RACGP
Royal Australian College of General Practitioners

# Standards for general practices

## 6th edition

ISQuaEEA International Society for Quality in Health Care External Evaluation Association
Accredited Standards 2026-2030

Table of contents

# Table of contents

- CG10 – Practice environment (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg10-practice-environment)
- CG11 – Practice equipment (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg11-practice-equipment)
- CG12 – Maintaining vaccine potency (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg12-maintaining-vaccine-potency)
- CG13 – Research (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg13-research)

Patient participation standard

- PP1 – Information about the practice (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/criterion-pp-1-information-about-your-practice)
- PP2 – Communications (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp2-communications)
- PP3 – Respectful, culturally appropriate and culturally safe care (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp3-respectful-culturally-appropriate-and-cultural)
- PP4 – Informed consent (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp4-informed-consent)
- PP5 – Accessibility of services (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp5-accessibility-of-services)
- PP6 – Health promotion and preventive care (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp6-health-promotion-and-preventive-care)
- PP7 – Open disclosure and complaints (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp7-open-disclosure-and-complaints-pp8-engaging-co)
- PP8 – Engaging consumers (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp8-engaging-consumers)
- PP9 – Responsive system for patient care (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp9-responsive-system-for-patient-care)
- PP10 – Care when the practice is not open (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp10-care-when-the-practice-is-not-open)

Continuous quality improvement standard

- CQI1 – Continuous quality improvement activities (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/continuous-quality-improvement-standard/criterion-cqi-1-continuous-quality-improvement-act)

Point of care testing standard

- PoCT and the Australian Register of Therapeutic Goods (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct-and-the-australian-register-of-therapeutic-go)
- PoCT1 – Clinical purpose (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct1-clinical-purpose)
- PoCT2 – Clinical responsibility (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct2-clinical-responsibility)
- PoCT3 – Qualifications, education and training of PoCT practitioners (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct3-qualifications-education-and-training-of-poc)
- PoCT4 – Facilities for testing (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct4-facilities-for-testing)
- PoCT5 – Performance of tests (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct5-performance-of-tests)
- PoCT6 – Data management (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct6-data-management)
- PoCT7 – Quality control procedures (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct7-quality-control-procedures)
- PoCT8 – External quality assurance program (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/point-of-care-testing-standard/poct8-external-quality-assurance-program)

Glossary (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/glossary) References (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standar

ds-for-general-practices-6th-edition/references) Disclaimer (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/disclaimer)

# *Introduction*

# Introduction

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

As such, the Standards support general practices to identify, develop and implement systems and processes that:

- are robust
- are contemporary
- provide a framework for continuous quality improvement.

# Developing evidence-based standards

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

When developing the Standards, the College has drawn on the following sources:

- A comprehensive literature review of current evidence
- Level IV evidence (where studies are not available), otherwise known as evidence from a panel of experts. To ensure that this Level IV evidence is as robust as possible, the Standards have been:
    - tested by Australian general practices and consumers
    - overseen by an expert committee consisting of GPs, academic GPs, nurses, practice managers, and consumer representatives
- The Quintuple Aim for healthcare improvement[1]
- The International Society for Quality in Health Care (ISQua) *Guidelines and principles for the development of health and social care standards* (6th edition)
- The Department of Health and Aged Care *Accreditation arrangements review* (2021) and *Gap Analysis of barriers to general practice accreditation* (2024)
- Feedback from the general practice profession, gained from consultation and piloting of the Standards.

# The quintuple aim for healthcare improvement

The five elements (listed below) of the quintuple aim for healthcare form the foundation of these Standards:

- improving the patient experience
- population health outcomes
- cost-efficiency of healthcare
- provider wellbeing
- health equity

### *Patient experience*

For the purpose of accreditation, the Standards prioritise and recognise the importance of the patient experience, through the principle of person-centred care. In other words, the Standards aim to put patients' needs, values and preferences at the forefront of care so that they are empowered to take an active role in their own healthcare. Criteria related to the practice environment, and how patients access services, communicate with the practice, and provide feedback address the patient experience.

### *Population health*

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

### *Reducing costs*

By encouraging general practices to continuously improve, reduce waste, and effectively allocate resources, the Standards aim to reduce the costs of primary care, thus helping to decrease the burden on the healthcare system.

### *Practice team wellbeing*

The Standards promote the wellbeing of the practice team by encouraging:

- collaboration and communication
- patient care and safety
- efficiency
- induction, training and continued professional development
- involvement and input from all members of the practice team
- a positive culture that supports each team member’s safety, health, and wellbeing.

### *Health equity*

The Standards promote equitable healthcare through:

- culturally appropriate care
- continued quality improvement principles
- promotion of accessible healthcare
- optimal management of patient health data.

# Environmental sustainability in the Standards

Environmental sustainability is embedded throughout the Standards. Together with a suite of RACGP's resources (https://www.racgp.org.au/advocacy/advocacy-resources/climate-change-and-health) , the Standards support general practices to implement environmentally sustainable measures.

Measures such as reducing energy consumption, minimising waste and promoting environmentally aware practices aim to mitigate the practice's impact on the environment. Implementing environmentally sustainable measures in the practice:

- safeguards public health
- upholds ethical responsibilities
- supports long-term viability.

# Point-of-care testing (PoCT) in the Standards

The Point-of-care testing (updated 6th edition) standard is optional for practices and aims to:

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

### *Benefits of PoCT*

The potential benefits of PoCT in general practice are:

- the healthcare practitioner can make immediate and informed decisions about a patient's care, together with the patient, which may result in improved clinical management
- greater patient compliance with pathology requests, especially from at-risk patients
- greater convenience and satisfaction for patients because of the speed of diagnosis, management and treatment decisions
- more equitable access to pathology, regardless of where patients live
- more opportunities for patients to engage with the practice team[2, 3].

# Structure of the Standards

## Standards and criteria

The Standards comprise of five standards. Each standard contains one or more named sets of criteria. Each criterion is assigned an alphanumeric code that identifies:

- the standard (prefix)
- the position of the criteria set within the standard (number)
- the position of the criterion within the set (letter).

| Prefix code | Standard |
|---|---|
| F | Foundations of general practice |
| CG | Clinical governance |
| PP | Patient participation |
| CQI | Continuous quality improvement |
| PoCT | Point-of-care testing |

## Consumer expectation statements

Consumer engagement has been shown to be linked to better patient health outcomes and safer care. The RACGP has worked with consumers to develop consumer expectation statements for each set of criteria so that consumer experiences and outcomes are central to the Standards.

The consumer expectation statements outline what consumers value, need, prefer and expect so that decision-making in general practices is person-centred.

## Guidance

The Standards provide Guidance for practices for each set of criteria:

- *Why this is important* – Why these criteria and sub-criteria are important from a quality and safety perspective.
- *Meeting these criteria* – Various ways the practice can choose to meet the criteria and sub-criteria.
- *Accompanying resources* – Supplementary resources that will help the practice meet criteria are provided in the accompanying guidance at each section.

## Using the guidance to meet the criteria

While each criterion sets out what a practice needs to achieve, the accompanying guidance explains how a practice may meet the criterion in practice. Reading the guidance in full is important, as it provides the context, intent and practical considerations that support consistent interpretation and application of the Standards.

The word “could” is used throughout the guidance to indicate that the examples provided are not mandatory or exhaustive. They illustrate a range of possible approaches that practices may choose from, adapt or build on, depending on their size, context and model of care. Practices are not required to implement every example listed, nor to adopt the examples exactly as written, provided the criterion itself is met.

## Focus on outcomes

The Standards are written with a focus on outcomes rather than processes.

By focusing on outcomes, practices can design systems and processes that best support person-centred, safe and effective care within their local context. An outcome-driven approach fosters greater ownership among the practice team and encourages consistent adherence to these processes.

# Required and aspirational criteria

All criteria in the Standards need to be met to achieve accreditation, apart from Aspirational Criterion.

Although the RACGP encourages practices to meet the aspirational criteria, they are not essential to achieve accreditation.

## Terminology

### Use of 'patient' and 'consumer'

The terms *patient*, *consumer*, and *consumer representative* are used as follows:

- *Patient* – a person seeking or receiving healthcare
- *Consumer* – a person using a health service, or someone supporting that person
- *Consumer representative* – a consumer providing advice on behalf of others.

See **Glossary** (#_Glossary_1) for full definitions.

### Definitions of roles and members in a practice

The Standards use the following terminology to refer to different roles and members of a practice:

- *Practice team* – everyone who works or provides care in the practice
- *Clinical team* – members of the practice team who hold health qualifications
- *Employed members* – individuals working under a formal employment agreement
- *Independent Doctors in Practice* – as defined in the Glossary.

Understanding these terms will help you to identify which criteria apply to whom. This is important because, for example, some criteria apply specifically to employed members of a practice, some to independent doctors in practice.

See **Glossary** (#_Glossary_1) for complete definitions of these and related terms.

## Citation of federal, state or territory legislation

This document is not intended to comprehensively address legislative obligations, so references to legislation occur only where it is particularly relevant to specific aspects of general practice.

Practices are responsible for identifying and complying with all applicable federal, state, territory, and local laws. While meeting the Standards may also help a practice to meet some legislative requirements, doing so does not guarantee compliance with all legal obligations.

# Definition of a general practice for the purpose of accreditation

For a practice or health service to seek accreditation:

- it needs to provide comprehensive, person-centred, whole-person and continuous care; and
- its services are predominantly* of a general practice nature.
  (* More than 50% of the practice's general practitioners' clinical time (ie collectively), and more than 50% of services for which Medicare benefits are claimed or could be claimed (from that practice) are in general practice.)

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

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

## GP-led care

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

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

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

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

## Comprehensive care

Comprehensive care is the coordinated delivery and/or facilitation of the total healthcare required or requested by a patient. The scope of clinical practice is challenging, spanning prevention, health promotion, early intervention for those at risk, and the management of acute, chronic and complex conditions within the practice population. Comprehensiveness means services are not limited by body system, disease process or service site.

This use of 'comprehensiveness' in the definition of a general practice for the purpose of accreditation is not intended to change the requirements for general practice as a speciality or for training purposes. This definition is to be used for practice accreditation. For training and achieving Fellowship the definition of Comprehensive Australian general practice (https://www.racgp.org.au/education/registrars/fellowship-pathways/policy-framework/program-handbooks-and-guidance-documents/guidance-documents/comprehensive-australian-general-practice-guidance) is used.

## Person-centredness

Person-centredness places the patient's needs, values and preferences at the forefront of medical decision-making, empowering patients to take an active role in their own healthcare. Patients are provided the information and health literacy to help them generate well-informed needs and preferences that are likely to improve health outcomes. Person-centredness is reflected in a general practice team's understanding that health, illness and disease are ultimately personal experiences, and that the role of the team is to collaborate with patients to support their healthcare.

## Whole-person care

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

## Continuous care

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

When patients visit the same GP over time, they develop a patient–practitioner relationship, which has been shown to reduce visits to emergency departments and preventable hospital admissions[4].

Patients who have continuity of care with a regular GP:

- report high levels of satisfaction with their experience of care[5]
- have lower rates of hospitalisation and emergency department attendances[6]
- have lower mortality rates[7]
- are more likely to receive appropriate and person-centred care.

# *Accreditation*

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

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

The RACGP supports accreditation as a voluntary scheme.

To be accredited against the Standards, a practice needs to:

- meet the definition of a general practice for the purpose of accreditation, and then
- be successfully assessed by an accrediting agency approved under the Australian Commission on Safety and Quality in Health Care (ACSQHC) National General Practice Accreditation Scheme ( https://www.safetyandquality.gov.au/our-work/accreditation/national-general-practice-accreditation-scheme) (the NGPA Scheme), which commenced on 1 January 2017.

Accreditation against the Standards seeks to:

- improve patient safety[8],[9],[10]
- promote person-centredness, including support for patients and their inclusion in decision-making relating to their care[11]
- improve the quality of healthcare[9]
- foster continuous quality improvement
- foster a culture of safety in general practice[9],[8]

Further information about the NGPA Scheme, approved accrediting agencies, and surveyor teams is available on the ACSQHC website (https://www.safetyandquality.gov.au/accreditation/national-general-practice-accreditation-scheme) .

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

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

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

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

# Acknowledgements

The RACGP gratefully acknowledges the generous contribution from the members of the RACGP Expert Committee – Standards for General Practices (REC-SGP):

- Dr Louise Acland (Chair)
- Dr Carl de Wet
- Dr Trina Gregory
- Dr John Houston
- Dr Heather Knox
- Dr Robert Menz
- Dr Lynne Reid
- Dr Tim Senior
- Dr Abhi Verma
- Ms Jane Bollen (APNA representative)
- Ms Madeline Jammal (AAPM representative)
- Ms Debra Walter (AAPM representative)
- Ms Diane Walsh (consumer representative)

The RACGP gratefully acknowledges the generous contribution from the members of the RACGP working group – Point-of-Care Testing:

- Dr Tim Senior (Chair)
- Dr Trina Gregory
- Dr Robert Menz
- Ms Rosy Tirimacco (Technical expert)

The RACGP gratefully acknowledges the generous contribution from the members of the RACGP Consumer Focus Group who developed the consumer expectation statements:

- Ms Diane Walsh (Chair)
- Mr Russell McGowan (co-Chair)
- Ms Toni Beauchamp
- Ms Jenny Berrill
- Ms Andrea Cooper
- Mr Brendan Johnson
- Ms Stacey Lewis
- Mr Dan Smith
- Ms Mary Wing
- Ms Shirani Wright

# *Foundations of general practice standard*

# About this standard

The Foundations of general practice standard addresses the fundamental principles and structures necessary for the effective operation and management of a general practice. This includes:

- defining strategic objectives and goal setting
- managing clinical risks
- ensuring continuity of services
- minimising environmental impact
- implementing IT continuity and security measures.

This standard seeks to promote a culture that encourages team involvement, supports practice team roles, and provides appropriate training. These elements form the cornerstone for a well-functioning, viable, and sustainable general practice.

# F1 – Defining and planning for the practice

## F1 | Defining and planning for the practice

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

**F1.A The practice has a strategic approach to the provision of healthcare that reflects its mission, vision, values, and commitment to safety and quality.**

The practice:

- defines and documents its mission, vision and values
- incorporates a strategic approach to the provision of healthcare for patients that continuously meets these safety and quality standards
- communicates its mission, vision and values to the practice team and consumers
- monitors how its mission, vision and values are reflected in the practice's operations, safety culture, and quality improvement activities
- assesses the practice's safety culture using feedback from team members or other appropriate methods.

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

The practice:

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

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

The practice:

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

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

The practice:

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

**F1.E The practice has processes to review, manage and resolve ethical issues.**

The practice:

- facilitates a process for the practice team to review, manage and resolve ethical issues within a defined timeframe of three months.

**F1.F The practice applies a governance process to support safe, high-quality care and accountable decision-making.**

The practice:

- applies a governance process that supports oversight of quality, safety, and performance
- designates governance roles and accountability to defined individuals within the practice
- ensures that the governance process informs practice-wide decision-making and continuous improvement
- aligns the governance process with the practice's size, structure, and scope of services
- regularly reviews the effectiveness of its governance process to support safe and sustainable service delivery.

**F1.G The practice identifies and manages governance risks.**

The practice:

- maintains documented processes for identifying, assessing, and responding to strategic, operational, and service-related risks
- implements, monitors and reports risk management and mitigation actions
- uses a risk register (or equivalent) to document and prioritise identified risks
- regularly reviews and reports risks, including their management and mitigation, to practice leadership.

## Why this is important

Defining a practice's mission, vision and values helps a practice achieve a consistent culture and purpose, guides decision-making, and aligns strategic and operational plans with core principles. Specifically, when clearly written:

- mission, vision and values statements help to prioritise efforts
- a strategic plan helps to achieve intentional, sustainable improvements in patient care and staff development
- operational plans help embed best practices into daily workflows, fostering efficiency, accountability, and a high standard of care.

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

## Meeting these criteria

### Mission and values

Within a general practice, values are lived experiences and actions that reflect a practice's commitment to its stated mission and vision. These could include:

- how the practice embeds a culture of continuous quality improvement
- its code of ethics, outlining the core principles and beliefs that guide the practice and set the tone for its culture
- patient and consumer empowerment
- cultural competence
- the adoption of innovation in healthcare delivery
- empathy and compassion

- engagement and collaboration with members of the practice team, consumers, and the community.

Promoting the practice's mission, vision and values to the practice team helps to increase alignment, motivation, and productivity. To do so, the practice could:

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

### Governance to support safe, high-quality care and accountable decision-making

Governance refers to how a practice oversees and is accountable for its operations, decisions, and responsibilities, including clinical, organisational, financial, and ethical aspects. The practice could have a formal governance framework or a more informal process depending on its size.

Responsibility for the practice's governance could rest with practice owners, management teams, clinical leads, or other designated roles.

The practice could:

- maintain a documented governance process, or a summary of the process, in the strategic plan or operational plan
- include governance responsibilities in role descriptions
- include governance review in team meetings
- periodically review the extent to which its governance arrangements are in line with F1.D to confirm that they are effective, fit for purpose, and aligned with the practice's needs and externally imposed requirements.

### Strategic plan

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

To develop a strategic plan, the practice could:

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

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

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

### Operational plan

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

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

If your operational plan includes creating and maintaining interdependencies with external organisations (for example, public health units and PHNs), this can streamline referrals and access to resources. Incorporating communication strategies also helps align the team with operational goals.

As an operational document, the operational plan needs to be updated when relevant changes are identified and reviewed for currency every two years.

### Strategic approach to safety

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

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

### Assessing safety culture

Assessing the practice's safety culture helps leaders understand how to improve it. Safety culture assessments could involve:

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

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

The document control process needs to include:

- naming conventions
- versioning
- clear responsibility for review and sign-off.

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

The practice could:

- implement centralised document storage (for example, use a digital folder such as Google Drive, SharePoint, or a practice management system) and train staff on how to use it
- use clear document-naming conventions that include the document name, version number, date of last update, assigned reviewer and next review date
- set up reminders to prompt reviews of governance documents
- discuss governance documents and their required updates at team meetings.

### Identifying and managing strategic, operational and service-related risks

Table 1 identifies practical ways the practice could implement, monitor, review and report risk management and mitigation actions. These are suggestions only, as the specific actions, size and complexity of the practice's risk framework can be proportionate to the practice.

Strategic, operational and service-related risks are different to clinical risks which are addressed in CG7 – Managing clinical risks and incidents.

**Table 1 Practical actions for managing strategic, operational and service-related risks**

| Step | What this involves | Examples of actions |
|---|---|---|
| Implementing: Establish risk controls or mitigation actions | Acting on identified risks by establishing appropriate controls, processes, or changes | • Installing a secondary internet connection, after identifying a single point of failure<br>• Introducing multi-factor authentication, after a cyber audit |

| | | |
|---|---|---|
| Monitoring: Track the status of actions and identify whether the controls are working | Regularly checking if the actions are being implemented, and if they are reducing the risk | • Conducting a monthly review of appointment delays to check the results of a rostering change<br>• Tracking feedback from the practice team post-implementation |
| Reviewing: Reassess the risk and the control to determine if further action is needed | Checking if the mitigation strategy is still effective or needs to be adjusted, especially if circumstances have changed | • Reviewing a data security process annually or after a near-miss<br>• Reassessing emergency plans after a local flood event |
| Reporting: Make practice leaders aware of potential risks | Recording risks and reporting to the practice leaders so they are aware of how the risks are being managed | • Regularly review and update risk register<br>• Report risks to practice leaders as often as needed |

### Ethical issues

Examples of ethical issues that could arise are:

- management of professional boundaries, for example when members of the practice team know patients outside of the practice, or when a patient offers them a gift
- management of confidentiality in the waiting room
- balancing legal obligations (for example, release of notes to child protection agencies)
- staff requests for appointments, including for workplace injuries.

To review, manage and resolve ethical issues, the practice could:

- **encourage open communication** by having clear practice policies that foster a culture where members of the practice team feel supported in raising and discussing ethical concerns
- **provide education and support** by offering training in ethical decision-making, that could include case-based and reflective discussions
- **facilitate discussions about ethics** and address challenges proactively by incorporating ethical considerations into team meetings or clinical case reviews
- **establish ethical guidelines** by developing clear policies that guide team members on how to manage ethical dilemmas, such as patients who are also staff or known to practice members
- **support reflection, transparency, and continuous learning** by developing and maintaining an ethical issues register so that team members can record ethical issues that arise in the practice, and the actions taken
- **seek external expertise** by consulting medical defence organisations or ethics advisory services when complex ethical issues arise.

When engaging independent doctors in practice, the practice needs to consider its procedures and/or agreements with the doctors to provide them with support services so that they are aware of the practice's:

- mission, vision and values
- procedures concerning governance that support safe, high-quality care and accountable decision-making
- strategic plan, the operational plan, the strategic approach to safety; and
- ethical requirements.

## Resources

- The RACGP's *General Practice Business Toolkit* (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-business-toolkit) includes modules that guide the establishment, management and enhancement of general practices.
- Business.gov.au (https://business.gov.au/planning/business-plans/develop-your-business-plan) provides information about how to develop a business plan, including a template, and guidance on how to manage risks, including aspects of insurance, health and safety laws, and cyber security.
- Ahpra's *Good medical practice: a code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx) addresses the adherence of ethical conduct principles.

# F2 – Response planning

## F2 | Response planning

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

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

The practice:

- documents its processes for how it prepares for, responds to and recovers from unexpected events
- has at least one member of the practice team who has primary responsibility for its response and emergency processes
- makes the practice team aware of plans for preparedness and response to unexpected events
- has a process for the clinical team to continue delivering care where feasible, in the event of an emergency that causes information and communication technology (ICT) to stop functioning
- tests its response plan.

### Why this is important

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

### Meeting these criteria

#### Response planning

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

- clinical emergencies
- infrastructure issues
- interruptions to information technology
- equipment and power failures
- cyber attacks
- public health emergencies
- natural disasters, such as fires, floods, and cyclones
- interruptions to communications
- loss of access to the practice
- staff shortages.

Rather than creating detailed plans for every scenario, practices need to focus on building core capabilities and systems that improve their readiness for everyday disruptions as well as larger emergencies.

#### Delivery of care during unexpected ICT outages

Governance refers to how a practice oversees and is accountable for its operations, decisions, and responsibilities, including clinical, organisational, financial, and ethical aspects. The practice could have a formal governance framework or a more informal process depending on its size.

Responsibility for the practice's governance could rest with practice owners, management teams, clinical leads, or other designated roles.

The practice could:

- maintain a documented governance process, or a summary of the process, in the strategic plan or operational plan
- include governance responsibilities in role descriptions
- include governance review in team meetings
- periodically review the extent to which its governance arrangements are in line with F1.D to confirm that they are effective, fit for purpose, and aligned with the practice's needs and externally imposed requirements.

### Emergency planning

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

For detailed guidance on preparing an emergency response plan, refer to Part B – Emergency planning and response, in *Managing emergencies in general practice* (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/managing-emergencies-in-general-practice/part-b-emergency-planning-and-response/pre-planning) .

### Testing response plans

The practice needs to regularly test its plans for effectiveness. Testing is proportionate to the practice's context and identified risks.

This could involve:

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

As practices can only test their own systems, not public infrastructure, some unexpected events, such as widespread telecommunications outages, may exceed the scope of internal testing. In such cases, documenting the event, as well as lessons learned and any system improvements made, is considered a valid form of testing and review.

## Resources

- The Emergency Response Planning Tool (ERPT) (https://www.racgp.org.au/your-practice/business/tools/disaster/erpt) – A subscription-based tool to support planning for and recovery from emergencies and pandemics.
- RACGP's *Managing pandemics in general practice* (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/managing-pandemics/managing-pandemics-in-general-practice) – Guidance and templates for pandemic planning and response.
- RACGP's *Disaster resources for general practice* (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/naturaldisasters) – Factsheets on different disaster types and how to manage them.
- RACGP's *Information for GPs in disaster-affected areas* (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/naturaldisasters) – Support, financial assistance, self-care, accreditation, and community resources. The RACGP also provides evacuation centre resources (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics/evacuation-centre-resources) .
- AJGP's *Situation report: Australian general practitioners in disaster health management* (https://www1.racgp.org.au/ajgp/2025/january-february/situation-report-1) – Overview of how GPs integrate into broader disaster response systems, with examples of PHN-led initiatives.

# F3 – Environmental sustainability and responsibility

## F3 | Environmental sustainability and responsibility

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

**F3.A The practice is aware of and takes steps to address/improve its climate resilience.**

The practice:

- identifies climate-related risks to its operations
- implements strategies to improve climate resilience.

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

The practice:

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

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

The practice:

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

### Why this is important

Climate change is a significant public health issue that poses risks to healthcare infrastructure and service provision[19, 20]. Environmentally sustainable measures in a practice can:

- safeguard public health
- improve patient wellbeing and satisfaction
- uphold ethical responsibilities
- reduce operational costs
- protect the long-term viability of a practice.

Climate resilience is increasingly critical for general practices, as extreme weather events such as heatwaves, bushfires, floods and storms can disrupt service delivery, threaten patient safety, and disproportionately impact vulnerable populations.

Embedding sustainability and personal agency into practice activities, and clearly communicating sustainability and climate resilience principles, helps foster a workplace culture of sustainability.

Integrating climate resilience into practice operations also aligns with broader public health goals and strengthens the role of general practice in climate adaptation at a community-level.

## Meeting these criteria

### Climate resilience

Table 2 contains suggested actions that general practices could take to improve climate resilience in key operational areas. These actions support practices in meeting environmental sustainability criteria, as well as F2 – Response planning (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/response-planning) , by helping practices anticipate, prepare for, and adapt to climate-related disruptions such as extreme weather events, infrastructure failures, and supply chain interruptions. The table includes practical, non-clinical measures that could be embedded into business continuity planning to safeguard service delivery and protect patient and staff wellbeing. It also supports practices in meeting Criterion CG4.C, which relates to supporting members of the clinical team to adopt clinical practices that are environmentally sustainable and climate-resilient.

### Reviewing and testing climate resilience strategies

The practice could periodically review and test its climate resilience strategies so they remain effective and relevant. This could include simulated drills for extreme weather events, audits of infrastructure readiness (such as backup power and ventilation), and updates to operational plans based on emerging or changing climate risks. Regular testing helps identify gaps and supports continuous improvement in the safeguarding of service delivery during climate-related disruptions.

**Table 2 Key actions to improve climate resilience**

| Climate resilience component | Possible actions |
|---|---|
| **Emergency preparedness** | • Assess the climate risks in the practice's location (eg temperature extremes, flooding, cyclones, bushfires, infectious diseases).<br>• Integrate climate risks (for example, bushfires, floods, heatwaves) into response plans. See F2 – Response planning (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/response-planning) .<br>• Develop mechanisms to maintain continuity of care during climate emergencies (eg telehealth readiness, offsite backups). |
| **Infrastructure** | • Assess HVAC systems for heat resilience.<br>• Install backup power sources for continuity during climate events.<br>• Improve insulation and ventilation to reduce energy use and maintain safe indoor conditions. |
| **Operational systems** | • Conduct climate risk assessments as part of strategic planning.<br>• Document strategies to reduce climate-related health risks to patients (for example, heatwave alerts, monitoring of air quality). |
| **Patient care and engagement** | • Identify patient groups particularly vulnerable to the health impacts of climate change (including Aboriginal and Torres Strait Islander people, people of certain culturally and linguistically diverse backgrounds, people with chronic conditions, older people, infants and children, and people experiencing homelessness or living in poor housing).<br>• Inform patients about climate-related health risks and protective behaviours. |
| **Staff training** | • Educate the team about climate-related health impacts and response strategies. |
| **Collaboration** | • Engage with PHNs, local councils, and emergency services about climate adaptation. |

### Environmental impact

The practice needs to:

- identify the potential impact that the practice has on the environment
- identify what the practice can do to reduce any negative impacts it has on the environment.

The practice team could support existing sustainability measures and actively contribute to reducing the practice's environmental footprint. Change is more likely to occur when the whole practice is involved, and the required actions are understood and easily implemented.

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

When considering the practice's policy outlining measures to address its environmental impact, some key areas of focus and examples of practical measures to address environmental impact are included in **Tables 3 and 4** below. **These examples are provided as suggestions for ways the practice could meet criterion F3.B**. They have been adapted from the RACGP's *Greening up: Environmental sustainability in general practice* (https://www.racgp.org.au/running-a-practice/security/managing-practice-information/e-waste) , which can be referred to for further detail.

Table 3 contains suggestions that focus on behavioural, operational, and team-based actions that do not require the practice to own the building/s in which they operate, but which any general practice could undertake.

Table 4 contains suggestions relevant to owner-occupied practices and practices with significant control over their premises. These include actions related to building upgrades, energy sourcing, and water systems, which may not be feasible for tenants without their landlord's cooperation.

**Table 3 Key non-clinical actions to improve environmentally sustainability of the general practice**

| Sustainability component | Possible actions |
|---|---|
| **Auditing for sustainability** | • Undertake a strategic-level review of the impact of environmental issues, the sustainability of service provision, and the possible mitigation of negative environmental impacts,<br>• Conduct an energy audit to establish baseline consumption, and identify high-use areas (for example, heating, cooling, lighting).<br>• Apply the approach known as the energy hierarchy (shown below), which prioritizes actions that will reduce the environmental impact:<br>1. reduce unnecessary use<br>2. improve efficiency<br>3. switch to renewables.<br>• Use environmental-impact metrics to assess and manage overall environmental footprint (see aspirational criterion CQI1.C (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/continuous-quality-improvement-standard/criterion-cqi-1-continuous-quality-improvement-act) for further guidance). |
| **Workplace culture** | • Promote effective leadership in relation to sustainability and encourage behavioural change by appointing 'climate champions' or a 'green team'.<br>• Educate and support consumers using digital posters that alert them to the effects of climate change on physical and mental health. |
| **Energy: Heating, ventilation and cooling (HVAC)** | • Adjust the practice's thermostat for each season, aiming to meet the recommended heating, ventilation, and air conditioning (HVAC) settings for maintaining acceptable comfort conditions with reasonable energy efficiency (for winter 20–22°C and for summer 24–26°C).<br>• Consider the best times to turn on HVAC systems so that appropriate temperatures (based on the season) are reached when employees and consumers arrive and leave the premises. |

| | |
|---|---|
| **Energy: Appliances and lighting** | • Review the energy rating of all appliances, and prioritise energy efficiency when purchasing appliances.<br>• Install timers or motion sensors for lighting and other power outlets (such as instant hot water in the kitchen), where it is possible and safe to do so.<br>• Turn off computers and screens when not in use, and turn off standby power at the end of each day by turning off all appliances at the wall or power board.<br>• Embed energy-saving processes either manually through work protocols or via building management systems.<br>• Change globes to LEDs, as they consume up to 75% less energy than halogen globes). |
| **Travel** | • Encourage members of the practice team and consumers (when appropriate) to use methods of transport other than cars, such as walking, public transport and cycling.<br>• Encourage cycling by providing bike racks and change facilities.<br>• Provide consumers with public transport options, routes and timetables.<br>• Ask members of the practice team to consider alternative or active transport and to explore car-pooling.<br>• Be a role model by using alternative or active transport.<br>• Have a dedicated 'green team' to promote active and alternative transport.<br>• Lobby local governments to provide electric vehicle charging stations. |
| **Professional services** | • Audit business services in order to identify high-carbon providers.<br>• Choose good and services (for example, phones, computers, IT support, finance, accountancy, payroll, insurance) with a smaller environmental footprint.<br>• Include sustainability criteria in procurement documents, and engage suppliers after considering their carbon reduction plans. |
| **Minimise e-waste** | • Avoid purchasing new electronic products that can't be reused or recycled.<br>• Reduce the consumption of electronic devices by repairing broken equipment before purchasing new items.<br>• Re-use electronic devices by donating items to charity, friends or family.<br>• Discard e-waste responsibly, (for example, engage a recycling company to collect various types of e-waste for recycling, drop off e-waste at organisations that offer recycling free of charge).<br>• Develop an e-waste recycling policy using the RACGP template (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Security/E-waste-policy-template.docx) . |
| **Reducing paper use** | • Move to e-prescribing, where practical.<br>• Use recycled paper.<br>• Reduce junk mail by putting a 'No junk mail' sticker on the practice's mailbox.<br>• Replace printed material with digital alternatives.<br>• Subscribe to online editions of journals rather than ordering printed copies.<br>• Discourage laminating materials. |
| **Carbon offsets** | • After reducing all possible emissions, consider purchasing carbon offsets to achieve net-zero emissions. Many companies offer carbon offsets with a range of validation and verification standards. |
| **Water efficiency** | • Use products (such as dishwashers and fridges) with a high water-efficiency rating.<br>• Only run the dishwasher when it is full. |

| | |
|---|---|
| **Recycling** | • Place recycling bins, including for food waste, either in each room or in a common area.<br>• Make sure recycling bins aren't contaminated with non-recyclable waste, perhaps by displaying informational posters from local council.<br>• Use recycled products (for example, paper, toilet tissue and toner cartridges) as much as possible.<br>• Do not fill medical waste bins with materials that could be recycled or disposed of in regular waste, as disposing of medical waste is costly and resource-intensive.<br>• Identify other items that can be recycled (for example, batteries, light globes and soft plastics), and set up easy collection methods. |
| **Waste management** | • **Reduce** use of single-use items wherever possible (eg minimise use of gloves where not clinically indicated; procure sterile packs that don't contain items the practice rarely uses).<br>• When using single-use items, reduce the use of plastic products where possible (consider more eco-friendly options).<br>• **Reuse** cleanable items where safe and appropriate, including non-invasive devices and equipment.<br>• **Recycle** appropriately by segregating waste streams and centralising recycling stations.<br>• Responsible disposal includes:<br>  ◦ disposing of hazardous waste correctly<br>  ◦ using recycling services for specific materials. This could include using recycling companies that specialise in processing materials like electronics, textiles, and metals.<br>• Implement a workplace recycling policy, establishing guidelines for recycling using templates from local environmental agencies.<br>• Conduct regular waste audits to identify avoidable waste and improve segregation practices.<br>• Inform members of the practice team about initiatives, activities, or organised efforts on waste management and sustainability.<br><br>*Waste management is also addressed by criterion CG9 – Infection prevention and control, including reprocessing (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg9-infection-prevention-and-control-including-rep), which requires practices to maintain an up-to-date practice-specific infection control policy that addresses waste management.* |
| **Business planning** | • Embed sustainability in business planning and incorporate sustainability goals in financial objectives.<br>• Perform an audit of energy use and carbon emissions to set a benchmark, then establish a framework aimed at reducing emissions based on data. Use a free online carbon-footprint calculator. Professional audits can be expensive and are unlikely to be cost-effective for smaller practices.<br>• Include sustainability as a standing item at practice meetings. |
| **Disaster management** | • Prepare for potential disasters by assessing and planning for threats related to climate change, such as extreme heat, flooding and bushfires. The RACGP has resources and guides (https://www.racgp.org.au/running-a-practice/practice-management/managing-emergencies-and-pandemics) to help practices manage, prevent, prepare for, respond to and recover from emergencies and pandemics. |

**Table 4 Key non-clinical actions for an environmentally sustainable general practice – Owner-occupied practices**

| Sustainability component | Possible actions |
|---|---|

| | |
|---|---|
| **Energy: Heating, ventilation and cooling (HVAC)** | • Regularly clean and maintain the HVAC for maximum efficiency, (for example, regularly clean filters).<br>• Consider ways of reducing demand of HVAC, including:<br>  ◦ improved building insulation<br>  ◦ high-performance window glazing<br>  ◦ natural ventilation<br>  ◦ external window shading<br>  ◦ appropriate window coverings.<br>• Consider an upgrade if the HVAC system is more than 10 years old.<br>• Plan for long-term upgrades such as insulation, air source heat pumps, and solar PV (photovoltaic). |
| **Energy: Sourcing renewables** | • Consider changing the practice's energy source to 100% renewables (or as much as possible if the cost is prohibitive). Find green-energy providers on the GreenPower website (https://www.greenpower.gov.au/get-greenpower/find-provider) .<br>• Consider converting from gas to electricity.<br>• If the practice owns its premises, consider installing rooftop solar. |
| **Water efficiency** | • If the practice has a garden, plant sustainable and drought-resistant plants.<br>• Install rainwater tanks or grey-water systems.<br>• Install low-water-use toilets.<br>• Promptly repair water leaks. |

### Responsibility for environmental sustainability

The practice team could support existing sustainability measures and actively contribute to reducing the practice's environmental footprint. Change is more likely to occur when the whole practice is involved, and the required actions are understood and easily implemented.

Having a designated member of the practice team with primary responsibility for environmental sustainability supports coordination, engagement and promotion of sustainability initiatives within the practice.

# F4 – Induction, training and supporting performance

## F4 | Induction, training and supporting performance

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

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

The practice:

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

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

The practice:

- trains employed members of the practice team about their role when they start working at the practice and provides ongoing training to address continued competency and adaptation to changes
- trains employed members of the practice team so that they work within the scope of their role
- makes members of the practice team aware of Medicare billing education resources
- confirms that employed members of the practice team have completed training appropriate to their role and the practice's patient population
- trains employed members of the practice team on the delivery of person-centred care.

**F4.C The practice provides role-appropriate training and has supporting processes for recognising and responding to abuse and violence, including family, domestic and sexual violence.**

The practice:

- adopts recognised guidelines and a practice framework for recognising and responding to abuse and violence
- makes local referral pathways available to the practice team to support safe, trauma-informed practice
- confirms that employed members of the practice team have completed role-appropriate training in recognising and responding to family, domestic and sexual violence
- obtains reasonable assurance that independent doctors in practice have completed role-appropriate training in recognising and responding to family, domestic and sexual violence
- promotes a consistent team approach through team discussions/briefings and access to current resources.

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

The practice:

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

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

The practice:

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

## Why this is important

### Recognising and responding to abuse and violence including family, domestic and sexual violence (FDSV).

Recognising and responding to adverse health impacts associated with FDSV – including child abuse, child sexual abuse, neglect, and coercive control – is essential for compassionate and effective patient care. FDSV can have significant short- and long-term health impacts, and general practice is often a point of contact for people experiencing or affected by violence. Building capability across the practice team supports confidence, safety, and a coordinated response that is consistent with the National Plan to End Violence against Women and Children 2022–2032 (https://www.dss.gov.au/national-plan-end-violence-against-women-and-children) . It is estimated that a full-time GP sees around five women per week who have experienced intimate partner violence in the last 12 months, representing an opportunity for early intervention and ongoing support.

### Discussing professional development

Professional development discussions are a valuable opportunity for employees and managers to:

- provide feedback
- set goals
- align their expectations
- identify strengths and areas for improvement.

A well conducted discussion can lead to improved performance and personal development, while fostering better communications and understanding in the team.

## Meeting these criteria

### Roles and responsibilities

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

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

Staff are required to sign their position description to indicate that they understand their role and responsibilities.

While all members of the practice team need induction, independent doctors in practice are not required to sign position descriptions.

### Induction and training

All members of the practice team need to undergo induction when they commence work, so that they understand the practice's:

- strategic approach to the provision of healthcare, including its mission, values, and commitment to safety and quality
- strategic and operational plans
- day-to-day operations, including systems, policies, and procedures
- workplace health and safety (WHS) requirements
- privacy and confidentiality requirements
- use of practice equipment and ICT, including internal data security measures, relevant to their role
- recall and reminder systems.

The induction needs to also include information about:

- key public health regulations
- local health and community services (for example, pathology, hospitals, referral networks).

Training is a continuous process, and regular training is needed to achieve competency when there are changes to the practice's processes, systems, and equipment.

### Professional development

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

Effective professional development means that the practice:

- has a clear professional development framework with scheduled discussions and defined objectives
- sets realistic goals that are aligned with the needs of the person and the practice
- tracks progress and recognises achievements
- has mechanisms for two-way feedback and open dialogue
- identifies learning opportunities, such as training and mentoring.

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

### Training in recognising and responding to abuse and violence including family, domestic and sexual violence (FDSV).

Training prepares the practice team to recognise signs that may be consistent with abuse or violence and to respond safely and respectfully when a patient raises or reports concerns, noting that such experiences occur outside the practice. Training does not require staff to screen or conduct clinical assessment.

To implement a practice pathway for members of the practice team, the practice could:

- adopt recognised guidance, such as the RACGP's White Book and relevant HealthPathways
- keep a simple internal framework that outlines where resources are located, includes safe-contact prompts, and identifies who to ask for assistance
- make available a brief local referral list, including after-hours or crisis support contacts, and note these resources during induction or team briefings.

Practices are not expected to develop or deliver their own training. The practice could link team members to recognised training options and accept evidence of completion from external providers.

Members of the practice team are expected to complete training that is appropriate to their role. Where a team member has personal safety concerns or may be at risk of vicarious trauma, the practice could offer supportive alternatives to enable safe completion of the required training (for example, a different format, mode or timing).

When implementing or adopting guidelines, the practice could maintain an up-to-date collection of relevant resources and referral information and make these easily accessible to the team. Resources are provided below.

### Medicare billing education resources

Medicare billing requirements are complex and subject to change. Awareness of reliable Medicare billing education resources supports accurate, ethical billing practices and helps reduce the risk of unintentional errors or non-compliance.

The practice could:

- make members of the practice team aware of authoritative Medicare billing education resources relevant to their role (for example, MBS Online, AskMBS, RACGP Medicare guidance, or Department of Health and Aged Care materials)
- include information about available Medicare billing resources during induction, role-specific training, or team briefings
- encourage team members involved in billing, claiming or administrative processes to access optional Medicare billing education or refresher activities appropriate to their responsibilities
- support ongoing awareness of updates to Medicare requirements by sharing relevant guidance or updates as they arise.

### Cardiopulmonary resuscitation (CPR) training

CPR training needs to:

- be conducted by an accredited training provider approved under the Australian Skills Quality Authority (ASQA) framework
- comply with ARC guidelines
- include the operation of an automated external defibrillator (AED), according to manufacturer's instructions
- require trainees to physically demonstrate their skills and competency at the completion of the CPR course. CPR training that is completed solely online does not meet this requirement.

The RACGP requires that team members complete this training at least once every three years. (Other professional bodies may have different requirements for the frequency of CPR certification.)

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

### Training for AI systems

If the practice uses artificial intelligence (AI) tools, training needs to:

- include information about the safe and effective use of these systems
- support the practice team to understand the purpose, limitations, and appropriate use of AI tools
- reinforce the importance of clinical oversight and judgement when interacting with AI-generated outputs.

Given the rapid pace of change and complexity in the AI space, practices need to update their training regularly to reflect new capabilities, risks, and regulatory requirements.

See F11 – Artificial intelligence (AI) (#_F11_–_Artificial) for further guidance and resources to support training in the use of AI systems.

### Training in person-centred care

Training or education in person-centred care could include:

- respecting the rights of consumers
- ensuring patient privacy and dignity
- communication skills
- shared decision-making
- understanding what matters and is most important in their care for an individual consumer
- understanding of and respect for different beliefs, customs and traditions.

This training could be provided by the practice or by external providers.

## Resources

**Medicare Benefits Schedule**

- MBS Online (https://www.mbsonline.gov.au/) and AskMBS (http://mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/MBS-interpretation)
- RACGP's MBS resources (https://www.racgp.org.au/running-a-practice/practice-resources/medicare/medicare-benefits-schedule-medicare-compliance)
- Department of Health, Disability and Ageing (DoHDA) *Understanding Medicare: Provider Handbook* (https://www.health.gov.au/resources/publications/understanding-medicare-provider-handbook?language=en)

**Recognising and responding to abuse and violence, including family, domestic and sexual violence (FDSV)**

- RACGP:
  - Abuse and violence: working with our patients in general practice (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/about-this-guideline), 5th edition (the White Book) – Practical guidance for abuse and violence in general practice
  - Trauma- and violence-informed care modules and online learning (https://www.racgp.org.au/familyviolence/modules.htm) – Online learning resources that support safe, respectful

communication and awareness of trauma- and violence-informed practice principles
    - "First do no harm" resources (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/first-do-no-harm/about-first-do-no-harm/introduction) – Reflective guidance on safe, person-centred communication and practice culture, with principles that align with trauma- and violence-informed care
    - Family violence factsheets and consumer-ready resources (https://www.racgp.org.au/familyviolence/resources.htm) – Practical tools to support safe information provision in general practice
- Department of Health, Disability and Ageing (DoHDA):
    - HealthPathways – Regionally developed pathways providing guidance, referral information and local service contacts for responding to family, domestic and sexual violence
    - 1800RESPECT (https://www.1800respect.org.au/professionals) – Nationally funded professional resources supporting trauma-informed communication, inclusive practice, coercive control awareness and referral pathways for workers who may encounter people experiencing FDSV
    - PHN-commissioned family violence training and referral resources – Local education and referral tools that support general practice teams
- National Centre for Action on Child Sexual Abuse (https://nationalcentre.org.au/resources/) – Resources to build and strengthen the capability of workers and organisations in how they respond to and support victims and survivors of child sexual abuse.
- DV Alert training (https://dvalert.org.au/) – Nationally funded training delivered across metropolitan, rural and remote areas to build understanding of the complexities of domestic and family violence and support appropriate responses.
- Blue Knot Foundation (https://www.blueknot.org.au/) – Training for health professionals on complex trauma.
- Phoenix Australia (https://www.phoenixaustralia.org/) – Trauma-informed care education.
- Our Watch (https://www.ourwatch.org.au/) – Training and resources on preventing violence against women.
- Safer Families (https://www.saferfamilies.org.au/) – Programs to build family violence response capabilities in primary care.
- Australian Institute of Family Studies (https://aifs.gov.au/resources) – Information about child abuse and mandatory reporting.
- National Association for Prevention of Child Abuse and Neglect (https://www.napcan.org.au) – Resources for child abuse prevention and professional development.
- National Principles for Child Safe Organisations (Australian Human Rights Commission) (https://humanrights.gov.au/resource-hub/resources-for-organisations-businesses/child-safe-organisations) – Framework promoting safe organisational systems and culture for children.

**Training in person-centred care**

- ACSQHC *Person-centred care in practice* webinar series (https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care/person-centred-care-practice-webinar-series)

# F5 – Registration and qualifications of practitioners

## F5 | **Registration and qualifications of practitioners**

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

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

The practice:

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

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

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

If engagement of recognised specialist GPs or doctors on a pathway to Fellowship has been unsuccessful, the practice needs to ensure doctors who it engages have the qualifications and training necessary to meet the needs of patients.

## Why this is important

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

## Meeting these criteria

### Registration and credentialing

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

### General practice is a specialist discipline

Doctors in general practices need to be appropriately trained and qualified in the discipline of general practice and meet at least one of the following requirements:

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

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

If specialist GPs and doctors on a pathway to Fellowship are not available (for example, in remote regions and towns), doctors who are not recognised specialist GPs need to be appropriately trained, supervised and supported through continual professional development to meet the needs of patients.

# F6 – Clinical autonomy of practitioners

## F6 | Clinical autonomy of practitioners

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

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

The practice:

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

### Why this is important

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

### Meeting these criteria

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

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

All members of the clinical team are required to, within the boundaries of their knowledge, skills, and competence, comply with the professional and ethical obligations required by law and their relevant professional organisation. Information about relevant codes of conduct is available at the Ahpra website (http://www.ahpra.gov.au) .

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

# F7 – Practice team culture, safety and involvement

## F7 | Practice team culture, safety and involvement

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

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

The practice:

- has a work health and safety policy
- manages and reduces the risk of occupational exposures
- supports the practice team during emergencies or other traumatic events
- supports staff involved in significant clinical incidents, including patient safety incidents
- educates the practice team in its work safety, health and wellbeing requirements
- has systems in place to protect members of the practice team from violence and aggression
- monitors and adjusts the workload of members of the practice team to support their wellbeing
- collects and analyses workforce data on staff sick leave and reasons for staff departures to inform improvements that support team wellbeing and retention.

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

The practice leadership group:

- has a systematic approach to obtaining feedback from the practice team on their experience of working for or engaging with the organisation to implement improvements based on this feedback
- actively seeks input from all members of the practice team
- maintains a process for members of the practice team to escalate and resolve issues
- has processes for the practice team to discuss administrative matters.

### Why this is important

#### Supporting the safety, health and wellbeing of the practice team

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

- advancing population health
- enhancing people's healthcare experience
- supporting healthcare providers' work life
- promoting health equity
- reducing healthcare costs[1].

Supporting staff involved in clinical and patient safety incidents improves psychological wellbeing and reinforces team trust. Practices support team resilience and promote shared responsibility for safety by offering structured debriefs, access to mental health resources, and opportunities to contribute to system improvements.

The practice owner/manager is obliged to meet their responsibilities as an employer by complying with relevant federal and state/territory workplace health and safety (WHS) laws, including those relating to equality, diversity, inclusion, and equity.

### Practice team involvement and input

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

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

### Practice culture and wellbeing

A cohesive, positive and strong team culture is crucial for providing high-quality patient care and ensuring patient safety. It also fosters:

- the wellbeing of the practice team
- open communication
- collaboration and mutual respect, which promotes provider and consumer satisfaction.

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

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

## Meeting these criteria

### Safety, health and wellbeing of the practice team

Table 5 provides areas of focus and actions that the practice could adopt.

**Table 5 Strategies to support the safety, health and wellbeing of the practice team**

| Theme | Focus area | Actions |
|---|---|---|

| | | |
|---|---|---|
| **Safety** | Safety features in the practice | • Install adequate external lighting around pathways, entrances, and carparks.<br>• Record emergency contacts for all team members and establish clear emergency protocols.<br>• Install duress alarms or security cameras to monitor and respond to threats.<br>• Develop and regularly review emergency exit plans.<br>• Prioritise safety-focused room design when planning renovations or fit-outs. |
| | Managing and reducing the risk of occupational exposures | • Implement a documented exposure management protocol, including steps for prevention, identification, reporting, and post-exposure follow-up.<br>• Provide training on safe handling of sharps, bodily fluids, hazardous materials, and the prevention of manual-handling injuries.<br>• Provide access to appropriate PPE and hand hygiene facilities.<br>• Maintain staff vaccination records and offer immunisations relevant to occupational risk (see CG8 – Immunisations (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg8-immunisations) ).<br>• Conduct regular risk assessments and update procedures accordingly.<br>• Provide access to counselling or debriefing following exposure incidents. |
| | Patient aggression and patient-initiated violence | • Have a clear, visible zero-tolerance policy (on signs, websites, phone systems).<br>• Facilitate staff training in de-escalation and incident response. Whole-of-practice training could be used to facilitate a collective approach to the prevention, identification and early response to violence and harassment.<br>• Record incidents for review and risk assessment.<br>• Know when it is appropriate to discontinue care for a violent patient.<br><br>The RACGP's Preventing and managing patient aggression and violence (https://www.racgp.org.au/patientaggression) provides detailed guidance on dealing with violence and aggression. |

| | | |
|---|---|---|
| **Health** | Healthy workload | • Encourage regular breaks during consulting time.<br>• Support team members attending GP appointments and taking preventive care.<br>• Provide access to support services for those experiencing workplace stress.<br>• Offer flexible work arrangements during crises or emergencies.<br>• Provide changing rooms, showers, staff toilets, and bike racks. |
| | Healthy lifestyle | • Provide smoking cessation programs.<br>• Participate in health awareness events, such as Close the Gap (https://closethegap.org.au/) , Crazy Socks 4 Docs (https://www.crazysocks4docs.com.au/) , International Nurses Day (https://www.icn.ch/how-we-do-it/campaigns/international-nurses-day) and RUOK Day (https://www.ruok.org.au/) .<br>• Organise walking meetings or lunchtime walks.<br>• Partner with local gyms or initiate team health challenges.<br>• Register as an RACGP parkrun practice (https://www.racgp.org.au/parkrunpractice) .<br>• Choose healthy catering options for events and meetings. |
| | Healthy physical environment | • Maximise natural lighting and introduce green spaces, plants or natural design elements to boost mood and productivity.<br>• Encourage sustainable transportation options, such as biking or walking, to improve staff fitness and mental health.<br>• Reduce the use of harmful chemicals and promote eco-friendly alternatives. |

| | | |
|---|---|---|
| **Wellbeing** | Wellbeing and inclusion | • Facilitate training on topics such as unconscious bias, cultural sensitivity, and diversity.<br>• Provide access to gender-neutral bathrooms.<br>• Foster a culture that celebrates diversity and open dialogue.<br>• Use software and tools that are compatible with assistive technology.<br>• Offer career support for staff on parental leave.<br>• Designate clean, private spaces for breastfeeding or pumping. |
| | Feedback and reflection | • Conduct surveys or structured feedback activities to assess team culture, wellbeing, communication, and psychological safety.<br>• Share results transparently and use them to inform team discussions, training needs, and quality improvement initiatives.<br>• Encourage anonymous feedback to support psychological safety and honest reflection. |
| | Cohesive, positive and strong team culture | • Display the practice values and ethics electronically and physically.<br>• Provide opportunities for learning and professional development.<br>• Have regular team discussions or check-ins (formal or informal, individual or as a team).<br>• Celebrate achievements, positive feedback and milestones.<br>• Host social activities and informal gatherings. |
| | Supporting staff in emergencies or after traumatic events | • Debrief as a team after a traumatic event.<br>• Adopt trauma-informed principles by promoting safety, trust, choice, collaboration and empowerment in team communication and debriefing.<br>• Use support services such as:<br>  ◦ Employee Assistance Programs (EAP)<br>  ◦ the GP Support Program (https://www.racgp.org.au/racgp-membership/member-offers/the-gp-support-program) – a free service for RACGP members that provides access to professional advice on personal and work-related issues<br>  ◦ the Nurse and Midwife Support Service (https://www.nmsupport.org.au/) – a support service for nurses that provides access to confidential advice and referral<br>  ◦ services offered by the local Primary Health Network. |

| | | |
|---|---|---|
| | Supporting staff involved in significant clinical incidents, including patient safety incidents | • Acknowledge that clinical incidents, including patient safety incidents, can be distressing and may affect the emotional wellbeing of team members involved.<br>• Use support services (as listed above).<br>• When reviewing incidents, apply a fair and just approach that avoids individual blame and focuses on improving the system.<br>• Involve affected members of the practice team in reflective discussions and in the process of identifying changes to prevent a recurrence.<br>• Foster a culture of openness and trust where members of the practice team feel safe, supported, and encouraged to:<br>  ◦ speak up about incidents<br>  ◦ contribute to understanding what happened and why it happened<br>  ◦ contribute to identifying how the practice can improve systems and processes to prevent similar issues in the future. |

### Mental health

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

- the RACGP's *self-care and mental health resources* (https://www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/self-care-and-mental-health-resources) , including the GP support program (https://www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/the-gp-support-program)
- DRS4DRS (https://www.drs4drs.com.au/) , which provides coordinated access to mental health and wellbeing resources
- the Nurse and midwife support helpline (https://www.nmsupport.org.au/accessing-support/telephone-support)
- the AAPM Member Assistance Program (https://www.aapm.org.au/index.cfm/resources/aapm-map/) .

### Practice team involvement and input

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

- use communication tools, such as digital message systems and notice boards, to collect feedback, ideas, or concerns
- facilitate feedback about staff experiences by having clear processes for escalating and addressing issues raised by team members
- invite all team members to participate in and contribute to regular meetings and discussions, noting that in smaller practices these discussions may occur informally
- keep and share records of meetings for transparency and follow-up
- during recruitment and induction, clearly communicate that all staff are encouraged and expected to provide input on how the practice operates
- conduct staff satisfaction surveys
- offer exit interviews to staff leaving the practice.

The feedback gathered from the practice team needs to be analysed for trends and used by the practice management to plan and implement improvements. Practices could consider trends in absolute numbers, as percentages alone can mask meaningful changes in staff wellbeing. Areas that might need improvement could include communication, staff training and support, technology, and the practice's processes.

## Resources

- RACGP's *Self-care and mental health resources* (https://www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/self-care-and-mental-health-resources) – Self-care and mental health resources to support the wellbeing of GPs and practice teams.
- RACGP's *Preventing and managing patient aggression and violence* (https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/preventing-and-managing-patient-aggression/introduction) – Practical guidance for managing aggression and violence in general practice settings.
- RACGP's GP wellbeing resources (https://www.racgp.org.au/wellbeing) – Self-care and mental health resources for GPs and practice teams, including the GP Support Program.

- RACGP's General Practice Business Toolkit (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-business-toolkit) – Modules on team culture, leadership, and workplace health and safety.
- Safe Work Australia (https://www.safeworkaustralia.gov.au/safety-topic/hazards/workplace-violence-and-aggression) – National guidance on workplace health and safety, including psychosocial hazards and managing violence and aggression.

# F8 – Information security

## F8 | Information security

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

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

The practice:

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

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

The practice:

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

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

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

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

The practice:

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

*Aspirational criterion*

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

The practice:

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

## Why this is important

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

## Meeting these criteria

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

Table 6 describes the components that are to be included in the practice's ICT continuity, protection, and recovery plan.

**Table 6 What to include in the practice's ICT continuity, protection, and recovery plan**

| Component | Description | |
|---|---|---|
| Cyber security incident response plan | A cyber security incident response plan outlines how the practice will respond to and manage a data breach, including the following actions: | |
| | Detection and analysis | • Measure the scope of data breaches<br>• Engage ICT providers or forensic specialists |
| | Containment and eradication | • Stop further malicious activity (for example, by blocking compromised accounts or disabling affected access).<br>• Isolate affected systems to prevent spread of the incident.<br>• Engage ICT/cyber security experts to remove malicious software and restore system integrity. |
| | Recovery | • Access essential systems and information to continue providing care |
| | Communication to patients/service users | • Notify patients and stakeholders<br>• Notify relevant authorities |
| | Post-incident analysis | • Review the incident and implement necessary improvements.Daily backup procedures |
| | Daily (or more frequent) backups of critical operational data (for example, appointments, billing, patient health info) that are ideally automated. | |

| | |
|---|---|
| Backup testing schedule | Regular tests to confirm that backups are correctly created, accessible, and readable. |
| Secure offsite/cloud backup | Use secure offsite or cloud-based storage with verified ability to restore data. |
| Third party provider agreements | Standard letters of agreement signed by ICT providers that clarify their obligations relating to security. |
| Malicious software protection | Active and updated antivirus/malware protection on all systems. |
| Email security | The process that scans incoming emails and their attachments for potentially malicious software or links to potentially malicious websites. |
| Automatic updates | Processes for timely and automatic updates of antivirus signature files and software patches. |
| Staff training | Ongoing training for team members about cyber safety, malware prevention, and incident reporting procedures. |
| Software updates and maintenance | Updates and installations, preferably run outside of practice hours, to minimise disruption. |
| Remote access | If the practice allows clinicians and other users to access its systems remotely, its documented policies will address remote access. Refer to the RACGP's *Information security in general practice* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice) for further information about remote access. |

### Relevant authorities in cyber security

The practice needs to:

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

### Designated member of the practice team

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

- knows when and how to escalate ICT issues
- distributes contact details of external experts to relevant members of the practice team
- educates the practice team on data security
- monitors the practice team's compliance with security policies
- oversees procurement and maintenance of ICT systems
- aligns ICT practices with the overall strategic plan.

The designated member of the practice team could facilitate education and training about the practice's ICT continuity, protection, and recovery plan, or whole-practice training to support mutual learning and the identification of any barriers to implementing these ICT processes.

### Engaging third party ICT providers

When contracting an external ICT provider, the practice needs to confirm that:

- the contracted provider understands and complies with the practice's data security policies
- the contracted provider is experienced in handling sensitive health data
- any contract specifies obligations, including for remote access.

The RACGP's *Information security in general practice* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/information-backup/practice-roles-for-the-backup-and-recovery-plan) provides advice on which factors to consider when developing a contractual agreement with a technical service provider or cloud service provider.

### Storage of health information and other data

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

### Retention of health information

The practice needs to:

- keep and securely store health records of both active and inactive patients in accordance with all applicable privacy and health information laws
- retain health information for the minimum periods required under Commonwealth and state or territory legislation
- maintain both digital and hard copy records securely during the retention period
- seek advice where necessary to confirm compliance with retention periods and any restrictions on destruction when records may be subject to legal proceedings.

### Destruction or de-identification of health information

The practice needs to:

- securely destroy or permanently de-identify health information when it is no longer required for any authorised purpose, in accordance with applicable laws
- have documented processes for the safe disposal of hard drives and other storage media, whether managed internally or by an external provider
- wipe all information from devices such as hard drives, printers, and photocopiers before recycling or disposal
- confirm that destruction methods meet privacy and security requirements to prevent unauthorised access or data recovery.

## Resources

- RACGP's *Information security in general practice* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/cybersecurity-attacks-and-how-to-respond) 'Cyber security attacks and how to respond' – Guidance on preparing for cyber security attacks.
- Australian Digital Health Agency's *Cloud services: Considerations for healthcare organisations* (https://www.digitalhealth.gov.au/sites/default/files/2020-11/Cloud_services-Considerations_for_healthcare_organisations.pdf) – Key considerations for healthcare organisations when assessing and implementing cloud services, including security, privacy, and compliance requirements.
- RACGP's *Using email in general practice – Guiding principles* (https://www.racgp.org.au/running-a-practice/technology/business-technology/using-email-in-general-practice) – Guide to using email securely and effectively, with a focus on privacy, consent, and clinical safety.
- RACGP's *Social media in general practice* (https://www.racgp.org.au/running-a-practice/technology/business-technology/social-media/social-media-in-general-practice/about-this-guide) – Guide to the safe and professional use of social media, that includes a template for a social media policy that complies with Ahpra's social media policy.
- Section 4.4 of Ahpra's Good medical practice: a code of conduct for medical practitioners (https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx) – Guidance on the use of social media.
- RACGP's *Information security in general practice* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/securing-your-network-and-equipment/hardware-requirements/secure-destruction-and-de-identification) 'Secure destruction and de-identification' – Guidance on de-identification of records and secure destruction of items, including hardware.

# F9 – Confidentiality and privacy of health and other information

## F9 | Confidentiality and privacy of health and other information

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

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

The practice:

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

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

The practice:

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

### Why this is important

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

### Meeting these criteria

#### Management of patient health information

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

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

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

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

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

There may be specific circumstances that allow or require the practice to share or disclose sensitive health-related information. This can only be done in accordance with the APPs, and in the interests of a patient's health and wellbeing, as described by the Office of the Australian Information Commissioner (https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/health-service-providers/guide-to-health-privacy/chapter-3-using-or-disclosing-health-information) and relevant legislation.

The RACGP's *Privacy and managing health information in general practice* (https://www.racgp.org.au/running-a-practice/security/managing-practice-information/privacy-of-health-information) explains the safeguards and procedures that general practices need to implement to meet legal and ethical standards relating to privacy and security. The practice's medical defence organisation can also provide information and advice about developing relevant strategies.

### A privacy policy

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

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

Refer to the RACGP's privacy policy template available at the resources page (https://www.racgp.org.au/getmedia/1a93aa6e-aa25-40f4-ab1a-7f351632ef30/RACGP-Privacy-Policy-Template-for-General-Practices.docx.aspx) on the RACGP website.

For further information about privacy, visit the Office of the Australian Information Commissioner's (http://www.oaic.gov.au) (OAIC's) website.

Consumers need to have access to the practice's privacy policy. This could be on the practice's website or reception staff could provide a copy when a consumer asks for one (for example, via a QR code or hard copy). See PP1 – Information about the practice (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/criterion-pp-1-information-about-your-practice) for more information on making information such as this accessible to patients.

### Disclosure of patient health information to a responsible person

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

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

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

### Familiarity with requirements

The practice needs to confirm that members of the practice team understand and implement its privacy policy.

As well as being familiar with the APPs, members of the practice team could:

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

### Appropriate access to systems, platforms and other information

Members of the practice team require access only to the systems, platforms and information they need to undertake their roles. Members of the practice team have a responsibility to use patient information only for its intended purpose and for the benefit of the patients. Different roles will require different levels of access, and the practice needs to allocate system permissions accordingly. Access could include, but is not limited to:

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

### Keeping health information concealed

Keep health information concealed from unauthorised sight and prevent unauthorised access, by adopting practical measures such as:

- positioning computer screens so they can't be viewed by unauthorised people
- using automated privacy tools, such as screensavers, when devices are unattended
- installing security measures on devices (for example, mobile phones, tablets, laptops, and other portable devices) that are of the same standard as the practice's desktop computers.

# F10 – Digital health technologies

## F10 | Digital health technologies

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

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

The practice:

- facilitates processes for members of the clinical team to obtain informed consent from patients when using digital health technologies
- has a documented process for assessing, costing, implementing and managing digital health technologies, including consideration of their potential impacts on the practice, members of the practice team and patients
- provides members of the practice team with access to and opportunities for collaboration with technical experts for the digital health technologies it uses in the provision of high-quality patient care.

### Why this is important

'Digital health technologies' refers to digital technologies that are used to deliver healthcare services remotely, or to enhance in-person care, and therefore improve accessibility, continuity, and efficiency in patient care.

The technologies include telehealth, mobile health apps, patient portals, remote monitoring devices, and secure messaging platforms.

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

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

### Meeting these criteria

#### Safe and secure digital health technology

The practice needs to support safe and secure use of digital health technologies by having relevant processes, policies systems, and Information and Communication Technology (ICT). The practice needs to ensure that:

- the practice has a reliable internet connection, capable of supporting multiple videoconferencing requirements if undertaking telehealth
- equipment and connectivity needed for digital health technologies can deliver sound and image of a quality that is suitable for clinical purposes
- any proposal for new technology includes a systematic, operational assessment of its impact before its implementation. This could include workflow changes, readiness of the team, resource requirements, costings and consumer experience
- to confirm its reliability, all hardware and software is tested regularly, as well as after any updates or changes to functionality
- if members of the practice team work off site, the practice has:
    - systems that enable communication to and from the practice (email, telephone, fax, secure messaging)
    - technology that enables remote access to clinical records
    - 'read and write' options for the practice's clinical information system
    - access to My Health Record if applicable.

Refer to the RACGP's *Guide to providing telephone and video consultations in general practice* (https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-guides/

guide-to-providing-telephone-and-video-consultatio/introduction) for more information about how to use digital health technologies safely and securely.

### Obtaining informed consent when using digital health technologies

When digital health technologies are used in patient care, practices need to support clinicians to obtain informed consent that is appropriate to the technology being used and the individual patient's needs.

The practice could:

- support clinicians to explain to patients how the digital health technology will be used as part of their care, including any limitations or risks
- inform patients about how their health information will be collected, used, stored and shared when digital technologies are involved
- support clinicians to tailor consent discussions to the patient's level of understanding, digital literacy and preferences
- provide guidance to clinicians on when consent may need to be reviewed or revisited (for example, if a different digital technology is introduced).

### Sharing health information securely with other providers and patients

When digital health technologies are used to share health information, practices share information securely in accordance with privacy legislation, informed consent requirements and principles that support continuity of care.

Digital health technologies could support this by enabling the practice to:

- use secure messaging platforms to exchange clinical information with other healthcare providers
- allow patients to access their own health information through patient portals or mobile health apps, where appropriate
- transmit information using encrypted or secure channels
- document patient consent for sharing information, particularly when using third-party platforms or services
- support continuity of care by ensuring shared information is timely, accurate and accessible to authorised recipients.

### Assessing, costing, implementing and managing digital health technologies

Before introducing or changing a digital health technology, practices need to consider its impacts.

The practice could:

- assess the proposed technology for its intended purpose, safety, usability and alignment with patient care needs
- consider the impacts on practice workflows, role responsibilities and readiness of the practice team
- identify resource requirements, including infrastructure, support arrangements and ongoing maintenance
- consider direct and indirect costs, including licensing, upgrades, integration and support
- define how the technology will be implemented, reviewed and managed over time, including how risks and issues will be identified and addressed
- review the use of the technology periodically to confirm it continues to support safe, high-quality patient care.

### Discussing implementation of digital health technologies

To seek input and feedback from members of the practice team that could inform decision-making and training needs, the practice could:

- seek input from the practice team in the initial stages of implementing a new digital health technology
- explain the benefits and expected outcomes to the practice team
- address training and support needs
- encourage ongoing feedback from the practice team to support assessment, evaluation and ongoing quality improvement.

### Collaboration with technical experts

Collaboration goes beyond arranging technical support after implementation: it also involves engaging technical experts when planning, implementing, and optimising digital health technologies, so the technologies support high-quality patient care. The practice could:

- schedule regular sessions with technical experts to review system performance and identify improvements

- involve technical experts in workflow design when introducing new digital tools
- establish feedback loops between members of the practice team and technical experts to address usability and safety concerns
- have technical experts provide training tailored to the practice's needs and patient population.

## Resources

Medical Board of Australia: Guidelines for telehealth consultations with patients (https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Telehealth-consultations-with-patients.aspx) – Guidance for registered medical practitioners on conducting safe and effective telehealth consultations, that includes consent, documentation, and clinical suitability.

# F11 – Artificial intelligence (AI)

## F11 | Artificial intelligence (AI)

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

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

The practice:

- facilitates processes for members of the clinical team to obtain and document informed consent from patients when aspects of care will be delivered using AI
- facilitates data deidentification/anonymisation when using AI tools that process patient data
- ensures that identified patient data is not used by AI tools unless its use is clinically necessary, explicitly authorised, and supported by documented governance and consent processes
- discusses the implementation and use of AI with members of the practice team to identify practical implications and training needs
- establishes governance processes for AI use, including accountability and compliance with legislation
- documents processes that support clinical oversight of AI outputs.

Members of the clinical team:

- are accountable for care decisions supported by AI tools.

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

The practice:

- has a process to assess and evaluate the use of AI, including risk mitigation, prior to implementation
- has processes for monitoring, review, and quality improvement to ensure AI tools deliver safe, high-quality care, with mitigation of any unintended consequences.

### Why this is important

Artificial intelligence (AI) describes the machine simulation of human cognitive capabilities such as learning, reasoning or problem-solving, and self-correction[12]. It encompasses a range of technologies, such as machine learning, deep learning, natural language processing, robotics, chatbots, image recognition and machine vision, and voice recognition[13]. In general practice, AI tools may include clinical decision-support systems, patient engagement platforms, diagnostic aids, administrative automation, and documentation tools, such as AI scribes. Having a strategy for the implementation of AI tools in a practice helps the practice to focus on how its adoption of AI enhances patient care, rather than adding unnecessary complexity or risk. While AI can bring significant benefits to healthcare (eg faster workflows, more accurate diagnoses, and more effective treatments), using it without thoughtful planning could lead to unintended consequences (eg misdiagnosis, privacy breaches, or ethical and legal issues). Ensuring that AI systems are used according to a structured governance framework that includes clinical supervision and accountability helps to:

- safeguard patient safety by providing clinicians with reliable tools, while maintaining transparency and oversight
- strengthen trust in these tools
- uphold high standards of quality and ethical responsibility.

Obtaining informed consent helps to maintain patient trust and autonomy because patients understand how AI is being used in their care. This also aligns with ethical healthcare practices and transparency principles. Open discussions with the practice team and clear lines of support aim to build confidence, knowledge, and readiness among the practice team to effectively integrate AI in their work. Including diverse perspectives from the practice team aims to reduce the risk of missing important considerations that only some members might notice. Implementing regular evaluation checks that AI systems are operating as intended helps to mitigate risks and prompts the identification of performance improvements.

## Meeting these criteria

### Informed consent and transparency

If the practice uses AI tools, it needs to inform patients of how these tools use their health information (for example, what information is collected, where it is stored and who has access to it).

Tools used to transcribe consultations may need to access patient health records or listen to the consultation in order to generate notes for the GP, and this could have implications for data security if the use of AI does not comply with Australian privacy legislation.

Patients have the right to withdraw consent for the use of AI tools in their care at any time. Practices need to inform patients of this right during the consent process and have a clear and accessible mechanism for patients to opt out. If a patient withdraws consent, the practice needs to:

- document the withdrawal in the patient's health record
- stop using AI tools in the patient's care unless clinically necessary and re-authorised
- provide alternative care pathways that do not rely on AI tools, where feasible
- communicate any limitations or implications of opting out in a transparent and respectful manner.

See PP4 – Informed consent (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp4-informed-consent) for further advice on obtaining informed consent.

### Artificial intelligence in general practice

If the practice uses AI tools, it must consider how to meet its obligations under the *Australian Privacy Act 1988* (https://www.legislation.gov.au/C2004A03712/2022-11-14/text) and the *Australian Privacy Principles* (https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-quick-reference) (APPs). Legal advice may be useful, particularly when determining relevant answers to the questions listed below.

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

### Accountability for AI output

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

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

Practitioners have professional obligations related to the use and review of AI tools used for clinical care. Ahpra provides advice (https://www.ahpra.gov.au/Resources/Artificial-Intelligence-in-healthcare.aspx) about meeting professional obligations and the potential challenges facing clinicians who use AI.

### Consideration of third parties

AI tools may be developed or operated by third-party vendors. Practices need to confirm that:

- any third-party technology used in patient care (including AI scribes, transcription tools, or decision-support systems) complies with privacy legislation
- patients are informed of the involvement of external providers (as per third party consent at PP4 Informed consent (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp4-informed-consent) )
- contracts with vendors address data handling, consent, and accountability.

When AI tools are provided by third parties, practices remain responsible for their safe and appropriate use.

### Assessment, evaluation and the ability to question AI output

AI systems need to be monitored and evaluated not only before implementation, but afterwards to confirm that they perform as intended and that risks are actively managed over time. Given the potential for significant impacts on patients or on the practice's operations, practices need to provide:

- a timely and accessible process for patients, consumers, and the practice team to question or challenge AI outputs
- transparent processes for responding to AI-related issues
- clinical autonomy for practitioners, including the ability to review and override AI outputs using clinical judgement
- access to information about how its AI systems work so that patients, consumers and members of the practice team can properly question its output if needed
- mechanisms for monitoring and reviewing AI performance, safety, and appropriateness, including regular evaluation against clinical standards and the practice's needs.

### Potentially disproportionate impact of AI

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

To determine whether AI tools are appropriate for diverse patient populations, practices could:

- assess whether the AI system has been trained on data that reflects the diversity of the practice's patient population
- evaluate whether outputs are culturally safe, inclusive, and clinically relevant for different groups
- involve consumer representatives and/or cultural advisors when selecting and evaluating AI tools
- evaluate accessibility for patients with low health literacy, language barriers, or disability
- review vendor documentation relating to bias mitigation, the extent to which their data represents different groups, and equity safeguards.

### Respecting Indigenous data sovereignty

When using AI tools that process patient data, practices need to be mindful of Indigenous data sovereignty (the right of Aboriginal and Torres Strait Islander peoples, communities and organisations to maintain, control, protect, develop, and use data that relates to them)[21], particularly when working with Aboriginal and Torres Strait Islander patients. The Maiam Nayri Wingara principles provide a framework for ensuring that Indigenous peoples have control over the collection, access, and use of data relating to them. These principles emphasise the need for:

- ownership of data by Indigenous communities
- control over how data is used and shared
- access to data that is relevant and meaningful
- custodianship of data in ways that respect cultural protocols[22].

### Monitoring and review

Practices strengthen their approach to monitoring and reviewing AI by implementing assessment activities. The practice could:

- collect structured feedback from members of the practice team about their experiences with AI systems, including its effectiveness and usability
- audit outcomes from AI-generated recommendations (for example, checking for over-diagnosis or missed diagnosis when AI tools are used for interpretation or triage)
- monitor consumer feedback and complaints related to the use of AI in their care, to identify safety concerns or opportunities for improvement
- track the number and nature of technical support requests or issues raised about AI system performance
- collect data on how often AI is used in clinical decision-making or administrative processes, and how often clinician-only approaches are used
- review updates and changes to AI systems to confirm they are not introducing new risks or reducing effectiveness.

### Regulatory compliance for AI tools

Some AI tools used in general practice (for example, diagnostic aids, clinical decision support systems, transcription tools) may be classified as medical devices under the Therapeutic Goods Act 1989.

If an AI tool meets the definition of a medical device, it must be included on the Australian Register of Therapeutic Goods (ARTG) before it can be lawfully supplied or used in Australia. Practices need to confirm that any AI tools used in clinical care:

- are appropriately registered on the ARTG
- comply with relevant Therapeutic Goods Administration (TGA) guidance
- come with documentation from the vendor explaining regulatory status and intended use.

If a practice is unsure whether an AI tool qualifies as a medical device, the practice can seek legal or regulatory advice to make sure there is no breach of TGA requirements. For more information on how AI medical devices are regulated, refer to the Department of Health Disability and Ageing's *Artificial Intelligence (AI) and medical device software* (https://www.tga.gov.au/products/medical-devices/software-and-artificial-intelligence/manufacturing/artificial-intelligence-ai-and-medical-device-software) .

## Resources

### RACGP's resources

The RACGP has developed the following resources for practices to use to guide the implementation of digital health technologies and/or AI in their practice.

- *Artificial intelligence (AI) scribes* (https://www.racgp.org.au/running-a-practice/technology/business-technology/artificial-intelligence-ai-scribes) : This resource describes AI scribe tools that can automate parts of the clinical documentation process for a medical practitioner, and explores the potential benefits and risks, as well as relevant considerations.
- *Conversational AI* (https://www.racgp.org.au/running-a-practice/technology/artificial-intelligence-ai/conversational-artificial-intelligence) : This resource aims to assist GPs weigh up the potential advantages and disadvantages of using conversational AI in their practice.
- Artificial intelligence in primary care (https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/artificial-intelligence-in-primary-care) position statement: This resource can help the practice team to understand the advantages and risks of AI in general practice.
- *Privacy and managing health information in general practice* (https://www.racgp.org.au/running-a-practice/security/managing-practice-information/privacy-of-health-information) : This resource aims to help the practice team understand relevant privacy laws, patient consent, and information management and security, and how to adapt these to digital health technology and AI.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) *Pragmatic Artificial Intelligence (AI) guidance for clinicians* (https://www.safetyandquality.gov.au/newsroom/latest-news/pragmatic-artificial-intelligence-ai-guidance-clinicians) **supports clinicians in the day-to-day use of AI** tools.

Ahpra's *Meeting your professional obligations when using Artificial Intelligence in healthcare* (https://www.ahpra.gov.au/Resources/Artificial-Intelligence-in-healthcare.aspx) explains how health practitioners must **apply existing professional obligations** when using artificial intelligence in healthcare.

Department of Industry, Science and Resources provides detailed guidance for **responsible AI governance** in *Guidance for AI Adoption: Implementation guidance* (https://www.ai.gov.au/staying-safe-and-responsible/essential-ai-practices/guidance-ai-adoption-implementation-guidance) and outlines the following six elements of responsible AI use:

1. Accountability
2. Impact assessment
3. Risk management
4. Transparency
5. Monitoring
6. Human oversight.

### AI ethics

The World Health Organization (WHO) *Ethics and governance of artificial intelligence for health: Guidance on large multi-modal models* (https://www.who.int/publications/i/item/9789240084759) addresses the use of different types of AI systems.

The federal Department of Industry, Science and Resources has published eight voluntary AI ethics principles (https://www.industry.gov.au/publications/australias-artificial-intelligence-ethics-framework/australias-ai-ethics-principles) which can assist the practice provide safe healthcare when

using AI. These principles encourage businesses to use AI in ways that:

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

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

# *Clinical governance standard*

# About this standard

The Clinical governance standard addresses the processes and systems that practices use to manage risk and protect the safety of patients and members of the practice team. These include:

- maintaining patient health records systems
- the use of current, evidence-based guidelines and standards
- transitions of care
- infection prevention and control
- practice environment and equipment
- research.

This standard aims to foster an open and transparent culture in general practices and to promote the digitisation of patient health records.

# CG1 – Clinical information systems

## CG1 | Clinical information systems

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

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

The practice:

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

## Why this is important

### Digital clinical information systems

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

### Using multiple digital clinical information systems

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

## Meeting this criterion

The practice has a digital clinical information system that meets its needs.

### Using multiple digital clinical information systems

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

- up-to-date patient health summaries (such as the same in each record) so that all pertinent information, including allergies and medications, is available in any system at any time. See CG3 – Facilitating complete patient health records (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg3-facilitating-complete-patient-health-records) for further information about records of each consultation and interaction in each patient health record, which also needs to include where the clinical notes are recorded.

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

- a note in the practice's clinical information system, notifying users that a consultation or interaction has occurred, and where to find the full details of that exchange
- a billing record to show where the consultation occurred (for example, the clinic, via telehealth).

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

It is good practice to:

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

## Resources

- RACGP's General practice toolkit: *Clinical information system* (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-business-toolkit/general-practice-tool-kit/module-2/technology)

# CG2 – Patient identification

## CG2 | **Patient identification**

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

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

The practice:

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

## Why this is important

### Verifying a patient's identity

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

Correctly identifying patients using a minimum of three identifiers confirms that practitioners have the correct patient health record for each consultation. For example, a parent and child could have the same first name, family name, and address, but will have different dates of birth.

## Meeting these criteria

Correct patient identification is necessary when:

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

### Confirming a patient's identifiers for telehealth sessions

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

### Asking for patient identifiers

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

- be mindful of privacy and confidentiality
- not compromise the safety of the patient
- ensure the correct patient is matched to their health record, particularly if they have a common or duplicated name

- seek identifying information from patients rather than providing the information to the patient and asking them to confirm that it is correct.

The practice could develop a process to remind reception staff to ask patients to identify themselves.

To protect patient privacy, especially for patients who may be at risk, the practice could:

- direct patients to a private area and use written prompts
- use discreet verification methods
- use privacy sensitive check-in processes.

For example, the practice could:

- identify patients via official documents such as a driver's licence or passport. Medicare cards cannot be used as a stand-alone patient identifier, as they do not include a photo of the patient and may share numbers across family members. However, a current Medicare card could be used as a secondary identifier alongside an approved patient identifier that has photo identification, such as a current driver's licence or passport
- if using an online check-in system to identify patients presenting for an appointment (for example, a tablet or kiosk in the waiting room, or via the patient's mobile phone), use multi-factor authentication
- provide patients with writing materials on which they can write details of their approved identifiers
- ascertain the correct spelling of the patient's name from their physical or digital Medicare card (if they have one) and ask the patient to confirm other approved identifiers in a way that is sensitive to their needs.

To confirm the currency and accuracy of patient information, reception staff may view an official government-issued photo identification document (for example, a current driver's licence or passport) that displays the patient's name and date of birth. Visual inspection of such documentation is sufficient, and copies must not be stored in the patient health record.

### Retaining patient identification documents is not advised

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

### Using consistent identifiers

The practice could develop internal procedures or prompts to support consistent use of three approved patient identifiers at relevant points of contact, helping to reduce the risk of patient mismatching and support patient safety, accuracy and continuity of care.

### Patients who wish to remain anonymous

In line with the Australian Privacy Principles, wherever it is lawful and practicable, patients need to be able to remain anonymous when receiving care from the practice and when practicable to do so[23]. Patients may choose to receive services anonymously if, for example, sensitive issues arise or they feel they may be at risk, such as in situations of family, domestic and sexual violence (FDSV) or difficult relationships. In these circumstances, the use of an alias or 'disguised identity' may be the most appropriate approach. The Office of the Australian Information Commissioner (https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-guidelines/chapter-2-app-2-anonymity-and-pseudonymity) (OAIC) provides information about:

- the differences between anonymity and pseudonymity (the use of a fictitious name or identifier)
- situations where it may be legally required to identify patients (eg when prescribing medications, referring to diagnostic services, or accessing benefits such as Medicare).

The practice could:

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

In high-risk situations, such as where there are safety concerns, the practice may support patients to use a preferred name or pseudonym in accordance with Australian Privacy Principle 2 (APP2), provided this does not conflict with legal requirements for prescriptions, referrals or benefits claims.

### Cultural considerations for Aboriginal and Torres Strait Islander peoples

Following the death of an Aboriginal or Torres Strait Islander person, some communities have cultural protocols to avoid naming deceased people, and this may influence the ways the practice identifies patients. As protocols differ throughout the country, the practice could ask the local Aboriginal or Torres Strait Islander community about correct procedures relating to avoidance of names, time periods for avoidance, and the use of images of deceased people. The RACGP's resource, *An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives* (https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/An-introduction-to-Aboriginal-and-Torres-Strait-Islander-health-cultural-protocols-and-perspectives.pdf) may provide useful information, however, it is always important to discuss protocols with local Aboriginal and Torres Strait Islander community members, or where possible, family members[24].

## Resources

- RACGP: *An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives* (https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/An-introduction-to-Aboriginal-and-Torres-Strait-Islander-health-cultural-protocols-and-perspectives.pdf)
- Office of the Australian Information Commissioner:
    - Healthcare identifiers (https://www.oaic.gov.au/privacy/privacy-legislation/related-legislation/healthcare-identifiers)
    - APPs chapter 2: Anonymity and pseudonymity (https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-guidelines/chapter-2-app-2-anonymity-and-pseudonymity)
- World Health Organization: *Patient identification* (https://cdn.who.int/media/docs/default-source/patient-safety/patient-safety-solutions/ps-solution2-patient-identification.pdf?sfvrsn=ff81d7f9_6#:~:text=Upon%20admission%20and%20prior%20to,be%20the%20patient's%20room%20number.).

# CG3 – Facilitating complete patient health records

## CG3 | **Facilitating complete patient health records**

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

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

The practice:

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

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

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

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

Members of the clinical team:

- document the assessment of the patient in the initial consultation
- document sufficient information for consultations and clinical related communications
- document matters that have been followed up from previous consultations
- document relevant safeguarding information when provided by the patient or a lawful authority and where it is necessary for safe communication or continuity of care.

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

The practice:

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

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

Members of the clinical team:

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

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

The practice:

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

Members of the clinical team:

- identify and respect patients' preferences or choices
- document shared decision making in the patient's health record
- document that individual treatment plans have been developed, are monitored, reassessed and modified in coordination with the patient and/or care giver.

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

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

**CG3.I Members of the practice team record all communications with patients.**

Members of the practice team:

- record attempts to contact, or successful contact with, a patient
- record patient-initiated contact, including the reason for contact and any advice and/or information provided
- record when a translation service was used for a patient, including relevant contact details of the service.

*Aspirational criterion*

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

- ethnicity
- birth sex
- gender
- preferred pronouns.

## Why this is important

### Patient health records

Maintaining accurate and comprehensive patient health records is a crucial element in the provision of continuity of safe, high-quality care and compliance with privacy laws.

The RACGP has developed the *Improving health record quality in general practice* (https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/improving-health-record-quality/introduction) guide which outlines what constitutes a high-quality health record and how practices could put systems in place so they produce health records that are fit-for-purpose.

In addition, it's important to accurately and objectively document information related to family, domestic and sexual violence (FDSV) and child sexual abuse. These records may be used in legal proceedings, therefore current and factual information supports patient safety, confidentiality and continuity of care.

### Using codable fields

Using a nationally recognised medical vocabulary in codable fields allows the practice to collect structured clinical data that can be used to:

- track care over time, both for individuals and the patient population
- identify necessary quality improvement activities
- collect benchmarking data for comparison with other practices.

## Meeting these criteria

### Use of codable fields

Codable fields are structured areas within the clinical information system that allow patient information to be recorded in a standardised, searchable format that uses clinical coding systems rather than free text.

This allows information to be consistently recognised, supporting clinical decision-making, continuity of care and quality improvement, as well as retrieval and use in the system.

To support the effective use of codable fields in the patient health summary, the practice could:

- include the use of codable fields as part of induction or ongoing support for clinicians when introducing or upgrading clinical information systems.
- provide guidance to the clinical team on which parts of the clinical information system are used for recording coded health summary information
- align workflows and documentation processes with how the clinical information system is designed to record and store coded information
- use system reports, prompts or audits (where available) to support identification and improvement of missing or incomplete coded health summary information

Patient information may be collected through a range of sources, including online booking systems or patient-facing applications, registration forms or questionnaires. Where information is collected outside the clinical information system, relevant details need to be accurately transferred into the patient health record and recorded in codable fields where appropriate.

### Keeping patient details up to date

Patient details (including the contact details of their emergency contact) need to be kept up to date. The practice could do this by:

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

### Recording patients' names

As many people use and are referred to by a name that may differ from some or all of their identity documents, the practice needs to record all names that the patient calls themselves, as well as the name recorded on official documents. Individual Healthcare Identifiers are based on the name registered with Medicare.

### Privacy laws

Members of the practice team are legally required to collect, handle, store and share all personal and sensitive patient information in accordance with applicable privacy laws. See F9 – Confidentiality and privacy of health and other information for more information.

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

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

Consistent recording of these details helps improve clinical care by enabling:

- a better understanding of a patient's experiences and beliefs (for example, if they a member of the stolen generation, have cultural obligations, or participate in cultural activities that contribute to their wellbeing)
- access to local care co-ordination services
- correct recommendations relating to immunisations
- appropriate recommendations for preventive healthcare interventions.

For those of Aboriginal and Torres Strait Islander origin, it also enables:

- participation in the Closing the Gap Pharmaceutical Benefits Scheme (PBS) co-payment measure
- access to particular medications on the PBS
- access to particular Medicare Benefits Schedule (MBS) item numbers and subsequent follow up by practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and allied health services.

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

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

Every patient has the right to respond to this question as they see fit.

The patient's response needs to be received without question or comment, and their response recorded without any amendments or annotations[31].

If a patient indicates that they do not wish to answer the question, record 'Not stated/inadequately described'. However, if the patient does not answer this question when it is on a form, follow up immediately in case they missed it by mistake, rather than assume that the patient has refused to answer.

### Providing person-centred care

The practice could record each patient's ethnicity and their country of birth if this is relevant to their care. In some circumstances, there may be direct genetic health risks or religious beliefs that affect health decisions.

For further information about providing culturally safe and respectful care to Aboriginal and Torres Strait Islander patients and diverse populations, see PP3 – Respectful, culturally appropriate and culturally safe care (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp3-respectful-culturally-appropriate-and-cultural) .

### Collecting sufficient information about consultations and communications

Patient health records are most useful when they are clear, contemporaneous and provide enough detail for another clinician to understand the patient's situation and continue care if required.

Records need to contain sufficient information to accurately document consultations and clinical-related communications. They also capture clinical-related communications that occur outside formal consultations where this information is relevant to the patient's care, safety or continuity of care.

This includes:

- an initial assessment documented at the first consultation, including relevant history, presenting concerns and clinical findings, to establish a baseline understanding of the patient and support safe and appropriate care planning
- documenting sufficient detail for each consultation and clinical-related communication (including advice, follow-up or information provided outside a consultation) to support safe clinical decision-making and continuity of care
- additional details collected during subsequent consultations, including matters that have been followed up from previous consultations, as the clinical team builds a relationship with the patient.
- relevant safeguard information provided by the patient or a lawful authority, where this information is necessary to support safe communication, continuity of care, or risk management for the patient or others.

### Maintaining a current health summary

A current and accurate health summary supports clinical decision-making, continuity of care and effective use of the clinical information system. A patient's health summary includes a range of coded information, such as current and past health problems, medicines and allergies, immunisations, health and lifestyle risk factors, family history and social history.

To support the currency of patient health summaries, the practice could:

- use system prompts to support clinicians to update coded information when new diagnoses, risks or treatments are identified
- use system prompts or review tools to identify records where key health summary fields are incomplete or outdated
- support consistent use of the clinical information system through guidance, templates or agreed workflows.

To support complete and reliable allergy documentation, the practice could:

- use system prompts or alerts to flag records where allergy status has not been recorded
- require allergy status to be confirmed and recorded during patient registration, consultations, or routine record reviews
- record either a known allergy or 'no known allergies' in a codable field, rather than leaving the field blank
- include allergy status as part of routine data-quality or record-review activities
- confirm allergy status when medications are prescribed, reviewed or reconciled.

### Keeping a current and accurate medicines list

Keeping an accurate and current medicines list supports safe prescribing, continuity of care and communication with other healthcare providers. Members of the clinical team could do this by:

- updating medicines at relevant patient interactions, including new prescriptions, changes or ceased medicines
- recording sufficient detail (for example, medicine name, dose and frequency)
- reconciling medicines when there are changes in care, such as after hospital discharge or specialist review.

The medicines list need to be included in referral letters and clinical correspondence to support coordinated care. Members of the clinical team could:

- incorporate medication review and reconciliation into routine consultations
- use clinical software prompts or workflows to support review of medicines
- provide guidance on consistent recording and updating of medicines.

### Shared decision-making

Shared decision-making takes place during a consultation when the clinician and patient collaborate to make health decisions after discussing the evidence base, benefits and harms, and consideration of the patient's preferences, values and circumstances[6]. Shared decision-making is applicable to most situations; however, it is particularly important when:

- evidence does not clearly support a particular option
- a preference-sensitive decision is needed (for example, the decision is heavily influenced by the patient's preferences and values[6].

To support shared decision-making, the practice needs to provide members of the clinical team with access to information and resources that assist discussions with patients about treatment and care options.

The practice could:

- make decisionsupport tools, clinical guidelines or patientfacing information available to clinicians for use during consultations
- support clinicians to tailor discussions to the patient's needs, preferences, health literacy and circumstances
- support the use of interpreters or culturally appropriate resources where required
- provide time, systems or workflows that enable meaningful discussion between clinicians and patients, particularly for preferencesensitive decisions.

### Identifying and respecting patient preferences

Identifying and respecting patient preferences is central to shared decision-making and supports patient-centred care. When patients are actively involved in decisions about their care, it can improve understanding, engagement, adherence to treatment, and overall health outcomes. It also helps ensure that care is appropriate, acceptable and aligned with the patient's individual circumstances.

Members of the clinical team identify and respect patients' preferences or choices by:

- exploring the patient's values, goals and concerns
- considering cultural, social and personal circumstances
- supporting patients to express their preferences and participate in decisions.

### Documenting shared decision-making and treatment plans

Documenting shared decision-making supports continuity of care, transparency and coordinated care across the practice team. To support this, members of the clinical team could:

- provide prompts or fields in the clinical information system to record discussions, patient preferences and decisions.
- record that individual treatment plans are developed in partnership with the patient and/or caregiver, including agreed goals, treatment options and planned actions
- track how treatment plans are monitored over time, including progress toward goals, response to treatment and any issues identified during follow-up consultations
- update treatment plans in coordination with the patient and/or caregiver, including any changes to goals, treatments or follow-up arrangements, and ensure these updates are clearly recorded.

### Professional obligations of the clinical team

Members of the clinical team have professional obligations relating to care and treatment decisions. *Good medical practice: a code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx) outlines how practitioners are required to work with their patients, and with other healthcare professionals when coordinating patient care.

Practitioners' registration includes obligations to comply with relevant legislation, including mandatory reporting requirements such as notifiable conduct under Ahpra's National Law and applicable child protection or safeguarding laws.

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

Members of the clinical team need to discuss, provide information about and record key aspects of care decisions with patients to support informed decision-making and shared understanding. When discussing and providing information to patients, members of the clinical team could:

- explain the purpose, importance, benefits, risks and potential side effects of proposed investigations, referrals, diagnoses, treatment options and management approaches

- discuss reasonable alternatives, including the option of no investigation or treatment where appropriate
- provide patients with information about what to expect following an investigation, referral or treatment decision
- document that these discussions have occurred in the patient health record.

When providing information about the purpose, importance, benefits, risks and side effects of actions to a patient, their carer, family member or other support person, the member of the clinical team could:

- consider the patient's physical, visual and cognitive capacities, as well as their health literacy (see PP1 – Information about the practice (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/criterion-pp-1-information-about-your-practice) )
- use plain English and arrange interpreter service where required (see PP2 – Communications (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp2-communications) )
- tailor information
- provide online or paper-based resources, including factsheets and brochures from trusted and accessible sources
- use relevant tools and resources (for example, visual resources, decision-support tools)
- check the patient's understanding using techniques such as the teach-back method
- encourage questions and provides opportunities for questions
- document which information resources they have given to the patient (for example by pasting the resource's URL into the patient health record).

### Refusal of treatment, advice or procedure

Patients may refuse a practitioner's recommended course of action, including advice, procedure, treatment or referral to other care providers.

When a patient refuses recommended treatment, advice or a procedure, members of the clinical team could record:

- the refusal and the context in which it occurred
- the information provided to the patient, including risks and alternatives discussed
- any agreed actions, follow-up or alternative management.

### Recording communications with patients

Recording communications with patients is essential to support continuity of care, patient safety and effective communication across the practice team. Accurate and timely recording ensures that relevant information is available to support follow-up, coordination of care and appropriate clinical decision-making by any member of the practice team.

Recording communications relies on the capacity of the practice's clinical information systems (See CG1 – Clinical information systems), which support the practice team to record, store and access patient communications in a consistent and secure manner.

Members of the practice team need to record patient communications that are relevant to the patient's care, including attempts to contact patients, patient-initiated contact, advice or information provided, and use of translation services.

To support consistent and reliable recording of patient communications, the practice could:

- provide clear guidance to the practice team about which patient communications are recorded in the patient health record
- promote consistent recording practices so that communications are documented in a way that can be understood by other members of the practice team
- support recording processes that maintain privacy, accuracy and accessibility of information for authorised users.

### Recording patients' safeguarding information

Members of the practice team need to accurately record and securely manage safeguarding information that may affect the safety, wellbeing or care of patients or their dependents, and this includes writing it in the patient's health record, appointment notes or any platform the practice uses. Safeguarding information must be factual, current and securely stored to protect confidentiality and to support coordinated care.

The practice records, where relevant:

- domestic violence orders (DVOs), apprehended violence orders (AVOs), child protection or other court orders
- agreed safety plans, special requirements or alerts

- communications with external agencies, such as child protection and family violence services.

For children and young people, the practice notes:

- custody or parental access arrangements
- how these were verified.

Safeguarding information recorded to support safe communication and continuity of care includes, where relevant:

- a patient's preferred or safest contact method
- restrictions on who may receive information
- restrictions on who may access information based on role (see F9 – Confidentiality and privacy of health and other information (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f9-confidentiality-and-privacy-of-health-and-other) )
- privacy flags within the health record
- any agreed communication protocols or cautions provided by the patient or a lawful authority.

### Safe documentation where records may be requested or subpoenaed

Records may be requested or subpoenaed. Entries made by any member of the practice team need to be factual, objective and limited to what is necessary for safe communication and continuity of care. This could include:

- recording facts or verbatim quotes rather than opinions or speculation
- being precise about dates, times and sources of information
- separating third-party information and avoiding unnecessary detail
- avoiding emotive or judgmental language
- noting only safeguarding information relevant to safety or continuity (for example, preferred or safest contact method, restrictions on who may receive information, privacy flags, agreed communication protocols, or relevant court/protection orders)
- storing information securely and in line with the practice's privacy policy.

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

The practice could record patients' birth-assigned sex, gender and preferred pronouns. Refer to the RACGP's fact sheet for guidance on collecting and recording information about patient sex, gender, variations of sex characteristics and sexual orientation (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Practice standards/5th edition/Collecting-and-recording-information-about-patient-sex-gender.pdf) .

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

- ensure all members of the practice team understand the importance and reasoning behind the sensitive collection of information about sex and gender
- in the patient registration form, clearly explain why these questions are being asked and how the answers will be used
- for each question, provide multiple options the patient can select from (preferred wording of questions and answer options can be found in the RACGP factsheet (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Practice standards/5th edition/Collecting-and-recording-information-about-patient-sex-gender.pdf) )
- with the patient's permission, document their preferred pronouns when transitioning their care (for example, in referral letters)
- have a policy or process addressing the collection, storage and disposal of information about sex, gender, sex characteristics and preferred pronouns, and include information about how this information is collected, and which members of the practice team are best placed to request and discuss this information with patients.

## Resources

- RACGP: *Improving health record quality in general practice* (https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/improving-health-record-quality/introduction)
- RACGP: *Collecting and recording information about patient sex, gender, variations of sex characteristics and sexual orientation* (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Practice standards/5th edition/Collecting-and-recording-information-about-patient-sex-gender.pdf)
- Australian Institute of Health and Welfare: *National best practice guidelines for collecting Indigenous status in health data sets* (https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/summary)

- Medical Board of Australia: *Good medical practice: a code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx)
- Australian Commission on Safety and Quality in Health Care: *Being involved in decisions about your care* (https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making)
- Medical Journal of Australia: *Shared decision making: what do clinicians need to know and why should they bother?* (https://www.mja.com.au/journal/2014/201/1/shared-decision-making-what-do-clinicians-need-know-and-why-should-they-bother)
- Australian Medical Association: Guide to Informed Financial Consent 2024 (https://www.ama.com.au/articles/AMA_Informed_Financial_Consent_Guide_2024)
- Agency for Clinical Innovation:
  - *Shared decision making* (https://aci.health.nsw.gov.au/projects/consumer-enablement/how-to-support/shared-decision-making)
  - *Yarning to make health decisions together* (https://aci.health.nsw.gov.au/shared-decision-making)
- EBSCO: *My Health Decisions* (https://www.ebsco.com/health-care/products/my-health-decisions) : a collection of shared decision-making aids
- Orygen: *Shared decision making for mental health, evidence summary* (https://www.orygen.org.au/Training/Resources/General-resources/Evidence-summary/Shared-Decision-Making/Orygen_Shared_Decision_Making?ext=)
- AskShareKnow: AskShareKnow decision making tool (https://askshareknow.org.au/)
- Healthdirect (https://www.healthdirect.gov.au/)
- Better Health Channel (https://www.betterhealth.vic.gov.au/)

# CG4 – Provision of clinical and medicines guidelines

## CG4 | **Provision of clinical and medicines guidelines**

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

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

The practice:

- ensures members of the clinical team have access to current evidence-based information relating to medicines, including information about the purpose, importance, benefits and risks of medicines.
- has processes for responding when a healthcare provider or patient identifies a suspected medicines-related issue.

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

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

The practice:

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

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

The practice:

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

### Why this is important

#### Current medicines information and clinical and emergency care guidelines

Having access to current, evidence-based medicines information and clinical and emergency care guidelines enables practitioners to undertake best practice prescribing of medicines based on community and patient demographics.

### Adopting environmentally sustainable clinical practices

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

### Antimicrobial stewardship

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

## Meeting these criteria

### Access to medicines information and clinical and emergency guidelines

The practice could:

- subscribe to guidelines and standards
- provide members of the clinical team with access to free services
- maintain a current version of clinical software databases that include drug guides, Consumer Medicine Information (CMI), medical dictionaries, coding classifications, and information about consumer medicine.

### Supporting members of the clinical team to adopt clinical practices that are environmentally sustainable

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

- provide evidence-based, non-prescriptive resources that incorporate sustainability principles, such as the *Australian Asthma Handbook* (https://www.asthmahandbook.org.au/) and RACGP guidance on reducing the carbon footprint of inhalers (https://www.racgp.org.au/running-a-practice/practice-management/business-operations/environmental-sustainability-in-general-practice/reducing-the-carbon-footprint-of-inhalers-climate)
- promote awareness of low-value care, and support clinicians to access decision-support tools that help reduce over-investigation, overdiagnosis and overtreatment
- facilitate access to guidelines and training addressing first-line non-pharmacological management options, such as lifestyle interventions and behavioural therapies
- support medication reviews and deprescribing initiatives, in order to address polypharmacy
- provide evidence-based comparisons of therapeutic goods, for consideration when making treatment decisions
- provide checklists or quick guides for common clinical scenarios, (for example, when to use reusable vs. single-use personal protective equipment (PPE), ways to reduce waste when prescribing)
- promote sustainability topics in CPD activities and team discussions
- include sustainability principles in clinical CPD activities and team discussions
- adopt prescribing software with default options that prioritise sustainability where clinically appropriate (for example, using e-scripts instead of paper).

To support climate-resilient clinical practices, the practice could:

- facilitate access to climate-informed training (for example, managing patients during heatwaves, air pollution events, thunderstorm asthma, floods, storms)
- provide resources about the symptoms, investigations and treatment of infectious diseases that are emerging due to climate change
- support clinicians to integrate patient risk assessments for climate-related health impacts
- encourage use of telehealth and continuity strategies during climate emergencies
- share local alerts and public health guidance about climate-related situations, such as bushfire smoke and extreme heat.

### Educating patients on safe antimicrobial use

Providing the clinical team and patients with information and resources in order to reduce inappropriate prescribing of antibiotics can help to:

- maintain the effectiveness of antibiotics
- prevent the emergence of antimicrobial resistance
- decrease preventable healthcare-associated infection.

The practice needs to:

- provide members of the clinical team with access to information to reduce the inappropriate prescribing of antibiotics
- provide patients with information about antimicrobial resistance and the appropriate prescribing of antibiotics and other drugs (for example, on the practice's website, a digital display, social media posts that could include posts from other healthcare organisations)
- display QR codes that link patients to this information
- consider how the practice can encourage each GP to reflect on their own patterns of prescribing and patient care, and to compare them to that of the other GPs in the practice
- use consumer fact sheets to facilitate shared decision-making relating to the use of antibiotics (see CG3 – Facilitating complete patient health records (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg3-facilitating-complete-patient-health-records) for information on shared decision-making).

## Resources

**Medicines information:**

- *Therapeutic guidelines* (https://www.tg.org.au/)
- the *Australian medicines handbook* (https://shop.amh.net.au) (jointly owned by the RACGP, the Pharmaceutical Society of Australia, and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists [ASCEPT])
- the *Medicines Advice Initiative Australia* (https://www.medicinesadvice.net.au/) develops educational interventions to target specific healthcare problems, and are written for GPs, Aboriginal Community Controlled Health Organisations, pharmacists, hospitals and other health services
- the *National medicines policy* (https://www.health.gov.au/resources/publications/national-medicines-policy?language=en) is a federal framework promoting the safe and high-quality use of medicines for all Australians
- the *National Medicines Policy resources collection* (https://www.health.gov.au/resources/collections/national-medicines-policy-resources-collection) contains resources related to the national medicines policy
    - Guiding principles for medication management in residential aged care facilities (https://www.health.gov.au/resources/collections/guiding-principles-for-medication-management-in-residential-aged-care-facilities-collection?language=en)
    - Guiding principles for medication management in the community (https://www.health.gov.au/resources/collections/guiding-principles-for-medication-management-in-the-community-collection?language=en)
    - Guiding principles to achieve continuity in medication management (https://www.health.gov.au/resources/collections/guiding-principles-to-achieve-continuity-in-medication-management-collection?language=en)

**Adverse event reporting resource:**

- Therapeutic Goods Administration: *Report an adverse event or safety problem* (https://www.tga.gov.au/safety/report-problem/report-adverse-event-or-safety-problem)

**Clinical guidelines:**

- Key RACGP guidelines (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/snap) (including the *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people* (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/national-guide), *Guidelines for preventive activities in general practice* (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/preventive-activities-in-general-practice/about-the-red-book) *(the Red Book)* and *Handbook of non-drug interventions* (https://www.racgp.org.au/clinical-resources/clinical-guidelines/handi) *(HANDI),* among others)
- The Royal Children's Hospital Melbourne: *Clinical practice guidelines* (https://www.rch.org.au/clinicalguide/)
- Australian Commission on Safety and Quality in Health Care:
    - *Access to therapeutic guidelines* (https://www.safetyandquality.gov.au/sites/default/files/2024-05/fact_sheet_-_access_to_therapeutic_guidelines_-_may_2024.pdf)
    - *Clinical care standards* (https://www.safetyandquality.gov.au/standards/clinical-care-standards)
- HealthPathways (available free of charge to general practice teams via local primary health networks)
- *UpToDate* (https://www.wolterskluwer.com/en-au/solutions/uptodate) decision-support subscription

**Emergency guidelines:**

- The Agency for Clinical Innovation (NSW): *Emergency care institute* (https://aci.health.nsw.gov.au/networks/eci)
- Australian and New Zealand Committee on Resuscitation (ANZCOR): guidelines (https://www.anzcor.org/).

**Environmental sustainability resources:**

- RACGP:
    - Environmental sustainability in general practice – *Reducing the carbon footprint of inhalers: Climate and clinical implications* (https://www.racgp.org.au/running-a-practice/practice-management/business-operations/environmental-sustainability-in-general-practice/reducing-the-carbon-footprint-of-inhalers-climate)
    - *Greening up – Environmental sustainability in general practice* (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-business-toolkit/general-practice-tool-kit/module-2/environmental-sustainability)
- Doctors for the Environment Australia: *Sustainable healthcare resources* (https://www.dea.org.au/sustainable_healthcare_resources)

**The following resources could help promote antimicrobial stewardship:**

- AJGP article: *How can general practitioners reduce antibiotic prescribing in collaboration with their patients?* (https://www1.racgp.org.au/ajgp/2022/january-february/reducing-antibiotic-prescribing-with-patients)
- RACGP: *First do no harm, Antibiotic use for acute otitis media in children* (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/first-do-no-harm/gp-resources/antibiotic-use-for-acute-otitis-media-in-children)
- Australian Commission on Safety and Quality in Health Care: *Antimicrobial stewardship resources and links* (https://www.safetyandquality.gov.au/our-work/antimicrobial-stewardship/antimicrobial-stewardship-ams-resources-and-links)
- Therapeutic guidelines: *Antibiotic* (https://www.tg.org.au/products/therapeutic-guidelines/updates/antibiotic/) .

# CG5 – Transitions of care

## CG5 | **Transitions of care**

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

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

The practice:

- supports consumers when coordinating care to be provided by other health services
- collaborates and communicates with internal and external practitioners and services throughout transitions of care
- documents and shares patient health information to allow continuity of care in accordance with the Australian Privacy Principles (APPs)
- provides templates that allow the clinical team to write referral letters containing all required information outlined in the RACGP's guidance document (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Practice resources/Referring-to-other-medical-specialists.pdf)
- has a process for handover of care in the event of expected or unexpected leave by a member of the clinical team.

Members of the clinical team:

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

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

The practice:

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

## Why this is important

### Timely transitions of care

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

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

The Australian Commission on Safety and Quality in Health Care has published best practice guidance (https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/principles-for-safe-high-quality-transitions-of-care-fact-sheet.pdf) for transitions of care, which cover:

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

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

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

## Meeting these criteria

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

- discussing with the patient who will take over their care
- supporting patients, carers and other relevant parties who will be involved in the clinical handover, according to the wishes of the patient
- passing on clinically relevant details that support safe, person-centred care, such as the patient's:
    - current risks, health goals, and preferences
    - relevant cultural, religious, or non-religious beliefs that may influence healthcare decisions
    - key family or carer contact information.

The practice could document processes for handovers, that specify:

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

### Transitions of care during acute health emergency situations

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

The practice could implement processes addressing transitions of care during emergency health situations. These processes could:

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

The practice could also have protocols relating to the follow-up care of patients who have been admitted to hospital or another facility (either while attending the general practice or otherwise). These could include processes to review and follow-up documentation such as discharge summaries, including those received electronically.

### Crisis intervention and acute mental health response

Crisis intervention refers to immediate action taken to support a patient experiencing a mental health emergency, such as suicidal ideation, psychosis, or severe distress. These situations may require urgent coordination with external services and careful consideration of legal and ethical responsibilities.

Aligning with relevant state or territory mental health legislation is essential when responding to mental health crises. This includes understanding criteria for involuntary assessment or treatment, and the obligations of practitioners under laws relating to mandatory reporting.

Referral protocols may include:

- contacting local crisis assessment and treatment teams (CATT)
- coordinating with emergency departments and/or ambulance services
- using HealthPathways or Primary Health Network (PHN) tools to identify appropriate localised crisis response options.

Documentation of crisis interventions supports continuity of care and legal compliance. This could include recording:

- the nature of the crisis
- actions taken
- referrals made
- any legal obligations fulfilled.

When coordinating care during crises, the practice needs to share safeguarding information relevant to safe communication or handover, such as preferred contact arrangements, privacy flags, or existing court or protection orders.

### Emailing referrals

The RACGP has developed a resource (https://www.racgp.org.au/your-practice/ehealth/protecting-information/email) that explains the risk associated with emailing certain types of information to patients or other healthcare providers, depending on the practice's policies and processes.

Although the Privacy Act 1988 does not prescribe the method of communication a healthcare organisation should use to pass on health information to patients or third parties, it does require that the practice takes reasonable steps to protect the information and the patient's privacy. Therefore, unless the patient has consented otherwise, the practice needs to protect patients' privacy when communicating electronically with or about them, by using a secure messaging system or another method of encryption. See F9 – Confidentiality and privacy of health and other information (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f9-confidentiality-and-privacy-of-health-and-other) for further advice.

### Responding to requests for patient health information

A patient's health information may be requested by the patient, another practice, or other third party. For example, a patient's new practice may request a copy of the patient's health record.

The practice's privacy policy needs to address the timely, authorised, and secure transferral of patient health information in response to valid requests.

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

### Transferring patient health information

When transferring patient health information to others, follow the relevant processes in the Australian privacy principles (APPs) and all requirements of relevant state or territory laws.

In line with F9 – Confidentiality and privacy of health and other information (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f9-confidentiality-and-privacy-of-health-and-other), practices need to transfer patient health information securely. If the practice chooses to send patient health information via email, security measures need to be in place to protect the information.

### Additional ways to facilitate timely transitions of care

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

- keep records of any issues in a clinical handover system that were identified and addressed
- have a policy explaining how to conduct internal and external handovers, including to locum practitioners
- have a shared-care arrangement when appropriate
- create and document a buddy system
- use internal messaging or internal email for members of the clinical team to communicate with each other
- use a clinical information system that enables the practice to upload a patient's shared health summary/record or event summary to the patient's national shared electronic health record at the patient's request

- have a policy or process that specifies how the practice responds to all correspondence (including paper and electronic communication) in a timely and appropriate manner
- inform patients of any potential costs associated with the transfer of their health information.

## Resources

- RACGP:
  - *A guide for ensuring good referral outcomes for your patients* (https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/referring-to-other-medical-specialists)
  - *Managing external requests for patient information* (https://www.racgp.org.au/running-a-practice/security/managing-practice-information/managing-external-requests-for-patient-information)
  - *Information security in general practice* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/information-security-strategy/roles-and-responsibilities-of-your-practice-team/internet-and-email-use)
  - *Patient communication via electronic media – including email* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/patient-communication-via-electronic-media-includi)
  - *Electronic sharing of information* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/electronic-sharing-of-information)
  - *Internet and email use* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/information-security-strategy/roles-and-responsibilities-of-your-practice-team/internet-and-email-use)
  - *Using email in general practice* (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Security/Using-email-in-general-practice-fact-sheet.pdf)
- The RACGP and Advanced Pharmacy Australia have developed the following resources to help practices manage medications during transitions of care:
  - *Medication management at transitions of care* (https://www.racgp.org.au/getmedia/e953800b-0ccc-46a6-b977-142a3996da39/Medication-Management-at-Transitions-of-Care-practice-update.pdf.aspx)
  - *Safe medication management at transitions of care* (https://www.racgp.org.au/getmedia/3acc69ca-430f-4b2e-994e-a7b403be1685/Safe-Medication-Management-at-Transitions-of-Care-resource-for-professionals.pdf.aspx)
  - *Consumer guide: Medication safety when moving between the community and hospital* (https://www.racgp.org.au/getmedia/4886e851-b223-4544-8bf5-e08d9f16e462/Medication-safety-when-moving-between-the-community-and-hospital-resource-for-consumers.pdf.aspx) .
- Australian Commission on Safety and Quality in Health Care:
  - *Principles for safe and high-quality transitions of care* (https://www.safetyandquality.gov.au/our-work/transitions-care/principles-safe-and-high-quality-transitions-care)
  - *Transitions of care* (https://www.safetyandquality.gov.au/our-work/transitions-care) .
- Australian Government Department of Health, Disability and Ageing: *Guiding principles to achieve continuity in medication management* (https://www.health.gov.au/resources/collections/guiding-principles-to-achieve-continuity-in-medication-management-collection?language=en)
- Services Australia: *Refer or request Medicare services* (https://www.servicesaustralia.gov.au/refer-or-request-medicare-services?context=20)
- NDIS:
  - National disability insurance scheme (https://www.ndis.gov.au/) (NDIS) website
  - *Information for GPs and health professionals* (https://www.ndis.gov.au/applying-access-ndis/how-apply/information-gps-and-health-professionals)
- Office of the Australian Information Commissioner (OAIC): *Guide to securing personal information* (https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/handling-personal-information/guide-to-securing-personal-information)
- Avant: *Email communication with patients: privacy and patient safety* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/patient-communication-via-electronic-media-includi) .

# CG6 – Follow-up systems

## CG6 | **Follow-up systems**

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

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

The practice:

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

Members of the clinical team:

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

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

The practice:

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

## Why this is important

### Acting on correspondence

The information obtained from investigations can affect the choices that a patient, the GP, and other clinicians make about the patient's care. Clinically significant results need to be communicated quickly and appropriately so suitable action can be taken to reduce the likelihood of an adverse patient outcome.

### Managing patient results

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

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

## Meeting these criteria

### Managing clinical information received

The practice needs to have systems to support the timely review, management and documentation of clinical information received about its patients.

Responsibility for reviewing incoming clinical information needs to be clearly allocated, including arrangements for cover when the requesting GP is unavailable. Clinical information needs to be directed to the appropriate clinician without delay.

The practice could use systems that support members of the clinical team to:

- review incoming clinical information
- record review and actions taken (for example, through electronic notation, or signature/initialling where information is received in paper form)
- act on information where required
- incorporate clinical information into the patient health record.

The practice needs to have processes to:

- identify and follow up clinical information that has not been reviewed or actioned
- follow up investigations and results that have not been received.

Actions taken in response to clinical information, including any required follow-up, need to be documented in the patient health record.

These processes support the timely review and management of clinical information and reduce the risk of missed or delayed care.

### Recalling patients

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

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

### Supporting the clinical team in managing recalls

To help make sure that clinical information is appropriately reviewed, notated, acted on and documented in the patient's health record, the practice could:

- provide clinicians with remote access to the clinical software
- use secure electronic platforms to issue recalls.

### Recall process

The practice's recall process could include:

- a policy or other document outlining how patients are followed up regarding recalls, including:
    - the roles and responsibilities of different members of the practice team in relation to recalls
    - how results and recalls are communicated to patients (for example, phone calls or text messages)
    - the number, frequency and nature of the attempts the practice will make to contact the patient (for example, up to three telephone calls at different times of the day followed by an email, text or letter), based on the practice setting
    - what information different members of the practice team can convey and how to convey it (if reception staff are responsible for making an appointment for patients

with clinically significant results, they need to know the suitable type of language to use in such a conversation)
    - how to consistently document each contact with the patient in their patient health record
    - the actions the practice will take if the patient:
        - does not respond to recall notifications
        - is not notified of an outstanding result during a consultation regarding an unrelated matter.
- recommendations about what information needs to be recorded (for example, clinical discussions and outcomes) in patient health records
- how the practice ensures tests and results are reviewed and acted upon in a timely manner.

For patients who may be at risk, the practice needs to use discreet or privacy-sensitive recall methods, including verifying preferred and safest contact channels before sending reminders or follow-up messages. When follow-up is required but the patient cannot be contacted, the practice needs to document attempts in a way that does not escalate any known or suspected risks (for example, avoiding detailed messages if voicemail or SMS may be accessed by others). If follow up is required outside normal opening hours, the practice could provide general information about appropriate afterhours or crisis support services.

### Reminders

Reminders are used to help manage preventive care by noting in a patient's health record when the patient is due to return to the clinic for a routine check, for example, the practice could message patients who are:

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

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

The practice could:

- appoint a member of the practice team to be responsible for managing recalls and reminders
- have reminders automatically sent via the clinical information system
- have templates in the clinical information system for standard correspondence to automatically be sent via text or email when a reminder is triggered
- educate members of the practice team so they can tell patients about the reminder process
- publish the reminder process on the practice's website.

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

The practice needs to have a policy to describe its processes for high-risk results that are identified outside of normal opening hours. This includes advising its main diagnostic services of appropriate contact details to communicate high-risk results to the referring GP or their delegate outside of normal opening hours. This contact information includes the requesting GP's phone number or contact information for the after-hours and medical deputising service (AHMDS). The practice must ensure that whichever contact is listed can reliably undertake timely communication and action when a high-risk result is identified.

If the practice engages an AHMDS, it is recommended that the practice explains to deputising doctors what is expected of them if they receive urgent and life-threatening results for one of the practice's patients. The deputising doctor has a responsibility to:

- contact the patient outside normal opening hours if necessary
- inform the general practice the following day.

## Resources

- RACGP Information security in general practice:
    - *Patient communication via electronic media – including email* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/patient-communication-via-electronic-media-includi)
    - *Electronic sharing of information* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/electronic-sharing-of-information)
    - *Internet and email use* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/information-security-strategy/roles-and-responsibilities-of-your-practice-team/internet-and-email-use)
    - *Using email in general practice* (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Security/Using-email-in-general-practice-fact-sheet.pdf)

- Office of the Australian Information Commissioner (OAIC): *Guide to securing personal information* (https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/handling-personal-information/guide-to-securing-personal-information)
- Avant: *Email communication with patients: privacy and patient safety* (https://www.racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/prevention-and-risk-assessment-1/hidden-risks/patient-communication-via-electronic-media-includi) .

# CG7 – Managing clinical risks and incidents

## CG7 | **Managing clinical risks and incidents**

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

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

The practice:

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

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

The practice:

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

## Why this is important

### Mitigating clinical risk

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

### Managing patient safety incidents

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

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

It is good practice to share learnings from significant clinical incidents and near misses with the practice team. This could include learnings from positive experiences as well, such as when a system or process prevented a significant clinical incident.

Information about reporting incidents through the Australian open disclosure process can be found at PP7 – Open disclosure and complaints (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp7-open-disclosure-and-complaints-pp8-engaging-co) .

## Meeting these criteria

### Clinical risk register

The clinical risk register used to identify, monitor and document clinical risk could be a simple tool such as a table or spreadsheet.

After clinical risks have been identified, the practice could develop a risk matrix to assess and define the level of each identified risk (for example, low, moderate, high, extreme) based on a combination of:

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

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

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

### Managing significant clinical incidents

A sound approach to managing significant clinical incidents is to foster a 'just culture', which recognises significant clinical incidents as opportunities to understand the cause rather than immediately assign blame[26]. It enables members of the practice team to voice concerns and learn when something has gone wrong without fear of blame or retribution.

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

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

### AI-related incidents

If the practice uses artificial intelligence (AI) tools, its incident management process needs to include steps for identifying, documenting, and responding to AI-related issues.

Identifying AI-related issues must not rely solely on feedback or complaints.

Examples of AI-related incidents include:

- incorrect or misleading outputs
- system failures or outages
- breaches of privacy or data handling protocols
- clinician or patient concerns about safety or appropriateness
- unexpected changes in AI behaviour after updates to the software.

If AI tools are provided by third parties, the practice could coordinate with vendors to report issues and track corrective actions.

## Resources

- Medical Board of Australia: *Good medical practice: a code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx) .

# CG8 – Immunisations

## CG8 | Immunisations

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

**CG8.A Our practice team is encouraged to obtain immunisations recommended by the current edition of the *Australian immunisation handbook* based on their duties and immunisation status.**

The practice:

- records the natural immunity to vaccine-preventable diseases or immunisation status of practice team members if known (with their consent)
- offers staff members immunisations recommended in the *Australian immunisation handbook*, as appropriate to their duties.

### Why this is important

Encouraging members of the practice team to have up-to-date immunisations protects everyone at the practice from preventable infectious diseases. Having a structured process for recording and monitoring immunisation status assists the practice to adhere to state/territory legal requirements.

### Meeting these criteria

#### Practice team immunisation

Members of the practice team are encouraged to have immunisations as mandated in the local state or territory in order to:

- protect the team from serious illness due to vaccine-preventable infectious diseases
- prevent them transmitting such infections to patients.

The practice also needs to communicate, recommend and offer members of the practice team any additional recommended immunisations that are appropriate to their duties.

The specific immunisations for practice members will depend on the risk of infection, which is based on the practice's location and patient population and the duties of each member. The practice could conduct a risk assessment to identify the immunisations each practice team member needs to have based on their role. For more information, please see RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents), the *Australian immunisation handbook* (https://www.health.gov.au/resources/publications/the-australian-immunisation-handbook) and CG9 – Infection prevention and control, including reprocessing (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg9-infection-prevention-and-control-including-rep).

The practice could:

- offer the practice team testing of their natural immunity to vaccine-preventable disease or immunisation status
- provide members of the practice team the option to either receive required vaccinations at the practice or from their own GP or immunisation service
- encourage members of the practice team to receive the recommended or mandated immunisations as soon as practicable, ideally before starting or within the first few weeks of working at the practice, and in line with the local state or territory health department guidance.

If a member of the practice team cannot receive vaccines, this needs to be documented so that they can be allocated appropriate alternative duties if there is an outbreak of an infectious disease.

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

## Resources

- RACGP: *Immunisation resources* (https://www.racgp.org.au/clinical-resources/immunisation-resources)
- Department of Health, Disability and Aged Care:
  - *Australian immunisation handbook* (https://immunisationhandbook.health.gov.au/)
  - *Questions about vaccination* (https://www.health.gov.au/resources/publications/questions-about-vaccination)
  - *Immunisation resources* (https://www.health.gov.au/topics/immunisation/immunisation-resources)
- National Centre for Immunisation Research and Surveillance Australia: *Factsheets, FAQs and other resources* (https://ncirs.org.au/resources)
- Australian Academy of Science: *The science of immunisation* (https://www.science.org.au/education/immunisation-climate-change-genetic-modification/science-immunisation)

# CG9 – Infection prevention and control, including reprocessing

## CG9 | **Infection prevention and control, including reprocessing**

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

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

The practice:

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

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

The practice:

- has at least one member of the clinical team who has primary responsibility for infection control and the use of sterile equipment (their responsibilities are outlined in the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) )
- documents the responsibilities of the practice's infection prevention and control coordinator in their job description
- ensures all members of the practice team are aware of who is the practice's infection prevention and control coordinator and their responsibilities.

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

The practice:

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

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

The practice:

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

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

The practice:

- includes in the practice-specific infection control policy details of risk assessment for reprocessing reusable medical devices
- reprocesses reusable medical devices in accordance with the RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) or another model that meets the current Australian standard.

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

The practice:

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

## Why this is important

### Keeping patients and the practice team safe

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

### Current, evidence-based Australian guidelines and standards

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

- state-based infection prevention and control guidelines
- *Australian guidelines for the prevention and control of infection in healthcare (2019)* (https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-guidelines-prevention-and-control-infection-healthcare)
- *Standards Australia guidelines for organisations on preventing, controlling and managing infectious diseases* (https://www.standards.org.au/standards-catalogue/standard-details?designation=ISO-45006-2023)
- *The aged care infection prevention and control guide* (https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/infection-prevention-and-control-aged-care) .

### Accountability in infection prevention and control

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

### Risk-based approach for reprocessing reusable medical devices

By incorporating a risk-based approach and following the RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) or another model that meets the current Australian standard for reprocessing reusable medical devices, the practice can systematically assess and mitigate potential hazards in order to protect patients from infection risks.

## Meeting these criteria

### Infection prevention and control policy

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

- the role and position description responsible for infection control and sterilisation processes
- the appropriate use and application of standard and transmission-based precautions
- management of sharps injuries
- management of blood and body-substance spills
- hand hygiene
- environmental cleaning of clinical and non-clinical areas of the practice
- use of aseptic and sterile procedures
- if relevant, procedures for reprocessing (sterilising) instruments on site or off site, and a requirement to document evidence that this reprocessing is monitored and has been validated
- management of occupational exposures, including steps to prevent, identify, and manage exposure incidents
- waste management, including the safe storage and disposal of clinical waste and sharps
- where patients and the practice team can access PPE
- how and when members of the practice team are educated about the appropriate application, removal, and disposal of PPE
- the practice's process for managing potentially infected patients.

### Review of infection control policy

The practice's infection control policy is an operational document and needs to be reviewed every two years (see criterion F1.E (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/defining-and-planning-for-your-practice) ).

Regularly reviewing and updating the infection control policy in line with current, evidence-based Australian guidelines and standards such as the RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) will:

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

The practice could:

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

### Infection prevention and control coordinator

The responsibilities of the infection prevention and control (IPC) coordinator are outlined in the Risk assessment and planning (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/1-principles/risk-assessment-and-planning) section of the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) .

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

### Educating the practice team

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

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

Refer to section 1 (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/1-principles/overview) of the current edition of the RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) for guidance about recording the relevant education of members of the practice team and how to evaluate their competency in this area.

All members of the practice team need to:

- know who the practice's infection prevention and control coordinator is
- have easy access to PPE (for example, masks, gloves, gowns, protective eye wear and hand sanitiser)
- understand relevant infection risks and modes of transmission of common pathogens
- know when PPE is required and what type
- know who is responsible for ensuring that essential procedures are performed and be aware of the cleaning schedule
- know what to do if there is an accident or incident that risks exposure to infection
- know how to implement standard (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/5-levels-of-precaution/standard-precautions) and transmission-based (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/5-levels-of-precaution/transmission-based-precautions) precautions, spills management and environmental cleaning (see Managing the risks of cross-infection in the practice (#_Managing_the_risk) below)
- be trained in the key components of education infection prevention and control (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/1-principles/education-and-training), as outlined in the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents)
- know how to perform hand hygiene
- educate patients on infection prevention and control activities.

### Managing the risk of cross-infection in the practice

Refer to and follow the applicable sections of the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents), which recommend the use of standard (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/5-levels-of-precaution/standard-precautions) and transmission-based (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/5-levels-of-precaution/transmission-based-precautions) precautions under the following circumstances:

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

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

- conducting a risk assessment (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/1-principles/risk-assessment-and-planning) and identifying strategies to eliminate or minimise the risk of transmission, including the management of non-critical devices (for example, shared patient equipment)
- implementing effective triage (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/11-disease-surveillance-and-outbreak-response/practice-response-to-threats) and appointment scheduling
- implementing distancing techniques, such as:
    - spacing patients in the practice in line with relevant health authority guidance
    - isolating an infected patient in a separate space
    - offering telehealth appointments to patients experiencing respiratory illness (if clinically appropriate)
    - considering home visits for vulnerable patients such as the elderly.

### Educating patients about infection prevention and control

Patient education about appropriate precautionary techniques could involve:

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

### Isolation

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

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

### Risk-based approach for reprocessing reusable medical devices

The practice needs to develop its own risk assessment process for reprocessing reusable medical devices if these are used at the practice.

The RACGP's *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) provide advice regarding the reprocessing of reusable medical devices (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/10-reprocessing-reusable-medical-devices/overview), including a template (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/10-reprocessing-reusable-medical-devices/risk-assessment) for general practices to conduct risk-based assessment of reprocessing reusable medical devices.

### Clinical waste management

Refer to and follow Cleaning, laundry and waste management (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/9-cleaning-laundry-and-waste-management/overview) in the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents), which provide guidance on clinical waste management that could be used when developing an infection prevention and control policy.

### Keeping up to date

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

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

### For practices without physical premises

If the practice is performing a procedure at an external home, facility or site:

- it is still responsible for infection control (including, for example, adherence to the IPC Guidelines, sterility, adherence to aseptic technique)
- it is not responsible for the site per se, however it is responsible for any service the practice provides at the site
- it needs to demonstrate that it has oversight of the site's adherence to the site's infection prevention and control and cold chain management, insofar as they relate to the practice's visits to that site.

## Resources

- RACGP: *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents)
- Australian Commission on Safety and Quality in Health Care: *Infection prevention and control resources and links* (https://www.safetyandquality.gov.au/clinical-topics/infection-prevention-and-control)
- National Health and Medical Research Council: Preventing infection (https://www.nhmrc.gov.au/about-us/publications/staying-healthy-guidelines/preventing-infection)
- Australasian College for Infection Prevention and Control: IPC for consumers (https://www.acipc.org.au/resources/ipc-for-consumers/)
- Standards Australia: *Guidelines for organisations on preventing, controlling and managing infectious diseases* (https://www.standards.org.au/standards-catalogue/standard-details?designation=ISO-45006-2023)

# CG10 – Practice environment

## CG10 | **Practice environment**

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

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

The practice:

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

## Why this is important

### Practice environment

The practice environment needs to enable members of the practice team to perform their duties safely and effectively otherwise patient care can be compromised and patient safety may be put at risk.

'Practice environment' in this context refers to practices that operate either with or without fixed physical premises.

## Meeting these criteria

To facilitate safe patient care, practices need to ensure that their practice equipment and environment are regularly inspected, cleaned and maintained. The Australian Commission on Safety and Quality in Health Care has resources on environmental cleaning (https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/environmental-cleaning-and-infection-prevention-and-control-resources) that can help the practice (whether it has a physical premises or not) implement processes to maintain a clean and hygienic environment. The resources include information about risk assessments, environmental cleaning audits, staff training, cleaning schedules, and the cleaning of equipment and products. The RACGP's *IPC Guidelines* provide guidance on scheduled cleaning (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/9-cleaning-laundry-and-waste-management/scheduled-cleaning) .

### Privacy and patient dignity

The practice needs to protect the dignity of each patient by optimising both visual and auditory privacy. If a consultation or examination space itself is not able to guarantee complete audible privacy, reasonable steps need to be taken to maintain privacy during patient consultations.

The practice could consider having:

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

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

This is achieved by:

- having gowns or sheets to cover patients in each consultation space
- providing curtains around the examination couches.

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

- using sound-proofing tape around door frames and a draught-excluder at the base of doors, without compromising adequate heating, ventilation and air conditioning
- playing appropriate background music to mask conversations between members of the practice team and patients.

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

### Design and layout

The practice needs to maintain patient privacy during consultations regardless of where those consultations occur.

If the practice has physical premises, its layout will ideally provide reception staff with clear sight of the waiting areas, so that they can see and monitor waiting patients.

A practice operating in a physical building can maintain privacy by using dedicated consultation rooms. However, if an outreach service consulting in the community does not have a dedicated space, it may need to employ privacy strategies that suit the setting.

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

The practice could consider ways to keep its premises at a comfortable temperature.

### Ventilation and building design

Good ventilation contributes to the reduction of the risk of airborne transmission of microbial infections in enclosed spaces. The practice could:

- conduct a risk assessment to identify the best type of ventilation for the practice, based on factors such as practice layout, patient demographics and cost
- use natural airflow (for example, open windows, provided patient privacy is not compromised)
- engage a ventilation engineer or occupational hygienist to embed good ventilation into the building design
- employ air cleaning by filtration (for example, by using a properly installed HEPA filter)
- use other air-cleaning and disinfection technologies[27].

### Privacy when providing consultations by telehealth

Telephone and video consultations also require physical, audio and visual privacy. Refer to the RACGP's *Guide to providing telephone and video consultations in general practice* (https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/guide-to-providing-telephone-and-video-consultatio/introduction) for guidance on how to maintain privacy and confidentiality when providing telephone and video consultations.

### Location of toilets and hand-cleaning facilities

Ideally, a practice has separate toilets for the practice team and for patients. If this is not possible, it may be possible to ensure access to toilets that are very close by (which may be possible, if, for example, the practice is in a shopping centre).

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

As per the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/table-of-contents) :

- the use of alcohol-based handrub is now recommended for routine hand hygiene for dry, visibly clean hands
- soap and water are required to be made available after using the toilet, before handling or eating food/drink, and when norovirus or Clostridioides difficile is present or suspected.

### Maintaining a clean practice environment

Practices need to have a cleaning policy that identifies:

- responsibilities related to the cleaning of the practice
- work health and safety issues
- procedures for routine scheduled cleaning, unscheduled cleaning, and monitoring of the effectiveness of the cleaning.

Refer to section 9 of the *Infection prevention and control guidelines* (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/9-cleaning-laundry-and-waste-management/policy-and-responsibilities) for details on what else is required in a practice cleaning policy.

### For practices without physical premises

If the practice does not have a physical premises where consultations occur:

- the practice needs to demonstrate how auditory and visual privacy is protected during consultations (for example, via mobile privacy screens, in-home consultation protocols, telehealth privacy workflows)
- a physical waiting area, reception area and patient toilets are not required, however, the practice needs to ensure that:
    - members of the practice team have access to hand hygiene facilities
    - clinical pathways requiring access to toilets (such as urine collection) are appropriately enabled. This could be achieved by referral to pathology or use of onsite facilities.

## Resources

- RACGP: General practice toolkit: Layout (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/general-practice-business-toolkit/general-practice-tool-kit/module-2/layout)
- RACGP: *Guide to providing telephone and video consultations in general practice* (https://www.racgp.org.au/FSDEDEV/media/documents/Clinical Resources/Guidelines/Guide-to-providing-telephone-and-video-consultations.pdf)

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

- RACGP: Infection prevention and control guidelines (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/12-planning-a-practice-design-fit-out-equipment-an/building-design-and-fit-out)
- AusHFG (Australasian health facility guideline) part D: *Infection prevention and control* (https://healthfacilityguidelines.com.au/part/part-d-infection-prevention-and-control-0)

# CG11 – Practice equipment

## CG11 | **Practice equipment**

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

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

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

↓ Required practice equipment:

↓ Doctor's bag:

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

The practice:

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

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

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

The practice:

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

## Why this is important

### Practice equipment

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

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

### Educating the clinical team

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

### Storage of medicines, samples and medical consumables

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

## Meeting these criteria

### Maintaining clinical equipment

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

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

The practice could:

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

When maintaining equipment in the practice, consider infection prevention and control (see CG9 – Infection prevention and control, including reprocessing (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg9-infection-prevention-and-control-including-rep) ). This could include adopting clearly defined actions such as:

- scheduling maintenance outside of patient visiting hours
- performing deep cleaning before and after maintenance
- using barriers to isolate the area where maintenance is being conducted.

### Range of equipment

The practice could:

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

### Height adjustable beds

Every practice with a physical premises needs to have a height adjustable bed, to ensure patient and staff safety. It is recommended that the bed be turned off when not in use to prevent user safety incidents.

Follow these guidelines when purchasing height-adjustable beds:

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

### Patient demographics

The practice could consider whether it is appropriate to have equipment that accommodates patients with particular needs, such as:

- bariatric beds, seats and scales
- mobility aids (for example, grab bars, raised seats).

### Storing a doctor's bag

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

The practice must comply with legislation relating to the acquisition, use, storage, and disposal of Schedule 4 and Schedule 8 medicines.

### Pharmaceutical Benefits Scheme emergency drugs for a doctor's bag

Certain medications are provided to prescribers without charge through the Pharmaceutical Benefits Scheme (PBS). A list of these medications to include in the doctor's bag is available at the PBS website (http://www.pbs.gov.au/browse/doctorsbag) . The emergency drug (doctor's bag) order form is available at the Services Australia (http://www.humanservices.gov.au/health-professionals/services/medicare/ordering-pbs-and-rpbs-prescription-forms) website.

### Emergency drugs for children

The Royal Children's Hospital Melbourne has developed an emergency medication and resuscitation resources (https://www.rch.org.au/clinicalguide/guideline_index/Emergency_Medications/) page and emergency drug dose calculator (https://www.rch.org.au/genmed/clinical_resources/Emergency_drug_dose_calculator/) that may be used when considering which items to include in a doctor's bag.

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

Determining the education needed for each member of the clinical team will depend upon:

- the specific equipment at the practice
- if the piece of equipment is relevant to the team member's role
- the education and training the team member has already completed.

Each member of the clinical team needs to identify their existing competence and training needs for each type of clinical equipment.

If the practice acquires a new piece or type of clinical equipment, it may need to provide relevant education.

All education and training need to be documented.

The practice could:

- include relevant education in the induction process
- facilitate ongoing education as needed
- keep a calendar, showing when refresher training is required.

### Spirometer

The practice needs to have timely access to a spirometer. The practice could:

- maintain an on-site spirometer
- refer patients to a local provider that can offer timely testing.

Practices are strongly encouraged to have an on-site spirometer to support comprehensive and accessible respiratory care.

### Storage and disposal of medicines

To ensure patients' safe use of medicines, vaccines and other healthcare products, the practice needs to:

- store these products appropriately and securely,
- dispose of them in accordance with relevant local and federal laws
- do not use or distribute them after their expiry dates.

The practice could appoint a designated person to have primary responsibility for the proper storage, security and disposal of medicines, vaccines and other healthcare products.

To support safe disposal that is in accordance with relevant legislation and local arrangements, the practice could work with local pharmacies to facilitate the return and appropriate disposal of unwanted medicines.

Practices need to comply with all legislative requirements relating to the acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines.

#### Consumables available at the practice

To effectively manage medical consumables, the practice could:

- schedule audits of expiry dates of medical consumables
- appoint a designated person to have primary responsibility for the management of medical consumables
- place consumables such as hand hygiene products so that those with an earlier expiry date are used first.

#### For practices without physical premises

Practices need to demonstrate that either they have all required equipment listed in the criterion, or that the sites they work from have the equipment required to provide safe quality care for the patients being visited at those locations.

If the practice provides care only at external sites that maintain their own equipment, the practice may rely on the equipment at those sites, if there is documented evidence that the equipment is present, accessible, and maintained.

Practices that own or use a mobile clinic requiring examinations need to maintain their own equipment accordingly.

## Resources

- Pharmaceutical benefit scheme (PBS) website (http://www.pbs.gov.au/browse/doctorsbag)
- Emergency drug (doctor's bag) order form: Services Australia (http://www.humanservices.gov.au/health-professionals/services/medicare/ordering-pbs-and-rpbs-prescription-forms)
- Australian Commission on Safety and Quality in Health Care:
    - National Mixed-Case Lettering List (https://www.safetyandquality.gov.au/our-work/medicines-safety-and-quality/safer-naming-and-labelling-medicines/national-mixed-case-lettering-list)
    - Principles for the safe selection and storage of medicines: Guidance on the principles and survey tool (https://www.safetyandquality.gov.au/publications-and-resources/resource-library/principles-safe-selection-and-storage-medicines-guidance-principles-and-survey-tool)
- Royal Children's Hospital Melbourne:
    - emergency medication and resuscitation resources (https://www.rch.org.au/clinicalguide/guideline_index/Emergency_Medications/)
    - emergency drug dose calculator (https://www.rch.org.au/genmed/clinical_resources/Emergency_drug_dose_calculator/) .

The practice could refer to the following resources related to spirometry use:

- Australian Commission on Safety and Quality in Health Care:
- Online training and resources: *Chronic COPD clinical care standard* (https://www.safetyandquality.gov.au/standards/clinical-care-standards/chronic-obstructive-pulmonary-disease-clinical-care-standard) *Australian Asthma Handbook* (https://www.asthmahandbook.org.au/)
- *Lung Foundation Australia* (https://lungfoundation.com.au/) .

# CG12 – Maintaining vaccine potency

## CG12 | **Maintaining vaccine potency**

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

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

The practice:

- maintains a cold chain management policy and procedure that is:
  - based on the current edition of the *National vaccine storage guidelines: Strive for 5* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en)
  - communicated to patients and members of the practice team
  - implemented by all members of the practice team
- has a record of all monitoring of vaccine refrigerators, including the temperature.

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

The practice:

- has a member of the practice with primary responsibility for cold chain management, which includes ensuring the practice complies with the current edition of the *National vaccine storage guidelines: Strive for 5* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en)
- ensures the responsible member of the practice team has had appropriate training in cold chain management and understands their role
- informs members of the practice team who is responsible for cold chain management
- has a process to delegate cold chain management when the member of the practice team with primary responsibility is unavailable.

## Why this is important

### Vaccine potency

The success of any vaccination program depends on the potency of vaccines when they are administered to patients. To maintain their potency, vaccines need to be transported and stored within temperature ranges recommended in the *National vaccine storage guidelines: Strive for 5* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en) .

The practice maintains vaccine potency by having a current cold chain management policy and a person responsible for cold chain management.

## Meeting these criteria

### Maintaining a cold chain management policy

The practice's cold chain policy needs to be based on the current edition of the *National vaccine storage guidelines: Strive for 5* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en) . To keep their cold chain policy current, the practice could:

- subscribe to updates from federal and state or territory health departments about cold chain requirements and public health alerts
- conduct regular quality improvement activities related to cold chain management.

### Review of cold chain management policy

The practice's cold chain management policy is an operational document and needs to be reviewed for currency every two years (see criterion F1.E (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/defining-and-planning-for-your-practice) ).

### Nominating a person with primary responsibility

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

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

The responsible person could:

- discuss the cold chain management policy in team meetings
- create a template to make monitoring and recording of refrigerator temperatures easier
- create a roster for monitoring cold chain compliance
- include education about cold chain management in induction and ongoing training for the practice team
- conduct an audit of vaccine storage to determine whether it complies with the *National vaccine storage guidelines: Strive for 5* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en) .

### Communicating cold chain processes to patients

Maintaining patient confidence in the safety and quality of vaccine handling is an important aspect of immunisation care. While the practice's cold chain policy is a documented operational procedure, communication with patients about vaccine storage and handling needs to be transparent and reassuring, rather than procedural or technical.

The practice could:

- display a short statement (for example, in the waiting room, in treatment rooms, on the practice website) that the practice adheres to national guidelines relating to cold chain management
- inform patients, if they ask, that vaccines are stored and managed according to best practice cold chain procedures
- include a brief explanation in patient information materials (for example, immunisation brochures and consent forms) that vaccines are stored under strict temperature-controlled conditions to ensure their safety and effectiveness.

## Resources

- Department of Health and Aged Care:
  - *National Vaccine Storage Guidelines 'Strive for 5'* (https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5?language=en)
  - *National Vaccine Storage Guidelines resource collection* (https://www.health.gov.au/resources/collections/national-vaccine-storage-guidelines-resource-collection)
- Primary Health Networks (https://www.health.gov.au/our-work/phn) (PHNs) provide localised cold chain management advice.

# CG13 – Research

## CG13 | **Research**

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

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

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

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

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

The practice:

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

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

The practice:

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

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

The practice:

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

## Why this is important

Research conducted in general practice settings, and by GPs, is crucial for the building of an evidence base that improves general practice settings and the care given to their patients.

Responsible research requires good governance and management, compliance with relevant legislation and the procurement of ethics approval (where applicable).

Research is often done in conjunction with a research institution who has responsibility for ensuring the research meets the legislative and other obligations, however, if the practice conducts its own research, it will need to comply with all relevant legislation and other obligations.

### Legislation and codes of conduct

Practices that conduct human research need to adhere to various codes of conduct and fulfil responsibilities under federal legislation. These include:

- the *Australian code for the responsible conduct of research* (https://www.nhmrc.gov.au/about-us/publications/australian-code-responsible-conduct-research-2018) (the Code), which was developed by the National Health and Medical Research Council (NHMRC). It promotes integrity of research and provides guidance about conducting responsible research.
- the *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research* (https://aiatsis.gov.au/research/ethical-research/code-ethics) (the AIATSIS Code), which was developed by the Australian Institute of Aboriginal and Torres Strait Islander Studies. If the patient sample includes Aboriginal and Torres Strait Islander peoples, the practice could refer to this code.

### Privacy

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

### Human research ethics committees

Human research ethics committees (HRECs) review research proposals that involve human participants in order to ensure that the proposed research is ethically acceptable and in accordance with relevant standards and guidelines. The HREC's assessment of the research proposal includes a review of the project's patient consent process.

There are many HRECs operating in institutions and organisations in Australia. A list of HRECs registered with the NHMRC is available here (https://www.nhmrc.gov.au/research-policy/ethics/human-research-ethics-committees).

Information about the RACGP's National Research and Evaluation Ethics Committee (NREEC) can be found at the RACGP website (https://www.racgp.org.au/the-racgp/governance/committees/national-committees/ethics-committee).

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

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

## Meeting these criteria

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

*The concept of research is broad and includes the creation of new knowledge and/or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies, inventions and understandings. This could include synthesis and analysis of previous research to the extent that it is new and creative*[28].

The practice team needs to be familiar with the NHMRC's Code when participating in research.

The practice may choose to develop a policy in collaboration with the research institution leading the research (if applicable) that is based on the practice's involvement in the research. The policy could include information about:

- selecting a specific group of patients for research (for example, patients with depression)
- the process and documentation of ethics approval
- any specific rooms needed to conduct the research
- data storage, record keeping and compliance with privacy laws
- relevant training for the practice team

- information provided to patients.

### Research indemnity and risk

Research activities may pose potential risks for the practice and its patients. Therefore, the practice needs to understand those risks and confirm that the appropriate indemnity is in place, based on the research project's level of risk.

The NHMRC *National statement on ethical conduct in human research 2025* (https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2025) (National Statement) gauges research by the amount of risk it may pose to people involved in the research. The NHMRC explains levels of risk in research as follows:

*Low risk research describes research, including some types of clinical trials, in which the only foreseeable risk is no greater than discomfort. Research in which the risk for participants or others is greater than discomfort is not low risk research. Research in this category carries risk of harm and is therefore considered higher risk research that requires review by a Human Research Ethics Committee (HREC).*

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

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

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

If the research is not a clinical trial, the practice needs to determine whether it needs extra insurance to indemnify the practice for research. To do this, it is recommended that the practice discusses all potential risks with the practice team and the lead external researcher, as well as its insurance broker or indemnity insurer.

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

### Formal data sharing arrangements

If the practice shares de-identified data for research or other purposes, the practice needs to enter a formal data-sharing agreement or contract with all external parties that intend to use the practice's data. The RACGP's *Three key principles for the secondary use of general practice data by third parties* (https://www.racgp.org.au/getmedia/771e3ed7-b50a-4a2b-a609-bb62ce77e394/Three-key-principles-for-the-secondary-use-of-general-practice-data-by-third-parties.pdf.aspx#page=4) provides guidance on what to consider when developing a data-sharing agreement. The practice could also obtain advice from a lawyer or Medical Defence Organisation (MDO) on what to include in the agreement.

### Data management best practice

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

- complying with the *Privacy Act 1988* (https://www.oaic.gov.au/privacy/privacy-legislation/the-privacy-act) and the *Australian Privacy Principles* (https://www.oaic.gov.au/privacy/australian-privacy-principles)
- acting ethically (https://www.racgp.org.au/getmedia/771e3ed7-b50a-4a2b-a609-bb62ce77e394/Three-key-principles-for-the-secondary-use-of-general-practice-data-by-third-parties.pdf.aspx#page=3) with regard to general practice data
- using the data only for the agreed purposes
- ensuring the security of all data
- special consideration of data linkage (such as bringing together data related to one individual, family, place or event from disparate sources), including obtaining informed consent from the patient/s involved.

### Informing patients of secondary use of data

The practice needs to provide patients with information about the use of their health data by third party organisations, and provide them with opportunities to opt out of providing their data for secondary use.

Ensuring information transparency includes having processes or protocols to inform patients about the privacy and ethical principles implemented when data collected in the practice. To inform patients about how their data is collected and used, as well as how to opt out of data collection for research purposes, the practice could:

- publish information on its website, social media channels and newsletters
- explain on the patient registration form how their health information will be collected and shared, and how they can refuse consent to participate in research or opt out of data collection for research purposes
- display the information on posters throughout the practice.

In line with criteria at PP2 – Communication (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp2-communications) , the practice needs to provide information so that it is understood by the practice's patients.

### Sharing de-identified data

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

- separate identifiable demographic data from clinical data prior to linkage
- make sure that:
    - people involved in the linking of identifiable data do not have access to the clinical data
    - people with access to clinical data are not involved in linking identifiable data.

## Resources

- RACGP:
    - Australian General Practice Research (https://www.racgp.org.au/education/research-grants-and-programs/research-grants-and-programs)
    - RACGP National Research and Evaluation Ethics Committee (NREEC) (https://www.racgp.org.au/the-racgp/governance/committees/national-committees/ethics-committee)
    - *Three key principles for the secondary use of general practice data by third parties* (https://www.racgp.org.au/getmedia/771e3ed7-b50a-4a2b-a609-bb62ce77e394/Three-key-principles-for-the-secondary-use-of-general-practice-data-by-third-parties.pdf.aspx#page=4)
- National Health and Medical Research Council (NHMRC):
    - *Australian code for the responsible conduct of research* (https://www.nhmrc.gov.au/about-us/publications/australian-code-responsible-conduct-research-2018)
    - *Human Research Ethics Committees* (https://www.nhmrc.gov.au/research-policy/ethics/human-research-ethics-committees)
    - *National statement on ethical conduct in human research 2025* (https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2025#block-views-block-file-attachments-content-block-1)
- Australian Institute of Aboriginal and Torres Strait Islander Studies: *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research* (https://aiatsis.gov.au/research/ethical-research/code-ethics)
- Office of the Australian Information Commissioner (OAIC):
    - *Privacy Act 1988* (https://www.oaic.gov.au/privacy/privacy-legislation/the-privacy-act)
    - *Australian Privacy Principles* (https://www.oaic.gov.au/privacy/australian-privacy-principles)

# *Patient participation standard*

# About this standard

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

# PP1 – Information about your practice

## PP1 | Information about the practice

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

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

The practice:

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

### Why this is important

> **Accessing information**
>
> Consumers need to be able to access the information they require about the practice, including the range and cost of services provided. This information needs to be accessible, correct and current, in order to promote healthcare that meets expected standards of quality and safety.

### Meeting these criteria

The information that consumers need, and how that information is presented, will differ between practices, based on patient population. Therefore, practices may determine what consumers need by engaging with them and asking about their preferences. The practice could do this by:

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

The practice can provide the information, or access to it, in different formats, including:

- the practice's website
- QR codes that link to the practice's website
- posts on social media
- printed sheets
- if the practice serves specific ethnic communities, written information in the languages most used by these consumers
- listing the languages spoken by members of the practice team (for example, on a sheet, on the practice website)

- pictures and simple-language versions to help consumers who would otherwise be unable to read or understand the information.

### Appointment types

The information the practice provides to consumers about appointment types needs to detail whether in-person and/or telehealth appointments are available and under what circumstances. The practice could inform consumers about the appointment-booking process and the benefits of the different appointment types and durations before their appointment.

### Billing principles

The practice could:

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

For further information about accessing other services for patients with healthcare needs beyond the scope of service, see CG5 – Transitions of care (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg5-transitions-of-care) and PP2 – Communications (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/pp2-communications) .

# PP2 – Communications

## PP2 | **Communications**

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

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

The practice:

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

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

The practice:

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

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

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

### Why this is important

Effective communication between members of the practice team and consumers contributes to building effective partnerships and delivering safe quality care.

Consumers have the right to:

- receive information about the practice's services, waiting times and costs
- understand the information and recommendations they receive, including risks of different tests and treatments
- make informed decisions about their health, treatments, referrals and procedures[29].

Effective communication with consumers allows consumers to:

- contact the practice during opening hours
- make appointments and receive other information in a timely fashion
- understand what to do in the event of a medical emergency
- have urgent enquiries dealt with in a timely and medically appropriate way.

## Meeting these criteria

### Communicating in the event of an emergency

All communication systems at the practice need to direct consumers to call 000 in case of an emergency. When receiving calls, reception staff must first ask if the matter is an emergency and never put the caller on hold before asking this. If it is an emergency, the reception staff must direct the caller to contact 000.

### Communicating by electronic means

For information about communicating with consumers electronically, see F8 – Information security (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f8-information-security)

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

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

### Communicating with patients with specific communication requirements

If the practice has patients who need to use other forms of communication (for example, they are from culturally and linguistically diverse backgrounds or have a specific communication requirement), the practice could use services such as:

- the National Relay Service (http://www.relayservice.com.au) (NRS) and Auslan signbank (https://auslan.org.au/) for patients who are deaf or have hearing or speech impairment
- the Translation and Interpreter Service (http://www.tisnational.gov.au) (TIS National) for patients who do not speak English or have limited English proficiency.

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

Appropriately qualified medical interpreters are the preferred choice for patients who do not speak English or have limited English fluency. The TIS National Service is free of charge for all private medical practitioners providing services that are eligible for Medicare rebates. Reception staff are also able to use this service when arranging appointments or providing results to patients.

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

Consider the needs of patients who require assistance with communication due to hearing, speech or visual disability, or cognitive requirements. Some people use what is referred to as Augmentative and Alternative Communication (AAC) when they use a form of communication other than speech[30]. For example, they might use:

- body movement or gestures
- sign language
- a computer or other device
- communication books or other printed material[30].

When communicating with a patient with a communication impairment, it is good practice to:

- ask the patient about the best way to communicate, if unsure
- speak directly to the patient, even if they are accompanied by a third party acting as a support person, advocate, or interpreter
- confirm the reason for their visit, their symptoms and other issues, and confirm that the patient has understood the information given to them

- use appropriate apps (for example, those that allow voice activation translation or enable non-speaking people to communicate)
- provide information in different formats, such as audio and Easy Read[31].

Further information about how the practice can communicate with patients with a communication impairment is available at Communication Rights Australia (http://www.communicationrights.org.au) and Novita Children's Services (http://www.novita.org.au) .

The practice could support trauma-informed communication by:

- avoiding asking patients about personal matters in public areas
- providing reception staff with discreet prompts or procedures to move conversations to a private space when needed.

These approaches can help protect patient privacy and reduce distress during interactions with the practice.

### Patient refusal of interpreter

There are potential risks when treating a patient who declines to use an interpreter, notably the possibility of a detrimental outcome if specific information is not communicated correctly to the patient or if the patient does not understand the information.

The practice could mitigate any associated risks if an interpreter is available, by:

- offering the interpretation services to the patient
- recording in the patient's health record, that the patient declined an interpreter.

### Translated and plain English resources

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

### Using digital communications and social media to enhance patient care

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

To raise patient awareness of the practice's policies relating to the use of digital communications and social media, the practice could:

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

## Resources

- Brisbane South PHN (https://bsphn.org.au/community-health/commissioning/multicultural-health) and North Western Melbourne PHN (https://nwmphn.org.au/wp-content/uploads/2020/12/Working-with-patients-when-there-are-language-barriers-A-guide.pdf) have education resources about communicating across cultures in primary healthcare.

# PP3 – Respectful, culturally appropriate and culturally safe care

## PP3 | **Respectful, culturally appropriate and culturally safe care**

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

PP3.A The practice recognises and respects the rights, diversity and individuality of all patients.

The practice:

- considers and respects patients' rights
- informs patients of their rights and responsibilities
- facilitates culturally safe care for Aboriginal and Torres Strait Islander patients
- recognises diversity within the patient population and provides respectful and person-centred care.

## Why this is important

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

### Patients' rights and responsibilities

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

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

### Understanding what culturally safe care is

When referring to the experiences of Aboriginal and Torres Strait Islander peoples, culturally safe practice is defined as the:

> *ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism*[32].

For Aboriginal and Torres Strait Islander peoples, clinical and cultural safety are inextricably linked. This means cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities as recipients of healthcare.

Culturally safe policies aim to create:

> *an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need, where there is shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening*[33].

Members of the practice team who are Ahpra registered have an obligation as a registered professional to promote culturally safe care that is free from bias and racism. To support them to do so, the practice could:

- acknowledge the factors that impact individual and community health, including colonisation, systemic racism, as well as social, cultural, behavioural and economic factors

- encourage the practice team to acknowledge and address their own racism and biases, assumptions, stereotypes and prejudices
- recognise the importance of shared decision-making, partnership and collaboration in healthcare that is self-determined by individuals, families and communities
- foster a safe working environment by providing leadership that supports the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues[32].

## Meeting these criteria

### Culturally safe care

To provide the most appropriate care that is culturally safe, the practice team needs to understand the demographics and cultural backgrounds of the practice's patient population. This could be achieved by using a digital data extraction tool or census data to identify cultural groups in the patient population.

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

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

### Trauma informed, culturally safe communication

The practice team could support safe and respectful communication by:

- using culturally safe, non-judgemental and trauma-informed communication practices, recognising that experiences of family, domestic and sexual violence (FDSV) may be shaped by cultural identity, intergenerational trauma, disability, gender diversity or migration experiences
- recognising that some patients may face cultural, linguistic, disability-related or historical barriers to raising safety concerns, and fostering communication environments that feel safe
- recognising that trauma can influence how some patients express distress, and that trauma-informed training can help members of the practice team to understand these responses and communicate in ways that support safety for patients and the practice team
- respecting a patient's choice not to proceed.

### Respectful and culturally appropriate care

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

- have a policy clearly setting out patients' rights and responsibilities
- educate the practice team about how to deliver care that is compassionate, person-centred and respects patients' rights
- have an anti-discrimination policy that complies with relevant discrimination laws
- have a process where members of the clinical team respectfully ask patients about their cultural identity and beliefs and record them in the patient's health record
- if possible and if culturally appropriate for the patient population, have separate sections in the waiting room for men and women
- hold meetings for the clinical team to discuss and identify the unique health needs of lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) patients and those of other gender and sexual diversities
- display LGBTIQA+ symbols and/or flags
- have gender neutral toilets
- display the practice's cultural protocols in the reception area, waiting areas and consultation rooms
- provide resources appropriate to the health literacy and cultural needs of patients

- consider having a patient representative or advocate who is invited to participate in meetings with partners and managers when changes need to occur in the practice, and when new policies or initiatives are being developed.

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

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

For information about patient rights and responsibilities, including posters that can be used by the practice to make patients aware of these, refer to the RACGP's *General Practice Patient Charter* (https://www.racgp.org.au/running-a-practice/practice-standards/general-practice-patient-charter), which draws on the *Australian Charter of Healthcare Rights* (https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights).

## Resources

- The RACGP Aboriginal and Torres Strait Islander Health (https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health) faculty has resources and guides (https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health/guides) to support practices. This includes *Cultural awareness and cultural safety training (https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health/education-and-training/cpd-activities-for-gps-and-health-professionals/cultural-awareness-and-cultural-safety-training)* and an *Introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives (https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/An-introduction-to-Aboriginal-and-Torres-Strait-Islander-health-cultural-protocols-and-perspectives.pdf)* which provides a guide to appropriate and respectful behaviour when interacting with Aboriginal and Torres Strait Islander Peoples as well as good practice tables (https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health/guides/naccho-racgp-good-practice-tables) which support culturally responsive healthcare.
- The RACGP's *Aboriginal and Torres Strait Islander Cultural and Health Training Framework (https://www.racgp.org.au/cultural-and-health-training-framework/home)* includes guiding principles and ways of working with Aboriginal and Torres Strait Islander Peoples.
- The RACGP's *General Practice Patient Charter (https://www.racgp.org.au/running-a-practice/practice-standards/general-practice-patient-charter)* and guide for implementation (https://www.racgp.org.au/FSDEDEV/media/documents/Running a practice/Practice standards/Implementation-Guide-General-Practice-Patient-Charter.pdf) supports the adoption of the principle of a person-centred health system.
- PHNs can support general practices to provide culturally safe and appropriate care, including training. Some examples include those developed by Hunter New England and Central Coast PHN (https://thephn.com.au/what-we-do/first-nations-health) and Brisbane South PHN (https://bsphn.org.au/education/discoverphn/discoverphn-learning-portal).
- Free online learning and resources at NACCHO (https://learn.naccho.org.au/) and Evolve Communities (https://www.evolves.com.au/free-resources/).

# PP4 – Informed consent

## PP4 | Informed consent

**Consumer expectation statement:**

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

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

The practice:

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

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

The practice:

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

## Why this is important

Patients have a right to make informed decisions about their health and the healthcare they receive. A patient can only make an informed decision about a proposed treatment, procedure or care plan when they have been provided with sufficient information to do so.

To comply with privacy laws and to protect the patient's right to confidentiality, the practice must ensure that the patient's consent is obtained before a third party is introduced during a consultation, procedures or treatment.

## Meeting these criteria

**What constitutes valid informed consent?**

Valid patient consent is:

- freely given without duress
- given by someone who is legally capable (competent) of consenting
- specific to the intervention or procedure to be performed[34].

If a patient does not have the legal capacity to provide consent (for example, due to a cognitive impairment), a parent, legally appointed guardian or substitute decision-maker may provide consent on the patient's behalf. In such cases, the clinician needs to:

- identify the relevant person in the patient's health record
- comply with the Australian Privacy Principles (APPs) in the *Privacy Act 1988* and other relevant state or territory law. See F9 – Confidentiality and privacy of health and other information (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f9-confidentiality-and-privacy-of-health-and-other) .

### Inferred or express consent

Consent may be:

- express – when a patient signs or clearly articulates their agreement
- inferred (or 'implied') – where it is reasonable to infer the patient has consented. For example, when a patient cooperates with the healthcare professional's treatment or routine procedure, such as taking medication given, extending an arm for a blood sample, or attending a follow-up appointment to receive information or advice about the management of a condition[34].

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

Documentation of expressed consent needs to include:

- an outline of the information provided to the patient
- the nature of the discussion (which needs to include a discussion of risks, potential harms and side effects)
- the patient's response.

Information about the cost of treatment or alternatives can be found in PP1 – Information about the practice (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/patient-participation-standard/criterion-pp-1-information-about-your-practice) . CG3 – Facilitating complete patient health records (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg3-facilitating-complete-patient-health-records) discusses shared decision-making information and resources.

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

Third parties can be interpreters, registrars, chaperones/observers, or medical, allied health or nursing students on placement.

The patient needs to be asked before the consultation commences if they consent to having a third-party present during the consultation. This needs to occur prior to the consultation. It is not acceptable for consent to be sought for the first time in the consulting room, because some patients may feel uncomfortable refusing consent in the presence of the third party, and therefore feel pressured into agreeing.

The practice could place signs in the waiting room when medical or nursing students are at the practice and observing consultations.

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

As it may be necessary to later identify third parties who were present during a consultation, details of the third party need to be recorded.  Their role could be recorded (for example, nurse, medical student) or their initials.

The practice could:

- maintain a policy addressing the requirements for having a third-party present during a consultation
- include information about the third-party policy in its induction manual.

# PP5 – Accessibility of services

## PP5 | **Accessibility of services**

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

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

The practice:

- has infrastructure and processes that enable patients with disabilities or impairment to access its services.

### Why this is important

To comply with the *Disability Discrimination Act 1992 (https://www.legislation.gov.au/C2004A04426/2018-04-12/text)* (amended 2018), the practice needs to ensure that people with disability or impairment can access the practice and its services in ways that maintain their dignity.

### Meeting these criteria

#### Access is important

To ensure that all patients, including those with disability or impairment, can physically access the practice's premises and services easily and safely, the practice could:

- provide pathways, hallways, consultation areas and toilets that are wheelchair-friendly
- have a wheelchair that patients can use while they are at the practice
- install appropriate ramps and railings
- use pictures, signs and other sources of information to help patients who have intellectual disability or vision impairment, or are not fluent in English
- have a transport service for patients who cannot otherwise get to the practice
- facilitate access for patients who do not use or have access to digital health technologies, so they are not disadvantaged.

To improve its non-physical access for patients with disability or impairment, the practice could:

- provide options that optimise comfort and safety and minimise distress (for example, adjust environmental, sensory and other elements of the practice setting)
- use existing and emerging technology to give patients access to telehealth consultations
- offer home visits, where appropriate.

To support patients who may have safety concerns when attending, the practice could:

- offering flexible appointment types, such as telehealth or home visits
- alternative contact arrangements
- quieter appointment times where appropriate
- alternative entry arrangements to the practice.

#### Accessible parking

Where possible, inform consumers of the nearest disability parking to the practice.

# PP6 – Health promotion and preventive care

## PP6 | Health promotion and preventive care

**Consumer expectation statement:**

- I expect that this practice provides me with preventive health information and information on all issues relevant to my healthcare.
- I expect that this practice provides me with information about my health, treatment and care choices in a way I can understand to make decisions that are right for me.

**PP6.A The practice provides patients with relevant information about preventive care, illness prevention and health promotion.**

The practice:

- provides information about preventive care, illness prevention and health promotion.
- Members of the clinical team:
  document in the patient's health record discussions or activities relating to preventive care, illness prevention and health promotion.

**PP6.B The practice shares information with patients about environmental issues relevant to the healthcare they receive.**

## Why this is important

### Health promotion, illness prevention and preventive care

Many health conditions can be avoided, or their impact reduced, by creating illness prevention and preventive care systems and environments[35]. Health promotion enables people to increase their control over, and improve, their health[36].

### Sharing information about environmental issues with patients

By sharing information about environmental factors that can influence health, general practices can support patients in making informed decisions to improve their health outcomes and benefit the environment.

## Meeting these criteria

### Providing patients with relevant information about preventive care, illness prevention and health promotion

To provide patients with relevant information about health promotion, illness prevention and preventive care, the practice could:

- review the practice's patient population and their healthcare needs, and provide relevant specific information
- in practice information, include health promotion material (for example, about bowel screening, kidney health checks, diabetes and infectious diseases)
- provide a directory of local, applicable and accessible services and businesses that offer programs to help patients modify their lifestyle

- refer patients to reputable websites and platforms that can help patients find health care services
- have culturally specific health information (for example, about Aboriginal and Torres Strait Islander health) in the practice
- provide information about how to seek help for family, domestic and sexual violence, such as QR codes or links to recognised national or local support services. This information could also be provided in discreet locations such as toilet areas.

### Health literacy

Health literacy has an important role in enabling effective partnerships between practitioners and patients. For partnerships to work, everyone involved needs to be able to give, receive, interpret and act on information such as treatment options and plans.

Assessing the health literacy of patients and then providing them with appropriate information based on that assessment can help to increase a patient's awareness and understanding of their diagnosis, condition, treatment options and the possible risks or side effects of medications or treatments.

To improve a patient's health literacy, practitioners could:

- recognise the patient's needs and preferences and tailor communication accordingly
- assume that most people will have difficulty understanding complex health information and concepts
- provide health information using words that the patient understands and without rushing through it
- use multiple forms of communication to confirm that information has been delivered and understood
- give the patient targeted information (for example, leaflets) telling them where they can access targeted information (for example, websites and online support groups)
- encourage the patient, carer and other relevant parties to say if they have difficulty understanding the information
- use proven methods of informing patients about the risks of treatment options.

### Sharing information about environmental issues with patients

The practice needs to share information about environmental issues with patients by using resources that relate to their healthcare. This can potentially improve the safety and quality of the healthcare patients receive from the practice. The practice could:

- provide patients with information that explains the importance of reducing waste, conserving energy, and the benefits of using environmentally friendly products
- inform patients about how to minimise the environmental impact of medications, such as returning unused drugs to a pharmacy so they can be properly destroyed
- provide information to consumers about managing the impact of climate change on their health, including extreme heat. For example, in the waiting area, the practice could display posters such as the RACGP's Climate change and health practice posters (https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/climate-change-and-health-practice-posters) and links to digital resources
- include sustainability-related topics when interacting with patients.

For more information, see the RACGP's *Greening up: Environmental sustainability in general practice* (https://www.racgp.org.au/running-a-practice/practice-management/business-operations/e-waste)

# PP7 – Open disclosure and complaints

## PP7 | **Open disclosure and complaints**

**Consumer expectation statement:** I expect that this practice manages and responds openly to complaints in a timely manner.

**PP7.A The practice applies the Australian Open Disclosure Framework.**

**PP7.B The practice uses a complaints management process to respond to complaints in a timely way.**

The practice:

- acknowledges receipt of each complaint to the complainant in a reasonable time
- maintains:
  - a complaints management process
  - a complaints register
  - practice information for consumers on how to escalate a complaint to the relevant complaints commissioner.

## Why this is important

### Open disclosure

Communicating openly and honestly after adverse events (including clinically significant incidents) shows compassion towards patients, improves the practice's relationships with its patients, and allows patients to be more engaged in their own care.

### Managing complaints

Patients need to be able to raise concerns or complaints about the quality and safety of care at the practice.

## Meeting these criteria

### Open disclosure

Open disclosure involves a discussion and other exchanges of information that may take place over several meetings. The practice has an obligation to:

- respectfully explain to patients when things go wrong
- express regret or make a genuine apology (if warranted)
- explain what steps the practice has taken so that the mistake is not repeated.

All relevant information (details of the incidents or near misses, along with the discussion and any apology) can be recorded in the patient's record as per the *Australian open disclosure framework* (https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework) .

To meet this criterion, the practice could:

- maintain an open disclosure process, policy and guidelines
- educate and encourage the practice team to follow the process
- discuss open disclosure during induction
- discuss open disclosure at practice team meetings
- introduce quality improvement initiatives based on learnings from incidents and near misses.

Disclosure to the patient following an incident that caused harm benefits both the patient and the practice. Disclosure may also be appropriate where no harm appears to have been caused, especially if there would otherwise be a reasonable likelihood of harm in the future.

Contact the practice's medical defence organisation and insurer for further guidance and advice about when the practice may need to participate in open disclosure, and what kind of documentation the practice would require for risk management initiatives.

### Managing complaints

If the practice receives a complaint, try to have the practice team resolve the issue in a reasonable amount of time. If the practice team cannot resolve the complaint, contact the practice's medical defence organisation for advice on resolving the complaint before any further action is taken.

The practice needs to:

- have a system to record, review and manage complaints
- maintain a complaints register
- advise consumers of the progress and outcome of their complaint
- inform consumers that the practice will always try to resolve complaints directly
- have information available at the practice or website for consumers about how they can escalate a complaint to the relevant state complaints commission.

The practice could:

- create a position description/s that include the responsibility for complaint resolution
- keep minutes or notes of meetings where consumer complaints have been considered and discussed
- introduce quality improvement initiatives based on complaints made to the practice.

## Resources

- Australian Commission on Safety and Quality in Health Care has resources and information for clinicians and consumers about open disclosure, including implementing the *Australian Open Disclosure Framework (https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework)* .
- Section 4 of the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx) provides advice about managing complaints at the practice level.

# PP8 – Engaging consumers

## PP8 | Engaging consumers

**Consumer expectation statement:** I expect that this practice engages consumers in a proactive, ongoing and meaningful way to gain feedback on their experiences, and uses these insights to improve care.

**PP8.A The practice engages with consumers to monitor, review and improve care.**

The practice:

- engages with consumers to improve care using formal and informal engagement
- informs consumers about how it has responded to feedback and used feedback to improve care.

### Why this is important

Engaging consumers in a proactive, ongoing and meaningful way to gain insights and feedback on consumer experience is linked with increased clinical effectiveness, improved patient safety, improved adherence to medication and more use of screening services[37].

### Meeting this criterion

#### Engaging consumers

Engaging consumers refers to consumers (of a healthcare system) working collaboratively with health professionals or health service providers/organisations with the aim of ensuring that the care being received meets those consumers' needs and is safe and of high quality[38]. As engaging consumers requires an ongoing relationship that allows for both planned and opportunistic engagement, it implies two-way communication between parties.

#### Consumer engagement approaches

There are various levels of engagement and different approaches that can be used to actively engage consumers in healthcare. Engagement approaches can be formal or informal.

Formal engagement occurs when the practice has a structured and planned process that:

- seeks direct input from consumers or consumer representatives
- requires input from consumers at specific times
- uses a combination of in-person and digital interactions[39].

Informal engagement uses instances of opportunistic engagement, and is a more fluid and flexible process that:

- seeks wide input from consumers
- allows for consumer input at any time
- may be online and digital in nature and, where this is the case, may be captured through digital analytics[39].

#### Adopting a formal approach to consumer engagement

Consumers can provide valuable insights about the practice, and a practice can use various methods to collect data relating to consumer outcomes and experiences to help make ongoing improvements to services.

Patient-reported measures (PRMs) are measurement tools used to collect information about patients' healthcare experiences and the outcomes of their care[40]. PRMs can be used to collect data across the care continuum, including general practices. There are standardised and validated

tools to measure PRMs that specifically focus on either:

- patient-reported experience measures (PREMs) that capture the patient's perception of their experience with healthcare or services; or
- patient-reported outcome measures (PROMs) that help patients to report on outcomes relating to their health.

PROMs capture patient perspectives about how illness or care impacts their health and wellbeing without interpretation of that perspective by a healthcare provider[41]. Insights from PROMs can be used to glean broader insights into health outcomes across the practice population if integrated with relevant clinical information[42].

The Australian Commission on Safety and Quality in Health Care has:

- evidence relating to the use of PROMs
- resources and information on the selection, use and implementation of validated PROMs
- consumer information and case studies of successful implementation.

Table 7 outlines formal approaches practices could take to engage consumers[43].

**Table 7 Mechanisms to formally engage consumer in general practice**

| Consumer Engagement Mechanism | Examples of consumer engagement with a general practice |
|---|---|
| Inform | • Social media and online platforms<br>• Receipt of health information, practice news and results from consumer feedback via newsletters, emails and other media. |
| Consult | • Focus groups<br>• Patient journey mapping<br>• Follow up calls<br>• Workshops and community events<br>• Yarning circles for Aboriginal and Torres Strait Islander consumers<br>• Use of technology for real-time feedback<br>• Suggestion boxes |
| Involve | • Collect PREMs and PROMs<br>• Speak on relevant topics at events conducted by the practice<br>• Participate in practice meetings about quality improvement activities or consumer feedback<br>• Review practice materials or resources (for example, factsheets and website copy) with a consumer lens |
| Collaborate | • Sit on consumer advisory councils<br>• Sit on quality improvement committees |
| Empower | • Be involved in the governance of the practice |

### Using consumer engagement to improve care delivery

After collecting and analysing feedback, the practice can identify key issues and decide on a quality improvement plan. To do this, the practice could:

- convene a team meeting dedicated to this activity
- seek team members' opinions on the priority of the activities that will address the feedback
- send each team member a summary of the feedback and ask for their thoughts on which quality improvement activities the practice could implement
- consider which feedback aligns with the practice's strategic objectives
- create specific action plans to address areas for improvement raised by consumers
- plan annual processes, such as flu vaccination, based on previous year's consumer feedback
- introduce a new service or healthcare provider or make other changes (for example, changes to reception, opening hours and/or days) based on consumer feedback and needs.

This could be done as part of the practice's continuous quality improvement activities in CQI1 – Continuous quality improvement activitie (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/continuous-quality-improvement-standard/criterion-cqi-1-continuous-quality-improvement-act) s (#_CQI1_–_Continuous)
.

Because consumers value knowing that their feedback has been respectfully considered and implemented where possible, inform them of the quality improvement activities that the practice has implemented, or is planning to implement. For example, the practice could display posters in

the waiting area, include relevant information on the practice's website or in its newsletter. If the practice has received a lot of feedback relating to a particular issue and it is not feasible to make changes, explain this to consumers.

## Resources

- The RACGP Aboriginal and Torres Strait Islander Health (https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health) *Introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives (https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/An-introduction-to-Aboriginal-and-Torres-Strait-Islander-health-cultural-protocols-and-perspectives.pdf)* provides a guide to five levels of engagement with Aboriginal and Torres Strait Islander peoples and considerations when planning to engage with Indigenous peoples.
- The Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-experience#:~:text=People%20receiving%20care%20have%20a,and%20how%20often%20it%20happens.) has developed a range of information and resources to support services to measure patient experience, including a *guide to implementing patient reported experience measures (PREMs (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-experience/implementing-patient-experience)* ).
- The Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcome-measures) has a range of tools to support the implementation of patient reported outcome measures (PROMs), including the validated generic PROMs (https://www.safetyandquality.gov.au/resources/full-proms-list-generic-and-conditions-specific) and specific high-burden conditions (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcomes/proms-lists/condition-specific-proms) .
- The Agency for Clinical Innovation (https://aci.health.nsw.gov.au/statewide-programs/prms) has resources for clinicians and patients to support the collection and use of PRMs, including how to use and select a patient survey, online training, research and evidence, and PREMs and PROMs surveys (https://aci.health.nsw.gov.au/statewide-programs/prms/for-health-professionals) . Clinicians and patients in New South Wales can access the Health Outcome and Patient Experience (HOPE) platform to support the collection of PRMs.
- Validated international PROMs that could be used, depending on patient population or health condition, include the Standard Sets of the International Consortium for Health Outcomes Measurement (ICHOM) (https://www.ichom.org/patient-centered-outcome-measures/) and the Patient-Reported Outcomes Measurement Information System (PROMIS) (https://www.healthmeasures.net/explore-measurement-systems/promis)
- CFEP Surveys' Practice Accreditation Survey (https://cfepsurveys.com.au/our-surveys/practice-accreditation-survey/) , the Insync Patient Satisfaction Instrument (PSI) (https://insync.com.au/customer-experience/patient-experience/patient-feedback-for-gp-accreditation/) , and the Consultation and Relational Empathy (CARE) (https://caremeasure.stir.ac.uk/) are validated PREMs for primary care. Other tools that could be adapted include the Australian Hospital Patient Experience Questionnaire Set (AHPEQS) (https://www.safetyandquality.gov.au/resources/australian-hospital-patient-experience-question-set-ahpeqs) (available in Easy English and 20 languages) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) (https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html) survey.
- The Centre for Culture, Ethnicity and Health (https://www.ceh.org.au/) (CEH) has consumer participation strategies (https://www.ceh.org.au/wp-content/uploads/2017/05/consumer-participation-strategies.pdf) to support engagement with consumers from culturally and linguistically diverse backgrounds. The Office of Multicultural Interests (https://www.omi.wa.gov.au) has *Tips for engaging culturally and linguistically diverse communities (https://www.omi.wa.gov.au/docs/librariesprovider2/resources/tips-for-engaging-cald-communities.pdf?sfvrsn=7ebcbbf9_1)* and a guide for engaging CALD communities (https://www.omi.wa.gov.au/docs/librariesprovider2/resources/engaging_communities.pdf?sfvrsn=b45ee785_3)
- The Patient-Reported Indicator Survey (PaRIS) (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-indicator-survey-paris) is an OECD-led initiative to better measure the outcomes and experiences of healthcare services in primary care for people living with chronic conditions.

# PP9 – Responsive system for patient care

## PP9 | **Responsive system for patient care**

**Consumer expectation statement:** I expect that this practice provides a variety of appointment types based on my current healthcare need.

**PP9.A The practice has a triage system for prioritising patient care.**

The practice:

- prioritises patients according to their urgency of need
- has a member of the clinical team who has primary responsibility for training the practice team in triage, including how to:
  - identify patients with an urgent medical need
  - identify emergency events and reprioritise appointments accordingly
  - seek urgent medical assistance from an appropriate member of the clinical team
  - manage patients with urgent medical needs when the practice is fully booked.

**PP9.B Patients can access different consultation types to accommodate their needs.**

The practice:

- provides a variety of consultation types
- provides information to patients about how they can access care when they are unable to attend in person.

## Why this is important

Patients need to be able to access care that is flexible and recognises their needs. Members of the clinical team are required to be able to identify patients' needs and provide appropriate care to treat patients effectively. Patients need to be referred to the right clinician to receive the right level of care within an appropriate period.

## Meeting these criteria

### Consultations accommodate different patients' needs

The practice needs to provide different types of consultations, such as long and short consultations, and different levels of access such as appointment systems or walk-in services or telehealth, based on patients' needs. The practice needs to have a process to inform patients of different appointment types, including options when they are unable to attend in person. Alternative sources of care may include:

- telehealth
- home or other out-of-practice visits, where safe and reasonable to do so
- access to after-hours services
- GP telephone advice lines
- emergency services.

### Triage

The practice needs to have a process for triaging patients according to their urgency of need. The practice could:

- have triage guidelines at the reception area
- have a triage flowchart available for reception staff members and the clinical team
- display a sign in the waiting area advising patients who have a high-risk condition or deteriorating symptoms to tell reception staff members
- show evidence that administrative staff members update the patient waiting list if there has been an emergency, and that they explain to patients that this may increase their waiting time.

### Triage training

The practice needs to have a member of the clinical team who has primary responsibility for training the practice team about triage, including how to:

- identify patients with an urgent medical need
- identify medical emergencies and reprioritises appointments accordingly
- seek urgent medical assistance from a member of the clinical team
- manage patients who have urgent medical needs when the practice is fully booked
- use sensitive and privacy-aware communication methods when patients indicate they have safety or confidentiality concerns.

# PP10 – Care when the practice is not open

## PP10 | **Care when the practice is not open**

**Consumer expectation statement:** I expect to find information about alternative ways to access care when this practice is closed.

PP10.A Consumers are informed how to access synchronous care that is provided by clinicians who meet Australian health professional obligations when the practice is not open.

### Why this is important

Consumers need to be informed of how they can access care when the practice is not open. This includes when the practice is closed during an after-hours period and during periods that are not specifically 'after-hours'. This allows consumers to access appropriate healthcare when they need it and may decrease demand on hospital emergency departments. Synchronous care is care delivered to consumers in real-time. This could include telehealth services or face-to-face.

### Meeting these criteria

#### Informing consumers about care outside of normal opening hours

To inform consumers about how they can access synchronous care outside normal opening hours, the practice could:

- have an out-of-hours message on the practice's afterhours phone number
- include the information on its consumer information sources (for example, the practice website, email signatures, social media and posters)
- display a clearly visible sign outside the practice stating the normal opening hours and arrangements for care outside of those hours
- provide information about recognised crisis support services, such as national helplines, as part of the practice's after-hours consumer information.

#### Provision of after-hours care by the practice

The practice could provide after-hours care directly, either during sociable after-hours or for the full after-hours period.

#### Provision of after-hours care by another provider

After-hours care may also be provided on behalf of the practice by another practice or provider, including urgent care clinics. If the practice uses a third-party provider (including one who provides care via telehealth only), the third-party provider's clinicians need to meet requirements to practice in Australia.

#### Australian health practitioner obligations

If the practice refers consumer to another service for care outside its normal opening hours, that service must be provided by Ahpra-registered doctors or nurses.

#### After-hours telehealth and arrangement with third-party providers

All after-hours telehealth consultations need to be synchronous (ie performed in real-time). If the practice refers patients to an after-hours telehealth provider or medical deputising service, there could be a formal written agreement with the provider to specify details of the arrangements, including:

- how and when the practice receives documentation and information about care provided to patients after-hours
- how the provider can contact the practice in exceptional circumstances, such as an emergency
- how the provider delivers safe and high-quality care that is:
    - person-centred
    - culturally appropriate
    - meets its obligations under the Australian Privacy Principles
- the triage and escalation process for patients who need to consult with a clinician via telehealth after-hours
- how the provider will ensure that patients who need an in-person consultation will be seen either by a practice GP at a clinically appropriate time or referred to the local hospital or facility
- the after-hours contact details of one or more GPs from the practice, so the third-party provider can access important information about a patient, particularly in an emergency.

### Healthdirect

The practice could refer consumers to Healthdirect (https://www.healthdirect.gov.au/) , a national, 24-hour helpline provided by the Australian government. When the practice is closed, Healthdirect can direct consumers to registered health professionals for health advice, including a call back or video call from a GP or registered nurse.

### Urgent care services

The practice could refer consumers to an urgent care service when the practice is closed and/or does not have an available appointment, and the patient requires urgent care. This service could be a Medicare Urgent Care clinic, state-run urgent care service or a privately owned urgent care service.

### Temporary closure periods

Examples of when a practice might be closed for a period that is not specifically 'after-hours' include:

- staff absences
- holiday closures
- emergencies such as a flood (See F2 – Response planning (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/response-planning) ).

If the practice manages these instances differently to how it manages regular after-hours arrangements, the practice could consider having a separate policy or procedure for these circumstances.

# *Continuous quality improvement standard*

# About this standard

The Continuous quality improvement (CQI) standard encourages general practices to continuously monitor, evaluate, and improve the quality of their services to enhance patient care and experiences.

# CQI1 – Continuous quality improvement activities

## CQI1 | **Continuous quality improvement activities**

**Consumer expectation statement:** I expect that this practice continuously monitors the services and care provided and makes improvements to enhance patient care.

**CQI1.A The practice team undertakes continuous quality improvement activities.**

The practice:

- trains member/s of the practice team who have the primary responsibility for quality improvement activities in the practice about their role
- has a system to identify quality improvement activities
- undertakes at least one quality improvement activity every 12 months, one of which includes the use of coded clinical data
- keeps a record of feedback from the practice team about quality improvement systems
- documents quality improvements made to the practice or practice systems in response to feedback, complaints, or audits
- has processes to report performance data and quality improvement activities to the practice's leadership.

**CQI1.B The practice assesses and acts on its environmental performance to track progress toward sustainability goals and compliance with its documented strategies to reduce direct and indirect carbon greenhouse gas emissions.**

The practice:

- assesses progress toward sustainability goals and compliance and reports it to the practice's leadership
- implements actions based on the practice's assessment that reduce direct and indirect carbon greenhouse gas emissions.

***Aspirational criterion*** **CQI1.C The practice measures environmental-impact metrics to assess and manage its overall environmental footprint.**

The practice:

- assesses and manages its overall environmental footprint.

### Why this is important

Continuous Quality Improvement (CQI) results in service improvements through continuous cycles of change led by the practice team. Using practice information and data to make quality improvements to practice structures, systems and clinical care will lead to improvements in patient safety and care.

Meeting these criteria contributes to the delivery of safe and high-quality healthcare. Improvements in environmental performance can:

- reduce exposure to pollutants
- support healthier indoor environments
- enhance the practice's resilience during climate-related disruptions.

These outcomes help safeguard vulnerable populations, reduce operational risks, and align the practice with public health and safety objectives.

## Meeting these criteria

### Roles and responsibilities

Having at least one member of the practice team who leads CQI in the practice establishes clear lines of accountability. The responsibilities of this role need to be agreed to and documented and included in a position description or process document.

### Engaging the practice team and leadership

Giving all members of the practice team an opportunity to come together to share information and consider how the practice can improve, means that they are all actively participating in quality improvement. To do this, the practice could:

- provide training for staff on quality improvement methodologies
- establish a quality improvement team that:
    - includes members from all parts of the practice
    - meets regularly to discuss practice and performance data
    - leads improvements that are shared with the practice team
- include quality improvement as a standing agenda item at team meetings
- keep a record of quality improvement discussions at planning meetings
- provide virtual or physical noticeboards or suggestion boxes where the team can contribute their ideas
- have a system for developing, mandating, implementing and reviewing policies and procedures and keeping the team up to date with any changes
- create short surveys for the team to complete and incorporate feedback and ideas into a quality improvement plan.

The practice needs to report performance data and quality improvement activities to the practice leadership team which could include the practice owner, practice manager and clinical leads. The report could be based on:

- structured or coded clinical data extracted from clinical software
- clinical audits of a particular treatment or service
- data reported to PHNs, such as Practice Incentives Program (PIP) and Quality Improvement (QI)
- activities undertaken by the practice quality improvement team
- activities that are informed by validated patient feedback.

Because formal reporting of performance data and quality improvement to the practice leadership is not necessary to meet this criterion, the practice could:

- provide verbal updates in team meetings
- produce short summaries of data to share and discuss in team meetings
- include data and quality improvement as a standing item on the team meeting agenda.

Analysing and sharing data with the practice team and leaders helps build a culture of continuous quality improvement.

### Continuous quality improvement activities

#### Determining performance indicators to monitor the quality of service

The practice needs to set performance indicators and use them to determine how well they have or have not performed against the practice's quality benchmarks. Elements of quality to be evaluated could include effectiveness, safety, timeliness, person-centeredness, efficiency, and equity. The practice could:

- use patient feedback to determine performance indicators
- use the Practice Incentives Program Quality Improvement (PIP QI) improvement measures to determine performance indicators
- establish its own performance indicators and justify them
- keep the same performance indicator for an accreditation cycle to see trends over time.

#### Improving care using clinical data

Analysis of coded data can be used to identify actions that will improve clinical care for the practice's patient population. This data could be:

- rates of immunisation
- chronic disease management and preventive health

- identifying patients with health/lifestyle risk factors such as smoking, alcohol consumption, physical activity
- the use of antimicrobials in the practice.

The practice could encourage clinicians to complete CPD that includes the use of coded clinical data Through this process, the practice could also identify processes to improve data accuracy and completeness.

The RACGP's CPD activities in your practice (https://www.racgp.org.au/education/professional-development/cpd/2023-triennium/activities-for-your-cpd) provides information about how GPs could meet CPD requirements that can also help them meet the requirements of criterion CQI1.A.

### Making practice performance data publicly available

Appropriate aspects of a practice's performance data need to be made publicly available. For example:

- improvements in a service's response to feedback
- achievements made through a health campaign such as immunisation targets

The Practice could display this information in the waiting area, or on its website.

## Quality improvement activities that consider environmental performance and impact

### Assessing environmental performance

The practice's quality improvement activities need to include an assessment of its environmental performance to track progress towards its environmental sustainability goals and strategies See F3 – Environmental sustainability and responsibility (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f3-environmental-sustainability-and-responsibility) ).

To assess its environmental performance, the practice could:

- agree on measures to review the practice's environmental impact over time, such as energy consumption, waste generation, recycling practices, water usage
- set specific, measurable, and time-bound improvement targets for reducing environmental impact (for example, improving resource efficiency)
- inform patients about the practice's commitment to environmental responsibility and the progress that has been made
- regularly review the actions taken to reduce the environmental impact and the effects of those actions.

The practice needs to report its progress towards its sustainability goals to the practice leadership teams. This could be done by including summaries of key environmental actions and outcomes as a standing agenda item of team meetings.

### Aspirational – Measuring environmental-impact

As criterion CQI1.C is aspirational, the practice could measure its environmental impact so that it can assess and manage its overall environmental footprint. This could include measuring, over time, of:

- water and electricity use
- waste reduction and recycling
- environmental outcomes of procurement choices
- the energy efficiency of practice equipment and appliances.

Many of the actions listed in Tables 1, 2 and 3 under F3 – Environmental sustainability and responsibility (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/f3-environmental-sustainability-and-responsibility) can be measured and assessed over time.

To achieve this, the practice could:

- define a set of relevant performance indicators for:
  - the sourcing of materials and products from sustainable suppliers
  - indoor air quality
  - the generation and correct disposal of clinical waste
  - energy consumption from renewable sources.
- use monitoring equipment to gather accurate and detailed information (for example, energy and water meters)
- review collected data to identify trends and areas where resource efficiency and sustainability can be improved
- communicate environmental metrics to staff and patients.

#### Introducing meaningful environmental sustainability improvements to the practice

Consider introducing small changes that can be enhanced over time. Whether the practice premises are owned or leased, the practice could make use of what is already available, such as:

- requesting utility usage data from owners instead of setting up additional monitoring
- contributing to existing initiatives in the building (if sharing premises)
- using existing property waste and recycling services.

As formal reporting of sustainable activities and results is not necessary to meet this criterion, the practice could produce summaries of key environmental actions and outcomes, and include them as a standing agenda item of team meetings.

## Resources

- Primary Health Networks provide useful quality improvement tools and resources for primary care. These include Practice Incentives Program (PIP) data to identify areas for improvement, how to use data extraction tools, quality improvement toolkits for specific conditions (for example, asthma, cardiovascular disease, COPD, diabetes), and templates for QI activities like a plan-do-study-act (PDSA) cycle. Examples can be found on websites of several PHNs, including Brisbane South PHN (https://bsphn.org.au/practice-support/quality-improvement) , Eastern Melbourne PHN (https://emphn.org.au/for-health-professionals/quality-improvement-in-practice/) , Hunter New England and Central Coast PHN (https://thephn.com.au/what-we-do/general-practice-support/quality-improvement-framework) , Nepean Blue Mountains PHN (https://www.nbmphn.com.au/health-professionals/practice-support/quality-improvement) and South West Sydney PHN (https://swsphn.com.au/primary-care-resources/qipc-resources/) .
- The Clinical Excellence Commission (https://www.cec.health.nsw.gov.au/improve-quality) has quality improvement resources, including QI toolkits (https://www.cec.health.nsw.gov.au/improve-quality/quality-improvement-toolkits) focusing on clinical areas where the risk of harm is well recognised (for example, antimicrobial stewardship).
- The Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au/standards/clinical-care-standards) clinical care standards can be used to support quality improvement in specific conditions, treatments, procedures and clinical pathways, in order to align with best practice.
- Business.gov.au (https://business.gov.au/environmental-management/develop-your-sustainability-action-plan) provides further rationale and a template to develop a sustainability action plan that can be easily adapted to practices for the purpose of meeting these criteria.
- MedicineInsight (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/medicineinsight) is a primary care quality improvement program using data from general practices I Australia to give insights into prescribing patterns and patient care.
- The Australian Atlas of Healthcare Variation Series (ATLAS) (https://www.safetyandquality.gov.au/our-work/healthcare-variation/australian-atlas-healthcare-variation-series) examines a series of health topics, investigates variations and the possible reasons for them, and provides specific achievable actions to reduce unwarranted variation.

# *Point of care testing standard*

# About this standard

The Point of care testing (PoCT) standard addresses the systems that practices need in order to ensure PoCT supports patient safety and high-quality care.

# PoCT and the Australian Register of Therapeutic Goods

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

The *Australian Register of Therapeutic Goods* (https://www.tga.gov.au/resources/artg) (ARTG) lists therapeutic goods that can be legally imported into Australia, or supplied for use in Australia, or exported from Australia.

Unless a specific exemption has been granted, it is a criminal offence under the *Therapeutic Goods Act 1989* (https://www.legislation.gov.au/Details/C2017C00226) to import into, supply in or export from Australia a medical device that is not listed on the ARTG.

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

# PoCT1 – Clinical purpose

## PoCT1 | **Clinical purpose**

**Consumer expectation statement:** I expect that this practice follows evidence-based processes to ensure my safety when suggesting and performing point of care testing.

**PoCT1.A The practice team can describe the clinical and diagnostic purposes of PoCT based on best practice evidence, and how it can be applied.**

The practice:

- describes the clinical and diagnostic purposes for using PoCT
- ensures the clinical and diagnostic purposes of PoCT are evidence-based.

**PoCT1.B The practice's specifications for the analytical performance of PoCT are determined by the relevant clinical and diagnostic purposes.**

The practice:

- provides evidence that the analytical performance specifications of each test method are based on the clinical and diagnostic purposes for which they will be used
- demonstrates that the analytical performance of each test method has been evaluated upon commissioning and following major repairs.

**PoCT1.C The practice team uses reference data that is based on best practice evidence and is regularly reviewed to interpret test results.**

The practice:

- demonstrates that it uses reference intervals and/or clinical decision limits for interpreting PoCT results
- demonstrates reference intervals and/or clinical decision limits are evidence-based.

**PoCT1.D The practice team uses processes that minimise the risk to patients and improve the quality of PoCT.**

The practice:

- records and addresses adverse and non-conformance events
- documents how it is reviewing adverse and non-conformance events, and documents the outcome of the review
- demonstrates that the practice can maintain continuity of care if PoCT is not available.

### Why this is important

PoCT can help healthcare practitioners make immediate and informed decisions about a patient's care and management[44], and thus improve the timeliness, efficiency and quality of care in some areas of clinical practice[45].

### How PoCT is intended to be used

When deciding on the clinical and diagnostic purposes where PoCT may benefit patients, consider current best practice evidence.

Because PoCT can be used to diagnose, monitor, manage or screen, the practice needs to define its analytical performance requirements, based on its intended clinical and diagnostic purposes. For example, using PoCT to monitor a patient's diabetes may have different analytical requirements to when it is used to diagnose infections with public health implications[46].

## Meeting these criteria

### Evaluation of PoCT systems

When evaluating PoCT systems, all aspects of PoCT need to be considered, including specimen collection, analysis, reporting and actioning. The quality of PoCT may be affected by many factors, including the storage of consumables, the knowledge and skills of PoCT practitioners, specimen quality, and variability between instruments[47].

The practice needs to perform due diligence (for example, consulting literature and professional bodies) to ensure a PoCT device meets the practice's needs. Evaluation of a PoCT system needs to address three aspects - Selection, Verification and Quality:

- Selection – PoCT devices need to be assessed against the manufacturer's claimed specifications, and can be evaluated and selected based on the practice's intended clinical use.
- Verification – This confirms (verifies) that a particular PoCT system performs to and meets the manufacturer's stated specifications, and that the results have been validated against a known standard.
- Quality (calibration, quality control and quality assurance) – always assess calibration, quality control and quality assurance before implementing a PoCT system, to independently confirm that its performance is appropriate and accurate.

### Interpreting test results

The practice can interpret test results by using reference data obtained from various sources, including PoCT suppliers, pathology providers, international bodies and professional societies.

The practice needs to:

- agree on which reference intervals and clinical decision limits it will use to interpret PoCT results
- only use reference intervals and clinical decision limits that are based on current best practice evidence
- regularly review reference intervals and clinical decision limits
- document reference intervals for groups where there are well recognised differences (for example, children and pregnancy).

### Quality use of PoCT

Having a consistent approach to PoCT, which includes having agreed reference intervals and clinical decision limits, may help GPs to interpret test results.

Each GP needs to exercise clinical judgement when:

- deciding whether to use PoCT
- deciding whether to use results of PoCT to make decisions about patient management.

Safe and effective PoCT is possible only if:

- GPs have the required skills and have received appropriate training
- PoCT is undertaken often enough to maintain those skills
- the practice records, addresses and reviews non-conformance and adverse events.

### Sources of information and evidence

PoCT suppliers, pathology providers, international bodies, professional societies and other sources can provide evidence about the clinical and diagnostic purposes, analytical performance and reference data for PoCT. The practice does not have to generate its own evidence.

It is recommended that the practice:

- seeks information from a validated source, relevant to the applicable PoCT
- selects information that is appropriate for the practice's clinical and diagnostic purposes and patient population.

### Evaluating PoCT systems' analytical performance

The practice needs to demonstrate how the analytical performance of a PoCT device has been verified to confirm that it performs to and meets the manufacturer's stated specifications at the following times:

- on commissioning
- after major repairs, new methods, reagent formulation changes and device maintenance
- at other times as needed (for example, if a result does not match the clinical picture).

### Quality improvement and risk management

To improve quality of care and to minimise risks to patients:

- apply quality improvement and risk management processes to PoCT
- record and address adverse and non-conformance events in a timely manner
- notify the member of the clinical team with nominated responsibility for PoCT of adverse and non-conformance events (adverse and non-conformance events could also be included as an agenda item in team meetings)
- review adverse and non-conformance events, including how they are addressed.

The practice could report adverse events to the Therapeutic Goods Administration (TGA). The TGA has the following resources on reporting relevant adverse events related to the performance of PoCT devices:

- *Medical device Incident Reporting and Investigation Scheme (IRIS)* (https://www.tga.gov.au/resources/resource/guidance/medical-device-incident-reporting-and-investigation-scheme-iris)
- information on *reporting an adverse event or problem* (https://www.tga.gov.au/report-adverse-event-or-problem-health-professionals#:~:text=adverse%20event%20reports.-,Medical%20device%20adverse%20events,-Complete%20the%20online) for health professionals.

### Continuity of care

In the event of unplanned loss of PoCT, the practice needs to demonstrate how it will ensure continuity of care for patients.

## Resources

- Pathology Tests Explained (https://pathologytestsexplained.org.au/) has information about the advantages of PoCT (https://pathologytestsexplained.org.au/ptests-pro.php?q=PoCT%20(Point%20of%20care%20testing)) , and a resource on reference intervals (https://pathologytestsexplained.org.au/pages.php?page=Reference%20intervals%20explained) and what they mean, and a video resource (https://www.youtube.com/watch?v=INdu1gfueaE) .
- The Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has published analytical goals for point-of-care testing (PoCT) used for diabetes management (https://hiv.guidelines.org.au/management/endocrine-disorders-in-hiv-infection-and-their-treatment/1-diabetes-mellitus/) .
- Scandinavian evaluation of laboratory equipment for primary health care (SKUP) (https://www.skup.org/) evaluates PoCT instruments and publishes their findings.
- specimencare.com (https://specimencare.com/) , sponsored and maintained by Becton, Dickinson and Company, provides best practice resources for the pre-analytical phase of testing.
- Journal article by Julie LV Shaw explores Practical challenges related to PoCT (https://www.sciencedirect.com/science/article/pii/S2352551715300056) .
- The Australasian Association of Clinical Biochemists (AACB) has published the Point of care testing implementation guide (https://aacblm.imiscloud.com/common/Uploaded%20files/aacb/guidelines%20and%20position%20statements/guidelines/aacb%20-endorsed%20guidelines/20191105%20SRA%20PoCT%20Implementation%20Guide.pdf) .

Further information on risk management can be found in CG7 – Managing clinical risks and incidents (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/clinical-governance-standard/cg7-managing-clinical-risks-and-incidents) .

# PoCT2 – Clinical responsibility

## PoCT2 | **Clinical responsibility**

> **Consumer expectation statement:** I expect that this practice takes responsibility for safe and quality delivery of point of care testing.

> **PoCT2.A The practice has at least one member of the clinical team who has primary responsibility for the quality of PoCT.**
>
> The practice:
>
> - has at least one member of the clinical team who has overall primary responsibility for the implementation, conduct, quality and accreditation of PoCT within the practice
> - has at least one member of the clinical team on duty when PoCT is being used who accepts the responsibility of running PoCT within the practice
> - demonstrates that the responsible member of the clinical team is competent in using PoCT.

### Why this is important

The successful implementation of PoCT requires skills, knowledge and time. To ensure results are of a uniformly high quality, the practice needs to properly manage relevant organisational and technical activities. This can be best achieved if one member of the clinical team is responsible for, and oversees, PoCT activities.

Effective clinical governance of PoCT ensures that:

- each member of the practice team takes ownership of PoCT processes, models good practice, and challenges poor practice
- each member of the practice team is jointly accountable for patient safety and high-quality care
- roles, responsibilities and accountabilities for achieving agreed outcomes are clearly allocated to and agreed to by members of the practice team, according to each person's scope of practice
- members of the practice team apply learning from continuous quality improvement practice to enhance patient safety and quality of care.

### Meeting these criteria

A designated member of the clinical team needs to have ultimate responsibility for PoCT undertaken by the practice. This person needs to:

- have an adequate understanding of PoCT, including:
  - the diagnostic and technical applications and any limitations
  - the PoCT Standards in this document
  - the practice's PoCT policies and procedures
- have competency in using the practice's PoCT program or system (demonstrated by providing evidence of appropriate PoCT training which could be external courses, in-house programs, or 'on the job' training at the practice)
- be able to delegate their day-to-day PoCT responsibilities to an appropriately trained PoCT practitioner, while retaining ultimate oversight of PoCT in the practice.

The practice could:

- maintain a clinical governance policy
- maintain a standing order for practice nurses to carry out PoCT and to interpret results according to their level of training and scope of practice.

# PoCT3 – Qualifications, education and training of PoCT practitioners

## PoCT3 | **Qualifications, education and training of PoCT practitioners**

**Consumer expectation statement:** I expect that practitioners at this practice understand their role and have up-to-date training to perform point of care testing.

**PoCT3.A Members of the practice team who perform PoCT:**

- **have successfully undertaken training**
- **participate in training and education updates.**

The practice:

- provides evidence that PoCT practitioners can demonstrate competency in PoCT
- provides evidence that PoCT practitioners receive regular training and education updates
- provides evidence that all PoCT practitioners receive training updates when:
  - significant changes to method(s) are introduced
  - new tests and/or instruments are introduced
  - CQI mechanisms identify issues.

### Why this is important

Having PoCT practitioners who are trained reduces the risk of errors and safeguards the validity of results that inform clinical decision-making, ensuring that the practice provides patients with safe, high-quality care.

The organisation responsible for providing the PoCT service needs to provide evidence that all PoCT practitioners:

- are suitably trained
- maintain the knowledge and skills that enable them to perform PoCT
- work within their scope of practice and competencies.

The quality of PoCT can be compromised by pre-analytical, analytical and post-analytical errors and issues, especially if performed by inadequately trained PoCT practitioners. This is why members of the practice team performing and managing PoCT require appropriate training and education, and need to be able to demonstrate competency when assessed[48].

### Meeting these criteria

The practice needs to maintain records that clearly show that the training of PoCT practitioners is appropriate for the PoCT they perform.

All PoCT practitioners need to receive updated training when:

- significant changes to the PoCT method/s are introduced
- a new test and/or instrument is introduced
- CQI mechanisms identify any issues.

Table 8 provides suggested training for different areas related to PoCT.

**Table 8 Training in Point of care testing in general practice**

| Area | Suggested training |
| --- | --- |

| | |
|---|---|
| General | • The practice's policies<br>• Overview of clinical purposes of PoCT |
| PoCT system | • Basic principles of analysis, calibration, bias, precision, range, sensitivity, specificity, interferences, method evaluation and method comparison<br>• Normal test performance according to the manufacturer's instructions<br>• Recognition of malfunctions and appropriate actions<br>• Error messages and actions<br>• Storage of consumables<br>• Care, maintenance and decontamination of the PoCT system |
| Patients and specimens | • Appropriate information for patients – including what the test is, why it is being done and the cost to the patient<br>• Patient preparation<br>• Specimen collection techniques<br>• Specimen identification and labelling<br>• Specimen handling and stability<br>• Recognition of unsuitable specimens<br>• Patient and staff safety |
| Results | • Recognition of abnormal, clinically urgent and erroneous results<br>• Documentation of the testing episode<br>• Data management |
| Quality | • Principles and procedures of PoCT quality control testing and external quality assurance programs<br>• Assessment of acceptable and unacceptable quality control testing and external quality assurance results, and appropriate actions |

The practice could:

- record each employee's qualifications in employment files
- keep a training calendar that lists PoCT professional development and training opportunities
- maintain documents that record each PoCT practitioner's training needs and training completed
- conduct annual performance reviews that identify learning and development goals.

### Assessment of PoCT practitioners

Members of the practice team need to be assessed for competency in all aspects of their PoCT duties and responsibilities.

# PoCT4 – Facilities for testing

## PoCT4 | **Facilities for testing**

**Consumer expectation statement:** I expect that this practice provides point of care testing in an environment that is clean, private, and uses equipment and consumables in line with manufacturer's guidelines.

PoCT4.A The practice conducts testing in a safe environment that ensures patient privacy.

The practice:

- demonstrates that specimen collection and testing and result communication is performed in a safe area where patients' visual and auditory privacy is ensured.

**PoCT4.B The practice ensures that instruments and consumables are located and managed to optimise performance.**

The practice:

- has a testing area that has appropriate space, lighting, power, security and ambient temperature for sample/specimen handling, testing and documenting
- maintains records of consumables
- stores the required quantity of within-date consumables as per the manufacturers' instructions
- disposes of used and expired consumables in accordance with local, state and federal requirements
- where temperature-sensitive consumables are stored as per the manufacturers' instructions, uses a minimum–maximum thermometer to monitor temperature, and keeps records of that monitoring
- has a documented contingency plan for continued operations in the event of equipment and other failures.

### Why this is important

Using and maintaining PoCT instruments and consumables properly helps to ensure accurate test results that clinicians can use when making clinical decisions.

Ensuring that PoCT is conducted in a private and safe environment reduces the risk of infection for patients and the practice team, and protects patient privacy.

### Meeting these criteria

When conducting PoCT, ensure the area has adequate space for instruments, consumables, documentation and waste disposal and does not compromise patient privacy.

Provided that patient privacy is maintained, the area does not need to be solely dedicated to performing PoCT. For example, a consultation or nurse's room may be suitable.

The practice could have a document, such as a log, that records consumables, lot numbers, expiry dates and monitoring. It may also include a risk matrix and contingency plans to follow in the event of unexpected events.

For standards and guidelines relating to cleanliness and hygiene, including disposal of sharps, waste management and management of body fluid spills, see the Clinical Governance standard and the RACGP's Infection prevention and control guidelines (https://www.racgp.org.au/running-a-practice/practice-standards/racgp-infection-prevention-and-control-guidelines/) . Safe use of PoCT includes following these standards and guidelines in relation to the environments where the practice stores and uses PoCT equipment and consumables.

# PoCT5 – Performance of tests

## PoCT5 | **Performance of tests**

**Consumer expectation statement:** I expect that this practice performs point of care testing in line with manufacturer's guidelines and results are communicated in an understandable and timely manner.

**PoCT5.A The practice follows the manufacturers' instructions for PoCT.**

The practice:

- demonstrates that it follows the manufacturer's instructions for each test method
- demonstrates that it checks the accuracy of transfers of data and transcription of results.

**PoCT5.B The practice records and communicates results appropriately.** The practice:

- demonstrates that the practice team records and communicates results to the responsible clinician and the patient in a timely manner
- demonstrates that results are acted upon appropriately.

**PoCT5.C The practice identifies and reviews errors and deviations.**

The practice:

- demonstrates that it records and investigates deviations appropriately.

**PoCT5.D The practice ensures that specimens remain positively identified with patients throughout the testing process.**

The practice:

- demonstrates that specimens remain positively identified with patients throughout the testing process
- clearly identifies patient specimens retained for any purpose.

**PoCT5.E The practice has documented its requirements for PoCT technical support services.**

The practice:

- demonstrates that it has ongoing arrangements with providers of technical support services.

**PoCT5.F The practice commissions and maintains PoCT equipment in accordance with each manufacturer's instructions.**

The practice:

- retains records of installation, major repairs and commissioning
- ensures that maintenance is undertaken by appropriately trained operators
- retains records of maintenance in accordance with the manufacturers' instructions
- retains a log of failures and investigations performed.

## Why this is important

The quality and safety of patient care depend on PoCT results being valid and reliable. To ensure that this is the case, equipment and consumables need to be used in a standard way in accordance with the manufacturers' instructions, and errors need to be identified and acted upon.

Consistency is best achieved if the practice documents and follows standard operating procedures and work instructions for all stages of testing, and ensures that they are in accordance with the manufacturers' instructions.

To ensure continuity of PoCT, the practice could have an established arrangement with third-party suppliers of goods and services. Suppliers of essential PoCT support services are also responsible for providing:

- consumables (directly or via authorised supplier channels)
- technical support
- maintenance (in addition to the routine maintenance the practice completes)
- education to members of the practice team who use their devices.

## Meeting these criteria

### Standard operating procedures

The practice must follow the instructions published by the PoCT manufacturer, as they are approved by the Therapeutic Goods Administration (TGA). However, the practice could also create and maintain standard operating procedures or work instructions for the practice, as the manufacturer's instructions may not include some critical components that the manufacturer is not responsible for, such as patient interactions and result management.

It is important for the practice to formally evaluate and approve any proposed changes to the standard operating procedures and work instructions before using them.

The practice could:

- maintain standard operating procedures for each test method, ensuring only the latest versions are used
- store a copy of the relevant procedures/work instructions with each test instrument.

### Communicating results

The practice needs to ensure that all PoCT results are communicated to the patient in a timely and appropriate manner in such a way that the patient understands the results.

Results also need to be recorded on and acted upon in a timely and appropriate manner.

### Deviations and errors

The practice needs to regularly review deviations and issues encountered during testing. Errors and deviations may be identified or confirmed by repeat testing.

### Avoiding transcription errors

Transcription errors are data entry errors that are usually the result of typographical mistakes made when transferring data and results. To avoid transcription errors, it is strongly recommended that results are transferred electronically[49], and that, where possible, manual transcriptions are checked by another person. The practice could demonstrate how it recognises and avoids potential transcription errors.

### Specimens

Although there is no requirement to label specimens that are to be used solely in the testing process:

- specimens need to remain positively identified with the patient throughout the testing process, including prior to specimen collection
- if specimens are kept after testing, they need to be clearly labelled and stored in accordance with relevant guidelines.

### Technical services

When making arrangements with technical support services, consider the following:

- required response time for maintenance
- required frequency of servicing
- ownership or leasing arrangements of instruments
- required training of PoCT practitioners
- support for technical updates and troubleshooting
- written agreements with third parties who provide technical support services, if it is appropriate.

Further information about business continuity and planning can be found in F1 – Defining and planning for the practice (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/defining-and-planning-for-your-practice) and F2 – Response planning (https://www.racgp.org.au/running-a-practice/practice-standards/standards-6th-edition/the-standards-for-general-practices-6th-edition/foundations-of-general-practice-standard/response-planning) .

### Consumables

When making arrangements with suppliers of consumables, consider:

- required frequency and volume of consumables
- required response time for urgent consumables
- time to expiry of consumables.

### Manufacturers' instructions

The practice needs to make records of preventive maintenance, service and calibration as per the manufacturers' instructions and keep these records as required by relevant state or territory and federal legislation.

Suppliers of routine maintenance should ideally provide the practice with a record of work and performance checks they undertake. If this is not possible, the practice needs to maintain its own records. This includes a log of failures and investigations undertaken.

## Resources

- specimencare.com (https://specimencare.com/) , sponsored and maintained by Becton Dickenson Pty Ltd, provides best practice resources for the pre-analytical phase of testing.
- The Clinical Excellence Commission has published a checklist for conducting root cause analysis (https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/607884/RCA-workbook-for-teams.pdf) .
- The Australian Commission on Safety and Quality in Health Care has Requirements for the packaging and transport of pathology specimens and associated materials (https://www.safetyandquality.gov.au/publications-and-resources/resource-library/requirements-packaging-and-transport-pathology-specimens-and-associated-materials-fifth-edition) .

# PoCT6 – Data management

## PoCT6 | Data management

**Consumer expectation statement:** I expect that my results from point of care testing are included in my health record.

**PoCT6.A The practice records PoCT results in the patient's health records.**

The practice:

- keeps PoCT records, including who performed the tests and the date.

***Aspirational criterion***

**PoCT6.B The practice facilitates the recording of PoCT results using a nationally recognised coding system.**

This criterion is aspirational. The practice could:

- use a clinical information system that facilitates coding of PoCT in patient health information.

### Why this is important

Maintaining appropriate records is a way of managing risks. By recording results of a specific examination in the patient's history examination, this enables informed clinical decision-making, which is essential for safe and high-quality care. Keeping records of PoCT results and associated processes with the relevant patient's health information is also in accordance with relevant legislation and guidelines.

### Meeting these criteria

If the practice needs to investigate the reliability of a test result, it will need to:

- identify the PoCT practitioner who conducted the test
- identify the kit or batch of reagents used
- identify whether quality control results were within the acceptable range
- review the transcription so that the possibility of errors and non-conformance events can be ruled out.

To ensure the results are accessible for future consultations, trend determination and quality improvement activities, the practice could code the information, rather than entering free text in the patient record.

The practice needs to demonstrate that it can readily retrieve from its health record systems all data related to a patient testing cycle.

# PoCT7 – Quality control procedures

## PoCT7 | Quality control procedures

**Consumer expectation statement:** I expect that this practice has processes in place to ensure the quality of all point of care testing.

**PoCT7.A The practice uses quality control procedures to ensure the PoCT is functioning optimally.**

The practice:

- demonstrates that all quality control procedures comply with manufacturers' recommendations and applicable regulations
- has standard operating procedures or work instructions that include the acceptable limits for quality control testing results and record actions taken in the event of an unacceptable result
- regularly reviews quality control results.

### Why this is important

Quality control (QC) testing helps the practice to:

- be confident that its PoCT is functioning properly
- detect and manage sub-optimal performance
- be confident that each PoCT practitioner is performing tests correctly.

### Meeting these criteria

#### QC testing

QC testing is usually performed on artificial samples that have different known levels of analytes covering the range that practices might encounter clinically. They are usually purchased from PoCT manufacturers or other commercial sources, as third party test materials are preferable, where available.

After QC testing is conducted on the samples, QC results are recorded, then compared with the target range or acceptable window specified by the manufacturer. The PoCT manufacturer can provide a simple quality control record sheet to enter, review and analyse QC results.

Results indicate the reliability of the testing process, as follows:

- results falling within the target range are considered acceptable
- results falling outside the target range are unacceptable and may indicate a problem with the testing process.

If the results are unacceptable:

- corrective actions are required and need to be confirmed before this PoCT can be used with patients
- these actions and potential impact on patient management need to be documented [50].

An acceptable window for QC results is usually determined by the manufacturer when a PoCT device is first implemented and they may do so again when new lot numbers of QC material are introduced. It is recommended that practices can demonstrate that they have a system for implementing QC at appropriate times.

#### Reviewing quality control results

It is important that the member of the clinical team who is responsible for PoCT:

- regularly reviews QC results

- investigates unacceptable results or performance
- records any remedial actions taken.

The practice could:

- compare PoCT results with results from a local laboratory for the same specimen from the same patient
- document the outcome.

## Resources

- The World Health Organization has a quality manual template (https://www.who.int/publications/m/item/laboratory-quality-manual) for a laboratory quality management system that could be adapted for PoCT.
- The Australasian Association of Clinical Biochemists (AACB) has published the Point of care testing implementation guide (https://aacblm.imiscloud.com/common/Uploaded%20files/aacb/guidelines%20and%20position%20statements/guidelines/aacb%20-endorsed%20guidelines/20191105%20SRA%20PoCT%20Implementation%20Guide.pdf) and Position Statement (https://www.aacb.asn.au/common/Uploaded%20files/aacb/guidelines%20and%20position%20statements/position%20statements/aacb%20position%20statements/20190701%20GPS%20AACB%20Position%20Statement%20on%20Point%20of%20Care%20Testing.pdf) .

# PoCT8 – External quality assurance program

## PoCT8 | **External quality assurance program**

> **Consumer expectation statement:** I expect that this practice participates in an external quality system to monitor point of care testing, detect issues early, and act if needed.

**PoCT8.A The practice participates in an external quality assurance program.**

The practice:

- enrols all test methods and instruments in an approved external quality assurance program from an accredited provider
- keeps records of participation
- reviews reports from external quality assurance programs
- keeps records of all action taken after investigation of suboptimal performance.

### Why this is important

External quality assurance programs rely on traceability of results to deliver peer review of PoCT systems and monitor PoCT performance. This enables issues to be detected early[49].

### Meeting these criteria

External quality assurance programs provide identical samples to all program participants who then each test the sample using their routine test method. The program collates the results and provides each participant with:

- the range of results achieved
- an indication of whether that participant's method is producing results significantly different to those produced by a different practice using the same method
- details of the accuracy and precision of that participant's results.

If the practice has suboptimal results or performance, it needs to:

- investigate the reasons for these results or performance
- record any remedial actions taken.

# Glossary

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

| Term | Definition |
| --- | --- |
| **Aboriginal or Torres Strait Islander status** | A patient's response, and the record of that response in the patient's file, when the practice asks them, 'Are you of Aboriginal and/or Torres Strait Islander origin?'<br><br>The standard response options should be provided verbally or in written form:<br>• No<br>• Yes, Aboriginal<br>• Yes, Torres Strait Islander<br>For people of both Aboriginal and Torres Strait Islander origin, both 'Yes' boxes should be marked when in written form. |
| **Aboriginal and Torres Strait Islander Health Worker/Practitioner** | A member of the Aboriginal and Torres Strait Islander health workforce. Roles include, but are not limited to:<br>• providing clinical functions<br>• liaison and cultural brokerage<br>• health promotion<br>• environmental health<br>• community care<br>• administration<br>• management and control<br>• policy development<br>• program planning<br>An Aboriginal and Torres Strait Islander Health Worker/Practitioner is often an Aboriginal and Torres Strait Islander person's first point of contact with the health workforce, particularly in remote parts of the country. |
| **Access** | The ability of consumers to obtain services, care and treatment from the practice. |
| **Accreditation** | A formal process to assess a practice's delivery of healthcare against the RACGP's *Standards for general practices*. |
| **Accuracy*** | A measure of how close the results of a test are to the true value. |
| **Active patient** | A patient who has attended the practice/service three or more times in the past two years. |
| **Active patient health record** | The health record of an active patient. |
| **Administrative staff** | Members of the practice team who provide clerical or administrative services and who do not perform any clinical tasks with patients. |
| **Adverse event or adverse incident** | Any event or circumstance arising during care that could have led, or did lead to, unexpected actual harm, loss or damage. Incidents include near misses, sentinel events and unsafe acts. |
| **Adverse medicines event** | An adverse event caused by a medicine. For example, harm that results from the medicine itself (an adverse drug reaction), potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident). |

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>After-hours service</td><td>A service that provides care outside the normal opening hours of a general practice, whether or not that service deputises for other general practices, and whether or not the care is provided physically in or outside of the clinic.<br><br>Services Australia defines normal and after-hours periods as follows:<br><table><tr><th>Day</th><th>Normal hours</th><th>Sociable after-hours</th><th>Unsociable after-hours</th></tr><tr><td>Weekdays</td><td>8.00 am – 6.00 pm</td><td>6.00–11.00 pm</td><td>11.00 pm – 8.00 am</td></tr><tr><td>Saturdays</td><td>8.00 am – 12.00 noon</td><td>None</td><td>Before 8.00 am / After 12.00 noon</td></tr><tr><td>Sundays and public holidays</td><td>None</td><td>None</td><td>All day</td></tr></table></td></tr>
<tr><td>Allied health professional</td><td>A health professional (for example, physiotherapist, dietitian, podiatrist) who collaborates with doctors and nurses to provide optimal healthcare for patients. The Australian Government recognises allied health professions that have all the following:<ul><li>a university qualification accredited by a relevant national accreditation body</li><li>a national professional organisation with clearly defined membership criteria</li><li>clear national entry-level competency standards and assessment processes</li><li>autonomy of practice.</li></ul></td></tr>
<tr><td>Analyte*</td><td>A chemical substance in a fluid or other specimen from the body that is undergoing analysis.</td></tr>
<tr><td>Analytical performance*</td><td>The ability of a Point of Care Testing system to detect and/or measure its intended analyte(s).</td></tr>
<tr><td>Appointment system</td><td>The system that a practice uses to assign consultations to patients and practitioners.</td></tr>
<tr><td>Artificial intelligence (AI)</td><td>The machine-based simulation of human cognitive capabilities such as learning, reasoning or problem-solving, and self-correction. It encompasses a range of technologies, such as machine learning, deep learning, natural language processing, robotics, chatbots, image recognition and machine vision, and voice recognition.</td></tr>
<tr><td>Artificial intelligence (AI) scribe</td><td>A tool that can automate parts of the clinical documentation process for a medical practitioner. AI scribes can convert a conversation with a patient into a clinical note, summary, or letter that can be incorporated into the patient's health record. Other terms include digital scribes, virtual scribes, ambient AI scribes, AI documentation assistants, and digital/virtual/smart clinical assistants.</td></tr>
<tr><td>Backup</td><td>A copy of all the files stored on a computer or server's hard drive made onto another device, such as a portable drive or an offsite server.</td></tr>
<tr><td>Bias*</td><td>A quantitative measure of inaccuracy or systematic departure from accuracy under specified conditions of analysis.</td></tr>
<tr><td>Buddy system</td><td>A system that enables a professional colleague (a 'buddy') to follow up results and correspondence, or continue the care of patients, on behalf of an absent colleague.</td></tr>
</table>

| Term | Definition |
| --- | --- |
| **Calibration*** | The process of testing and adjusting an instrument, kit or test system, to provide a known relationship between the measurement response and the value of the substance being measured by the test procedure. |
| **Care outside of normal opening hours** | Clinical care that is provided to patients when the practice is normally closed. |
| **Carer** | A person who provides unpaid care and support to one or more family members and/or friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue, or who are frail aged. |
| **Chaperone** | An impartial observer to a consultation between a practitioner and a patient. |
| **Climate resilience** | The ability of a general practice to anticipate, prepare for, respond to and recover from climate-related events or environmental changes in ways that maintain safe, continuous and high-quality care. |
| **Coding** | The process of recording patient health information using codable fields linked to a nationally recognised medical vocabulary, such as SNOMED CT-AU or ICPC-2.<br><br>Coding allows consistent recording of diagnoses, procedures and other data to support quality improvement, population health reporting and continuity of care. |
| **Clinical decision limits*** | Specific cut-off points or limits that inform decisions about diagnoses or well-defined specific actions, based on guidelines from expert groups. |
| **Clinical governance** | A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care. |
| **Clinical handover** | The transfer from one professional person or group to another of professional responsibility and accountability for some or all aspects of a patient's care. |
| **Clinical information system** | An item of software used in general practice to perform a range of clinical and administrative functions, including the management of patients' personal details, histories, recalls and reminders, medications and prescriptions, referrals and reports, diagnostic correspondence and clinical decision support. |
| **Clinical information** | All information the practice receives about their patients from sources other than the patient. It could include (but is not limited to) pathology results, imaging reports, investigation reports, discharge summaries and letters received from other doctors and other clinical correspondence. |
| **Clinical risk management system** | A system to manage the risk of errors and adverse events in the provision of healthcare. |
| **Clinical significance** | A way of referring to an assessment of:<br>• the probability that a patient will be harmed if they do not receive further medical advice, treatment or other diagnostics<br>• the likely seriousness of the harm. |
| **Clinical team** | All members of the practice team who have health qualifications that qualify them to perform clinical functions (including doctors, nurses, workers, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and allied health care professionals). Members of the clinical team could include employees and independent doctors in practice. |

| Term | Definition |
| --- | --- |
| **Code of conduct** | A set of principles that describe good practice and explicitly state the standards of ethical and professional conduct that the practice believes professional peers and the community expect of members of the practice team. |
| **Cold chain management** | The system of transporting and storing vaccines from the time they leave the place of manufacture to the point of administration in order to keep the vaccines within the temperature range of 2–8°C. |
| **Communicable disease** | An infectious disease that is transmissible from one person to another, or from an animal to a person, by:<br>• direct contact with an infected person or animal<br>• direct contact with an infected person's or animal's discharges<br>• indirect means. |
| **Complaint** | Any verbal or written expression of dissatisfaction or concern with an aspect of the general practice. A complaint may be made using, for example, a complaints process, consumer surveys or focus groups. |
| **Comprehensive care / Comprehensiveness** | The coordinated delivery of the total health care required or requested by a patient. The scope of clinical practice is challenging, spanning prevention, health promotion, early intervention for those at risk, and the management of acute, chronic and complex conditions within the practice population whether in the home, practice, health service, outreach clinic, hospital or community. Comprehensiveness ensures services are not limited by body system, disease process or service site. |
| **Confidentiality** | The act of keeping information secure and/or private, so that it is only ever disclosed to, or accessed by, an authorised person. |
| **Consequence** | The effect that an event had, has, or would have, on one or more of the practice's objectives. |
| **Consultation note** | A note in a patient's health record, made during or after a consultation, that contains relevant information about the consultation. |
| **Consumables*** | Products required to perform a point of care test, such as cartridges, reagents, and calibrators. |
| **Consumer** | A person who uses a health service, or someone who provides support for a person using a health service. Consumers can be patients, carers, family members or other support people. As a collective, consumers are referred to as a community. |
| **Consumer engagement** | The meaningful involvement of consumers in decision-making about health service design, care and treatment. |
| **Consumer representative** | A consumer who has taken on a specific role to provide advice on behalf of consumers, with the overall aim of improving healthcare. |
| **Continuing Professional Development (CPD)** | Educational activities endorsed by the RACGP that lead to improved quality of clinical care. |
| **Continuity of care / Continuous care** | When a patient experiences a series of discrete healthcare events and/or services that are coherent, connected and consistent with their medical needs and personal circumstances. |
| **Controls*** | The material used to perform quality control testing. |
| **Cooperative** | A group of general practices that have an arrangement to work together to provide care to patients outside the normal opening hours of their practices. |
| **Cultural background** | Details of a patient's cultural heritage that the practice has collected and recorded. |

| Term | Definition |
| --- | --- |
| **Cultural safety** | The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs. |
| **Current, evidence-based guidelines and standards** | Guidelines and standards that use a broad evidence base, are peer reviewed and endorsed by the general medical sector, including research and tertiary education institutions, peak bodies such as medical colleges, and government agencies. |
| **Cyber** | Relating to, or characteristic of, the culture of computers, information technology, and virtual reality. |
| **Cyber security incident** | A malicious ICT event, whether attempted or successful, that involves an attempt at stealing, altering or destroying data, money, or intellectual property, or disrupting the proper operation of computers or networks. |
| **Demographic** | A particular sector of a population. |
| **Digital communications** | The exchange of information using digital technologies. Digital communication tools used by a general practice can include, but are not limited to, emails, SMS and other messaging apps, electronic health records, patient portals, mobile health apps, and remote patient monitoring. |
| **Digital health technologies** | The use of digital technologies and platforms to deliver healthcare services remotely or to complement in-person care. They include telehealth, mobile health apps, patient portals, remote monitoring devices, and secure messaging platforms. |
| **Disability** | A condition characterised by any or all the following features:<br>• Impairments resulting in problems in body function or structure<br>• Activity limitations resulting in difficulties in executing activities<br>• Participation restrictions resulting in problems in participating in life situations |
| **Discrimination** | Different treatment or consideration of a patient based on characteristics, such as gender, age, ethnicity and religion.<br><br>Positive discrimination enhances the care given to the patient. Negative discrimination potentially reduces, or does reduce, the quality of the care given to the patient. |
| **Duty of care** | The legal obligation to safeguard others from harm while they are in the care of clinicians, using practice services, or exposed to any of the practice's other activities. |
| **Electronic communication** | The electronic transfer of information (including, but not limited to, patient health information) within or outside the practice, via, for example, clinical information systems, email, internet communications, text message or facsimiles. |
| **Emergency** | A serious, unexpected, and often dangerous situation requiring immediate action. For example, natural, public health and patient emergencies. |
| **Emergency contact** | The person whom a patient has nominated to be contacted if they are involved in an emergency. |
| **Employed members of the practice team (Employees)** | Individuals who work directly for the practice under a formal employment agreement. They receive wages, benefits, and are generally subject to the practice's management and policies, with their working hours and responsibilities directly controlled by the practice. |
| **Encryption** | The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity. |

| Term | Definition |
| --- | --- |
| **Environmental cleaning** | The process of removing all visible dust, soils and other material from a surface. |
| **Environmental-impact assessment** | Methods for assessing the environmental impact of an activity or item, including observations, routine practices, and periodic reviews, in order to identify ways to reduce the practice's environmental impact. |
| **Ergonomic assessment** | The process of evaluating the extent to which a workstation and workspace is designed to minimise the risk of injury and to maximise productivity. Also referred to as a workstation assessment. |
| **Ethical dilemma** | A situation in which there is a need to choose between two courses of action, both of which will result in an ethical principle being compromised. |
| **Ethics (or code of ethics)** | The principles adopted by an organisation to guide its decisions and actions in accordance with accepted professional standards of conduct. |
| **External quality assurance program*** | An external program enabling a practice to compare Point of Care test results with a reference sample. |
| **Ethnicity** | Details of a patient's ethnicity that the practice has collected and recorded. |
| **Firewall** | Security software that prevents unauthorised (and usually external) access to information stored on a private network, and controls the flow of data according to specific rules defined by the practice. |
| **Follow up** | Activities that are the logical and responsible steps to take after earlier related actions. Examples include:<br>• making a phone call to find out the status of tests and results that are expected but have not yet been received<br>• contacting a patient to discuss a report, test or results. |
| **Gender** | A social and cultural concept that refers to social and cultural differences in identity, expression and experience as a man, woman or non-binary person. 'Non-binary' is an umbrella term describing gender identities that are not exclusively male or female. |
| **General practice** | The provision of GP-led, comprehensive, person-centred, whole-person and continuous primary healthcare to individuals, families and communities. |
| **General practitioner (GP)** | A registered medical practitioner who:<br>• is qualified and has the required competence to provide general practice anywhere in Australia<br>• has the skills and experience to provide comprehensive, person-centred, whole-person and continuous primary healthcare to individuals, families and communities<br>• maintains their professional competence in general practice. |
| **GP-led** | GP-led care refers to primary healthcare services:<br>• that are clinically governed primarily by one or more GPs<br>• have GPs who are physically present and provide patient consultations in person on a regular and ongoing basis. |
| **Governance risk** | The potential for adverse impacts arising from how an organisation is managed. |
| **Hard copy** | A physically printed or written document, including records, information, or data. |
| **Hardware** | The physical components of a computer, including monitors, hard drives and central processing units. |

| Term | Definition |
| --- | --- |
| **Harm** | A damaging effect on a person, such as disease, injury, suffering, disability or death. Harm may be physical, social or psychological. |
| **Health information** | A subset of a patient's personal information that is collected in connection with the provision of a health service. It includes information and opinions about the health and/or disability of an individual, and a patient's wishes about future healthcare and health services. |
| **Health literacy** | The ability of a person to access, understand, appraise and apply health information in order to make informed decisions and take appropriate actions regarding their health and healthcare. |
| **Health outcome** | The health status of an individual, group of people or specific population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals. |
| **Health promotion** | The process of enabling people to increase their control over their health and change their behaviour in order to improve their health. It also encompasses a wide range of social and environmental interventions. |
| **Health summary** | Documentation usually included in a patient's health record that provides an overview of all components of the patient's healthcare, such as current medications, relevant past health history, relevant family history, allergies and adverse drug reactions. |
| **High-risk results** | Clinical test results that are seriously abnormal and indicate a life-threatening condition and need to be communicated as soon as practicable. |
| **Home visit** | A general practice consultation conducted in the patient's (or someone else's) home. |
| **Human research ethics committee (HREC)** | A committee constituted according to National Health and Medical Research Council requirements that assess applications from people and organisations undertaking research projects involving human subjects. |
| **Human resources** | There are two definitions:<br>• The people who work in an organisation<br>• An area of business management that addresses the recruitment, training and management of the people who work in an organisation. |
| **Hybrid patient health record** | A combination of digital clinical information systems used by one or more practitioners to record patient information. |
| **Incident** | An event or situation that resulted, or could have resulted, in:<br>• unintended and/or unnecessary harm to a person<br>• a complaint, loss, damage or claim for compensation. |
| **Inactive patient** | A patient who has not attended the practice/service three or more times in the past two years. |
| **Indemnity** | A form of security or protection against a financial loss or other financial burden. Medical indemnity insurance is a compulsory condition of registration for all medical practitioners in Australia. |
| **Independent doctor in practice** | A registered medical practitioner who provides care to their patients while operating their own business from the practice, as an independent professional rather than as an employee or contractor of the practice. |

| Term | Definition |
| --- | --- |
| **Individual healthcare identifier** | A patient's unique 16-digit number allocated by the Department of Human Services. Each eligible Australian patient who seeks healthcare is allocated one. |
| **Induction program** | A structured process designed to welcome new members of the practice team and introduce them to the practice's systems, processes and structures. |
| **Infection** | The invasion and reproduction of pathogenic (disease-causing) organisms inside the body that can cause tissue injury and can lead to disease. |
| **Infection control measures** | Actions to prevent the spread of pathogens between people in a healthcare setting. |
| **Information and Communication Technology (ICT)** | Technological tools and systems used to transmit, store, create, share, and access information. Comprising computer hardware and software, as well as telecommunication networks, it enables effective communication and the exchange of information across multiple platforms. |
| **Information management** | The policies, processes and systems that govern the creation, use and storage of information. |
| **Information security** | The protection of the confidentiality, integrity and availability of information. |
| **Instrument*** | A platform, system or device used for testing. |
| **Interpreter service** | A service that provides interpretation or translation of one or more languages, delivered face-to-face, or by telephone or digital communication. The interpretation or translation is conducted by trained personnel. |
| **Informed consent** | A person's decision, given voluntarily, to agree to a treatment, procedure or other intervention. Consent is considered to be informed if the person providing the consent:<br>• has been given accurate and relevant information about the proposed intervention and other available options; and<br>• has adequate knowledge and understanding of the relevant benefits and risks of the proposed intervention. |
| **Informed refusal** | A patient's refusal of proposed or recommended treatment when they understand all relevant information, including the implications of refusing the treatment. |
| **Innate variations of sex characteristics** | Innate genetic, hormonal or physical sex characteristics that do not conform to medical norms for female or male bodies. This encompasses a wide spectrum of variations to genitals, hormones, chromosomes and/or reproductive organs. It is also referred to as 'differences/disorders of sex development'. |
| **In-person consultation** | A consultation between a medical practitioner and a patient when they are in the same room. It could be conducted at general practice premises, at a hospital or aged care facility, or via a home visit. |
| **Intersex** | A person born with genetic, hormonal or physical sex characteristics that are not typically male or female. |
| **Intravenous consumables** | The equipment used to administer fluid or medications intravenously. When referring to the practice equipment and doctor's bag, this includes items such as cannulas or butterflies, bungs, and film dressing or tape, but does not necessarily include fluids. |
| **In vitro*** | Outside the body; in a clinical or research laboratory; in an artificial environment such as a test tube or petri dish. |

| Term | Definition |
| --- | --- |
| **In vitro diagnostic medical device (IVD)*** | A medical device (including a reagent, calibrator, control material, kit, specimen receptacle, software, instrument, apparatus, equipment or system) used in vitro to examine specimens from a human body. |
| **Issue** | A relevant event that was not planned (such as a problem, query, concern or risk) and requires action. |
| **LGBTIQA+** | Initialism for lesbian, gay, bisexual, transgender, intersex, queer, asexual, and other gender and sexual diversities. |
| **Lifestyle risk factors** | Habits or behaviours that people engage in that, if changed, can directly affect some medical risk factors by reducing the likelihood of developing disease. |
| **Medical consumable** | A medical product used for a therapeutic purpose that is not pharmaceutical and is not re-usable (for example, a syringe). |
| **Medical deputising service** | A service that arranges for, or facilitates, the provision of medical services to a patient by a medical practitioner (deputising doctor) during the absence of, and at the request of, the patient's GP (principal doctor). |
| **Medicine** | A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. It includes prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered. |
| **Members of the clinical team** | Individual members of the practice team who have health qualifications that qualify them to perform clinical functions. For example, doctors, nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, and allied healthcare professionals. See clinical team (#clinicalteam) . |
| **Member of the practice team** | An individual member of the practice team. See practice team ( #practiceteam) . |
| **Mission** | The fundamental purpose of an organisation that sets the direction for daily operations. |
| **Natural disaster / emergency** | A situation caused by natural events, like floods or fire, that significantly disrupts normal operations and poses a threat to the safety of patients, members of the practice team, and/or the practice. |
| **Natural immunity** | Immunity to a particular infection that is not the result of vaccination or previous infection, but is inherent in the genetic make-up of the individual, family, etc. |
| **Near miss** | An incident that had the potential to cause harm, but did not result in actual harm. |
| **Network** | A group of computers and peripheral devices that are connected in order to facilitate the electronic storage and sharing of information. |
| **Next of kin** | A person's closest living relative or relatives, as identified by that person. |
| **Non-conformance*** | Departures from standard procedures, or instances where the process or system does not comply with the predetermined specifications. |
| **Normal opening hours** | The advertised opening hours of a practice. |

| Term | Definition |
| --- | --- |
| **Nurse** | Any of the following:<br>• **Enrolled Nurse (EN):** A nurse with a diploma-level qualification who provides nursing care under the direction and supervision of a Registered Nurse, and practises within a defined, delegated scope.<br>• **Registered Nurse (RN):** A nurse with an accredited degree who practises independently and collaboratively, to provide comprehensive assessment, planning and delivery of nursing care, and the supervision of Enrolled Nurses.<br>• **Nurse Practitioner (NP):** An experienced Registered Nurse endorsed for advanced practice, who is authorised to diagnose, order tests, prescribe medicines and manage patient care autonomously. |
| **Open disclosure** | An open discussion with a patient and their carer about an incident(s) that resulted in harm to that patient while they were receiving healthcare. An open disclosure includes all of the following:<br>• an apology or expression of regret (including the word 'sorry')<br>• a factual explanation of what happened<br>• an opportunity for the patient to relate their experience<br>• an explanation of the steps being taken to manage the event and prevent recurrence. |
| **Operational plan** | A plan that specifies operational objectives, specific actions and steps, and day-to-day activities necessary to achieve strategic goals. |
| **Operational objective** | Specific, precise actions or steps to be taken to achieve a goal, by breaking down the goal into manageable parts. |
| **Organisational chart** | A representation (often presented visually) of an organisation's structure, which includes components such as departments, divisions, properties, hierarchies, roles, responsibilities and professional relationships between people. |
| **Other visit** | A general practice consultation in a facility other than the general practice or the patient's home (for example, a residential aged care facility). |
| **Outside of normal opening hours** | The hours other than the practice's normal opening hours. |
| **Over-the-counter medicine** | Medicines that people can purchase from retailers (such as pharmacies, supermarkets and health food stores) for self-treatment. |
| **Patient** | A person who is seeking or receiving healthcare. |
| **Patient emergency** | Any urgent medical situation experienced by a patient that necessitates immediate assessment and treatment to prevent serious harm or deterioration in their health. |
| **Patient health information** | A patient's name, address, Medicare number and any other information (including opinions) about the patient's health. Examples include, but are not limited to, clinical results, referrals, care plans, incoming and outgoing correspondence and hospital discharge summaries. |

| Term | Definition |
| --- | --- |
| **Patient health record** | Information held about a patient in paper form or electronic form, which may include:<br>• contact information<br>• demographic information<br>• medical history<br>• notes on treatment<br>• observations<br>• correspondence<br>• investigations<br>• test results and photographs<br>• prescription records<br>• medication charts<br>• insurance information<br>• legal information and reports<br>• work health and safety reports. |
| **Person centredness** | An approach to healthcare that places a person's needs, values and preferences at the forefront of decision-making about their healthcare, thereby empowering them to take an active role in their own health and wellbeing. |
| **Personal protective equipment (PPE)** | Equipment used as an infection prevention and control measure. It includes gloves, waterproof gowns, goggles and face shields, masks and appropriate footwear. |
| **Point-of-care testing (PoCT)*** | Pathology testing performed at the point or time of care that helps healthcare practitioners make immediate and informed decisions about a patient's care. |
| **Point-of-care testing practitioners (PoCT practitioners)*** | Members of the practice team who perform PoCT who:<br>• have undertaken training<br>• participate in training and education updates. |
| **Policy** | A documented requirement that specifies the practice's principles and rules relating to specific activities or behaviours. Policies need to be documented (in either paper or electronic form) and easily accessible by all members of the practice team. |
| **Position description** | A document describing the role, responsibilities and conditions of employment of an employed member of the practice team. |
| **Post-analytical*** | Post-testing processes, such as reporting. |
| **Practice environment** | The facilities or area used to conduct practice operations and provide care to patients. This could include, but is not limited to, a clinic, vehicle or home office. |
| **Practice leadership** | The members of the general practice leadership team which could include the practice owner, practice manager and clinical leads. |
| **Practice management** | The strategic planning, reviewing and implementation of processes that aim to increase a practice's efficiency and contribute to excellence in healthcare. |
| **Practice team** | Everyone who works for or provides care from the practice, including employees and independent doctors in practice. |
| **Practitioner/clinician** | A member of the practice team who has health qualifications that qualify them to perform clinical functions (including a doctor, nurse, Aboriginal Health Worker, and allied healthcare professional). |
| **Pre-analytical*** | Pre-testing processes, such as test requests. |
| **Precision*** | The measure of the closeness of results obtained after analysing the same sample more than once. |

| Term | Definition |
| --- | --- |
| **Privacy policy** | A document formulated by a practice that specifies how they manage patient health information in compliance with the requirements of the Australian Privacy Principles (APPs). |
| **Public health emergency** | A widespread threat to public health, often caused by infectious diseases or other hazards, that requires coordinated efforts to control and mitigate its impact on the community. |
| **Qualified** | Holding the educational or other qualifications required to perform a specific activity, or hold a specific role such as GP or registered nurse. |
| **Quality assurance** | The maintenance of a desired level of quality in a service or product, especially by attending to every stage of the process of delivery or production. |
| **Quality control (QC)*** | The set of procedures designed to monitor a test method and its results to ensure consistent quality performance of a test system. These procedures include testing control materials, charting the results and analysing them to identify sources of error, and evaluating and documenting any consequential remedial action taken. |
| **Quality improvement** | One or more activities undertaken by a practice to monitor, evaluate, or improve the quality of the healthcare it delivers. |
| **Reagent*** | A substance that produces a chemical reaction in a sample, allowing an analyte to be detected and measured. |
| **Recall** | The act of requesting a patient to attend a consultation to receive further medical advice on matters of clinical significance. |
| **Reference interval*** | In relation to a particular test, the average value for the 'normal' population group together with the variation around that value (plus or minus two standard deviations from the average). In this way, ranges quoted represent the values found in 95% of individuals in the chosen non-diseased or 'reference' group. |
| **Referral** | The process of sending or directing a patient to another practitioner. |
| **Relevant family history** | Information about a patient's family history that the practitioner considers important in order to provide the patient with appropriate clinical care. |
| **Reminder** | A prompt to remind patients to visit their general practice or carry out routine or important tasks related to their health. |
| **Research** | The process of creating new knowledge and/or using existing knowledge in a new or creative way to generate new concepts, methodologies, inventions and understandings. Research in general practice could involve patients through:<br>• direct patient involvement (for example, through clinical trials, observational activities, interviews or focus groups)<br>• indirect patient involvement (for example, through the collection of deidentified patient data). |
| **Respiratory etiquette** | Public health measures used to reduce the spread of respiratory infections, such as encouraging people to cover their mouth or nose when coughing or sneezing, use tissues to blow their nose, dispose of used tissues, and wash their hands after touching their nose. |
| **Response plan** | A plan that specifies how a practice will continue providing services if unexpected events (for example, natural disaster, health emergency, cyber emergency, disruptions to business as usual) affect the continuity of its services. |
| **Risk** | An event or set of events that, if they occurred, would adversely affect the achievement of objectives. |

| Term | Definition |
| --- | --- |
| **Risk management** | Systematic application of principles, approaches and processes to:<br>• identify, assess and minimise risks<br>• plan appropriate responses if a risk was to become a reality<br>• implement appropriate responses when required. |
| **Risk matrix** | A matrix used to categorise risks according to their probability and the severity of the effects they would cause. |
| **Risk register** | A document used to record problems and issues that could result in a risk becoming a reality, and the steps taken to minimise the likelihood or effect of the risk. |
| **Safe and reasonable** | A description of the desired outcome of a clinical care decision made by a practice that was based on relevant factors, such as the practice's location and patient population, and an understanding of what their peers would agree was safe and reasonable. |
| **Safety** | The condition that means potential risks and unintended results are avoided or minimised. |
| **Schedule 4 medicines** | Substances, the use or supply of which should only be by or on the order of people permitted by State and Territory legislation to prescribe, and available from a pharmacist on prescription. |
| **Schedule 8 medicines** | Substances that are available for use, but for which there are strict regulations relating to their manufacture, supply, distribution, possession and use, in order to reduce abuse, misuse, and physical and psychological dependence. |
| **Screen*** | The examination of asymptomatic people to classify them as likely or unlikely to have a disease. |
| **Screensaver** | A software program that, after a specified time of inactivity, displays constantly changing images, or dims the brightness of a display screen in order to protect the screen and restrict unauthorised access to the computer. |
| **Secure** | The state of being protected against unauthorised access, alteration, or disclosure through appropriate physical, technical, and administrative measures. |
| **Security** | The administrative, technical and physical safeguards in an information system that protect the system and its information from unauthorised use and disclosure. |
| **Server** | A computer that provides services to users via a network that connects a series of computers. Services can include access to files and software, central storage of data, and printing. |
| **Sex** | A person's assigned sex at birth, determined by sex characteristics observed at birth or infancy. A person's sex can change over the course of their lifetime and may differ from their assigned sex at birth. |
| **Sex characteristics** | A person's chromosomal, gonadal and anatomical characteristics associated with sex. |
| **Shared decision-making** | A consultation process whereby a clinician and their patient collaborate to make health decisions after discussions about the evidence-base, benefits, and harms of possible treatment options, and consideration of the patient's preferences, values and circumstances. |
| **Significant clinical incident** | Any event or circumstance arising during the provision of healthcare, or lack of care, that could have or did lead to unexpected actual harm. They include near misses, sentinel events and unsafe acts. |
| **Sociable hours** | The after-hours period from 6.00 pm – 11.00 pm on weeknights. |

| Term | Definition |
| --- | --- |
| **Social media** | Online social networks used to disseminate information through online interaction. |
| **Standard precautions** | Methods and practices that health professionals use to prevent infection of themselves and others, based on the assumption that all blood and body fluids are potentially infectious. |
| **Sterile** | A condition characterised by the absence of protozoa, spores, mycobacteria, fungi, Gram-positive and Gram-negative bacteria, chlamydia, Rickettsia, mycoplasma and viruses. |
| **Sterile barrier system** | The packaging for items placed in a steriliser. |
| **Sterilisation** | A validated process used to render a product free from all forms of viable microorganisms. |
| **Strategic plan** | A plan that sets specific goals and the actions needed to achieve those goals. A strategic plan answers the question: "How will we achieve our mission?" |
| **Strategic goals** | Overarching goals designed to guide the practice towards its desired future state, and which serve as a roadmap for decision-making and resource allocation. |
| **Strategy** | A method or plan for an organisation to achieve its short-term, medium-term, and long-term goals. |
| **Synchronous care** | Care delivered to consumers in real-time, which could include telehealth services or face-to-face. |
| **Technology infrastructure** | The underlying framework and components that support the functioning of a general practice's technological needs. It can include:<br>• hardware such as computers, tablets, and medical devices<br>• software for communication, the creation, storage and access of electronic health records, and security protocols<br>• networking systems, internet connectivity, and data storage solutions. |
| **Telehealth** | The use of communication technologies to transmit voice, data, images and information in order to provide telemedicine, medical education and health education, when in-person consultations are not practicable. |
| **Telephone triage** | A method of determining, over the telephone, the nature and urgency of care required, so that patients with greater urgency can be prioritised. |
| **Test method*** | A method or procedure that produces a test result. |
| **Timely** | Within an appropriate period of time for the given situation, as might reasonably be expected by professional peers. |
| **Tracking and tracing** | Part of a sterilisation process that refers to batch control identification of instruments used for a procedure on a patient. |
| **Transcription errors*** | Data entry errors that usually occur because of typographical mistakes when transferring data and results. |
| **Transition of care** | The transferral of all or part of a person's healthcare between health providers or services, whether temporary or long term. |
| **Transmission-based precautions** | Methods and practices used to prevent infection when a patient is known or suspected to be infected with a highly transmissible infection, such as influenza. They include droplet precautions, airborne precautions and contact precautions, and involve the use of appropriate measures such as triage, PPE and isolation. |

| Term | Definition |
| --- | --- |
| **Treatment plan** | A detailed plan that contains information about treatment for a patient, including the patient's condition, the goal of treatment, the treatment options and their possible side effects, and the expected length of treatment. |
| **Triage** | The prioritisation of patients, based on where resources can be best used or are most needed. |
| **Unique individual identification** | An electronic method of verifying a person's identity by ensuring they are uniquely distinguishable from others. This can include passwords, multi-factor authentication, or biometric methods such as fingerprint recognition, voice recognition, or retinal screening. |
| **Unsociable hours** | The following after-hours periods:<br>• weekdays – 11.00 pm – 8.00 am<br>• Saturdays – before 8.00 am and after 12.00 noon<br>• Sundays and public holidays – any time. |
| **Urgent** | Requiring immediate action or attention. |
| **Values** | An organisation's aspirations and goals that can guide decision-making and encourage members of the practice team to work towards common goals. |
| **Vision** | A desired future in which the practice's mission is actioned. |
| **Whole-person care** | The consideration of the interplay between the various bio-psycho-social contributors to health, leading to a deep understanding of the whole person and the ability to manage complex conditions and circumstances. A GP who provides whole-person care functions as a physician, counsellor, advocate and agent of change for individuals, families and their communities. It is also referred to as holistic care. |

# References


1. Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. Jama. 2022;327(6):521–2.
2. Department of Health and Ageing. Point of care testing in general practice trial final report. Canberra: DHA; 2009.
3. Spaeth BA, Shephard MD, Schatz S. Point-of-care testing for haemoglobin A1c in remote Australian Indigenous communities improves timeliness of diabetes care. Rural and remote health. 2014;14(4):2849.
4. Menec VH, Sirski M, Attawar D, Katz A. Does continuity of care with a family physician reduce hospitalizations among older adults? Journal of health services research & policy. 2006;11(4):196–201.
5. van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. Journal of evaluation in clinical practice. 2010;16(5):947–56.
6. Western Australia Primary Health Alliance. Comprehensive primary care: What patient centred medical home models mean for Australian primary health care. Belmont, WA: WAPHA; 2016.
7. World Health Organization. Continuity and coordination of care: A practice brief to support implementation of the WHO framework on integrated people-centred health services. Geneva: WHO; 2018.
8. Hussein M, Pavlova M, Ghalwash M, Groot W. The impact of hospital accreditation on the quality of healthcare: a systematic literature review. BMC Health Services Research. 2021;21(1):1057.
9. Debono D, Greenfield D, Testa L, Mumford V, Hogden A, Pawsey M, et al. Understanding stakeholders' perspectives and experiences of general practice accreditation. Health policy (Amsterdam, Netherlands). 2017;121(7):816–22.
10. van Vliet EJ, Soethout J, Churruca K, Braithwaite J, Luxford K, Stewart J, et al. International approaches for implementing accreditation programmes in different healthcare facilities: a comparative case study in Australia, Botswana, Denmark, and Jordan. International Journal for Quality in Health Care. 2023;35(2).
11. Bergholt Md, Falstie-jensen Am, Brink valentin J, Hibbert P, Braithwaite J, Johnsen Sp, et al. Patients experience more support, information and involvement after first-time hospital accreditation: a before and after study in the Faroe Islands. International Journal for Quality in Health Care. 2021;33(4).
12. Academy of Medical Royal Colleges. Artificial Intelligence in Healthcare. London, UK: AOMRC; 2019.
13. Lin SY, Mahoney MR, Sinsky CA. Ten Ways Artificial Intelligence Will Transform Primary Care. Journal of general internal medicine. 2019;34(8):1626–30.
14. Carers Australia. Who is a carer? (https://www.carersaustralia.com.au/about-carers/who-is-a-carer/) Canberra, ACT: Carers Australia; 2025.
15. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Primary and Community Healthcare Standards. (https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare) Sydney, NSW: ACSQHC; 2024.
16. Australian government Department of Health and Aged Care. National Medicines Policy. Canberra, ACT: DoHAC; 2022.
17. Hoffmann TC, Légaré F, Simmons MB, McNamara K, McCaffery K, Trevena LJ, et al. Shared decision making: what do clinicians need to know and why should they bother? The Medical journal of Australia. 2014;201(1):35–9.
18. Burns P, Reay E, Sandy K, Robertson N. Situation report: Australian general practitioners in disaster health management. Australian Journal for General Practitioners. 2025;54:16–24.
19. Parise I. A brief review of global climate change and the public health consequences. Australian Journal for General Practitioners. 2018;47:451–6.
20. Australian Commission on Safety and Quality in Health Care. Joint Statement: Working together to achieve sustainable high-quality health care in a changing climate. Sydney: ACSQHC; 2024.

21. Lowitja Institute. Indigenous Data Governance and Sovereignty. (https://www.lowitja.org.au/wp-content/uploads/2023/10/328550_data-governance-and-sovereignty.pdf) Carlton, Victoria: Lowitja Institute; 2021.
22. Lowitja Institute. Taking Control of our Data. (https://www.lowitja.org.au/wp-content/uploads/2024/01/Taking-Control-of-Our-Data-Discussion-Paper.pdf) Lowitja Institute; 2024.
23. Australian Government Office of the Australian Information Commissioner. Chapter 2: APP 2 Anonymity and pseudonymity. (https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-guidelines/chapter-2-app-2-anonymity-and-pseudonymity) OAIC; 2019.
24. Royal Australian College of General Practitioners. An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives. Melbourne, VIC: RACGP; 2012.
25. Australian Institute of Health and Welfare. National best practice guidelines for collecting Indigenous status in health data sets. Canberra: AIHW; 2010. Cat. no. IHW 29.
26. Murray JS, Clifford J, Larson S, Lee JK, Sculli GL. Implementing Just Culture to Improve Patient Safety. Military Medicine. 2022;188(7-8):1596–9.
27. Marr Linsey C, Samet Jonathan M. Reducing Transmission of Airborne Respiratory Pathogens: A New Beginning as the COVID-19 Emergency Ends. Environmental Health Perspectives. 132(5):055001.
28. Australian Government National Health and Medical Research Council. Australian Code for the Responsible Conduct of Research. Canberra, Australia: National Health and Medical Research Council; 2018.
29. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights (second edition). ACSQHC; 2020.
30. Communication Hub. Augmentative and Alternative Communication (AAC). (https://communicationhub.com.au/Communication_Hub/Resources/Fact_Sheets/Augmentative-and-Alternative-Communication.aspx) 2023.
31. Easy Read Australia. Easy Read (or Easy English). (https://easyreadaust.com.au/easy-read/) Easy Read Australia; 2022.
32. Ahpra and National Boards. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025. Ahpra; 2020.
33. Williams R. Cultural safety — what does it mean for our work practice? Australian and New Zealand Journal of Public Health. 1999;23(2):213–4.
34. Australian Commission on Safety and Quality in Health Care. Informed Consent — Fact sheet for clinicians. ACSQHC; 2020.
35. Australian Government Department of Health and Aged Care. About preventive health in Australia. (https://www.health.gov.au/topics/preventive-health/about) DoHAC; 2023.
36. World Health Organization. Health promotion. (https://www.who.int/health-topics/health-promotion#tab=tab_3) WHO; n.d.
37. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013;3(1):e001570.
38. Australian Commission on Safety and Quality in Health Care. Partnering with consumers. (https://www.safetyandquality.gov.au/our-work/partnering-consumers) Canberra: ACSQHC; 2024.
39. Commonwealth of Australia Department of Health and Aged Care. Draft National Consumer Engagement Strategy for Health and Wellbeing. Canberra, ACT: DoHAC; 2023.
40. NSW Government Agency for Clinical Innovation. About patient-reported measures. (https://aci.health.nsw.gov.au/statewide-programs/prms/about) Sydney, NSW: ACI; n.d.
41. Australian Commission on Safety and Quality in Health Care. About PROMs. (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcome-measures/about-proms) Canberra, ACT: ACSQHC; 2024.
42. Australian Commission on Safety and Quality in Health Care. PROMs for implementers. (https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcomes/proms-implementers) Sydney, NSW: ACSQHC; 2024.
43. Victorian Comprehensive Cancer Centre (VCCC) Alliance. Model of Consumer Engagement. VCCC Alliance; n.d.
44. Tirimacco R. Evolution of Point-of-Care Testing in Australia. The Clinical biochemist Reviews. 2010;31(3):75–80.
45. Tideman P, Simpson P, Tirimacco R. Integrating PoCT into Clinical Care. The Clinical biochemist Reviews. 2010;31(3):99–104.

46. Shephard M, editor. A Practical Guide to Global Point-of-Care Testing. CSIRO Publishing; 2016. 488 p.
47. Nichols JH. Quality in point-of-care testing. Expert review of molecular diagnostics. 2003;3(5):563–72.
48. Shephard MD, Mazzachi BC, Watkinson L, Shephard AK, Laurence C, Gialamas A, et al. Evaluation of a training program for device operators in the Australian Government's Point of Care Testing in General Practice Trial: issues and implications for rural and remote practices. Rural and remote health. 2009;9(3):1189.
49. Gill JP, Shephard MD. The Conduct of Quality Control and Quality Assurance Testing for PoCT Outside the Laboratory. The Clinical biochemist Reviews. 2010;31(3):85–8.
50. National Pathology Accreditation Advisory Council. Requirements for point of care testing (Second Edition 2021). Canberra, ACT: NPAAC; 2021.

# Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. This publication is not exhaustive of the subject matter and should not be taken to be. The information set out in this publication does not constitute medical, legal or other professional advice; persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates. RACGP does not warrant the accuracy or completeness of third-party materials referenced in this publication.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP)  its assignees, employees, agents and any subsidiaries shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information. To the extent permitted by law, all express or implied warranties, representations and guarantees are excluded. Nothing in this disclaimer excludes, restricts or modifies rights that cannot lawfully be excluded under the *Competition and Consumer Act* 2010 (C'th) and or any equivalent state or territory legislation.

**Recommended citation**

The Royal Australian College of General Practitioners. Standards for general practices. 6th edn.  East Melbourne, Vic: RACGP, 2026.

The Royal Australian College of General Practitioners Ltd 100 Wellington Parade East Melbourne, Victoria 3002

Tel 03 8699 0414 Fax 03 8699 0400 www.racgp.org.au

ABN: 34 000 223 807

Published July 2026



We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.