RACGP Submission to the Australian Commission on Safety and Quality in Health Care

National Safety and Quality Primary and Community Healthcare Standards Guide for Healthcare Services Consultation (February 2023)

About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. We are Australia's largest professional general practice organisation representing more than 40,000 urban and rural general practitioner members. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

The RACGP has a long and proud history of keeping general practice at the forefront of the quality agenda, supporting our members in their pursuit of excellence in patient care and community service and, supporting efforts aimed at improving quality and safety across the health system.

The RACGP has a 30-year history in the development of standards for use in a primary healthcare setting. The RACGP *Standards for general practices*, now in their5th edition, (the Standards) are profession led and form a foundational benchmark for quality and safety in Australian general practice. They are developed after an extensive public consultation and incorporate consideration of the expectations of consumers, and stakeholders. They are subject to rigorous and continuous evaluation and independently accredited by the International Society for Quality and Safety in Health Care.

The Standards are widely accepted by the profession and recognised as a benchmark across the health sector. This demonstrates and highlights the importance of having standards that are owned and supported by the profession within which they are to be applied. With this history and accumulation of expertise, the RACGP is well placed and willing to support the development of standards for other primary healthcare settings.

Previous feedback

The RACGP thanks the Australian Commission on Quality and Safety in Health Care (ACSQHC) for the opportunity to contribute to the consultation on the National Safety and Quality Primary and Community Healthcare Standards Guide for Healthcare Services (the Guide). As the ACSQHC is aware, the RACGP has previously provided significant feedback on the National Safety and Quality Primary and Community Healthcare Standards (NSQPCHS) since the commencement of its development in 2017. Our initial submission was made in 2017, with subsequent feedback provided in 2019.

The RACGP supports efforts to improve patient safety, avoid unnecessary duplication, and improve communication and collaboration between providers. However, we remain unclear as to how identical standards for all non-general practice primary healthcare settings will achieve these outcomes.

The RACGP met with the ACSQHC in June 2021 and assurances were provided by ACSQHC management that specific guidance would be added to clarify that:

1. the NSQPCHS are not intended to replace profession-led and authored standards that already exist
2. the RACGP's *Standards for general practices* (5th edition) are the accreditation requirements for the Australian general practice profession.

However, despite agreement to do so at the meeting, the final version of the NSQPCHS does not include this clarification and the ACSQHC continues to release supporting material which includes general practice.

Global feedback

Language and useability

The RACGP has previously provided feedback regarding concerns about the use of a national set of standards for all non-general practice primary healthcare settings (other primary healthcare settings). Our concerns are based on the significant variances between practice models, clinical focus, patient cohorts and services provided.

These significant differences make it difficult, if not impossible to implement a single set of national standards. However, the RACGP accepts that the NSQPCHS are now published, with accreditation due to commence in 2023. As such, for the Guide to be useful, we recommend that a significant revision is undertaken especially to explanatory materials in the Guide.

Plain English

As it stands, the language used in the Guide is complex and requires simplification. The use of jargon contributes to this complexity making the interpretation of each Action a challenge. Simplifying the language and minimising the use of jargon will improve the useability and accessibility of the document, particularly for sole traders or smaller healthcare services.

The RACGP recommends that the Guide is re-written in plain English with a focus on the reader (ie using a reader-centred tone of voice) to ensure that the content is clear and concise with less ambiguity. Using a reader-centred tone of voice will improve not only interpretation of the NSQPCHS but also ensure that patient-centred intent and outcomes are appropriately expressed and conveyed.

Increased specificity

The proposed explanatory notes lack specificity and do not provide the required context for healthcare services to understand the intent of the requirements. To support interpretation, each Action should be described in greater detail with clear linkages to the consumer outcome of each Standard and Criteria.

As other primary healthcare services differ in size, scope of practice and patient cohort, it may be useful to include setting-specific information/ examples to support interpretation of each Action. Including setting-specific examples will clarify the requirements and expectations of the NSQPCHS for healthcare services. Providing more specificity will improve interpretation of the NSQPCHS, making the process of implementation more meaningful for healthcare services as well as ensure the requirements reflect what actually occurs in the healthcare service rather than developing policies and processes that will not be implemented because they are not meaningful to the team.

Terminology

The RACGP appreciates the rationale for terminology use that is clarified at the start of the document, however, there is additional terminology used throughout the Guide that requires clarification. For example, the NSQPCHS makes several references to 'safety and quality' in the context of training and development (1.15), roles and responsibilities (1.17) and evaluating performance (1.18).

The RACGP recommends that the use of 'safety and quality' in this context is described in greater detail in the Guide supported by specific examples to clarify the intent of these actions.

This is one example, there are other terms within the Guide that would benefit from being defined.

Enhance patient centricity

The RACGP commends the ACSQHC on the development of a detailed guide to support implementation of the NSQPCHS. However, the RACGP is concerned that the 'Key tasks' and 'Examples of evidence' identified for compliance to the NSQPCHS within the guide are overly prescriptive and process driven and do not reflect the outcome the healthcare service needs to achieve. This moves the NSQPCHS away from being patient-centred to being compliance driven.

The RACGP recommends that the 'Key tasks' within each Action are reviewed and rewritten with patient centric focus, linking directly to the statement of intent and consumer outcome for each Action. Similarly, the 'Reflective questions' section of each Action would benefit from a rereview to ensure that a patient centric lens is applied. Clear linkages to each Standard and Criteria consumer outcome statements will provide the 'why' for each requirement clarifying the intent and the expected outcome for healthcare services.

Excessive documentation

The RACGP is concerned at the breadth of evidence that healthcare services are expected to generate in order to be accredited against the NSQPCHS. The current examples within the Guide do little to encourage healthcare services to move towards a patient-centred, safety and quality framework for the delivery of health care. While not all Actions require evidence in the form of documentation, the majority of them do. The evidence required for accreditation should be generated in the normal course of clinical care and service management, and not as a result of preparing for assessment. This runs the risk of healthcare services developing documentation purely for compliance purposes rather than as part of an applied outcomes focussed, safety and quality system. Further, excessive documentation directs capacity away from patient care, resulting in poor health outcomes.

For example, the evidence listed in Action 1.04 (Risk management) requires healthcare services to provide documentation of processes, risk registers and training. This may be excessive for sole traders or smaller healthcare services and runs the risk of accreditation becoming a box-ticking exercise and therefore contributing very little to patient safety.

The RACGP recommends that the ACSQHC reviews the required evidence requirements and identifies more outcomes focussed opportunities to demonstrate compliance. By focussing on outcomes, healthcare services can develop processes and systems that reflect their preferred way of working. This will increase the likelihood that a framework or system will be adopted.

Where possible, documentation should be consolidated and cross referenced to streamline the accreditation process and reduce duplication. For example, to meet Actions 1.04(a) (Risk management) and 3.01(b) (Integrating clinical governance), healthcare services should only need to supply a risk register with clinical safety entries. Similarly, healthcare services should be able to meet both Action 1.15 (Safety and quality training) and Action 3.01(c) (Integrating clinical governance), by providing relevant training documents.

Clarity on the interface between standards that comprise NSQPCHS

The interface between each of the three standards (Clinical governance, Partnering with consumers, Clinical safety) in the NSQPCHS should be made at the outset of the Guide, with detailed information on how the NSQPCHS is designed to be implemented. While the information is available, it is currently located within the explanatory notes in some Actions of the Clinical Safety standard with no mention of the linkage in either the Clinical Governance or the Partnering with Consumer standards.

Clarity is required at the outset to ensure healthcare services can adequately prepare for accreditation without duplication of effort, and to be able to streamline, where possible, all necessary evidence required. This will set clear expectations for healthcare services and aid in creating consistency in the preparation for accreditation and assessment against the NSQPCHS.

Consistency in expectations

The RACGP previously provided feedback on the NSQPCHS, which noted that some Actions are quite broad while others have more specific requirements. It is important that additional guidance is provided where Actions are broad and non-specific.

The NSQPCHS and the Guide would benefit from a consistent 'voice' in identifying the requirements for healthcare services. For example, in both Action 1.09 and 1.10 (Patient populations and social determinants of health), further information could be added in the explanatory notes to guide healthcare services on the type of planning or service delivery that could address health inequity and improve health outcomes in their setting. This will not only set clear expectations for healthcare services but ensure that the level of compliance expected from healthcare services is communicated at a similar level.

Further, as mentioned above, it might be useful that setting-specific information is provided, where relevant.

Duplicated actions from the National Safety and Quality Health Services Standards

The RACGP notes that some Actions within the NSQPCHS have been directly adapted from the National Safety and Quality Health Service (NSQHS) Standards. While the RACGP understands that the intent is to create a national framework for safety and quality in primary care, it is critical that requirements are appropriately contextualised within the Guide and considers how primary healthcare environments operate.

For example, Action 1.19 (Scope of clinical practice) has been adapted from, if not directly duplicated from Action 1.23 in the NSQHS Standards. While the RACGP agrees with the importance of ensuring that healthcare providers are practicing within their designated scope of practice, it is unclear how healthcare services are expected to "[m]onitor […] healthcare providers' practices to ensure they are operating within their designated scope of practice". The Guide notes that healthcare services can undertake a "[r]eview of services provided against described scope of practice" or "communication that demonstrates monitoring" to show compliance. Not only are the examples provided impractical, they demonstrate a lack of understanding of the primary healthcare environment. The implementation of this Action as described in the Guide would create unnecessary administrative burden for healthcare services. Further, to undertake monitoring of healthcare providers' practices as described in the example could impinge on their clinical autonomy and create a culture of micromanagement and distrust.

Action 1.21 (Variation in care delivered and health outcomes) is another example of a requirement that has been adapted from the NSQHS Standards (Action 1.28) without due consideration to the primary healthcare environment. The explanatory materials list an example of evidence as "[r]ecords of clinical practice audits where service delivery was compared against best practice guidelines and opportunities for improvement identified". Again, this is an impractical example for primary healthcare services. As with Action 1.19 above, Action 1.28 would contribute to the increase in administrative burden and create a negative environment with a heavy focus on process and procedures instead of patient outcome.

The RACGP recommends that the explanatory notes for these Actions (and other Actions directly taken from the NSQHS Standards) are revised and adapted to ensure applicability to the primary healthcare environment. The multiple modalities of primary healthcare must also be considered. As the intent of both Actions 1.19 and 1.21 are ultimately to reduce the risk of patient harm, the RACGP suggests that it is better managed through the healthcare service's risk management process. This way, healthcare providers can determine how they will identify, discuss and monitor new and existing risks to mitigate against the likelihood of any adverse patient events (ie quarterly clinical governance meetings).

RACGP clinical guidelines

The RACGP has developed a suite of comprehensive clinical guidelines for use in general practice. The RACGP recommends that RACGP clinical guidelines are listed as a resource within Action 1.20 (Evidence-based care) to support healthcare services provide safe and quality primary health care to their patients.

Key RACGP clinical guidelines include:

- Guidelines for preventive activities in general practice (Red Book)
- RACGP Aged care clinical guide (Silver Book)

- National guide to preventive health assessment for Aboriginal and Torres Strait Islander people
- Management of type 2 diabetes: A handbook for general practice.

RACGP clinical guidelines are available at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines.

These RACGP clinical guidelines are developed by working groups of general practitioners (GPs) and subject matter experts to ensure that the content is valuable and useful for GPs and their teams.

While the RACGP clinical guidelines have been developed for use by general practitioners, their usefulness can extend to other primary healthcare settings and their providers. Patients who receive care from other primary healthcare settings, also receive care in general practice. Therefore, the RACGP guidelines can be used to inform multidisciplinary care and improve and facilitate collaboration between healthcare providers.

Specific feedback

Feedback and complaints management

Collecting and responding to feedback about patients' experiences has been shown to improve clinical effectiveness and patient safety, as well as contributing to adherence by patients to recommended medication and treatments. While patient feedback can be used to improve the quality of care provided by a healthcare service, it can also enhance quality improvement and risk mitigation for non-clinical aspects of the healthcare service (eg communication).

Patient feedback is an important aspect of partnering with consumers that can be used to inform the planning, design, monitoring and evaluation of both clinical and non-clinical aspects of a healthcare service. For example, patient feedback can be used to inform patient experience of the healthcare service itself, improve the healthcare service's facilities or improve administrative and reception services.

The RACGP recommends expanding the explanatory notes for Action 1.07 and 1.08 (Feedback and complaints management) to include non-clinical aspects of patient feedback, linking directly to Actions within the Partnering With Consumers standard.

The RACGP's Patient feedback guide contains useful information on collecting patient feedback including the methods of collection, analysis of feedback and tips for developing questions.

Effective, culturally safe and responsive healthcare for Aboriginal and Torres Strait Islander people

The RACGP welcomes the ACSQHC's commitment to including culturally safe health care for Aboriginal and Torres Strait Islander people in the NSQPCHS. However, as it currently stands it is not clear how the NSQPCHS would promote and appropriately equip healthcare services to deliver culturally safe health care. The NSQPCHS could potentially cause harm as healthcare services are misled into a false reassurance that they are delivering culturally safe services when in fact meeting the requirements would not amount to any demonstrable impact on patient services.

The underlying principle of cultural safety is that it should really be determined by Aboriginal and Torres Strait Islander people who use the service. This means that the specific Actions related to culturally safe care should be developed and assessed by Aboriginal and Torres Strait Islander people themselves. The process of developing these requirements around cultural safety must in itself be culturally safe, and the organisation's setting and assessment of the NSQPCHS should model cultural safety.

With this in mind, the development of the NSQPCHS and the assessment process against the NSQPCHS needs to outline the involvement of Aboriginal and Torres Strait Islander people and organisations.

The RACGP also notes that, while many of the healthcare providers who would be using the NSQPCHS would be registered with Ahpra and have to meet professional requirements regarding cultural safety, no reference to the Ahpra expectations is made in the NSQPCHS or the Guide.

Acknowledging the importance of anti-racist practice to reduce service level barriers to culturally safe care could strengthen the standards.

Objective 8.3 of the National Aboriginal and Torres Strait Islander health plan is to ensure racism complaints procedures are available and accessible. The NSQPCHS and the Guide could be strengthened by acknowledging that "Aboriginal and Torres Strait Islander people's experiences of racism and discrimination must be fed back into system improvement processes to ensure whole-of-health system accountability and change".

Within the NSQPCHS and the Guide there is some duplication and contradiction within the specific sections that relate to cultural safety for Aboriginal and Torres Strait Islander communities.

Action 1.09 (Patient Populations and social determinants of health) makes reference to "People of Aboriginal and Torres Strait Islander origin" among other groups (which may in itself be inappropriate) and discusses identification of such groups. A healthcare service can simply meet this Action by identifying Aboriginal and Torres Strait Islander people by "a review of health records and observation within the service," with self-identification being optional. This is wholly inappropriate and could reinforce stereotypes of Aboriginal and Torres Strait Islander people (not to mention people of other "diverse" backgrounds) and in fact be harmful.

This Action is negated by Action 3.22 (Planning and delivering comprehensive care) which does require healthcare services to ask patients if they are of Aboriginal or Torres Strait Islander origin. While this Action is an improvement on the previous (ie Action 1.09), healthcare services can still meet this Action without asking the right questions or recording it correctly (as described in the National Best Practice Guidelines).

Ensuring that there is clarity for healthcare services in what they must do to identify their patient population is crucial for all the other healthcare service activities related to cultural safety.

Action 1.16 (Safety and quality training) and Action 1.25 (Safe environment) are closely related with Action 1.16 (Safe environment) being a component of Action 1.25. It is hard to imagine that a healthcare service could meet Action 1.25 (that the services provide a culturally safe environment) without also meeting Action1.16 (that staff are supported to provide a culturally safe environment). These two could be combined into a single Action about the provision of a culturally safe service **as determined by Aboriginal and Torres Strait Islander patients themselves.** The RACGP notes that the definition of cultural safety used by the ACSQHC doesn't include this crucial aspect.

The Actions required of other primary healthcare services don't necessarily demonstrate that cultural safety has been achieved, and there is only a requirement to partner with Aboriginal and Torres Strait Islander people and healthcare services "when carrying out a review of the design, use and layout [of the] healthcare service." The recommendation to consult with local Aboriginal Community Controlled Health Services in these reviews may be appropriate in principle but does not take account of the capacity of the local service to do this, and the RACGP would recommend consulting with the National Aboriginal Community Controlled Health Organisation (NACCHO) on such a proposal. There is also the risk that the NSQPCHS is essentially promoting a superficial engagement in Aboriginal and Torres Strait Islander commemorative events such as NAIDOC.

For ideas on other Actions and evidence that might be useful in demonstrating cultural safety, the Australian Institute of Health and Wellbeing's Cultural safety in health care for Indigenous Australians: monitoring framework is likely to be useful in showing how a wide variety of organisational and patient experience measures can demonstrate aspects of cultural safety.

While the RACGP acknowledges that the principles and strategies outlined in the NSQHS Standards user guide for Aboriginal and Torres Strait Islander people are broadly applicable, further consideration should be given to how they specifically apply to non-general practice primary healthcare settings and be included in the Guide.

Antimicrobial stewardship

The RACGP supports a collaborative multi-sectorial approach to ensure appropriate antimicrobial use and efforts to reduce antimicrobial resistance in Australia. We endorse interventions which prevent antimicrobial resistance whilst minimising harm, morbidity and mortality from infectious disease. However, it is important to acknowledge that hospital-

based antimicrobial stewardship programs cannot be successfully implemented in the general practice and other primary care environments as they are a less hierarchical environments than secondary care and characterised by unique pressures and concerns. Tailored approaches are required to support the primary healthcare sector in the implementation of Action 3.14 (Antimicrobial stewardship).

As such, the RACGP recommends that the guidance provided in Action 3.14 is revised to account for the primary healthcare environment, acknowledging that a range of community-based approaches are required. Some of these approaches can include:

- gathering and analysis of community prescribing data
- public education and awareness campaigns
- training and education to primary healthcare providers
- supporting the development and implementation of an audit and peer feedback program. [1]

The RACGP provides specific information on antimicrobial stewardship within the Infection and sepsis, Anticipatory care and Urinary incontinence chapters of the *Aged Care Clinical guide* (Silver book). The RACGP position statement on Antimicrobial stewardship highlights the importance of community-based strategies to reduce antimicrobial use provides an opportunity to reduce the spread of antimicrobial resistance.

Criterion QI2.2 – Safe and quality use of medicines and Criterion GP4.1 – Infection prevention and control, including sterilisation of the *Standards for general practice* (5th edition) also contain information and strategies on antimicrobial stewardship in general practice.

Safe and quality use of medicines

The RACGP commends the ACSQHC for the detailed guidance provided in Medication Safety (Actions 3.15, 3.16, 3.17 and 3.18).

A healthcare service's role in supporting the safe and quality use of medicines is to ensure that all healthcare providers working within the healthcare service have access to best practice guidelines such as the Therapeutic Guidelines and the Australian Medicines Handbook. The Australian Medicines Handbook is an evidence-based, independent medicines reference and is jointly owned by the RACGP, the Pharmaceutical Society of Australia, and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists. It is extensively peer reviewed by Australian experts and practising GPs, specialists, nurses and pharmacists.

The RACGP acknowledges that some information on the use of evidence-based care is listed in Action 1.20 (Evidence-based care) but recommends cross-referencing the Actions within Medication Safety to Action 1.20. The Australian Medicines Handbook should be added as a resource in the explanatory materials in Action 3.15 and Action 1.20.

Social determinants of health

The explanatory notes in Action 1.09 (Patient population and social determinants of health) are unclear and do not address the 'social determinants of health' as defined by the World Health Organization (WHO). The WHO defines social determinants of health as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" [2]

The heading 'Patient population and social determinants of health' in Action 1.09 is misleading as it does not require healthcare services to address health inequalities through the social determinants of health as defined by the WHO. While there is an attempt to address this in Action 1.10, the actions (as recommended in the 'Key tasks') only relate to non-specific issues around access. Further, the explanatory notes offer no appropriate guidance on how healthcare services should identify and record their patient population information. The suggestion that a healthcare service should determine a patient's social and cultural background through observation is entirely inappropriate and should be removed the Guide.

The RACGP recommends the removal of the term 'social determinants of health' from the heading of Actions 1.09 and 1.10. In addition, the explanatory notes should be expanded to include culturally safe and appropriate guidance on how healthcare services should identify their patient population.

Health record system

The RACGP notes that there is no requirement within the NSQPCHS for a healthcare service to transition to a fully electronic health record system, specifically in Action 1.11 (Healthcare records) and Action 3.26 (Processes for effective communication). The explanatory notes in Action 1.11 specifies that an "effective healthcare record system must be applied consistently" regardless of whether the healthcare record is paper-based, electronic or a hybrid system.

The RACGP recommends that specific guidance is included that encourages healthcare services to transition to a fully electronic health record system as a priority. A fully electronic health record system is preferrable to one that is entirely a paper-based, or hybrid system as it significantly reduces patient risk by improving accessibility, legibility and reducing duplication. An electronic health record system also better supports clinical decision making, for example through the use of alerts and reminders.

A hybrid system should be strongly discouraged. Where hybrid systems are in use, healthcare services must be able to demonstrate that all practitioners are aware that the health record system is a hybrid system. The explicit expectation of the NSQPCHS should be that where a hybrid record system is in use that all patient health information exists within both systems and readily available at all times.

The RACGP *Standards for general practices* (5th edition) provides more information on patient health record systems in Criterion C6.2 – Patient health record systems.

Health service environment and equipment

Appropriate facilities and equipment are important to ensure a safe environment for patient care, and the healthcare providers providing it. Both design and layout are important aspects of this, and a well-designed layout is critical to not only protecting patient privacy and confidentiality, but also to providing equitable access for people with a disability.

While there is broad guidance on supporting access to health care for people with a disability in the explanatory notes for Action 1.24 (Safe environment), more specific guidance is required. Additionally, it is unlawful under the Disability Discrimination Act 1992 to discriminate against a person with a disability from gaining access to a premise.

It is therefore important for bricks and mortar healthcare services to have:

- pathways, hallways, consultation areas and toilets that are wheelchair-friendly
- wheelchair(s) that patients can use while they are at the premises
- appropriate ramps and railings
- alternate means of providing patient access to care, such as home visits.

Equipment used in the healthcare service must be fit-for-purpose with consideration to the type of health care provided and patient cohort. Research has shown that people with a disability continue to experience poorer health outcomes when compared to the broader population . Height-adjustable beds provide people with a disability with dignified patient care. They can also help prevent workplace injuries by reducing the need for healthcare providers to assist patients on/off an examination bed that is too high and reduce the risk of patient falls.

The explanatory notes for Action 1.22 (Safe environment) should be strengthened to include design and layout aspects mentioned above. The RACGP also recommends inclusion of guidance on the importance of height-adjustable beds for people with a disability in the explanatory notes of Action 1.24.

The RACGP *Standards for general practices* (5th edition) contains further information about the practice environment and facility equipment in Criterion GP5.1 – Practice facilities and Criterion C2.3 – Accessibility of services.

Preventing and controlling infections

Action 3.04 (Standard and transmission-based precautions) in the NSQPCHS requires healthcare services to apply standard and transmission-based precautions that are consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. While the Australian guidelines are a national resource, feedback received from RACGP members indicate that the document is too large, contains information that is not applicable or appropriate to smaller, office-based healthcare services.

The RACGP Infection prevention and control guidelines (IPC Guidelines) is a targeted document developed by the RACGP in partnership with the Australian Primary Health Care Nurses Association (APNA) specifically for general practice and other office-based primary care practices. The guidelines were released in November 2022 and provide updated guidance to general practices and other office-based practices on planning and implementing high standards of infection prevention and control in their workplaces.

The IPC Guidelines were developed by experts in the fields of infectious diseases, microbiology and infection prevention and control, as well as doctors, practice nurses and practice managers. The IPC Guidelines draw from: the RACGP *Standards for general practices* (5th edition); the Australian Guidelines for the Prevention and Control of Infection in Healthcare; the National Hand Hygiene Initiative manual; Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure-prone procedures at risk of exposure to blood borne viruses; and Australian Standards and Australian/New Zealand Standards. The IPC Guidelines contain consolidated and contextualised advice from these sources for general practices and other office-based practices. The IPC Guidelines include additional detail for practices to help meet these existing requirements. They also include extensive detail on reprocessing reusable medical instruments in general practice, aligned to the national standards (AS/NZS 4815 and AS/NZS 4187), but which is not addressed in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

As a web-based resource, the IPC Guidelines will be updated to reflect changes from across its sources, as well as new evidence.

The RACGP strongly recommends that the explanatory notes in the section: Preventing and controlling infections (Actions 3.04, 3.05, 3.06, 3.07, 3.08, 3.09, 3.10, 3.11, 3.12 and 3.13) include information about the IPC Guidelines. The RACGP recommends that the IPC Guidelines are listed in the 'Where to go for information' sections of each Action. The ACSQHC may also wish to review the IPC Guidelines to determine if any information is suitable to be included in the discussion within said Actions.

Health promotion and illness prevention

The RACGP recommends that the Guide provide expanded information about how healthcare services can ensure that health promotion and illness prevention messages are tailored to the patient population. This expanded discussion should be provided in Action 3.20 (Health promotion and prevention). The RACGP notes that there are some examples provided in the explanatory notes (ie podiatrist working in a community with high rates of type 2 diabetes and community health service working in an area with large Aboriginal or Torres Strait Islander population). However, the examples do not offer the necessary guidance for healthcare services to consider the breadth of health promotion and illness prevention, including culturally appropriate messages and resources.

Updated and expanded explanatory materials should encourage healthcare services to adopt a systematic approach to health promotion and illness prevention. A systematic approach can include activities such as conducting patient prevention surveys, reviewing and understanding the healthcare service's patient population and their healthcare needs, establishing a reminder system and maintaining a directory of local services that offer programs to help patients modify their lifestyle. Taking a systematic approach means that healthcare services can also monitor and evaluate the effectiveness of their health promotion and illness prevention programs. Further, this process may assist healthcare services in identifying any gaps in resources (eg training). Where relevant, explanatory notes for Action 3.20 should be cross referenced to those in Action 1.15 (Safety and quality training).

Patient identifiers

The RACGP is concerned that the explanatory notes for Actions 3.25 and 3.26 (Process for effective communication) encourages healthcare services to use patient identifiers *only* when a healthcare provider is unfamiliar with a patient or in a high-risk scenario. The failure to correctly identify patients is a major risk to patient safety and can result in serious errors in medication, testing and procedure undertaken in the provision of patient care. While it may appear unnecessary or illogical to ask a patient who is well known to the healthcare service for identifiers every time they attend or call the practice, it is not uncommon to have patients with identical or similar names, or dates of birth, and to therefore mismatch patients and patient health records.

The use of a minimum of three patient identifiers is a mandatory requirement in Criterion C6.1 – Patient identification in the RACGP *Standards for general practices* (5th edition). Rand Corporation, a non-profit research organisation, provides further information about the importance of correctly identifying patients at www.rand.org/pubs/monographs/MG753.html. The RACGP strongly recommends that the use of patient identifiers to be mandatory for all patients, and for this to be reflected in the explanatory notes for Actions 3.25 and 3.26.

Planning for safety

A healthcare service requires not only strategies to respond to patients who are distressed, but also strategies to prevent distress and aggression.

Approaches such as employing a friendly and patient-centred approach to communication (eg sensitivity to personal factors, demonstration of empathy) can help reduce the likelihood of distress and aggression. Other strategies include having emergency appointment slots, rescheduling late patients to reduce impact of delay, and reminder systems to alert patients to arrive early for their appointment can help. De-escalation strategies can also assist a healthcare service to improve their management of aggressive behaviours (eg providing patients who are in distress with privacy).

The explanatory notes in Action 3.32 (Planning for safety) should be expanded to include guidance on the use of a systematic approach to manage and respond to patients who are distressed or exhibit aggression. Healthcare services should also be encouraged to undertake regular review of critical incidents as part of their regular risk management process. Action 3.32 should be linked to Action 1.02 (Policies and procedures) and 1.23 (Safe environment).

Managing patients in distress is part of Criterion C2.1 – Respectful and culturally appropriate care in the Standards for general practices (5th edition).

Communication of critical information

The RACGP notes that the Action 3.29 (Communication of critical information) has been taken directly from Action 6.09 and Action 6.10 of the National Safety and Quality Heath Service (NSQHS) Standards. However, the explanatory notes in Action 3.29 have not been suitably adapted to the primary care environment.

The intent of the Action is unclear and further clarification is required. The explanatory notes rightly state that the "communication method adopted will depend on the information provided and the level of urgency involved" and that "the nature of critical information or a risk to patient care identified depends on factors such as the type of service delivered and patient risks". However, the ACSQHC has failed to identify for healthcare services what is meant by "critical information". The explanatory notes provide a list of examples of the types of critical information but neglects to clarify how information is assessed as 'critical'.

Without appropriate guidance (eg the application of a risk management approach), Action 3.29 will create unnecessary communication and administrative burden for healthcare providers. Further, the intent of the Action as it relates to the primary healthcare setting is unclear and confusing. The explanatory notes allude to the related aspects of recall (missed referral and results) and clinical handover (change in patient goals, preferences or condition) and as a result the intent and outcome of the Action is ambiguous.

The application of Action 3.29 as it stands contradicts the patient and clinical safety framework that the NSQPCHS espouses as it could potentially create enormous distress and harm for patients. Patient consent is required for the disclosure of any health information, including family members/ carers and must be done in accordance with the Australian Privacy Principles and relevant state or territory legislation. Again, this critical information is absent from the explanatory notes.

The RACGP strongly recommends that a significant revision of the explanatory notes for Action 3.29 is undertaken. The explanatory materials must clarify for healthcare services the intent of the Action, as well as the outcome. Additionally, the method by which information is assessed as critical must also be clearly and concisely stated, with consideration to the primary healthcare environment.

The ACSQHC may wish to consider the practical application and relevance of Action 3.29 to the primary healthcare sector, and whether the Action can be covered elsewhere under Action 1.12 (relating to recalls) and Action 3.19 (relating to communicating with other healthcare providers; clinical handover).

Conclusion

As has been demonstrated by our consistent engagement with the ACSQHC, we confirm our ability, experience and willingness to work with the ACSQHC to contribute to better health and wellbeing for all Australians. The RACGP looks forward to future collaboration with the ACSQHC on the implementation of the NSQPCHS in non-general practice primary care.

To this end, the RACGP recommends that the ACSQHC provide publicly available, concise guidance to clarify the applicability of the NSQPCHS to other primary healthcare services. To put it another way, the RACGP requests that the ACSQHC confirm that where professional-led accreditation requirements exist, such as the RACGP's Standards for general practices (5th edition), that these are the most applicable to Australian general practice, and that no further general practice related explanatory materials will accompany the NSQPCHS.

References

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