detention centres. These Standards recognise the patient’s ‘ownership’ of their personal health information; however, it is recognised that there may be some circumstances in which the detention services provider or DIAC staff may need information relating to a patient’s physical and mental health to enable them to properly care for that person (eg. where the patient is at risk of self harm). Patients need to be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling legal circumstances (eg. concern about imminent harm to the patient or to others).
INFORMATION ABOUT THE HEALTH SERVICE
Standard 1.2
Our service provides the opportunity for patients to communicate their health problems and concerns, and to receive sufficient information to enable them to make informed decisions regarding their care.

Criterion 1.2.1 Health service information (continued)

Indicators

A. Our health service information sheet is available to patients and contains at a minimum:
   • a feature that distinguishes the material as belonging to the health service
   • first names of the staff working in our service
   • our consulting hours and arrangements for care outside our service’s normal opening hours
   • an explanation of how patients can directly contact the health service to make an appointment
   • an explanation of the arrangements in place for interpreters
   • an explanation of the relationship between our health service, the detention service provider and the Department of Immigration and Citizenship
   • an explanation of how to provide feedback or complain to the health service
   • the health service’s policy on the use of patient health information (document review).

B. Our health service information sheet is prepared and delivered to patients by our health service staff (document review, interview).

C. Our staff can describe how essential service information is provided to patients who are unable to read or understand our written information sheet (interview).
CRITERION 1.2.2
Informed patient decisions

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

Explanation

It is important that patients have sufficient information to make appropriate decisions about their own health care. Information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments need to be tailored to the individual patient’s needs. This information needs to be delivered in language appropriate to the patient’s cultural understanding of health and determinants of health and illness – without jargon or complicated terms – and where necessary including clear diagrams and written information. Consideration also needs to be given to the patient’s physical, visual and/or cognitive capacities, which may impact on their ability to understand the information, make decisions or provide consent. Consideration needs to be given to how information about potentially sensitive investigations or tests is communicated (e.g. sexually transmitted infections, blood borne viruses, fetal abnormality screening and pregnancy tests). In cross cultural situations, special care must be taken to ensure that there is a shared understanding between the medical or clinical staff member and the patient about the information provided.

The Australian Council for Quality and Safety in Health Care encourages patients to actively discuss with their health care provider the purpose, importance, benefits and risks associated with their health care. The publication ‘10 tips for safer health care’ provides further detail (see resources). Health services may find it useful to refer patients to this information to help create an understanding of shared responsibility between the patient and the health service.

The provision of information about medicines and medicine safety (including Consumer Medicines Information) may assist patients to make informed decisions about their medicines. Health professionals need to be confident that patients understand any reasons for changes to their medications and, if a particular medication is not available, the implications of using an alternative medication. Consumer Medicines Information provides an online version of leaflets produced by pharmaceutical companies for the general public (see resources). When it is not possible for a patient to continue using the medication they had been taking prior to detention, it is important that the reasons for this be explained to patients to encourage trust, compliance and open communication.

If a patient decides not to follow the advice of the medical or clinical staff member after receiving sufficient information to make an informed decision about their care, their refusal and their awareness of its implications should be documented in the patient health record and an attempt made to provide alternative culturally appropriate care (criterion 2.1.1).

Some people in immigration detention centres may take or consider taking self destructive or self harming behaviour (e.g. over or under medicating, hunger striking). Where a patient considers, or embarks on a self destructive or self harming behaviour, a medical staff member may need to make judgments about the competence of the person to form an unimpaired and rational judgment concerning the consequences of such an action. Staff may need to explain to the patient the consequences of such actions so that the patient can make an informed decision about
INFORMATION ABOUT THE HEALTH SERVICE

**Standard 1.2**

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

**Criterion 1.2.2 Informed patient decisions (continued)**

their actions. The Australian Medical Association (AMA) position statement on health care for asylum seekers and refugees (see resources) provides guidance to medical staff on appropriate management of hunger striking patients.

In some circumstances, it is the responsibility of other medical specialists and health care providers to give patients information about the actual costs of any treatments or investigations that they provide. In the detention context, these circumstances are relatively uncommon, and usually arise where the care is elective.

Medical and clinical staff can help patients to make informed decisions about referrals to other specialists or health care providers by advising if there may be a cost involved. Patients need to be informed of the possibility of incurring costs arising from referrals, investigations (e.g., pathology, diagnostic imaging or other investigations) or consultations with other practitioners (e.g., dentists). Patients should be advised to ask the service or specialist to whom they have been referred about the exact fees that may arise. Medical and clinical staff are not required to know the actual fee for each referred test or treatment, but they need to indicate to patients that there is the potential for a fee to be incurred. If no fee for health services is charged, this should be communicated to patients.

When medical or clinical staff refer patients to institutions or services in which the staff member has a direct financial interest, the staff member needs to provide full disclosure of such interest. Medical staff are referred to the AMA Code of ethics 2004 (see resources) for further information.

**Indicators**

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

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

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

D. Our medical and clinical staff can describe how patients are advised of any potential costs when they are referred for investigation, or for initial consultation with a medical specialist or allied health professional (interview).
CRITERION 1.2.3
Interpreter services

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

Explanation

Health care staff have a professional obligation to ensure that they understand their patients’ problems, and that their patients understand the health care staff’s information and recommendations. The use of interpreters is sometimes challenging and time consuming; in some situations, however, the use of interpreters is essential to providing quality care, and health care staff need to be comfortable and trained in the use of interpreter services.

The Australian Government provides a Translating and Interpreting Service (TIS) to assist health services in immigration detention centres to provide care to patients. The Australian Government also funds a free interpreting service for patients who are deaf and use Australian Sign Language (AUSLAN) (see resources for more information about TIS and AUSLAN services).

All reasonable arrangements need to be made to access an interpreter with a dialect and of an acceptable ethnic group compatible with that of the patient and of the gender requested by the patient. Inadequate access to appropriate interpreters may discourage patients from seeking care from the health service.

Indicators

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

B. Our health service has a list of contact numbers for interpreter services (document review).
HEALTH PROMOTION AND PREVENTION OF DISEASE

Standard 1.3

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

CRITERION 1.3.1
Health promotion and preventive care

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

Explanation

Health services in immigration detention centres need a systematic approach to health promotion, preventive care and early detection and intervention. The health service also has the potential to coordinate with other health professionals and key agencies to achieve health promotion and preventive care objectives. This holistic approach to care allows for each patient’s individual circumstances to be considered when providing health promotion, preventive care, early detection and intervention.

Health services are encouraged to provide patients with information about health promotion and illness prevention. Health promotion is distinct from the education and information that medical and clinical staff use to support their diagnosis and choice of treatment. Such prevention, education and health promotion may be delivered by doctors, dentists, nurses or other allied health professionals and reinforced through the use of written materials and resources.

It is useful for patients to self select information on a range of health issues that may affect or interest them. The provision of written material is recommended as patients remember only three to four key messages from a consultation. This criterion refers to the many health pamphlets and brochures available from sources such as departments of health, nongovernment organisations, health promotion programs, local community organisations, and support and self help groups. Some educational materials are also produced in audiovisual format, which may complement the written material in the health service. Health services are encouraged to be selective about the leaflets, brochures and pamphlets they provide; these materials may vary in quality and reliability. Providing information about health issues through the use of the internet is also becoming more common. Health services need to consider the quality of the information available on internet sites before recommending them to patients. Health services are encouraged to use the checklist in the current edition of the RACGP’s Putting prevention into practice (the ‘green book’) (see resources) to help determine whether patient education materials – including those on the internet – are of sufficient and high quality (eg. HealthInsite at www.healthinsite.gov.au). The Australian Psychological Association also has resources for use by psychologists in health promotion (available at www.psychology.org.au) and the Multicultural Mental Health Australia website has health promotion materials in a range of languages (available at www.mmha.org.au).

This criterion also requires health services to have a systematic process for providing preventive care to patients. This may occur through the use of formal preventive activities such as patient prevention surveys, or the use of disease registers and recall and reminder systems. It may also occur when patient presentations at the health service are used as an opportunity to provide health promotion and illness prevention activities additional to those relating to the specific reason for the patient’s visit.

Preventive activities need to be based on the best available evidence. Reminder systems need to operate in such a way as to protect the privacy and confidentiality of patient health information. Health services also need to consider their responsibility to their patients if the health service ceases using a reminder system.
HEALTH PROMOTION AND PREVENTION OF DISEASE

Standard 1.3

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

Some information may also be transferred to national registers (eg. immunisation data) or state and territory based systems (eg. cervical screening or familial cancer registries) in order to improve care. Many state and national registers (such as immunisation and cervical screening registers) can register people living in Australia who are not legal residents of Australia. Health services should be encouraged to use these registers (with the patient’s consent) for patients detained in immigration detention centres, as it is possible that these people may become part of the Australian community, and it is also possible that they may be detained for extended periods and therefore benefit from the reminders that are in place in such registers.

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

Further information regarding health promotion and preventive activities is available in the current editions of the RACGP Guidelines for preventive activities in general practice (the ‘red book’), the green book, and the RACGP Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice (see resources).

Multilingual prompt cards might be displayed in consulting rooms to help the health service engage the most appropriate interpreter for the patient.

Indicators

- A. There is evidence that our service provides multilingual information about health promotion and illness prevention to patients (health records review, document review).
- B. There is a range of multilingual posters, leaflets, and brochures about health issues available or on display in the waiting area or consulting areas (direct observation).
- C. Our medical and clinical staff can describe how they provide information to patients on issues relating to health promotion and illness prevention, including issues relevant to common patient presentations (interview).
- D. Our service uses one or more of the following:
  - flagging of patient health records for opportunistic preventive activities (subject to informed patient consent)
  - paper or electronic system showing due dates for preventive activities (subject to informed patient consent)
  - paper or electronic reminder system with appropriate informed patient consent (health records review, document review).
- E. Our service participates in national/state or territory reminder systems/registers (subject to informed patient consent) (document review).
Evidence based practice

Our service ensures that our approaches to common and serious conditions are consistent with best available evidence.

Explanation

Contemporary practice is based on best available evidence in the current Australian context. This criterion recognises that in the absence of well conducted clinical trials or other higher order evidence, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at that time.

Clinical practice guidelines must be up to date and may include recommendations from sources such as:

- Australian medicines handbook (www.amh.net.au)
- Australian Prescriber (www.australianprescriber.com)
- Australian Psychological Association resources (www.psychology.org.au)
- Central Australian Rural Practitioners Association (CARPA) treatment and reference manuals (www.carpa.org.au)
- Cochrane database
- Foundation House in Victoria (www.foundationhouse.org.au) and STARTTS in NSW (www.startts.org) resources for refugees who have experienced trauma and/or torture in their countries of origin
- RACGP ‘Safety every time – our general practice checklist’ (a checklist to reduce the risk of errors in medical procedures) (see resources)
- Multicultural Mental Health Australia (www.mmha.org.au)
- National Health and Medical Research Council (www.nhmrc.gov.au)
- National Prescribing Service (www.nps.org.au)
- RACGP Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice (see resources)
- RACGP Guidelines for preventive activities in general practice (‘red book’) (see resources)
- RACGP Infection control standards for office based practices (4th edition) (see resources)
- RACGP Putting prevention into practice (the ‘green book’) (see resources)
- RACGP Medical care of older persons in residential aged care facilities (the ’silver book’) (see resources)
- Rational Assessment of Drugs and Research (RADAR)
- Therapeutic Guidelines (www.tg.com.au)

It is important that medical, clinical and allied health staff in health services in immigration detention centres have access to a range of relevant resources relating to mental health and the care of people who may be detained in the centre (such as refugees or asylum seekers).
DIAGNOSIS AND MANAGEMENT OF SPECIFIC HEALTH PROBLEMS

Standard 1.4

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

It may be important for medical staff – especially those undertaking procedural work and minor surgery – to use the ‘Safety every time – our general practice checklist’ (see resources) or an equivalent protocol that incorporates the five steps. Compliance with the protocol reduces the risk of error for medical staff who perform procedures in health services.

Medical and clinical staff find it valuable – both for their treatment of patients and for their own professional development – to have access to resources about a range of clinical issues including resources relevant to care provided to patients detained in immigration detention centres. These may include paper based resources (eg. textbooks and peer reviewed journals) and electronic resources (eg. access via the internet or CD-ROM). These resources may relate to clinical matters (eg. infectious diseases or female genital mutilation) and information about cultural beliefs and health practices of various cultural groups, but might not be limited to what the profession would consider to be references on ‘evidence based practice’.

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

Patients often use complementary and alternative medicines. This may be a particularly important consideration for people detained in immigration detention centres, who may come from non-Western countries and have a history of treatment with non-Western medicines (eg. Chinese medicine). Health services are referred to the RACGP/Australian Integrative Medicine Association joint position statement on complementary medicine, the Australian Medical Association statement on complementary and alternative medicines (see resources).

**Indicators**

- **A.** Our service can demonstrate that we have ready access to a range of current references relevant to primary care (including mental health care) (direct observation).
- **B.** There is evidence in our patient health records that our service provides care of common and serious conditions that is consistent with clinical practice based on best available evidence (health records review).
- **C.** Our medical and clinical staff can describe how they ensure that their approaches to common and serious conditions are broadly consistent with clinical practice based on best available evidence (interview).
- **D.** Our medical and clinical staff can describe and have access to the clinical practice guidelines used to assist in the management of serious and common conditions (interview).
CRITERION 1.4.2  
Clinical autonomy for medical, clinical and allied health staff

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

Explanation

The intent of this criterion is that medical, clinical and allied health staff are free – within the parameters of evidence based care – to make decisions that affect the clinical care they provide, rather than having these decisions imposed upon them. The Australian Medical Association Code of ethics 2004 (see resources), which has been endorsed by the RACGP, indicates that in order to provide high quality health care, clinical independence and professional integrity must be safeguarded from increased demands from society, third parties, individual patients and governments.

Staff need to be free to care for their patients without having their ability for independent professional judgment challenged by obligations or pressures placed on them by third parties. There are international guidelines for health professional practice in such circumstances.  

This criterion also means that the health service needs to discuss with the medical and clinical staff their individual preferences for the systems the health service uses to provide clinical care (including investigation options, appointment scheduling, patient load, equipment, length of counselling sessions), rather than requiring them to use systems that impact on their ability to provide care as individual practitioners.

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

Some organisations have developed codes of practice so that health service systems do not restrict the abilities of medical and clinical staff to provide clinical care. For example, there is a code of conduct for corporations involved in the provision of management and administrative services in medical centres in Australia (see resources), which emphasises the importance of general practitioners having professional independence and not being compelled to use certain providers or services, and outlines processes for complaint about such matters.

The choice of some providers of services may not be within the control of health service staff (eg. there may be corporate level agreements about the provision of pathology services). Where this is the case, medical, clinical and allied health staff need to have clear avenues for raising concerns about the quality of the services provided under these arrangements and for expressing their desire to use alternatives (eg. criterion 3.1.2).

Health services in immigration detention centres concerned about impediments to exercising appropriate clinical autonomy or about the quality of ancillary services need to have clear protocols for notifying the detention service provider, the Department of Immigration and Citizenship (DIAC) and, if needed, the Human Rights and Equal Opportunity Commission and/or Commonwealth Ombudsman. This process needs to be understood by all staff. Any such notification would need to be documented in the patient’s health record.
**Indicators**

A. Our medical, clinical and allied health staff are free to determine:
   - the specialists and other health professionals to whom they refer
   - the pathology, diagnostic imaging or other investigations they order, and the provider they use
   - how and when to schedule follow up appointments with individual patients (interview).

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

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

D. Our staff can describe the notification process if they believe a third party has restricted or is restricting their ability to provide or coordinate health care (interview).

E. Our service has a documented protocol for the notification of concerns regarding the provision of health care (document review).
CONTINUITY OF CARE

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

CRITERION 1.5.1
Continuity of comprehensive care

Our service facilitates continuity of comprehensive care to patients.

Explanation

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

There are a number of types of continuity:

- the sense of affiliation between the patient and their health professional (‘my doctor’, ‘my nurse’, ‘my psychologist’, ‘my dentist’ or ‘my patient’), sometimes called ‘relational continuity’ (criterion 1.5.2)
- consistency of care by the various people involved in a patient’s care (ie. not working at ‘cross purposes’), sometimes called ‘management continuity’ (criterion 1.5.3)
- continuity of information across health care events, particularly through documentation, handover and review of notes from previous consultations, sometimes called ‘informational continuity’ (criterion 1.5.4).

The health service acts as the coordinator and advocate of all health and allied health services for patients detained in Australian immigration detention centres. These patients have a restricted capacity to choose health care providers and rely on the health service to provide, coordinate and/or facilitate primary health care (including mental health care), specialist health care, dental health care, allied health care and emergency health care. As such, coordination and continuity of ‘comprehensive’ care for these patients is critical.

Indicator

A. Our service has strategies or policies that encourage continuity of comprehensive care (interview, document review).
CRITERION 1.5.2
Continuity of the therapeutic relationship

Patients attending our service are able to see the medical or clinical staff member of their choice, if available.

Explanation

Relational continuity refers to a sustained relationship between a single practitioner and a patient (or sometimes more than one practitioner and a patient) that extends beyond individual consultations or episodes of illness. This can be described as a sense of affiliation between a patient and their doctor (‘my doctor’, ‘my nurse’, ‘my psychologist’, ‘my patient’). It is often viewed as the basis for continuity of care. Health services in immigration detention centres may need to consider the ways in which they can build trust and confidence with patients who are detained in the immigration detention centres.

It is acknowledged that some health services do not have formal, written appointment schedules through which patients are booked to see a medical or clinical staff member. However, such services need to be able to demonstrate that they have a ‘system’ or a ‘rationale’ for determining how patients may see the health professional of their choice, if requested.

The expectation of patients may not always be realistic for some health services, but the health service needs to be able to demonstrate that patients are able to see their health professional of choice when it is fair and reasonable for them to do so. This is particularly important if the patient requests to see a health professional of their own gender. While nurses may triage many clinical issues in health services in immigration detention centres, patients need to be able to request to see a doctor or other health professional, and reasonable arrangements must be made to accommodate the patient’s request.

Many health services employ nurses or allied health professionals as part of the team. The principles in this criterion relate to the patient’s right to see their preferred medical or clinical staff member, nurses and allied health professional.

Coordination of care is a critical issue in providing safe, quality care to patients detained in Australian immigration detention centres. Coordination is a significant factor where multiple health professionals provide episodic and isolated care with no individual professional taking leadership of the coordination and follow up of care. The health service needs to identify a particular person (medical staff member or otherwise) who coordinates the clinical care for individual patients.

Indicators

A. Our staff can describe how patients can request their preferred medical or clinical staff member when making an appointment or attending our service (interview).

B. A sample of patient health records indicates that patients generally see the same medical or clinical staff member (health records review).

C. Our medical, clinical and allied health staff can identify the person who coordinates the clinical care for each individual patient (interview).
CRITERION 1.5.3
Consistent approach

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

Explanation

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

This consistency is just as important in a small health service where the receptionist or nurse needs to have an approach (e.g. to providing information) that is consistent with that of the doctor, psychologist or other mental health professional, as it is in large services with numerous clinical and allied health staff.

In addition to ensuring that clinical care is consistent with the best available evidence (criterion 1.4.1) it is important that there is continuity in the clinical care provided to the patient. Management continuity involves having a consistent and coherent approach to the management of a health condition that is responsive to the patient’s changing needs, and assists to ensure that the people providing services are not working at ‘cross purposes’. An example is ensuring that doctors and psychologists treating a patient with depression provide consistent advice to the patient about their treatment and care. Management continuity is particularly important for people with chronic or complex diseases. For example, it may involve having a plan for the patient’s care that is shared by the people providing the care.

Another way of ensuring that the members of the team who are providing clinical care to patients adopt a consistent approach (within the parameters of evidence based practice) is by discussing clinical issues in a meeting.

Indicators

A. Our medical, clinical and allied health staff can describe how they ensure consistency of diagnosis and management of common and serious conditions (within the parameters of evidence based care) within our service (interview).

B. Our service has regular meetings to discuss clinical care (interview, document review).

C. Our medical, clinical and allied health staff can describe how they ‘hand over’ or transfer care of individual patients between staff in our health service (interview).
CRITERION 1.5.4
System for follow up of tests and results

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

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

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

‘Follow up’ can mean:
- following up the information
  - following up on expected tests and results that have not yet been received by the health service
- following up the patient
  - chasing or tracing the patient to discuss the report, test or results after they have been received by the health service and reviewed, or if the patient did not attend as expected.

The responsibilities of the individual health professional and the health service reflect the recognition that the health professional-patient relationship is based on trust and that the relationship is characterised by the health professional having special knowledge and skills that the patient generally does not have. While health services are not expected to follow up every test ordered or contact patients with the results of every test or investigation undertaken, there may be considerable risk in not following up clinically significant tests and results.

During the review of the Standards for general practices (2nd edition), members of the profession expressed concern about the way in which the RACGP would reflect the profession’s standards in the area of follow up. Some within the profession felt the courts had inappropriately shifted patient responsibilities onto doctors. Others commented that the decisions of the courts were less important to them than the emotional consequences of missing clinically significant results.

In response, the RACGP commissioned a legal opinion on the issue and considered that opinion and the views of the profession when preparing the Standards. The RACGP decided to provide lengthy detail in this explanation to assist in clarifying the issues.

Medical and clinical staff are not always legally responsible for failures for everything that goes wrong: the patient or a third party provider (eg. the pathology company) may be legally responsible instead of (or together with) the medical or clinical professional.

In some circumstances, people detained in immigration detention centres will require the detention service provider to assist in providing their care (eg. arrange transport to attend offsite services). Health services in immigration detention centres will need to have a system in place to follow up on this assistance as it represents a link in the chain of care which has the potential to be broken (eg. an activity is overlooked with the immigration detention centre management is busy).

The health service needs a system aimed at ensuring that:
- all received test results and clinical correspondence (eg. reports from other health care providers) relating to a patient’s clinical care are reviewed
- clinically significant tests and results are followed up
- the system can anticipate individual cases requiring different levels of follow up depending on the clinical significance of the case.
The nature and extent of responsibility for following up tests and results will depend on what is reasonable in all of the circumstances. Overall, the following factors are important in determining if a test or result is clinically significant:

- the probability that the patient will be harmed if adequate follow up does not occur
- the likely seriousness of any potential harm
- the burden of taking steps to avoid the risk of harm.

The clinical significance of a test or result needs to be considered in the overall context of the patient’s history and presenting problems. Clinically significant results are not necessarily restricted to ‘abnormal’ results. For example, a normal mammogram in a woman with a breast lump or a normal electrocardiogram in a patient with chest pain does not preclude the need for further consultation, investigation and management. ‘Clinical significance’ is a judgment made by the medical or clinical staff member that something is clinically important for that particular patient in the context of that patient’s health care. The judgment may be that an abnormal result is clinically important and requires further action. On the other hand, the result may be normal but may still require further action.

The persistence required of the health service in following up with the detention service provider will similarly depend on the likelihood (as identified by the health professional) that the investigation, test or referral will be clinically significant and the degree of urgency of action required.

The health service needs to have in place a process or system for following up – even a system as basic as using a simple diary entry, or logbook containing ‘worrying’ or ‘high risk’ cases – so that a reminder occurs where there is a concern about the significance of the test or result. Medical and clinical staff do not necessarily need to supervise such a system directly, but the system needs to operate consistently where it is needed (although it will be the medical or clinical staff members who will identify the ‘worrying’ cases).

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

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

Patients also have responsibility in their own health care; this includes seeking results. It is important to have follow up systems in the health service that are meaningful for patients, create a shared understanding of what is going to happen, define who is responsible for follow up, and encourage patients to discuss how they can help manage their own health. These systems might include outlining the health service’s policy for follow up in the patient information sheet, and having medical and clinical staff routinely describe the health service’s system for follow up to patients when requests for pathology or imagining tests are made. The standards for ensuring that patients have the information they need to make informed decisions are covered in criterion 1.2.2.
At an early stage in the patient’s care, the health service needs to focus on reinforcing the respective rights and responsibilities of the patient and members of the health service team in following up tests and results. Developing this understanding with patients reinforces for patients that they should actively engage with their health provider, and that part of this requires them to think about the way they help manage their own health. Brief but accurate documentation of the discussion and outcome of such discussions is important.

Documenting relevant clinical information provides a trigger to the medical or clinical professional, or to others who may later view and rely upon the records. The standards for maintaining patient health records are covered in criteria 1.7.1, 1.7.2 and 1.7.3.

Relying on patient memory or motivation alone does not reduce the need for an effective follow up system in the health service. Patients may not follow the recommendations provided by the health service because of their particular circumstances, fear, ignorance, personality, expectations, beliefs, cultural background or a range of other factors. The health service needs to have systems to identify and respond to situations in which a particular patient is unlikely to, or may not understand or comply with, their responsibilities to proceed with a test or to follow up the results with the health service. Medical and clinical staff need to reflect on which patients, tests and results justify a suspicion or concern. The health service needs to have a system that will allow medical or clinical staff to take action to address their concerns. These concerns could be based on a suspicion that the information from a test is likely to be clinically significant, or that the patient might not have the test performed.

In the rare case where a patient indicates they do not intend to comply with the recommendation for a test, the health service needs to ensure that the patient has received sufficient information with which to make an informed decision and to understand the consequences of their actions (or inactions). This discussion needs to be recorded comprehensively in the patient health record (criterion 1.2.2).

In a case where the medical or clinical professional suspects that the results will be clinically significant, the health service needs to create additional safeguards to ensure that potentially clinically significant information does not get ‘lost in the system’. One approach is to obtain a clearly expressed agreement from the patient (which is documented in the health record) that the patient will have the tests performed and/or receive the results. However, this alone might be insufficient for follow up in all circumstances. The health service needs to have a system that protects against both the health professional and the patient forgetting to follow up on tests or results. These systems need to allow for more intensive follow up if the circumstances require.

The location of the detention centre may also impact on the diligence needed for follow up. Both the regularity of the attendance of clinical staff (eg. the health service doctors and nurses), and the proximity of services such as consultant services to which patients are referred, may affect the way in which the follow up system needs to be designed in order to ensure that investigations, tests and referrals are followed up appropriately.

Review and action on results or reports needs to be completed in a timely manner. The speed with which results and reports are acted on, and the degree of effort taken to contact the patient to discuss the results, will depend on the health professional’s judgment of the clinical significance of the result or report, and the context, duration and longevity of the clinical relationship. If the health service needs to initiate follow up contact with a patient, it needs to do so in a reasonable manner. The number and types of attempts will take into account all of the circumstances. These attempts at follow up need to be documented in the patient’s health record.
A close analysis of how and when things go wrong in the follow up of patients with clinically significant tests or results often indicate a problem, or several problems, with the health service system, including:

- the quality and content of discussions with the patient
- the recording of those discussions
- the recording of the clinical encounter.

It is therefore useful for health services to understand that protecting patients and health professionals from errors involves a series of safeguards and involves devising, implementing and monitoring systems in the health service.

The RACGP recognises that information technology can be a useful tool in follow up, however, the current clinical information systems have limitations and may not provide sufficient and reliable safeguards in all cases.

**Indicators**

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

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

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

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

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

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

G. Our service has a written policy to follow up and recall patients with clinically significant tests and results (document review).
CRITERION 1.6.1
Engaging with other services

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

Explanation

Engaging other medical services (e.g. diagnostic services, hospitals and consultants), allied health services (e.g. dental services) and social, disability and community services can assist the health service to provide optimum care to patients whose health needs require integration with other services. For example, patients requiring rehabilitation or mental health services can benefit from the health service taking an active role in engaging other services to assist in their care. For health services in immigration detention centres, these other ‘services’ also include the detention service provider and the Department of Immigration and Citizenship (DIAC).

Health services in immigration detention centres are required to coordinate and integrate patient care across the primary health care setting into other health care, allied health care (e.g. dental health) and social, disability and community services. The health service needs to have readily accessible written or electronic information about local health, disability and community services and how to engage with them to plan and facilitate patient care.

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

The health service responsible for coordinating care for a patient needs to engage with the detention service provider where it plays a role in matters such as facilitating travel, providing access to offsite services and assisting with access to medication or specific nutritional requirements, or following up on medical instructions provided to patients. It may be useful for the health service to schedule regular briefing meetings to discuss the role, responsibilities and obligations of the health service in providing health care to patients and invite DIAC or detention service provider staff to attend.

Indicators

A. Our service demonstrates how it engages with the following:
   - medical services such as diagnostic services, hospitals and specialist consultant services
   - allied health services (e.g. dental services)
   - disability and community services
   - health promotion and public health services and programs
   - the detention service provider
   - the DIAC (document review, interview).

B. There is evidence that our service refers patients to health, community or disability services (health records review).
CRITERION 1.6.2
Referral documents

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

Explanation

Referral documents are a key tool in integrating the care of patients with external health care providers and therefore need to be legible (preferably typed) and contain sufficient information to allow the other health care provider to provide care to the patient. Most of the information needed for a referral may be found in the patient’s health summary. Patients need to be aware that their patient health information is being disclosed in these referral documents.

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

For both medicolegal and clinical reasons, health services need to keep copies of important (nonroutine) referral letters — ie. new referrals or those for serious conditions — in the patient’s health record. While the significance of individual letters is judged by medical and clinical staff, health services which have not retained any referral letters would have difficulty meeting this criterion.

In referring patients to external providers it is important to emphasise the independence of the primary health team within the immigration detention centre context. This will encourage adequate communication between external health care providers and the health service. Some external providers may be unclear about the immigration detention centre context and reluctant to provide information about a patient’s health care back to the health service if they believe it will not be treated confidentially. This breakdown in communication has ramifications for continuity of care and should be minimised where possible.

Indicator

A. Our service can demonstrate that referral letters are legible and where appropriate:
   - include the purpose of the referral
   - include relevant history, examination findings and current management
   - include a list of allergies and current medicines
   - are recorded on appropriate health service stationery
   - are documented in patients’ health records (health records review).
CRITERION 1.7.1

Patient health records

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

Explanation

Health services need to have an effective system for storing an individual patient’s health information in a dedicated patient health record. Health records need to include the patient’s contact details, name, date of birth and other demographic information, medical history, consultation notes (including any care outside normal opening hours of the health service and visits to patient’s living quarters), letters received from hospitals or consultants, other clinical correspondence, investigations or referrals, and results. The patient health record may also contain relevant nonclinical information pertaining to the patient, such as relevant legal reports.

Medical errors and breaches of personal privacy can occur if information is accidentally recorded in or obtained from another patient’s health record. As a result, it is important to have an accepted protocol for the ordering of given and family names, and ways of distinguishing the files of patients with similar or identical names.

For health services in immigration detention centres, the patient’s health record needs to be independent and separate from that person’s immigration records. The patient’s health information should remain private and confidential (as outlined in criterion 4.2.1).

A patient health record may be solely electronic, solely paper based, or may be a combination (hybrid) of paper and electronic records. If health information about a patient is kept in two sites (as in the case of hybrid records), health services need to ensure they have a system in place to ensure all the information is available and accessible when needed.

The information required from each patient might be collected by having new patients complete a generic form or by having health service staff interview patients in a private environment prior to consultation.

It is critical that patient health records are legible (able to be read and understood) so that another practitioner can take over the care of the patient if necessary, and if the health service scans documents such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.

Health services also need to work toward the routine recording of the patient’s preferred contact person in an emergency and the patient’s self identified cultural background. Health services which have not been routinely recording this information need to demonstrate how they are improving the consistency with which they record this information in the patient health record.

Keeping separate, individual patient files is a risk reduction approach to managing patient health information. The RACGP encourages health services to keep individual patient health information filed in separate patient folders or on computer, rather than in family folders. Depending on the system of record keeping for family folders, there may be a risk that pathology results, diagnostic reports or other communication may be misfiled with the wrong family member. In a family file,
the information needs to be stored and accessed in a way that maintains its confidentiality, privacy and security. If a health service keeps family folders, it needs to ensure that each family member’s health information is separated within the folder, and that it contains all the information about that individual.

Indicators

A. There is evidence that each patient has an individual patient health record containing all clinical information held by our service relating to that patient (health records review).

B. Our patient health records are legible (health records review).

C. Our active patient health records include contact and demographic information (where appropriate) including:
   • the patient’s full name
   • date of birth
   • gender
   • contact details (health records review).

D. Our service can demonstrate that we are working toward recording the following information in our active patient health records:
   • self identified cultural background
   • the patient’s preferred contact person in an emergency (interview or health records review).
CRITERION 1.7.2
Health summaries

Our service incorporates health summaries into active patient health records.

Explanation

A health summary is a vital component of a quality health record. All active records should contain an up to date health summary. A good health summary assists the patient’s own doctor, other doctors, allied health staff and clinical staff members in the health service to rapidly obtain an overview of all components of the patient’s care. Health summaries reduce the risk of inappropriate management including medicine interactions and side effects (particularly when allergies are recorded). Health summaries provide the social and family overview vital to whole patient care.

A health summary will assist with health promotion by highlighting lifestyle problems and risk factors (e.g. smoking, alcohol, nutrition, physical activity status). It also helps disease prevention by tracking immunisation and other preventive measures.

An up to date health summary is critical in the smooth transfer of care from one practitioner (in the health service) to another (in the health service, or more importantly to a practitioner external to the immigration detention centre). As such, 90% of all patient records in immigration detention centres are required to contain a health summary.

While it is important to record all allergies in health summaries, it is particularly important to record allergies to medicines as this facilitates safer prescribing (especially when computer based) and reduces the likelihood of adverse patient outcomes. It is important also to record ‘no known allergies’ so that this is not assumed in the absence of recorded data.

The recording of recent important events covers a wide range of social events of importance to the patient, which may include changes in accommodation, family structure (e.g. death of family members) and important events in the person’s immigration process. Recent important events can alter patient preferences, values and the context of care.

Where a health service does not meet the 90% level in an element of a health summary (e.g. risk factors), the health service needs to describe how it is attempting to improve the completeness of that element of the health summary. A health service that knows it has a deficit in the recording of any information needs to have a plan for improvement.

This criterion applies to active patient health records only. In the case of health services in immigration detention centres, an active health record is a record of a patient who currently resides in the immigration detention centre.

The RACGP appreciates that family and social history especially should only be recorded in a health summary where it assists patient care and does not impair patients’ rights to privacy and, as such, not all health summaries will include all the items listed in indicator B.
A. At least 90% of our active patient health records contain a record of allergies in the health summary (health records review).

B. At least 90% of our active patient health records contain a health summary. A satisfactory summary includes, where appropriate:
   - adverse medicines events
   - current medicines list
   - current health problems
   - past health history
   - risk factors
   - immunisations
   - relevant family history
   - relevant social history (health records review).

C. Our patient health records show evidence that health summaries are updated to reflect recent important events (health records review).

D. If our service uses both an electronic and paper based system for recording a patient’s health summary, our service can demonstrate how the patient’s health information is made accessible (interview).
CRITERION 1.7.3

Consultation notes

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

Explanation

A consultation is an interaction between the health service and the patient related to the patient’s health issues. A consultation may be with a medical staff member (e.g., general practitioner or other specialist doctor) or with another staff member who provides clinical care within the health service (e.g., nurse or psychologist).

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

Ideally, information about the consultation needs to be entered into the patient health record as soon as is practical at the time of the consultation, or as soon as information (e.g., results) becomes available.

As part of the continuing care that health services in immigration detention centres provide, information concerning patients is gathered over more than one consultation. It is important that there is a connecting process so that information about clinically significant, separate events in a patient’s life and in the care provided are not overlooked but are recorded and managed in a way that makes this information readily accessible. Regularly updated health summaries are one method of managing this information. Clinically significant information may include the patient’s health needs and goals, medical condition(s), preferences and values. All this contributes to care that is responsive to patient needs.

Medical defence organisations have identified lapses in following up on problems and issues raised previously by patients as a considerable risk. This can occur when patients are not seen by their usual medical or clinical staff member, though it can also occur when a staff member is busy or distracted. It is useful for health services to have systems that reduce the risk of such lapses to ensure high quality patient care.

It is also important for health services to document in a patient’s health record if there is a delay between the patient requesting health care and the provision of that health care (for whatever reason). It may be useful (for medicolegal purposes) to document the reason for the delay and what follow up occurred as a result.
CONTENT OF PATIENT HEALTH RECORDS

Standard 1.7

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

Criterion 1.7.3 Consultation notes (continued)

Indicators

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

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

RIGHTS AND NEEDS OF PATIENTS

Standard 2.1 COLLABORATING WITH PATIENTS
Our service respects the rights and needs of patients.
CRITERION 2.1.1

Respectful and culturally appropriate care

Our service provides respectful and culturally appropriate care to patients.

Explanation

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

Immigration detention centres create a challenging environment in which to provide health care. In this setting, transcultural awareness is central to a health care professional understanding an individual patient’s perception of health and illness. This awareness requires an understanding of the multitude of patients’ cultural, religious, sociopolitical and linguistic backgrounds. It is important to acknowledge that many patients within immigration detention centres may be from minority groups in their home countries and therefore may not subscribe to the same belief systems as the mainstream culture from their country of origin. It is also important to foster cultural sensitivity regarding a patient’s past experiences (e.g. time spent in refugee camps or in situations of persecution) which may influence their perception of the detention experience and therefore their trust of health care workers. There are many useful resources available to improve health professionals’ understanding of culture and its impact on mental and physical health including www.cimh.unimelb.edu.au/links/psychologists and www.vtpu.org.au/links/#background, and www.foundationhouse.org.au and www.startts.org.

Demonstrating respect for patients extends beyond face to face interaction between the staff and the patient to the recording of patient’s health information. Making or recording derogatory, prejudiced, prejudicial or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters, and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other health professionals and will result in differential treatment for such patients. Health services need to be aware that the Disability Discrimination Act 1992 (Commonwealth) as well as the various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion). The Human Rights and Equal Opportunities Commission provides further information, including guides to the relevant legislation and links to state and territory agencies with similar responsibilities (available at www.humanrights.gov.au).

The ideal health professional-patient partnership is a collaboration based on mutual respect and a mutual responsibility for the patient’s health. The health professional’s duty of care is to explain the benefits and potential harm of specific treatments and to clearly and unambiguously explain the consequences of not adhering to a recommended management plan. The use of interpreters should be considered in every consultation when the patient is known to have a non-English speaking background, to avoid misunderstandings and to assist in developing trust between the patient and health care professional. Patients need to be encouraged to notify their health care professional when they are choosing to follow another health care provider’s management advice. This allows the original health care provider the opportunity to reinforce any potential risks of this decision. Where patients do seek further clinical opinions, an appropriate risk management strategy
for health services includes documenting this decision in the patient’s health record. The health service is also encouraged to document in the patient’s health record an explanation of the actions taken when a patient seeks a further clinical opinion, including referral to other care providers if arranged.

Where patients refuse advice, procedures or treatments, an appropriate risk management strategy for health services needs to include recording of such refusals in the patient’s health record, including referrals to other care providers, if arranged. It is recommended that any action taken is documented in the patient health record. This includes the documentation of refusal of medical care if the patient is engaging or proposing to engage in self destructive behaviour (e.g. hunger striking), and the assessment of the person’s competence to make such decisions. If a patient refuses to act on medical advice, this needs to be seen with respect to the patient’s cultural background as outlined above, and attempts need to be made to provide care in a culturally appropriate context.

Where a patient requests to be transferred to the care of another health care professional, a copy of the patient health information needs to be transferred to the other health professional in a timely manner to help facilitate the patient’s care. Staff need to comply with the requirements of the state or territory legislation governing the transfer of patient health information. Where the health service produces a summary for transfer to another health provider, it is useful to keep a copy of the summary in the patient’s health record. It is recommended that a copy of the patient health information be transferred and that the health service retain the original health information.

When patients detained in immigration detention centres are released or transferred into another detention placement (e.g. residential housing accommodation), it is important that the health service arranges the transfer of care to another health care practitioner. A comprehensive health summary needs to be provided (with the patient’s consent) to the health professional who will be coordinating the care for the patient outside the detention centre or to the patient (if no health professional has been identified). It is useful for this transfer of care to be managed by the person in the health service identified as leading the care for that individual patient (criterion 1.5.2, indicator D).

There may be patients the medical or clinical staff no longer consider it appropriate to treat (e.g. where there has been some cause for a significant breakdown in the therapeutic relationship). The medical, clinical or allied health staff member has the right to discontinue treatment of that patient, especially when they think they can no longer give the patient their best care.

There are concerns about violence both within and outside general practice. One Australian study suggests that violence toward doctors and staff in general practice is common. The most common forms of violence were ‘low level’ violence, such as verbal abuse (42.1% of general practitioners reported at least one incident in the previous year), property damage/theft (28.6%) and threats (23.1%). A smaller proportion of GPs had experienced ‘high level’ violence such as sexual harassment (9.3%) and physical abuse (2.7%). This study also found a significant association between high level violence and practices located in lower socioeconomic status areas, practices staffed by female GPs, practices in populations with a greater incidence drug-related problems, and practices that provided home visits during business hours. More experienced GPs encountered less violence for every additional 5 years of practice. This suggests that the area in which the service is situated, the gender of its GPs and staff, the experience of the GPs and staff, and the characteristics of the population served by the service are relevant considerations when considering the safeguards needed for the service.
COLLABORATING WITH PATIENTS

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

Criterion 2.1.1 Respectful and culturally appropriate care (continued)

The health service is encouraged to have a risk management strategy detailing the steps taken to protect staff and to deal with these distressing situations, and the steps taken to assist patients with ongoing care, including referral to other health care providers. Some states and territories have introduced specific legislation governing the cessation of treatment (eg. when a health service closes down), and health services need to be aware of their obligations.

A patient in distress may feel more comfortable in a private area than in a public waiting area. Health services – even those with limited facilities – need to attempt to provide privacy for such patients (eg. by allowing them to sit in an unused room, staff room or other area). This does not mean that a health service needs to have a room permanently set aside for such patients, but that it does need to have a plan that can be implemented as the need arises to ensure the patient is treated respectfully.

Indicators

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

B. Our staff can describe how they provide care for a patient who refuses a specific treatment, advice or procedure (interview).

C. Our staff can describe what they do when a patient informs them that they intend to seek a further clinical opinion (interview).

D. Our staff can describe what they do to transfer care to another health professional in our service or in another health service (interview).

E. Our staff can describe arrangements for managing the transfer of care of a patient whom they no longer wish to treat (interview).

F. Our staff can describe how our service provides privacy for patients in distress (interview).

G. Our staff can identify important or significant cultural groups within our service, and outline our strategies for meeting their needs (interview).
CRITERION 2.1.2

Patient feedback

Our service provides opportunities for, and responds to, patient feedback.

Explanation

Patients can provide unique information about patient needs and the quality of care provided by a health service. Openly discussing patient feedback and concerns helps staff to understand strengths in their health service, potential problems, and how to make improvements. It is helpful to know what patients think about a health service and what they are likely to tell other people. The more feedback a health service receives – whether it be complaints, compliments or suggestions – the better it will be able to provide care.

The ‘Turning wrongs into rights: learning from consumer reported incidents project’, a national project funded under the auspices of the Australian Council for Safety and Quality in Health Care (ACSQHC), has undertaken research into the complaints management practices of Australian health care organisations and has developed guidelines on complaints management in health care.

The importance and value of effective complaints management was expressed by the ACSQHC in its publication ‘Better practice guidelines on complaints management for health care services’:

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

The complexities of providing health care to patients detained in immigration detention centres mean that it is very important that the health service be transparent about the relationship between the health service and other parties (as discussed in criterion 1.2.1). It also means that gaining useful feedback (especially complaints) from patients about the health service (as distinct from other parties) may be challenging. The service needs to explicitly support and encourage patients to provide useful feedback, rather than allow service structures and processes to directly or indirectly impede the making of complaints. To this end, it is suggested that patients who wish to make a complaint to the service are encouraged to do so with the assistance of advocates who may assist in helping the patient and the service clarify the nature of the complaint and work to find a resolution. The health service needs to assure patients that they can make complaints against the service without fear of negative repercussions.

It is essential that health services provide a structured mechanism for obtaining patient feedback. It is recognised that obtaining valid feedback from patients who are detained in immigration detention centres can be challenging. Health services need to determine the most appropriate means of obtaining meaningful feedback about the health service for their context and patient population. This might include asking patients to complete a questionnaire about the health service, or obtaining feedback through focus group discussions (where patients are invited to come together to discuss their views on the health service), or through some other method that is appropriate to your patient population. Given the challenges in obtaining feedback from people in detention, the health service needs to demonstrate that it is working toward finding a structured mechanism to ask patients about a range of issues.
COLLABORATING WITH PATIENTS

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

Criterion 2.1.2 Patient feedback (continued)

Patient feedback is critically important for identifying opportunities for improvement. It is important that health services demonstrate that they have used patient feedback in implementing improvements.

Indicators

A. Our service has a process for receiving and responding to feedback and complaints from patients and other people (document review).

B. Our staff can describe the processes for receiving and responding to feedback and complaints from patients and other people (interview).

C. Our service makes contact information for the Human Rights and Equal Opportunity Commission (HREOC), Commonwealth Ombudsman and state or territory health complaints agency readily available to patients on request (interview, document review).

D. Our service can describe an improvement we have made in response to patient feedback or complaints (interview).

E. Our practice is working toward a systematic way to elicit feedback from patients about our service, including whether:
   - patients are satisfied with the health service’s process of scheduling care
   - health service staff discuss health promotion and illness prevention with patients
   - patients are able to see the health professional of their choice
   - health service staff treat patients in a respectful and culturally appropriately manner
   - patients receive sufficient information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments proposed by the health service staff to enable them to make informed decisions about their health
   - patients are confident that any feedback or complaint to the health service will be handled properly
   - the presence of a third party in a consultation occurs only with the patient’s permission prior to the consultation
   - patients are offered the use of an interpreter
   - patients find it easy to contact the service
   - patients are satisfied with facilities in the consultation area(s)
   - patients think the service makes adequate provisions for their privacy (document review).
CRITERION 2.1.3
Presence of a third party

The presence of a third party observing or being involved in the clinical care during a consultation occurs only with the permission of the patient prior to the consultation.

Explanation

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

In some circumstances, however, the patient or the staff member may feel more comfortable if a third party is present during an examination. Appropriate consent needs to be obtained from the patient where the health professional requests the presence of a third party. Where a patient is accompanied to the health service by a third person (such as a detention service provider security staff member), it is also important to ensure that the patient consents to the presence of that person in their consultation.

Ideally, permission should be sought prior to the consultation. It is not acceptable to seek permission in the consulting room, as some patients may feel ‘ambushed’ and unable to refuse. The presence of a third party in the consultation (including an interpreter) should be documented in the patient’s health record.

A tension may arise between respecting the rights to privacy and confidentiality of the patient and the need to manage any security or safety risks that the patient may pose to the health staff during a consultation. Health services in immigration detention centres may need to negotiate their policy for managing these risks with the detention service provider, and with the Department of Immigration and Citizenship if necessary. The policy needs to outline the circumstances in which third parties need to be present during a consultation for security purposes, and the way in which the disclosure of personal health information to the third party will be minimised during the consultation.

Indicators

A. Our staff can describe how and when they inform patients and obtain their prior permission for the presence of a third party during consultations (interview).

B. Our service has a policy about the presence of third parties in consultations (documents review).
section three
SAFETY, QUALITY IMPROVEMENT AND EDUCATION

**Standard 3.1 SAFETY AND QUALITY**
Our service is committed to quality improvement.

**Standard 3.2 EDUCATION AND TRAINING**
Our service supports quality improvement through education and training.
SAFETY AND QUALITY
Standard 3.1
Our service is committed to quality improvement.

CRITERION 3.1.1
Quality improvement activities

Our service supports quality improvement activities.

Explanation
It is very important that the Standards for health services in immigration detention centres encourage quality improvement and incorporate systems of continuous improvement.55

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

Quality improvement activities can range from activities designed to improve the day to day operations of the health service (eg. improving patient health record keeping, changing the way patient complaints are handled, or altering systems in response to ‘near misses’), to those specifically designed to improve the health of the whole health service population (eg. improving rates of immunisation, improving care of patients with diabetes, or altering the systems used to identify risk factors for illnesses that are particularly prevalent in the health service’s patient population). Quality improvement is not restricted to clinical areas and may include improvements made in response to feedback from patients (criterion 2.1.2) or other nonclinical aspects.

Quality improvement activities are underpinned by effective information management techniques that allow health services to analyse their data and make decisions for service changes based on the data collected. Innovative use of information technology can assist health services in performing quality improvement activities to improve the health of their population. Ideally, health services need to investigate their own data for quality improvement purposes.

Engaging in quality improvement activities is an opportunity for staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a health service, and achieving improvements may require the collaborative effort of the health service team.

Indicators

A. Our staff can describe an aspect(s) of our service we have improved in the past 3 years (interview).

B. Our service uses data about our health service population for quality improvement (interview or document review)
CRITERION 3.1.2
Clinical risk management system

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

Explanation

Slip ups, lapses and mistakes in clinical care that might harm patients can occur in all health services. One review of studies about slips and lapses suggests that the frequency with which a general practitioner will be involved in an incident in which an error occurred will be between five and 80 times per 100 000 consultations.\(^5^6\) The evidence about the frequency of slips, lapses and mistakes varies, and the better constructed studies suggest even higher rates of occurrence.

Most health services already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent slips, lapses and mistakes. Some medical or clinical staff talk to other trusted peers or supervisors. Other services have formal processes that include team discussions about the cause of the slip, lapse or mistake, and how to reduce the likelihood of it happening again, or using structured techniques to analyse the causes of the error and reduce the likelihood of its recurrence.

The same mistake can have different causes on different occasions. A quality improvement process involves having a consistent clinical risk management system so that the causes of slips, lapses and mistakes are identified and processes improved to reduce the likelihood of them occurring again.

If the health service does not make improvements after identifying a slip, lapse or mistake, patients may be exposed to an increased risk of adverse outcomes, and the staff may be exposed to an increased risk of medicolegal action. An example of this situation is where a clinically significant test result is not communicated to the patient or adequately followed up; the health service knows about this, and yet makes no attempt to prevent a recurrence. Another example might be if an important detail in a previous consultation is not considered or read by the medical or clinical staff member at that patient’s next consultation, resulting in a problem being overlooked; the health service becomes aware of this, and yet does not act to prevent it happening again. This second example is more likely with the use of certain electronic based record systems that do not show the previous consultation record when a patient’s record is opened.

The vast majority of slips, lapses and mistakes do not lead to patient harm as they are ‘near misses’ that are caught before any harm occurs. An example of this is when the doctor prescribes a medicine for a patient and then the patient tells the doctor that they are allergic to that medicine. Another is when a doctor notices that the nurse has prepared an incorrect vaccine before the vaccination takes place and replaces it with the correct vaccine. These ‘near misses’ can provide opportunities for quality improvement.

The health service needs to have a process by which health service staff – including nursing and other staff involved in clinical care – know how to (and who to) notify when a slip, lapse or mistake occurs, or when there is an unanticipated adverse outcome. A recent study\(^5^7\) suggests that staff members who are able to hold discussions about difficult subjects such as disrespect, micromanagement, competence and error are likely to be involved with better patient health outcomes, remain longer in their positions, and be more satisfied with their work.
Health services will have very different systems in place to identify and reduce clinical risk; it is important however, for health services to be able to demonstrate how and why they have made changes to improve clinical care.

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

A number of parties are involved in caring for people detained in immigration detention centres. Health service staff need to know how to and who to report to if they have a concern that the actions of another party (e.g. the Department of Immigration and Citizenship [DIAC] or the detention service provider) may compromise the quality and safety of care the health service provides to a patient.

The health service is also required to advise the DIAC of ‘critical incidents’ or adverse events and other risks to patient safety. In providing care to patients detained in immigration detention centres, it is critical that the health service have the capacity to notify the DIAC in the event that an administrative, detention or other immigration processing issue is likely to cause an error or risk to patient safety (as outlined in criterion 1.4.2).

Indicators

A. Our medical and clinical staff can describe the process for identifying and reporting a slip, lapse or mistake in clinical care (interview).

B. Our medical and clinical staff can describe an improvement we have made to prevent slips, lapses and mistakes in clinical care from recurring (interview).
**CRITERION 3.2.1**

**Medical staff qualifications**

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

**Explanation**

All doctors providing care in the health service need to meet the standards of their relevant Australian specialist medical college – both in terms of their vocational training, and in terms of their continuing professional development.

General practice is a distinct discipline in medicine and requires specific training. Doctors providing general practice care need to be appropriately trained and qualified in the discipline of general practice, and be either vocationally recognised or have Fellowship of the RACGP (FRACGP). The RACGP defines a general practitioner as a registered medical practitioner who is qualified and competent for general practice in Australia, has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care, and who maintains professional competence for general practice (through continuing professional development).58

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

Doctors providing general practice care who are not participating in RACGP quality assurance and continuing professional development (QA&CPD) activities need to demonstrate recent and continuing participation in activities equivalent to Category 1 activities of the RACGP QA&CPD Program. The RACGP QA&CPD Program is based on adult learning principles (ie. knowledge is more likely to be gained when the adult undertaking the learning recognises a ‘need to know’, seeks knowledge and reviews what has been learnt) and requires GPs to undertake two Category 1 activities in each triennium (eg. small group learning or clinical audits). (Further information about the RACGP QA&CPD Program is available at www.racgp.org.au/qacpd).

The RACGP recognises that cardiopulmonary resuscitation (CPR) skills in particular are used infrequently, and there is evidence that these skills diminish without use. There may be additional medicolegal risk for a medical practitioner who is perceived not to have assisted a patient by providing CPR. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training and how recently these skills have been used by its doctors.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator). Medical, clinical and allied health staff should be trained in CPR and the use of the defibrillator.
EDUCATION AND TRAINING

Standard 3.2
Our service supports quality improvement through education and training.

Indicators

A. All doctors can provide evidence of current state or territory based medical registration (document review).

B. Our service demonstrates that all our doctors are recognised Fellows of their relevant medical colleges

OR

where recruitment of Fellows of relevant specialist medical colleges has been unsuccessful, our service demonstrates that doctors have the qualifications and training necessary to meet the needs of patients (interview, document review).

C. Our service can provide evidence of satisfactory participation in the relevant specialist medical colleges continuing professional development program by all our doctors (document review).

D. Our doctors have undertaken training in CPR in the past 3 years (document review).

E. Our doctors can describe how to use our defibrillator (interview).
EDUCATION AND TRAINING

Standard 3.2

Our service supports quality improvement through education and training.

CRITERION 3.2.2

Clinical staff qualifications

All staff involved in clinical care are appropriately trained for their role in our service.

Explanation

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

The RACGP recognises that cardiopulmonary resuscitation (CPR) skills in particular are used infrequently, and there is evidence that these skills diminish without use. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training and how recently these skills have been used by its clinical staff.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator). Clinical and allied health staff should be trained in CPR and the use of the defibrillator.

Indicators

A. Our clinical and allied health staff have appropriate training, qualifications and current registration, and participate in continuing education relevant to their profession (interview, document review).

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

C. Our staff involved in clinical care have undertaken training in CPR in the past 3 years (document review).

D. Our staff involved in clinical care can describe how to use our defibrillator (interview).
CRITERION 3.2.3
Training of staff who have nonclinical roles

Our administrative staff participate in training.

Explanation
Administrative staff (such as receptionists and managers who do not provide clinical care) need training to be successful in their roles. This may include formal training (eg. a computer course, training in the use of software programs, training in first aid, management, medical terminology, medical reception, cross cultural training) or ‘on the job’ training provided by staff in the health service (eg. making appointments, recognising urgent situations, confidentiality requirements, familiarisation with the policy and procedures manual).

Cardiopulmonary resuscitation (CPR) skills training for all members of the community has been shown to improve outcomes and is supported by the RACGP. Clinical, allied health and administrative staff should be trained in CPR.

The RACGP recognises that CPR skills in particular are used infrequently, and there is evidence that these skills diminish without use. The RACGP sought the view of the Australian Resuscitation Council and suggests that the health service consider how frequently it requires or provides CPR (refresher) training, dependent on how recently these skills have been used by its administrative staff.

The nature of detention means that patients have a restricted ability to directly contact and use mainstream primary health and emergency services compared to people within the community. As such, health services in immigration detention centres need to stock emergency care and resuscitation equipment (including an automated external defibrillator).

Indicators

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

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

C. Our administrative staff have undertaken training in CPR in the past 3 years (interview, document review).

D. Our administrative staff can describe how to use our defibrillator (interview).
section four

SERVICE MANAGEMENT

Standard 4.1 SERVICE SYSTEMS
Our service demonstrates effective human resource management processes.

Standard 4.2 MANAGEMENT OF HEALTH INFORMATION
Our service has an effective system for managing patient information.
**SERVICE SYSTEMS**

**Standard 4.1**

Our service demonstrates effective human resource management processes.

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**CRITERION 4.1.1**

**Human resource system**

Our service has a system to manage its human resources.

**Explanation**

Research from both general practice and other industries supports the importance of giving attention to a range of aspects of human resources. For example, research in Australia and the United States confirms that teamwork is important to the quality of care. The research literature identifies teamwork as an important success factor in a number of safety initiatives across different industries. The authors of one study identified alignment of role, competence and licensing (where required) as a common element of high performing clinical teams.13

Staff need to have position descriptions that outline their roles, responsibilities and conditions of employment. A position description establishes the role of the employee within the organisation, documents the parameters of the responsibilities and duties associated with that position, and forms the basis for evaluation and lines of accountability. Recruitment, training and development, performance evaluation, remuneration management and succession planning can all be based on the measure of an individual against their position description.

It is important for the health service to have an induction program for new medical staff (including registrars and locums), allied health staff, other clinical staff and administrative staff. New staff need to understand the daily operations of the health service including the occupational health and safety issues (eg. infection control policies) relevant to their roles, as well as the processes by which the privacy and confidentiality of patient health information is maintained within the health service (including the kinds of information that can be released to the Department of Immigration and Citizenship or the Commonwealth Ombudsman). Medical, allied health and clinical staff in particular need to be aware of key public health regulations (eg. reporting requirements for communicable diseases) that will affect how they work. Medical and clinical staff need to be made aware of the existence of local health and community services (including pathology, hospital and other services they are likely to refer to in the course of normal consulting). Medical, clinical and administrative staff need to understand the role of the Commonwealth Ombudsman and the role of state or territory health complaints bodies. An induction program that covers these issues as well as the specific operational processes of the health service is essential to assist new staff to perform their roles.

It is important for health services in immigration detention centres to appropriately and sufficiently inform new staff members of a range of issues that are specific to that context of care. In particular, it is suggested that any induction program in immigration detention centres include the following:

- the rights and obligations (particularly relating to health care access) of people detained by the Department of Immigration and Citizenship (DIAC)
- processes for engaging with the detention service provider or the DIAC (criterion 1.6.1)
- the protocol for the notification of concerns about the provision of health care (criterion 1.4.2)
- the payment arrangements for the health service’s clinical services and external health providers
- information about particular cultural groups within the patient population
- information about identifying previous trauma and clinical information when managing patients with a history of trauma or torture.

Health services that have not employed new staff in the past 3 years are not required to have already developed an induction program. However, these health services need to be able to describe how they plan to induct new staff members in the future.
It is important that the health service team identify leaders in areas such as clinical care and improvement, information management, complaints and feedback, and human resources. Clinical care leadership might include convening a health service meeting to review the quality of care provided to a patient or the mentoring of new staff. Clinical improvement leadership might involve instigating a plan to monitor the management of patients on particular treatments (e.g., warfarin) with a view to improving the way the health service manages these patients. Sometimes, the person who leads the clinical care may not lead the clinical improvement strategy within the service, though both are important.

Health services need to identify the person in the health service who will be responsible for responding to patient feedback, examining issues raised by patients and facilitating improvements in the health service. It is possible that a single individual within the health service may assume all these leadership responsibilities (e.g., a principal doctor, nurse or psychologist). In some health services however, different members of the health service team will undertake leadership in these areas. In these cases, the Standards require that health services provide a structured opportunity for staff to discuss and agree on clinical matters.

It is important that health service staff have the opportunity to discuss administrative issues with the health service management and/or owners when necessary. When a person or body other than the practising medical staff owns the health service, medical, allied health and clinical staff need to have defined methods of discussing health service administrative matters with the owner(s). This criterion does not require a formal staff meeting (although this is desirable, particularly in larger health services).

Further information about human resource issues can be obtained from:

- a variety of resources from the Australian Medical Association (www.ama.com.au)
- the RACGP Employment kit: *tips in negotiating an employment contract in general practice* (see resources)
- the Australian Competition and Consumer Commission’s (ACCC) *Guide for general practitioners to the authorisation granted by the ACCC to The Royal Australian College of General Practitioners* (see resources).

**Indicators**

- A. Our staff can describe their roles within our service (interview).
- B. Our service can identify the person/people who coordinate the seeking of feedback, and the investigation and resolution of complaints (interview).
- C. Our service can identify the person/people leading its clinical improvement (interview).
- D. Our health service can identify the person/people leading the clinical care for our service (interview).
- E. Our staff are able to discuss administrative matters with the health service managers and/or owner(s) when necessary (interview).
- F. Our service has an induction program for new staff (document review).
- G. Our staff have position statements/job descriptions (document review).
- H. We have a regular staff meeting (interview or document review).
CRITERION 4.1.2
Occupational health and safety

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

Explanation

The occupational health and safety of health service staff is governed by state, territory and federal occupational health and safety legislation, and legislation may vary from state to state. Health services need to consider how they ensure the service is a safe working environment for all staff.

A doctor cannot be both a receptionist and a medical practitioner at the same time. To support occupational health, safety and wellbeing, health services need to be staffed by at least one additional person during normal opening hours. This person needs to be trained to take telephone calls, make appointments and assist with medical emergencies and cardiopulmonary resuscitation. (Normal opening hours are those the health service advertises as being its regular hours of opening for routine consultations during which patients can see a primary health care staff member).

The health and wellbeing of staff is an important issue and health services might find the following resources useful:

• AMA position statement on personal safety and privacy for doctors (see resources)
• AMA doctors health database (see resources)
• the RACGP publication Keeping the doctor alive: a self care guidebook for medical practitioners (see resources).

Additional resources are provided by the following organisations:

• Australian Association of Practice Managers (www.aapm.org.au)
• General Practice Registrars Australia (www.gpra.com.au)
• local divisions of general practice (www.adgp.com.au)
• NSW Rural Doctors Network (www.nswrdn.com.au)
• state and territory Doctors Health Advisory (www.doctorshealth.org.au).

Health services can support the health and wellbeing of all staff in many ways. For example, scheduling regular breaks in consulting time may reduce fatigue and support the health and wellbeing of the medical and clinical staff, as well as enhancing the quality of patient care. Fatigue and related factors (sometimes called ‘human factors’) can lead to increased risk of harm to patients. Health services can also make information available to their staff about support services in their state or territory. Another strategy is to have a plan for how to reallocate work flow (patient appointments) if a medical or clinical staff member is unexpectedly absent from the health service.

Supporting the psychological health and wellbeing of clinical staff is of growing concern to the medical and allied health care communities. Providing health care to people detained in Australian immigration detention centres may be emotionally and professionally challenging for health professionals.63–65 Systems of professional support for medical and clinical staff working in these services are vital to supporting their health and wellbeing and, ultimately, to retaining their services.
SERVICE SYSTEMS
Standard 4.1
Our service demonstrates effective human resource management processes.

Criterion 4.1.2 Occupational health and safety (continued)

Indicator D requires a health service to have a documented occupational health and safety policy. Given the infrequent (but possible) risks to the safety and security of health service staff posed by some patients detained in immigration detention centres, this policy needs to explicitly outline the processes and systems put in place to ensure safety. The security components of this policy need to be negotiated with the Department of Immigration and Citizenship (DIAC) and the detention service provider. The health service should have its own occupational health and safety policy that is consistent with, but does not rely on, the detention service provider’s occupational health and safety policy.

The nature of providing care to patients who are detained in an immigration detention centre means that careful consideration needs to be given to occupational health and safety issues relating to security. Staff should have a mechanism to immediately alert others to any risk to their safety. This might be achieved through a duress alarm in consultation rooms or personal duress alarms for staff – or some other mechanism appropriate to the environment. Services are referred to the information about safety for GPs and their practice teams at www.racgp.org.au/gpissues/safety. Health services are advised to consider what action will be taken in the event of a security breach.

Indicators

- A. Our service and office equipment is appropriate for its purpose (direct observation).
- B. At least one staff member, in addition to the medical or clinical staff member, is present when our service is open for routine consulting (interview).
- C. Our staff can explain how our service supports their health and wellbeing (interview).
- D. Our service has a documented occupational health and safety policy (document review).
- E. Our staff have mechanisms to immediately alert others of a risk to their safety (direct observation).
CRITERION 4.2.1
Confidentiality and privacy of health information

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

Explanation

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

The RACGP Handbook for the management of health information in private medical practice describes minimum safeguards and procedures that need to be followed to meet appropriate legal and ethical standards concerning the privacy and security of patient records (see resources). Health services are encouraged to become familiar with relevant federal and state and territory privacy legislation as this will also impact on the way in which health services manage patient health information (see www.privacy.gov.au).

The health service needs to have a documented policy for managing patient health information. This policy needs to outline:

• the health service’s procedures for informing new patients about privacy arrangements (including how patients are informed about the use of their information for quality assurance, research and professional development)
• the range of people (eg. doctors, nurses, psychologists) who may have access to their patient health records and the scope of that access
• the procedures for patients to gain access to their health information
• the way in which the health service gains patient consent before disclosing personal health information to third parties
• the health service’s process of providing health information to another health professional if requested by the patient
• how the health service maintains the security of information held at the service
• how the health service addresses complaints about privacy related matters
• the policy for the retention of patient health records.

The policy also needs to detail the type of personal health information that may need to be relayed to the Department of Immigration and Citizenship (DIAC) or detention service provider during centre meetings or when assessing special needs of patients, and how confidentiality can be maximised if a third party is present in the consultation without the consent of the health professional or patient.

These Standards recognise the patient’s ‘ownership’ of their personal health information; however, it is recognised that there may be some circumstances in which the detention service provider, the Commonwealth Ombudsman or the DIAC may require information relating to a patient’s physical and mental health to enable them to properly care for that person. Patients need to be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling legal circumstances (eg. concern for the patient’s safety or the safety of others).
The health service, in conjunction with the DIAC and the detention service provider, needs to determine the types of risks or events that would warrant the transmission of information with or without the consent of the patient. A balance must be struck between confidentiality and privacy and the proper care and protection of the individual patient. There must be mechanisms in place to ensure that information flows freely between those who are involved in the day to day care of detained people and medical staff when necessary but within the bounds of the law. Any such transfer of information to a third party without the consent of the patient needs to be documented in the patient health record.

Patient consent is often provided at an early stage in the process of clinical care. As a result, health services need to ensure that patients develop a shared expectation about the use of the data in a number of different circumstances. This includes the degree of access that individual health service staff may have and the likelihood of the use of individual patient information during quality improvement activities within the service.

Research is an important component of primary health care activity in Australia. Health services are encouraged to participate in research both within their own services and through reputable external bodies. The RACGP Handbook for the management of health information in private medical practice provides advice about privacy related issues for health services seeking to be involved in research activities. Many hospitals, universities and professional organisations involved in research will have a human research ethics committee (HREC) to review research proposals. Further information about HRECs and research can be found in the National Health and Medical Research Council (NHMRC) National statement on ethical conduct in research involving humans (see resources). Research activities that require HREC approval are distinct from audits undertaken by a health service as part of a quality improvement activity. Health services involved in research need to consider how ‘identifiable’ their patient information will be. There is a difference between identifiable patient information (by which a patient can be individually identified), deidentified patient information (which cannot be traced back to the individual patient) and potentially identifiable information (which can possibly be traced back to that patient).

Privacy, confidentiality and security of patient health information are equally important for health services that have paper based, hybrid paper and electronic, and solely electronic based systems of information management. Each system will pose different challenges to privacy and information security, with hybrid systems having a distinct vulnerability to errors in information management as both electronic and paper materials always need to be congruent.

Indicators

- A. Our staff can describe how they ensure confidentiality and security of patient health records (interview).
- B. Our staff can demonstrate that patient health records can be accessed by authorised staff at the time of consultation (interview, direct observation).
- C. Our staff can describe the processes we use to provide patients with access to their health information (interview).
- D. If our service participates in research, we can show evidence that this research has been approved by a HREC, constituted according to NHMRC guidelines (document review).
- E. Our service has a written policy for the management of patient health information (document review).
CRITERION 4.2.2

Information security

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

Explanation

The RACGP Handbook for the management of health information in private medical practice (see resources) and the General Practice Computing Group’s (GPCG) Computer security self assessment guide and checklist for general practitioners (see resources) provide information and explanations about the safeguards and procedures that need to be followed by general practices in order to meet appropriate legal and ethical standards concerning privacy and security of patient health information. These documents also contain suggestions for additional security procedures. The Privacy Act 2001 (Cwlth) states that a patient’s personal health information includes a person’s name, address, account details and any health information (including medical or personal opinions) about the person. Sometimes, details about a person’s medical history or other contextual information can identify them, even if no name is attached to that information. This is still considered to be ‘personal health information’ (more information is available at www.privacy.gov.au).

It is likely that different health service staff members will have different levels of access to patient health information (administrative staff may not have access to patient health information, for example). The policy and procedures manual needs to document which staff are authorised to access patient health information.

The health service must also ensure that both active and inactive patient health information and records are kept and stored securely. An inactive patient health record is generally considered to be a record of a patient who is no longer detained in the immigration detention centre. It is recommended that inactive patient health records be retained by the health service indefinitely or as stipulated by the immigration legislation and contractual requirements with the Department of Immigration and Citizenship (DIAC).

Staff need to ensure the confidentiality and security of patient health information and other sensitive health service materials and equipment. The presence of an additional person in the health service (besides the medical or clinical staff member on duty) will increase security and safety for patients and staff, and reduces the risk of unauthorised access to patient health information (criterion 4.1.2).

When a health service uses computers to store patient health information, the health service needs to maintain regular back ups and have an information disaster recovery plan: a documented plan in the case of an emergency (eg. power failure) in order to protect and save the information stored on the health service’s computers. The GPCG Computer security self assessment guide and checklist for general practitioners contains further information for health services about information disaster recovery plans.
 MANAGEMENT OF HEALTH INFORMATION  

Standard 4.2  
Our service has an effective system for managing patient information. 

Criterion 4.2.2 Information security (continued) 

Indicators 

A. Patient health information in our service is neither stored nor left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided (interview, direct observation). 

B. Our facsimile machines, printers and other communication devices are only accessible to authorised staff (direct observation). 

C. Our staff can describe how they ensure security of patient health records (interview). 

D. If our service uses computers to store patient health information, our service ensures that: 
   - our staff have personal passwords to authorise appropriate levels of access to health information 
   - screensavers or other automated privacy protection devices are enabled 
   - back ups of electronic information are performed at a frequency consistent with a documented information disaster recovery plan 
   - back ups of electronic information are stored in a secure offsite environment 
   - antivirus software is installed and updated 
   - all internet connected computers have firewalls installed (document review). 

E. If our service uses computers to store personal health information, our service has developed, tested and documented an information disaster recovery plan (document review).
CRITERION 4.2.3
Transfer of patient health information

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

Explanation

Health services need to facilitate the transfer of patient information to another health care provider or service at the patient’s request to assist that patient to access care.

When transmitting patient health information to a third party, health services need to have ways of ensuring that the patient has consented to the transfer. Consent may be given for the release of some information beyond an individual consultation.

Health services also need to have systems in place to ensure that patients share with the health service an understanding of the extent and boundaries of the use of personal information for administrative purposes.

The personal health information of patients is not the only information that people may wish to remain private. Staff working patterns may also be identified through data. Issues surrounding consent to disclosure of data that might identify staff members need to be considered prior to any transfer outside the health service.

Some continuing professional development (CPD) activities may involve the transfer of patient health information outside a health service (eg. National Prescribing Service activities) and these activities need to comply with relevant guidelines on CPD issued by an appropriate medical specialist college; they also need to be approved by that college. If the health service is transferring identifiable patient health information (any information that can identify the patient), then the health service needs to gain the consent of the patient to do so. If the health service is transferring deidentified patient information (information by which individual patients cannot be identified), then the health service needs to retain a copy of the CPD approval for that activity.

Patient health information that is transmitted electronically over a public network (eg. the internet) can pose significant privacy risks. It is technically possible for a third party to intercept and read emails, or for emails to be inadvertently sent to the wrong person. Encryption allows for the ‘scrambling’ of the message so that it can only be read by the intended person who verifies their identity using a unique identifying code. The General Practice Computing Group’s (GPCG) Computer security self assessment guide and checklist for general practitioners provides further information about security procedures (including encryption such as public key infrastructure [PKI]) for practices (see resources). Some general practices and other health services have begun to use encryption to transfer patient health information. Health services should not transfer patient information via email unless it is encrypted.

For patients detained in immigration detention centres, it is important that the health service arranges the transfer of care to another health care practitioner when the patient is released from the immigration detention centre or transferred into another detention placement, eg. residential housing accommodation. This may be at the request of the patient, however, health services should be proactive in ensuring that the patient’s health information is provided to the health professional who will carry on their care outside of the immigration detention centre. A comprehensive health
RACGP STANDARDS FOR HEALTH SERVICES IN AUSTRALIAN IMMIGRATION DETENTION CENTRES

MANAGEMENT OF HEALTH INFORMATION

Standard 4.2
Our service has an effective system for managing patient information.

Criterion 4.2.3 Transfer of patient health information (continued)

summary needs to be provided (with patient consent) to the health professional who will coordinate
the care for the patient outside the detention centre or to the patient (if no health professional
has been identified). It is useful for this transfer of care to be managed by the person in the health
service identified as leading the care for that individual patient (criterion 1.5.2).

Indicators

A. Our staff can describe the procedures for transferring patient health information
to another service provider or health service (interview).

B. We record the request by the patient to transfer patient health information
on the file. This note includes details of where the information was sent and
who authorised the transfer (health records review).

C. When we collect identifiable patient health information for CPD activities,
we only transfer it to a third party if the patient provides their consent
(document review).

D. When we collect deidentifiable patient health information for CPD activities,
we only transfer it to a third party if we have approval to do so from a
recognised medical college’s CPD process (document review).

E. Our electronic data transmission of patient health information over a public
network is encrypted (document review).
MANAGEMENT OF HEALTH INFORMATION

Standard 4.2
Our service has an effective system for managing patient information.

CRITERION 4.2.4
Retention of patient health information

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

Explanation

The commonwealth Privacy Act 1988 requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

Health services need to be aware that there may be specific legislation in their state or territory requiring a minimum period of retention of health records. Such legislation normally recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer.

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

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

The health service must also ensure that inactive patient health information/records are kept and stored securely. An inactive patient health record is a record of a patient who is no longer detained in an immigration detention centre.

The arrangements under which health care (including mental health care) is provided to people detained in immigration detention centres means that information about their treatment needs to be available to the DIAC within the requirements of the privacy principles.

The health service needs to be able to comply with the conditions of the contract with the DIAC for the provision of health services to people in detention. These conditions include compliance with obligations contained in the commonwealth Privacy Act 1988. Under the Act, the health service may not provide access to the health records to any third party other than the person the record relates to or to a person authorised by that person in writing to have access to the record.

Following the expiration of the record retention period outlined in the contract with the DIAC, or the requirements in the relevant state or territory legislation concerning the minimum period for the retention of health records, whichever is the longer, the health service needs to be able to return all copies of the records to the commonwealth or otherwise destroy any copies as directed by the commonwealth.

Indicators

A. Our practice keeps individual patient health information until the patient has reached the age of 25 years or for a minimum of 7 years from the time of our last contact with the patient, whichever is the greater (interview).

B. Our service has a process for identifying, storing and retrieving inactive patient health information (interview, direct observation).

C. Our service has an appropriate method of destruction prior to disposal (eg. shredding) of any material containing patient health information (interview, direct observation).
section five

PHYSICAL FACTORS

Standard 5.1 FACILITIES AND ACCESS
Our service provides a safe and effective working environment for our team and patients.

Standard 5.2 EQUIPMENT FOR COMPREHENSIVE CARE
Our service provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Standard 5.3 CLINICAL SUPPORT PROCESSES
Our service has processes in place that support safety and the quality of clinical care.
CRITERION 5.1.1
Health service facilities

Our service facilities are appropriate for a safe and effective working environment for patients and staff.

Explanation

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

While this criterion discusses consultation ‘rooms’, it is acknowledged that some health services may have ‘areas’ rather than rooms in which to treat patients. These consultation areas need to be appropriate for the health and safety of staff and patients. Consultation ‘areas’ refer to those areas used for medical, clinical or allied health care of patients.

To encourage a therapeutic environment, consultation rooms need to be clearly marked as space associated with the health service (e.g. through the use of signage on the door). Consultation rooms should be for the exclusive use of the health service and should not be shared with non-health service parties (such as the Department of Immigration and Citizenship [DIAC] or the detention service provider).

Consultation room temperature needs to be such that a patient undressed for a clinical examination remains comfortable.

Visual privacy and dignity can be afforded to patients during clinical examinations by the use of a gown or sheet and an adequate curtain or screen positioned in such a way as to maximise the patient’s privacy, particularly when a patient is required to undress for a clinical examination or procedure. This includes situations in which there is a door opening to an area to which staff of DIAC or the detention service provider have access, and also when patients are required to dress or undress in the presence of the medical or clinical staff member.

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

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

All environments should satisfy the relative state and federal occupational health and safety laws.

The health service needs to have an area that caters for the specific needs of patients who are at risk of self harm. This ‘safe room’ should be situated within or in close proximity to the health service to facilitate continual monitoring of the health (including mental health) of the patient inside and allow for immediate intervention if needed. The room should be designed with consideration of minimising potential for self harm (e.g. no points from which patients could attempt to hang themselves).
FACILITIES AND ACCESS

Standard 5.1
Our service provides a safe and effective working environment for our team and patients.

Criterion 5.1.1 Health service facilities (continued)

Indicators

- A. Our service has at least one dedicated consulting/examination room for the exclusive use of every medical and clinical staff member working in our service at any time (interview, direct observation).

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

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

- D. Our service has a waiting area sufficient to accommodate the usual number of patients and other people who would be waiting at any time (direct observation).

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

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

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

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

- I. Our service has the capability for electronic communication by facsimile or email (direct observation).

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

- K. Our service can demonstrate that we ensure there is no smoking in our service (interview, document review, direct observation).
**CRITERION 5.1.2**

**Physical conditions conducive to confidentiality and privacy**

The physical conditions in our service encourage patient privacy and confidentiality.

**Explanation**

It is important that patients have confidence that their health information is being treated respectfully and with consideration to their privacy and confidentiality. Privacy and confidentiality of patient information needs to be considered at all times. The physical arrangements of the health service need to be considered in providing privacy and confidentiality to patients.

The layout of reception and waiting areas can also assist in encouraging patient privacy and confidentiality, especially when patients are discussing personal issues with staff.

Consultations need to be private and there should be no possibility of consultations being overheard. Auditory privacy within the health service can be enhanced by the use of background music to mask conversations between staff members and between staff and patients. The privacy of patients may also be ensured by the use of a curtain or screen, and gown or sheet when the patient needs to undress for a clinical examination or procedure (criterion 5.1.1).

Health services have a responsibility to protect the privacy and confidentiality of patients, and this may be achieved through the physical set up of the service and through processes that protect patients’ health information (criteria 4.2.1 and 4.2.2).

**Indicators**

- **A.** The physical facilities of our service encourage patient confidentiality and privacy (direct observation).
- **B.** Visual and auditory privacy of consultations is ensured (direct observation).
CRITERION 5.1.3
Physical access

Our service provides appropriate physical access to our premises and services including access for people with disabilities.

Explanation

Good physical ‘access’ to the health service facilities and services is of high importance to patients. Health services need to make all reasonable efforts to facilitate physical access to their premises and services.

It is recommended that health services refer to the Australian standards regarding access to buildings for people with disabilities to help inform appropriate design for health services being built or undergoing renovations. These standards can be accessed through Standards Australia (www.standards.com.au).

Health services need to consider the needs of patients with a disability when considering what is ‘reasonable’. The health service may take a range of steps to assist patients with a disability, such as having signage that is pictorial rather than textual (for patients with an intellectual disability), accessible pathways from the door to reception and to consultation rooms that are wide enough for patients in wheelchairs, and a unisex wheelchair accessible toilet for patients with disabilities. Staff need to consider the ways in which they can help facilitate access to the health service and its services for patients.

The Human Rights and Equal Opportunity Commission (HREOC) has expressed concern that health services may not be complying with the Disability Discrimination Act if they cannot provide effective access to people with disability with respect to height adjustable beds.

In response to the HREOC, the RACGP Council has endorsed a new (unflagged) indicator. The Standards recommend visiting www.hreoc.gov.au for more information relating to the Disability Discrimination Act 1992 (Cwlth) and legislation regarding the right to access primary health care.

Indicators

A. There is wheelchair access to our service and its facilities (direct observation)
   OR
   if physical access is limited, our service provides visits to patient living quarters (interview).

B. Our staff can describe how they facilitate access to our service for patients with disabilities (interview).

C. Our practice has a height adjustable bed.
CRITERION 5.2.1
Health service equipment

Our service has access to medical equipment necessary to ensure comprehensive primary care and resuscitation.

Explanation

Health services in immigration detention centres need to have access to the necessary equipment to provide comprehensive primary care and resuscitation. To meet this criterion, such equipment must be present and in working order. It should be noted that there is a wide range of equipment that health services may require. Additional equipment to which a health service has access will depend on the nature of the health service, the interests and requirements of the medical, clinical and allied health staff, the procedures the health service undertakes and the nature of the patient population.

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

Equipment that requires calibration or that is electrically or battery powered (eg. electrocardiographs, spirometers, autoclaves, vaccine fridges, scales, defibrillators) needs to be serviced on a regular basis to ensure that they are maintained in good working order.

There is evidence – both internationally and in Australia – to suggest that immediate defibrillation significantly improves the chance of survival after cardiac arrest. Although cardiac arrest in primary care situations is a very rare event, the difference in outcomes between early defibrillation and defibrillation performed a few minutes after the arrest is very significant (10% increase in mortality for each minute from the time of the arrest). Patients detained in immigration detention centres have restricted access to mainstream emergency care compared to people within the community, and health services in immigration detention centres need to have access to equipment for emergency care and resuscitation (including an automated external defibrillator). As the health service is unlikely to be staffed 24 hours a day, it is recommended that the defibrillator is placed in an area where detention service provider staff and/or the Department of Immigration and Citizenship (DIAC) staff can access it in the case of an emergency (eg. outside the main door to the health service).
EQUIPMENT FOR COMPREHENSIVE CARE

Standard 5.2

Our service provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

Criterion 5.2.1 Health service equipment (continued)

Indicators

A. Equipment for comprehensive primary care and resuscitation is available within our service, including:
   - auriscope
   - blood glucose monitoring equipment
   - disposable syringes and needles
   - equipment for resuscitation, equipment for maintaining an airway, equipment to assist ventilation (including bag and mask), 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 (and the means to administer it)
   - patella hammer
   - peak flow meter or spirometer
   - scales
   - spacer for inhaler
   - specimen collection equipment
   - sphygmomanometer
   - stethoscope
   - thermometer
   - torch
   - tourniquet
   - urine testing strips
   - vaginal speculae
   - visual acuity charts
   - X-ray viewing facilities (direct observation).

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

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

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

E. Our service has an automated external defibrillator (direct observation).
CRITERION 5.2.2

Doctor’s bag

Our service ensures that our medical and clinical staff have access to a doctor’s bag.

Explanation

Equipment need only be in the doctor’s bag (or resuscitation bag) when it is being used. The health service is not required to maintain two sets of equipment, but rather the necessary items can be placed in the bag in an emergency or when the doctor is attending a consultation in a patient’s living quarters. More than one doctor or nurse in the health service may share the use of a doctor’s bag. It is acceptable for items of equipment to be kept in more than one bag so that they collectively include all the items listed in indicator B. Large health services need to consider whether more than one doctor’s bag is needed to ensure that doctors or nurses have access to a doctor’s bag when required.

It would be useful for health services to consider which medicines they use in their doctor’s bags. Consideration needs to be given to the service location, the type of clinical conditions likely to be encountered, the shelf life (or date of expiry) and climatic vulnerability of the various medicines, and the cost and size of the doctor’s bag.

This criterion requires that the health service take sensible measures to keep the bag and its contents secure and that health services are aware of the security measures for the bag and its contents as outlined in state and territory regulations.

Indicators

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

Standard 5.3

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

CRITERION 5.3.1

Medicines

Our service ensures that all medicines (including S4 and S8 medicines) are stored securely and are only accessed by authorised personnel.

Explanation

All sensible security measures need to be taken to prevent unauthorised access to medicines.

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

Furthermore, the use of Schedule 8 medicines must be correctly recorded in accordance with state and territory legislation and appropriate documentation is required in relation to the date of administration, patient details, quantity of incoming medicines, quantity of outgoing medicines, quantity of medicines still held, comments about prevailing conditions (eg. breakages) and signatures of the persons entering the data and administrating the medicine.

Some states and territories also have specific legislation relating to the storage, use and disposal of Schedule 4 medicines, and health services are encouraged to become familiar with these requirements.

Indicators

A. Schedule 4 and Schedule 8 medicines in our service are securely stored (direct observation).

B. The acquisition, storage, use, transfer and disposal of Schedule 4 and Schedule 8 medicines in our service are appropriately documented (document review).
CRITERION 5.3.2
Vaccine potency

Our service has appropriate processes that maintain the potency of vaccines.

Explanation

The success of any vaccination program depends on the potency of vaccines when they are administered. The essential reference for this criterion is the current published edition of the National Health and Medical Research Council (NHMRC) guidelines *The Australian immunisation handbook* (see resources) which outline exactly what a health service needs to do in relation to cold chain management. It is important that health services follow the current published edition of these guidelines in relation to cold chain management and monitoring during storage, use, transfer and disposal of vaccines.

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

Vaccines may be safely stored in domestic refrigerators if appropriate safeguards are in place. Safeguards may include a combination of the following:
- a temperature probe placed in the vicinity of stored vaccines
- staff taking the correct action when out of range temperatures are recorded
- the use of trays in which to place stored vaccines.

Standards relating to cold chain management change from time to time and there are a number of bodies that make recommendations. The NHMRC recommendations, however, are seen as the authoritative advice on this health service process.

Indicators

A. Our service can demonstrate how our cold chain management processes meet the current published edition of the NHMRC guidelines (direct observation).

B. Our staff can describe how the process used for cold chain management meets the current published edition of the NHMRC guidelines (interview).

C. Our service has a documented policy for cold chain management procedures in accordance with the current published edition of the NHMRC guidelines (document review).
CLINICAL SUPPORT PROCESSES

Standard 5.3

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

CRITERION 5.3.3

Perishable materials

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

Explanation

To promote the safe use of medicines, vaccines and other health care products, health services need to ensure that they do not keep perishable materials beyond their expiry dates. This is also relevant for perishable sample medicines or other health products that need to be stored, used and provided to patients before their expiry dates.

It is also important to ensure that medicines, vaccines and other health care products are stored (and secured) appropriately.

Indicators

A. Our service does not use or keep medicines, vaccines or medical consumables beyond their expiry date in our service or doctor’s bag(s) (direct observation).

B. Relevant health service staff can describe the procedure for checking expiry dates of perishable materials and for disposing of such materials where necessary (interview).

C. Our service has a written procedure for checking expiry dates of perishable materials and for disposing of such materials where necessary (document review).
CRITERION 5.3.4
Infection control

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

Explanation
Infection control is concerned with the sterility of clinical equipment, the occupational health and safety of staff, and managing the risk of cross infection in the health service environment.

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

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

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

Health services that sterilise onsite need to demonstrate that sterilising equipment is used and maintained correctly.

Where the health service uses offshore sterilisation facilities, the health service needs to be able to document the procedures for safe transport of instruments to and from the health service, and demonstrate that the offshore facility correctly performs the sterilisation and validates its processes. This may be demonstrated by providing evidence that the facility is accredited to the Australian Council on Healthcare Standards.

Health services that employ single use disposable instruments need to be able to demonstrate that the packaging of the instruments is not compromised and the instruments have remained sterile or disinfected appropriately until their use.
CLINICAL SUPPORT PROCESSES

Standard 5.3

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

Criterion 5.3.4 Infection control (continued)

In relation to waste management within the health service, the 1999 NHMRC National guidelines for waste management in the health care industry define three categories of waste produced by health care industries and outline the appropriate disposal mechanism for each:

- **clinical waste**
  - includes discarded sharps, laboratory and associated waste directly involved in specimen processing, human tissues (but excluding hair, teeth, urine and faeces), materials or solutions containing free flowing or expressible blood and animal tissues or carcasses used in research
  - most clinical waste can be disposed of in a safely located yellow, leak proof container displaying a biohazard symbol
  - sharps can be disposed of in a safely located yellow, leak proof and puncture resistant container displaying a biohazard symbol (eg. mounted on a wall or on a bench) in all areas where sharps are generated

- **related waste**
  - includes cytotoxic waste, pharmaceutical waste, chemical waste and radioactive waste

- **general waste**
  - includes all waste materials produced that do not fall into the clinical or related waste categories. Gauze that has blood on it (but which cannot be expressed), used disposable vaginal spatulae, cervical spatulae and brushes, and tongue depressors are likely to be the most common items in this category
  - general waste contaminated with blood or body substances (though not to such an extent that it would be considered clinical waste, ie. not contaminated with ‘expressible blood’) may be disposed of in a small bin lined with plastic mounted on the wall or on a bench and then through the general waste processes of the health service
  - general waste not contaminated by blood or body fluids can be disposed of in the usual waste paper bin under the desk.

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

Potential infection risks to staff need to be reduced. In this context, it is important for health services to ensure that all staff are familiar with infection control procedures within the health service (including standard and additional precautions, spills management, environmental cleaning), for the health service to be aware of the immunisation status of the staff, and for the health service to ensure that staff are offered appropriate immunisation for their roles.

Standard precautions apply to work practices that assume that all blood and body substances are potentially infectious. The NHMRC recommends the use of personal protective equipment including heavy duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste (Indicator D).

Additional precautions apply to dealing with patients known or suspected to be infected with highly transmissible pathogens. In health services in immigration detention centres, this may be achieved by minimising the period of exposure to other patients and staff through the use of masks or by isolating the patient in a separate room or seeing that patient ahead of other patients (Indicator D).

It is important that health services remain alert to changes to guidelines for infection control, and be in a position to implement new guidelines accordingly. Health services should also have systems for monitoring and obtaining information about national and local infection outbreaks, and emerging risks of cross infection such as the advent of avian flu and SARS. This is particularly important for health services in immigration detention centres, as patients may be recent arrivals.
in Australia from other countries. The health service may need to be alert to outbreaks in patients’ countries of origin (eg. those who are detained for short periods for not having valid visas, and are subsequently deported).

Health care services in immigration detention centres need to be aware of the risk of infectious diseases from people recently arrived in Australia (eg. tuberculosis) and containment processes for the immigration detention centre as a whole. Staff need to be familiar with their responsibilities in relation to monitoring and reporting disease outbreaks to the relevant state or territory authorities and the detention service provider, and in responding with the implementation of appropriate precautions. Appropriate infection control measures need to be instituted to prevent the risk of diseases spreading to the population in the immigration detention centre. Furthermore, there needs to be a system in place that allows for the monitoring for threats of outbreaks (eg. varicella, measles, lyssavirus, hendra virus) and emerging disease (eg. SARS, avian influenza, community associated methicillin resistant Staphylococcus aureus [CAMRSA]).

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

Indicators

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

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

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

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

Standard 5.3

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

Criterion 5.3.4 Infection control (continued)

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

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

G. Our induction program ensures that staff who are new to our service are familiar with standard precautions against infection and other issues appropriate to their duties (document review, interview).
section six
REFERENCES
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The RACGP Standards for health services in immigration detention facilities are based on published evidence about quality and safety.
Reference lists of published materials supporting these Standards are available on the RACGP website at www.racgp.org.au/standards.
RESOURCES

Publications and online resources

‘10 tips for safer health care’
Australian Council for Safety and Quality in Healthcare
www.safetyandquality.org/internet/safety/publishing.nsf/Content/10-tips

ACCC info kit for the medical profession
Australian Competition and Consumer Commission
www.accc.gov.au/content/index.phtml/itemid/575092

The Australian immunisation handbook
National Health and Medical Research Council

Computer security self assessment guideline and checklist for general practitioners
General Practice Computing Group

Consumer medicines information
Consumer Medicines Information
www.racgp.org.au/medicineinformation

Guide for general practitioners to the authorisation granted by the ACCC to The Royal Australian College of General Practitioners
Australian Competition and Consumer Commission
www.accc.gov.au/content/index.phtml/itemid/307373

Guidelines for preventive activities in general practice (6th edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/redbook

Handbook for the management of health information in private medical practice
The Royal Australian College of General Practitioners
www.racgp.org.au/privacy/handbook

Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting
Australian Government Department of Health and Ageing

Infection control standards for office based practices
The Royal Australian College of General Practitioners
www.racgp.org.au/infectioncontrol
Medical care of older persons in residential aged care facilities (3rd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/silverbook

National statement on ethical conduct in research involving humans
National Health and Medical Research Council

‘Points for using telephone interpreting’
Australian Government Department of Immigration and Citizenship

Putting prevention into practice (2nd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/greenbook

The RACGP employment kit: tips on negotiating an employment contract in general practice
The Royal Australian College of General Practitioners
www.racgp.org.au/publications/tools#7

‘Safety every time – our general practice checklist’
The Royal Australian College of General Practitioners
www.racgp.org.au/safety

‘Safety for general practitioners and their practice teams’
The Royal Australian College of General Practitioners
www.racgp.org.au/gpissues/safety

Smoking, nutrition, alcohol and physical activity (SNAP): a population health guide to behavioural risk factors in general practice
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/snap

Standards for general practices (3rd edn)
The Royal Australian College of General Practitioners
www.racgp.org.au/standards

Codes

‘Code of conduct for corporations’
The Royal Australian College of General Practitioners
www.racgp.org.au/guidelines/codeofconduct

Code of ethics 2004
Australian Medical Association.
Position statements

Complementary medicine
Australian Medical Association

Health care of asylum seekers and refugees
Australian Medical Association

Joint position statement on complementary medicine
RACGP/Australian Integrative Medicine Association
www.racgp.org.au/Content/NavigationMenu/Advocacy/RACGPpositionstatements/
2006compmedstatement.pdf

Position statement on personal safety and privacy for doctors
Australian Medical Association
Privacy_for_Doctors.pdf

Statement on complementary and alternative medicine
Medical Council of New Zealand

Services

National Auslan Interpreter Booking & Payment System
www.nabs.org.au

Translating and Interpreting Service (TIS) for non-English speakers
Department of Immigration and Citizenship

Other resources

Doctors health database
Australian Medical Association
The RACGP has enjoyed a long history of developing standards for general practices on behalf of the profession. The college’s standards reflect a commitment to develop standards that reflect the general practice profession’s views on the high quality of care their practices provide. These Standards for health services in immigration detention centres are based on the RACGP Standards for general practices (3rd edition).

The RACGP Standards for general practices and the associated accreditation process were developed in the 1990s with the long term aim of engaging general practices in an ongoing process of quality improvement. In 1992, the RACGP established the Standards Reference Group with a grant from the Australian Government. The RACGP Entry standards for general practices were then developed to provide entry level standards for general practices to meet through a formal accreditation process.

The Entry standards and assessment processes were field tested by the RACGP in 1994 with financial assistance from the Australian Government. One hundred and ninety-nine randomly selected practices from urban, rural and remote areas of Australia participated. The field test of the Entry standards sought to test the acceptance and achievability of the standards through an accreditation process. The field test demonstrated high levels of validity, reliability, acceptance and achievability. The field test also sought to test the feasibility, reliability and validity of employing an assessment process through an accreditation system.\textsuperscript{40,41} One of the major outcomes of the field test was the demonstration of significant levels of change undertaken or planned by the practices involved.

In 1994 and 1995 the (then) Commonwealth Department of Human Services and Health commissioned and financed divisions of general practice to undertake local demonstration trials of the Entry standards and the accreditation process. The trials were designed as an extension of – and were complementary to – the RACGP field test. The demonstration trials involved 500 general practices, either self selected or randomly chosen from metropolitan, rural and remote areas in all states and territories of Australia. The focus was on trialing the ways in which the Entry standards could be applied in a general practice accreditation setting.\textsuperscript{42}

In 1996, the RACGP established a committee – now known as the National Expert Committee on Standards for General Practices (NECSGP) – to oversee the development and monitoring of the Standards and the accreditation process.

In 1998, the RACGP published the Standards for medical deputising services as an appendix to the Entry standards.

The Entry standards were revised in 1999 following further research and feedback from consultation with the profession. A second edition of the Standards for general practices was released in August 2000.
In 2003, the RACGP embarked on a review of the *Standards for general practices* (2nd edition). The review included an extensive consultation process with:

- individual GPs, practice staff and consultation organisations
- three expert working groups (Practice Management, Care Outside Normal Opening Hours and Information Management), which included representatives from the RACGP, Australian Association of Practice Managers, Australian Divisions of General Practice (ADGP), Australian Medical Association, Consumers’ Health Forum and the Rural Doctors’ Association of Australia
- analysis of questionnaires distributed at the ADGP Division of General Practice Network Forum conference in November 2003 and at the AGPAL conference in February 2004
- direct invitation for comments from 47 key stakeholder organisations including accreditation providers
- a fax survey of over 1000 rural RACGP members in March 2004
- receipt of 115 formal submissions between October 2003 and June 2004 from GPs, practice staff, and other stakeholders.

In July 2004, the draft of the revised *Standards for general practices* (3rd edition) was released for public comment and active feedback sought. As part of the consultation process the RACGP conducted a national field test of the revisions to the *Standards*. The field test was conducted in collaboration with both accreditation organisations, 200 general practices around Australia and 144 general practice accreditation surveyors. The field test generated qualitative and quantitative data and collected information about which indicators general practices were currently achieving, which indicators general practices found acceptable, and which indicators practices and surveyors found feasible to include in a new edition of the *Standards*. In addition, the field test tested the achievement, acceptance and feasibility of the revisions in the *Standards* in diverse general practices, exploring results in relation to the rurality of the practice, size of the practice, information management system used by the practice, whether the practice was undergoing accreditation or re-accreditation, and if the practice was an Aboriginal medical service.

The field test formed one component – albeit a significant component – of the process used by the RACGP to revise the draft *Standards*. Consideration was also given to a number of other aspects including:

- feedback from the consultation process between August 2004 and January 2005
- consideration of structure, process and outcome indicators
- the evidence base for the indicators
- the relevance of the indicators for Australian general practices
- the capacity for practices to alter processes to meet the indicators
- reliability of measurement of indicators
- capacity of indicators to be described unambiguously
- capacity for indicators to differentiate between high and low quality practices
- any duplication of indicators, and
- the number of indicators in the *Standards*.

In December 2006, the RACGP was advised that the *Standards for general practices* (3rd edition) were awarded accreditation by the International Society for Quality in Health Care (ISQua). This is important international recognition for the rigour of the RACGP’s standards setting, and follows the RACGP’s application for certification and review of its standards by an international expert panel.
In 2006, the Australian Government Department of Immigration and Citizenship (formerly the Department of Immigration and Multicultural Affairs) sought the assistance of the RACGP in developing standards for use in health services in immigration detention centres, and agreed that the RACGP should develop these standards. The RACGP considered that the Standards for general practices (3rd edition) could be customised in a way that would make them applicable to detention centre settings.

In the Palmer Report on the circumstances of the immigration detention of Cornelia Rau, Mr Mick Palmer made a number of recommendations relating to standards of health care. These recommendations include establishing a health advisory panel and developing national accreditation standards that all immigration detention service providers will be required to meet. Development of health care standards for use in immigration detention centres fell within the responsibility of the Detention Health Advisory Group (DeHAG).

In July 2006 DeHAG members agreed that DIAC should progress the development of health care standards based on the RACGP Standards of general practices. Members of the DeHAG have worked closely with the RACGP and the DIAC in the development of the RACGP Standards for health services in Australian immigration detention centres.

The development of the RACGP Standards for health services in Australian immigration detention centres in 2006 and 2007 included:

- consultation with DeHAG including nominees from the Australian Dental Association, Australian Medical Association, Australian Psychological Society, Commonwealth Ombudsman, Forum of Australian Services for Survivors of Torture and Trauma, Immigration Detention Advisory Group, Mental Health Council of Australia, Public Health Association of Australia, Royal Australian and New Zealand College of Psychiatrists, the RACGP, Royal College of Nursing, Australia and the Victorian Healthcare Association
- consultation visits to Villawood, Baxter, Maribyrnong, Perth and the Northern immigration detention centres
- consultation with general practice and allied health professionals with experience in detention centre health and/or refugee health
- a pilot test of draft proposals at the Maribyrnong Immigration Detention Centre
- a focus group discussion of draft proposals at the Maribyrnong Immigration Detention Centre.

These RACGP Standards for health services in Australian immigration detention centres were published in April 2007.
GLOSSARY

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

Active patient: A patient who is detained in an immigration detention centre

Active patient health record: Refers to records of patients who are detained in the immigration detention centre

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

Adverse event: An incident in which unintended harm was caused to a person receiving health care

Antivirus software: Software (computer program) that protects the computer or network from virus programs that can corrupt software and impede its functioning

Allied health staff: A nonmedical staff member who provides clinical care of the patient consistent with their professional training

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

Asylum seeker: A person who is seeking to be recognised as a refugee

CALD: Refers to people from culturally and linguistically diverse backgrounds

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

CD-ROM: A compact disc for storing electronic information

Clinic based care: Care that is provided when patients attend the health service, as opposed to when they are visited in their living quarters

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

Clinical risk management system: A system or process the health service has put in place to management potential opportunities for error and adverse effects

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

Clinical staff: Nonmedical staff who provide clinical care to patients (including allied health staff who provide clinical care)

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

Confidentiality: The discretion used in keeping information secret

Consumer medicines information: Written information for the general public produced by pharmaceutical companies in relation to their medicines
Continuity of care: The degree to which a series of discrete health care events is experienced by the patient as coherent and connected and consistent with the patient’s medical needs and personal context. Three aspects of continuity have been defined in the literature:

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

CPD (continuing professional development): Educational activities which lead to quality improvement in clinical care

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

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

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

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

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

Encryption: A process to convert text into cipher text (meaningless data) as a way to protect the contents of electronic communication and guarantee its authenticity

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

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

Firewall: Any of a number of security schemes that prevent unauthorised users from gaining access to a computer network

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

General practice: A health care setting that provides initial, continuing, comprehensive and coordinated medical care for individuals, families and communities and which integrates biomedical, psychological, social and environmental understandings of health

General practice registrar: A registered medical practitioner who is enrolled in a general practice training program approved by the RACGP to achieve Fellowship of the RACGP
**General practitioner (GP):** A registered medical practitioner who is qualified and competent for general practice anywhere in Australia, has the skills and experience to provide whole person comprehensive and coordinated and continuing medical care, and maintains professional competence for general practice

**Hardware:** The physical components of a computer (eg. monitor, hard drive)

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

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

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

**Immigration detention centre:** A secure facility for detaining people under Section 273 of the *Migration Act 1958 (Cwlth)*

**Inactive patient health record:** A record of a patient who is not longer detained in the immigration detention centre.

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

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

**Informed consent:** Consent by a patient (either written or verbal) to proposed investigations, treatments or investigations or participation in research after achieving an understanding of the relevant purpose, importance, benefits, and associated risks

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

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

**Medical staff:** Staff who have current state or territory based medical registration

**Near miss:** An incident that could have caused harm (eg. to a patient) but did not result in harm

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

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

**Normal opening hours:** The normal consulting hours of the health service

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

**Outside normal opening hours:** The hours not covered by the health service’s normal opening hours
**Patient health information:** A patient’s health information includes a person’s name, address, account details and any health information (including opinion) about the person. Sometimes, details about a person’s medical history or other contextual information can identify them, even if no name is attached to that information.

**Patient health record:** The place (either computerised or hard copy) where an individual patient’s personal health information is stored.

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

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

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

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

**Psychologist:** A mental health expert qualified and registered with the Psychologist Registration Board in their state or territory.

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

**Public key infrastructure (PKI):** A secure method of transmitting information electronically to provide authentication and confidentiality. Public key infrastructure is used to transfer information between doctors and specialists, and hospitals, doctors and other health services.

**Referral:** To send on or direct a patient to another practitioner.

**Refugee:** A person who has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or opinion and who is unwilling or unable to return to their country of origin because of that fear.

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

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

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

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

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

**Screensaver:** A software program that displays constantly changing images or dims the brightness of a display screen to protect the screen from having an image etched onto its surface, or being read.
**Self identified cultural background:** Patients identifying as being of a particular ethnic or cultural background or heritage

**Server:** A computer in a network that provides services to the users connected to the network (eg. printing, accessing files)

**Software:** Computer programs that perform specific functions (eg. word processing or management of information)

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

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

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

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

**Team:** Teams of staff who provide care within the health service (eg. doctors, receptionists, managers, psychologists or other mental health experts, nurses, allied health professionals)

**Timely:** An appropriate length of time

**Urgent:** A health need requiring immediate action or attention

**Visits to patient living quarters:** A consultation conducted in the patients’ living quarters or rooms of the immigration detention centre.
Standards for health services in Australian immigration detention centres