RACGP

Standards for Garrison Health Facilities in the Australian Defence Force

Based on the RACGP Standards for general practices (4th edition)

Standards for Garrison Health Facilities in the Australian Defence Force
Based on the RACGP Standards for general practices (4th edition)

Disclaimer

This publication contains information from a variety of sources. Except for material which is obviously in the public domain, all copyright in the publication is owned between The Royal Australian College of General Practitioners (RACGP) and the Commonwealth of Australia (represented by the Department of Defence). No publication material may be copied (except as legally permitted) or disseminated without the written permission of these organisations.

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. Nor is this publication exhaustive of the subject matter. 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 a health professional and the premises from which the health professional operates.

Whilst the text is directed to health professionals possessing appropriate qualifications and skills in ascertaining and discharging their professional (including legal) duties, it is not to be regarded as clinical advice and, in particular, is no substitute for a full examination and consideration of medical history in reaching a diagnosis and treatment based on accepted clinical practices.

Accordingly, the RACGP and the Commonwealth and their respective employees and agents 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.

Published by
The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne VIC 3002 Australia

Tel 1800 472 247
www.racgp.org.au

RACGP Standards for general practices (4th edition)
ISBN: 978-0-86906-318-7
Published October 2010, updated May 2013

Standards for Garrison Health Facilities in the Australian Defence Force
Based on the RACGP Standards for general practices (4th edition)
ISBN: 978-0-86906-427-6
Published February 2015

Standards for Garrison Health Facilities in the Australian Defence Force

Based on the RACGP Standards for general practices (4th edition)

Introduction to the Standards for Garrison Health Facilities in the Australian Defence Force

The *Standards for Garrison Health Facilities in the Australian Defence Force* is based on The Royal Australian College of General Practitioners (RACGP) *Standards for general practices* (4th edition). The RACGP and the Australian Defence Force (ADF) worked in collaboration to produce this set of Standards which will provide a robust template for safe, high quality care in the Australian Defence Force.

The mission of the ADF is to defend Australia and its national interests. Personnel who serve in the ADF are not employees, but serving members of a disciplined service who are subject to regulations above and beyond the normal civilian laws.

ADF personnel are required to maintain their medical and dental fitness in order to undertake their operational duties. As such, the provision of healthcare by the ADF is a requirement of service. Within the Garrison context, this is provided by Joint Health Command through its Garrison Health Facilities (managed by the Directorate of Garrison Health Operations on behalf of the Commander Joint Health Command) located within Defence bases/establishments across Australia.

The relationship between a Commander and their people is different to the normal employer-employee relationship. ADF Commanders are responsible for the health and welfare of their personnel, which extends beyond the immediate work environment. Commanders require sufficient information about a member's health to permit effective management of an individual's health and welfare, meet organisational Workplace Health and Safety responsibilities, and maintain capability. The information required relates to the effect an individual's health has on their employability (including safety aspects) and deployability. They also require information on the individual's rehabilitation plan in order to provide appropriate unit support.

The primary function of a Garrison Health Facility is to provide health services to entitled ADF personnel. Secondary functions include training of ADF medical personnel and providing operational health support to the ADF.

Garrison Health Facilities are staffed by a combination of ADF personnel, Australian Public Service (APS) personnel and civilians contracted to the ADF.

The type of health support provided by Garrison Health Facilities differs from that offered in a standard non-Defence general practice. In general terms, Garrison Health Facilities provide a wider scope of practice applied to a narrower patient distribution. The practice scope is wider in that it includes primary care, preventive health programs, health surveillance, occupational medicine, public health medicine, and pre- and post-operational health support. The patient distribution is narrower than standard general practice in that it does not usually include paediatrics, aged, patients with chronic disabilities, the unemployed or the socially disadvantaged.

All Garrison Health Facilities contain a waiting area, reception and administration area, consultation room(s) and treatment /resuscitation area(s), regardless of their size and scope. The range of services offered may include medical,

pharmacy, dental, physiotherapy, rehabilitation and mental health.

Unless there are specific operational requirements, Garrison Health Facilities generally only provide services during normal working hours. After-hours (emergency) services are provided by a combination of:

- a 24-hour health call centre (1800IMSICK) which directs ADF personnel to the appropriate level of local health support, which may be Defence or civilian
- access to the local public hospital
- emergency '000' services.

ADF personnel who receive after-hours health services are required to ensure a health summary of the event is included in their medical record.

All ADF personnel posting into or out of a base/establishment are required to visit their local Garrison Health Facility as part of this process. This means ADF personnel are made aware of the services provided by their local Garrison Health Facility on post in and are entrusted with ensuring their medical record is forwarded to the appropriate Garrison Health Facility.

Just as in civilian general practice, ADF personnel have a choice of available medical officers (MO) in most instances. One of these will be their nominated treating doctor, with the option of changing MOs according to their preferences or circumstances. ADF personnel are responsible for ensuring their medical record is updated when they attend medical services outside of a Garrison Health Facility and where records of this attendance would not otherwise be captured. When hard copy medical records are held, either a scanned or hard copy is maintained off-site. When electronic medical records are held, a back-up electronic record is maintained on the Defence eHealth system. The electronic patient record can be accessed from any designated ADF medical computer connected to the Defence Restricted Network.

Defence has arrangements in place to ensure that, where referred by an ADF MO, ADF members have access to specialist medical practitioners and allied health professionals at no cost.

The provision of healthcare within the ADF is governed by Health Manuals that provide policy and guidance to assist in the coordinated care of ADF members.

Joint Health Command has a separate Directorate (of Clinical Governance) to manage compliments, complaints and clinical incidents arising from Garrison Health Facility activities.

While many Garrison Health Facilities offer integrated health services, these Standards relate to the general practice component of the facility.

Please note that for some Standards there is no ADF context box. This is because the context, including Criterion, Indicators and Explanatory Notes apply to an ADF health facility.

Acknowledgments for the Standards for general practices (4th edition)

The RACGP *Standards for general practices* (4th edition) are standards developed by the profession for the profession.

The Royal Australian College of General Practitioners undertook an extensive consultation process to develop the 4th edition *Standards* and would like to thank all those who offered ideas and suggestions, provided comments on successive drafts, participated in field testing and attended workshops and webinars. This collective effort has produced a set of *Standards* which provide a robust template for quality care and risk management in Australian general practice.

The RACGP would particularly like to thank:

- General practitioners and other general practice staff for their ongoing commitment to high quality healthcare for the Australian community
- Consumers and consumer groups for their considered feedback
- External stakeholders for their submissions, opinions and advice
- Members of the specialist working parties on e-health; clinical governance; medication safety and healthcare associated infections, for their expert advice
- National E-Health Transition Authority for their expert advice on e-health initiatives
- Our faculties and other RACGP committees for their input and feedback, often with tight timelines
- Divisions which provided feedback and organised focus groups
- Surveyors and staff of Australian General Practice Accreditation Limited and GPA ACCREDITATION *plus* for their extensive knowledge and practical advice
- Members of the RACGP National Expert Committee on Standards for General Practices for their expertise, outstanding commitment to excellence in general practice, sheer hard work and supportive families
- Dr Lynton Hudson, GP (Chair)
- Dr Glynn Kelly, GP
- Mrs Julianne Badenoch, Australian Practice Nurses Association representative
- Dr Michael Civil, GP
- Dr Karen Douglas, GP
- Dr Craig Lilienthal, GP
- Ms Angela Mason-Lynch, Australian Association of Practice Managers representative
- Ms Robin Toohey AM, Consumer Health Forum representative
- Dr Howard Watts OAM, GP
- Dr Noela Whitby AM, GP.

Finally, the RACGP also acknowledges the staff whose work underpins our 4th edition *Standards*: Mrs Leanne Rich, Program Manager for Standards for General Practices, who managed this project with the assistance of other project staff; Ms Judy Evans, Project Manager e-Health; Dr Jiri Rada, Manager RACGP Foundation; Ms Lauren Cordwell, Manager Faculty of Aboriginal and Torres Strait Islander Health; Ms Helen Bolger-Harris, Manager Clinical Improvement Unit and Ms Josephine Raw, General Manager Practice Innovation and Policy. This team has displayed great skill and unwavering commitment to our College and our ideals.

In the development of the Standards for Garrison Health Facilities in the Australian Defence Force, the Australian Defence Force has demonstrated their commitment to high quality healthcare for the ADF Community.

Contents

Contents

Foreword for the Standards for general practices (4th edition)

Over the past 12 months, the RACGP National Expert Committee on Standards for General Practices has been revising the *Standards* to produce this, the 4th edition of the *Standards for general practices*.

Our *Standards* are one of the pillars of safety and quality in the Australian healthcare system and are used by over 80% of Australian general practices for accreditation.

In reviewing the *Standards for general practices* (3rd edition), the National Expert Committee has built on a world class document created through the passion and dedication of past committees with valued input from like-minded RACGP members and other stakeholders within primary care.

The comprehensive and wide ranging process of review that commenced in October 2009 has again tapped the virtue, passions and expert knowledge of many wonderful people and organisations in the primary healthcare sector. During the process of developing successive drafts, field testing proposed new criteria and indicators and writing the final version of the *Standards* (4th edition), over 700 people and organisations were consulted.

The *Standards* are designed to be a template for safe and high quality care in the increasingly complex environment of Australian general practice. With three less criteria, 38 less indicators and more explanatory and resource material, we have tried to make the *Standards* more workable for busy general practices.

We would like to thank the large number of people and organisations listed in the acknowledgments for their dedication and support. We would particularly like to thank the National Expert Committee and College staff for their tireless efforts to deliver a new edition.

It is with pride that we present the RACGP *Standards for general practices* (4th edition).

Dr Lynton Hudson
Chair
National Expert Committee on Standards for General Practices
RACGP

Dr Christopher Mitchell
Immediate Past President
RACGP

and

Professor Claire Jackson
President
RACGP
May 2013

Preamble to the Standards for general practices (4th edition)

RACGP *Standards for general practices* (4th edition): A template for quality care and risk management in contemporary Australian general practices

The RACGP *Standards for general practices* (4th edition) (the *Standards*) provide a template for quality care and risk management in Australian general practice.

The *Standards* are designed to keep Australian general practice at the forefront of safe, high quality primary healthcare delivery in Australia.

The *Standards* have evolved with the changing landscape of Australian healthcare and reflect contemporary practice (see Appendix A).

The *Standards* provide a framework for the continuing development of well performing practice teams to enable them to focus on quality care and risk management.

Keeping the *Standards* current

It is important that the RACGP *Standards for general practices* reflect contemporary general practice and pave the way for quality improvement and innovation.

The RACGP *Standards for general practices* (3rd edition) were released in July 2005, with a revised edition published in July 2007.

The RACGP *Standards* (4th edition) were developed by the National Expert Committee on Standards for General Practices (NECSGP) in close consultation with general practice stakeholders – GPs, nurses, practice managers, patients and a range of external organisations. In its comprehensive consultation process, the RACGP received feedback from nearly 700 individuals and organisations. This included feedback through submissions, online surveys, focus groups run by the RACGP and divisions, field trials and seminars.

Issues that have influenced the 4th edition *Standards*

The *Standards* are designed to accommodate key trends in the general practice environment:

1. Evolution of general practice teams

The *Standards* reflect a move away from the GP as the person solely responsible for quality and safety systems and acknowledge that other practice team members can and do contribute expertise in risk management within the practice (eg. infection control).

The language of the 4th edition *Standards* reflects this evolution where:

- 'general practice team' refers to all those who work in the practice – both administrative and clinical, and
- 'clinical team' refers to those members of the practice team who provide clinical care to patients.

2. Impact of healthcare reform

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is developing a set of National Safety and Quality Health Service Standards that will form part of a national accreditation scheme.

The RACGP has incorporated key elements of the new ACSQHC National Standards into the RACGP *Standards for general practices* to ensure the RACGP *Standards* remain contemporary and congruent with the national health reform process (see Appendix B).

The new criteria from the ACSQHC National Standards reflected in the RACGP *Standards* include:

- Criterion 1.5.2 Clinical handover
- Criterion 3.1.3 Clinical governance
- Criterion 3.1.4 Patient identification
- Criterion 5.3.1 Safe and quality use of medicines.

3. E-health initiatives

The RACGP *Standards* have been updated to allow for evolving national e-health initiatives including standardised electronic health records and unique patient identifiers.

The criteria which reflect e-health initiatives include:

- Criterion 1.7.1 Patient health records
- Criterion 1.7.2 Health summaries
- Criterion 3.1.4 Patient identification.

The RACGP has also updated and produced a new edition of the RACGP *Computer security guidelines*, which provide in-depth guidance and tools to assist practices to understand and implement the RACGP *Standards* in these areas.

4. Consumer engagement

During the consultation process for the 4th edition *Standards*, consumers raised particular issues including:

- continuity of care, especially in relation to timely access to health information when a record transfer is requested (see Criterion 2.1.1D Respectful and culturally appropriate care)
- access to height adjustable beds which was considered important by many patients, particularly the elderly and people with a disability; this is now a flagged indicator (see Criterion 5.1.1G Practice facilities)
- patients wanting to be informed of changes made by a general practice in response to their feedback; this preference is expressed in a new unflagged indicator (see Criterion 2.1.2E Patient feedback).

5. Using patient feedback for quality improvement

Patient feedback is a fundamental component of quality improvement. In the past, patient feedback focused on a patient's satisfaction with a health service. However, more recent advances in the field of patient feedback suggest it is more important to ask patients about their experience of healthcare.

The RACGP therefore commissioned advice on the best way for practices to collect patient feedback. As a result, the RACGP has produced a new resource for members entitled RACGP *Patient feedback guide*: *learning from our patient*s.

The tools used to measure patient feedback need to be rigorous to ensure the integrity of data subsequently used by practices for quality improvement purposes. For this reason, the RACGP *Standards* stipulate that practices must obtain patient feedback by using a validated patient experience questionnaire that has been approved by the RACGP, or by using practice specific methods (survey or focus group or patient interviews), that adhere to the requirements outlined in the *Patient feedback guide* (www.racgp.org.au/standards).

6. Collection and recording of Indigenous status

In 2007, the Council of Australian Governments (COAG) signed a National Indigenous Reform Agreement for inter-jurisdictional cooperation to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. This initiative, better known as 'Closing the Gap' in Indigenous disadvantage, requires general practices to improve their procedures for identifying their Aboriginal and Torres Strait Islander patients.

COAG has accepted the *National best practice guidelines for collecting Indigenous status in health data sets* released by the Australian Institute of Health and Welfare (AIHW) in 2010 as the national identification standard.

The RACGP *Standards* reflect this initiative in Criterion 1.7.1E Patient health records.

7. Compliance with legislation applicable to general practices

It is the responsibility of general practices to comply with relevant jurisdictional legislation.

In general, references to legislation have been removed in the RACGP *Standards for general practices* (4th edition) as federal, state/territory and local legislation override any non-legislative standards. On occasion, legislation is cited in the *Standards* where it is particularly important to a defined aspect of general practice (see Criterion 4.2.1 Confidentiality and privacy of health information).

8. Removal of criteria/indicators

The RACGP *Standards* (4th edition) include three less criteria and 38 less indicators. The following principles governed such decisions:

- Merge RACGP *Standards* (3rd edition) criteria of similar themes (see Criterion 1.2.4 Costs within our practice and Criterion 1.2.5 Costs for referred services)

- Remove RACGP *Standards* (3rd edition) criteria where legislation supersedes the *Standards* (see Criterion 5.3.1 Schedule 8 medicines)
- Remove indicators relating to patient feedback and provided a patient feedback guide entitled RACGP *Patient feedback guide*: *learning from our patient*s.

Accreditation

Many practices choose to be assessed against the *Standards* by an independent third party to gain formal 'accreditation' against the RACGP *Standards*.

Achieving independent accreditation against the *Standards* shows patients that your practice is serious about providing high quality, safe and effective care to standards of excellence determined by the general practice profession.

The only model of third party review supported by the RACGP for these *Standards* is peer review where one surveyor must be a general practitioner (see Appendix C).

The RACGP envisages that formal accreditation against the RACGP *Standards* will be based on common sense and will not seek to penalise or exclude practices on the basis of technicalities.

Previously, the RACGP *Standards* dictated how practices should demonstrate compliance with the *Standards* (eg. interview, document review, observation).

Those requirements have been removed from the RACGP *Standards* (4th edition) so that practices themselves and peer surveyors can now decide how practices demonstrate achievement of the RACGP *Standards*.

The explanatory material which accompanies each criterion is designed to provide guidance to practices on satisfying each of the related indicators.

How will the RACGP *Standards* evolve?

This edition of the RACGP *Standards* is one more stage in the continuing process of standards development. The RACGP *Standards* will always be subject to the ongoing scrutiny of the profession and the community at large.

In order to incorporate feedback from the profession, new research evidence, advances in knowledge and changes in the way primary healthcare is delivered in Australia, the RACGP will update the *Standards* as required.

It is envisaged that the process for updating the *Standards* will include addenda published as necessary, with new editions published from time to time whenever a significant change in the general practice environment dictates the need for a major process of consultation and review.

RACGP support for practices

In developing the RACGP *Standards* (4th edition), the RACGP was mindful of the resources required by general practices to achieve the *Standards*.

The RACGP will continue to support practices to implement the *Standards*, through the provision of education sessions and high quality tools such as:

- RACGP *Infection control standards for office based practices* (4th edition)
- RACGP sterilisation records suite
- RACGP schedule 8 medicines record books (practice and doctors bag size)
- RACGP *Patient feedback guide: learning from our patients*
- RACGP *Computer security guidelines* (3rd edition)
- 10 tips for safer patient care
- RACGP *Pandemic flu kit*.

Further information and support to practices can be obtained from the RACGP standards team by phone (03) 8699 0414, or email (standards@racgp.org.au).

We welcome your feedback

The RACGP National Expert Committee on Standards for General Practices welcomes feedback on the *Standards*.

Comments may be forwarded to:
Chair, National Standing Committee – Standards for General Practices

The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne, Victoria 3002

Telephone 1800 472 247
Email standards@racgp.org.au
Website www.racgp.org.au/standards

► This symbol means a particular indicator is 'flagged' or mandatory; indicators which are not 'flagged' are discretionary.

Section 1

Practice services

Standard 1.1

Access to care

Our practice provides timely care and advice.

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Standard 1.3

Health promotion and prevention of disease

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

Standard 1.4

Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

Standard 1.5

Continuity of care

Our practice provides continuity of care for its patients.

Standard 1.6

Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Standard 1.1

Access to care

Our practice provides timely care and advice.

Criterion 1.1.1

Scheduling care in opening hours

Our practice has a flexible system that enables us to accommodate patients' clinical needs.

Indicators

- ▶ A. Our practice can demonstrate that we have a flexible system for determining the order in which patients are seen, to accommodate patients' needs for urgent care, non urgent care, complex care, planned chronic disease management, preventive healthcare and longer consultations.
- ▶ B. Our practice can demonstrate how we identify, prioritise and respond to life threatening and urgent medical matters (triage).

Services providing care outside normal opening hours

- ▶ C. Our service obtains feedback from practices for which we deputise, about the quality and timeliness of our care for their patients.

Explanation

Key points

- Practice staff need to be able to quickly and accurately identify patients' needs for urgent care as well as non urgent, complex, planned chronic care and preventive healthcare consultations
- Administrative staff members of the practice team require appropriate 'triage' training
- Practices need a responsive system for seeing patients
- Practices need procedures for administrative and clinical staff outlining:
  - identifying patients with urgent medical matters
  - seeking urgent medical assistance when required
  - managing patients who have urgent medical needs when the practice is operating at full capacity
  - a system for documenting triage responses by administrative staff.

Flexible systems to suit patients and setting

The needs of patients vary widely, as do the settings of general practice, so practices need to have flexible systems that can accommodate urgent, non urgent, complex and planned chronic care, as well as the preventive health needs of patients during normal opening hours. Such systems may focus on determining the order in which patients are seen, rather than an appointment system, in settings such as some Aboriginal medical services and other 'walk in' services.

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

There are times when patients need urgent access to primary medical care and practices need to have systems that accommodate this. For example, some practices have an appointment system which includes unbooked appointment times for patients with urgent medical needs. Patients also value the opportunity to see a general practitioner within a reasonable time where possible for non urgent and preventive health matters.

Triage

Both administrative staff and members of the clinical team need to be able to describe the practice's policy and procedures for identifying patients with urgent medical matters and the procedures for seeking urgent medical assistance from a clinical staff member. The practice team also needs to be able to describe how the practice deals with patients who have urgent medical needs when the practice is operating at full capacity (eg. when it is fully booked).

When patients contact general practices by telephone, often the reason for contact is to make an appointment. It is necessary for administrative staff receiving incoming calls to assess the urgency of the need for care (ie. 'triage' patients). Staff should ask the caller 'Is the matter urgent or may I put you on hold?', so that patients with urgent needs are able to convey this information. As administrative staff do not usually have access to patient health records, the practice needs to have a method for appropriately communicating triage responses by administrative staff.

The practice's policy on triage should make a distinction between triage undertaken by members of the clinical team and triage undertaken by staff with non-clinical roles. Appropriate training should be provided to assist administrative staff and members of the clinical team such as practice nurses to identify patients in need of urgent care. Such training may be undertaken within the practice or by an external training provider.

Length of consultations

The length of individual consultations will vary according to clinical need. Data from Bettering the Evaluation and Care of Health (BEACH 2008–2009) show average consultation times in Australian general practice are 14.6 minutes. Patients should be encouraged to book longer consultations if they feel more time with the GP will be required. Members of the practice team should be sensitive to the need for longer consultations when the need for a longer appointment could be anticipated (eg. when the patient is attending for multiple or complex problems, chronic disease management or procedures). Practices generally recognise that some of their patients always need longer appointments.

Key indicators for whether consultation times are long enough include factors such as the adequacy of patient health records. Assessment of this criterion needs to take into account the specific circumstances of the practice.

Patients with special needs

The practice system needs to include consultations of appropriate length for patients with special or more complex needs. Longer consultations may be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if the patient's carer or a translator is present. Patients need to be encouraged to ask for a longer consultation if they think it is necessary. Staff need to have the skills and knowledge to assist in determining the most appropriate length and timing of consultations at the time of booking. Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that practices have systems that predict and endeavour to meet this need.

Practice closures

Where a practice is planning to close, the practice should develop a process which minimises any disruption to care. It is suggested the practice give patients at least four weeks notice of the practice closure and assist patients (especially those with high needs) in locating an alternative general practice or general practitioner. The practice should ensure that patient records are made available to the patient or transferred to an alternative general practice or care provider before the closure of the practice. Alternatively, patients should be given contact details for requests to access their health records.

Criterion 1.1.1 – ADF CONTEXT

Garrison Health Facilities have scheduling arrangements to meet the focus on ensuring maximum availability of personnel for duty. Garrison Health Facilities have significant provisions for walk-in patients at the start of each day in order to cater for those members who need to be assessed for their fitness for duty that day. This arrangement is known as 'sick parade' and consists of a registration followed by a triage process involving assessment by an ADF medic or registered nurse, and referral to the GP as required.

Normal bookings are coordinated through the Garrison Health Facility reception, with standard appointment times. Longer appointments can be arranged for ADF members with more complex issues in order to ensure they are appropriately assessed.

Garrison Health Facility closures often occur for short periods over Christmas. The closure of facilities is notified at the base and at a regional level. Administrative instructions are released to ADF members via the intranet and include information on how care is to be accessed during this period. Those members undergoing active treatment during this period have their care transferred to an appropriate facility to ensure continuity of care.

Standard 1.1

Access to care

Our practice provides timely care and advice.

Criterion 1.1.2

Telephone and electronic communications

Patients of our practice are able to obtain timely advice or information related to their clinical care by telephone and electronic means (where in use) where a GP determines that this is clinically safe and that a face-to-face consultation is unnecessary for that patient.

Indicators

- ▶ A. Our practice team can demonstrate how we receive and return telephone and (if applicable) electronic messages from patients.
- ▶ B. For important communications, there is evidence of practice/patient telephone or electronic advice and information in our patient health records.
- C. Our practice's 'on hold' message (if we have one) provides advice to call 000 in case of an emergency.

Explanation

Key points

- Practices need a policy about how they communicate with patients
- Practices can communicate with their patients using electronic means
- Practices need to advise patients about their policy on the use of electronic methods of communication, including limitations of use and any costs involved
- All telephone callers being put on hold by practice staff should first be asked if the matter is an emergency
- If the practice has an 'on hold' telephone message, it should include a message to 'phone 000 in an emergency'.

Communications without compromise to quality care

While patients appreciate the ability to have access to a member of the clinical team by telephone or electronic means to discuss their care, the clinical team need to consider the quality and safety of care they can provide to patients via telephone or electronic means. It is acknowledged that practices can judge the appropriateness of individual communications and that full consultations cannot usually be conducted by telephone or electronic means.

Many practices provide the results of investigations to their patients by telephone. The person responsible for giving the results should ensure that the recipient of the advice is correctly identified using three patient identifiers so that patient confidentiality is not compromised. As outlined in Criterion 3.1.4 Patient identification, approved patient identifiers are those items of information accepted for use in patient identification and include:

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

General practitioners may wish to obtain advice from their medical defence organisation about the appropriateness of providing advice by telephone or electronic means.

Telephone and electronic equipment

The practice needs sufficient telephone and electronic equipment to support reliable and efficient communications.

Privacy and confidentiality

Some practices choose to communicate with patients using electronic means, such as email or SMS. Communication with patients via electronic means needs to be conducted with particular regard to the privacy and confidentiality of the patient's health information, since there is a higher risk of information inadvertently being seen by another person. It is recommended that practices consider whether it is appropriate to communicate particular information by electronic means or whether other methods would be more suitable (eg. for sensitive information such as HIV status or pregnancy results). It is also recommended that practices obtain documented patient consent before health information is communicated by email or SMS. Practices should cross check a patient's identification (using three approved patient identifiers) and verify the patient's contact details before any information is sent (see Criterion 3.1.4 Patient identification, Criterion 4.2.1 Confidentiality and privacy of health information and Criterion 4.2.2 Information security).

Practices need to have documented processes for ensuring that telephone and electronic messages from patients are recorded and given to the person for whom they are intended on the day of receipt, or in that person's absence, to the person who is caring for that absent team member's patients.

If the practice decides to provide patients with access to the practice by email, it is important that patients are made aware that their privacy and confidentiality may be compromised when communicating by email without encryption. Patients should also be made aware that only non urgent matters should be communicated by email, as opposed to telephone, as the practice team may not necessarily read all their emails on a daily basis. Similarly, information provided by the practice by email should be of a general nature when privacy is not assured. Information provided by fax may be even less secure when persons other than the patient may have access to the fax machine.

Referring important communications to GPs

Reception staff need to know which telephone calls should be transferred to GPs or to other staff who provide clinical care. It is recommended that GPs make time available in each session to take or return telephone calls. General practitioners and staff involved in clinical care need to make a record of all important contacts in the patient's health record. It is also important that staff are aware of individual GPs' policies on receiving telephone calls during consultations; ideally there will be a uniform system within the practice.

Peer reviewers need to take a common sense approach to the interpretation of the meaning of important communications.

Fees for telephone and electronic communications

Some practices may choose to charge a fee for telephone or electronic communication. Whenever a fee is charged, patients should be made aware of this and information about the costs of telephone/electronic consultations must be readily available as outlined in Criterion 1.2.4 Costs associated with care initiated by the practice. A frequent complaint from consumers is that they were unaware of the potential for costs when they telephoned a practice for advice outside normal opening hours.

Communications for patients with special needs

General practitioners and practice staff need to be aware of alternative modes of communication used by their patients, including those with a disability. Examples include the National Relay Service (NRS) for patients who are deaf and the Translation and Interpreter Service (TIS) for patients from a non-English speaking background. For further information about the NRS see www.relayservice.com.au and for TIS see www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/.

Standard 1.1

Access to care

Our practice provides timely care and advice.

Criterion 1.1.3

Home and other visits

Regular patients of our practice are able to obtain visits in their home, residential aged care facility, residential care facility or hospital, both within and outside normal opening hours where such visits are deemed safe and reasonable.

Indicators

- ▶ A. There is evidence that patients of our practice access home and other visits both within and outside normal opening hours.
- ▶ B. Our practice team can demonstrate our practice's policy on home and other visits, both within and outside normal opening hours, and the situations in which a visit is deemed appropriate.
- ▶ C. Our practice has a written policy on home and other visits, both within and outside normal opening hours.

Explanation

Key points

- In general, home and other visits need to be available to regular patients of the practice where clinically appropriate
- Practices need a home and other visits policy specifying:
  - factors that are deemed to make home or other visits safe and reasonable
  - geographic area for home and other visits
  - types of problems that necessitate a home visit
  - an alternative to a home visit if a home or other visit is not available.

Defining 'safe and reasonable' in the local context

Home and other visits such as visits to residential aged care facilities, residential care facilities or hospitals need to be available to regular patients of the practice where such visits are safe and reasonable and are clinically necessary. Visits may be performed by, or on behalf of, the practice.

There needs to be a direct continuing relationship between the practice GP(s) and those doctors who perform the home and other visits on their behalf, including services that provide care outside normal opening hours. This includes arrangements to exchange clinical details about patient care and any concerns the practice may have about the safety of a visiting GP.

General practitioners and other members of the practice team need to be able to describe the conditions under which a home or other visit is deemed appropriate. Examples include deciding upon a reasonable distance within which visits are provided and the types of problems that necessitate such visits. What is 'safe and reasonable' has not been defined here, as it is a decision that each practice needs to make in their local context (eg. with regard to location, patient population). What is safe and reasonable should be considered by the practice in light of what peers (or practices in the same area) would agree was safe and reasonable.

Information that may assist in determining what is safe and reasonable is available from the Australian Medical Association (AMA) Position Statement,

Personal Safety and Privacy for Doctors' (available at http://ama.com.au/node/2182) and the RACGP publications *Keeping the doctor alive: A self care guidebook for medical practitioners* (www.racgp.org.au/peersupport) and *General practice – a safe place* (www.racgp.org.au/gpsafeplace).

Documentary evidence that the practice provides care outside the practice may include medical records, appointment schedules and Medicare data. Such documentary evidence may be stored at the practice or at an external facility (eg. residential aged care facility progress notes).

Access to alternative sources of care

The RACGP does accept that there will be individual circumstances where home or other visits will be neither safe nor reasonable. In these circumstances the practice should be able to clearly document the alternative system of care that these patients can access. There should be documentary evidence that this system provides care for the practice's patients who require such services and ought to take into account the approach of similar practices in the area.

The RACGP understands that in future other models of care outside normal opening hours may be developed (eg. GP telephone advice line).

Patients with special needs

Practices need to consider how to provide continuity of care to patients who can no longer attend the practice due to disability. Patients value an ongoing relationship with their GP, even when their needs change.

Who can perform home or other visits

Home and other visits need to be performed by recognised GPs (either Fellows of the RACGP or vocationally recognised). In some areas it may not be possible to recruit recognised GPs. In such circumstances, doctors who provide home visits, and who are not recognised GPs, need to be appropriately trained and qualified to meet the needs of the practice community. Doctors who are not recognised GPs need to have been assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP (see Criterion 3.2.1 Qualifications of general practitioners).

In some situations, other health professionals, such as nurses or Aboriginal health workers, do home visits under the supervision of a suitably qualified doctor. Alternatively, health professionals sometimes transport a patient back to the practice for a consultation.

Safety of health professionals

The following guidelines may enhance the safety of health professionals undertaking home and other visits on behalf of the practice:

- Patients must have a telephone number which the general practice can call back
- A health professional is not sent to a patient/caller requesting pain relief unless a pain management plan is in place
- Police are requested to attend where a patient is threatening suicide
- A health professional is not sent to premises where there is evidence of a threatening or abusive person present – police are requested to attend in these instances

- Callers are asked to restrain dogs, to turn on an outside light at night and provide guidance on identifying the residence in the absence of a house number (eg. nearest intersection)
- Patients are asked to provide their date of birth, and the name of their regular GP/general practice. Where these details or a contact telephone number are not provided, consideration is given to referring the patient to hospital or calling an ambulance (as appropriate).

(Adapted from the National Association for Medical Deputising Services)

Services providing care outside normal opening hours

Medical deputising services (MDS) must provide home visits.

This criterion and indicators are not applicable for services providing care outside normal opening hours that only provide consultations within a clinic (ie. make no home and/or other visits).

Criterion 1.1.3 – ADF CONTEXT

Due to the demographics of the ADF population, home visits are rarely required. However, care in the home can be arranged for the ADF member where clinically indicated. The service provider will differ depending on locality. A risk assessment will be conducted prior to the home visit.

ADF members living in on-base accommodation and who cannot safely remain there due to illness or injury will have arrangements made for admission to a suitable in-patient facility or to travel home to their family.

Standard 1.1

Access to care

Our practice provides timely care and advice.

Criterion 1.1.4

Care outside normal opening hours

Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours.

Indicators

- ▶ A. There is evidence of one (or a combination) of the following for our patients:
  - our practice's GPs provide their own care for patients outside normal opening hours, either individually or through a roster, or
  - formal arrangements for cooperative care outside the normal opening hours of our practice exist through a cooperative of one or more local practices, or
  - formal arrangements exist with an accredited medical deputising service, or
  - formal arrangements exist with an appropriately accredited local hospital or an after hours facility.
- ▶ B. Patient health records contain reports or notes of consultations occurring outside normal opening hours by, or on behalf of, our practice.
- ▶ C. A message on our practice's telephone answering machine, call diversion system or paging system and a sign visible from outside our practice provide information to patients on how to obtain care outside our practice's normal opening hours.
- ▶ D. Our practice team can demonstrate how we provide medical care outside our normal opening hours.

Services providing care outside normal opening hours

- ▶ E. Our service can demonstrate that:
  - We provide timely reporting of the care provided back to the patient's nominated general practice/GP
  - There is a defined means of access for the deputising practitioner(s) to patient health information and to the practice(s) whose patients are seen in exceptional circumstances, including the contact details of the general practices and their normal opening hours
  - Care is provided by appropriately qualified health professionals.

Explanation

Key points

- Practices need to define their normal opening hours
- Practices need to have a documented arrangement for the care of their patients outside normal opening hours
- Practices need a formal agreement with an alternative provider
- Alternative providers and pathology providers need a manner of contacting the practice for urgent matters when the practice is closed
- Practices need to inform patients about the arrangements for care outside normal opening hours.

Options for care outside normal opening hours

Sometimes patients of the practice require provision of medical care outside normal opening hours.

The RACGP believes that patients value an ongoing relationship with a GP which is built on trust, and which provides continuity of comprehensive and coordinated medical care throughout the 24 hour period.

Practices are required to make and be able to demonstrate reasonable arrangements for access to primary medical care services for their regular patients within and outside normal opening hours. Some practices use their own GPs to provide care or alternatively use a local cooperative of GPs or a medical deputising service. Where a deputising service is not available practices may have an agreement with a local hospital. Some practices use a combination of all these arrangements.

It may be necessary for practices to consider which option for care outside normal opening hours will provide the highest quality of care while maintaining the safety of patients and GPs. In these circumstances, GPs may want to discuss those trade offs with peer surveyors.

Formal agreement

Documentation of an agreement with a provider of services outside normal opening hours should include:

- Reference to the timely reporting of the care provided back to the patient's nominated practice
- A defined means of access for the deputising practitioner to patient health information and to practice GPs in exceptional circumstances
- Assessment by the practice that the care outside normal opening hours will be provided by appropriately qualified health professionals.

Documenting the practice's system for care outside normal opening hours

Regardless of the arrangements used to provide care outside normal opening hours, documentary evidence of the system the practice uses to provide such care needs to be available. If the practice uses other GPs to provide care (such as a medical deputising service or GP cooperative), the practice needs to

have evidence of how and when it receives information about any care provided to their patients outside normal opening hours, and also how the GPs providing that care can contact the practice in an emergency or in the case of exceptional circumstances.

Regular patients of the practice who seek care outside normal opening hours will generally be better known to the practice than to the service providing care on behalf of the practice. Therefore it may be of substantial benefit if the doctor providing care is able to contact a GP within the practice for clarification or help regarding background information relating to that patient (especially in an emergency situation).

Follow up of seriously abnormal and life threatening results

The effective follow up of abnormal and life threatening results outside normal opening hours relies on general practices having robust and reliable systems for contact. Failures in pathology follow up have been the subject of criticism in coroners' inquests where patients have been harmed through a lack of robust systems for communicating urgent information. It is recognised that seriously abnormal and life threatening results do not arise frequently outside normal opening hours, but when they do occur prompt and adequate follow up is an important issue affecting patient safety.

General practices need to have arrangements in place to allow seriously abnormal and life threatening results identified by a pathology provider outside normal opening hours to be conveyed to a medical practitioner in a timely way, so the medical practitioner can make an informed and appropriate medical decision that is acted on promptly.

General practices need to specify what they expect of deputising doctors receiving urgent and life threatening results for a patient of the practice. Ideally this will be outlined in a formal agreement between the general practice and the service providing care outside normal opening hours.

Ideally, if the general practice uses another service to provide care outside normal opening hours, (eg. a GP cooperative, a medical deputising service or a local hospital) then the general practice should have a defined and reliable system for the deputising practitioner to access patient health information in exceptional circumstances. Those deputising for a general practice have a responsibility to contact the general practice in exceptional circumstances to ensure safe patient treatment. A distinction should be made between being 'on call' and 'being available' to deal with exceptional circumstances.

Who can provide after hours care for the practice

General practice care outside normal opening hours needs to be provided by recognised GPs (either Fellows of the RACGP or vocationally recognised). In some areas it may not be possible to recruit recognised GPs. In such circumstances, doctors who provide general practice care outside normal opening hours, and who are not recognised GPs, need to be appropriately trained and qualified to meet the needs of the practice community. Doctors performing general practice care who are not recognised GPs need to have been assessed for entry to general practice

and be supervised, mentored and supported in their education to the national standards of the RACGP as outlined in Criterion 3.2.1 Qualifications of general practitioners.

In some situations, other health professionals such as Aboriginal health workers or nurses provide care outside normal opening hours under the supervision of a suitably qualified doctor.

When the practice's GPs themselves cannot safely or reasonably deliver care outside normal opening hours, the practice should be able to clearly document the alternative system of care that is available for their patients during these times. Assessment of this criterion needs to take into account the approach of similar practices in the area. It is necessary that the care be appropriate to the needs of the patient; that it be timely and reliable; and that what is claimed to be available is actually provided. What is 'safe and reasonable' has not been defined here as it is a decision that each practice needs to make in their local context (eg. with regard to location and patient population). What is safe and reasonable should be considered by the practice in light of what their peers (or practices in the same area) would agree was safe and reasonable.

General practices which have arrangements with services that provide care outside normal opening hours need to describe their preferred arrangements for the management of patients who live beyond the boundaries of the service provider.

Communicating your after hours arrangements

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

Criterion 1.1.4 – ADF CONTEXT

ADF members' care outside of normal opening hours is provided from selected Garrison Health Facilities, where adequate resources are available. These are typically inpatient facilities that provide 24-hour care.

A national '1800' telephone nurse triage service (1800IMSICK or 1800 467 425) is provided for those members not able to access a Garrison Health Facility that provides care outside of normal opening hours. ADF members are made aware of this number via information available from the Garrison Health Facility and the ADF intranet.

The triage service will advise the member if they need to be seen urgently, and provide the details of local healthcare providers, whether they can wait until business hours or transfer the caller to emergency services (call 000). Reports of any calls made to this service are provided to Garrison Health Operations within an hour for emergency cases, or the next business day for routine cases. This information will include the member's name and date of birth, employee ID/PM Keys number, base, unit and location, and personal phone contact details, as well as a brief description of what advice was provided to the member.

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.1

Practice information

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

Indicators

- ▶ A. Our practice information sheet is available to patients and is accurate and contains at a minimum:
  - our practice address and telephone numbers
  - our consulting hours and arrangements for care outside our practice's normal opening hours, including a contact telephone number
  - our practice's billing principles
  - our practice's communication policy, including receiving and returning telephone calls and electronic communication
  - our practice's policy for the management of patient health information (or its principles and how full details can be obtained from the practice)
  - the process for the follow up of results
  - how to provide feedback or make a complaint to the practice including contact details of the local state or territory health complaints conciliation body.
- ▶ B. Our practice team can demonstrate how we communicate essential information to patients who are unable to understand our practice information sheet.
- ▶ C. If our practice has a website, the information is accurate and contains at a minimum the information included in our practice information sheet and meets the advertising requirements of the MBA Code of Conduct.

Explanation

Key points

Providing written information about the practice is important as it informs patients about the range and cost of services provided by the practice, such as:

- what clinical services are available at the practice
- how to obtain medical care within and outside normal opening hours
- billing principles, such as bulk billing, accounts settlement, representative or approximate costs for treatment
- communication policies, including the use of electronic means (eg. SMS and email)
- patient health information management policy (eg. how to obtain a copy of the health information kept by the practice)
- the process for follow up of results (eg. who will contact whom and by when)
- how to provide feedback and complaints to the practice (eg. a contact number for the person responsible for dealing with feedback and complaints).

Format of the information sheet

A photocopied, typed or electronically generated information sheet is acceptable. The information on the practice information sheet is important to all patients and the

practice needs to find alternative ways to provide or discuss this information with patients who are unable to read or understand it. Pictorial representations or a simple language version of the information may be helpful.

Where a practice serves defined ethnic communities, it is appropriate to make written information available in the most common languages used by the practice population.

Font style and size can be an issue for people with vision limitations. Vision Australia has produced legibility guidelines which practices may find useful. The guidelines are available at www.visionaustralia.org.au/info.aspx?page=785.

Providing feedback or making a complaint

Practices are encouraged to be open about the way patients can provide feedback or make a complaint. It may be useful to state that the practice is receptive to feedback and will always endeavour to resolve any complaints directly, but where a matter can not be resolved, the relevant health complaints commissioner can be contacted by the practice or by the patient for advice and possible mediation.

Practice websites

Where a practice has a website, it needs to ensure the information is regularly updated to reflect changes in the practice. Information on the website needs to be accurate and contain, at a minimum, the information included in the practice information sheet.

Advertising within practice information

Information provided by the practice (eg. practice information sheet, health promotion information or 'tailor made' health information magazines) may contain local advertising. The practice should include a disclaimer that the inclusion of advertisements is not an endorsement by the practice of these services or products.

All advertising needs to comply with the MBA Code of Conduct on advertising including:

- Making sure that any information you publish about your medical services is factual and verifiable
- Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients
- Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations
- Not offering inducements or using testimonials
- Not making unfair or inaccurate comparisons between your services and those of colleagues.

The MBA Code of Conduct is available at http://goodmedicalpractice.org.au/.

Criterion 1.2.1 – ADF CONTEXT

Garrison Health Facilities are required to comply with ADF and Commonwealth direction regarding internet and intranet websites. This means Garrison Health Facilities do not maintain specific internet pages related to their services. Garrison Health Facilities does maintain an intranet site on the Defence Restricted Network, in accordance with Defence web page design policies.

Health promotion information is available in Garrison Health Facilities, often in the form of pamphlets.

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.2

Informed patient decisions

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

Indicators

- ▶ A. Our clinical team can demonstrate how we provide information to our patients about the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments.
- ▶ B. Our clinical team can describe how we use leaflets, brochures or written or electronic information to support our explanation of the diagnosis and management of conditions when appropriate.
- ▶ C. Our clinical team can describe how we provide information (printed or otherwise) about medicines and medicine safety to patients.

Explanation

Key points

- Patients have the right to make informed decisions about their health
- Practices need to provide information in ways that are easy for individual patients to understand to support informed decision making
- This criterion cross references to Criterion 1.7.1 Patient health records, Criterion 1.2.4 Costs associated with care initiated by the practice and Criterion 4.2.1 Confidentiality and privacy of health information.

Appropriate and sufficient information

It is important that patients have sufficient information to make appropriate decisions about their own healthcare. Information about the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments needs to be tailored to the individual patient's needs.

This information needs to be delivered in appropriate language and format – avoid the use of jargon or complicated terms – and where necessary include clear diagrams and written information. Consideration also needs to be given to the patient's physical, visual and/or cognitive capacities, which may impact on their ability to understand the information, make decisions or provide consent.

Consideration needs to be given to the way information is communicated in relation to potentially sensitive investigations or tests (eg. sexually transmissible infections, blood borne viruses, fetal abnormality screening and pregnancy tests).

If working with patients from a different cultural background, special care is needed to ensure there is a shared understanding between the GP and the patient about the information provided.

In situations where patients are dependent on a third party for their ongoing care it is important to ensure all appropriate information is also provided to carers.

Although it is not necessary for the practice to know the exact costs of referred services, patients need to be advised of the potential for out-of-pocket costs before a referral is made. Where patients require exact information about the costs of referred services they can be invited to make their own enquiries. If the

patient indicates that such costs pose a barrier to the suggested referral, alternatives may need to be discussed (eg. referral to public services).

Informed consent also applies to any research being undertaken by a member of the practice team, in accordance with the NHMRC 'National statement on ethical conduct in human research' (www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf).

Patient-doctor collaboration

The Australian Commission on Safety and Quality in Health Care encourages patients to actively discuss with their healthcare provider the purpose, importance, benefits and risks associated with their care. The publication '10 tips for safer healthcare' is available at www.health.gov.au/internet/safety/publishing.nsf/content/10-tips and provides further detail. Practices may find it useful to refer patients to this information to help create an understanding of shared responsibility between the patient and the practice.

If a GP is aware that a patient has decided not to follow the advice of the GP after receiving sufficient information to make an informed decision about their care, their refusal and their awareness of its implications, as discussed with the GP, should be documented in the patient health record (see Criterion 2.1.1 Respectful and culturally appropriate care).

Medicines

The provision of information about medicines and medicine safety including consumer medicines information (CMI) may assist patients to make informed decisions about their medicines. Consumer medicines information provides an online version of leaflets produced by pharmaceutical companies and is available to the general public at www.nps.org.au/consumers.

GPs could offer to discuss any issues about medicines that could be confusing to patients and could also usefully suggest that patients obtain information about their medicines from their pharmacist.

Criterion 1.2.2 – ADF CONTEXT

ADF members are subject to the same provisions of informed consent as the general public. There are mandatory immunisation requirements for service in the ADF. Refusal of these vaccinations is permitted; however, members will be subject to administrative action, which could result in termination of service because it impacts on their ability to safely deploy on operations.

Appropriate consent is obtained from members prior to the required treatment and when information about their condition is to be shared with people outside of the clinical sphere. For example, informed consent is obtained if an ADF member's medical information is required to be shared with rehabilitation consultants, Commanders and the Service personnel agencies in order to consider their overall fitness for service.

Human research activities within Defence are generally governed by the Australian Defence Human Research Ethics Committee (ADHREC).

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.3

Interpreter and other communication services

Our practice provides for the communication needs of patients who are not proficient in the primary language of our clinical team and/or who have a communication impairment.

Indicators

- ▶ A. Our clinical team can describe how they communicate with patients who do not speak the primary language of our staff or who have a communication impairment.
- ▶ B. Our practice has a list of contact details for interpreter and other communication services including the Translating and Interpreter Service.

Explanation

Key points

- GPs have a professional obligation to understand their patients' problems
- Patients have a right to understand the information provided by GPs and their recommendations
- Practices need to know how to access interpreter services.

Interpreting services for GPs

The Department of Social Services provides free telephone interpreting services for GPs when providing Medicare-rebateable consults in private practice:

- Doctors Priority Line (available 24 hours a day, seven days a week)
- Delivered by the Translating and Interpreting Service (TIS National)
- On-site interpreting service (subject to interpreter availability).

Information on these services including how to register is available at www.dss.gov.au/free-interpreting or by calling 1300 575 847.

Friends and relatives as Interpreters

Qualified medical interpreters should be the interpretation medium of choice.

The use of patients' relatives and friends as interpreters is common. This is acceptable if it is an expressed wish of the patient and the problem is minor. However, further consideration should be given to the following:

- whether friends and relatives will put their own interpretation into the translated communication
- the use of friends and relatives in sensitive clinical situations or where serious decisions have to be made may be hazardous
- the use of children as interpreters is not encouraged.

Translating services

The HealthInsite website at www.healthinsite.gov.au/ provides helpful educational material for patients on a range of clinical conditions in a variety of languages.

Some websites offer free translation of brief information. To protect patient confidentiality, practices should ensure that no identifying information is revealed.
A list of websites providing translation services is available at www.word2word.com/free.html.

Patients with special needs

A free AUSLAN service for patients who are deaf is available at www.nabs.org.au.

Information about communicating with a person with impaired communication is available at www.betterhealth.vic.gov.au.

Information about communicating with a person with an intellectual disability is available at www.cddh.monash.org/assets/documents/working-with-people-with-intellectual-disabilities-in-health-care.pdf.

Criterion 1.2.3 – ADF CONTEXT

English language proficiency is a requirement for entry into the ADF. An independent authorised translator is provided where significant interaction with service personnel from a non-English speaking background is expected.

Standard 1.2

Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.4

Costs associated with care initiated by the practice

Our practice informs patients about the potential for out-of-pocket expenses for health care provided within our practice and for referred services.

Explanation

Key points

- Cost can be a barrier to care
- Patients need to know in advance about the potential for out-of-pocket expenses
- Patients need to know in advance about consultations that do not attract a government subsidy
- This criterion cross references to Criterion 1.2.2 Informed patient decisions.

Costs and informed decision making

Patients and advocacy groups have indicated to the RACGP that the cost of treatment or investigations can pose a barrier to care.

Information provided in advance about the costs of healthcare is an important component of informed decision making by patients. It is important for patients to know in advance whether the healthcare services they may require from the practice will attract costs over and above consultation fees so they can make an informed decision about their own healthcare.

Clear communication about unexpected developments can assist the patient to understand the need for additional costs. While it is not practical to stop in the middle of a procedure and inform patients that it will cost more than originally thought, effort to inform patients of the possible cost of additional treatments or procedures is needed before proceeding.

Special care should be taken to advise patients of the costs of consultations that do not attract a government subsidy (eg. cost of telephone and electronic consultations and diving or commercial driving licence medical examinations).

Components of health costs

Costs can include:

- brief, standard and longer consultations
- additional costs for late or missed appointments
- telephone and electronic communication
- nursing consultations
- home/other visits or care outside the practice's normal opening hours
- medicines (where the medicine is not subsidised or where the brand name prescribed is more expensive than a generic version).

Costs of other services

The practice should advise patients of the potential for out-of-pocket costs related to services such as pathology, imaging, specialist or allied health. It is not necessary for the practice to provide more detailed information.

If the patient indicates that such costs pose a barrier to the suggested referral, alternatives may need to be discussed (eg. referral to public services).

Criterion 1.2.4 – ADF CONTEXT

Health services delivered to ADF members through Garrison Health Facilities are provided in accordance with Defence policy that defines the level of entitlement at Commonwealth expense. This is broadly aligned with Medicare-funded services but, for a range of specific service-related or operational reasons, does occasionally exceed that normally provided under Medicare.

ADF members are made aware upon entry that healthcare within entitlements does not require the member to pay any out-of-pocket expenses.

The referring practitioner in the Garrison Health Facility will advise the member where a service is not available to them at Commonwealth expense (ie. is outside of the members entitlement. For example, cosmetic surgery).

In such circumstances, members are expected to fund these services or arrange funding by other agencies. For example, the Department of Veteran Affairs if they have accepted a claim for the condition.

Standard 1.3

Health promotion and prevention of disease

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

Criterion 1.3.1

Health promotion and preventive care

Our practice provides health promotion, illness prevention and preventive care and a reminder system based on patient need and best available evidence.

Explanation

Key points

- Practices need a systematic approach to health promotion, preventive care and early detection and intervention
- Practices are encouraged to provide patients with information about health promotion and illness prevention
- Practices need access to up-to-date resources for both patients and clinical staff
- This criterion cross references to Criterion 1.4.1 Consistent evidence based practice and Criterion 1.7.1 Patient health records.

General practice as the gateway

General practices are the gateway to healthcare for most of the Australian population and are therefore well placed to play a key role in health promotion, illness prevention and preventive care. General practices also have the potential to coordinate with other health professionals and key agencies to achieve health promotion and preventive care objectives. The holistic approach to care that general practices provide, allows for each patient's individual circumstances to be considered when providing health promotion, preventive care, early detection and intervention.

Health promotion is distinct from the education and information that GPs use to support their diagnosis and choice of treatment. Such prevention, education and health promotion may be delivered by GPs, general practice nurses or allied health professionals and reinforced through the use of written materials and other resources such as health promotion points in the 'on-hold' telephone messaging system or chronic disease self management/education clinics run by GPs or practice nurses.

Take home information

Education about health promotion and preventive care can be provided verbally during a consultation. It is also useful for patients to self select information on a range of health issues that may affect or interest them. The provision of written material is recommended as patients remember only three to four key messages from a consultation. This criterion refers to the many health pamphlets and brochures available from sources such as health departments, non-government organisations, health promotion programs, local community organisations and support and self help groups. Some educational materials are also produced in audio-visual format, which may complement the written material provided by the practice.

Aboriginal medical services often develop culturally appropriate material for their patients.

Practices are encouraged to be selective about the leaflets, brochures and pamphlets they make available, as these may vary considerably in quality and reliability.

Online information for patients

The use of the internet as a source of health information is becoming

more common. Practices need to consider the quality of the information available on internet sites before recommending them to patients.

Practices are encouraged to use the checklist in the current edition of the RACGP 'green book' *Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting* to help determine whether patient education materials, including those on the internet, are of sufficient quality. The 'green book' is available at www.racgp.org.au/greenbook.

The HealthInsite website at www.healthinsite.gov.au/ is another useful resource and information is available in different languages.

A systematic approach to preventive care

Regular consultations are an opportunity for health promotion.

However, this criterion also requires practices to have a systematic approach to health promotion and preventive care for patients, including those with a physical or intellectual disability.

Systems may include patient prevention surveys, use of disease registers, recall and reminder systems and local service directories to assist with referrals to lifestyle modification programs.

Reminder systems need to operate in such a way as to protect the privacy and confidentiality of patient health information. Practices also need to consider their responsibility to their patients if the practice ceases using a reminder system.

Preventive activities need to be based on the best available evidence and where possible incorporate the use of clinical guidelines.

Health risk assessment

Health risk assessment is a key component of preventive care. General practitioners play an important role in the early detection of disease though screening programs such as the cervical and bowel cancer screening programs.

Managing patient information to support preventive care

Members of the clinical team routinely collect information that should be transferred to a patient's health summary. A complete health summary makes a useful statement of the patient's main health issues. This contributes to better continuity of care within the practice and when patients seek care in other settings.

Some information may also be transferred to national registers (eg. immunisation data) or state and territory based systems (eg. cervical screening or familial cancer registries) in order to improve care. Where the practice participates in national registers, patients should provide consent for the transfer of related health information to a register or be made aware that they can opt out of such registers. The RACGP *new patient form* is a useful tool for informing patients about national registers and recording a patient's consent to the transfer of health information or their decision to opt out of a register. The *new patient form* can be ordered through RACGP publications.

Practices might also use data collected in the practice's clinical software or paper based systems (eg. smoking status, diabetes register) to improve the targeting and

use of prevention activities (eg. smoking cessation, weight management). They may use collected information transferred from private pathology providers (eg. diabetes screening, cervical screening). This is not only a quality improvement activity (see Criterion 3.1.1 Quality improvement activities); it also provides a check that the practice is identifying all relevant patients for their health promotion and preventive care activities.

Useful resources for the practice

- RACGP PrimaryCare Sidebar® is an electronic platform that can host a range of products including prompts which notify GPs of follow up activities required. The PrimaryCare Sidebar® has add-ons including the RACGP *Guidelines for preventive activities in general practice* (the 'e-red book'). This means the GP is automatically notified about which preventive care activities are outstanding, up-to-date or unknown for the patient record that is opened. The preventive activities are based on the latest evidence based recommendations from the e-red book. Further information is available at www.racgp.org.au/ehealth/primarycaresidebar.
- RACGP *Guidelines for preventive activities in general practice* (the 'red book') are available at www.racgp.org.au/guidelines/redbook.
- RACGP *Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting* (the 'green book') is available at www.racgp.org.au/greenbook.
- RACGP Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practice is available at www.racgp.org.au/guidelines/snap.
- RACGP learning modules are available at www.GPlearning.com.au.
- Australian absolute cardiovascular disease risk calculator is available at www.cvdcheck.org.au.
- Information on cancer screening is available at www.cancerscreening.gov.au.
- The National Preventative Health Strategy launched in 2009 includes technical papers on obesity, tobacco control and the prevention of alcohol related harm and can be found at www.health.gov.au/internet/preventativehealth/publishing.nsf/content/national-preventative-health-strategy-1lp.
- The Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) is an evidence based diabetes risk assessment tool that can directly link into the provision of a lifestyle modification program for patients who are found to be at risk of diabetes. The tool is available at www.health.gov.au/internet/main/publishing.nsf/content/C73A9D4A2E9C684ACA2574730002A31B/$file/risk_assessment_tool.pdf.
- The Department of Health and Ageing Lifescripts initiative provides general practice with evidence based tools and skills to help patients address the main lifestyle risk factors for chronic disease: smoking, poor nutrition, alcohol misuse, physical inactivity and unhealthy weight. The initiative assists with the provision of tailored advice to patients on modifying their lifestyle. Resources are available at www.health.gov.au/lifescripts.

Services providing care outside normal opening hours

The RACGP acknowledges that the provision of information by services that provide care outside normal opening hours about health promotion and illness prevention is likely to be opportunistic.

Standard 1.4

Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

Criterion 1.4.1

Consistent evidence based practice

Our practice has a consistent approach for the diagnosis and management of conditions affecting patients in accordance with best available evidence.

Indicators

- ▶ A. Our clinical team uses current clinical guidelines relevant to general practice to assist in the diagnosis and management of our patients.
- ▶ B. Our clinical team can describe how we ensure consistency of diagnosis and management of our patients.
- ▶ C. Our clinical team can demonstrate how we communicate about clinical issues and support systems within our practice.
- ▶ D. Our clinical team can explain how we access and use specific clinical guidelines for patients who identify as Aboriginal or Torres Strait Islander.

Explanation

Key points

- Consistency and quality of care can be assisted by the use of clinical guidelines
- Consistency and quality of care can be assisted by communication between team members.

Best available evidence

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

Clinical practice guidelines provide important recommendations for clinical care and should be accessible at the point of care. Practices need to check that clinical practice guidelines are current.

Resources that support evidence based practice

General practitioners and clinical staff find it valuable, both for the treatment of patients and their own professional development, to have access to resources about a range of clinical issues. These may include paper based resources (eg. text books and peer reviewed journals) and electronic resources (eg. access via the internet or CD-ROM). This criterion does not necessarily require access to the most recent editions of texts, materials or publications, nor does it require those resources to be in electronic format. However, resources need to contain information that is consistent with current practice and not recommended management that is no longer applicable.

Recommendations on clinical care are available from sources such as:

- Australian Cancer Network clinical practice guidelines at www.cancer.org.au/healthprofessionals/clinicalguidelines.htm

- Australian Commission on Safety and Quality in Health Care *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol* at www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/former-pubs-archive-correct
- Australian Medicines Handbook at www.amh.net.au
- Australian Prescriber at www.australianprescriber.com
- Central Australian Rural Practitioners Association (CARPA) treatment and reference manuals at www.carpa.org.au
- Cochrane database at www.3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME
- Diabetes Australia at www.diabetesaustralia.com.au
- National Aboriginal Community Controlled Health Organisation (NACCHO) at www.naccho.org.au/resources/guidelines.html
- National Asthma Council at www.nationalasthma.org.au
- National Health and Medical Research Council at www.nhmrc.gov.au/guidelines/index.htm
- National Heart Foundation at www.heartfoundation.com.au
- National Prescribing Service at www.nps.org.au
- RACGP *Guidelines for preventive activities in general practice* (the 'red book') at www.racgp.org.au/guidelines/redbook
- RACGP *Medical care of older persons in residential aged care facilities* ('silver book') at www.racgp.org.au/guidelines/silverbook
- RACGP *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (the 'green book') at www.racgp.org.au/greenbook
- RACGP Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practice at www.racgp.org.au/guidelines/snap
- Rational Assessment of Drugs and Research (RADAR) at www.nps.org.au/health_professionals/publications/nps_radar
- Royal Children's Hospital Melbourne clinical guidelines at www.rch.org.au/clinicalguide
- Therapeutic Guidelines at www.tg.com.au/home/index.html.

Patient identification

It is important to ensure the correct patient gets the correct procedure. A useful resource for GPs, especially those undertaking procedural work and minor surgery, is the *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol* from the Australian Commission on Safety and Quality in Health Care, or an equivalent protocol that incorporates these five steps. This is a nationally agreed protocol for public hospitals; compliance with the protocol reduces the risk of error for GPs who perform procedures in public or private hospitals, or in their own practices.

Health inequalities

The Australian Institute of Health and Welfare (AIHW) report *Australia's Health 2010* (available at www.aihw.gov.au/publications/aus/ah10/ah10.pdf) outlines some significant differences in key indicators of general health and wellbeing. This information is important because it highlights the need for primary healthcare interventions tailored to specific groups within the Australian community.

The AIHW report explains that while the health of the Australian population improved markedly during the 20th century, health gains have not been equally shared across all sections of the population and today Australia is characterised by large morbidity and mortality inequalities between population subgroups. This includes homeless youth, children of single parent families, people with developmental disabilities, Aboriginal and Torres Strait Islander people, refugees and those from culturally and linguistically diverse populations.

For example, the AIHW identifies that Aboriginal and Torres Strait Islander people have a life expectancy that is significantly less than that of other Australian men and women.

The RACGP encourages and supports practices to accommodate the specific health needs of individuals who experience disadvantage. In particular, the RACGP has worked with the National Aboriginal Community Controlled Health Organisation to produce guidelines for the care of Aboriginal or Torres Strait Islander people (available at www.racgp.org.au/aboriginalhealth/nationalguide).

A consistent approach is vital

Consistency in the approach to diagnosis and management of care across the various people who are involved in the clinical care of an individual patient (ie. the people involved do not work at 'cross purposes') is an important aspect of continuity of care. Patients value consistency in the quality of treatment they receive from a practice and expect that treatment and advice given by different GPs within the practice will not be in conflict. If the practice employs nurses or allied health professionals, patients expect that advice provided by these professionals will be consistent with the diagnosis and management approach of the treating GP. Providing consistency in diagnosis and management of health issues across a team of GPs, or a multidisciplinary general practice team, assists in ensuring that the practice provides continuity of care for patients (see Criterion 1.5.1 Continuity of comprehensive care and the therapeutic relationship).

This consistency is just as important in small or solo practices where the receptionist needs to have an approach (eg. to providing information) that is consistent with that of the GP, as it is in large practices with numerous clinical staff.

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

Communication within the clinical team

Good communication between members of the clinical team is important for ensuring a consistent approach to clinical care. Face-to-face meetings of the clinical team are preferable but communication books and electronic notice boards can be useful to consider clinical issues.

Standard 1.4

Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

Criterion 1.4.2

Clinical autonomy for general practitioners

Our practice ensures that all GPs in our practice can exercise autonomy in decisions that affect clinical care.

Explanation

Key points

- General practitioners are free, within the parameters of evidence based care, to determine:
  - the appropriate clinical care of their patients
  - the specialists and other health professionals to whom they refer
  - the pathology, diagnostic imaging or other investigations they order and the provider they use
  - how and when to schedule follow up appointments with individual patients
  - whether to accept new patients (subject to Criterion 2.1.1 Respectful and culturally appropriate care).
- Members of the clinical team are consulted about:
  - the length and scheduling of appointments
  - equipment and supplies the practice uses.

Clinical autonomy within evidence based care

The intent of this criterion is that GPs are free, within the parameters of evidence based care, to make decisions that affect the clinical care they provide, rather than having these decisions imposed upon them.

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

Professional and ethical obligations

All members of the clinical team should comply with the professional and ethical obligations required by law and the relevant professional organisation and practice within the boundaries of their knowledge, skills and competence. While this criterion is about the clinical autonomy of GPs, it is recognised that other members of the clinical team also exercise clinical autonomy relevant to their knowledge, skills and competence and their role within the practice team.

AMA Code of Ethics (2004), Editorially Revised 2006

Section 3 of the AMA Code of Ethics (2004) outlines the importance of professional independence and argues that to provide high quality healthcare, doctors must safeguard clinical independence and professional integrity from increased demands from society, third parties, individual patients and governments. The AMA Code is available at www.ama.com.au/codeofethics.

Corporate entities

Some organisations have developed codes of practice to ensure general practice systems do not restrict the ability of GPs to provide good medical care. It is important that such codes respect the professional independence of GPs in relation to clinical decision making and allow for the clinical team to be consulted on issues such as the length and scheduling of appointments, preferred supplies and equipment and preferred service providers.

The AMA *Code of conduct for corporations involved in the provision of management and administrative services in medical centres in Australia* (November 2001) can be found at http://ama.com.au/node/3752.

Criterion 1.4.2 – ADF CONTEXT

Defence is obliged to follow Commonwealth procurement policies when purchasing health services at the Commonwealth's expense. A contract arrangement that complies with Commonwealth procurement guidelines is in place for the purchase of these services.

The referral arrangements in place under this contract ensure GPs working within Garrison Health Facilities retain autonomy and remain the decision makers when determining an appropriate healthcare plan for ADF members. Where there is no suitable provider available within the contract, a GP is able to refer to a non-contracted provider, subject to approval from the relevant Commonwealth delegate.

Standard 1.5

Continuity of care

Our practice provides continuity of care for its patients.

Criterion 1.5.1

Continuity of comprehensive care and the therapeutic relationship

Our practice provides continuity of comprehensive care to patients.

Indicators

- ▶ A. Our staff can describe how patients can request their preferred GP when making an appointment or attending our practice.
- ▶ B. Our practice team can describe how we encourage continuity of comprehensive care.

Explanation

Key points

There are several types of continuity:

- the sense of affiliation between the patient and their doctor ('my doctor' or 'my patient'), sometimes called 'relational continuity'
- consistency of care by the various people involved in a patient's care (ie. not working at 'cross purposes'), sometimes called 'management continuity'
- continuity of information across healthcare events, particularly through documentation, handover and review of notes from previous consultations, sometimes called 'informational continuity'.

Provider continuity and patient outcomes

A systematic review by van Walraven et al[1] provides evidence that increased provider continuity is associated with improved patient outcomes and satisfaction. Research undertaken in the US[2] found that discontinuity of primary care physician visits is associated with patients seeing more different specialists, which in turn is associated with higher costs, more procedures and more medications.

Continuity within general practice

By the RACGP's definition, general practices provide patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities and it is important that patients have the opportunity to develop an ongoing relationship with the practice, GPs and staff members. One way to demonstrate continuity of care is through patient health records that show patients attending the practice over time.

Continuity is the degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected and consistent with the patient's medical needs and personal context. Continuity of care is distinguished from other attributes of care by two core elements: care over time and the focus on individual patients. This criterion focuses on those two elements: the attendance of individual patients, over time, at the general practice.

Doctor–patient relationship

Relational continuity is a sustained relationship between a single practitioner and a patient (or sometimes more than one practitioner and a patient) that extends beyond individual consultations or episodes of illness. This can be described as a sense of affiliation between a patient and their doctor ('my doctor' or 'my patient'). It is often viewed as the basis for continuity of care.

Many general practices now work with other health professionals such as practice nurses, mental health nurses, allied health professionals and Aboriginal health workers as part of the practice team. The principles in this criterion relating to the patient's
right to see their preferred GP also apply to appointments with other members of the clinical team.

System for supporting preferred relationships

It is acknowledged that some practices do not have formal, written appointment schedules by which patients are booked to see their preferred GP or another member of the clinical team. However, such practices need to be able to demonstrate that they have a system or a rationale for determining how patients may see the GP of their choice. It is noted that within Aboriginal medical services, continuity of comprehensive care may involve a wider set of relationships, extending from the patient to the GP, Aboriginal health workers and practice nurses.

Courtesy notifications

When a GP ceases to be a member of the practice team, it is courteous to notify the GP's regular patients. Depending on the circumstances, it may be appropriate to advise patients how they can access their own health information if required.

Services providing care outside normal opening hours

The therapeutic relationship between the patient and the GP who usually provides their continuing comprehensive healthcare needs to be preserved. Indicator A is not applicable to services which provide care outside normal opening hours.

Criterion 1.5.1 – ADF CONTEXT

Garrison Health Operations balances the needs of the members (patient focus) against the needs of their Chain of Command (unit focus) in allocating members to a GP.

To enhance communication about members with the Chain of Command, Garrison Health Facilities attempt to allocate a primary GP to each unit as a point of contact about their members. That GP is then the main doctor to provide primary care services to unit members. However, there is scope to allow access to other GPs when the primary GP is not available, or if a good rapport has not been established.

Members can choose which GP within a Garrison Health Facility they would prefer to see. Members are encouraged to maintain a clinical relationship with a primary provider if possible to help ensure better continuity of care.

Standard 1.5

Continuity of care

Our practice provides continuity of care for its patients.

Criterion 1.5.2

Clinical handover

Our practice has an effective clinical handover system that ensures safe and continuing healthcare delivery for patients.

Indicator

► A. Our practice team can demonstrate how we ensure an accurate and timely handover of patient care.

Explanation

Key points

- Clinical handover of patient care occurs frequently in general practice both within the practice to other members of the clinical team and to external care providers
- Clinical handover communications can be face-to-face, written, via telephone and also by electronic means
- Failure or inadequate transfer of care is a major risk to patient safety and a common cause of serious adverse patient outcomes. Inadequate handover can also lead to delayed treatment, delayed follow up of significant test results, unnecessary repeat of tests, medication errors and increased risk of medicolegal action
- Practices and services that provide care outside normal opening hours should have standard and documented processes for timely clinical handover
- Practices should encourage the reporting of near misses and breakdowns in clinical handover procedures and make improvements to minimise the risk of recurrence.

Defining clinical handover

Clinical handover has been defined by the Australian Medical Association as 'the transfer of professional responsibility and accountability for some or all aspects of a patient's or a group of patients' care to another person or professional group on a temporary or permanent basis'.

Clinical handover needs to occur whenever there is an interface of care by different providers. Examples of clinical handover include:

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

Whenever clinical handovers occur, whether external or internal, practices should ensure patients are aware of who will take over their care in the absence of their regular doctor. Patients need to be involved in the decision, particularly when they consult with more than one GP in the practice or a specialist or other care provider.

System for clinical handover

Practices are encouraged to have a documented policy on clinical handover to ensure standard processes are followed. When appropriate, it is prudent to record the clinical handover in the consultation notes and document that the patient has shared in decision making and has been informed (see Criterion 1.6.2 Referral documents).

Clinical handover within the practice

Clinical handover between GPs has become perhaps more common in recent years, with so many GPs now working on a sessional basis at a practice. Handover is important when a GP or other clinical staff member is away because of annual leave or illness. Practices should have a defined method to cover the handover of care of patients who have been under the care of the absent clinical team member. Many practices have a 'buddy' system whereby a 'buddy' follows up results and correspondence or continues the care of patients on behalf of an absent colleague. If a practitioner has a 'buddy' system to hand over care, this should be standardised and previously agreed, rather than ad hoc. Such arrangements do not necessarily have to be documented in the consultation notes, although the identity of the treating GP does need to be recorded.

Adequate clinical records, including a health summary, will enable another doctor to safely and effectively continue the routine care of patients. Practitioners should routinely read the patient's preceding clinical records for the past few consultations.

Clinical handover outside the practice

Clinical handover of a patient's care outside the practice occurs in many ways. It includes but is not limited to: referral for an investigation, referral to an ancillary healthcare provider, referral to a specialist and referral to a hospital, as an outpatient or as an in patient. Criterion 1.6.2 Referral documents states that referral letters include sufficient information to facilitate optimal patient care including details of 'the purpose of the referral'. As an example, clarifying, rather than assuming, who will manage the responsibility for follow up of investigations when referring a woman with a breast lump to a breast physician or surgeon.

When shared care ceases

Where a clinical handover involves complex or high risk patient care, such as suicidal patients, or patients on complex medication regimens, it is important for a GP to request that they be notified if the care of the patient ceases. Equally, if the GP stops seeing a patient they are treating on a handover basis, or the patient ceases to attend for treatment, it is important for the GP to notify others in the treating team in the interests of patient safety. This issue has been the subject of several coroners' recommendations.

Medical deputising services

Many practices hand over care of all their patients to a medical deputising service or other provider outside the normal opening hours of the practice. It is prudent to notify the deputising care provider of patients that you anticipate may need care (eg. a patient with a terminal illness). Deputising services need to have a defined means of timely contact with a GP from the practice when they are deputising, should they need to access more detailed health information about a patient. Deputising services are responsible for handing the care of a patient back to the patient's regular medical practitioner in a timely and appropriate manner.

Clinical handover to an emergency department

If a GP calls an ambulance from the practice to attend a patient's home, or if the GP is aware that an ambulance has been called to a patient's home to take the patient to an emergency department, the handover to the ambulance service should be face-to-face where practical or by telephone. When an ambulance service is not involved, the practice should ensure that sufficient information is provided to the emergency department about the clinical condition of the inbound patient, to facilitate prompt and appropriate care.

Handover of tests and results

Pathology services sometimes need to contact a practice doctor after the practice is closed concerning a serious result (eg. an unexpected result suggesting a patient has acute leukaemia or a raised INR).

General practices need to have arrangements in place to allow abnormal and life threatening results identified by pathology outside normal opening hours to be conveyed to a medical practitioner in a timely way, so the medical practitioner can make an informed and appropriate medical decision that is acted on promptly (see Criterion 1.1.2 Telephone and electronic communications).

There are occasions when the need for a handover process is more critical, such as a patient having a test that is anticipated to be abnormal and may need to be followed up when the referring GP is not on duty; or the review of a child with undifferentiated abdominal pain later in the day to ensure he/she does not have a surgical condition such as acute appendicitis. While most practices do this well, these are occasions of greater risk of harm when failure of adequate handover occurs (see Criterion 1.5.3 System for follow up of tests and results).

Transfer of patient health information

Where the practice produces a summary for transfer to another practice, the practice should keep a copy of the summary in the patient's health record. It is recommended that only a copy of the patient health information be transferred and that the practice retain the original health information.

Errors in clinical handover

When errors in clinical handover occur, every member of the practice team is encouraged to report them using de-identified data, so the event can be analysed and processes introduced to reduce the risk of a recurrence and harm occurring to other patients (see Criterion 3.1.2 Clinical risk management systems). It is important that the practice nurture a culture of just and open communication to support the resolution of errors in clinical handover.

Useful resources

- Australian Commission on Safety and Quality in Health Care OSSIE guide to clinical handover (electronic format only) is available at www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/con-clinical-ossie.
- Wong MC, Yee KC, Turner P. (2008). Clinical handover literature review, eHealth Services Research Group, University of Tasmania, is available at: *www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgramÂ]05.*
- Australian Medical Association (2006). Safe handover: Safe patients. Guidance on clinical handover for clinicians and managers is available at www.ama.com.au/web.nsf/doc/WEEN-6XFDKN.

Standard 1.5

Continuity of care

Our practice provides continuity of care for its patients.

Criterion 1.5.3

System for follow up of tests and results

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

Indicators

- ▶ A. Our patient health records contain evidence that all pathology results, imaging reports, investigation reports and clinical correspondence received by or performed in our practice have been:
  - reviewed by a GP
  - signed or initialled or electronic equivalent
  - where appropriate, acted upon in a timely manner.
- ▶ B. Our practice team can describe the system by which pathology results, imaging reports, investigation reports and clinical correspondence received by our practice are:
  - reviewed
  - signed or initialled (or the electronic equivalent)
  - acted on in a timely manner
  - incorporated into the patient health record.
- ▶ C. Our practice has a written policy describing the review and management of pathology results, imaging reports, investigation reports and clinical correspondence received by our practice.
- ▶ D. Our practice team can describe how patients are advised of the process for the follow up of results.
- ▶ E. Our practice team can describe how we follow up and recall patients with clinically significant tests and results.
- ▶ F. Our practice has a documented system to identify, follow up and recall patients with clinically significant results.

Explanation

Key points

- The practice needs a documented system for the follow up of tests and results, with a strong focus on risk management
- The practice system should delineate mechanisms for dealing with normal results, abnormal results (urgent and non urgent) and important tests/referrals
- The practice system should delineate mechanisms for the follow up of results and the follow up of clinically significant tests
- The practice system should cover how tests and results are communicated to patients.

Definitions

'Follow up' can mean:

- following up the information – following up on tests and results that are expected but have not yet been received by the practice

- following up the patient – tracing the patient to discuss the report, test or results after they have been received by the practice and reviewed, or tracing the patient if the patient did not take a test as expected.

'Recall' means:

- a system to make sure patients receive further medical advice on matters of clinical significance.

'Clinical significance' is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained
- the likely seriousness of the harm.

'Follow up system' is required by the practice to ensure that:

- all received test results and clinical correspondence (eg. reports from other healthcare providers) relating to a patient's clinical care are reviewed
- clinically significant tests and results are followed up
- patients are made aware of the seriousness of not attending for follow up
- patients are made aware of who is responsible for communicating with whom about results and when this is to occur.

A rigorous follow up system is essential

This criterion focuses on the systems that general practices need to use to follow up tests and results. The information gained from tests and results can have considerable impact on the choices patients and GPs make in patient care.

The GPs' and practice's responsibilities reflect the recognition that the patient-doctor relationship is a special one based on trust. It is also characterised by the GP having special knowledge and skills that the patient generally does not have. While practices are not expected to follow up every test ordered, or to contact patients with the results of every test or investigation undertaken, there may be considerable risk in not following up clinically significant tests and results.

During previous reviews of the RACGP *Standards for general practices*, members of the profession expressed concern about the way in which the College would reflect the profession's standards in the area of follow up. Some felt the courts had inappropriately shifted patient responsibilities to GPs. Others commented that decisions of the courts were less important than the emotional consequences of missing clinically significant results. In response, the RACGP commissioned a legal opinion on the matter and that advice has been incorporated in the Standards at www.racgp.org.au/Content/NavigationMenu/PracticeSupport/StandardsforGeneralPractices/Changes_to_College_Standards_Advice_re_Medical_Legal_Repercussions.pdf.

The follow up system needs to be designed in a way that anticipates that individual cases will require different levels of follow up depending on the clinical significance of the case.

Reliance on patient memory or motivation alone does not reduce the need for an effective follow up system in the practice. Patients may not follow the recommendations for tests provided by the practice because of their particular

circumstances, fear, ignorance, personality, expectations, beliefs, cultural background or a range of other factors. The practice needs to have systems to identify and respond to situations where a particular patient may not understand or comply with their responsibilities to go through with a test or to follow up the results with the practice. General practitioners in the practice need to reflect on which patients, tests and results justify a suspicion or concern. The practice needs to have a system that will allow GPs to take action to address their concerns. These concerns could be based on suspicion that the information from a test is likely to be clinically significant, or that the patient might not have the test performed.

In cases where a GP suspects that the results will be clinically significant, the practice needs to create additional safeguards to ensure that potentially clinically significant information does not get 'lost in the system'. One approach is by obtaining a clearly expressed agreement from the patient (which is documented by the GP) that the patient is responsible for having the recommended tests performed and/or getting the results. However, this alone might not be sufficient for follow up in all circumstances. The practice needs to have a system that protects against the failure of both the GP and the patient remembering to follow up on tests or results. These systems need to allow for more intensive follow up action if required by the circumstances.

Follow up systems in a group practice

In a group practice, it is ideal for all GPs to have the same system for the follow up of tests and results. This consistency will ensure that all members of the practice team are fully aware of the practice system. If there are different follow up systems in place for different doctors in the practice, this needs to be very carefully documented to ensure the follow up of tests and results is managed effectively across the whole practice.

Clinical significance

The nature and extent of responsibility for following up tests and results will depend on what is reasonable in all of the circumstances. Overall, the following factors are important in determining if something is clinically significant and therefore requires follow up:

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

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

The practice needs to have in place some process or system for following up – even if it is as basic as a simple diary entry or logbook containing 'worrying' or 'high risk' cases – so that where there is a concern about the significance of the test or result a reminder occurs. General practitioners do not necessarily need to supervise such a system directly, but it needs to operate consistently where it is needed (although the GPs will be the ones who identify the 'worrying' cases).

Communicating tests and results to patients

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

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

Patients' obligations

Patients also have responsibility for their own healthcare; this includes the seeking of results. It is important to have follow up systems in the practice that are meaningful for patients; that create a shared understanding of what is going to happen; that define who is responsible for follow up and that encourage patients to discuss how they can help manage their own health. These systems might include outlining the practice's policy for follow up in the patient information sheet, placing a notice in the waiting area, and having the GPs and clinical staff routinely describe the practice's system for follow up to patients when requests for pathology or imaging tests are made. The standards for ensuring that patients have the information they need to make informed decisions are covered in Criterion 1.2.2 Informed patient decisions.

At an early stage in the patient's care, the practice needs to focus on the reinforcement of the respective rights and responsibilities of the patient and members of the general practice team in following up tests and results. Developing this understanding with patients reinforces for patients that they should actively engage with the GP and that part of this requires them to think about the way they help manage their own health. Brief but accurate documentation of the discussion and outcome of such discussions is important. Documentation of relevant clinical information is also required so that the information provides a trigger to the GP or to others who may view, and rely on, the records later. The standards for maintaining patient health records are covered in Criterion 1.7.1 Patient health records, Criterion 1.7.2 Health summaries and Criterion 1.7.3 Consultation notes.

Where a recommended test is refused

In rare cases where a patient indicates they do not intend to comply with the recommendation for a test, the practice needs to ensure that the patient has received sufficient information with which to make an informed decision and to understand the consequences of their actions (or inaction). This discussion between the GP and patient needs to be recorded comprehensively in the patient health record (see Criterion 1.2.2 Informed patient decisions).

Timely review and action on tests and results

The review of results or reports and related action needs to be completed in a timely manner. The speed with which results/reports are acted on and the degree of effort taken to contact the patient to discuss the results will depend on the GP's judgment of the clinical significance of the result/report and the context, duration and longevity of the clinical relationship. If the practice needs to initiate follow up contact with a patient, it needs to do so in a reasonable manner. The number and types of attempts will take into account all of the circumstances. Depending on the likely harm to the patient, three telephone calls at different times of the day and follow up by mail to the address in the patient's health record may be needed. These attempts at follow up need to be documented in the patient's health record.

What most commonly goes wrong

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

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

It is therefore useful for practices to understand that protecting patients and GPs from errors involves a series of safeguards and devising, implementing and monitoring systems in the practice.

Practice software

The RACGP recognises that information technology can be a useful tool in the follow up of tests and results. The RACGP supports the development of reliable systems for the follow up of tests and results by the medical software industry as a high priority.

Services providing care outside normal opening hours

Services that provide care outside normal opening hours need to have a system to ensure that all received results and clinical correspondence relating to a patient's clinical care are reviewed and that clinically significant tests and results are followed up by the medical practitioner who ordered the test, with copies forwarded to the patient's regular GP.

Standard 1.6

Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

Criterion 1.6.1

Engaging with other services

Our practice engages with a range of health, community and disability services to plan and facilitate optimal patient care.

Indicators

▶ A. Our practice team can demonstrate how we plan and coordinate comprehensive care by our interaction with other services such as:

- medical services including diagnostic services, hospitals and specialist consultant services
- primary healthcare nurses
- allied health services
- pharmacists
- disability and community services
- health promotion and public health services and programs.

Services providing care outside normal opening hours

▶ B. Our service seeks feedback about the quality and responsiveness of our service from the practices whose patients we see.

Explanation

Key point

- **Engaging with other services is an important feature of high quality healthcare.**

Engaging with other services for optimal patient care

Engaging other medical services (eg. diagnostic services; hospitals and consultants; allied health; social, disability and community services) can assist the practice to provide optimal care to patients whose health needs require integration with other services.

Coordination of care for individuals, families and communities is part of the accepted definition of a GP. Where relevant, practices are encouraged to coordinate patient care across the general practice setting with other health services including allied health and pharmacy as well as social, disability, indigenous health and community services. The practice needs to have readily accessible written or electronic information about local health, disability, community and mental health services and how to engage with them to plan and facilitate patient care.

It is important for practices to identify relevant services within the local area that can enhance patient care, to develop registers of such services and to build good working relationships with these service providers to facilitate good collaborative care. These registers will be particularly useful for new members of the practice team.

Practices need to be aware of different referral arrangements for public and private providers.

Services providing care outside normal opening hours

Services that provide care outside normal opening hours may, where clinically appropriate, coordinate referrals through the patient's usual GP/general practice.

Standard 1.6

Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

Criterion 1.6.2

Referral documents

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

Indicator

▶ A. Our practice can demonstrate that referral letters are legible, contain at least three approved patient identifiers, state the purpose of the referral and where appropriate:

- are on appropriate practice stationery
- include relevant history, examination findings and current management
- include a list of known allergies, adverse drug reactions and current medicines
- the doctor making the referral is appropriately identified
- the healthcare setting from which the referral has been made is identified
- the healthcare setting to which the referral is being made is identified
- if known, the healthcare provider to whom the referral is being made is identified
- if the referral is transmitted electronically then it is done in a secure manner
- a copy of referral documents is retained in the patient health record.

Explanation

Key points

- Practices need to ensure enough information is provided on referrals to ensure that:
  - the correct patient is referred
  - the person to whom the patient is referred receives sufficient relevant information to manage the patient
  - patient confidentiality is preserved
  - 'known allergy' means a hypersensitivity reaction to a medicine or other substance that is made known to a GP
  - 'adverse drug reaction' means harm that results from a medicine
  - this criterion cross references to Criterion 3.1.4 Patient identification.

Patient identification

The correct identification of patients is crucial in referring patients to ensure the right patient receives the right treatment. This issue is covered in more detail in Criterion 3.1.4 Patient identification.

Approved patient identifiers include:

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

Sufficient information

Referral documents are a key tool in integrating the care of patients with external healthcare providers and therefore need to be legible (preferably typed) and contain sufficient information to allow the other healthcare provider to provide care to the patient, without disclosing sensitive patient health information that is not relevant to the referral (eg. inclusion of sensitive material such as a previous termination of pregnancy or STI would be unlikely to be of clinical relevance to a local physiotherapist, but would be important in an obstetric or gynaecological referral). Most of the information needed for a referral may be found in the patient's health summary; many practices routinely incorporate a copy of the patient health summary into a referral letter or attach the summary as a separate document.

Disclosure of patient information

Patients need to be aware that their patient health information is being disclosed in these referral documents. Practices may consider whether patients should be given the opportunity to read the content of the referral letter before it is forwarded to another care provider.

Referrals sent electronically

Unless the patient has provided informed consent to do otherwise, referrals forwarded by email should be encrypted and the practice must comply with standards for the secure transmission of health information to avoid a breach of patient confidentiality (see Criterion 4.2.2 Information security).

Unique patient identifiers

The National E-Health Transition Authority is developing a system of unique patient identifiers for patients, as well as individual healthcare providers and organisations. Unique patient identifiers will support the electronic transfer of information and where available should be used to complement the three required patient identifiers. These identifiers will facilitate the accurate and secure transfer of patient health information between the different areas that provide care to an individual patient.

Telephone referrals

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

Keep copies of referrals

For both medicolegal and clinical reasons, practices need to keep copies of important (non routine) referral letters (ie. new referrals or those for serious conditions) in the patient's health record. While the significance of individual letters is at the discretion of the GP, practices where no referral letters have been retained would not meet this criterion.

Practice software

The RACGP is aware that due to the limitations of some software which groups allergies and adverse drug reactions together, some practices may be unable to keep separate lists of known allergies and adverse drug reactions for a patient.

Services providing care outside normal opening hours

Services that provide care outside normal opening hours need to forward a copy of referral letters to the patient's regular GP/general practice.

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Criterion 1.7.1

Patient health records

For each patient we have an individual patient health record containing all the health information held by our practice about that patient

Indicators

- ▶ A. There is evidence that each patient has a legible individual patient health record containing all health information held by our practice about that patient.
- ▶ B. Where our practice has an active hybrid medical record system, for each consultation/interaction, our practice can demonstrate that there is a record made in each system indicating where the clinical notes are recorded.
- ▶ C. Our active patient health records include patient identification, contact and demographic information (where appropriate) including:
  - the patient's full name
  - date of birth
  - gender
  - contact details.
- ▶ D. Our practice can demonstrate that we routinely record the person the patient wishes to be contacted in an emergency.
- ▶ E. Our practice can demonstrate that we routinely record Aboriginal and Torres Strait Islander status in our active patient health records.
- F. Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.

Explanation

Key points

- Practices need to ensure that where a patient's information is held in different records it must be available when needed
- Practices need to routinely record the person the patient wishes to be contacted in an emergency (not necessarily the next of kin)
- This criterion cross references to Criterion 1.2.2 Informed patient decisions.

Dedicated patient health records

Practices need to have an effective system whereby a patient's health information is stored in a dedicated patient health record. Health records need to include: the patient's contact and other demographic information, medical history, consultation notes (including care outside normal opening hours and home visits), letters received from hospitals or consultants, other clinical correspondence, investigations or referrals, and results. Besides clinical information, the patient health record may

also contain other relevant information pertaining to the patient such as any WorkCover or insurance information or relevant legal reports.

It is critical that patient health records are legible so that another practitioner could take over the care of the patient if necessary. Not only does written information need to be legible (able to be read and understood), if the practice scans documents such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.

Culling information from paper based record systems

Ease of storage may be assisted by culling outdated test results that no longer have clinical relevance (in line with relevant state and territory legislation regarding the retention of patient health information). In these circumstances, the practice needs to have a system for the timely identification of information that is no longer relevant. General practices may want to consult their GPs' medical defence organisations when determining the practice's policy regarding culling results.

Risks of hybrid and paper record systems

There are potential risks associated with hybrid patient health record systems, where some information is recorded on a computer (eg. medicines list) and some information on paper notes (eg. past medical history). When the patient notes are stored in two areas it is possible for important issues to be overlooked, particularly if another doctor sees the patient. To make this less of a problem, a note in each system improves the continuity of these hybrid systems.

If health information about a patient is kept in two sites (as in the case of hybrid records or records held in a residential aged care facility), practices need to ensure all the information is available and accessible when needed.

In the interests of risk management, the RACGP recommends that practices with hybrid patient health record systems work toward the electronic recording of at least allergies and medications.

Collecting information from patients

The information required from new patients might be collected by practice staff having new patients complete a generic form, or by interviewing patients in a private environment before consultation. Practices should also have a system whereby patient information is updated regularly so that it remains current and accurate. Practices should routinely record the person the patient would like contacted in an emergency.

Recording cultural background

Practices in all clinical settings should work toward identifying and recording the cultural background of all patients since this background can be an important indication of clinical risk factors and can assist GPs in providing relevant care.

Recording Aboriginal and Torres Strait Islander status

The standard indigenous status question is: 'Are you of Aboriginal or Torres Strait Islander origin?' This question should be asked of all patients, irrespective of appearance, country of birth or whether the staff know of the client or their family background.

Sometimes practice teams feel concerned that obtaining Aboriginal or Torres Strait Islander status can be perceived as discriminatory. However, the information is very important because of the different health needs of Aboriginal and Torres Strait Islander people. The practice may wish to collect this information as part of a patient questionnaire and preface questions on cultural background by explaining that such information helps the practice provide appropriate healthcare.

The AIHW *National best practice guidelines for collecting Indigenous status in health data sets* provide useful background information and practical advice and are available at: www.aihw.gov.au/publications/index.cfm/title/11052.

An RACGP fact sheet is available at www.racgp.org.au/standards/factsheets.

Indicators E and F apply prospectively. The practice may wish to seek information on cultural background from existing patients through a simple mechanism such as an update-your-information questionnaire.

Criterion 1.7.1 – ADF CONTEXT

Defence maintains a longitudinal record of a member's health throughout their service. An electronic health record was implemented in Garrison Health Facilities in 2014. The legacy paper-based health records, which include separate medical and dental records, will remain relevant until the individual separates from Defence.

The legacy paper records will only be used to supply historical information relating to the member's past medical issues and treatment. All new content will be recorded on the electronic health record to avoid problems around having a hybrid system.

Copies of the paper records are held by the Defence central records agencies in accordance with relevant Government policy. Health records of Defence personnel are currently retained permanently.

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Criterion 1.7.2

Health summaries

Our practice incorporates health summaries into active patient health records.

Indicators

- ▶ A. Our practice can demonstrate that at least 90% of our active patient health records contain a record of known allergies.
- ▶ B. Our practice can demonstrate that at least 75% of our active patient health records contain a current health summary. A satisfactory summary includes, where appropriate:
  - adverse drug reactions
  - current medicines list
  - current health problems
  - relevant past health history
  - health risk factors (eg. smoking, nutrition, alcohol and physical activity)
  - immunisations
  - relevant family history
  - relevant social history including cultural background where clinically relevant.
- C. Our practice has documented standardised clinical terminology (such as coding) which the practice team uses to enable data collection for review of clinical practice.

Explanation

Key points

- Health summaries assist in providing ongoing care, both within the practice and on referral to other healthcare providers
- Health summaries need to be developed on a progressive basis and kept up-to-date
- Practices need to routinely record known allergies in the health record
- Coding has many beneficial uses that improve patient care including practice audit, identifying patients with particular medical conditions (eg. chronic disease registers for conditions such as diabetes) and other quality improvement activities
- 'Known allergy' means a hypersensitivity reaction to a medicine or other substance that is made known to a GP
- 'Adverse drug reaction' means harm that results from a medicine.

Health summaries for safe and high quality care

A vital component of a quality health record is a health summary. The RACGP encourages practices to aim for all active records to contain an up-to-date health summary. A good health summary assists the patient's own GP, other GPs in the practice, locums, registrars and students to rapidly obtain an overview of all components of the patient's care. Health summaries reduce the risk of inappropriate management including medicine interactions and

side effects (particularly when allergies are recorded). Health summaries provide the social and family overview vital to whole patient care. A health summary will assist with health promotion by highlighting lifestyle problems and risk factors (eg. smoking, alcohol, nutrition, physical activity status). It also helps disease prevention by tracking immunisation and other preventive measures.

This criterion applies to active patient health records only. An 'active patient health record' is a record of a patient who has attended the practice/service three or more times in the past 2 years. The medical records of patients who have attended the practice in the past 2 years should all have a health summary.

Even if a patient has only attended the practice once, the content of the summary should contain, as a minimum, sufficient information for the GP to safely and effectively provide care for the patient. The specific details listed would vary depending on the nature and context of the consultation (eg. a child with a minor laceration would generally not need to have a detailed past and family history, but immunisation details, especially tetanus immunisation, allergies, current medical problems and current medications could be relevant). Similarly, should a patient attend while on a round Australia trip and need to have a repeat of medications, it would be expected that a list of current medications and adverse drug reactions as well as current and past history would be documented in the health summary.

Practices with high numbers of recurrent, transient patients (eg. those in resort areas) will need to identify health records of regular patients for review if undertaking an external peer review.

Known allergies

While it is important to record all known allergies in the health record, it is particularly important to record adverse drug reactions as this facilitates safer prescribing (especially when computer based) and reduces the likelihood of adverse patient outcomes. Where there are no known allergies, it is important to record 'no known allergies' in the patient's health record to indicate this has been checked with the patient. Where a practice uses a hybrid health record system, it is particularly important that the allergy status of the patient is recorded in the same system that is used for prescription writing.

Social history and recent important life events

The recording of recent important events covers a wide range of social events of importance to the patient, which may include changes in accommodation, family structure (eg. birth of children, separation or divorce, death of family members) and employment. Recent important events can alter patient preferences and values and the context of care.

It is also important to record aspects of a patient's social history which may signify an increased risk of poor health (eg. Aboriginal or Torres Strait Islander status, refugee status, homelessness, sexuality and gender identity). The RACGP appreciates that family and social history especially should only be recorded in a health summary where it assists patient care and does not affect a patient's right to privacy. As such, not all health summaries will include all the items listed in Indicator B.

Where an appropriate member of the practice team checks with the patient and then determines there is no relevant health, family or social history, this should be recorded in the health summary to indicate the appropriate questions have been asked of the patient. The RACGP recognises that in some situations such as Aboriginal medical services and refugee health services, social and family histories may be collected by team members other than the GP (eg. Bringing Them Home coordinator, trauma counsellors).

Active patient health records

An active patient health record is defined by these *Standards* as the record of a patient who has attended the practice/service three or more times in the past 2 years. There is an expectation that practices which do not meet the 75% requirement at survey will achieve this threshold by the time of their next survey.

Coding

Consistent data coding systems drive meaningful quality improvement activities. Coding is an effective means to address issues of having consistent clinical terminology. This can be readily addressed by means of a software system that uses 'drop down box functionality' in defining medical diagnoses. Coding can form the basis of chronic disease registers and avoids the confusion that can result from 'free text' style descriptions in the medical history.

It is preferable for the practice to use nationally recognised coding systems rather than a system which is idiosyncratic to the practice. Coding does not necessarily need to replace details in past medical histories that have been recorded in free text. It should be seen as a useful adjunct to a comprehensive past medical history. Certain aspects of a person's past medical history may be difficult to formally code and yet remain important information for that particular patient.

Services providing care outside normal opening hours

Services that provide care outside normal opening hours are exempt from Indicator B since in general they do not have active patients as defined in these Standards and do not provide continuity of care for patients. However, health summaries produced by services that provide care outside normal opening hours should contain, as a minimum, sufficient relevant information for the GP to provide safe and effective care. Copies of such summaries should be provided to the patient's regular GP.

Criterion 1.7.2 – ADF CONTEXT

The summary in the electronic health record will note the member's adverse drug reactions, current medications health issues, relevant past history and immunisation status, with health risk factors, family and social history captured with Periodic Health Examination (PHE).

Standard 1.7

Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

Criterion 1.7.3

Consultation notes

Each of our patient health records contains sufficient information about each consultation to allow another member of our clinical team to safely and effectively carry on the management of the patient.

Indicators

- ▶ A. Our patient health records document consultations including consultations outside normal opening hours, home or other visits and telephone or electronic communications where clinically significant, comprising:
  - date of consultation
  - patient reason for consultation
  - relevant clinical findings
  - diagnosis
  - recommended management plan and, where appropriate, expected process of review
  - any medicines prescribed for the patient (including name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed)
  - complementary medicines used by the patient
  - any relevant preventive care undertaken
  - any referral to other healthcare providers or health services
  - any special advice or other instructions
  - who conducted the consultation (eg. by initial in the notes, or audit trail in an electronic record).
- ▶ B. Our patient health records show evidence that problems raised in previous consultations are followed up.
- ▶ C. Our practice can demonstrate that we are working toward recording preventive care status (eg. currency of immunisation, smoking, nutrition, alcohol, physical activity, blood pressure, height and weight [body mass index]).

Explanation

Key points

- Patient health records should be legible and understandable by another GP or clinical staff member to facilitate safe and effective care
- Complementary medicine consumption by patients should be documented to minimise drug interactions
- Patient health records should be updated as soon as practicable at or after consultations and visits. The records should identify the person in the clinical team making the entry.

Consultation notes are important for safe and high quality care

A consultation in general practice is the entry point to the healthcare system for most Australians. A consultation is an interaction between the practice and the patient related to the patient's health issues.

A consultation may be with a GP, nurse or other staff member who provides clinical care within the practice.

The quality of patient health information needs to be such that another GP or clinical staff member could read and understand the terminology and abbreviations used, and, from the information provided, be equipped to manage the care of the patient.

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

Many people now take complementary and over-the-counter medicines which may react adversely with conventional medicines. Therefore, complementary medicines prescribed by a member of the clinical team or self reported by a patient need to be documented in the same manner as other medicines.

As part of risk assessment, practices are encouraged to routinely record patients' height, weight and blood pressure at intervals of their choosing. This is useful in children to assess normal growth or failure to thrive and also to document weight loss and gain over a period of time in all age groups as this may be an indicator of disease.

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

Consultation notes are a risk management tool

Medical defence organisations have identified lapses in following up on problems and issues raised previously by patients as a considerable risk. This can occur when patients are not seen by their usual GP, although it can also occur when a GP is busy or distracted. Thus, for high quality patient care, it is useful for general practices to have systems that reduce the risk of such lapses.

Coding

Consistent coding of diagnoses, when available, should be used in the consultation notes to support continuous quality improvement of clinical care and patient outcomes.

Services providing care outside normal opening hours

Consultation notes produced by services that provide care outside normal opening hours should contain, as a minimum, sufficient relevant information for the GP to provide safe and effective care. Copies of such notes should be provided to the patient's regular GP.

Section 2

Rights and needs of patients

Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.

Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.

Criterion 2.1.1

Respectful and culturally appropriate care

Our practice provides respectful and culturally appropriate care for patients.

Indicators

- ▶ A. Our practice does not discriminate against or disadvantage patients in any aspect of access, examination or treatment.
- ▶ B. Our clinical team can demonstrate how we provide care for patients who refuse a specific treatment, advice or procedure.
- ▶ C. Our clinical team can describe what they do when a patient informs them that they intend to seek a further clinical opinion.
- ▶ D. Our practice team can describe what they do to transfer care, in a timely manner, to another GP in our practice or to another practice when a patient wants to leave the GP's care.
- ▶ E. Our practice team can describe arrangements for informing a patient and transferring the care of a patient whom a GP within our practice no longer wishes to treat.
- ▶ F. Our practice team can describe how our practice provides privacy for patients and others in distress.
- G. Our practice team can identify important/significant cultural groups within our practice and outline the strategies we have in place to meet their needs.

Explanation

Key points

- Patients have the right to respectful care, which promotes their dignity, privacy and safety
- The Federal Disability Discrimination Act (1992), as well as various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics
- Where patients indicate they wish to seek a second opinion, this should be documented in the patient's health record
- Where patients refuse advice, procedures or treatments, this should be recorded in the patient's health record
- Practices need a strategy which details the steps to be taken when GPs or the practice team no longer consider it appropriate to treat a particular patient, including how to assist the patient with ongoing care
- Practices need a plan to respectfully manage patients in distress
- Indicators C, D and E cross reference to Criterion 1.5.2 Clinical handover
- Indicator G cross references to Criterion 1.7.1 Patient health records.

MBA Code of Conduct – a valuable resource

The Medical Board of Australia (MBA) has adopted a code of conduct that defines clear, nationally consistent standards of medical practice. The code is entitled *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

Section 3 of the Code of Conduct is on 'working with patients' and it contains helpful information and advice on the doctor-patient partnership, effective communication, culturally safe and sensitive practice, and informed consent. The MBA Code of Conduct is available at www.medicalboard.gov.au/codes-and-guidelines.aspx.

Patients' rights

This criterion requires that both GPs and other members of the practice team deal with all patients in a respectful, polite and professional manner. Where a carer plays an ongoing role in the day-to-day care of a patient, it is generally advisable to include the carer in the doctor-patient relationship with the permission of the patient (if the patient is competent to give such consent).

Practices need to be aware that the Federal Disability Discrimination Act (1992), as well as the various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion).

Further information is provided by the Australian Human Rights Commission at www.hreoc.gov.au/. This website has guides to the relevant legislation and links to state and territory agencies with similar responsibilities.

The Australian Commission on Safety and Quality in Health Care has produced an Australian Charter of Healthcare Rights available in several languages at www.health.gov.au/internet/safety/publishing.nsf/content/priorityprogram-01.

Mutual respect for successful collaboration

Patients have the right to respectful care that promotes their dignity, privacy and safety. Patients have a corresponding responsibility to give respect and consideration to their GPs and other practice staff. All members of the practice team need to have appropriate interpersonal skills to work with patients and others in the practice. Much of the success of a practice depends on the positive, friendly, attentive, empathetic and helpful behaviour of staff at the reception desk.

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

General practitioners have a responsibility to ensure that when taking a history from a patient and developing subsequent management plans, they themselves fully understand the discussion that takes place and that, in turn, the patient fully understands the proposed management and treatment. This may be facilitated by the use of translating services. It is of the utmost importance that GPs ensure there is clear and effective communication between both parties in the doctor-patient relationship so that GPs can effectively manage their patients' healthcare.

Second opinions

Patients have the right to seek further clinical opinion from other healthcare providers. Practices are encouraged to document in the patient's health record any indication that a patient intends to seek a further clinical opinion. Patients need to be encouraged

to notify their GP when they are choosing to follow another healthcare provider's management advice. This allows the GP the opportunity to reinforce any potential risks of this decision.

Where patients do seek further clinical opinion, an appropriate risk management strategy for practices includes documenting this decision in the patient's health record. In addition, the GP is encouraged to document in the patient's health record an explanation of the actions taken when a patient seeks a further clinical opinion, including referral to other care providers if arranged.

Refusal of treatment or advice

If a GP is aware that a patient has refused advice, procedures or treatments, an appropriate risk management strategy for practices needs to include recording of such refusals in the patient's health record, including referrals to other care providers and an explanation of the action taken.

Patient requests for transfer of care

When a patient requests to be transferred to the care of another GP in another practice, a copy of patient health information needs to be transferred to the other practice in a timely manner to help facilitate care of the patient. Practice staff need to comply with the requirements of the state or territory legislation governing the transfer of patient health information.

GP requests for transfer of care

There may be patients whom a GP no longer considers it appropriate to treat (eg. when a patient has behaved in a threatening or violent manner, or where there has been some other cause for a significant breakdown in the therapeutic relationship). General practitioners have the right to discontinue treatment of a patient, especially when the GP thinks they can no longer give the patient optimal care. In such circumstances it is advisable for the practice to document a process to be followed by practice staff if the patient makes any subsequent contact with the practice. In rural and remote areas it may be difficult for the practice to uphold a decision to discontinue the treatment of a patient. The College reminds GPs that irrespective of a decision to discontinue the treatment of a patient, there is still a professional and ethical obligation to provide emergency care. Section 2 of the MBA Code of Conduct provides helpful advice on these areas (available at www.medicalboard.gov.au/en/codes-and-guidelines.aspx).

Dealing with patients who are distressed

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

Managing health inequalities

The RACGP supports the choice of general practices to favour or specifically 'target' people and communities with high needs for comprehensive primary care, where choices need to be made about the allocation of limited resources. One way of addressing the health inequalities of some individuals, families and communities is by providing targeted, culturally appropriate care to these patients. In these cases,

the RACGP believes the general practice is still providing initial, continuing, comprehensive and coordinated medical care to individuals, families and communities, despite targeting a specific patient group. For these practices it is important that the practice has clear systems to deal with requests for care by patients outside the target population. Examples of specific patient groups with high needs for comprehensive primary care include refugees, asylum seekers, prisoners, people of indigenous background or people from other cultural backgrounds associated with known health risk factors.

Respectful patient health records

Demonstrating respect for patients extends beyond the face-to-face interaction between the practice staff and the patient to the recording of patient health information. Making or recording derogatory, prejudiced, prejudicial, or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other GPs and can result in differential treatment for such patients.

Cultural awareness education

For information on the RACGP cultural awareness and cultural safety project see www.racgp.org.au/aboriginalhealth/culturalawareness.

Reconciliation Australia provides information about organisations that offer cultural awareness training available at www.reconciliation.org.au/home/reconciliation-action-plans/rap-community/cultural-awareness-training-register).

The Cultural Dictionary, a project of the Migrant Resource Centre Canberra & Queanbeyan Inc, aims to increase cultural understanding for service providers and is available at www.dhcs.act.gov.au/__data/assets/pdf_file/0017/5282/Cultural_Dictionary.pdf).

Criterion 2.1.1 – ADF CONTEXT

Any entitled person within the ADF is able to access care at any Garrison Health Facility. Members are made aware of their rights through information pamphlets and signage within these facilities.

Issues around refusal of care may impact on the individual's fitness for service. Such issues should be documented in the medical record and the member is counselled on the potential impact of refusing treatment.

ADF members move locations relatively frequently and their Defence medical record follows them as they move. This also results in care being transferred to the receiving facility. Care may also be transferred to another practitioner at either the member's or the GP's request. The practice manager may be involved to coordinate this transfer.

All ADF members are provided with cultural awareness education and there is an expectation that all ADF members are treated in a fair and equitable manner.

Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.

Criterion 2.1.2

Patient feedback

Our practice seeks and responds to patients' feedback on their experience of our practice to support our quality improvement activities.

Indicators

- ▶ A. Our practice has a process for seeking and responding to feedback from patients and other people and our practice team can describe this process.
- ▶ B. Our practice has a complaints resolution process and makes contact information for the state/territory health complaints agencies readily available to patients if we are unable to resolve their concerns ourselves.
- ▶ C. At least once every 3 years, our practice actively seeks feedback about patients' experiences of our practice by:
  - using a validated patient experience questionnaire that has been approved by the RACGP, or
  - developing and using our own individual practice specific method that adheres to the requirements outlined in the RACGP *Patient feedback guide: learning from our patients* (questionnaire or focus group or patient interviews).
- ▶ D. Our practice can demonstrate improvements we have made in response to analysis of patient feedback.
- E. Our practice provides information to patients about practice improvements made as a result of their input.

Explanation

Key points

- Patient experience is an outcome of healthcare
- Good patient experiences are positively related to other aspects of healthcare
- Collection of feedback about patient experience needs to be rigorous so that actions based on patient feedback can lead to meaningful quality improvement
- This criterion cross references to Crtierion 1.2.1 Practice information.

Must-have resource

Practices are advised to refer to the RACGP *Patient feedback guide: learning from our patients* (available at www.racgp.org.au/) to understand the rationale for collecting and using patient experience feedback and suitable methods for collecting feedback, which can then be used to drive quality improvement.

Patient experience

Internationally and in Australia there is growing emphasis on the robust and meaningful collection of information about patient experiences in both primary and tertiary care settings. In Australia there is a range

of patient 'charters' or 'principles' of patient centred care and consumer involvement. These relate to the provision of healthcare that involves, engages and prioritises the role of the consumer/patient in their care – sometimes referred to as a 'partnership approach' to healthcare. Critical to this type of healthcare, although only one element of it, is a process for patients to provide feedback (both positive and negative) to individual members of the clinical team and the wider practice team on their healthcare experience.

Issues critical to the patient experience

There is strong evidence in the published literature that there are six broad categories of issues that are critical to patients' experience of primary healthcare. Practices will need to seek feedback on all six of these categories:

- access and availability
- information provision
- privacy and confidentiality
- continuity of care
- communication skills of clinical staff
- interpersonal skills of clinical staff.

Collecting patient feedback on a day-to-day basis

The practice needs to have day-to-day mechanisms for gaining feedback from patients (such as a 'suggestion box' at reception) to allow for the timely consideration of comments, concerns or complaints. Where possible, patients should be encouraged to raise any concerns with the practice team directly and attempts should be made to resolve such concerns within the practice.

Managing complaints

Practices should attempt to resolve patient complaints themselves. If the matter can not be resolved, the relevant Health Complaints Commissioner can be contacted by the practice or by the patient for advice and possible mediation.

Section 3 of the MBA Code of Conduct contains advice about managing complaints at the practice level (available at www.medicalboard.gov.au/codes-and-guidelines.aspx).

Basic steps include:

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

The practice should make a habit of contacting the relevant insurer when a patient makes a complaint about a member of the clinical team, in order to seek advice on resolving the complaint before any action is taken.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) publication *Better practice guidelines on complaints management for health care services* provides guidance on effective complaints management in the Australian healthcare setting and is available at www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F3D3F3274D393DFCCA257483000D8461/$file/guidecomplnts.pdf.

Systematic methods for collecting patient experience feedback

Practices have four options for collecting patient experience feedback:

- use an RACGP approved questionnaire, or
- develop an individual practice specific questionnaire, or
- conduct a series of focus groups with patients, or
- conduct a series of interviews with patients.

Each option has advantages and disadvantages and practices will need to decide which method best suits their practice and patients. Detailed guidance is available in the RACGP *Patient feedback guide: learning from our patients*. Structured/systematic patient experience feedback needs to be collected at least once every 3 years. There is good evidence to suggest that the most meaningful changes to practice can occur from collecting and using patient experience feedback on a more regular basis. Practices are therefore encouraged to consider collecting structured patient experience feedback more frequently than the required minimum. Where practices choose to collect patient feedback using methods other than an RACGP approved questionnaire, these methods need to meet the requirements outlined in the RACGP *Patient feedback guide*.

Using patient experience information to improve quality

Once patient feedback data has been collected and analysed, it is recommended the practice convene a dedicated staff meeting to reflect on the results and map out a plan of action for quality improvement. The plan needs to consider other information about the practice such as safety and cost issues. It is recommended the action plan focus on a few key issues. Not every suggestion made by patients will be practical, feasible or desired and it is up to the practice to determine a set of priorities for action.

Telling patients about quality improvement initiatives

Patients value knowing that their feedback has been useful to the practice. It is therefore recommended that practices communicate the findings of the feedback process in suitable ways (eg. a practice poster, newsletter or website, or at an individual level as appropriate).

Services providing care outside normal opening hours

For services that provide care outside normal opening hours, Indicator A includes responding to feedback from the practices for which they deputise and providing practices for which they deputise with any patient feedback directed at the patient's regular practice.

Standard 2.1

Collaborating with patients

Our practice respects the rights and needs of patients.

Criterion 2.1.3

Presence of a third party

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

Indicator

▶ A. Our practice team can demonstrate how we obtain the prior consent of a patient for the presence of a third party during the consultation.

Explanation

Key points

- Patients must be asked to provide consent for the presence of a third party before the consultation commences
- Third parties can be interpreters; carers; relatives; friends; medical, allied health or nursing students on placement; general practice registrars or chaperones
- When prior consent for the presence of a third party has been provided, it is prudent to check that the consent remains valid at the outset of the consultation.

Prior consent

Ideally, permission for the presence of a third party during the consultation needs to be sought when the patient makes an appointment, or, failing that, when they arrive at reception. It is not acceptable to ask permission in the consulting room, as some patients may feel 'ambushed' and unable to refuse. Once prior consent has been sought and given, the GP should confirm at the outset of the consultation that the patient has consented to the presence of any third party.

Chaperones

In some circumstances, the patient or GP may feel more comfortable if there is a chaperone present during an examination. Appropriate consent needs to be obtained from the patient where the doctor requests the presence of a third party for this purpose. The RACGP has a position statement on the use of chaperones available at www.racgp.org.au/policy/chaperones_in_GP.pdf.

Third parties such as family or carers

Where a patient is accompanied to the practice by a third person (such as a family member or carer) it is equally important to ensure that the patient consents to the presence of that person in their consultation and it is useful to record this consent in the consultation notes.

Practice staff need to be mindful of the particular needs of people with intellectual disabilities who may not be able to provide consent. In such cases a legal guardian or advocate may have been appointed to oversee the interests of the patient. More information on guardianship can be found at www.hreoc.gov.au/disability_rights/hr_disab/areas/appendices.htm#app1.

Students on clinical placement

Exposure to general practice is important for the recruitment and training of our future GPs as well as other health professions.

Recent graduates and international medical graduates are more likely to enter general practice if they have exposure to general practice in their university education. The general practice term is the most important part of vocational training and most general practice registrars report that the experience is valuable. Hence, education and training are among the most important reasons for a third party to observe or to be involved during the consultation.

The permission of the patient must be obtained before the consultation if undergraduate students, general practice nurses or other doctors or health professionals are to be involved in the consultation, whether through direct observation, interview or examination.

Section 3

Safety, quality improvement and education

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Criterion 3.1.1

Quality improvement activities

Our practice participates in quality improvement activities.

Indicators

- ▶ A. Our practice team can describe aspects of our practice that we have improved in the past three years.
- ▶ B. Our practice uses relevant patient and practice data for quality improvement (eg. patient access, chronic disease management, preventive health).

Explanation

Key points

- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute
- This criterion cross references to Criterion 2.1.2 Patient feedback and Criterion 1.3.1 Health promotion and preventive care.

Quality improvement is an essential business activity

Improvement in general practice can involve examining practice structures, systems and clinical care. Improvement needs to be based on evidence produced by the practice's own data. This data can be gathered from patient or staff feedback, an audit of clinical databases, or the analysis of near misses and mistakes.

Examples of quality improvement

It is important that standards for general practices encourage quality improvement and identify opportunities to make changes that will increase quality and safety for patients.

It is critical the practice has a plan for carrying out any improvements it has identified as being necessary. Quality improvement activities can encompass changes to the day-to-day operations of the practice (eg. scheduling appointments, normal opening hours, improving patient health record keeping, changing the way patient complaints are handled, or altering systems in response to 'near misses'). Quality improvement can also encompass activities specifically designed to improve clinical care or the health of the entire practice population (eg. improving rates of immunisation, improving the care of patients with diabetes or hypertension or altering the systems used to identify risk factors for illnesses that are particularly prevalent in the practice's local community such as cardiovascular disease). For example, practices could undertake an internal assessment of their clinical handover processes by checking with randomly selected referral recipients whether the practice's clinical handover processes are consistently satisfactory.

Patient experience feedback

Patient feedback is an essential component of quality improvement activities in both clinical and system domains (see Criterion 2.1.2 Patient feedback).

Practice accreditation as a driver of quality improvement

One of the most effective quality improvement activities is formal accreditation using these *Standards*; peer surveyors can provide extremely useful ideas about how a practice can improve in a range of areas.

Information management

Quality improvement activities are underpinned by effective information management techniques that allow practices to collect and analyse practice data and make decisions for service changes based on that data. Innovative use of information technology can assist practices in performing quality improvement activities to improve the health of their practice population. Ideally, practices need to review their own practice data for quality improvement purposes. Where such data is not easily accessible (eg. in non-computerised practices) national recall and reminder registers such as the Australian Childhood Immunisation Register can provide practice specific data for practices to use in quality improvement activities.

Data collection

Consistent data coding systems drive meaningful quality improvement activities. Coding is an effective means to address issues of having consistent clinical terminology. This can be readily addressed by means of a software system that uses 'drop down box' functionality in defining medical diagnoses. Coding can form the basis of chronic disease registers and avoids the confusion that can result from 'free text' style descriptions in the medical history.

It is preferable for the practice to use nationally recognised coding systems rather than a system which is idiosyncratic to the practice.

Quality improvement is a team activity

Engaging in quality improvement activities is an opportunity for the practice's GPs and other staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team as a whole.

Quality improvement tools and other resources

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

- The Clinical Audit Tool (CAT), a software application used within the general practice that allows analysis of identifiable practice information
- The Clinical Health Improvement Portal (CHIP) a secure web based data warehouse that builds on the clinical and business improvement opportunities available via CAT and allows analysis of de-identified practice information against GP-agreed clinical indicators.

More information about Oxygen products and services is available at www.racgp.org.au/ehealth.

The National Prescribing Service offers free quality improvement activities that help GPs review their prescribing habits at www.nps.org.au/health_professionals/activities/clinical_audits_for_GPs.

Australian Primary Care Collaboratives offer subsidised learning workshops on a model for improvement at www.apcc.org.au/.

The RACGP Quality Framework included in the January/February 2007 issue of *Australian Family Physician* discussed the theory of quality improvement in general practice and included an examination of the RACGP Quality Framework at www.racgp.org.au/afp/200701). Further information including a schematic diagram of the framework is available at www.racgp.org.au/qualityframework.

RACGP QI&PD services offer a wealth of quality improvement tools and guides including clinical audit mechanisms. Visit www.racgp.org.au/qacpd/20082010triennium/GPforms.

The RACGP has produced and endorsed a wide range of guidelines to assist GPs and practice teams in their work. These resources are available at www.racgp.org.au/guidelines.

The *Measurement for improvement toolkit* is a tool produced by the Australian Commission on Safety and Quality in Healthcare and is available at www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/publications-M.

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Criterion 3.1.2

Clinical risk management systems

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

Indicators

- ▶ A. Our practice team can demonstrate how we:
  - regularly monitor, identify and report near misses and mistakes in clinical care
  - identify deviations from standard clinical practice that may result in patient harm.
- ▶ B. Our practice has documented systems for dealing with near misses and mistakes.
- ▶ C. Our practice team can describe improvements made to our systems to prevent near misses and mistakes in clinical care.
- ▶ D. Our practice monitors system improvements to ensure successful implementation of changes made to our clinical risk management systems.
- ▶ E. Our practice has a contingency plan for adverse and unexpected events such as natural disasters, pandemic diseases or the sudden, unexpected absence of clinical staff.

Explanation

Key points

- There should be one member of the practice team with primary responsibility for clinical risk management systems (see Criterion 3.1.3 Clinical governance)
- Near misses and mistakes in clinical care occur in all general practices
- Practices need systems to recognise and analyse near misses and mistakes so solutions can be implemented to prevent their recurrence
- Solutions need testing to ensure they work effectively
- Deviations from standard clinical practice may be interpreted as deviations from practice which might reasonably be expected by the public or professional peers.

Allocation of responsibility

The practice should appoint one member of staff with primary responsibility for clinical risk management systems. Specific areas of responsibility can be delegated to other nominated members of the practice team and these particular responsibilities should be documented in the relevant position descriptions.

Defining mistakes and near misses

Mistakes are errors or adverse events that result in harm. (Adapted from the RACGP education module Thinking safety, being safer).

Near misses are incidents that did not cause harm but could have.

The core elements of risk management

The following information has been adapted from the Avant website.

For simplicity's sake, medicolegal risks and strategies can be classified into three areas.

1. Clinical knowledge and skill

Fundamental strategies here include:

- keeping up-to-date
- taking a thorough history and examination and documenting thoroughly in the clinical record
- being aware of your own limitations and referring patients on appropriately
- investigating further if treatment is not working
- making use of protocols, checklists and diagnostic support aids
- looking after yourself
- preventing and dealing with fatigue
- reporting your concerns if you feel unsafe work practices are enforced on you.

2. Communication

Risks can be minimised by:

- building a doctor-patient relationship based on trust and honesty
- listening to patients and showing empathy
- minimising interruptions during consultations
- managing unrealistic patient expectations
- communicating with your practice staff
- encouraging an environment in the practice where patients feel welcome and staff are skilled in all aspects of managing patients
- fostering strong relationships with colleagues and other health professionals involved in the care of your patients
- Keeping open channels of communication with health facilities you interact with (eg. hospitals, radiology practices)
- Managing adverse events or complaints in a way that does not leave the patient feeling abandoned or that their concerns were ignored
- Ensuring your consent process allows the patient to understand the implications of a proposed treatment, medication or procedure so they can make up their own mind as to whether they want to have it or not.

3. Systems

Systems which can be 'fine tuned' to decrease medicolegal risk include:

- complaints handling process
- tracking tests ordered and referrals made
- recording of appointments, cancellation and any failure to attend
- infection control procedures

- recruitment, training and management of staff
- managing confidentiality and privacy.

Mistakes happen

Near misses and mistakes in clinical care that might harm patients occur in all general practices. The evidence about the frequency of near misses and mistakes varies and the better constructed studies suggest even higher rates of occurrence.

Most GPs and practices already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent near misses and mistakes. Some GPs talk to other trusted peers or supervisors for advice. Other practices have a more formal process that includes practice discussions about what went wrong and how to reduce the likelihood of it happening again, or using structured techniques to analyse the causes of an error and reduce the likelihood of its recurrence.

Just and open communication is vital

A systems approach to thinking about adverse events and errors highlights a need to shift away from the immediacy of blaming individual practitioners to cultivating a just, open and supportive culture where individual accountability and integrity is preserved, but mediated by thoughtful and supportive response to error (see the RACGP education module *Regaining trust after an adverse event*).

The practice needs to have a process in place where members of the practice team know who and how to notify when a near miss or mistake occurs, or when there is an unanticipated adverse outcome. All members of the practice team, no matter how junior, should feel empowered to recognise and report near misses and mistakes without fear of recrimination.

A study by Maxfield et al[3] highlights the critical importance of open communication. The study found that people see others make mistakes, violate rules or demonstrate dangerous levels of incompetence repeatedly and over long periods of time in ways that hurt patient safety and employee morale. However, they don't speak up and the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront. These findings give practices a powerful reason for focusing on open communication as a vital tool in clinical risk management.

Consistent use of risk management systems reduces clinical risk

The same mistake can have different causes on different occasions. Part of the quality improvement process is to make sure there is consistent use of clinical risk management systems, so that the causes of near misses and mistakes are identified and processes improved to reduce the likelihood of them occurring again.

If the practice does not make improvements after identifying a near miss or mistake, patients may be exposed to an increased risk of adverse outcomes and the GPs and practice staff may be exposed to an increased risk of medicolegal action. An example of this situation is where a clinically significant test result is not communicated to the patient or adequately followed up; the

practice knows about this and makes no attempt to prevent a recurrence. Another example might be when an important detail in a previous consultation is not considered by the GP at that patient's next consultation, resulting in a problem being overlooked; the practice becomes aware of this and yet does not act to prevent it happening again. This second example is more likely with the use of certain electronic based record systems that do not show the previous consultation record when a patient's record is opened.

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

Practices will have different systems in place to identify and reduce clinical risk. It is important, however, for practices to be able to demonstrate how and why they have made changes to improve clinical care.

Find it, fix it, confirm it approach

Poor performance and poor practice can too often thrive behind closed doors. Implementing a clinical governance framework should assist a practice in finding the balance of 'find it', 'fix it' and 'confirm it' functions in relation to improving the quality and safety of care.

- 'Find it': practices can use tools such as clinical audits and performance indicators to identify where quality improvement programs could impact on the quality of care delivered and improve patient health outcomes
- 'Fix it': once the gaps in quality care have been identified, practices can implement strategies to address the issue (eg. redesign of clinical services and the development of policies and procedures)
- 'Confirm it': confirmation of the improvement can be measured through an effective evaluation process (eg. systematic re-audit of targeted indicators).

Event registers

Practices may find it beneficial to keep a record of de-identified near misses and mistakes to facilitate quality improvement initiatives. In April 2005 the RACGP obtained legal advice from Milstein and Associates which is pertinent to the use of event registers/records. The advice is still relevant and is available at www.racgp.org.au/content/navigationmenu/practicesupport/standardsforgeneralpractices/changes_to_college_standards_advice_re_medical_legal_repercussions.pdf

Notifying your medical defence organisation is vital

The RACGP recommends that GPs notify their medical defence organisation of all events or circumstances that they perceive might give rise to a claim and certainly before any action is taken to resolve a complaint or apologise for a mistake involving clinical care.

Contingency plans

Practices need to have contingency plans for unusual events that may disrupt patient care such as natural disasters or disease outbreaks that overstretch the practice's capacity, or the sudden, unexpected absence of key members of the clinical team.

Emergency communication from RACGP

Subscribers to the RACGP *Fridayfacts* bulletin (www.racgp.org.au/fridayfacts) will receive notification via special emergency bulletins of any notices issued by the Commonwealth Chief Medical Officer in relation to national emergencies (eg. adverse reactions to vaccination of under fives or responses to pandemic).

Resources

- RACGP guide *Using near misses to improve the quality of care for your patients* is available at www.racgp.org.au/publications/orders.
- RACGP *Regaining trust after an adverse event: an education module on managing adverse events in general practice* is available at www.racgp.org.au/content/navigationmenu/practicesupport/runningapractice/patientsafetyinitiatives/currentprojects/regainginggrustworkbook.pdf.
- RACGP education module *Being human, being safer* on human factors in general practice is a useful resource for all members of the practice team and is available at www.racgp.org.au/safety/beinghuman.
- RACGP education module *Thinking safety, being safer* is designed to help all members of the practice team understand and utilise 'near miss' analysis to improve the quality of patient care and is available at www.racgp.org.au/safety/thinkingsafety.
- RACGP *Pandemic flu kit* outlines disaster management and is available at www.racgp.org.au/pandemicresources. This section of the College website also provides links to the relevant departmental health units for up-to-the-minute information on areas such as human swine influenza.
- RACGP *Infection control standards for office based practices* (4th edition) provide information on infection control principles for general practices to prepare for an influenza pandemic. Topics include: how micro-organisms are acquired and grown; the use of standard and additional precautions; the correct use of personal protective equipment; the correct use of high filtration and surgical masks (eg. N95/P2 masks); cleaning the practice environment and equipment; triage and disease surveillance systems in the general practice. A copy can be ordered via the RACGP website at www.racgp.org.au/publications/standards.
- MBA Code of Conduct section 3.10 (available at www.medicalboard.gov.au/codes-and-guidelines.aspx) provides useful information on dealing with adverse events.

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Criterion 3.1.3

Clinical governance

Our practice has clear lines of accountability and responsibility for encouraging improvement in safety and quality of clinical care.

Indicators

- ▶ A. Our practice has leaders who have designated areas of responsibility for safety and quality improvement systems.
- ▶ B. Our practice shares information about quality improvement and patient safety within the practice team.

Explanation

Key points

- **Good clinical governance ensures the accountability of individuals for the delivery of safe and effective quality care**
- **It takes leadership to build an empowered and participative team that delivers high quality and safe care to patients.**

Clinical governance

Clinical governance is a 'system through which organisations are responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.[4]

The elements of clinical governance commonly include:

- education – basic and ongoing
- clinical audit
- clinical effectiveness – evidence based practice
- risk management – clinical and general
- research and development
- openness.

The Australian Commission on Safety and Quality in Health Care proposes a similar model[5] and argues that effective clinical governance includes:

- recognisably high standards of care
- transparent responsibility and accountability for maintaining those standards
- a constant dynamic of quality improvement.

In a recent study, Phillips et al[6] explored the link between quality and clinical governance in primary healthcare and found seven key areas to support clinical governance: ensuring clinical competence, clinical audit, patient involvement, education and training, risk management, use of information and staff management.

Clinical leaders

The appointment of a clinical leader is designed to ensure:

- the ongoing development of an organisational culture wherein participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded

- the ability to hold accountable all staff involved in monitoring and improving care and services
- a multidisciplinary team approach developed to endorse and promote a climate of safety and quality that does not blame, but rather seeks to solve problems.

In small practices one person may fulfil the role of clinical leader, while in larger practices several team members may become designated clinical leaders. Although a clinical leader will have primary responsibility for a particular area of activity (such as infection control), other members of the practice team may have delegated responsibility for specific activities (such as environmental cleaning or sterilisation within the area of infection control). Whatever the allocation of leadership responsibilities within a practice, it is vital that all members of the practice team take individual responsibility for a multidisciplinary culture of safety, quality and open communication.

Role of clinical leaders

Through the clinical leader a general practice can develop a systematic approach to monitoring, managing and improving safety. This will include clear delineation of, and support for, corresponding staff accountability and responsibility. This approach should ensure practices have:

- a team based approach to care, in which each team member will be aware of their role and responsibilities for improving the patient's clinical outcomes
- an accurate record of each patient's health history
- supports to assist members of the clinical team in providing evidence based care
- mechanisms to identify and mitigate clinical risk for the practice, the staff and the patients
- systems and procedures to learn and share safety lessons and to implement solutions to prevent harm through changes to practice processes
- strategies to decrease variability in care delivery and outcomes for patients
- procedures to provide timely and equitable access to care
- accurate registers of patients with specified chronic conditions
- systems to manage patients with chronic conditions systematically and to proactively identify those at special risk or those who would benefit from special intervention
- the capacity to extract specified clinical data and to collate that data to guide improvement in the practice.

Sharing information about quality improvement and patient safety

Good clinical leadership is required to engage the entire practice team in a commitment to excellence. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team as a whole. The clinical leader will need to nurture a culture of openness and mutual respect that allows just and open discussions about areas for improvement.

Resources

A useful article on the role of clinical governance in improving quality has been published by Phillips et al and is available at www.anu.edu.au/aphcri/Spokes_Research_Program/Stream_Thirteen.php.

Standard 3.1

Safety and quality

Our practice is committed to quality improvement.

Criterion 3.1.4

Patient identification

Our patients are correctly identified at each encounter with our practice team.

Indicator

▶ A. Our practice has a patient identification process using three approved patient identifiers and the practice team can describe how it is applied.

Explanation

Key points

- Correct patient identification is vital for patient safety and the maintenance of patient confidentiality
- Use at least three approved identifiers for each patient encounter or activity such as making appointments, writing prescriptions, writing referrals to other providers, giving results or entering results or correspondence into records
- Don't assume you have the correct patient record when treating familiar patients
- This criterion cross references to Criterion 1.7.1 Patient health records.

Approved patient identifiers

All practice staff should be trained to check for approved patient identifiers as a matter of course.

Approved patient identifiers are those items of information accepted for use in patient identification and include:

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

A Medicare number is not an approved identifier.

Why three approved patient identifiers are required

Identifying patients consistently and correctly is a key element in reducing the risk of adverse events and enhancing patient safety.[7,8] Studies have confirmed that an adequate level of correct patient identification can be achieved by using at least three approved patient identifiers each time identification is made,[9] whether the practice has computer or paper based records. This minimises the risks of misidentification of patients and mismatches when they are undergoing procedures or clinical tests. Studies undertaken in the USA[10] using databases of medical records have demonstrated that the risk of false positive matching falls from a two in three chance using last name only to a one in 3500 chance when first and last names, postcode and date of birth are used.

Asking for patient identifier information

When asking for patient identifier information, practice team members should ask the patient to state their name, date of birth and address rather than volunteering the information from the record the staff member has open. It is not appropriate for staff to volunteer patient identifier information and then ask the patient to confirm it – errors will occur if patients who are nervous, over obliging or hearing impaired verify incorrect information. In asking for patient identifier information, staff need to be mindful of privacy and confidentiality issues (see Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy).

When a patient is very familiar to the practice team, it may appear almost nonsensical to check their identity, but most practices have patients with identical names and the mismatching of patients and patient health records is not uncommon. Some practices overcome this by routinely asking patients to verify their address and other particulars each time they attend. This approach has the added benefit of ensuring patient contact details are kept up-to-date.

Telephone and electronic identification

It is important to ensure correct patient identification when a patient telephones for a test result to maintain patient confidentiality and safety as identity checking is more difficult when the patient is not physically present. As before, patients should be asked to provide identifying information rather than asked to confirm information provided by the staff member.

Practices need to exercise caution in the use of text messages or emails to communicate clinical information to patients, since both methods can risk inaccurate patient identification and a breach of patient confidentiality.

It is equally important to ensure correct patient identification when patients ask for a repeat of their medications without attending the practice.

Referral documents

Referral documents to another healthcare provider, such as a specialist, pathology or imaging service or hospital, should also document at least three of the approved patient identifiers of the patient being referred (see Criterion 1.6.2 Referral documents).

Unique patient identifiers

The National E-Health Transition Authority is developing a system of unique patient identifiers for patients, as well as individual healthcare providers and organisations. Unique patient identifiers will support the electronic transfer of information and where available should be used to complement the three required patient identifiers. These identifiers will facilitate the accurate and secure transfer of patient health information between the different areas that provide care to an individual patient.

With the introduction of unique patient health identifiers, the practice's capacity to collect patient data and utilise this in quality improvement activities will be enhanced.

Errors in patient identification

If errors in patient identification do occur, every member of the practice team is encouraged to report them, so that the event can be analysed and processes introduced to reduce the risk of a recurrence and harm occurring to other patients (see Criterion 3.1.2 Clinical risk management systems).

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Criterion 3.2.1

Qualifications of general practitioners

All GPs in our practice are appropriately qualified and trained, have current Australian registration and participate in continuing professional development.

Indicators

- ▶ A. All of our doctors can provide evidence of appropriate current national medical registration.
- ▶ B. Our practice demonstrates that all our doctors are recognised GPs, with the exception of:
  - doctors enrolled in a recognised general practice training program
  - other specialists practising within their specialty
  - trainees undertaking a placement to gain experience in general practice as part of another specialist training program
  - where recruitment of recognised GPs has been unsuccessful, our practice demonstrates that doctors have the qualifications and training necessary to meet the needs of our patients.
- ▶ C. Our practice can provide:
  - evidence of satisfactory participation in the RACGP QI&CPD Program by all our GPs, or
  - evidence that our doctors participate in quality improvement and continuing professional development to at least the same standard as the RACGP QI&CPD Program.
- ▶ D. Our GPs have undertaken training in cardiopulmonary resuscitation (CPR) in accordance with RACGP QI&CPD recommendations.

Explanation

Key points

- General practitioners must be suitably qualified and trained and maintain the necessary knowledge and skills to provide good clinical care
- For practices unable to recruit vocationally recognised GPs, other doctors can be recruited provided they have the qualifications and training to meet the needs of patients
- General practitioners must undertake CPR training in accordance with RACGP QI & CPD recommendations.

General practice is a specialist discipline

General practice is a distinct discipline in medicine and requires specific training. Doctors in general practices need to be appropriately trained and qualified in the discipline of general practice and be either vocationally recognised, or have achieved Fellowship of the RACGP (FRACGP).

The RACGP defines a GP as a registered medical practitioner who is qualified and competent for general practice in Australia; has the skills and experience to provide patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities; and who maintains professional competence for general practice through continuing professional development.

Where vocationally recognised GPs are unavailable

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

Continuing professional development requirements

Doctors working in general practices who are not enrolled in the RACGP QCPD Program need to demonstrate recent and continuing participation in activities equivalent to Group 1 activities of the RACGP QI&CPD Program. The RACGP QI&CPD Program is based on adult learning principles (ie. knowledge is more likely to be gained when the adult undertaking the learning recognises a need to know, goes looking for the knowledge and reviews what has been learnt). The RACGP QI&CPD Program requires GPs to undertake two Group 1 activities in each triennium (eg. small group learning or clinical audits). Further information about the RACGP QI&CPD Program is available at www.racgp.org.au/QICPD.

The RACGP also has a fact sheet that explains in detail the educational requirements for various subgroups such as GPs undertaking postgraduate studies, taking extended leave and starting in general practice. The fact sheet is available at: www.racgp.org.au/standards/factsheets.

Cardiopulmonary resuscitation skills

The RACGP recognises that CPR skills are used infrequently and thus may diminish over time.

The College's QI&CPD Program states the requirements for CPR training:

- basic CPR courses must be consistent with current Australian Resuscitation Council (ARC) guidelines available at www.resus.org.au/policy/guidelines/section_9/9_1_1_feb07.pdf
- CPR courses must be a minimum of 1 hour in duration
- trainers must have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies available at www.resus.org.au/policy/guidelines/section_9/9_1_2_nov97.pdf.

Although Indicator D does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

MBA Code of Conduct

The Medical Board of Australia has adopted a code of conduct for Australian doctors, which sets out expectations on good patient care such as recognising and working within the limits of an individual's competence and scope of practice and ensuring adequate knowledge and skills. The code also sets out expectations for maintaining professional performance and professional behaviour. The MBA Code of Conduct is available at www.medicalboard.gov.au/codes-and-guidelines.aspx.

Criterion 3.2.1 – ADF CONTEXT

All contracted and APS medical officers are required to be registered as a specialist in general practice. ADF medical officers who are not registered as a specialist in general practice will normally be enrolled in recognised general practice training. Some ADF medical officers may be progressing training towards another approved specialty and will be provided supervision commensurate with their level of experience.

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Criterion 3.2.2

Qualifications of clinical staff other than medical practitioners

Other members of our clinical team are appropriately qualified and trained, have relevant current Australian registration and participate in continuing professional development.

Indicators

- ▶ A. All our nurses and allied health professionals have:
  - current national registration where applicable
  - appropriate credentialing and competence
  - work within their current scope of practice
  - actively participate in continuing professional development relevant to their position in accordance with their professional organisation's requirements.
- ▶ B. Our other team members involved in clinical care have appropriate qualifications, training and competence and participate in continuing professional development relevant to their role.
- ▶ C. Our other team members involved in clinical care have undertaken training in CPR in accordance with the requirements of the relevant registration Act or professional organisation or at least every 3 years.

Explanation

Key points

- Members of the clinical team must be suitably qualified and trained
- Members of the clinical team should work within their scope of practice and competencies
- Members of the clinical team should maintain the necessary knowledge and skills to provide good clinical care and to responsibly undertake delegated duties as required
- Cardiopulmonary resuscitation training needs to be undertaken at least every 3 years.

Other clinical staff

Practices are increasingly employing clinical staff in addition to GPs. This may include general practice nursing staff, medical students, allied health professionals, Aboriginal health workers or other clinical staff who provide clinical care. These health professionals are responsible for maintaining their own knowledge and skills and working within the limits of their competence and scope of practice.

Delegation

The RACGP Position statement on delegation of tasks is available at www.racgp.org.au/policy/GPs_and_their_teams.pdf.

The principles of task delegation include:

- respect and support for the patient-doctor relationship
- clearly defined roles that are aligned with licensing requirements, competency, education and training of the individual in that role

- practice systems that enable the provision of safeguards against error and harm
- mechanisms for ensuring provision of relevant patient information including the meeting of the ethical and legal requirements of the patient consent process
- availability of effective medical indemnity insurance
- availability of resources
- acceptability to the people – healthcare providers, patients and the broader community.

Nurses in general practice

For information regarding employment and professional standards of practice nurses, refer to the following:

- Australian Nurses and Midwifery Council has produced a suite of competency standards for registered nurses, midwives, nurse practitioners and enrolled nurses and details are available at: www.anmc.org.au/
- Australian Practice Nurses Association has produced a number of resources specific to nursing in general practice, such as the 'A guide for the supervision of enrolled nurses in general practice'. For further information email admin@apna.asn.au or telephone 1300 303 184 (freecall).
- The Australian General Practice Network position statement on nursing in general practice is available at: www.aGPn.com.au/__data/assets/pdf_file/0010/4420/Nursing-in-General-Practice.pdf.

Continuing professional development requirements

Other members of the clinical team are expected to comply with the professional development requirements of the relevant professional organisation, whether or not the individual is a member of the organisation.

Codes of conduct

Other clinical team members are expected to comply with the code of conduct of the relevant professional organisation, whether or not the individual is a member of the organisation.

Training

Training may be gained through participation in external courses or 'on the job' training at the practice. This criterion relates only to other clinical staff employed by the practice and not to co-located independent health practitioners who are not employed directly by the practice.

CPR training

The RACGP recognises that CPR skills are used infrequently and will thus diminish over time. As other clinical staff may be present during a medical emergency, they need to be trained in CPR to assist the medical team. Cardiopulmonary resuscitation training for other clinical staff may be conducted by medical staff and the RACGP encourages practices to use medical staff who have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies. Alternatively, CPR training for other clinical staff may be conducted by an accredited training provider. Cardiopulmonary resuscitation training that is solely online does not meet ARC requirements for the physical demonstration of skills by trainees at the completion of the CPR course.

Although indicator C does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

Standard 3.2

Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

Criterion 3.2.3

Training of administrative staff

Our administrative staff participate in training relevant to their role in the practice.

Indicators

- ▶ A. Our administrative staff can provide evidence of training relevant to their role in the practice.
- ▶ B. Our administrative staff have CPR training at least every 3 years.

Explanation

Key points

- Administrative staff play a vital role in the provision of quality general practice care
- Administrative staff require training appropriate to their role in the practice
- Administrative staff are required to have CPR training at least every 3 years.

Training relevant to the role

Administrative staff such as receptionists and practice managers who do not provide clinical care need training to be successful in their roles. This training may include formal courses in areas such as practice management, computers, software applications, first aid, medical terminology, medical practice reception and cross cultural engagement.

Additionally or alternatively, training may be 'on the job' training provided by GPs or other staff in the practice in areas such as learning how to use the patient health records system, making appointments, recognising medical emergencies when patients present in reception, confidentiality requirements and familiarisation with the practice policy and procedures manual.

Triage training

From a risk management perspective, it is particularly important that the relevant nonclinical staff receive triage training in order to recognise medical emergencies and prioritise appointments for patients with urgent clinical needs. Triage training may be delivered by clinical staff within the practice or by appropriate external providers. If in doubt as to the urgency of a patient's need, administrative staff should be trained to consult with the practice nurse or GP to assess the degree of clinical urgency.

CPR training

The RACGP recognises that CPR skills are used infrequently and will thus diminish over time. As administrative staff may be present during a medical emergency, they need to be trained in CPR to assist the medical team. Cardiopulmonary resuscitation training for administrative staff

may be conducted by medical staff or other clinical staff who feel competent to train colleagues and the RACGP encourages practices to use medical or other clinical staff who have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies. Alternatively, CPR training for administrative staff may be conducted by an accredited training provider. Cardiopulmonary resuscitation training that is solely online does not meet ARC requirements for the physical demonstration of skills by trainees at the completion of the CPR course.

Although Indicator B does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

Resources

Information on courses run by the Australian Association of Practice Managers is available at www.aapm.org.au/html/s01_home/home.asp.

Section 4

Practice management

Standard 4.1

Practice systems

Our practice demonstrates effective human resource management.

Standard 4.2

Management of health information

Our practice has an effective system for managing patient information.

Standard 4.1

Practice systems

Our practice demonstrates effective human resource management.

Criterion 4.1.1

Human resource system

Our practice supports effective human resource management.

Indicators

- ▶ A. All members of our practice team have position descriptions and can describe their role in the practice.
- ▶ B. Our practice has an induction system that orientates new GPs and other members of our practice team to the practice's specific systems.
- ▶ C. Our practice team can identify the person(s) with primary responsibility for leading our practice's quality improvement and risk management processes.
- ▶ D. Our practice team can identify the person(s) who coordinate the seeking of administrative feedback and the investigation and resolution of administrative and/or other complaints.
- ▶ E. Our practice team can discuss administrative matters with the principal GPs, practice directors or owners when necessary.
- ▶ F. Our practice can show evidence of regular practice discussions that encourage involvement and input from members of the practice team.
- G. Our practice has a system to monitor team members' performance against their position descriptions.

Explanation

Key points

- Practice team members need clarity regarding their role and responsibilities in the practice
- Practice team members need to know who is responsible for various aspects of the practice's operations, including who has primary responsibility for quality improvement, risk management and infection control
- Practices need a system for assisting new members of the practice team to learn their role (ie. induction and monitoring of progress in their new role)
- Team discussions support good team performance
- Indicator C cross references to Criterion 3.1.3 Clinical governance.

Good human resource management supports good clinical care

Research from both general practice and other industries supports the importance of attention to human resources. For example, the alignment of role, competence and (where required) licensing was identified by the authors of a study of high performing clinical teams as a common element.

General practitioners and other staff need documented position descriptions that outline their roles, responsibilities and conditions of employment. A position description establishes the role of the employee

within the organisation, documents the parameters of the responsibilities and duties associated with that position and forms the basis for evaluation and lines of accountability. Recruitment, training and development, performance evaluation, remuneration management and succession planning can all be based on the parameters of a position description. Position descriptions should be signed by employees to indicate that roles and responsibilities are acknowledged and understood.

Desired characteristics of general practice teams

The RACGP position statement on GPs and their teams suggests the following attributes are desirable for a general practice team:

- a just, supportive, transparent, cohesive and collaborative culture, which is associated with improved patient outcomes and enhanced patient safety
- defined goals, including an identifiable overall practice 'mission' and specific, measurable operational objectives that are shared by all team members
- a 'systems' approach that includes the development of both clinical systems and administrative systems
- division of labour, including the delegation of tasks and assignment of tasks among team members, based on the principles outlined earlier in these *Standards*
- effective training, both for the functions that people routinely perform and cross training to substitute for other roles in cases of absences or changed/increased work demands
- excellent communication, including supportive interpersonal communication through well designed communication structures and processes.

For further information see the RACGP position statement at www.racgp.org.au/policy/GPs_and_their_teams.pdf.

Induction program

It is important for the practice to have an induction program for new GPs (including registrars and locums) and other new staff to assist new members of the practice team to perform their roles.

New GPs and staff need to understand the day-to-day operations of the practice as well as key occupational health and safety issues, such as infection control and the processes for maintaining the privacy and confidentiality of patient health information.

It is useful for new staff to have an understanding of the local health and cultural environment in which the practice operates. For example, if the practice is located in an area with a high level of problems caused by illicit drug use, it is useful for new staff to understand the practice's policy concerning management of Schedule 8 medicine prescribing. Furthermore, staff and GPs in particular need to be aware of key public health regulations (such as reporting requirements for communicable diseases or mandatory reporting of child abuse) that will affect how they work. General practitioners need to be made aware of

local health and community services including pathology, hospital and other services they are likely to refer to in the course of normal consulting.

Practices that have not employed new staff in the past 3 years are not required to have an induction program already developed. However, these practices need to be able to describe what they plan to do when employing a new staff member.

Leadership

It is important that the practice team has identified leaders in areas such as clinical care, information management, complaints/patient feedback and human resources. It is possible a single individual within the practice may assume all these leadership responsibilities. In some practices, however, leadership will be undertaken by different members of the practice team, although leadership of clinical care would remain the responsibility of a principal GP.

This criterion cross references to Criterion 3.1.3 Clinical governance in achieving safe, high quality clinical care. In the clinical area, leadership might include convening a practice meeting to review the quality of care provided or the mentoring of new GPs. It might also mean instigating a plan to monitor the management of patients on particular treatments such as warfarin with a view to improving the way the practice manages these patients overall.

In order to respond to patient feedback and make improvements, practices need to identify the person in the practice with primary responsibility for examining issues raised by patients and facilitating improvements in the practice.

Teamwork

Research in Australia and the USA confirms that teamwork is important to the quality of care. The research literature identifies teamwork as an important success factor in a number of safety initiatives across different industries.[11]

Regular discussions where all staff are encouraged to have input are important in building a high performing team. In general, the decisions made at staff meetings should be documented along with the person responsible for implementing the related action.

It is important for practices to cultivate a just, open and supportive culture where individual accountability and integrity is preserved, but there is a whole-of-team approach to the quality of patient care.

It is important that all members of the practice team have the opportunity to discuss administrative issues with the practice directors and/or owners when necessary. When the practice is owned by a person or body other than the practising GPs, then GPs and other staff need to have defined systems for discussing administrative matters with the owner(s). These discussions do not necessarily require a formal staff meeting, although this is desirable, particularly in larger practices.

Resources

The Australian Association of Practice Managers publication *The Guide: AAPM business manual for healthcare* is available for purchase from www.aapm.org.au.

Standard 4.1

Practice systems

Our practice demonstrates effective human resource management.

Criterion 4.1.2

Occupational health and safety

Our practice implements strategies to ensure the occupational health and safety of our GPs and other members of the practice team.

Indicators

- ▶ A. At least two members of the practice team are present during normal opening hours.
- ▶ B. Our practice team can describe how our practice supports their safety, health and wellbeing.

Explanation

Key points

- Safety and wellbeing of practice teams is an occupational health and safety requirement
- Safety after hours requires special attention
- Access to support services for practice staff is important
- Design and set up of general practices have an impact on staff safety
- This criterion cross references to Criterion 5.3.3 Healthcare associated infections.

OH&S is a legal obligation

The occupational health and safety of the practice team is governed by occupational health and safety (OH&S) state/territory and federal legislation, which may vary from state to state. Practices need to consider how they ensure the practice is a safe working environment for the practice team.

Safety during normal opening hours

Normal practice hours are the hours the practice advertises as being its regular hours of opening for routine consultations during which patients can see a GP.

A GP cannot be both a receptionist and a medical practitioner at the same time. During normal practice hours, practices need to be staffed by at least one additional person who is trained to take telephone calls, make appointments, assess the urgency of requests for appointments and assist with medical emergencies.

Practices are encouraged to consider setting up a duress alarm system as a mechanism for protecting the safety of practice staff.

Safety after hours

The requirement for two members of staff to be present in the practice need not apply to consultations conducted within the practice outside normal opening hours. However, where a GP is providing consultations in the practice without another member of the practice team present, extra attention needs to be applied to safety and security issues.

Staff health and wellbeing

Practices can support the health and wellbeing of GPs and other practice staff in many ways. For example, scheduling regular breaks in consulting time may

reduce fatigue and support the health and wellbeing of the GP, as well as enhancing the quality of patient care, since fatigue and related factors (sometimes called 'human factors') are associated with increased risks of harm to patients.

It is helpful to have a plan for reallocating patient appointments if a GP is unexpectedly absent from the practice, to minimise the burden on other GPs in the practice.

Practices can make information available to their GPs and other practice staff about relevant support services in their state or territory. Providing support for GPs and other practice staff is important in all areas of Australia, but perhaps even more important in areas of workforce shortage where GPs face additional pressures and workloads.

Violence in general practice

Concerns about violence in general practice continue to be raised by the profession, especially following the deaths of several GPs and assaults and threats to general practice staff. In order to deal with these uncommon but distressing situations, the practice should have a risk management strategy which details the steps to be taken to protect doctors and staff of the practice.

Where a GP no longer considers it appropriate to treat a patient who has behaved in a violent or threatening manner, the GP has the right to discontinue the care of that patient (see Criterion 2.1.1 Respectful and culturally appropriate care). The GP may choose to end the therapeutic relationship during a consultation or, depending on the circumstances, by letter or telephone. Safety should dictate the method chosen. It is advisable for the practice to document a process to be followed by practice staff if the patient makes any subsequent contact with the practice.

The RACGP has published a useful tool to assist practices to deal with these distressing situations. Entitled *General practice: a safe place,* it is available at www.racgp.org.au/GPsafeplace.

RACGP GP Support Program

The RACGP provides counselling for GPs facing crises in their professional or personal lives.

Appointments for face-to-face or telephone counselling can be made by calling 1300 366 789 during business hours (prebooking is essential).

For traumatic incidents or crisis counselling call 1800 451 138 (24 hours/7 days).

For more information on consultations and a full list of locations visit: http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/racgpMentalHealth1/MentalHealthReviewnewsletterMHR/200812MHRnewsletter.pdf

RACGP self care guidebook

The RACGP acknowledges the pressures of working in general practice and has developed a special self care guide for GPs. *Keeping the doctor alive: A self care guidebook for medical practitioners* provides strategies to deal with stress and is available at www.racgp.org.au/peersupport.

Doctors' Health Advisory Service

Contact details for doctors' health advisory services in each state and territory are available at www.dhas.org.au/content/view/1/21/.

Other OH&S resources

Other organisations providing resources include:

- Australian Association of Practice Managers offers resources for AAPM members at www.aapm.org.au
- AMA Position statement *Personal Safety and Privacy for Doctors* at www.ama.com.au/policy/positionstatements?page=1
- Australian General Practice Network has a variety of resources available for network members in its Network Resource Centre at http://www.aGPn.com.au/home

Safety and practice design

The RACGP guide *Rebirth of a clinic* describes building and layout designs for safety and is available at www.racgp.org.au/publications/tools.

Services providing care outside normal opening hours

Indicator A is only applicable to services providing care outside normal opening hours that provide clinic based services.

Criterion 4.1.2 – ADF CONTEXT

Garrison Health Facilities are required to comply with the Defence Work Health and Safety Policy to ensure compliance with the *Commonwealth Work Health and Safety Act 2011*.

Defence places great emphasis on the safety, health and wellbeing of its personnel. Organisational values and accepted behaviours are reinforced on an ongoing basis and underpin the annual performance appraisal process.

Safety and security are both strongly emphasised in a Defence environment. Access to Garrison Health Facilities is generally restricted by gate access at the base. The need for security is constantly reinforced once on base, as it relates to electronic security, the spoken word and written documents. Work Health and Safety and health information security are domains within a much wider Defence safety and security culture.

Access to medical information is highly controlled. All authorised personnel using computer terminals have individual user identification. All computer terminals are password-protected, with health record access privileges restricted on an as-needed basis. Stored unit medical records are locked in dedicated filing spaces.

Garrison Health Facilities have advertised procedures in place to respond to a variety of emergencies and threats, including fire, suspicious parcel, medical emergency and armed intruders. Defence also provides a range of support services to ADF and APS staff, including counselling support and conflict resolution.

Standard 4.2

Management of health information

Our practice has an effective system for managing patient information.

Criterion 4.2.1

Confidentiality and privacy of health information

Our practice collects personal health information and safeguards its confidentiality and privacy in accordance with Australian Privacy Principles.

Indicators

- ▶ A. Our practice team can describe how we ensure the confidentiality of patient health records.
- ▶ B. Our practice team can demonstrate how patient health records can be accessed by an appropriate team member when required.
- ▶ C. Our practice team can describe the processes we use to provide patients with access to their health information.
- ▶ D. Our practice team can demonstrate how patients are informed about our practice's policy regarding management of their personal health information.
- ▶ E. Our practice team can describe the procedures for transferring relevant patient health information to another service provider.
- ▶ F. Our practice team can demonstrate how we facilitate the timely, authorised and secure transfer of patient health information in relation to valid requests.
- ▶ G. When we collect patient health information for quality improvement or professional development activities, we only transfer identified patient health information to a third party once informed patient consent has been obtained.
  Amended in May 2013.
- ▶ H. Whenever any member of our practice team is conducting research involving our patients, we can demonstrate that the research has appropriate approval from an ethics committee.

Explanation

Key points

- Privacy of health information is a legislative requirement
- The practice needs to have a documented privacy policy for the management of patient health information
- Patients need to be informed about the practice's privacy policy
- *Guidelines on Privacy in the Private Health Sector (2001)* will assist general practices to meet their legal obligations in relation to the collection, use and disclosure of health information.

National Privacy Principles

The Privacy Amendment (Private Sector) Act (2000) extends the operation of the Privacy Act (1988) to cover the private health sector throughout Australia. The ten National Privacy Principles form part of the legislation. The Principles promote greater openness between health service providers and consumers in relation to the handling of health information. The legislation complements the culture of confidentiality that exists in general practice.

Practices should make themselves familiar with the *Guidelines on Privacy in the Private Health Sector (2001)* published by the Office of the Federal Privacy Commissioner (OFPC). The *Guidelines* are not legally binding, but aim to help health service providers comply with the National Privacy Principles.

The OFPC *Guidelines* are available at www.privacy.gov.au/materials/types/guidelines/view/6517.

RACGP Handbook

The RACGP *Handbook for the management of health information in private medical practice* describes minimum safeguards and procedures that need to be followed by general practices in order to meet appropriate legal and ethical standards concerning the privacy and security of patient records. This valuable resource is available at www.racgp.org.au/publications/tools.

Privacy legislation

As well as being familiar with the Federal Privacy Act and National Privacy Principles, practices need to be familiar with the relevant state/territory privacy legislation as this will also impact on the way in which practices manage patient health information. For more information visit www.privacy.gov.au.

Personal and health information

The Federal Privacy Act (1988) applies to personal information. Health information is a particular subset of personal information and can include any information collected to provide a health service, such as a person's name, address, account details, Medicare number and any health information such as a medical or personal opinion about a person's health, disability or health status.

Sometimes details about a person's medical history or other contextual information such as details of an appointment can identify them, even if no name is attached to that information. This is still considered health information and as such it must be protected under the Privacy Act.

Practice privacy policy

National Privacy Principle 5 requires the practice to have a document that clearly sets out its policies on handling personal information, including health information. This document, commonly called a privacy policy, must be made available to anyone who asks for it.

The privacy policy should outline:

- the practice's contact details
- what information is collected
- why information is collected
- how the practice maintains the security of information held at the practice
- the range of people within the practice team (eg. GPs, general practice nurses, general practice registrars and students and allied health professionals), who may have access to patient health records and the scope of that access
- the procedures for patients to gain access to their own health information on request
- the way the practice gains patient consent before disclosing their personal health information to third parties

- the process of providing health information to another medical practice should patients request that
- the use of patient health information for quality assurance, research and professional development
- the procedures for informing new patients about privacy arrangements
- the way the practice addresses complaints about privacy related matters
- the practice's policy for retaining patient health records.

Communicating with patients

The privacy policy can be made available to patients in a number of ways including a sign at reception, a separate brochure, a section of the patient information sheet or a notice/link on the practice website.

The Privacy Act sets out two compulsory mechanisms for informing patients about how their health information will be used.

1. A practice privacy policy. Organisations are required to provide this policy on request and commonly satisfy this requirement by making their privacy policy available on their website or on a sign at reception.

2. A 'collection statement' which sets out the following information:

- the identity of the practice and how to contact it
- the fact that patients can access their own heath information
- the purpose for which the information is collected
- other organisations to which the practice usually discloses patient health information
- any law that requires the particular information to be collected
- the main consequence for the individual if important health information is not provided.

Patient consent

Patient consent should be provided at an early stage in the process of clinical care. It is important to distinguish between consent to treatment and consent to the handling of patient health information even if such consent processes happen to occur at the same time.

Transfer of health information

The correct process for transferring patient health information to others, such as other health service providers or in response to third party requests, is outlined in section 2 'Use and Disclosure' in the OFPC *Guidelines on Privacy in the Private Health* Sector. Practices are advised to contact their insurers if they have any concerns about third party requests for the transfer of patient health information.

Research

Research is an important component of general practice in Australia. Practices are encouraged to participate in research both within their own practice and through reputable external bodies.

Where a practice is using de-identified patient health information, there are some situations in which a practice is required to obtain informed patient consent and some situations where informed patient consent is not required. The requirement for consent when using de-identified data will be decided by a Human Research Ethics Committee.
Amended in May 2013.

Further information about research in general practice, including the requirements for ethics approval, can be found in the National Health and Medical Research Council (NHMRC) *National statement on ethical conduct in human research* available at www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf.

Quality improvement

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

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

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

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

Disclosure of health information to carers

In 2008 the Australian Law Reform Commission recognised that disclosure of information to 'a person responsible for an individual' can occur within current privacy law. If a situation arises where a carer is seeking access to a patient's health information, practices are encouraged to contact their medical defence organisation for advice before such access is granted.

Practice closures

The correct process for handling patient health information on the closure of a practice is available in the OFPC *Guidelines* at www.privacy.gov.au/materials/types/guidelines/view/6517.

Criterion 4.2.1 – ADF CONTEXT

The ADF is subject to the Australian Privacy Principles (APP) and is considered an agency in accordance with the Privacy Act.

Commanders require sufficient information about the health of their personnel in order to exercise their duty of care for their health and welfare, and to meet their obligations under the Work Health and Safety Act. This information allows Commanders to make informed decisions regarding their personnel's support needs, as well as safe employment and deployment. Member consent is sought to share relevant information that enables Commanders to exercise their duty of care.

The information required relates to the effect an individual's health condition has on their employability (including safety aspects) and deployability. Commanders also require information on the individual's rehabilitation plan in order to provide appropriate unit support. Such information is provided in accordance with Defence policy and within the bounds of the APPs.

Standard 4.2

Management of health information

Our practice has an effective system for managing patient information.

Criterion 4.2.2

Information security

Our practice ensures the security of our patient health information.

Indicators

- ▶ A. Our practice team can demonstrate that the personal health information of patients of our practice is neither stored, nor left visible, in areas where members of the public have unrestricted access or where constant staff supervision is not easily provided.
- ▶ B. Our practice ensures that our practice computers and servers comply with the RACGP computer security checklist and that:
  - computers are only accessible via individual password access to those in the practice team who have appropriate levels of authorisation
  - computers have screensavers or other automated privacy protection devices are enabled to prevent unauthorised access to computers
  - servers are backed up and checked at frequent intervals, consistent with a documented business continuity plan
  - back up information is stored in a secure off site environment
  - computers are protected by antivirus software that is installed and updated regularly
  - computers connected to the internet are protected by appropriate hardware/software firewalls.
- ▶ C. If our practice uses computers to store personal health information, we have a business continuity plan that has been developed, tested and documented.
- ▶ D. Our practice has a designated person with primary responsibility for the practice's electronic systems and computer security.
- ▶ E. Our communication devices are accessible only to authorised staff.
- ▶ F. Electronic data transmission of patient health information from our practice is in a secure format.
- ▶ G. Our practice has an appropriate method of destroying health record systems before disposal (eg. shredding of paper records, removal and reformatting of hard drives).

Explanation

Key points

- The privacy and security of health information held by a practice is a legal obligation
- Computer security is an important aspect of information security
- Information security must encompass availability of information, integrity of information and designated access to information

- Computerised practices need a contingency plan to cover computer crashes
- The practice needs a designated staff member with primary responsibility for computer security.

RACGP resources

The RACGP *Computer security guidelines: A self assessment guide and checklist for general practice* (3rd edition) is available at www.racgp.org.au/ehealth/csg. The accompanying template for developing a policy and procedure manual should be completed by the designated staff member responsible for the practice's computer security and will form part of the practice's policy and procedure manual.

Computer security

It is important to have a designated member of the practice team with responsibility for computer security.

This person needs to know who and when to call for expert advice, educate staff on data security and ensure security protocols are followed. The contact details of any external expert used by the practice need to be available to other relevant practice staff.

Business continuity plan

When a practice uses computers to store patient health information, the practice needs to have a sound backup system and a contingency plan to protect practice information in the event of an adverse incident, such as a system crash or power failure. This plan needs to encompass all critical areas of the practice's operations such as making appointments, billing patients and collecting patient health information. Once a plan has been formulated, it needs to be tested on a regular basis to ensure backup protocols work properly.

Consideration needs to be given to the increasing portability of computer based systems. These need to be managed in an equally secure manner as the main practice network. Furthermore, being potentially more accessible to people outside the practice team, the physical security of portable equipment needs to be taken into account (eg. laptop computers, personal digital assistants [PDAs] and mobile telephones carried by GPs when travelling between different locations).

Replacing equipment with hard drive memory

The practice is advised to review the RACGP *Computer security guidelines: A self assessment guide and checklist for general practice* (3rd edition) when equipment is to be made redundant by the practice, to ensure key information is not lost or transferred inadvertently. Deleting records is insufficient to clear data from a computer system.

Practices need to be aware that other equipment such as photocopiers and fax machines may have hard drive memory and that confidential information needs to be properly removed before the practice disposes of such equipment.

Preventing unauthorised access to patient health information

It is likely that practices will have different levels of access to patient health information for different staff members and this differentiated access needs to

be documented in the practice's policy and procedure manual. To protect the security of health information, GPs and other practice staff should not give their computer passwords to others in the team.

Patient health records and computer screens should be positioned so confidential information is not readily visible to anybody but the appropriate members of the practice team. Screen savers or other automated privacy protection devices should be used to prevent unauthorised access to computers in a situation like a doctor momentarily leaving the consultation room. Although the focus of this criterion is information security, it is noted that many doctors now use the computer screen as a useful tool for sharing information with patients during a consultation.

Active and inactive patient health records

The practice must ensure that both active and inactive patient health records are kept and stored securely. An inactive patient health record is generally considered to be the record of a patient who has not attended the practice/service three or more times in the past 2 years. It is recommended that inactive patient health records are retained by the practice indefinitely or as stipulated by the relevant national, state or territory legislation. General practices may want to consult their GPs' medical defence organisations when deciding on the practice's policy with respect to the retention of records.

Changes to computer hardware and software over time may prevent older versions of medical software from running correctly on newer systems and provision needs to be made for this eventuality, which may include retaining older systems for record storage purposes.

Criterion 4.2.2 – ADF CONTEXT

Garrison Health Facilities operate within the Defence information and communications technology (ICT) policy, regulations and processes. Network security is provided by the Defence-wide ICT service, with no provision of local network administration.

Access to the Defence Electronic Health System is reliant on the individual having the relevant security clearance and permissions. Members' information is stored and password-protected so access rights are limited to what is required for the healthcare provider to perform their job.

Section 5

Physical factors

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Standard 5.2

Equipment for comprehensive care

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

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Criterion 5.1.1

Practice facilities

Our practice facilities are appropriate for a safe and effective environment for patients and the practice team.

Indicators

- ▶ A. Our practice has at least one dedicated consulting/examination room for every member of our clinical team working in our practice at any time.
- ▶ B. Each of our consultation rooms (which may include an attached examination room/area):
  - is free from excessive noise
  - has adequate lighting
  - has an examination couch
  - is maintained at a comfortable ambient temperature
  - ensures patient privacy when the patient needs to undress for a clinical examination (eg. by the use of adequate curtains or screens and gowns or sheets).
- ▶ C. Our practice has a waiting area sufficient to accommodate the usual number of patients and other people who would be waiting at any given time.
- ▶ D. Our practice has toilets and hand cleaning facilities readily accessible for use by both patients and staff.
- ▶ E. Prescription pads, letterhead, administrative records and other official documents are accessible only to authorised persons.
- ▶ F. Our practice and office equipment is appropriate to its purpose.
- ▶ G. Our practice has one or more height adjustable beds.
- H. Our practice waiting area caters for the specific needs of children.

Explanation

Key points

- Practice facilities need to be safe for GPs, other practice staff and patients
- Patients should have auditory and visual privacy (eg. by the use of curtains, screens, drapes or gowns)
- Practices need to have one or more height adjustable beds
- This criterion cross references to Criterion 5.1.3 Physical access.

Occupational health and safety

Health and safety requirements cover both consultation areas and all other areas of the practice. The practice facilities need to provide appropriate security for staff, patients and visitors.

Design and layout

The RACGP publication *Rebirth of a clinic* assists practices with the design and layout of practice facilities which are fit for purpose and address security needs. It is available at www.racgp.org.au/publications.

Ideally, the practice layout should enable reception staff to see and monitor waiting patients to identify medical emergencies and reprioritise appointments as required.

While this criterion discusses consultation and examination 'rooms', it is acknowledged that some practices have consultation or examination 'areas' instead. Such consultation areas need to meet the same requirements for safety and appropriateness.

Ambient temperature

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

Privacy and patient dignity

The dignity of the patient should be protected by suitable visual and auditory privacy. Visual privacy can be afforded to patients during the clinical examination by the use of a gown or sheet and an adequate curtain or screen. This requirement includes situations in which there is a door opening to an area to which the public may have access and also when patients are required to undress/dress in the presence of the GP or practice nurse.

Location of toilets and hand cleaning facilities

Ideally, toilets should be located within the practice. Toilets not within the practice itself need to be within close proximity. Toilets need to be easily accessible and well signposted. Separate staff and patient toilets are desirable. Washbasins need to be situated in close proximity to the toilets to minimise the possible spread of infection and need to be easily accessible to GPs, other staff and patients.

Height adjustable beds

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

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

Height adjustable beds may assist general practice teams to:

- reduce the risks associated with patients getting on and off the examination couch, especially for people with impaired mobility
- reduce the risk of misdiagnosis or nondetection of serious medical conditions through difficulty in conducting an examination if a patient is not able to be examined on a standard examination couch
- reduce the risk of practice staff injuring themselves when examining patients or assisting patients on and off an examination couch

- reduce risks associated with the practice's legal responsibilities under the Disability Discrimination Act to ensure equal access for people with disability to the same range and quality of medical care as others.

Practices need to consider where a height adjustable bed may be best located. Many practices have told the RACGP that they have their height adjustable bed in a treatment room, rather than a consultation room.

The RACGP acknowledges that cost is a factor for some practices. The RACGP continues to advocate for infrastructure support for general practices in its representations to the Department of Health and Ageing.

Rebates for practice equipment that relates to occupational health and safety may be available through state and territory jurisdictions. Practices are advised to check jurisdictional WorkSafe websites for information on rebates that could apply.

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

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

Services providing care outside normal opening hours

For services providing care outside normal opening hours that only provide visit based care, Indicators A, B, C, D, F, G and H are not applicable. However, all reasonable efforts should be made to protect the patient's privacy during a consultation and these services need to refer to, and meet, the infection control criterion in these Standards (see criterion 5.3.3 Healthcare associated infections).

While Indicator D is not applicable, services will need to ensure that effective hand cleaning (eg. with alcohol based hand rub) can occur when patients are seen outside the general practice.

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Criterion 5.1.2

Physical conditions conducive to confidentiality and privacy

The physical conditions in our practice support patient privacy and confidentiality.

Indicators

- ▶ A. The physical facilities of our practice support patient privacy and confidentiality.
- ▶ B. Visual and auditory privacy of consultations and treatments is supported.

Explanation

Key points

- Visual privacy includes physical privacy for patients and the privacy of patient health information
- Auditory privacy means a patient's conversation with a member of the clinical team cannot be overhead by an inappropriate person, such as another patient or staff member
- This criterion cross references to Criterion 5.1.1 Practice facilities.

Visual privacy

Visual privacy can be afforded to patients during the clinical examination by the use of a gown or sheet and an adequate curtain or screen. Members of the clinical team need to be sensitive to patient dignity when patients are required to undress/dress in the presence of the GP or practice nurse.

Auditory privacy

Where possible, consultations should not be able to be overheard by others. Auditory privacy within the practice can be enhanced by the use of appropriate background music to mask conversations between staff members and between staff and patients. In areas of the practice such as nurses' treatment bays where auditory privacy is not possible, patients should be offered a private room for conversation as required.

The auditory privacy of consultation rooms can be significantly enhanced by having solid doors (rather than doors with paper cores), using 'draught proofing' tape around door frames and a draught excluder at the base of the door.

Protection of health information

It is important that patients have confidence their health information is being treated respectfully and with consideration to privacy and confidentiality. Privacy and confidentiality of patient information needs to be considered in all situations including discussions between staff members and telephone conversations between staff and patients.

Patient records and computer screens should be positioned such that confidential information is not readily visible to anybody but the appropriate members of the practice team and screen savers should

be used (see Criterion 4.2.2 Information security). Although the focus of this criterion is confidentiality and privacy, it is noted that many doctors now use the computer screen as a useful tool for sharing information with patients during a consultation.

Physical layout of the practice

The RACGP has produced a design guide entitled *Rebirth of a clinic*: *A workbook for architecture in general practice and primary care* (2008). The design guide can assist practices with practical ideas on how to ensure auditory and visual privacy. The design guide is available through RACGP publications at www.racgp.org.au/publications.

Services providing care outside normal opening hours

There is a range of circumstances in which patient confidentiality may be compromised when care outside normal opening hours is being provided. Patient privacy is as relevant in an environment outside a general practice (eg. patients' homes and residential aged care settings) as within.

Standard 5.1

Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

Criterion 5.1.3

Physical access

Our practice provides appropriate physical access to our premises and services including access for people with disabilities or special needs.

Indicators

- ▶ A. There is wheelchair access to our practice and its facilities, or if physical access is limited, our practice provides home or other visits to patients with disabilities or special needs.
- ▶ B. Our GPs and other practice staff can describe how they facilitate access to our practice for patients with disabilities or special needs.

Explanation

Key points

- **General practitioners and other practice staff need to consider practical ways to facilitate access to the practice and its services**
- **This criterion cross references to Criterion 5.1.1 Physical facilities.**

Good physical access is important

For more information relating to the Federal Disability Discrimination Act (1992) and legislation regarding the right to access general practices, the Disability Discrimination Act is described in a fact sheet entitled 'A brief guide to the Disability Discrimination Act' available at www.hreoc.gov.au/disability_rights/dda_guide/dda_guide.htm.

Consumer representatives have informed the RACGP that access to general practice facilities and services is of high importance to patients. Practices need to make reasonable efforts to facilitate physical access to their premises and services for all patient groups including those people with a disability or other special needs. When considering what is reasonable, practices need to consider the needs of patients with restriction of movement that prevents safe access to the practice. For example, it is useful to make wheelchair access available for patients with a disability or special needs including pathways, hallways, consultation areas and toilets that are wheelchair friendly. The practice may find it useful to have its own wheelchair to assist patients as necessary.

The practice can usefully be equipped with appropriate ramps and railings to assist a patient with special needs and pictorial signage may assist patients with an intellectual disability or vision impairment.

In Aboriginal medical services, patients may be brought in to a general practice from an outlying area in a car, accompanied by an Aboriginal health worker or a practice nurse.

Disability (Access to Premises – Buildings) Standards for new buildings and renovations

The Premises Standards come into operation on 1 May 2011 and will apply to buildings where building approval is lodged on or after that date.

A fact sheet on the Premises Standards can be obtained from www.ag.gov.au/www/agd/agd.nsf/page/humanrightsandanti-discrimination_Disability(AccesstoPremises-Buildings)Standards.

When a new practice building is planned or renovations are to be undertaken, practices need to be cognisant of changed requirements, for example:

1. Improvements in signage in relation to accessible facilities
2. Increases in the number of accessible entrances and doorways to buildings
3. Increases in circulation space requirements in most areas such as in lifts, accessible toilets and at doorways
4. The introduction of a requirement for passing and turning spaces on passageways in some contexts.

Accessible parking

Where possible, patients with a disability need to be able to park their vehicles within a reasonable distance of the practice and practices are encouraged to provide parking bays specifically marked for the use of patients with a disability parking entitlement. Ideally, parking spaces should accommodate the loading and unloading of wheelchairs.

Home or other visits

For patients who are not able to access the general practice premises because transfer to the practice is too difficult or could cause harm, the practice needs to provide home or other visits. Patients in this category could include people receiving end stage palliative care, people with severe motor dysfunction such as quadriplegia or motor neurone disease and residents of nursing homes.

Services providing care outside normal opening hours

This criterion and indicators are not applicable for services providing care outside normal opening hours that provide visit only care.

Standard 5.2

Equipment for comprehensive care

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

Criterion 5.2.1

Practice equipment

Our practice has access to the medical equipment necessary for comprehensive primary care including emergency resuscitation.

Indicators

▶ A. Our practice has equipment for comprehensive primary care and emergency resuscitation including:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask), IV access, and emergency medicines
- examination light
- eye examination equipment (eg. fluorescein staining)
- gloves (sterile and nonsterile)
- height measurement device
- measuring tape
- monofilament for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- scales
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer with small, medium and large cuffs
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips
- vaginal specula
- visual acuity charts
- X-ray viewing facilities.

▶ B. Our practice has timely access to a spirometer and electrocardiograph.

▶ C. Our practice can demonstrate that the equipment we use is sufficient for the procedures we commonly perform.

▶ D. Our practice can demonstrate how we maintain our key equipment, according to a documented schedule.

E. Our practice has a pulse oximeter.

Explanation

Key points

- Practices need to have the necessary equipment for comprehensive primary care and emergency resuscitation
- Equipment that requires calibration or that is electrically or battery operated requires regular servicing in accordance with the manufacturer's instructions.

Range of equipment

Practices need to have the necessary equipment for comprehensive primary care and emergency resuscitation. To meet this criterion, equipment must be in good working order. There is a wide range of equipment that practices may need in order to provide services which meet local needs, serve the nature of the practice and support any procedures the practice performs.

All equipment must be in good working order

Equipment that requires calibration or that is electrically or battery powered (eg. electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales or defibrillators) needs to be serviced on a regular basis in accordance with the manufacturer's instructions to ensure it is maintained in good working order.

It is useful for practices to maintain a register of equipment in the practice, which includes the schedules for servicing or maintenance.

Automated external defibrillator (AED)

There is evidence, both internationally and in Australia, to suggest that immediate defibrillation significantly improves the chance of survival after cardiac arrest. Although cardiac arrest in the general practice setting is a rare event[12], the difference in outcomes between early defibrillation (within 8 to 9 minutes) and later defibrillation is very significant (10% increase in mortality for each minute from the time of the arrest). Practices may choose to purchase an automated external defibrillator in view of the significant improvement in patient outcomes achieved by early defibrillation.

Electrocardiograph and spirometer

Practices need timely access to an electrocardiograph and a spirometer. Some practices will choose to purchase this equipment and other practices will choose to make arrangements for timely access to the equipment (eg. arrangements with a pathology service or nearby local hospital).

For practices which have an electrocardiograph or spirometer on site, it is important that staff are properly trained to use and maintain the equipment and analyse results.

The assessment of 'timely' access needs to be based on clinical need and what peers would consider to be an acceptable timeframe.

Pulse oximeters

Pulse oximeters have been demonstrated to be useful in the general practice setting[13] for the assessment of hypoxia and, in some instances, to identify unsuspected hypoxia.

Hazardous materials

All hazardous materials including liquid nitrogen and oxygen should be stored securely.

Services providing care outside normal opening hours

Services providing care outside normal opening hours need to be able to demonstrate how the minimum equipment requirements outlined in this criterion would be accessed when needed.

Standard 5.2

Equipment for comprehensive care

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

Criterion 5.2.2

Doctor's bag

Our practice ensures that each GP has access to a doctor's bag.

Indicators

▶ A. Each of our GPs has access to a fully equipped doctor's bag for emergency care and routine visits and the bag contains:

- auriscope
- disposable gloves
- equipment for maintaining an airway in both adults and children
- in-date medicines for medical emergencies
- ophthalmoscope
- practice stationery (including prescription pads and letterhead)
- sharps container
- sphygmomanometer
- stethoscope
- syringes and needles in a range of sizes
- thermometer
- tongue depressors
- torch.

Explanation

Key points

- The doctor's bag should be fully equipped with required equipment
- General medicines for the doctor's bag will depend on the practice's location and the type of clinical conditions likely to be encountered
- The doctor's bag needs to be stored securely.

Security

Doctors' bags must be kept secure in accordance with state and territory legislation.

Equipping the doctor's bag for use

All GPs in the practice require ready access to a doctor's bag. Bags should always contain core equipment, medications and stationery so when they are required the GP can simply add equipment in regular use (eg. auriscope, ophthalmoscope or stethoscope) to make the bag ready for use.

Medicines for the doctor's bag

Practices need to consider what general medicines they should keep in their doctors' bags. In general this will be determined by the location of the practice, the health needs of the local community and the type of clinical conditions likely to be encountered. The shelf life and climatic vulnerability of various medicines needs to be accommodated.

To ensure patient safety, it is important that GPs are familiar with the medicines that are included in their doctor's bag, including the general usage, suggested dosage and possible side effects. It is recommended that GPs seek appropriate and ongoing education on these as required.
Amended in May 2013.

Suggested emergency medicines include:

- adrenaline
- aspirin
- atropine sulphate
- benztropine mesylate
- benzylpenicillin
- chlorpromazine or haloperidol
- diazepam
- ergotamine maleate
- frusemide
- glucose 50% and/or glucagon
- glyceryl trinitrate spray or tablets
- hydrocortisone sodium succinate or dexamethasone
- metoclopramide hydrochloride
- morphine sulphate or appropriate analgesic agent
- naloxone hydrochloride
- prednisone
- promethazine hydrochloride
- salbutamol aerosol.

PBS emergency drugs for doctors' bags

Through the Pharmaceutical Benefits Scheme (PBS), certain medications are provided to prescribers without charge. Prescribers can, in turn, supply them free to patients for emergency use.

A review of these medications was undertaken in December 2012 and a comprehensive and up-to-date list of PBS medications available for doctors' bags is available at www.pbs.gov.au/browse/doctorsbag.

The Emergency Drug (Doctor's Bag) Order Form is available from Medicare.
Amended in May 2013.

Emergency drugs for children

Paediatric emergency drugs and dosages can be found in the Royal Children's Hospital *Pharmacopaecia*, available at www.rch.org.au/pharmacy/dev/index.cfm?doc_id=11341.

Australian prescriber article on emergency medicines for the doctor's bag
The 2007 article by Andrew Baird, 'Drugs for the doctor's bag', provides a useful explanation of PBS and other medicines for the doctor's bag. The article is available at www.australianprescriber.com/magazine/30/6/143/6/.

Criterion 5.2.2 – ADF CONTEXT

In Garrison Health Facilities, the capability to respond to emergencies outside the practice building will be facilitated by a suitably equipped ambulance or a Thomas Pack.

Where either of these is available they will conform to this criterion in terms of doctors being familiar with the contents of the Thomas Pack and the equipment available in the ambulance, appropriate storage arrangements and adequate maintenance of items in date.

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Criterion 5.3.1

Safe and quality use of medicines

Our clinical team prescribes, dispenses and administers appropriate medicines safely to informed patients.

Indicators

- ▶ A. Our clinical team can demonstrate how our patients are informed about the purpose, importance, benefits and risks of their medicines and how patients are made aware of their own responsibility to comply with the recommended treatment plan.
- ▶ B. Our clinical team can demonstrate how we access current information on medicines and review our prescribing patterns in accordance with best available evidence.
- ▶ C. Our clinical team can demonstrate how we ensure patients and other health providers to whom we refer receive an accurate and current medicines list.
- ▶ D. Our clinical team can demonstrate how we ensure that medicines (including samples and medical consumables) are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and jurisdictional requirements.

Explanation

Key points

- Patients need to understand the purpose and importance of medicines, to assist them to comply with a recommended treatment plan
- General practitioners need access to current information on medicines to enable best practice prescribing
- Patients need accurate and current medication lists
- Referral documentation should include accurate and current medication lists
- Practices need to ensure that medicines (including samples and medical consumables) are not used beyond their expiry dates
- Practices must comply with jurisdictional requirements on Schedule 4 and Schedule 8 medicines.

Medication purpose, options, benefits, risks

Patients need to understand the rationale for taking medications, and the benefits and risks associated with particular medicines. This will assist patients to make informed decisions regarding their treatment and may also assist in improving compliance with the recommended treatment plan.

Information resources for consumers

- Consumer Medicines Information (CMI) can assist patients in understanding their medicines. Where patients cannot understand written language or where information is not available in the patient's language, the use of pictorial media or translators may be appropriate. It is particularly important that patients understand the difference between generic drugs and trade named drugs so dosage problems are avoided.

- The APAC Guiding principles for medicines management in the community Principle 1 includes a list of information resources:
  – www.nps.org.au or telephone 1300 888 763
  – www.betterhealth.vic.gov.au (select 'library' then 'medicines guide')
  – www.appco.com.au/appguide
  – www.health.gov.au/internet/wcms/publishing.nsf/Content/
  – nmp-consumers-cmi.html
  – www.medicinesaustralia.com.au
  – www.nps.org.au/consumers/tools_and_tips/medicines_list.
- Pharmacists can facilitate the optimal use of medicines. A good partnership between the GP, patient and pharmacist can enhance the benefits to the patient in managing their medicines.

  Community pharmacists can assist in providing a comprehensive review of a patient's medicines and feedback to the GP, either through an in-pharmacy Medicines Use Review or an in-depth Home Medicines Review.

Using and reviewing best practice treatment

The use of Therapeutic Guidelines is now considered standard practice. Therapeutic Guidelines are available at www.tg.org.au/index.php?sectionid=97.

Relevant therapeutic guidelines available at this website to support best practice prescribing include:

- analgesic guidelines
- antibiotic guidelines
- cardiovascular guidelines
- dermatology guidelines
- respiratory guidelines.

Particular care needs to be taken with soundalike or lookalike medicines, particularly when using 'drop down' boxes in electronic prescribing programs.

The RACGP PrimaryCare Sidebar® is an electronic platform that can host a range of products which individual GPs and practices can select from to suit their needs. The PrimaryCare Sidebar® has add-ons including the Australian Medicines Handbook (AMH) Online (single user licence). Australian Medicines Handbook Online is an interactive and quick to search format, which enables GPs to access independent, evidence based drug information at the point of care. Further information is available at www.racgp.org.au/ehealth/primarycaresidebar.

Ensuring medicines lists are accurate and current

General practitioners need to regularly review the list of a patient's current medications to ensure the list is up-to-date and does not lead to errors when prescribing or referring.[14] Single use medications, including antibiotics, should be removed from patients' records when they are no longer required.

Reviewing a medicines list with a patient[15] also provides an opportunity for the GP to assess the patient's compliance with a medication regime to identify the need for any further education/support. Many GPs routinely perform this task prior to prescribing or changing treatment. It is recommended that GPs clarify a patient's current medicines list and known allergies at every patient contact.

Patients also need to be provided with a new medicines list when their medicines are changed. This is particularly important when multiple medicines are being taken.[16] In assessing this indicator the 'common sense rule' needs to be applied: a medicines list may not need to be provided for antibiotics or contraceptive pills.

General practitioners need to be aware of the use of complementary medicines and the potential for side effects and drug interactions with conventional medicines. This should be noted on letters of referral including those for hospital admissions. In summary, it is useful to include all medicines (prescription and nonprescription medicines and complementary healthcare products, if known) on the medication list.

Following the manufacturer's directions

To ensure the safe use of medicines, vaccines and other healthcare products, practices need to make sure they do not use perishable materials beyond their expiry dates. It is also important to ensure that medicines, vaccines and other healthcare products are stored appropriately, including being secured where appropriate.

It is useful to appoint a designated person to take primary responsibility for the proper storage and security of medicines, vaccines and other healthcare products.

Schedule 4 and Schedule 8 medicines

The acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines are subject to jurisdictional legislative requirements.

For information on jurisdictional requirements refer to the drugs and poisons branch of the relevant jurisdiction:

Australian Capital Territory

Pharmaceutical Services, ACT Health
Telephone: 02 6205 1700 Fax: 02 6205 0997

Northern Territory

Poisons Control, Department of Health & Families
Telephone: 08 8922 7341 Fax: 08 8922 7200

New South Wales

Pharmaceutical Services Branch NSW Health

Telephone: 02 9879 3214 Fax: 02 9859 5165

Queensland

Drugs and Poisons Policy and Regulation, Enviromental Health Unit,
Queensland Health
Telephone: 07 3328 9310 Fax: 07 3328 9354

South Australia

Pharmaceutical Services and Strategy, Department of Health
Telephone: 08 8204 1942 Fax: 08 8226 9837

Tasmania

Pharmaceutical Services Branch, Department of Health and Human Services,
Tasmania
Telephone: 03 6233 2064 Fax: 03 6233 3904

Victoria

Drugs and Poisons Regulation Group, Department of Health
Telephone: 1300 364 545 Fax: 03 9096 9168

Western Australia

Pharmaceutical Services Branch, Disaster Managements, Regulation and Planning Directorate, Department of Health, Western Australia
Telephone: 08 9222 6883 Fax: 08 9222 2463

The RACGP has produced summaries of the jurisdictional requirements in relation to Schedule 8 medicines, available at www.racgp.org.au/standards/factsheets.

Other useful resources

- National Prescribing Service national medicines line (1300 633 424) is a telephone service providing consumers with information on prescription, over-the-counter and complementary (herbal/'natural'/vitamin/mineral) medicines. Patients can be referred from anywhere in Australia for the cost of a local phone call (calls from mobiles may cost more).
- Guiding principles to achieve continuity in medication management are available at www.health.gov.au/internet/main/publishing.nsf/content/nmp-guiding.
- Guiding principles for medication management in the community are available at: http://www.health.gov.au/internet/main/publishing.nsf/content/apac-publications-guiding .
- Guidelines for medication management in residential aged care facilities are available at www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm.
- National Prescribing Service (NPS) *Indicators of quality prescribing in Australian general practice* (February 2006). The NPS indicators implement QUM principles, and are a useful tool to describe and assess practice processes and prescribing habits. They can be viewed at www.nps.org.au/health_professionals/tools/quality_prescribing_indicators_in_australian_general_practice.

5.3.1 – ADF CONTEXT

The provision of medicines through Garrison Health Facilities is controlled by Defence procurement policies.

Defence operates a series of pharmacies co-located within selected Garrison Health Facilities. Dispensing services are provided from these centres to the co-located practice, as well as other facilities in the local area.

There is provision for a drug imprest system, which is the regular restocking of medicines to a pre-determined level. This allows commonly issued medications to be available to the GP when a pharmacist is not on-site, nurse-initiated prescribing and after-hours supply by non-pharmacists.

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Criterion 5.3.2

Vaccine potency

Our practice maintains the potency of vaccines.

Indicators

- ▶ A. Our practice team can identify the person with primary responsibility for cold chain management within the practice.
- ▶ B. The person with primary responsibility for cold chain management has this responsibility defined in their position description and can describe how the process used for cold chain management complies with the current edition of the *National Vaccine Storage Guidelines.*
- ▶ C. Our practice can demonstrate how we review the following processes to ensure potency of our vaccine stock:
  - ordering and stock rotation protocols
  - maintenance of equipment
  - annual audit of our vaccine storage procedures
  - continuum of cold chain management, including the handover process between designated members of the practice team
  - accuracy of our digital vaccine refrigerator thermometer.

Explanation

Key points

- The success of any vaccination program depends on the potency of vaccines when they are administered to patients
- A cold chain management system for the transportation and storing of vaccines aims to keep vaccines within the safe temperature range of 2–8ºC
- Self auditing of cold chain management should form part of a routine quality assurance and risk management process
- There needs to be a member of the practice team with primary responsibility for cold chain management.

National Vaccine Storage Guidelines

Vaccines are delicate biological products and if not stored appropriately they become ineffective.

The essential references for this criterion are:

- the current edition of the *National Vaccine Storage Guidelines: Strive for 5,* and
- the current edition of the NHMRC *Australian Immunisation Handbook*.

These references outline the requirements for general practices and other immunisation providers in relation to cold chain management and are available online at www.immunise.health.gov.au.

Essential steps in proper cold chain management

For practices to be confident that the potency of vaccines is maintained, practices must:

- monitor and record the maximum and minimum temperature of refrigerators in which vaccines are stored at least once daily when the practice is open, before any vaccines are used (generally at the beginning and end of each working day)
- have a reliable refrigerator, capable of maintaining a stable temperature and of adequate size for the practice's storage needs and frequency of vaccine ordering
- develop routine processes to maintain the cold chain, which are clearly documented. This may include identification, through a risk analysis, of potential situations of risk to vaccine potency and documentation of appropriate management strategies
- ensure that all practice staff handling vaccines receive ongoing education (supported by the practice) that is appropriate for the responsibility in performing their role
- know what action to take (including reporting and documentation) if the temperature of the refrigerator has been outside the recommended range of 2–8ºC.

Refrigerators

Vaccines should be stored in an appropriate refrigerator. If the practice is using a domestic refrigerator, certain modifications are necessary to reduce the risk of adverse vaccine storage events. This may include a combination of the following:

- a digital thermometer probe placed in the vicinity of stored vaccines to monitor the maximum and minimum refrigerator temperature
- storage of vaccines in their original packaging in a set of sliding plastic drawers or enclosed plastic containers to increase insulation (never in the door of the refrigerator)
- placement of bottles of salt water or unfrozen ice packs/gel packs in unused areas (eg. refrigerator door or identified colder areas of the refrigerator) to help stabilise the temperature.
- temperature 'data loggers' that can be placed in various vaccine storage areas to measure temperatures and keep a record of temperature fluctuations over a period of time.

Note that cyclic defrost and bar refrigerators are not recommended because they produce wide fluctuations in internal temperatures.

Data loggers

Data loggers can be used in audits to verify cold chain efficacy and to enable a quality control check of the vaccine refrigerator temperature. They are small electronic devices that continuously measure temperatures and keep a record of the results over a period of time. They require computer software to download the readings. Data loggers may be inbuilt in some vaccine refrigerators, or external data loggers may be purchased. (Data logging services

are provided by some state/territory immunisation programs and some local divisions of the Australian General Practice Network.)

Data loggers are useful in determining and recording:

- the accuracy of the refrigerator thermometer
- temperature fluctuations within the refrigerator and how long the refrigerator stayed at this temperature
- potential cooler or warmer areas within the refrigerator – areas which may not be suitable for vaccine storage.

Nominating a person with primary responsibility

A member of the practice team needs to be nominated to take primary responsibility for cold chain management and achieve compliance with cold chain management guidelines. The role and responsibilities need to be clearly articulated within a position description and there should be the opportunity for appropriate training as required. There needs to be a process for handing over to another designated and trained staff member when the responsible person is unavailable to perform their duty.

Self auditing

Routine self auditing helps to ensure that potent vaccines are being administered. An example of a self audit is contained in the appendix of the *National Vaccine Storage Guidelines: Strive for 5* (see page 117).

Standard 5.3

Clinical support processes

Our practice has working processes that support safety and the quality of clinical care.

Criterion 5.3.3

Healthcare associated infections

Our practice has systems that minimise the risk of healthcare associated infections.

Indicators

- ▶ A. Our practice team can identify the person with primary responsibility for coordinating infection control processes within our practice and this person has such responsibility defined in their position description.
- ▶ B. Our practice has a written, practice specific policy that outlines our infection control processes.
- ▶ C. The practice team member with delegated responsibility for the sterilisation process can describe in detail how sterile procedures are undertaken, including, where relevant:
  - provision of an adequate range of sterile reprocessed or disposable equipment
  - procedures for having instruments sterilised off site, including documentary evidence of a validated process
  - procedures for on site sterilisation of equipment, including monitoring the integrity of the whole sterilisation process, validation of the sterilisation process and steriliser maintenance
  - safe storage and stock rotation of sterile products.
- ▶ D. All members of our practice team can demonstrate how risks of potential cross infection within our practice are managed (as appropriate) including procedures for:
  - hand hygiene
  - the use of personal protective equipment (PPE)
  - triage of patients with potential communicable disease
  - safe storage and disposal of clinical waste including sharps
  - managing blood and body fluid spills.
- ▶ E. Our practice is visibly clean.
- ▶ F. The practice team member with delegated responsibility for environmental cleaning can describe the process for the routine cleaning of all areas of the practice and can provide documentation on the practice's cleaning policy.
- ▶ G. The practice team member with delegated responsibility for staff education on infection control can describe how the induction program for new staff covers our infection control policy as relevant to their role, and the requirements for providing ongoing staff education and assessing staff competency.
- ▶ H. Subject to the informed consent of individual practice team members:
  - the natural immunity to vaccine preventable diseases or immunisation status of practice team members is known
  - staff members are offered NHMRC recommended immunisations, as appropriate to their duties.
- ▶ I. Our practice team can explain how patients are educated in respiratory etiquette, hand hygiene and precautionary techniques to prevent the transmission of communicable diseases.

Explanation

Key points

- The practice needs a team member with primary responsibility for coordinating infection control processes
- The practice needs a written infection control policy
- All practice staff need to be offered immunisation appropriate to their role in the practice, in accordance with occupational health and safety obligations
- The practice team needs support for ongoing education to sustain effective infection control
- This criterion cross references to Criterion 3.1.3 Clinical governance.

Allocation of responsibility

The practice should appoint one member of staff with primary responsibility for infection control processes. Specific areas of responsibility can be delegated to other nominated members of the practice team and these particular responsibilities should be documented in the relevant position descriptions (eg. infection control processes, sterilisation process, environmental cleaning, staff immunisation, staff education).

Key elements of an infection control policy

The practice's written infection control policy should include:

- immunisation for staff working within the practice in accordance with recommendations in the current *Australian Immunisation Handbook*
- the appropriate use and application of standard and transmission based precautions
- sharps injury management
- blood and body substance spills management
- hand hygiene
- environmental cleaning of both clinical and nonclinical areas of the practice
- aseptic and sterile procedures for disposable instruments and/or instruments sterilised on site or off site. If sterilisation is performed on site, the policy needs to include the procedure for instrument reprocessing, sterilisation and the validation process. If sterilisation is performed off site, the policy needs to include evidence of the validation process and appropriate and safe transport arrangements
- waste management, including the safe storage and disposal of clinical waste and sharps
- access for patients and staff to personal protective equipment (PPE) and evidence of education on the appropriate application, removal and disposal of PPE
- pathology testing done within the practice.

Additional evidence

In addition to an infection control policy, practices need to provide evidence of:

- the ongoing education and training in infection control provided to each staff member and the mechanism for assessing staff competency in infection control procedures

- cold chain monitoring
- monitoring of the sterilisation process and sterilisation equipment maintenance if applicable (practices performing on site sterilisation)
- annual validation records if applicable (practices performing on or off site sterilisation)
- staff immunisation records.

Sterilisation processes

In terms of the reprocessing of reusable equipment, the RACGP *Infection control standards for office based practices* (4th edition) recommends sterilisation as the preferred process for the reprocessing of all reusable instruments and equipment (noncritical, semi critical and critical) that can withstand this process, regardless of their intended use.

Where the practice uses off site sterilisation facilities, the practice needs to be able to document and describe the procedures for safe transport of instruments and equipment to and from the practice and demonstrate that the off site facility correctly performs the sterilisation and validates its processes.

Waste management

Practices are responsible for ensuring compliance with state/territory or local government regulations in relation to waste management. In some jurisdictions, this legislation will override the guidance below.

In relation to waste management within the practice, the RACGP *Infection control standards for office based practices* (4th edition) define three categories of waste produced by healthcare facilities and outlines the appropriate disposal mechanism for each.

1. Clinical waste: includes discarded sharps, laboratory and associated waste directly involved in specimen processing, human tissue (excluding hair, teeth, urine and faeces unless the patient has a transmissible illness), and materials or solutions containing free flowing or expressible blood.
2. Related waste: includes cytotoxic waste, pharmaceutical waste, chemical waste and radioactive waste.

Disposal of clinical and related waste:

- for most clinical waste: into a safely located and clearly labelled leak proof container displaying a biohazard symbol
- for sharps: into a safely located and clearly labelled yellow, leak proof and puncture resistant container displaying a biohazard symbol in all areas where sharps are generated (eg. mounted on a wall or on a bench)
- a licensed contractor should be engaged to dispose of clinical waste.

3. General waste: includes all waste materials that do not fall into the clinical or related waste categories. General waste contaminated with blood or body substances (though not to such an extent that it would be considered clinical waste (ie. not contaminated with expressible blood), may be disposed of

through the general waste process of the practice, but must not be accessible to children. Gauze that has blood on it (but which cannot be expressed), used disposable vaginal spatula, cervical spatula and brushes and tongue depressors are likely to be the most common items in this category.

Disposal of general waste:

- a bin lined with a leak proof plastic bag which can then be disposed of through the general waste stream
- the usual waste paper bin under the desk can be used for waste not contaminated by blood or body fluids.

Contaminated general waste and clinical waste must not be accessible to children.

Managing cross infection within the practice

Potential infection risks to the practice team and patients need to be reduced. In this context, it is important for all staff to be familiar with infection control procedures within the practice, including the use of standard and special precautions, spills management and environmental cleaning.

Standard precautions apply to work practices that assume that all blood and body substances, including respiratory droplet contamination, are potentially infectious.

The RACGP *Infection control standards for office based practices* (4th edition) recommend the use of hand hygiene; PPE, including heavy duty protective gloves, gowns, plastic aprons, masks and eye protection; or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste.

Transmission based precautions are used for patients known or suspected to be infected with highly transmissible infectious agents (eg. influenza). In general practice this may be achieved by minimising exposure to other patients and staff through:

- the use of PPE (eg. masks)
- distancing techniques (one metre between patients in the waiting room, isolating the patient in a separate room)
- effective triage and appointment scheduling, and
- hand hygiene.

Environmental Cleaning

The practice should have a cleaning policy that sets out a schedule and responsibilities for cleaning all areas of the practice (see chapters 2–5 of the RACGP *Infection control standards for office based practices* (4th edition).

Where the practice engages commercial cleaners for environmental cleaning, the practice should have a written contract that outlines a cleaning schedule, suitable cleaning products and areas to be cleaned. A cleaning log can be useful.

Staff education

Staff education is crucial to effective infection control within the practice. Education needs to be relevant to the role of particular staff members and needs to start with the staff induction program.

Staff education and the evaluation of staff competency needs to be recorded in line with chapter 1 RACGP *Infection control standards for office based practices* (4th edition).

Staff immunisation

Practices have an occupational health and safety responsibility to protect their staff from exposure to harmful substances.

Practice staff need to be offered immunisation appropriate to their duties, to ensure they are protected from vaccine preventable infectious diseases. The exact requirements will vary, and need to be assessed according to the risk presented by the type of practice and the duties performed by the staff member.

Practices are advised to check the section of the *Australian Immunisation Handbook* on recommended vaccinations for healthcare workers available at www.immunise.health.gov.au/internet/immunise/publishing.nsf/content/handbook-specialrisk238. The following immunisations can be considered for office based health professionals:

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

The refusal to be vaccinated or receipt of vaccines and any natural immunity to disease should be recorded in the personnel folder of each staff member. It cannot be assumed that staff will seroconvert post immunisation (eg. hepatitis B). It is therefore recommended that post immunisation status is serologically confirmed wherever possible and that further vaccinations are provided as required. Post-immunisation immunity, if known, should be documented.

Personal protective equipment

All practice staff should have easy access to personal protective equipment and be educated on its proper use (eg. face masks, gloves, gowns, eye protective wear). Staff need to have a clear understanding as to the purpose of this equipment and how to apply, remove and dispose of it appropriately.

Staying up-to-date

It is important that practices remain alert to changes in legislation and guidelines for infection control and be in a position to implement them promptly. General practices should also have systems for monitoring and obtaining information about national and local infection outbreaks and public health alerts, such as pandemic influenza, measles and pertussis outbreaks.

Resources

Useful resources include

- www.racgp.org.au/infectioncontrol
- www.racgp.org.au/pandemicresources.

Additional resources include:

- *National Hand Hygiene: 5 moments for hand hygiene* available at www.hha.org.au/home/5-moments-for-hand-hygiene.aspx
- *Australian Immunisation Handbook* available at www.immunise.health.gov.au
- Department of Health and Ageing, *Infection control guidelines for the prevention of transmission of infectious disease in the healthcare setting* available at www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm

To order a copy of the RACGP *Infection control standards for office based practices* (4th edition) contact RACGP publications on 03 8699 0414 or order from www.racgp.org.au/publications/standards.

Appendix A

Applicability of the RACGP Standards for general practices

The RACGP *Standards for general practices* (4th edition) have been written by the general practice profession for general practices in Australia. One of the great strengths of general practice is its diversity. If your practice is a general practice – even if it seems to have an unusual or unconventional structure – then these *Standards* are applicable.

General practice

The RACGP defines general practice as the provision of patient centred continuing comprehensive, coordinated primary care to individuals, families and communities. The Standards are wholly relevant to general practices which meet this definition.

Special interest practices

The *Standards* might also be relevant for health services that do not necessarily see themselves as 'general practices' but as 'special interest practices' in primary care. Special interest practices may focus on a single clinical area (eg. mental health or skin cancer) or a single treatment modality (eg. acupuncture).

Services providing care to specific populations

The *Standards* may apply to primary healthcare services that are not organised like an office based private general practice, but which nevertheless provide general practice care to a distinct community (eg. Aboriginal medical services, community health services, or mobile clinics caring for homeless people).

The RACGP has worked extensively with the Aboriginal Community Controlled Health Organisation sector to develop an interpretive guide on the RACGP *Standards*.[17]

Services providing care outside normal opening hours

There are several options for the provision of care outside normal opening hours, or the advertised opening hours of the practice. Some practices use their own GPs to provide care or alternatively use a local cooperative of GPs or a medical deputising service. Where a deputising service is not available practices may have an agreement with a local hospital. Some practices use a combination of all these arrangements.

Except where specifically indicated, all standards, criteria and related indicators are applicable to services providing care outside normal opening hours.

Self assessment against the *Standards*

The RACGP encourages all services that provide primary healthcare to consider the *Standards* as a template for quality improvement and risk management. Most standards and related criteria will be relevant and will enable practices to build the fundamentals of quality and safety into their systems.

Primary health services which do not meet the RACGP definition of general practice and are therefore unable to be formally accredited against the *Standards* are nevertheless able to conduct a self assessment.

If a practice is undertaking a self assessment against the *Standards*, it may be helpful to discuss the assessment informally with trusted colleagues. A 'fresh set of eyes' over practice systems can assist in identifying areas where the practice does really well and areas where the practice needs to improve. Most importantly, peers can provide feedback on quality improvement activities – they can help the practice verify if changes based on practice data have brought about intended outcomes.

Independent accreditation against the Standards

When the RACGP *Standards* are used as the basis of an accreditation process, practices are expected to meet the *Standards* at all times, not just on the day of the accreditation survey. This is important for the safe and effective care of patients.

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

The only model of third party review supported by the RACGP for the *Standards* is by two or more surveyors who meet defined selection criteria and where at least one surveyor is a GP.

Appendix B

Clinical governance

Introduction

There are several concepts in the RACGP *Standards for general practices* 4th edition that are multifaceted and which are reflected in different parts of the *Standards*. Clinical governance is one of these.

This appendix outlines what makes clinical governance important to the *Standards*, and provides an overview of the aspects of the *Standards* which contribute to good clinical governance. The RACGP defines clinical governance as a framework through which clinicians and health service managers are jointly accountable for patient safety and quality care. The Australian Commission on Safety and Quality in Health Care describes a model of governance[18] that includes both corporate and clinical governance where corporate governance provides a structure through which corporate objectives (social, fiscal, legal and human resources) are set and achieved and performance is monitored.

The concept of clinical governance

Clinical governance as a concept may seem daunting to some people, especially people who are new to the healthcare environment or general practice. In the discussion below we outline how it is just a pragmatic approach to producing quality care.

Clinical governance involves the establishment of long term and trusting relationships. It requires respect and ongoing open communication. Some aspects involve mentoring and nurturing. Others involve encouraging self discipline and the willingness to be responsible for one's actions. There is a component in clinical governance which involves being mindful of risk and opportunity. Although clinical governance can involve some personally and professionally challenging times, it is also a framework in which many people thrive.

The environment for clinical governance

The Australian Standard on corporate governance[19] says 'the essence of good governance is accountability'.

One side of this accountability reflects the longstanding dictum 'do no harm'. This side of accountability is being accountable for preventing harm and appropriately managing harm where it occurs. The other side of this accountability is concerned with grasping opportunities to improve the quality of care and the working environment. These opportunities occur, for example, when new treatments become available or when new knowledge is discovered about existing treatments. Other opportunities are arising from the capability of new electronic information systems to ease the process of clinical coding and thus create better information for making quality improvements in the practice.

In broad terms, there are two areas of accountability that require an environment that is transparent, supportive and just. The first area is accountability to patients to prevent harm or manage harm when it occurs, including the

disclosure of harm to patients by people who care for them. The second area of accountability is to the clinical team, to provide a safe, supportive and just work place and culture.

While a distinction is sometimes made between a focus on patients and a focus on the health team which cares for patients, in terms of clinical governance it is useful to see the situation more like a symbiosis, where an environment of accountability creates the opportunity for people to share their enthusiasm and insights and maintain a momentum of quality improvement.

There is a substantial focus in the RACGP *Standards* on taking a patient centred focus. Such criteria as 2.1.2 Patient feedback reflect this. Additionally, the RACGP has responded to the profession's increasing concern for the health and wellbeing of the people who work within general practice, by complementing this patient centred concern with one for the people who work in the field.

The environment needs to be one that is active, rather than passive – one in which there is ongoing attention to the opportunity for harm.[20] The Australian Commission on Safety and Quality in Health Care[21] (ACSQHC) says effective clinical governance includes:

- recognisably high standards of care
- transparent responsibility and accountability for maintaining those standards
- a constant dynamic of quality improvement.

Rather than a constant hypervigilance, the environment needs to cultivate an ongoing present mindedness to the risk of safeguards failing and harm occurring. The *Standards* focus on a number of mechanisms that bring potential and actual lapses in quality to the attention of the people who can prevent harm or manage its ongoing impact.

The link between quality and clinical governance

Phillips et al[22] explored the link between quality and clinical governance in the Australian primary healthcare sector and found seven key areas to support clinical governance.

These, together with aspects of the RACGP *Standards* which reflect them, are:

- ensuring clinical competence (reflected in criteria such as Criterion 3.2.1 Qualifications of general practitioners, Criterion 3.2.2 Qualifications of clinical staff other than medical practitioners and Criterion 3.2.3 Training of administrative staff, which address both qualifications and the need for ongoing education)
- clinical audit (reflected in criteria such as Criterion 3.1.1 Quality improvement activities)
- patient involvement (reflected in criteria such as Criterion 1.2.2 Informed patient decisions and Criterion 2.1.2 Patient feedback)

- education and training (reflected in criteria such as Criterion 3.2.1 Qualifications of general practitioners, Criterion 3.2.2 Qualifications of clinical staff other than medical practitioners and Criterion 3.2.3 Training of administrative staff)
- risk management (reflected in criteria such as Criterion 3.1.1 Quality improvement activities and Criterion 3.1.2 Clinical risk management systems)
- use of information (reflected in Standard 1.7 Content of patient health records and Standard 4.2 Management of health iInformation, and criteria such as Criterion 3.1.1 Quality improvement activities)
- staff management (reflected in Standard 4.1 Practice systems).

Making clinical governance work

In a review of the literature on clinical governance, Braithwaite and Travaglia[23] identified a number of issues as key to effective governance:

- links between a health service's clinical and corporate governance
- the use of clinical governance to promote quality and safety through a focus on quality assurance and continuous improvement
- clinical governance structures designed to improve safety and quality and manage risk and performance
- strategies to ensure the effective exchange of data
- knowledge and expertise
- a patient centred approach to service delivery.

This suggests that it is critically important for the owners of a general practice (and others involved in its corporate governance) to play an active role in cultivating clinical quality. This concept is reflected, for example, in Criterion 1.4.2 Clinical autonomy for general practitioners. This work also suggests it is important to remember that clinical governance is not an end in itself. The purpose of clinical governance is the promotion of safety and quality.

The structures which form the clinical governance model within a general practice need to be designed with this aim in mind. As the RACGP *Standards* reflect there is an important role for pragmatism – for a practice structure that will really work to improve quality.

The RACGP *Standards* contain a number of criteria which focus on the effective exchange of information and data. These range from criteria about information collection, storage and transfer to criteria which encompass practice meetings to discuss the healthcare provided by a practice. In this way, the *Standards* reflect the general findings of Braithwaite and Travaglia.

Conclusion

Although the area of clinical governance can seem complex and sometimes onerous, the RACGP *Standards* provide a framework which allows clinical governance to become a vital and useful part of practice life.

Appendix C

General practice surveyors

Definition of peer surveyor

A 'peer' is defined by the RACGP as a general practitioner (GP) who has the experience and currency of practice to meet the requirements outlined below.

It is the RACGP's position that two surveyors undertake survey and assessment for the purposes of accreditation of general practices. One surveyor must be a GP.

Expanded definition: non GP surveyors of general practice

The RACGP recognises that a practice nurse, practice manager, allied health professional or Aboriginal health worker, can also assess and survey against the RACGP *Standards for general practices*.

General practice surveyors are health professionals with qualifications, experience and technical expertise relevant to general practice who have been selected according to the guidelines below.

Guidelines for the selection of general practice surveyors (peer and non peer)

The selection of general practice surveyors needs to be a reliable and transparent process.

Surveyors need to be selected to provide a balance of skills and experience and to match the needs and characteristics of individual general practices, taking into consideration cultural appropriateness and geographic location.

General practice surveyors need to demonstrate the following:

- contemporary knowledge of general practice, sufficient to make a reliable assessment of the competence of the general practice to provide safe, high quality products, processes or services
- thorough knowledge of the RACGP *Standards for general practices* and relevant assessment method and documentation
- familiarity with applicable legislation (e.g. drugs and poisons legislation, registration requirements, environment protection requirements)
- thorough knowledge of and experience in risk management, including the ability to analyse systems and their potential for failure
- health professional background with qualifications relevant to general practice
- substantial technical experience in at least one area relevant to general practice (e.g. practice management)
- the ability to communicate effectively
- declaration of conflicts of interest (eg. relationship with the general practice seeking external review such as previously employed by the general practice and/or provided consultancy services to it).

At all times the practice has the right to veto suggested surveyors. The RACGP recommends practices have access to the curriculum vitae of proposed surveyors to enable the practice to make an informed decision about the survey team.

Guidelines on the training of surveyors

1. Initial training of new surveyors

New surveyors require thorough orientation, supervision and mentoring in order to provide a consistent and credible service to general practice.

The RACGP believes that new surveyors require the input of the RACGP in the following areas:

- theoretical concepts of RACGP *Standards* development
- aspects of *Standards* assessment (eg. observation, document review, patient feedback, interview).

2. Continuing professional development of surveyors

Surveyors need continuing professional development for skill development, including the input of the RACGP in the following areas:

- interpretation of RACGP *Standards for general practices* and other standards developed for special interest areas (eg. cosmetic medicine, skin cancer medicine, Aboriginal medical services)
- discussion of areas of inconsistent interpretation as reported to the RACGP.

Glossary

Aboriginal and Torres Strait Islander status: Patients able to be identified as being of Aboriginal or Torres Strait Islander origin in response to the practice asking the standard Indigenous Australian status question

Aboriginal health worker: A member of the Indigenous health workforce who undertakes various roles including clinical functions (often as the first point of contact with the health workforce, particularly in remote parts of the country); liaison and cultural brokerage; health promotion; environmental health; community care; administration, management and control; and policy development and program planning

Access: The ability of patients to obtain services from the general practice

Accreditation: A formal process to ensure delivery of safe, high quality healthcare based on assessment against the RACGP *Standards for general practices*

Active patient: A patient who has attended the practice/service three or more times in the past 2 years

Active patient health record: The record of an active patient

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

Adverse drug reaction: See adverse medicines event

Adverse medicines event: An adverse event due to a medicine. This includes the harm that results from the medicine itself (an adverse drug reaction) and 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)

Adverse event: An incident that results in harm to a patient, where harm includes disease, injury, suffering, disability and death

After hours services: Services that provide care outside the normal opening hours of general practices, whether or not they deputise for other general practices, and whether or not they provide clinic or visit based care

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

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

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

CALD: People from culturally and linguistically diverse backgrounds

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

Carers: People who provide care and support to family members and friends who have a disability, mental illness, chronic condition or terminal illness or who are frail

Clinic based care: Care that is provided when patients attend a general practice, in contrast to when they are visited at home

Clinical governance: A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care

Clinical indicator: A measure, process or outcome used to judge a particular clinical situation and indicate whether the care delivered was appropriate

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

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

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

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

Cold chain management: The system of transporting and storing vaccines within the temperature range of 2–8°C from the place of manufacture to the point of administration

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

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

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

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

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

Cooperative (as in after hours): General practitioners from different practices working together to provide care to patients outside the normal opening hours of their practices

Cultural background: The particular ethnic or cultural heritage of a patient as collected and recorded by the practice

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

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

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

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

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

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

Enhanced Primary Care: Relates to a government program to assist people with chronic illness and other people who need a range of services to support them in the community

Enrolled nurse: A nurse who works under the direction and supervision of a registered nurse as stipulated by the relevant nurse registering authority, where the enrolled nurse retains responsibility for his/her actions and remains accountable in providing delegated nursing care

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

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

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

Full backup: A copy of all files residing on a computer or server hard drive. The files are marked as having been 'backed up'

Gender: Refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. By way of contrast, 'sex' refers to the biological and physiological characteristics that define men and women

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

General practice registrar: A registered medical practitioner who is enrolled in a general practice training program approved by the RACGP to achieve Fellowship of the RACGP

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

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

Health outcome: The health status of an individual, a group of people or a population which is wholly or partially attributable to an action, agent or circumstance in general practice

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

Home visits: A general practice consultation conducted in the residence of a patient

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

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

Incident: an event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person, and/or complaint, loss, damage or claim for compensation

Induction program: A form of training provided to new staff members or GPs to introduce them to the practice systems, processes and structures

Infection: The invasion and reproduction of pathogenic (disease causing) organisms inside the body. This can cause tissue injury and progress to disease

Infection control or infection control measures: Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection (HAI) surveillance, infectious disease monitoring, hand hygiene and personal protective equipment

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

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

Known allergy: A hypersensitivity reaction to a medicine or other substance that is made known to a GP (see adverse drug reaction)

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

Medication history: an accurate recording of medications, comprising a list of all current medicines including all current prescription and non prescription medicines, complementary healthcare products and medicines used

intermittently; recent changes to the medication list; past history of adverse drug reaction including allergies and recreational drug use.

Mistake: an error or adverse event that results in harm

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

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

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

Normal opening hours: The advertised opening hours of the general practice

Nurse: A registered nurse demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes and context of care. The registered nurse practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and other healthcare workers

Nurse practitioner: A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role where the scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice

Other visit: A general practice consultation conducted in a facility other than the general practice or the patient's home (eg. residential aged care facility)

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

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

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

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

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

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

Policy and procedures manual: A resource document containing written practice information about the practice's policies and procedures

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

Practice information sheet: A photocopied, typed or electronically generated information sheet which includes essential information for patients about services provided by the practice and methods of access to those services

Practice team: Teams of staff who provide care within the practice (eg. GPs, receptionists, practice managers, general practice nurses, allied health professionals)

Primary care nurse: a nurse who works in primary care where primary care nurses are not a formally identified profession

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

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

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

QI&CPD: Quality improvement and continuing professional development – educational activities that lead to quality improvement in clinical care as endorsed by the RACGP (formerly known as QA&CPD)

Quality improvement: An activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the practice. Ethics approval is not required for quality improvement activities, including clinical audits using a tool such as CAT or 'plan, do, study, act' cycles, undertaken within a general practice

Recognised GP: See vocationally recognised GP

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

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

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

Risk: an activity or factor that may increase the likelihood of disease or harm

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

Safe and reasonable: A decision that each practice needs to make in light of factors affecting their practice (eg. location, patient population) in providing clinical care. What is safe and reasonable needs to be considered by the practice in light of what their peers (or practices in the same area) would agree was safe and reasonable

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

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

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

SNAP: An acronym used for major risk factors to a patient's health, viz. smoking history, nutrition, alcohol consumption and physical activity

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

Standard clinical practice: Practice which might reasonably be expected by the public or professional peers

Staff involved in clinical care: Staff employed by the practice who perform any clinical tasks with patients

Structure indicators: Indicators that relate to material resources, facilities, equipment and the range of services provided at the general practice

System: An organised and coordinated method or procedure

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

Urgent: A health need compelling immediate action or attention

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

ADF Glossary

1800IMSICK: The access telephone number (1800IMSICK or 1800 467425) to a national 24-hour call centre to provide non-emergency medical advice to ADF personnel

ADHREC: Australian Defence Human Research Ethics Committee. Sits within Joint Health Command with oversight of human research ethical standards

ADF: Australian Defence Force

APS: Australian Public Service

Augmentee: An ADF member assigned to a unit on a temporary basis to fill a shortage or to provide particular skills, but who does not belong to that unit

Chain of Command: The organisational structure through which administrative command of an individual within the ADF is exercised

CHP: Contracted Health Professional. Qualified civilian health personnel contracted to provide support at a Garrison Health Facility

Contracted: Contracted to the Commonwealth to provide health or other services

Defence Work Health and Safety: Concerned with providing oversight of Work Health and Safety matters across Defence

DRN: Defence restricted network. An intranet network within Defence capable of managing information up to the level of 'Restricted'

Employee ID: Unique numeric identifier assigned to an ADF member. See also 'PMKeyS Number'

Entitled person: Only currently serving ADF personnel (referred to in the singular as 'entitled person') are entitled to receive non-emergency healthcare at a Garrison Health Facility

Garrison: All ADF units assigned to a base or area for defence, development, operation, and maintenance of facilities

Garrison Health Operations: Branch within Joint Health Command that oversees the provision of Garrison Health Facilities

Garrison Health Facility: Healthcare facility of any size or capacity staffed and managed by Garrison Health personnel

Health centre: Medium-sized Garrison Health Facility that is typically staffed by multiple medical officers, nurses, medics and allied health professionals

Health centre manager: Person responsible to Defence for the management of a Garrison Health Facility

Health Clinic: Small Garrison Health Facility typically staffed by one or two medical officers supported by nurses and medics

ICT: The Information and Communications Technology Delivery Division is that part of Defence responsible for the design, development, implementation and ongoing support of applications and systems in the Defence Information Environment

MEC: Medical Employment Classification. An alphanumeric system of assigning physical or administrative limitations to the employability or deployability of ADF personnel

MECRB: Medical Employment Classification Review Board. Part of Joint Health Command that oversees the assignment of changes to Medical Employment Classifications

Medic: Shortened version of the term 'medical assistant' (sometimes referred to as an MA). A military person qualified to provide a level of medical assistance to ADF personnel below that level usually provided by a medical officer or nursing officer. They have an endorsed nurse qualification and pre-hospital care training

Medical unit: An establishment or other unit, whether military or civilian, organised for medical purposes, namely the search for, collection, transportation, diagnosis or treatment of the wounded, sick and shipwrecked, or for the prevention of disease. May be fixed or mobile, permanent or temporary. For example, hospital or similar unit, blood transfusion centre, preventive medicine centre and institute, medical depot, and medical and pharmaceutical store of such units

MO: Medical Officer. Recognised qualified medical practitioner who is an ADF member, or as recognised by any agreement which may be in place between the ADF and other parties

Non-contracted: Person who is not contracted to the Commonwealth to provide health or other services

Periodic health examination: Regular detailed health assessments the ADF requires of some of its members. Determined by a range of circumstances

PMKeys Number: Personnel Management Key Solution Number. Unique number identifier given to each ADF member as part of the ADF personnel administration software package

Supplementary staff: Member of a unit's staff who is additional to that unit's usual staff entitlement

Thomas Pack: ADF man-portable back pack stocked with emergency response medical equipment and consumables according to a pre-determined list of contents. For use by healthcare providers within their scope of practice

UMECR: Unit Medical Employment Classification Review. Where an ADF member has sustained a short-term or less severe cause of medical restrictions, these restrictions may be lifted through a unit-level medical administrative process

UMR: Unit Medical Record. Each entitled ADF member has a UMR secured within their local Garrison Health Facility. This contains copies of patient consultation records, periodic medical examination findings, specialist medical reports, pathology and radiology results, and psychology reports

Unit: Any military element whose structure is prescribed by competent authority, such as a table of organisation and equipment. Specifically, part of an organisation

References

1. van Walraven C, Oake N, Jennings A, et al. The association between continuity of care and outcomes: a systematic and critical review. J Eval Clin Pract 2010;16:1–10.
2. Starfield B, Chang H-Y, Lemke K, et al. Ambulatory specialist use by nonhospitalized patients in US health plans. J Ambul Care Manage 2009;32:216–25.
3. Maxfield D, Grenny J, McMillan R, et al. Silence kills – the seven crucial conversations for healthcare, 2005. Available at www.aacn.org/WD/Practice/Docs/PublicPolicy/SilenceKills.pdf.
4. Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. BMJ 1998;317:61–5.
5. Australian Commission on Safety and Quality in Health Care. Draft National Safety and Quality Healthcare Standards. Sydney: ACSQHC, 2009.
6. Phillips C, Hall S, Pearce C, et al. Improving quality through clinical governance in primary healthcare. Canberra: Australian Primary Healthcare Research Institute, 2010
7. Makeham M et al. Patient safety events reported in general practice: a taxonomy. Qual Saf Health Care 2008;17:53–7.
8. Makeham M, Bridges-Webb C, Kidd MR. Lessons from the TAPS Study: Errors relating to medical records. Aust Fam Physician 2008;37:243–4.
9. Australian Commission on Safety and Quality in Health Care. Draft National Safety and Quality Healthcare Standards. Sydney: ACSQHC, 2009.
10. Hillestad R, Bigelow JH, Chaudhry B, et al. Identity crisis: an examination of the costs and benefits of a unique patient identifier for the U.S. Healthcare System. 2008. Available at www.rand.org/pubs/monographs/MG753.
11. Mohr J, Batalden P. Improving safety on the frontlines: the role of microsystems. Qual Saf Healthcare 2002;11:45–50.
12. Hudson L, Jacobs I. Defibrillators – their use in general practice. Aust Fam Physician 2008;37:63–4.
13. Potter VAJ. Pulse oximetry in general practice: How would a pulse oximeter influence patient management? Eur J Gen Pract 2007;13:216–20.
14. Miller G, Britt H, Valenti L. Adverse drug events in general practice patients in Australia. Med J Aus 2006;184(7):321–4.
15. Sorensen L, Stokes JA, Purdie DM, et al. Medication reviews in the community: results of a randomized, controlled effectiveness trial. Br J Clin Pharmacol 2004;58:648–64.
16. Easton K, Morgan T, Williamson M. Medication safety in the community: a review of the literature. Sydney: National Prescribing Service, 2008.
17. The Royal Australian College of General Practitioners. Interpretive guide of the RACGP Standards for general practices (3rd edition) for Aboriginal and Torres Strait Islander health services. South Melbourne: The RACGP, 2010.
18. Australian Commission on Safety and Quality in Health Care. Draft National Safety and Quality Healthcare Standards. Sydney: ACSQHC, 2009.
19. Standards Australia International. AS 8000–2003 Corporate governance – good governance principles. Sydney: Standards Australia International, 2004.
20. Reason J. Human error: models and management. BMJ 2000;320:768–70.
21. Australian Commission on Safety and Quality in Health Care. Draft National Safety and Quality Healthcare Standards. Sydney: ACSQHC, 2009.
22. Phillips C, Hall S, Pearce C, et al. Improving quality through clinical governance in primary healthcare. Canberra: Australian Primary Healthcare Research Institute, 2010.
23. Braithwaite J, Travaglia F. An overview of clinical governance, policies, practices and initiatives. Aust Health Review 2008;32:10–22.

Index

D

E

F

G

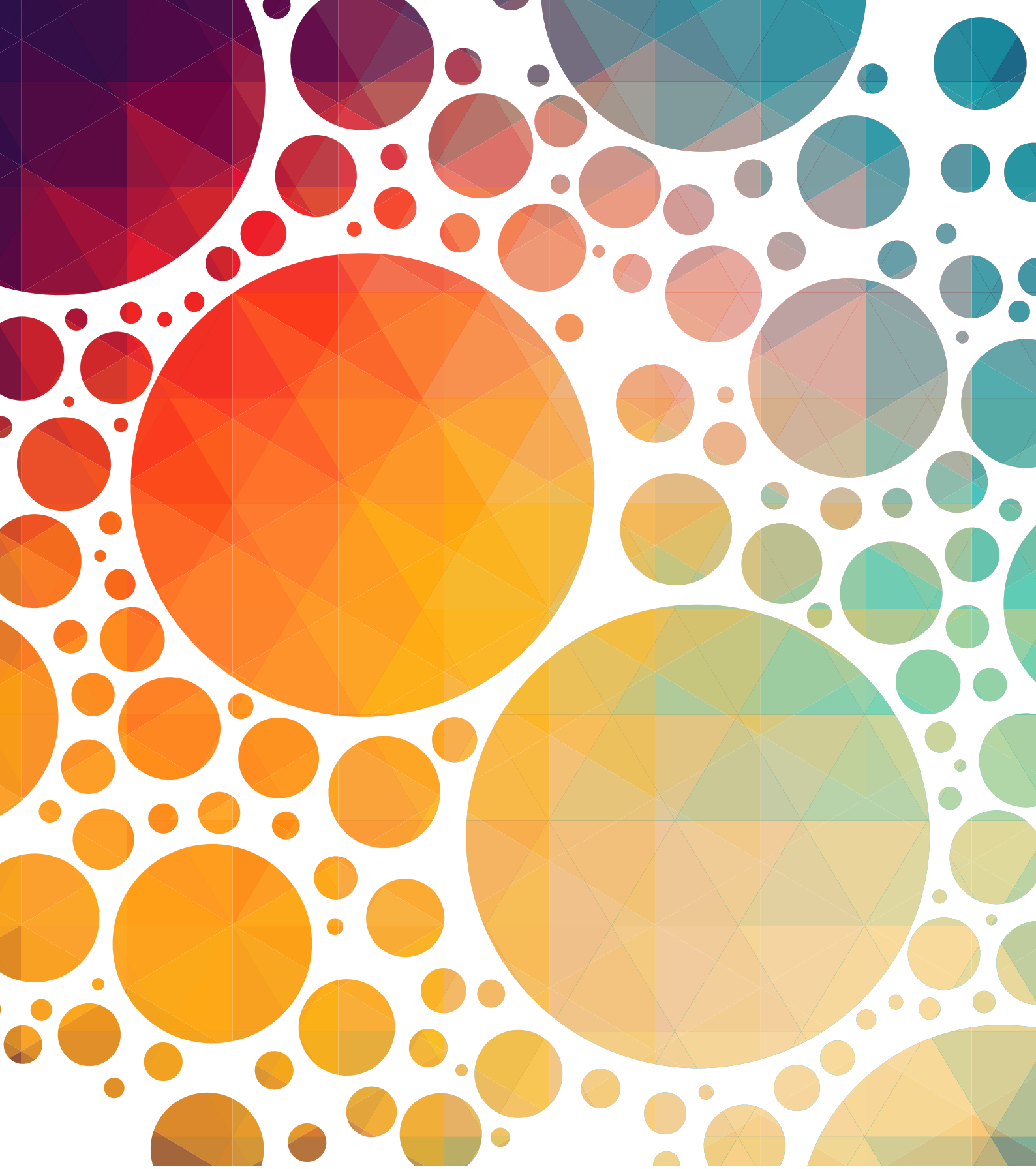
H

I

Q

R

S



RACGP