

Foundation Standard

& INTERPRETATION GUIDE



Guidance notes



Resources

VERSION 3.2

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The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Acknowledgements

The Foundation Standard has been developed from *Aiming for Excellence RNZCGP Standard for General Practice* 2011 (and earlier editions) and the Midlands Health Network Core Standard for General Practice.

Aiming for Excellence builds on the work of other international Colleges, particularly the Royal Australian College of General Practitioners, who have shared their experience of standards development and assessment.

A Project Board governed the development of the Foundation Standard. The Project Board was chaired by Sue Chetwin, Chief Executive Officer of the Consumer Institute, and included Dr Brendon Eade, Ms Shelley Frost, Dr Bryn Jones, Ms Helen Morgan-Banda, Dr John Wellingham, and Ms Angela Wilson.

A Working Group was responsible for identifying the indicators and criteria that comprise the Foundation Standard. The Working Group was chaired by Dr John Wellingham and included Ms Keriana Brooking, Dr Jane Burrell, Ms Rosemary Gordon, Dr Bryn Jones, Ms Stella MacFarlane, Dr Mick Ozimek, Dr Ian Smiley, Ms Fiona Thomson, Dr Jim Vause and Ms Dawn Wilson.

The College was also assisted by a consumer advisory panel and a Māori consumer advisory panel.

Disclaimer

This evidence guide provides examples of what evidence practices can provide to demonstrate compliance with each of the criteria that comprise the FOUNDATION STANDARD. The evidence guide does not provide a full and final list of all evidence that may be used to demonstrate compliance. Practices may have additional or other evidence that is valid. Links to websites are provided to support understanding of what is expected from each criterion.

While this document has been developed after consultation with many people and the relevant laws, consideration should be given to the changing nature of the environment and law, and neither the RNZCGP nor any other person associated with the preparation of these standards accepts the responsibility for the results of any action taken, or not taken, by any person as a result of anything contained in or omitted from this publication.

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Foreword

Welcome to the Royal New Zealand College of General Practitioners' Foundation Standard (the Standard) for general practice. Developed in 2013, the Standard is the result of the collaborative effort of our membership, with the support of Primary Health Networks and Organisations who share a vested interest in general practice standards.

By establishing a minimum national standard for general practice we are seeking to guide practices in a positive direction by identifying what they should be doing to ensure the safety of their patients and practice team.

The College extends sincere thanks to those who participated in the development of the Standard. The participation of our key stakeholders has ensured that the Standard will be relevant to all types and sizes of general practices in New Zealand.

We invite practices to become familiar with the requirements of this Standard and to support its ongoing development as the minimum standard for general practice in New Zealand.



Dr Tim Malloy
President, RNZCGP

Introduction

In establishing the Foundation Standard for General Practice, the Royal New Zealand College of General Practitioners (the College) is seeking to ensure that all general practices throughout New Zealand demonstrate their commitment to ensuring the safety of their patients and general practice team.

The criteria in this document reflect what the College considers to be the minimum legal, regulatory and professional standards that a general practice in New Zealand should comply with.

The Foundation Standard does not include all legal, regulatory and professional standards that may be applicable to general practice. General practices may be required to comply with other legal and regulatory requirements for other purposes.

The Interpretation Guide is a resource to support understanding of what evidence is required to meet the requirements of this Standard.

The overarching principles used to identify foundation criteria included:

- recognising patient care and safety is the utmost priority;
- describing the Foundation Standard in a way that is easily understood and accepted by patients, the public and general practice team;
- promoting and supporting equity in patient care;
- supporting current and future general practice care; and
- supporting monitoring mechanisms that are efficient and cost-effective

Other standards offered by the College

The Foundation Standard is distinctive from the *Aiming for Excellence* standard in that its focus is on **quality assurance**. *Aiming for Excellence* extends a practice through the attainment of advanced standards that focus on **quality improvement**.

Practices who are CORNERSTONE®-accredited with *Aiming for Excellence* have met the requirements of the Foundation Standard.

How to use these guidelines

The Foundation Standard comprises 31 Indicators. Each indicator in the Foundation Standard has criteria. Criteria are listed in the left-hand column under the heading of the indicator. The right-hand column describes evidence that can be used to meet the requirements of the criteria.

Guidance notes are provided to give more detailed information about the indicator, as well as references to websites that can also provide further information.

Indicators and criteria

Each indicator describes a high-level statement of performance expected by a practice to meet the requirements of this Standard.

Criteria define the specific requirements that must be met to satisfy the indicator. Criteria are discrete, measurable and explicit.

Evidence of compliance

To be considered to have met the requirements of the Foundation Standard, a practice must demonstrate compliance with all indicators and criteria. While examples of evidence have been provided, there may be alternative (valid) evidence a practice provides to demonstrate compliance.

Training

Some indicators require the practice to undertake training to ensure that all the general practice team are familiar with legislative or professional standards. Where training is required, the College would expect the practice to consider (as appropriate):

- A. Identification of all staff who require training.
- B. New staff that may require training.
- C. Retraining staff when there are changes made to standards or legislation.

These guidance notes do not include a list of training providers. If a practice requires assistance to identify a training provider the College may be able to assist with information or contacts.

Training levels

Level 1: Provided by externally recognised training agency/provider.

Level 2: Internal training facilitated by a person who has attended level 1 training and maintains currency of knowledge within the subject matter.

Subject	Training requirement
1.3 The general practice team has received training to implement The Code.	Level 1 and/or 2
2.2 The general practice team has received training on the requirements of the Privacy Act 1993, and Health Information Privacy Code 1994.	Level 1 and/or 2
5.2 The general practice team are trained in Te Tiriti o Waitangi/The Treaty of Waitangi including the principles of 'Partnership, Participation and Protection'.	Level 1
6.1 The practice team are trained in cultural competence and cultural safety.	Level 1 and/or 2
15.2 General practice team members responsible for managing infection control have received sterilisation and disinfection training, within the last three years.	Level 1
22.1 Non-clinical team members responsible for first line interaction with patients are trained to identify and respond appropriately to patients with urgent medical conditions.	Level 1 and/or 2
22.4 All practice team members who may be required to administer CPR must have current certification to an appropriate level from certified trainers.	Level 1

Terminology used in this guideline

Clinical team refers to clinical staff only.

General practice team refers to both clinical and administrative staff and includes full- and part-time employees, contractors and long-term locums.

Maintenance of Professional Standards (MOPS)

To practise medicine in New Zealand doctors must be registered with the Medical Council of New Zealand (MCNZ) and hold a current practising certificate issued under the Health Practitioners Competence Assurance Act 2003. The MCNZ requires that all doctors comply with continuing professional development requirements in order to hold an annual practising certificate.

The College's continuing professional development programme (MOPS) is designed to enable the recertification of vocationally registered doctors working in general practice or rural hospital medicine.

MOPS credits are gained from a combination of activities:

- Professional Development Plan (PDP)
- Audits of Medical Practice (AoMP)
- Continuing Medical Education (CME)
- Peer Review activities

MOPS runs in a three-year cycle (triennium) and the College programme satisfies the requirements of the Medical Council of New Zealand for recertification.

Contact us for more information or telephone +64 4 496 5999 and speak with a MOPS coordinator.

We have stated where specific indicators in the Foundation Standard relate to activities that may be claimed for continuing professional development. Further information can be obtained in the [MOPS triennium handbook](#).

SECTION 1

Patient experience and equity

The purpose of this section is to ensure that patients are aware of their rights as consumers, and the general practice team are suitably trained and equipped to provide services that meet patients' rights.



Guidance notes



Resources

INDICATOR 1

The practice meets the requirements of the Code of Health and Disability Services Consumers' Rights 1996

Criteria	Evidence may include	<input checked="" type="checkbox"/>
1.1 The practice displays a copy of The Code of Health and Disability Services Consumers' Rights 1996 (The Code) poster prominently in the practice and brochures about The Code are available for patients to access.	■ Posters on prominent display in the reception area identifying The Code, and brochures are available.	<input type="checkbox"/>
1.2 The practice has a policy that describes how The Code is implemented.	■ A documented policy that describes how the general practice team is made aware of and implements the requirements of The Code.	<input type="checkbox"/>
1.3 The general practice team has received training to implement The Code.	■ Evidence of general practice team training on how The Code is implemented.	<input type="checkbox"/>
1.4 Information about the local health advocacy service is displayed where patients can view it.	■ Poster and/or brochures on display in the reception area identifying local health advocacy services.	<input type="checkbox"/>

Guidance notes

The Code can be downloaded free of charge from the [Health and Disability Commissioner](#) website.



The rights of patients are:

1. The right to be treated with respect
2. The right to freedom from discrimination, coercion, harassment, and exploitation
3. The right to dignity and independence
4. The right to services of an appropriate standard
5. The right to effective communication
6. The right to be fully informed
7. The right to make an informed choice and give informed consent
8. The right to support
9. Rights in respect of teaching or research
10. The right to complain

Resources

- [The Code of Health and Disability Services Consumers' Rights 1996](#)
- [Health and Disability Commissioner](#)
- [Training on the Code of Health and Disability Services Consumers' Rights 1996](#)



INDICATOR 2

The practice meets the requirements of the Health Information Privacy Code

Criteria	Evidence may include	<input checked="" type="checkbox"/>
2.1 The Practice has a Privacy Policy that complies with the Privacy Act 1993 and Health Information Privacy Code 1994.	<ul style="list-style-type: none"> A documented policy that describes how the general practice team is made aware of, and implements the requirements of the Privacy Act 1993, and Health Information Privacy Code 1994. 	<input type="checkbox"/>
2.2 The general practice team has received training on the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994.	<ul style="list-style-type: none"> Evidence of general practice team training on the Privacy Act 1993 and Health Information Privacy Code 1994. 	<input type="checkbox"/>
2.3 The collection, use, storage, disposal and disclosure of individual patient information comply with the Health Information Privacy Code 1994.	<ul style="list-style-type: none"> The general practice team can demonstrate/describe the process for the collection, use, storage, disposal and disclosure of individual patient information. 	<input type="checkbox"/>
2.4 There are safeguards* in the reception area to ensure confidentiality of patient information.	<ul style="list-style-type: none"> Safeguards are identified and demonstrated. 	<input type="checkbox"/>

* Examples of safeguards are: Computer screens turned away from customers, gentle music playing in the reception area, clinical notes and files kept out of direct reach of patients and visitors.

Guidance notes

The [Health Information Privacy Code 1994](#) (the Code) applies to identifiable health information about individual patients. The Code takes account of the characteristics of health information (such as its confidentiality, sensitivity and use by different health care providers) to protect individuals. Practices must identify measures needed to protect individual health information privacy that meet the legislative requirements set out in Code. The Code has twelve information privacy principles. For the full text of each, click on its number. As a brief guide:



Collection of information [Principle 1](#), [Principle 2](#), [Principle 3](#), and [Principle 4](#).

This includes the reasons why personal information may be collected, where it may be collected from, and how it is collected.

[Principle 12](#) governs how 'unique identifiers' – such as IRD numbers, bank client numbers, driver's licence and passport numbers - can be used.

Use of information [Principle 5](#) governs the way personal information is stored. It is designed to protect personal information from unauthorised use or disclosure.

Access to information [Principle 6](#) gives individuals the right to access information about themselves. [Principle 7](#) gives individuals the right to correct information about themselves.

Disclosure of information [Principle 8](#) and [Principle 9](#), [Principle 10](#), and [Principle 11](#) place restrictions on how people and organisations can use or disclose personal information. These include ensuring information is accurate and up-to-date, and that it isn't improperly disclosed.

The Privacy Commissioner advises the following:

Rule 5 of the Health Information Privacy Code requires that health agencies, such as GPs, take reasonable steps to keep the health information that they hold secure against loss, misuse and unauthorised access. What is “reasonable” depends on the circumstances, such as the nature of the information, the possible harm if it is lost or inappropriately accessed, and the practicality (including space and cost) of securing it. An example of a reasonable safeguard, as expressed by the Privacy Commissioner, would be having lockable cabinets in which to store paper medical records.

If lockable cabinets are not a practicable safeguard for a practice then the onus is on the practice to demonstrate how it is ensuring the health information it holds in paper form is kept safe using another method. Relying on open areas to be constantly staffed, such as by storing files in a manned open area behind reception, will not be sufficient in itself to meet the requirements of Indicator 2. The College may independently moderate on whether practices have met Indicator 2.


Resources

- [On the Record: A practical guide to health information privacy; Health Privacy Toolkit](#)
- [The Privacy Act 1993](#)
- [Office of the Privacy Commission – see factsheet1: Overview](#)
- [Privacy Commission online training course](#)



INDICATOR 3

The practice upholds the patient's right to complain in accordance with Right 10 of the Code

Criteria	Evidence may include	
3.1 The practice has a policy that describes how complaints will be managed by the practice team.	<ul style="list-style-type: none"> ■ A documented policy that describes how the general practice team is made aware of, and implements its complaints process in accordance with Right 10 of the Code. 	<input type="checkbox"/>
3.2 The practice has a designated Complaints Officer responsible for the implementation and management of the practice's complaints policy.	<ul style="list-style-type: none"> ■ A description of the role of the Complaints Officer in the practice; and ■ A current job description that identifies the appointment of a Complaints Officer; and ■ The Complaints Officer can describe the practice's complaints process and the principles of Right 10 of the Code; and ■ Where available current examples of complaints can be discussed that have been documented and processed in accordance with the practice's complaints process. 	<input type="checkbox"/>

Guidance notes

The practices' complaints procedure must be managed to comply with relevant time frames and legal requirements under [Right 10 of the Code of Health and Disability Services Consumers' Rights 1996](#) (the Code).



Under the Code the practice must write to the complainant within five working days, (unless the complaint has been resolved to the satisfaction of the consumer in this period), to let them know the practice has received the complaint and tell them about your complaints procedure, the independent advocacy service, and their right to contact the Health and Disability Commissioner's Office about the complaint. The complainant can also take the complaint directly to the Commissioner's Office. Senior members of the Commissioner's staff carefully review the complaint and the Commissioner decides the best way of dealing with it.

Within 10 working days of acknowledging receipt of the complaint the practice must decide whether you accept the complaint, or whether you need more time to consider it. The practice must let the complainant know what you have decided, and why, as soon as practicable. The practice must also inform the complainant about progress on the complaint.

Resources

- [The Code of Health and Disability Services Consumers' Rights 1996](#)
- Health and Disability Commissioner – [learning from complaints leaflet](#) and [complaints information](#)
- [Complaints Management Guide for General Practice](#) prepared by the Health and Disability Services Commission



INDICATOR 4

Patients can make informed choices about their health care

Criteria	Evidence may include	<input checked="" type="checkbox"/>
4.1 Information is available and accessible to assist patients to make informed choices about their health care.	<ul style="list-style-type: none"> ■ A copy of the Code of Health and Disability Services Consumers' Rights 1996; and ■ A variety of information on treatment, benefits and complications; and ■ List or contact details for interpreter services; and ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
4.2 The practice provides patients with information describing the services provided and any associated costs.	<ul style="list-style-type: none"> ■ Practice signage or guidance sheets are provided describing services and associated costs. 	<input type="checkbox"/>
4.3 Patients are informed of their right to have a support person present during a consultation.	<ul style="list-style-type: none"> ■ Support person poster. ■ Patient record notes the offer of a support person and the patient's response. 	<input type="checkbox"/>
4.4 Informed consent is obtained from a patient or legally designated representative when agreeing to a treatment or procedure.	<ul style="list-style-type: none"> ■ Consent forms. ■ Evidence of signed consent where required. ■ Evidence of verbal and/or implied consent. ■ Patient record reviews (see Indicator 21) 	<input type="checkbox"/>

Guidance notes

Consent law is patient centred in New Zealand. Patient-centered care supports active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment.



Informed consent is basic to the individual's freedom, right and self-determination. It comprises four key elements:

- **Competence:** The person giving consent for the service either for themselves or for others (e.g. their child) must have the ability and/or support to make a decision based on the information provided. Competence is not determined by age but rather by the ability to make a decision.
- **Voluntarism:** The consenting party must have been able to make the decision of their own free will. They also have the right to withdraw that decision at a later date.
- **Full information:** All necessary information must be given to allow the consenting party to make an informed choice about their options.
- **Full comprehension:** Information needs to be given in an environment that enables open and honest communication. There must be opportunities to freely ask questions about any aspects of service being offered. Interpreters should be used where necessary.

Right 6 of the Code of Health and Disability Services Consumers' Rights 1996 confers the right on consumers to be fully informed:

1. The right to the information that a reasonable consumer in that consumer's circumstances, would expect to receive including –
 - an explanation of his or her condition; and
 - an explanation of the options available including an assessment of the expected risks, side effects, benefits, and costs of each option; and
 - advice of the estimated time within which the service will be provided; and
 - notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
 - any other information required by legal, professional, ethical, and other relevant standards; and
 - the results of tests; and procedures.

This list is not exhaustive and further issues may need to be included. In some circumstances it may be necessary and prudent for providers to also disclose the likely consequences of not having treatment.

Right 7 of the Code of Health and Disability Services Consumers' Rights 1996 confers the right on consumers to make informed choice and give informed consent to receive health and disability services.

Informed consent is a fundamental patient right; it is a two-way communication process which results in the patient feeling confident that they have enough information to agree to undergo a specific medical intervention.

1. Services may only be provided if a consumer has made an informed choice and given consent (some exceptions apply – see Code for details).
2. The Code makes the assumption that every consumer of health and disability services is competent to make an informed choice and give consent, unless there are reasonable grounds for believing that the consumer is not competent.
3. Consumers with diminished competence retain the right to make a choice and give informed consent within their level of competence.
4. Where a consumer is not competent and an entitled person is not available to consent on their behalf the provider can provide services under certain circumstances - see Code for details
5. Consumers can use an advanced directive – see below
6. Informed consent must be in writing if –
 - the consumer is to participate in any research; or
 - the procedure is experimental; or
 - the consumer will be under general anaesthetic; or
 - there is a significant risk of adverse effects on the consumer.
7. Consumers have a right to refuse services or to withdraw consent.
8. Consumers can request who will provide the service and have their preference met where practicable.
9. Consumers have a right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained during the course of a health care procedure.
10. Body part or bodily substance removed or obtained during the course of a health care procedure may be stored, preserved, or used otherwise only in specific circumstances – see Code for details.

Right 8 of the Code of Health and Disability Services Consumers' Rights 1996 states that every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed. Patients need to know that they can ask to have someone to support them during a consultation.

Patients may not remember everything from the verbal discussion so it is worthwhile supporting the consult by written material such as brochures and pamphlets. The information may also be accessed from reputable websites such as: www.healthnavigator.org.nz.

The Medical Council states in [Cole's Medical Practice in New Zealand](#) that the more major the procedure, and the more risks it involves, the more prudent it is to have the patient sign a consent form. In the absence of a signed consent form it is necessary to add an annotation in the patient's clinical record that the patient has consented to the treatment.

Compulsory written informed consent

Informed consent must be in writing if any of the following apply:

- the consumer is to participate in any research; and/or
- the procedure is experimental; and/ or
- the consumer will be under general anaesthetic; and/or
- there is a significant risk of adverse effects on the consumer.

Advance directives

An advance directive is a written or oral directive in which a person makes a choice about possible future health care treatment, and this choice is intended to be effective only when the person is no longer competent. An advance directive may be the result of the advance care planning process. Advance care planning is a voluntary process of discussion and shared planning for future health care between a person and health professionals. The College recognises advance care planning as an important quality of care issue.

Right 7(5) of the Code of Patient Rights provides “every consumer may use an advance directive in accordance with the common law”. Advance directives enable patients to indicate in advance their objection to, or prohibition of, treatment which would otherwise be provided. They may also specify the type of treatment they would wish to undergo should they become incompetent. A “do not resuscitate” (DNR) order is a type of advance directive.

The legal status of an advance directive rests with its validity, which should be established before it is given effect. The legal criteria that an advance directive needs to meet are:

- The person was competent to make the decision, when the decision was made.
- The decision was made free from undue influence.
- The individual was sufficiently informed to make the decision.
- The person intended the directive to apply to the present circumstances.
- The existence and validity of the advance directive must be clearly established.

If a valid advance directive exists, it is legally binding and treatment may either be given or not be given in accordance with the directive. A health practitioner may still refuse to give treatment indicated in the advance directive, including where that treatment is not clinically indicated or otherwise available.

Resources

- [The Code of Health and Disability Services Consumers' Rights 1996](#)
- [Medical Council of New Zealand – Information, choice of treatment and informed consent](#)
- [Ministry of Health, Advance Care Planning: A Guide for the New Zealand health care workforce, Wellington, 2011](#)
- [National Ethics Advisory Committee, Ethical Challenges in Advance Care Planning, Wellington, Ministry of Health, 2014](#)
- [Health and Disability Commissioner, Fact Sheet 1 – Informed consent for consumers who are not competent, 26 September 2013](#)
- [Health and Disability Commissioner, Fact Sheet 2 – “Do Not Resuscitate” \(DNR\) orders, 14 July 2014](#)



INDICATOR 5

The practice acknowledges and is responsive to the special status, health needs and rights of Māori

Criteria	Evidence may include	<input checked="" type="checkbox"/>
5.1 The practice has a documented Māori Health Plan.	<ul style="list-style-type: none"> A practice-specific Māori Health Plan. 	<input type="checkbox"/>
5.2 The general practice team are trained in Te Tiriti o Waitangi/The Treaty of Waitangi including the principles of 'Partnership, Participation and Protection'.	<ul style="list-style-type: none"> Evidence of training in The Treaty of Waitangi principles of 'Partnership, Participation and Protection' by all general practice team members. 	<input type="checkbox"/>
5.3 The practice addresses the health needs of its enrolled and geographic Māori population to reduce health inequalities.	<ul style="list-style-type: none"> Targeted services for the enrolled Māori population are documented. 	<input type="checkbox"/>
5.4 The general practice team can explain how they work in partnership with local Māori organisations, provider groups and whānau.	<ul style="list-style-type: none"> Examples of how the general practice team work in partnership with local Māori organisations, provider groups and whānau. 	<input type="checkbox"/>
5.5 The general practice team makes use of appropriate resources to assist staff to use correct pronunciation of te reo, particularly te reo Māori patient names.	<ul style="list-style-type: none"> Te Reo resources are available for all the general practice team and staff can explain the importance of correct pronunciation of te reo Māori patient names. 	<input type="checkbox"/>

Guidance notes

Te Tiriti o Waitangi is New Zealand's founding document and forms part of New Zealand's constitutional fabric. The College acknowledges the status of the Treaty and its principles of partnership, participation and active protection.



A Māori Health Plan describes how to reduce disparities. The plan must include the practice demographics for Māori. The plan can then be linked to the local District Health Board or other primary health organisation's Māori Health Plan. The Māori Health Plan must state how it will:

- address Māori health priority areas and specific practice population issues for Māori (the Government has identified a range of priority areas in He Korowai Oranga: Māori Health Strategy for improving Māori health and to improve access to appropriate, affordable and acceptable primary health services); and
- implement measures to address priority areas as stated in He Korowai Oranga: Māori Health Strategy; and
- target services for the enrolled Māori population; and ensure ethnicity data on Māori is available and robust; and establish priorities for Māori in the practice and set goals that will benefit their health outcomes; and

- demonstrate that they are making additional efforts to address the needs of Māori. These efforts might include:
 - having specific targets and timelines, e.g. measure statins in Māori versus non-Māori
 - encouraging enrolment of Māori patients on specific programmes such as MOH and DHB programmes in Chronic Care Management
 - identifying any barriers for Māori to access the practice services and addressing these, such as the percentage of Māori enrolled with the practice versus the percentage residing in the practice catchment area.

It is recommended the Plan include:

- The percentage of Māori enrolled with the practice.
- Health status of Māori enrolled with the practice.
- Key linkages (local, regional and national).
- Strategies (both short and long term).
- How progress will be monitored and evaluated.

Resources

- **Māori language resources**
- **Ministry of Health – Māori Health**
- **Ministry of Health. He Korowai Oranga—Māori Health Strategy. Wellington, NZ: Ministry of Health; 2002**
- **Medical Council of New Zealand. Best health outcomes for Māori: Practice implications**
- **The Royal New Zealand College of General Practitioners. Cultural competence—Advice for GPs to create and maintain culturally competent general practices in New Zealand. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2007**
- **RNZCGP Māori Health Strategy**



Maintenance of Professional Standards

- Contribution to the development of the Māori Health Plan can be claimed as a CME practice improvement activity.
- Any training or practice research undertaken is claimable as a CME practice improvement activity.
- Any audits undertaken can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 6

The practice provides services that are responsive to the cultural needs of diverse patient groups

Criteria	Evidence may include	<input checked="" type="checkbox"/>
6.1 The general practice team are trained in cultural competence and cultural safety.	<ul style="list-style-type: none"> Evidence of general practice team training in cultural competence and cultural safety. 	<input type="checkbox"/>
6.2 The practice collects, documents and audits patient ethnicity data consistent with the Health Information Privacy Code 1994 and the MOH Ethnicity Data Protocols for the Health and Disability Sector.	<ul style="list-style-type: none"> The enrolment form correctly records ethnicity data. Audits of ethnicity data from primary health organisations. 	<input type="checkbox"/>
6.3 The general practice team can access interpreters and resources for people with limited English proficiency.	<ul style="list-style-type: none"> List of contact details for interpreter services. 	<input type="checkbox"/>

Guidance notes

The [Health Practitioners Competence Assurance Act 2003](#) (HPCA Act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards.



The population of New Zealand is becoming increasingly more diverse. This has implications not only on the ethnic composition of the practice populations but also the medical workforce. One of the major barriers to culturally appropriate, accessible, safe and equitable health services is the lack of cultural awareness, knowledge and skills of health professionals.

Cultural competency is intended to help general practice staff recognise when issues arise that may lead to miscommunication, and provide tools to help maintain a strong rapport and clear understanding. It is important to realise that simply knowing the information is insufficient; to achieve cultural competence, general practice teams must integrate the knowledge into specific practices and policies that are applied to appropriate settings.

Developing an understanding of cultural competency will allow a general practice to:

- Build strong relationships with patients
- Find out more about the patient and their condition in order to make a more informed diagnosis
- More effectively explain the diagnosis, treatment and what the planned follow-up will be by using a patient centric approach to the consultation
- Improve cultural competence skills on a daily basis by incorporating these skills into daily practice
- Understand each patient's environment and make recommendations that are more realistic and likely to succeed

- Significantly affect numerous patient outcomes, including emotional health, symptom resolution, function, physiologic measures (i.e. blood pressure and blood sugar level) and pain control
- Increase doctor and patient satisfaction
- Enhance continuity of care
- Avoid unintentional offence

Providing quality ethnicity data will ensure the government is able to track health trends by ethnicity and effectively monitor its performance to improve health outcomes and reduce health inequalities. Ethnicity data must not be transferred from another form as it may have been incorrectly collected.

The registration form will include a field to capture ethnicity data. When collecting ethnicity, self-identification must be the process used to identify a patient's ethnic group. It is unacceptable for the collector to guess any patient's ethnicity or to complete the questions on behalf of the patient based on what they perceive to be the respondent's physical appearance.

Ethnicity capture must align with '[Enrolment Requirements for Providers and Primary Health Organisations](#)'. The ethnicity question must be worded and set out exactly as specified in the MOH policy as this is the standard ethnicity question required by the '[Ethnicity Data Protocols for the Health and Disability Sector](#)'. A sample enrolment form is available in the policy including a privacy statement, an explanation of Primary Health Organisations for patient and model answers to frequently asked questions.

Resources

- [The Royal New Zealand College of General Practitioners. Cultural competence—Advice for GPs to create and maintain culturally competent general practices in New Zealand](#)
- [MOH Refugee Handbook 2012](#)
- Medical Council of New Zealand: [Statement on cultural competence](#)
- Medical Council of New Zealand: [Best health outcomes for Māori](#)
- Medical Council of New Zealand: [Best health outcomes for Pacific Peoples: Practice Implications](#)
- Ministry of Health: [Ethnicity Data Protocols for the Health and Disability Sector](#)
- [Cultural and Linguistically Diverse Resources](#)



Maintenance of Professional Standards

- Any training or practice research undertaken is claimable as a cultural competence activity.
- Any audits undertaken can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 7

24-hour health care is accessible to the practice population

Criteria	Evidence may include	<input checked="" type="checkbox"/>
7.1 The practice makes provision for 24-hour health care.	<ul style="list-style-type: none"> ■ Poster/signage; and ■ Patient information brochure/pamphlet; and ■ Contract with after-hours provider (if applicable); and ■ Memorandum of understanding with alternate provider (if applicable). 	<input type="checkbox"/>
7.2 Patients can access the after-hours provider using a maximum of two calls.	<ul style="list-style-type: none"> ■ After-hours telephone message or call diversion to after-hours provider. 	<input type="checkbox"/>

Guidance notes

Patients must be able to access after-hours care, or be directed to the provider when they need it, by using methods that take into account local situations and enable flexibility if the practice does not provide its own 24-hour care. Call diversion and voice messaging must provide explicit information about which service is providing access to care if after-hours care is not provided at the practice. If a practice does not provide after-hours care, it must arrange for medical services to be covered 24 hours a day, 7 days a week.




Patients should be advised of the name, address and contact details of the after-hours provider. Examples include but are not limited to:

- Poster/signage on the front door/window in the event of a patient attending the premises when the practice is closed.
- After-hours message on the answer phone.
- Addition to practice patient information brochure pamphlet.
- Poster in waiting area about after-hours provider.
- Practice website includes information on the after-hours provider.

INDICATOR 8

The practice works with other agencies and community services to provide integrated care

Criteria	Evidence may include	
8.1 The clinical team can demonstrate relationships and linkages with other organisations and community services to coordinate patient care.	<ul style="list-style-type: none"> ■ Directory – electronic/hardcopy; and ■ Other resources such as pamphlets, handout, brochures; and ■ Meeting minutes (if applicable); and ■ Patient records (demonstrating referral/advice). 	<input data-bbox="1283 680 1334 725" type="checkbox"/>

Guidance notes

The general practice team should have a compendium of regional and national health, social and community services applicable for case management and comprehensive care. Opportunities to work collaboratively to provide seamless care for patients depend on understanding what other services are available. Practices should identify where allied services might be available to fill service gaps. These efforts will contribute to improving continuity, reduce variation or disparities within care and contribute to improving the health of populations.



Resources

- Ministry of Health – [The New Zealand Health System](#).



INDICATOR 9

The practice includes patients' input into service planning

Criteria	Evidence may include	<input checked="" type="checkbox"/>
9.1 The practice includes feedback from patients when making decisions about the services provided in the practice.	<ul style="list-style-type: none"> ■ Survey form or other form of collection tool; and ■ Survey methodology; and ■ Survey results; and ■ Evidence of changes made as a result of patient feedback; and ■ Patient newsletters / flyers / posters. 	<input type="checkbox"/>

Guidance notes

The practice should demonstrate it has surveyed patients to capture their experience and to respond to any identified gaps in service provision. This has occurred within the last three years. The survey should reflect a cultural and demographic mix of the practice population.

Consider whether the patients' first language is English. The Better Practice Patient Questionnaire (BPPQ) available from the Royal New Zealand College of General Practitioners and is available in several languages including English, Samoan, Māori, Mandarin and Korean.

Encourage the patients to complete the form before leaving the surgery otherwise it becomes expensive supplying stamped addressed reply envelopes.

Other ways to survey patients may include:

- Focus groups
- Community groups
- Online tool such as [Survey Monkey](#)
- Telephone surveys
- Touch poll

Remember the survey is only part of a suite of useful activities to gain patient feedback. The challenge is to use the information for transformational change within the practice. Not all suggestions may have practical applicability and patients may need to be included in discussions about trade-offs between various elements. A planned approach to improvement ensures a better chance of success.

Resources

- [Consumer engagement – Health Quality and Safety Commission](#)
- [RNZCGP Better Practice Patient Questionnaire](#)

Maintenance of Professional Standards

- 30 BPPQ surveys collected per practitioner can be claimed as an audit activity.
- Patient feedback surveys can be claimed as an AoMP activity as long as at least 30 surveys are collected for the individual practitioner. A patient survey reflection form should be kept as evidence.

SECTION 2

Practice environment and safety

The purpose of this section is to ensure that practice facilities meet the needs and safety of patients and the general practice team, that there is appropriate access for patients and their whānau, and that the privacy of patients is protected.



Guidance notes



Resources

INDICATOR 10

The practice premises are safely accessible and clearly identifiable

Criteria	Evidence may include	<input checked="" type="checkbox"/>
10.1 External signage is clear, visible, well placed and able to be read from a distance.	■ External signage, external lighting.	<input type="checkbox"/>
10.2 People with mobility difficulties are able to access the practice premises.	■ Building design, dedicated disabled car parking.	<input type="checkbox"/>
10.3 The waiting area has specialised seating for patients with mobility difficulties.	■ The number of seating options provided is appropriate to the size and scope of the practice and includes elevated seating with arms.	<input type="checkbox"/>

Guidance notes

External signage must enable a patient or caregiver to readily identify the practice from a distance. This is particularly important in an emergency situation. Types of signage (size, location, height from the ground, sandwich boards, illumination) may be restricted by territorial (regional council) bylaws or the building owner. If the signage is informative it must accurately reflect the capability of the practice to provide the advertised services. For example, it is not acceptable to display opening hours as 9 am to 5 pm and then close over the lunchtime.



Access must not act as a barrier if mobility is compromised due to a permanent or temporary physical disability or illness. Where applicable the practice must have ramps, rails or other structural design that enables patients with mobility difficulties to easily access the premises. This includes patients using mobility aids such as crutches, walking sticks, wheel chairs and mobility frames. New buildings and alterations to existing structures must align with [legislated codes of practice for buildings and associated facilities used by the disabled](#).

Modified seating addresses the special needs of patients who have mobility difficulties. The practice has a range of seating including elevated seating with arms to assist patients with disabilities such as arthritis or orthopaedic problems.

Resources

- [Barrier Free New Zealand Trust](#)
- [Department of Building and Housing—Building Code Compliance Documents](#)
- [Department of Building and Housing and Barrier Free New Zealand Trust. Accessible car parking spaces. Wellington, NZ: Department of Building and Housing; 2008](#)
- [Department of Building and Housing and Barrier Free New Zealand Trust. Accessible reception and service counters. Wellington, NZ: Department of Building and Housing; 2007](#)
- [Standards New Zealand. NZS 4121:2001 Design for access and mobility: Buildings and associated facilities. \(Code of practice for design of access, use of buildings and facilities by disabled persons and others—this applies to new buildings and in some cases alterations to existing buildings\)](#)



INDICATOR 11

The practice facilities meet the comfort, safety and privacy needs of patients

Criteria	Evidence may include	<input checked="" type="checkbox"/>
11.1 The waiting area has adequate space, seating, heating, lighting and ventilation.	■ The waiting area has adequate space, seating, heating, lighting and ventilation.	<input type="checkbox"/>
11.2 Each consultation room has adequate space, seating, ventilation, lighting and task lighting.	■ The consultation rooms have adequate space, seating, ventilation, lighting and task lighting.	<input type="checkbox"/>
11.3 Examination couches are accessible, safe and visually private.	■ Examination couches are accessible, safe and visually private.	<input type="checkbox"/>
11.4 The practice has made provision for patients who require a toilet with mobility access.	■ The practice has a toilet available which provides for patients who require mobility support.	<input type="checkbox"/>

Guidance notes

The waiting area must be large enough to comfortably accommodate patients and whānau. There must be adequate space to manoeuvre wheelchairs, push chairs and walking frames. Patient consultations take place in private areas with visual and auditory privacy. Where treatment beds are separated by curtains, patients must be made aware of alternate options for a more private environment. This may take the form of a poster or notice.



Examination couches must be safe and accessible to all patients particularly the frail and elderly. The beds/plinths/couches are at a comfortable working height with manual or hydraulic mechanisms or steps to enhance access. Ensure portable steps are safe and stable and are not hazards to the visually impaired. The accessible toilet must be available within the same premise as the practice, in close proximity on the same floor or easily accessible by lift. Patient safety, privacy, and the convenience and accessibility of the alternative site will be high priority.

Access for people with disabilities is part of a safe and convenient environment for everyone. The accessible toilet must be available within the practice, or in close proximity to the practice (on the same floor) or easily accessible by lift. Alternative sites will be considered on a case-by-case basis for accreditation.


Resources

- Barrier Free New Zealand Trust
- Department of Building and Housing – Building Code Compliance Documents
- Department of Building and Housing and Barrier Free New Zealand Trust. Accessible car parking spaces. Wellington, NZ: Department of Building and Housing; 2008
- Department of Building and Housing and Barrier Free New Zealand Trust. Accessible reception and service counters. Wellington, NZ: Department of Building and Housing; 2007
- Standards New Zealand. NZS 4121:2001 Design for access and mobility: Buildings and associated facilities. (Code of practice for design of access, use of buildings and facilities by disabled persons and others – this applies to new buildings and in some cases alterations to existing buildings)



INDICATOR 12

The practice uses a Practice Management System

Criteria	Evidence may include	
12.1 All clinical information generated in the practice is recorded electronically.	<ul style="list-style-type: none"> ■ A practice management system (electronic). ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
12.2 The practice can demonstrate implementation of its policy for security of electronic health information.	<ul style="list-style-type: none"> ■ The practice policy for security of information is provided and explained; and ■ Records of back-ups occurring. 	<input type="checkbox"/>
12.3 The practice has a reliable backup and retrieval system to protect electronic patient information.	<ul style="list-style-type: none"> ■ There is a process for restore from back-up. 	<input type="checkbox"/>

Guidance notes

Electronic records are essential for managing and auditing patient information. Continuity of care requires that information is robust and available when needed so that practice teams can manage and track conditions. Effective electronic data is up to date, readily accessible and safely stored.



Files are secure or password protected from unauthorised access, unless in active use by a practice team member. The electronic Patient Management System should be secure. The longer the password the better – use a mixture of upper and lower case letters mixed with numbers and special characters. Passwords are not shared.

Terminals and personal computers are positioned so the screen cannot be seen by unauthorised personnel. Password protected screensavers or automated security applications are used when computers are left unattended. The practice has (as a minimum) a system to backup essential electronic data on a daily basis (if not in real time).

Resources

- [Health \(Retention of Health Information\) Regulations 1996](#)
- [The Health Information Privacy Code 1994](#) (including commentary)
- Medical Council of New Zealand. [The maintenance and retention of patient records \(2005\); Statement on use of the internet and electronic communication \(2006\); Information choice of treatment and informed consent \(2011\)](#)
- The Privacy Commissioner. [On the record: A practical guide to health information privacy](#)
- [HISO 10029 Health Information Security Framework](#)
- Standards New Zealand. [SNZ PAS 8170:2005 Primary Health Care Practice Management Systems: Publicly Available Specification](#)



INDICATOR 13

The practice prevents unauthorised access to controlled drugs

Criteria	Evidence may include	<input checked="" type="checkbox"/>
13.1 Controlled drugs are stored in accordance with the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977.	<ul style="list-style-type: none"> ■ Controlled drug safe; and ■ Controlled drug register (consecutively numbered and balanced). 	<input type="checkbox"/>

Guidance notes

Storage – Regulation 28 – Controlled drugs not for immediate use:

- a. Keep it in a locked cupboard, or a locked compartment, that is constructed of metal or concrete or both, and that, in the case of a cupboard or compartment installed in a building after the commencement of these regulations, is of an approved type; and
- b. Ensure that the cupboard or compartment is securely fixed to, or is part of, the building, ship, aircraft, or vehicle within which the controlled drug is kept for the time being; and
- c. Ensure that the key of the cupboard or compartment is kept in a safe place when not in use. Where the building, ship, aircraft, or vehicle within which the controlled drug is kept for the time being is left unattended, that safe place shall not be within the building, ship, aircraft, or vehicle.



Register – Regulation 37: Every person who is licensed to deal in or to possess controlled drugs shall keep, in any premises at which he is licensed to deal in or possess controlled drugs, a Controlled Drugs Register in Form 1 in Schedule 1 to these Regulations in the manner required by regulation 37(2)(a) of these Regulations.

Controlled drugs registers have the following characteristics: bound volume; and each page is numbered consecutively; and each page identifies one form of controlled drug; and entries must be made no later than the ordinary business day following the day of the transaction. Balances shall be undertaken on the last working day of June and December each year and at the time of obtaining new stock. Entries should be legible, indelible and in the format specified in the Regulations.

Resources

- [Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977](#)
- Medical Council of New Zealand. [Good prescribing practice \(2010\)](#)
- [The Medicines Act 1981](#) and [Medicines Regulations 1984](#)
- [Approved register for controlled drugs.](#)



INDICATOR 14

There is safe storage and disposal of health care waste

Criteria	Evidence may include	<input checked="" type="checkbox"/>
14.1 Practice waste is correctly categorised, safely stored, collected and disposed of in accordance with the industry standard NZS 4304:2002.	<ul style="list-style-type: none"> ■ Waste management policy; and ■ Waste collection units; and ■ Waste storage area; and ■ Method of waste disposal. 	<input type="checkbox"/>
14.2 In all areas where sharps are used, the practice has puncture resistant sharps containers that are out of reach of children, and that display a biohazard symbol in accordance with NZS 4304:2002	<ul style="list-style-type: none"> ■ Sharps containers located out of reach of children, and marked in accordance with NZS 4304:2002. 	<input type="checkbox"/>

Guidance notes



New Zealand Standard NZS 4304:2002 details how health care waste is managed. To ensure compliance, practices should obtain a copy from Standards New Zealand. The essentials are summarised here but the Standard should be consulted for detail. Management of some hazardous waste will require reference to other sources (e.g. National Radiation Laboratory Code or controls under the HSNO Act).

Health care waste refers to all waste generated by a health care facility and includes 'non-hazardous', 'controller' and hazardous' waste. Non-hazardous waste constitutes the bulk of waste generated and is managed in the same way as household waste.

Hazardous waste requires proper handling, storage, transport and disposal to minimise risk to personnel, the public and the environment, and to prevent causing cultural or aesthetic offence.

A fundamental principle of waste management is the minimisation of waste.

Hazardous waste

This is initially classified as either sharps or non-sharps waste.

Sharps waste is categorised as radioactive, cytotoxic or infectious and is subject to controls for both sharps and the appropriate hazardous waste.

Non-sharps waste is categorised as infectious (including body parts), radioactive, cytotoxic or other (e.g. solvents, chemicals, pharmaceuticals).

Controlled waste

This includes waste that is recognisable as coming from a health care facility and that is contaminated with body fluids (that cannot be expressed) or may be aesthetically offensive. It includes intravenous tubing, catheters, cannulas, empty syringes (no needles), disposable sheeting, disposable scopes, used dressings, disposable gloves or other surgical garments.

Non-hazardous waste

Categorised as recyclable (paper, glass, plastics, metal) or general waste (solid or liquid).

Segregation

Waste must be segregated according to its category at the time and place it is generated, and then be bagged, packaged or containerised as appropriate.

Sharps must be placed in sharps containers.

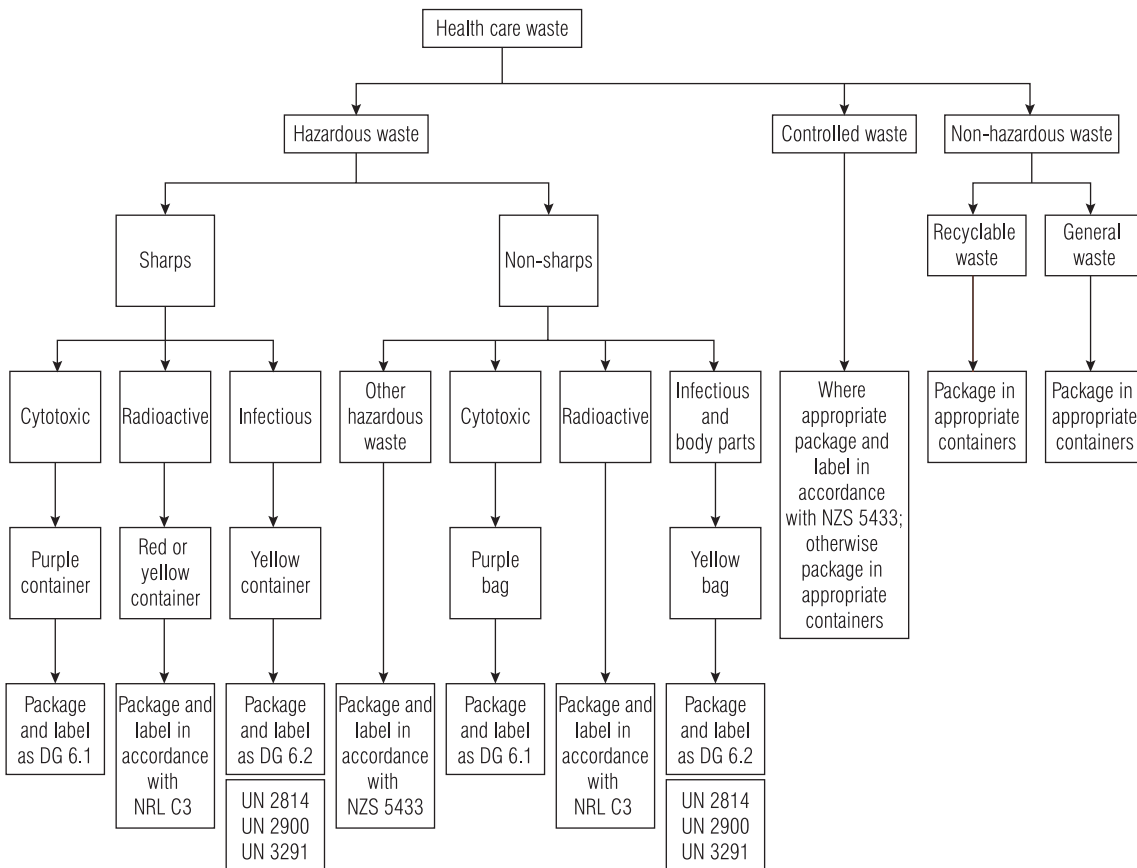
Hazardous waste requiring refrigeration must be stored in a dedicated refrigerator.

Radioactive waste must be segregated and stored in accordance with the National Radiation Laboratory Code of Safe Practice.

Containers and packaging

Figure 2 shows the appropriate containers for packaging different categories of health care waste.

Figure 2. Segregation and packaging process



Bags

Bags for the collection and storage of waste other than sharps must

- have sufficient strength to contain waste
- comply with NZS 7603 (for plastic bags)
- conform to the colour coding and marking system (in Figure 2)
- be filled to not more than two-thirds of their capacity

- allow for the secure final closure when two-thirds full
- be secured with closure devices that do not have sharp protuberances (e.g. staples).
- Paper bags must not be used for hazardous waste.

Sharp containers

These must meet the requirements in AS/NZS 4261 (Reusable containers for the collection of sharp items used in human and animal medical applications).

Sharps containers should be in place in all clinical and treatment areas or where any hazardous waste may be generated such as sluice/sterilising rooms. The disposal of sharps is the responsibility of the person generating the sharps. Used sharps should be disposed of directly after use not left on work surfaces. Needles should never be bent, broken or recapped. Fill containers to the designated level only. When full, securely attach the well-fitting lid and dispose of through a licensed operator. These measures reduce the risk of inadvertent needle stick injuries. Holders for the biohazard containers should preferably be wall mounted at chest height, out of doorways and high traffic areas. Loose biohazard containers (not wall mounted) in current use, should not be left on the floor, on trolley tops, on consultation desks or on any surface within easy reach of children.

Rigid-walled containers

Reusable rigid-walled containers (e.g. mobile garbage bins) should be resistant to leakage, impact rupture and corrosion and should be inspected after each use to ensure they are intact.

Packaging and labelling for transport

Hazardous and controller waste must be packaged, labelled and documented for transport in accordance with NZS 5433 (Transport of dangerous goods on land).

Health care waste storage

Hazardous and controlled waste must be stored in designated areas and must not be left unattended at road-side or other area where the public may have unsupervised access.

The storage areas must be sufficient to maintain segregation of waste and separation from other stored materials. It must:

- be secure
- be vermin-proof and easily cleaned, with walls and floors of impervious material and floors bunded or graded to a valved sewer outlet
- have adequate access and space for movement
- have adequate lighting so it can be effectively cleaned and information on containers and documents easily read
- have adequate ventilation to remove odours and exhaust vents must prevent exhaust entering buildings or public areas
- be identified with signs appropriate to the categories of waste stored
- must have ready access to materials for managing spills, suitable protective clothing and handwashing facilities.

Each regional council will have its own bylaws and regulations with regard to waste disposal, which practices must be cognisant of and comply with.

Resources

- [Standards New Zealand. NZS 4304:2002 Management of Health care Waste](#)



INDICATOR 15

The practice ensures effective infection control to protect the safety of patients and general practice team members

Criteria	Evidence may include	<input checked="" type="checkbox"/>
15.1 The practice has infection control policies and procedures that align with the AS/NZS 4815: 2006 Standard.	<ul style="list-style-type: none"> ■ Infection control policy; and ■ Copy of AS/NZS 4815:2006 standards. 	<input type="checkbox"/>
15.2 General practice team members responsible for managing infection control have received sterilisation and disinfection training, within the last three years.	<ul style="list-style-type: none"> ■ Infection control training records – name of provider, date of delivery, names/certificates or persons attending. 	<input type="checkbox"/>
15.3 The practice can demonstrate how it monitors the effectiveness of each sterilisation cycle.	<ul style="list-style-type: none"> ■ Sterilisation documentation. ■ Records of effective sterilisation cycles. 	<input type="checkbox"/>
15.4 A current calibration and validation record is available for the steriliser.	<ul style="list-style-type: none"> ■ Calibration and validation records. 	<input type="checkbox"/>

Guidance notes

General practices frequently undertake invasive procedures such as minor surgery, and there are emerging antimicrobial resistant organisms and blood-borne viral infections. It is important to provide a safe environment for staff, patients and other people in the practice. To ensure this, all team members should be equipped with the requisite knowledge, skills and attitudes required for good infection control practices.



The infection control policy should include but is not limited to:

- Facilities, equipment, and procedures necessary to implement standard and additional (transmission based) precautions for control of infections.
- Cleaning, disinfecting and reprocessing of reusable equipment.
- Cleaning schedule for the practice premises.
- Waste management.
- Special situations, e.g. influenza epidemics, norovirus, H1N1.
- Staff immunity and infections.
- Hand hygiene.
- Prevention and management of infection by service providers.
- Antimicrobial usage.
- Single-use items.
- Management of occupational exposure to blood and body fluids.
- Cleaning, decontamination, disinfection and sterilisation of instruments and equipment wound management.
- Linen services.
- Venepuncture.
- Cryotherapy.
- Cleaning and servicing of the steriliser.

Resources

- Ministry of Business, Innovation & Employment. [An introduction to Employers' Rights and Responsibilities under the Health and Safety in Employment Act; 2003](#)
- Hazardous Substances and New Organisms Act 1996
- Health and Safety in Employment Act 1992
- Standards New Zealand. [AS/NZS 4815:2006 Office-based health care facilities—Reprocessing of reusable medical and surgical instruments and equipment and maintenance of the associated environment](#)
- Standards New Zealand. [NZS 4304:2002 Management of Health Care Waste](#)
- Infection Prevention and Control
- Hand Hygiene NZ



Maintenance of Professional Standards

- Any training or practice research undertaken is claimable as a CME practice improvement activity.



INDICATOR 16

The practice stores vaccines and maintains the Cold Chain in line with national guidelines

Criteria	Evidence may include	<input checked="" type="checkbox"/>
16.1 The practice has Cold Chain Accreditation in accordance with the MOH protocol.	<ul style="list-style-type: none"> ■ Cold Chain Certificate; and ■ Records of cold chain temperature monitoring. 	<input type="checkbox"/>

Guidance notes

Cold Chain Accreditation (CCA) is a process that allows providers of immunisation to demonstrate their management of vaccine storage in accordance with existing national cold chain standards. The CCA process aims to minimise the levels of vaccine wastage and ensures the provision of effective vaccines for the National Immunisation Schedule Vaccines. Compliance with cold chain standards will be demonstrated through a practice/provider self-assessment followed by a review by a local Immunisation Facilitator/Coordinator. Cold Chain Accreditation will be valid for up to three years, based on the assessor's findings.



Resources

- [Immunisation Advisory Centre.](#)
- [Medicines Act 1981](#)
- [Ministry of Health. Immunisation Handbook 2014. Wellington, NZ: Ministry of Health; 2014](#) – (includes cold chain accreditation information)
- [The Centre for Adverse Reactions Monitoring \(CARM\)](#)
- [Cold Chain Management.](#) Ministry of Health.



INDICATOR 17

Medical equipment and resources are available and maintained

Criteria	Evidence may include	<input checked="" type="checkbox"/>
17.1 The practice has all the medical equipment and medicines as listed in Appendix 1.	<ul style="list-style-type: none"> ■ Medical equipment and medicines are available. 	<input type="checkbox"/>
17.2 At least one set of emergency equipment and medicines are easily accessible in a single location.	<ul style="list-style-type: none"> ■ Emergency equipment is centralised to one location in the case of an emergency. 	<input type="checkbox"/>
17.3 There is a process to check and maintain all emergency equipment, medicines and impress items, including portable clinical/emergency kits, to ensure availability and expiry dates.	<ul style="list-style-type: none"> ■ Documented process for the checking and maintenance of all emergency equipment, medicines and impress items. 	<input type="checkbox"/>
17.4 Medical equipment, medicines and pharmaceutical products are stored so that they are not accessible to unauthorised people.	<ul style="list-style-type: none"> ■ Medical equipment, medicines and pharmaceutical products are stored so that they are not accessible to unauthorised people. 	<input type="checkbox"/>
17.5 There is an audit trail to monitor the servicing of all medical equipment according to Electrical (Safety) Regulations 2010 Clause 60 & 91 and relevant standards (AS/NZS 3000;3003;3551), maintenance and operating instructions.	<ul style="list-style-type: none"> ■ Treatment or consulting rooms with medical electrical appliances are certified as 'Body Protected Areas' in accordance with AS/NZS 3003. ■ Documented record of servicing, which may include <ul style="list-style-type: none"> – Evidence that equipment has been tested/serviced by way of annual tagging equipment by the service company. – Annual electromedical testing documents. – Records of calibration. 	<input type="checkbox"/>
17.6 Residual Current Devices (RCDs) are used to protect patients and members of the practice team in accordance with the Electrical (Safety) Regulations 2010.	<ul style="list-style-type: none"> ■ Documented record of assessment by an authorised person in accordance with AS/NZS3003; and ■ RCDs must be medical grade 10 mA. 	<input type="checkbox"/>

Guidance notes



All medical equipment and resources must be suitable for supporting comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered.

All essential medical equipment and resources must be available when needed, and members of the practice team must know how to use the equipment. Equipment must be calibrated as required, in working order and have current expiry dates for servicing.

The adequacy and appropriateness of basic equipment is determined by the circumstances of the practice and any omissions must be able to be justified by the practice.

If a defibrillator is available in the practice, clinical team members have been trained in its use. If an electrocardiograph is available in the practice, appropriate clinical team members should be trained in rhythm recognition and general practice team members should add this to the training record.

The Medicines Act 1981 – Section 47 states:

Storage and delivery of medicines

1. No person who is in possession or charge of any prescription medicine or restricted medicine shall put it—
 - (a) in any cupboard, box, shelf, or other place of storage in which articles of food or drink are stored or kept for ready use; or
 - (b) in any place to which young children or unauthorised persons have ready access.
2. No person shall pack any medicine, or prepare it for use, in any room, or on any table or bench, that is used for the purpose of packing, preparing, or consuming any food or drink.
3. Except as otherwise provided in any regulations made under this Act, no person who is in possession, for the purposes of any business, of a prescription medicine or a restricted medicine that is kept for the time being within any building or vehicle shall leave that building or vehicle unattended, unless he has taken all reasonable steps to secure that building or vehicle, or the part of it in which the medicine is kept, against unlawful entry.

Medical equipment testing and servicing

Medical equipment must be inspected, tested and serviced in accordance with the Electricity Act 1992 and Electricity (Safety) Regulations 2010, other relevant standards and the manufacturer's operating instructions.

The practice should hold:

- a register of the medical equipment with a schedule and reminder process to ensure it is safe and in working order
- a copy of the annual medical equipment servicing report.

Body Protected Area

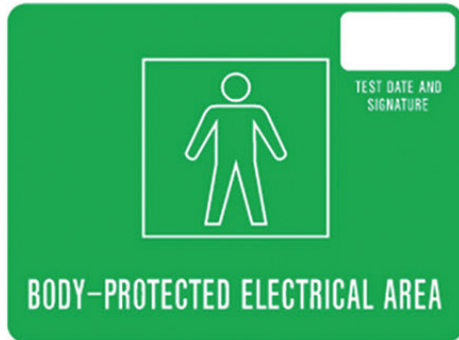
Any area within a medical facility where patients are treated, diagnosed or monitored using medical electrical appliances must be classed as a Body Protected Area. This almost always includes treatment or procedure rooms, and may include consulting rooms where medical electrical appliances are used. Some larger facilities may have other specialised areas that need to be Body Protected, such as an X-ray room or a plaster room.

The specific requirements for Body Protected Areas are described in a joint Australian/New Zealand standard AS/NZS3003. The Electricity Safety Regulations 2010 require that all medical facilities be compliant with this standard as a means of ensuring patient safety.

What are the key features of a Body Protected Area?

There are several requirements, but the important ones are:

- All socket outlets must be protected by medical grade 10mA RCDs. The RCDs must be within the Body Protected Area they service, they can't be in another room or on the switchboard.
- The area must be designated by a green Body Protected Area sign on the wall as below:



The sign is of a specified size, must be located in a visible location at a height of 2000 mm from the floor to the top of the sign. The area to the top right of the sign gives the test date and signature of the certifying person. The certification is current for 12 months from the test date.

- All appliances used within the area (both medical appliances and general appliances) must be tested to the AS/NZS3551 standard.
- At least one socket outlet shall be provided for cleaning equipment and shall be marked 'Cleaning Purposes Only'. In some cases this can be outside the Body Protected Area.
- The area must be certified annually to the requirements of AS/NZS3003.

How often must a Body Protected Area be recertified?

A Body Protected Area must be recertified every 12 months. This involves checking that all the switch socket outlets and other electrical fittings and fixtures are in good condition, and that the RCDs trip at the correct current and within the correct timeframe. Part of the check ensures that all required labels markings and indicators are in place.

Our treatment room is not currently a Body Protected Area. What do we need to do?

There are a number of approaches to this, but for most existing buildings it is possible to establish a Body Protected Area to comply with the standard relatively easily. In many cases it is just a case of replacing the standard socket outlets with outlets that incorporate a built-in RCD of the correct type.

In a new building the entire Body Protected Area could be protected by one RCD, but for existing buildings this might require substantial rewiring and the cost of using multiple RCDs will be less. There is of course the consideration of ongoing costs as each RCD will need to be individually tested on an annual basis. Your electrician can advise you on the best approach for your building. Once the RCDs are installed, a green Body Protected Area sign is placed on the wall and a label is affixed to it to indicate that the area has been tested and is compliant.

Who can install RCDs or undertake other work required for a Body Protected Area?

This work can only be undertaken by a Registered Electrician. Some electricians will be more experienced with the requirements for Body Protected Areas than others.

Who can certify a Body Protected Area?

The inspection and testing requirements for Body Protected Areas have been formulated so as an electrician's licence is not required, however it is essential that the person undertaking the

tests has a comprehensive knowledge of the requirements of AS/NZS3003. Usually this means the person who undertakes testing will be a qualified biomedical technician or engineer, or a registered electrician with experience of medical locations.

Under what circumstances can medical electrical appliances be used outside a Body Protected Area?

1. In an emergency where a patient's life or safety is at risk. For example when an ECG is taken after a patient has collapsed.
2. In situations where it is known that treatment will be required outside a Body Protected Area, a portable or built-in RCD may be used. For example a therapeutic ultrasound used for sports medicine. Ideally battery operated equipment should be utilised in such situations wherever possible.

We have a computer in our treatment room. Does this need to be tested for electrical safety?

Yes to does. Any mains powered electrical appliance within the designated Body Protected Area must be routinely tested to AS/NZS3551. This includes non-medical appliances such as computers, radios and electric fans.

Resources

- AEDs in your community
- PRIME National Standards 2008
- Electrical (Safety) Regulations 2010 Clause 60
- Electrical (Safety) Regulations 2010 Clause 91
- AS/NZS 3000:2007 Electrical installations (known as the Australian/New Zealand Wiring Rules)
- AS/NZS 3003:2011 Electrical installations - Patient areas
- AS/NZS 3551: 2012 Technical management programs for medical devices and Amendment 1: 2005
- Electrical safety regulations 2010
- Standards New Zealand. AS/NZS 2500: 2004 Guide to the safe use of electricity in patient care
- Requirements for General Practice Medical Centres



INDICATOR 18

The practice has planned response and procedures for fires, disasters or emergencies

Criteria	Evidence may include	<input checked="" type="checkbox"/>
18.1 The practice has an Evacuation Scheme in accordance with the Fire Safety and Evacuation of Buildings Regulations 2006.	<ul style="list-style-type: none"> ■ Documented evacuation scheme; and ■ Portable fire extinguisher approved by the fire service. 	<input type="checkbox"/>

Guidance notes

The Fire Service Act 1975 requires a building owner providing nursing, medical or geriatric care to have an evacuation scheme approved by the National Commander of the Fire Service – see [Section 21B\(1\)](#); [Section 21A\(1\)\(f\)](#); [Section 21C](#).



Exemption from an evacuation scheme: Where a building is providing employment for 10 or more persons **and** it has an automated sprinkler system as defined in the Act, the building owner can apply for an exemption to have an evacuation scheme – see [Section 21B\(2\)](#); [Section 21E](#).

Clause 17 of the Fire and Safety Evacuation of Buildings Regulations 2006 outlines the requirements of an evacuation scheme.

It is the responsibility of the building owner to take fire safety precautions in their building including fire evacuation procedures. The owner must maintain a means of escape from fire for the building so as to ensure that:

- they are kept clear of obstacles at all times; and
- their exit doors are not locked, barred, or blocked so as to prevent any building occupants from leaving the building; and
- their smoke-control and fire-stop doors are not kept open other than in a way that complies with the building code; and
- their stairways and passageways are not used for storage or accumulation of waste.

The owner must have a procedure in place to:

- evacuate building occupants safely, promptly and efficiently in the event of a fire; and
- enable the occupants to evacuate to a place of safety so that the occupants can be accounted for; and
- erect signs and notices at appropriate places within the building that clearly display the evacuation procedure
- inform the occupants about the:
 - route of travel to the place of safety
 - fire alarm signals used or available
 - any firefighting equipment available for use.

Resources

- [Fire Service Act 1975](#)
- [Fire and Safety Evacuation of Buildings Regulations 2006](#)
- [Evacuation Scheme Clause 17](#)
- [The Ministry of Health's website](#) has access to information, resources and the Regional Primary Care Emergency Planning Coordinators
- Ministry of Health. [National Health Emergency Plan](#). Wellington, NZ: Ministry of Health; 2008
- Ministry for the Environment. [Climate change impacts in New Zealand](#)
- [New Zealand Fire Service Evacuation Scheme](#)
- Ministry of Health. [New Zealand Influenza Pandemic Plan: A framework for action](#). Wellington, NZ: Ministry of Health; 2010
- Ministry of Health. [Infection prevention and control during an influenza pandemic](#). Wellington, NZ: Ministry of Health; 2006



INDICATOR 19

The practice team is committed to ensuring health and safety in the workplace

Criteria	Evidence may include	<input checked="" type="checkbox"/>
19.1 The general practice team is able to demonstrate how they comply with the Health and Safety at Work Act 2015	<ul style="list-style-type: none"> ■ Hazard register; and ■ Incident register; and ■ Health and safety policies and processes. 	<input type="checkbox"/>
19.2 The practice has a designated Health and Safety Officer responsible for the Health and Safety at Work Act 2015.	<ul style="list-style-type: none"> ■ There is a Health and Safety Officer. ■ They can describe their role and responsibilities. ■ Position description. 	<input type="checkbox"/>

Guidance notes

On 4 April 2016, the Health and Safety at Work Act 2015 (HSWA) came into force. It is part of reforms introduced to reduce work-related injuries and deaths by at least 25 percent by 2020.

These mark a shift of focus, from monitoring and recording incidents to identifying and managing risk.

This does not necessarily mean major changes to how you operate. It establishes a duty for a practice to consider the health and safety of workers, contractors, patients, and visitors. Practices must identify health and safety risks that could cause them harm and act to eliminate or minimise them.

Most practices already do this. In summary your practice must identify and manage health and safety risks, make sure staff are informed, and give staff the opportunity to participate in health and safety.

For more see *Worksafe NZ: Health and Safety at Work Act 2015* and *Knowing the risks in your sector: Health services*.

Key components of an effective health and safety system

Start by documenting all health and safety policies and processes, and communicate them to staff. All documentation should reflect the Health and Safety at Work Act 2015. You should review and update health and safety policies, procedures and forms at least once a year. Let staff contribute to the health and safety review, including ongoing development and improvements.

Health and Safety leadership

Under the law, your practice has a primary duty of care to ensure the safety of workers and anyone affected by your work.

Good health and safety requires good leadership. It is vital that company partners and directors (as officers) use due diligence, and ensure their business is managing health and safety risks effectively.

PCBU

A PCBU is a 'person conducting a business or undertaking'. The PCBU may be a specific person, or the organisation. It may be a sole trader.

In most cases, the PCBU is an organisation (in our context, the practice). The PCBU has primary responsibility for workplace safety.

General practices will have different ownership/management models, which will affect where this responsibility lies. You should take time to work out where this responsibility lies. The HSWA does not define the terms 'business' and 'undertaking,' but broadly:

- 'Business' refers to any activity for profit or gain
- 'Undertaking': refers to non-commercial activity.

For more information on PCBU, see [Worksafe NZ: What is a PCBU?](#)

Key term

PCBU: person (or company) conducting a business or undertaking

Officers

Anyone in a senior leadership position or with significant influence on the management of a PCBU is an officer. Organisations usually have more than one officer.

Officers include:

- company directors
- any partner in a partnership (other than a limited partnership)
- any general partner in a limited partnership
- someone comparable to a director in a body corporate or an unincorporated body
- anyone who influences management of the PCBU (e.g. the Chief Executive).

The following people are not officers:

- health and safety managers
- team leaders, line managers and supervisors
- workplace health and safety officers and advisors
- people whose job title includes 'officer', such as Corrections Officer, Police Officer or Administration Officer.

Every officer has a duty – it is not a joint duty.

Officers have a duty because they make policy and investment decisions that can affect workers' health and safety. People in senior leadership positions have an important role in leading health and safety culture throughout a PCBU.

An 'Officer' under the Act is distinct from a Health and Safety Officer. This person helps the practice team understand how to meet regulatory requirements. Details should be in their employment agreement.

Due diligence

Officers must exercise due diligence to make sure that the PCBU meets its legal obligations. They must use reasonable care to avoid harm to people or their property.

Due diligence includes taking reasonable steps to:

- a. stay up to date on health and safety matters
- b. understand their business and the hazards and risks associated with its operations
- c. make resources available to eliminate or minimise risks to health and safety
- d. make sure there are processes to track and respond to incidents, hazards, and risks, and
- e. make sure processes comply the Act.

The primary duty of care

As far as *reasonably practicable*, a PCBU must ensure there is no risk to staff (and others) health and safety. This is the 'primary duty of care'.

Reasonably practicable means you don't have to do everything humanly possible; you do what is suitable in the circumstances to first try to eliminate the risk. If the risk can't be eliminated, then you minimise it.

Key term

Reasonably practicable

You don't have to do everything humanly possible; you do what is suitable in the circumstances to first try to eliminate the risk. If the risk can't be eliminated, then you minimise it

Specific obligations

The primary duty of care includes:

- providing and maintaining a work environment without risk to health and safety
- providing and maintaining safe plant and structures
- providing and maintaining safe systems of work
- ensuring the safe use, handling and storage of plant, structures and substances
- providing facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities e.g. toilets, changing rooms, first aid facilities
- providing information, training, instruction, and supervision to protect people from risks while working
- monitoring health and safety to prevent injury or illness.

Working together on Health and Safety

Everyone in a practice has a role in managing health and safety. The practice team should contribute to solutions that are appropriate for your practice. Rather than prescribing specific systems, the new law is flexible and allows for innovation: what is most important is that actions are effective.

It's about doing what is 'reasonably practicable' and proportional; balancing the level of risk, the likelihood of an incident happening, the impact on people, and how much influence or control the PCBU has to manage it.

Staff will know where the health and safety pressure points are. They can suggest practical, cost-effective solutions, and are more likely to make them happen when they are involved.

Worker Engagement and Participation

The duties of engagement and participation involve a conversation about health and safety.

Engagement is how a business involves its workers in decisions.

Participation involves enabling staff to raise health and safety concerns, be part of decisions, and offer suggestions. Consider having health and safety as an agenda item for regular staff meetings, offering regular training, and creating a suggestion book/board, etc.

The Act provides some flexibility for you and your practice to decide what participation and engagement practises work best for your size, risk and staff. Encourage staff to contribute to improvements by raising issues, generating ideas, and participating in the development, implementation, monitoring and review of systems.

However, on a specific health or safety matter, the PCBU only needs to engage with the staff affected.

You should document how you will:

1. take into account staff views on health and safety matters, and
2. enable staff to suggest improvements or raise concerns.

You may not need an elected health and safety representative (HSR). These are only required if you have 20 or more staff (or work in high-risk sector or industry).

See Work Safe NZ [Worker Engagement Participation and Representation Good Practice Guidelines](#).

Engage with staff:

- When you identify and assess hazards
- On decisions about:
 - addressing risks
 - staff welfare facilities
 - monitoring health and workplace conditions
 - staff training and communication
 - work health or safety procedures
- When determining work groups
- On any change that affects health and safety
- Developing worker participation practices (i.e. ways for workers to participate in improving work health or safety on a day-to-day basis).

Managing hazards and risks in your practice

There are risky things in all practices big or small. The first step in managing health and safety is to identify these hazards in your practice and assess the likelihood or risk of them causing a serious injury or illness.

You will need to write hazards and risks down in a hazard/risk register. Try focusing on your people when you are looking for hazards/risks - you're simply looking for all the things that could hurt the people that come into your practice.

This register should list all hazards to staff, visitors, patients and contractors along with a rating for the risk of each hazard and how you plan to control and manage them. To help you, use tables like Worksafe NZ's [Risk Rating Table](#).

A common question is what the difference between a hazard and a risk is. A hazard is anything that can cause harm, like a hazardous substance, equipment, fatigue, repetitive movements on the computer, bullying, and so on. A risk is the likelihood that death, injury or illness might occur

when exposed to a hazard. So for each hazard think about how likely it is to occur and write that down in your register.

What you must do:

- **identify the hazards** in all work areas in your practice
- regularly review your accident and incident register to work out the hazards that cause harm
- **involve your staff** in identifying hazards and risks
- reassess when there are new hazards or processes (for example when you introduce a new piece of equipment or work process).

Incidents

You will need to go further than just writing hazards down. Incidents and near misses are a fact of life in any business and staff should be encouraged to report any incident (or near miss) so that you can all learn and improve health and safety in your practice. These then need to be recorded, investigated and followed up. Write down any details and findings in an incident register, and any follow up required.

Some major incidents and accidents will require you to notify Worksafe NZ. See their website for more information on **notifiable events** and familiarise yourself with any requirements for notifying these.

Resources

- [WorkSafe New Zealand website](#)
- [WorkSafe New Zealand HSWA Guidance](#)
- [HSWA terms and definitions](#)
- [Health and Safety at Work \(General Risk and Workplace Management\) Regulations 2016](#)
- [Health and Safety at Work \(Worker Engagement, Participation, and Representation\) Regulations 2016](#)
- [Health and Safety Leadership: A guide for small to medium business owners and company directors](#)
- [Employers and Manufacturers Association](#)
- [WorkSafe New Zealand: Emergency procedures](#)
- [Environmental Protection Agency: Emergency Procedures](#)
- [Information for schools and ECE services, but with useful factsheets: Ministry of Education: Health and safety system for schools and ECE services](#)
- [MinterEllisonRuddWatts: Health and Safety Toolkit](#)



SECTION 3

Clinical effectiveness

The purpose of this section is to ensure that there are structures to support and maintain safe, comprehensive and effective care for patients and manage in continuity, coordination and integration of care across health and community interfaces.



Guidance notes



Resources

INDICATOR 20

Continuity of care is facilitated by registration of new patients and timely transfer of medical records

Criteria	Evidence may include	<input checked="" type="checkbox"/>
20.1 There is a patient registration process that collects demographic and essential health information.	<ul style="list-style-type: none"> ■ Registration or enrolment form (including new patient medical questionnaire). ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
20.2 There is an effective and timely system that enables medical records to be obtained and transferred between practices within 10 working days.	<ul style="list-style-type: none"> ■ Electronic or hardcopy record to track the retrieval and/or transfer of medical records. 	<input type="checkbox"/>
20.3 There is a system to manage tracking and retrieval of medical records to, from, and within the practice.	<ul style="list-style-type: none"> ■ Electronic or hardcopy record to track receipt of medical records. 	<input type="checkbox"/>

Guidance notes

The practice has a process to collect personal and health information at the time of registration.

The clinical condition of the patient may affect their ability to provide all the relevant information at the time of registration particularly a full medical history. The practice is advised to have a system to identify these patients to enable staff to complete the capture of the information at another consultation. Staff who have the authority to enter the data in clinical records must use a standardised approach to where information will be entered in the electronic patient record.

The ethnicity question must be worded and set out exactly as specified in the MOH policy as this is the standard ethnicity question required by the 'Ethnicity Data Protocols for the Health and Disability Sector'.

A sample enrolment form is available in the MOH policy including a privacy statement, an explanation of Primary Health Organisations for patient and model answers to frequently asked questions.

Collection should comply with the [Health Information Privacy Code 1994](#) particularly Rule 3 and 4.

Rule 3: Collection of Health Information from Individuals. The individual must be aware of:

- the fact the information is being collected;
- the purpose for which the information is being collected;
- the intended recipients of the information;
- the name and address of the health agency that is collecting the information; and the agency that will hold the information;
- whether or not the supply of the information is voluntary or mandatory and if mandatory the particular law under which it is required;

- the consequences (if any) for that individual if all or part of the requested information is not provided; and
- the rights of access to, and correction of, health information provided by rules 6 and 7.

The collection of health information for care and treatment and the related routine administrative aspects (for example billing) are usually clear and may require brief explanation. The intended recipient of the information may not always be apparent particularly where health information is sought to meet monitoring and purchaser requirements. Some accident and medical centres send consultation information to an individual's general practitioner after the individual has received treatment at the centre. This should be done only with the individual's knowledge and authorisation since he or she may not otherwise anticipate or agree to the disclosure.

Reasonable steps to inform include:

- an oral explanation in appropriate language;
- a notice on display in the health agency's premises;
- an explanatory letter;
- an explanatory note on standard forms used for capturing health information;
- explanatory brochures.

The practice complies with Rule 6: Access to Personal Health Information.

The principle does not determine ownership of documents. Rule 6 does not give individuals the right to take away original records. A request cannot be refused on the basis that the agency "owns" the record or that they are not the requester's property.

Under Transfer of requests (s39) the agency is required to transfer the request promptly, and in any case within 10 working days, and to inform the individual accordingly. Health agencies should have appropriate procedures in place so that time limits are met. There should also be procedures to allow requests to be dealt with on an urgent basis if required.

Where a request for access is made an agency should:

- satisfy itself as to the identity of the individual making the request
- ensure the information sought is received only by the individual or his or her agent. This may involve registered mail or requiring the individual to sign a receipt for the information
- ensure that where a request is made by an agent, the agent has a current written authority and is otherwise properly authorised to obtain the information. Agencies should set out policies for what evidence of authorisation will be acceptable and communicate those policies to staff.

Information management to track medical records may be in an electronic or hardcopy format.

Examples of tracking receipt of medical records by another authorised agency may include the inclusion of a fax back form, the use of registered mail or courier packs with a signature required to authorise release.

Resources

- **Standards New Zealand. SNZ HB 8169:2002 Health Network Code of Practice**
- **The Code of Health and Disability Services Consumers' Rights 1996**
- **Health Information Privacy Code 1994**
- Privacy Commissioner. **On the record: A practical guide to health information privacy. Wellington, NZ: The Office of the Privacy Commissioner; 2011**
- **Medical Council of New Zealand. The maintenance and retention of patient records (2005)**
- **Ethnicity data protocols**, Ministry of Health.



Resources cont.

- Medical Council of New Zealand. **Good medical practice—A guide for doctors.** Wellington, NZ: Medical Council of New Zealand; 2008
- Privacy Act 1993
- Standards New Zealand. **NZS 8153:2002 Health records**
- Standards New Zealand. **SNZ PAS 8170:2005 Primary Health Care Practice Management Systems: Publicly Available Specification**
- Standards New Zealand. **AS/NZS ISO/IEC 27002:2013 Information technology – Security techniques- Code of practice for information management**

**Maintenance of Professional Standards**

- Audits of transfer of medical records can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 21

Patient records meet requirements to describe and support the management of health care provided

Criteria	Evidence may include	<input checked="" type="checkbox"/>
21.1 Patient records contain information to identify the patient and document: the reason(s) for the visit, relevant examination and assessment, management, progress and outcomes (management/risk factors screening/continuity/referral/tests/investigations).	<ul style="list-style-type: none"> ■ Record reviews for 10 records per clinical practitioner; and ■ Internal audits completed within the last 12 months. 	<input type="checkbox"/>

Guidance notes

Electronic patient records must meet legal requirements to describe and support the management of health care. They must contain information that enables the identification of the patient and facilitates continuity of care. Assessment, management, progress and outcomes must be documented in a way that enables another team member to carry on with coordination, management of care, and referral to other services.



Electronic patient records contain sufficient information to identify the patient and document: the reason(s) for a visit, relevant examination and assessment, management, progress and outcomes. All entries in a patient's clinical notes must clearly identify the person who has made the entry. It is not acceptable to make entries in the electronic records under another provider's name or initials.

Patient records must be neutral, objective and non-judgemental.

Patient record requirements

1. Patient records are electronic, secure and traceable:
 - All clinical information is recorded electronically, password protected and reliably backed-up.
 - Clinical notes are dated and reliably identify the author.
 - The date and author of any alterations made to the notes are recorded.
2. Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements:
 - Information stored for each patient includes: Name of patient; NHI number; Gender; Address; Date of birth; Ethnicity; Registration status.
3. The record is objective, contemporary and sources are identified:
 - Notes are made as soon as possible after contact and any delay is identifiable.
 - When information is provided by other than the patient, the source is identified.

4. Important medical warnings (or the absence of any) are displayed for all records:
 - Medical warnings, past medical history, and/or previous medication adverse reactions are recorded, where relevant.
 - All important medical alerts available on the practice management system are activated.
 - Allergy status (allergies or the absence of known allergies) is recorded for each patient.
5. Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point:
 - Patient needs and instructions recorded include, where applicable, directives by patient, disabilities of patient, drug dependencies, end of life needs, and special alerts (e.g. deaf, blind, communication requirements, mental health issues), and name of any interpreter used.
6. The recorded history is adequate for both safe management and evidential purposes:
 - The reason for the encounter is recorded or apparent from the notes.
7. The record of the examination includes all findings essential to diagnosis and management:
 - Sufficient positive and negative findings are present to justify management decisions.
 - Objective measurements (BP, pulse, temp., respiratory rate, pA02 etc.) are recorded, where relevant.
8. The working diagnosis/differential is apparent and consistent with supporting information:
 - The diagnosis (and any differential) and level of certainty is clear from the notes.
9. The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent:
 - Patient notification of test results and other clinical findings is recorded.
 - There is evidence of advice given to support any necessary consent and its confirmation.
 - The record includes evidence of signed or verbal consent to procedures as required.
10. Clinical management decisions and any interventions provided are recorded:
 - The management/treatment plan is clear from the notes, including contingency plans and follow-up arrangements (safety netting) where necessary.
 - The notes include any clinical management decisions made outside consultations (e.g. telephone calls) and off-site consultations (home visit, aged care facilities etc.).
11. The record identifies all medication treatment provided including the type, dosage and total amount of any medications prescribed:
 - There is a record of all prescriptions issued including drug name/dosage/frequency/time/volume and total amount.
12. The record identifies all investigations requested and tracks high-risk tests:
 - All tests and investigations requested are recorded.
 - High-risk tests (e.g. histology, cervical smears) are tracked for completion.
13. The record supports effective and timely referral for treatment and transfer/continuity of care:
 - Copies of referral letters to and from the practice, certifications, referrals and responses, discharge summaries and test results are included in the patient PMS record or accessibly filed.
 - Referrals include urgency, reason/expectation of referral, relevant findings, classifications, warnings and current treatment.
 - The record confirms that all referrals are enacted in a timely way.
 - The record confirms appropriate and timely action in response to incoming correspondence.

14. Follow-up arrangements are clearly documented and actions are recorded:
- Follow-up actions on test results and referrals are recorded.
15. Screening history and results (or patient decline) are recorded:
- Screening history and results (or patient decline) is recorded for routine screening areas (this may vary with current national guidelines but examples include cervical smears, mammograms, cardiovascular risk assessment, diabetes screening).
 - Screening recall status can be easily tracked.
16. Immunisation history and status is recorded:
- There is evidence that compulsory immunisations are conducted and updated according to the national schedule.

Resources

- [The Royal New Zealand College of General Practitioners. Medical Record Review Tool.](#)
- [St George I. Cole's Medical Practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2013](#)



Maintenance of professional standards

- Audits of patient records can be claimed as an AoMP activity if at least 10 records are collected for the individual practitioner. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 22

The practice team identifies and responds to patients with clinically urgent health needs

Criteria	Evidence may include	<input checked="" type="checkbox"/>
22.1 Non-clinical team members responsible for first line interaction with patients are trained to identify and respond appropriately to patients with urgent medical conditions.	<ul style="list-style-type: none"> ■ Training record for non-clinical members; and ■ Documented triage process that identifies non-clinical staff members' responsibilities; and ■ Reference material, including triage process posters and algorithms. 	<input type="checkbox"/>
22.2 The practice has systems in place to observe the clinical condition of patients.	<ul style="list-style-type: none"> ■ Demonstrate a clear view of patients in the waiting room to monitor clinical status of patients. 	<input type="checkbox"/>
22.3 There is a system to manage patients with urgent medical needs.	<ul style="list-style-type: none"> ■ Process on how to manage urgent medical conditions. 	<input type="checkbox"/>
22.4 All practice team members who may be required to administer CPR must have current certification to an appropriate level from certified trainers.	<ul style="list-style-type: none"> ■ Current CPR certificates for applicable practice team members. 	<input type="checkbox"/>

Guidance notes

Every general practice operates in a different way so the protocols or guidelines must be designed to meet the needs of the individual practice.



It is important that front line team members understand their role in observing waiting patients and how to alert clinical team members if they are concerned about a patient in the waiting room. Systems to observe patients may include direct observation, two way windows, concave mirrors and close circuit TV. Secondary waiting areas, distant from the main waiting area, need robust systems to detect a change in the condition of waiting patients.

It is essential to have a triage system in place, to recognise and respond to an emergency. This will assist the staff to monitor and assess patients, decide how urgent their illness or injury is and how soon treatment is required. The triage system will be managed by the clinical team.

Levels of timely access to care may be:

- Emergency Immediate
- Urgent 20 minutes
- Interrupt doctor As soon as possible
- Today Same day
- Within 24 hours

Training

It is recommended that the general practice team training sessions give staff the opportunity to practise acting out specific scenarios, such as the patient with chest pain or the patient who is very short of breath, so they will know how to manage these conversations.

Training programmes should include recognition of medical emergencies in patients who are phoning the medical centre and for putting callers 'on hold'.

The training should be:

- simple and workable with readily available and accessible reference material from which to make a decision;
- inclusive of definitions for presenting problems to include but not limited to pain, altered level of consciousness, extreme concern, dehydration, fever;
- non-exhaustive as it is not possible to cover every possibility which may arise;
- non-diagnostic: framed to identify 'presenting problems' and make a judgement on timely access to care. Non-clinical team members must not diagnose the patient's medical condition or make a clinical decision;
- comprehensive and patient focused to include self-care, first aid and/or ongoing monitoring.

CPR training

Cardiopulmonary resuscitation (CPR) skills are essential for all members of the clinical team who interact with patients and each must understand their specific role and the response required during any medical emergency in the practice.

In some locations non-clinical team members may be required to initiate CPR or to assist at a medical emergency. Examples may include solo and rural practices or where reception staff are working in isolation of any clinical team members available onsite, for example where the receptionist opens the medical centre before any clinical staff are in the practice.

The employers should consider the risks associated with staff working alone particularly around health and safety. If the situation cannot be eliminated the employer should make available a safe environment in which to work. This may include but is not limited to: personnel alarms, securing public access, panic buttons.

The employer also takes vicarious responsibility for the actions of that staff member who may be forced in an emergency, to work outside their level of expertise.

It is increasingly recognised that the management of an acute medical emergency is not simply about making a diagnosis or having appropriate knowledge, but instead relies on a co-ordinated approach to delivery of care (Crisis Resource Management). This includes gathering appropriate personnel, having defined roles and responsibilities and systems to ensure such rules are followed, ensuring staff have a global overview of the crisis, having appropriate communication between staff members, and ready access to organised, and necessary equipment. Responsibility for the management of any resuscitation lies with all team members.*

* Findings of Coroner M A McDowell; COR REF: CSU-2012-AUK-000499

Resources

- New Zealand Resuscitation Council guidelines and flowcharts
- New Zealand Resuscitation Council training
- St John resuscitation courses
- Academic Life in Emergency Medicine – Crisis Resource Management
- Sydney Clinical Skills and Simulation Centre – Crisis Resource Management
- P.R.I.M.E. – St John

Maintenance of Professional Standards



- ACLS training requirements – General practitioners participating in the RNZCGP Maintenance of Professional Standards must participate in a resuscitation course to New Zealand Resuscitation Council Level 5 or higher. Practice nurses participating in Professional Development Recognition Programmes (PDRPs) and those who are authorised vaccinators should be certified to a minimum of Level 4. Practice CPR training records should show that all team members required to administer CPR are trained to the correct level (NZRC Core 1-7), as well as recording the certified trainer (e.g. NZRC, St John, New Zealand Heart Foundation).

INDICATOR 23

The practice has an effective system for the management of clinical correspondence, test results, urgent referrals and other investigations

Criteria	Evidence may include	<input checked="" type="checkbox"/>
23.1 There is a policy describing how laboratory results, imaging reports, investigations and clinical correspondence are managed.	<ul style="list-style-type: none"> Policy on to how to manage and track laboratory results, imaging reports, investigations and clinical correspondence. 	<input type="checkbox"/>
23.2 All incoming test results or other investigations are sighted and actioned by the practice team member who requested them, or by a designated deputy	<ul style="list-style-type: none"> Policy for the management of incoming test results and other investigations. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
23.3 Patients are provided with information about the practice procedure for notification of test results.	<ul style="list-style-type: none"> Patient information – verbal and documented, poster, notice, website, leaflet and/or brochure. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
23.4 The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals.	<ul style="list-style-type: none"> Policy that describes how the practice identifies and tracks significant investigations and urgent referrals. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
23.5 A record is kept of communications with patients informing them about test results.	<ul style="list-style-type: none"> Medical record to demonstrate communication of test results. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>

Guidance notes

Practices must operate a reliable and defined process for recording and managing clinical investigations. There should be a clear indication of what action was initiated on all reports to enable correct tracking and management. The principle is that patient reports are not lost in the system and are processed to ensure the right people get the right information within the time frames identified by the practice. For every report or test there must be a person in the practice responsible for management and tracking. Good practice requires that practices should keep a record of telephone conversations with patients about test results, noting the date and who advised the patient.



Members of the practice team can describe the system used by the practice to monitor, review and act on all incoming test results and medical reports.

The practice audit process should:

- Identify missing results i.e. not received from the laboratory, or ordered but information not complete;
- Provide information about what has happened to medical investigations that have been returned to the practice primary and secondary care;
- Requested medical investigations should have a clear pathway to an outcome (Request, results, communicate results, record results, patient informed, action taken, dated, time limit identified);
- Appoint a clinical team member responsible for monitoring the review and action on all incoming test, results and medical reports;
- Appoint a designated deputy to process the reports if that requester is not available – for example locum, is on leave;
- Track specialist referrals.

Tracking methods may include:

- Automated electronic 'flag' to alert the requester at an identified period of time.
- Automated electronic 'task' to direct the requester to investigate receipt of results at an identified period of time.

The Health and Disability Commissioner recommends doctors discuss the notification of test results with patients in advance; obtain where possible, the patient's consent to the notification of only abnormal results and encourage patients to call if they want confirmation of a normal result or have any questions. (NZGP 3 April 2002)

The Health and Disability Commissioner states it is acceptable for doctors to have a clear arrangement that patients will only be notified when test results are of concern. However, unless there is clear evidence, that such an arrangement has been made; patients need to be told all their results. It must be made clear to patients that they are entitled to be notified of all test results, and that even if they agree to be notified only of abnormal results, they are welcome to call the medical facility and check whether their results have been received and what they are.

Leaving patients to assume that silence means their test results are OK is not acceptable. See the [Health and Disability Commissioner](#) website.

Communication about tests should be recorded in the electronic health record with:

- The date;
- The person identified who provided the result to the patient;
- A brief record of what information was conveyed;
- A record of what method was used to convey the information – telephone, letter, email, SMS (consider security of message system - Health Information Privacy Code 1994).

Vicarious liability

Medical centres will not ordinarily be held liable for lapses in care or communication by an individual practitioner who they "employ". However, if the lapse was attributable to poor systems or inadequate protocols at the centre, the centre may be held vicariously liable. In practice, medical centres should have good, robust systems in place, provide appropriate training, guidance and support, and ensure ongoing audit and review.

Under the Health and Disability Commissioner Act 1994, "employing authorities" will avoid vicarious liability if they can show that they took such steps as were reasonably practicable to prevent the acts or omissions that amount to a breach of the Code of Health and Disability Services Consumers' Rights.

Resources

- **Health and Disability Commissioner**
- The Royal New Zealand College of General Practitioners. **Managing patients test results—minimising error.** Wellington, NZ: RNZCGP Discussion Paper 2003; 2nd edition 2005




Maintenance of Professional Standards

- Involvement in policy development can be claimed as a CME practice improvement activity. A schedule of meetings or completed learning reflection form should be kept as evidence.



INDICATOR 24

Prescribing is accurate and appropriate

Criteria	Evidence may include	
24.1 Prescriptions of all medicines including controlled drugs are recorded in the electronic record and comply with all legislative and regulatory requirements.	<ul style="list-style-type: none"> ■ Electronic record of prescribing. ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
24.2 The practice has a documented policy for repeat prescribing.	<ul style="list-style-type: none"> ■ Documented policy for repeat prescribing. 	<input type="checkbox"/>
24.3 Where utilised, Standing Orders are in place and comply with Ministry of Health Guidelines	<ul style="list-style-type: none"> ■ Current Standing Orders. 	<input type="checkbox"/>

Guidance notes

Prescriptions must be legibly and indelibly printed and personally signed by the prescriber. Therefore those issued by email or other electronic means do not meet New Zealand legislative standards under regulations **40–41 of the Medicines Regulations**. Faxed or telephone prescriptions are permitted, but only in cases where the prescriber requires a medicine to be dispensed urgently. In such cases the original prescription must be forwarded to the pharmacist within 7 days.



When writing a prescription, prescribers should avoid using abbreviations which might be misunderstood. A prescription must be legible, unambiguous and contain all the information necessary to ensure appropriate dispensing and compliance with all legislative and subsidy requirements, including:

- the name and physical address of the patient.
- the name of the drug, its strength, form and quantity.
- full instructions for use of the drug.*
- full date (day, month and year).
- the period of supply, repeats (if any) and any other dispensing conditions.
- your printed name, physical address, Medical Council [or relevant registration authority] number and signature.
- the patient category code (co-payment) if patient is eligible for funded services, and any Special Authority number the patient has been allocated for the prescribed medicine.

In certain cases additional information should also be recorded such as the patient's weight and/or age (for example where the patient is a child and where this information would affect dosage).[†]

* The Coroner has recommended that prescriptions should specify the day of the week medication is to be taken where the medication is to be taken weekly. Findings of Coroner C J Devonport COR REF: CSU-2012-DUN-000286

† Medical Council of New Zealand. Good prescribing practice (2013)

Patient records

- The patient record should include adequate patient medication history including:
 - current medical conditions;
 - any previous adverse reactions;
 - concurrent or recent use of medicines (including non-prescription, complementary and alternative medicines).

The Coroner has recommended that all medication alerts available on Practice Management Software should be activated.†

Repeat Prescriptions

- Before signing a repeat prescription there must be secure procedures in place to ensure that:
 - the patient is issued with the correct prescription.
 - each prescription is regularly reviewed so that it is not issued for a medicine that is no longer required.
 - the correct dose is prescribed for medicines where the dose varies during the course of the treatment.
 - any subsidy conditions that have changed since the last prescription are amended.
 - all relevant information has been reviewed before completing the prescription, and that the patient record is maintained and up-to-date.
- Repeat prescriptions should include:
 - details about the number of the repeats allowed within a given time frame.
 - clear instructions for patients relating to the dosage including quantity, frequency and route.
- Patients receiving repeat prescriptions should be assessed in a face-to-face consultation on a regular basis to ensure that the prescription remains appropriate. The practices repeat prescription policy must include a definition of what constitutes 'appropriate regular' face to face consultation. This will take into consideration individual patients' needs and specific medications.
- Patients who need a further examination or assessment should not receive repeat prescriptions without being seen by a doctor. This is particularly important in the case of medicines with potentially serious side effects.
- Recording prescribing information electronically provides accurate, readily accessible data for continuity of patient care and an audit trail of activity.

Standing Orders

The Ministry of Health has Guidelines for the Development and Operation of Standing Orders. The guidelines cover the issuer, people working under stand orders, medicines, content of a standing order, period for which the standing order applies, record keeping, competency including training, countersigning and audit of standing orders, review of standing orders and availability of standing orders.

The Regulations require that the standing order list:

- the medicines that may be supplied or administered under the standing order,
- the indications for which the medicines is to be administered and the recommended dose or dose range for those indications,
- the contraindications for the medicines, the validated reference charts for calculation of dose (if required),
- the method of administration, and
- the documentation required.

† Findings of Coroner C J Devonport COR REF: CSU-2012-DUN-000286

Resources

- [Guidelines for the Development and Operation of Standing Orders](#)
- [The Code of Health and Disability Services Consumers' Rights 1996](#)
- Health Quality and Safety Commission New Zealand. [Safe Medication Management Programme](#). Medicine Reconciliation Toolkit; 2011
- Medical Council of New Zealand. [Good prescribing practice](#) (2013)
- Ministry of Health. [Outlines the November 2010 changes to the Medicines Act](#)




Maintenance of Professional Standards

- Audits of prescribing and repeat prescribing can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 25

The practice maintains an effective screening and recall system

Criteria	Evidence may include	
25.1 The practice demonstrates the system used to identify patients eligible for screening and recall.	<ul style="list-style-type: none"> System used to identify patients for screening and recall. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>

Guidance notes

Offering screening to presenting individuals rather than populations is an important risk management approach that can enable early detection of disease in a preclinical state and informs where to link people to care.

Screening programmes as part of the screening pathway are planned and coordinated. The programme targets two population groups:

- population screening programmes involve entire populations or a large and easily identifiable group such as cervical and breast screening; and
- population-based screening programmes involves an invitation to a defined, identifiable population. This involves identifying and inviting the target population for example through the PMS. An example would be antenatal HIV screening.

The National Screening Unit (NSU) is a separate unit of the Ministry of Health, and is responsible for the safety, effectiveness and quality of health and disability screening programmes:

- Antenatal HIV Screening Programme** - screens pregnant women for HIV to reduce the chances of HIV being passed to the baby.
- Breast Screen Aotearoa** – screens women for breast cancer
- National Cervical Screening Programme** - screens women for abnormal changes to cells on the cervix.
- Newborn Metabolic Screening Programme** - screens newborn babies for certain metabolic disorders.
- Universal Newborn Hearing Screening Programme** - screens newborn babies for hearing loss.

Resources

- National Screening Unit.** Improving quality: A framework for screening programmes in New Zealand. Auckland, NZ: National Screening Unit; October 2005
- National Health Committee. **Screening to improve health in New Zealand. Criteria to assess screening programmes.** Wellington, NZ: National Advisory Committee on Health and Disability (National Health Committee); April 2003
- The New Zealand Health Strategy.** Wellington, NZ: Ministry of Health; December 2000
- Unsolicited Electronic Messages Act 2007**

Maintenance of Professional Standards

- Audits of patient screening and recall can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.

INDICATOR 26

The practice maintains an effective immunisation programme

Criteria	Evidence may include	<input checked="" type="checkbox"/>
26.1 The practice identifies and recalls all patients requiring immunisations on the national schedule.	<ul style="list-style-type: none"> ■ Data showing rates of immunisation. ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
26.2 General practice team members responsible for performing immunisations hold current authorisation.	<ul style="list-style-type: none"> ■ Documented current authorisation from Medical Officer of Health. 	<input type="checkbox"/>

Guidance notes

Immunisations help minimise the risk of infection among at-risk populations. Immunisation programmes help to control diseases at population level. Success of these programmes relies on correct identification and recording to monitor effectiveness and reduce the risk of outbreaks.



Vaccination should be undertaken in compliance with the Ministry of Health's current regulations and standards for authorisation of vaccinators.

The GP vaccinator is not required to hold an authorised vaccinator certificate but is required to have attended an appropriate training programme.

The practice has an audit process that monitors monthly immunisation rates and identifies those overdue for immunisation.

The national schedule is reviewed on a triennial basis but may also be subject to interim changes.

Resources

- Ministry of Health. [Current regulations and standards for authorisation of vaccinators](#)
- Ministry of Health. [Immunisation Handbook 2014](#). Wellington, NZ: Ministry of Health; 2011
- [National Immunisation Register](#)
- [Immunisation Advisory Centre](#)
- [Well women and family trust](#)



Maintenance of Professional Standards

- Audits of identification and recall of patients requiring immunisation can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 27

The practice has processes to ensure continuity of care

Criteria	Evidence may include	<input checked="" type="checkbox"/>
27.1 The practice can demonstrate continuity of care management for patients within the practice.	<ul style="list-style-type: none"> ■ Practice policies and processes that support continuity of care, which may include: <ul style="list-style-type: none"> – team meeting minutes. – patient records. – patients have a nominated and named practitioner or mini team of practitioners that they are assigned to. ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>
27.2 The practice can provide evidence of effective electronic linkages between the practice and secondary care interfaces.	<ul style="list-style-type: none"> ■ Evidence of referrals and discharge summaries and follow-up. ■ Evidence of referral letters showing continuing of care focus. ■ Evidence of electronic referrals (if available). ■ Patient record reviews (see Indicator 21). 	<input type="checkbox"/>

Guidance notes

Practices have a shared responsibility to provide seamless care that assists a smooth transition between primary, secondary or community interfaces. Practice teams must also provide comprehensive care that recognises and acts on the full range of health-related needs in the patient population, and refer patients on if specific services are not provided by the practice.

Effective communication and robust information is essential for working across interfaces and preventing patients getting lost in the system. This is particularly important where information is shared across systems, in multidisciplinary teams and in networks. Lapses in continuity of care have occurred when patient information is not well documented, or when the pathway forward is not clear to other clinicians.

The Medical Protection Society (MPS) has developed a referral and referral back checklist to help doctors manage the referral process.

These checklists can be used as an aide memoire or integrated into referral and reply letters. You may also choose to add additional items specific to your discipline or practice to ensure that all important areas are covered.



'Referring a patient to a colleague' checklist

- Scope of the referral
- Significant history – presenting complaint, past medical, social, family, drug/allergies
- Physical findings
- Results of investigations done to date
- Provisional diagnosis
- Current medications
- Patient expressed preferences regarding treatment
- Information provided to the patient about the condition and the referral
- Preferred method of being contacted if urgent reporting back is required.

'Referring patient care back to a colleague' checklist

- History obtained
- Diagnosis made
- Investigations conducted
- Procedures performed
- Additional morbidities investigated/treated
- Treatment instigated
- Further treatment planned
- Care required to be provided by original doctor
- Planned follow-up
- Forecasting results still to be received and who is to follow them up
- Discharge medications
- Information provided to the patient about the condition, the extent of your involvement and follow-up.


Maintenance of Professional Standards

- Audits of continuity of care management can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 28

There is an effective Incident Management System

Criteria	Evidence may include	
28.1 The practice has an Incident Management Policy.	<ul style="list-style-type: none"> An incident management policy. 	<input type="checkbox"/>
28.2 The Incident Reporting Register records incidents and near misses.	<ul style="list-style-type: none"> An incident recording register. 	<input type="checkbox"/>
28.3 Adverse reactions to medicines and immunisations are recorded in the PMS and reported to the Centre for Adverse Reactions Monitoring (CARM).	<ul style="list-style-type: none"> Medical record – record of adverse reaction; and CARM form/bookmarked website. Patient record reviews (see Indicator 21). 	<input type="checkbox"/>

Guidance notes

Early warning systems that outline the process for reporting, management and follow-up help prevent adverse outcomes and promote excellence in practice.



Recording incidents assists with the management of incidents or near misses, and enables learning opportunities for patients and team members.

Reporting adverse reactions assists with understanding more about why there was an adverse outcome or why there is a risk to patients.

Resources

- **The Centre for Adverse Reactions Monitoring (CARM)**—accessed through the NZ Pharmacovigilance Centre's website
- Ministry of Health. **Immunisation Handbook 2014**. Wellington, NZ: Ministry of Health; 2014
- **HQSC Reportable events**.



Maintenance of Professional Standards

- Audits of incident management can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.



INDICATOR 29

The practice has evidence of organisational planning

Criteria	Evidence may include	<input checked="" type="checkbox"/>
29.1 The general practice team can provide examples of how their practice has improved in the past year.	<ul style="list-style-type: none"> Examples of quality improvement activities in the past year. 	<input type="checkbox"/>
29.2 The general practice team has clinical goals for the year.	<ul style="list-style-type: none"> Clinical goals for the year are documented. 	<input type="checkbox"/>

Guidance notes

The goals that you set for the year can be used to demonstrate compliance to both criteria for this indicator. Establishing goals should be completed as a team.



Goals should be SMART:

- Simple
- Measurable
- Achievable
- Realistic
- Timely

The goals can be recorded in a table such the example provided below:

Clinical Goal	Measurement	Indicators that the goal has been achieved
Explain the goal and its importance to your community and/or general practice team.	Explain how you will measure the achievement of the goal.	List examples of what you will expect to see, or what data will tell you that your goal has been achieved.

Resources

- Medical office – 5 steps to a strategic plan
- SWOT analysis tools
- Mind tools – goal setting.



Maintenance of Professional Standards

- Involvement in organisational planning can be claimed on an hourly basis as a CME practice improvement activity. A schedule of meetings or completed learning reflection form should be kept as evidence.



SECTION 4

Professional development

The purpose of this section is to ensure that all general practice team members demonstrate their ongoing competence to perform their duties and ensure that the general practice team are engaged in a Maintenance of Professional Standards programme.



Guidance notes



Resources

INDICATOR 30

The practice team complies with the Health Practitioners Competence Assurance Act 2003

Criteria	Evidence may include	<input checked="" type="checkbox"/>
30.1 All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003.	<ul style="list-style-type: none"> Annual practising certificates. 	<input type="checkbox"/>

Guidance notes

It is an offence for a health professional to practise without a current practising certificate. It is the health professional's responsibility to maintain competence to practise in accordance with the Health Practitioners Competence Assurance Act 2003. For risk management it is recommended the practice maintains a record of certification including expiry dates.



Resources

- Health Practitioners Competence Assurance Act 2003
- Medical Council of New Zealand
- Nursing Council of New Zealand
- New Zealand College of Primary Health Care Nurses
- New Zealand Medical Association



INDICATOR 31

The practice has appropriate employment structures in place

Criteria	Evidence may include	<input checked="" type="checkbox"/>
31.1 All the general practice team have current signed employment agreements and current position descriptions.	<ul style="list-style-type: none"> Current signed employment agreements and current position descriptions for all the general practice team. 	<input type="checkbox"/>
31.2 All new general practice team members (including locums) are orientated to the practice when they commence employment.	<ul style="list-style-type: none"> Documented orientation programmes. 	<input type="checkbox"/>
31.3 Each member of the clinical team is insured to cover liability.	<ul style="list-style-type: none"> Members of the clinical team must be covered by organisational and professional insurance. 	<input type="checkbox"/>
31.4 All the general practice team participate in continuing professional development.	<ul style="list-style-type: none"> Current CPD records for all practice team members. 	<input type="checkbox"/>
31.5 The practice completes children's worker safety checks in accordance with the Vulnerable Children Act 2014.	<ul style="list-style-type: none"> Practice process for safety checking of employees and contractors; Evidence of screening and vetting of employees and contractors 	<input type="checkbox"/>

Guidance notes

There is a documented workplace induction programme to orientate new employees and independent contractors, including locums, to the practice. The programme takes into account the new staff member's duties and responsibilities as well as their previous education and work experience. The workplace induction programme must be commenced in the first week of employment.



The programme should take into account: legislative and professional requirements; safety issues including fire and emergency procedures; contractual obligations; financial allocations/restrictions; employment contract provisions; environment/location information.

It is the health professional's responsibility to maintain competence to practise through continued professional development in accordance with the Health Practitioners Competence Assurance Act 2003. All health professionals must be engaged in continuing professional development.

The following guidance on children's worker safety checks draws heavily on advice from the Children's Action Plan Directorate found in [Children's worker safety checking under the Vulnerable Children Act 2014](#) (May 2015).

Scope of requirements under the Vulnerable Children Act 2014

Under the Vulnerable Children Act 2014 (the VCA), specified organisations are required to undertake safety checks of children's workers they employ or engage. The College understands that most GPs and practice nurses will be children's workers and will need to be safety checked.

A 'specified organisation' is any of the State services or an organisation that receives funding (including partly or indirectly) from a State service to provide regulated services, and employs or engages children's workers to perform a regulated service. Public hospitals, publicly funded medical practices or facilities, medical practices belonging to PHOs, and other publicly funded providers of health services provide regulated services.

'Children's workers' are people providing a regulated service, and whose work may or does involve regular or overnight contact with children, and this takes place without a parent or guardian of the child being present. A 'core worker' is a children's worker whose work requires or allows them to be the only children's worker present, or who has the primary responsibility for, or authority over, children (section 23 of the VCA).

A 'child' means a person who is under the age of 14 years, or a young person between 14 years and 17 years who is not married or in a civil union (sections 15 and 23 of the VCA).

Implementation dates

The safety checking requirements are being phased in. The key dates are:

- From 1 July 2015 new core children's workers must be safety checked before they start work.
- From 1 July 2016 new non-core children's workers must be safety checked before they start work.
- By 1 July 2018 existing children's core workers (i.e. those currently employed, or engaged as a contractor) must have been safety checked.
- By 1 July 2019 all existing non-core children's workers must have been safety checked.

The required checks

The safety checks required for new children's workers include:

1. Identity confirmation

Method (a) through an electronic identity credential (e.g. the [RealMe](#) identity verification service), and a search of personnel records to establish the uniqueness of the claimed identity.

Method (b) following the regulatory process to establish:

- (i) the identity exists by checking an original **primary identity document** (as listed in Part 1 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015);
- (ii) the identity is a living identity and is used in the community by verifying an original **secondary identity document** (as listed in Part 2 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015);
- (iii) the identity is linked to the presenter;
- (iv) the uniqueness of the identity by searching personnel records.

2. An interview which should be face-to-face, but may be via telephone or other communications technology. The Children's Action Plan Directorate suggests considering whether to conduct two interviews (to enable follow-up and clarification) and whether to have a small panel of interviewers. Interviewers should be chosen for their experience, knowledge and skill, with at least one having broad child protection knowledge. In addition to role-related questions, the interview should explore the children worker's view on safe practice. The Directorate suggests that questioning elicit information such as:

- whether complaints have been made about the worker's professional practice, whether they have been convicted of an offence, and reasons for leaving previous employment;
- how they have dealt with a situation (or what they would do if such a situation arose) where a child or young person disclosed abuse;

- what they think constitutes professional practice when working with children;
- other relationships they have with children outside the working environment;
- the kind of relationships they hope to develop with children and families in the new role.

3. **Work history** – consider the previous five years.
4. **At least one referee** – consider the information from three referees where possible, which includes information on how the potential children's worker relates to children. Referees must not be related or be part of the individual's extended family.
5. **Seek information** from any relevant professional organisation, licensing authority, or registration authority, and confirmation that the person is a member of the organisation or registered by the authority.
6. **New Zealand Police vet.** To use the [Police Vetting Service](#), agencies or individuals need to meet the required criteria and obtain approval from the New Zealand Police.
7. **Assessment of the risk** the potential children's worker would pose to the safety of children if employed or engaged by evaluating the above information.

Risk assessment

It is important to follow the correct process, including the completion of a risk assessment of the potential children's worker, and to keep accurate records. All relevant information gathered during the safety checking process must be considered to inform the final decision.

The Children's Action Plan Directorate expects decision making to be reasoned, based on evidence, and to put the child at the centre. Principles to follow include:

- Use professional judgement to identify patterns of concerning attitudes or behaviours. People conducting safety checks should consider the information holistically.
- Always consider indicators in context. Give people the opportunity to respond to concerns about their suitability.
- Follow up on potential indicators (e.g. by asking for evidence).

Moreover, safety checking must always be done in accordance with existing legal protections such as the Privacy Act 1993 and the Human Rights Act 1993. The final decision may be based on a range of factors, and ultimately the decision maker should be satisfied that the children's worker poses no undue risk to the safety of children if employed or engaged. Decision makers should also consider whether they need to seek outside expert advice and further referees, and to raise any issues with the children's worker.

For children's workers who are **already employed or engaged** by the organisation, fewer checks are required: confirmation of identity, checks with the relevant professional registration body or licensing authority, a fresh New Zealand Police vet, and a risk assessment based on these checks.

Periodic rechecking every three years requires: confirmation of any changes of an officially recorded name; updating the checks with the relevant professional registration body or licensing authority; a fresh New Zealand Police vet; and a risk assessment based on these checks.

Relying on previous checks or checks done by others

Organisations may rely on checks that meet the standard (i.e. have met or exceeded all of the regulatory requirements) that they conducted up to three years previously (for previous employees or contractors starting in a new role/contract), and on checks done by individuals or organisations on behalf of the specified organisation. However, the Children's Action Plan Directorate states that:

- it is good practice to recheck previous employees or contractors if there has been a significant period of absence.
- for core workers, their New Zealand Police vet needs to have been done to the required standard.
- where relying on a check done by a third party on their behalf, organisations should have a process in place to confirm that the person they are employing or engaging is the person who the third party has checked. This should include an identity verification process.

Responsibility for safety checking rests with the employing or contracting organisation, and they should exercise due diligence when relying on checks undertaken by others.

Safety checking contractors and the self-employed

The VCA applies to some, but not all, self-employed persons or sole practitioners. If a self-employed person or sole practitioner is contracted by a State service, then they will need to be safety checked by that State service.

Similarly, if a self-employed person or sole practitioner is contracted by an organisation or individual that is funded by a State service to provide regulated activities, the funded organisation or individual is required to ensure that a safety check of the practitioner is done. This situation includes self-employed or sole practitioners who have formed separate legal entities, and are employed or engaged by them. Although a separate screening service might be developed for self-employed and sole practitioners in the future, the Children's Action Plan Directorate has provided no advice on how this is to be done.

Resources

- [Employment Relations Act](#)
- [Department of Labour](#)
- [Employment agreement builder](#)
- [Ministry of Business Innovation and Employment - Induction](#)
- [Obligations for new staff](#)
- [Human Resources Institute of New Zealand – Employee induction](#)
- [RNZCGP – CPD programme](#)
- [Nurses – CPD programme](#)
- [Healthy Practice \(MAS\)](#)
- [Vulnerable Children Act 2014](#)
- [Vulnerable Children \(Requirements for Safety Checks of Children's Workers\) Regulations 2015](#)
- [Safety checking \(Children's Action Plan website\)](#)
- [Children's worker safety checking under the Vulnerable Children Act 2014](#) – this includes advice on interpreting and applying the VCA and regulations, sample interview questions, and a useful checklist
- [Safer recruitment, Safer children: Guidance for choosing safe people to work with children](#)
- [Safer organisations, Safer children \(Children's Action Plan, February 2015\)](#)
- [Ask for Police vetting](#) (New Zealand Police)
- [New Zealand Police Vetting Service: Purpose Statement & Agency Approval Criteria Purpose](#)
- [RealMe](#)



APPENDIX 1:

Medical equipment register

All medical equipment and resources must be suitable for supporting comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered. All essential medical equipment and resources must be available when needed, and members of the practice team must know how to use the equipment. Equipment must be calibrated, in working order and have current expiry dates for servicing. The adequacy and appropriateness of basic equipment is determined by the circumstances of the practice and any omissions must be able to be justified by the practice.

All essential basic equipment is available including:

- auriscope
- automated external defibrillator (AED) – should be accessible within 10 min; if held in the practice, clinical team members should know how to operate
- blood glucose test strips/glucometer – expiry dates must be current.
- cervical smear equipment
- disposable proctoscope
- dressings adequate to the services provided
- electrocardiogram – should be accessible within 10 min; if held in the practice, the clinical team members should know how to read the tracings
- eye local anaesthetic
- fluorescein dye for eyes
- gloves
- height measure
- monofilament
- ophthalmoscope
- peak flow meter or spirometer
- pregnancy testing kit
- reflex hammer
- spacer device
- spatula
- sphygmomanometer – extra wide and paediatric cuffs – calibrated within the last year if aneroid; mercury sphygmomanometer needs only rubber pipes checked
- stethoscope
- surgical instruments appropriate for any procedures carried out
- suture equipment
- syringes and needles
- thermometer
- tuning forks – 256 Hz, 512 Hz
- urinary catheters and local anaesthetic gel or other means for urgent catheterisation e.g. referral in urban area
- urine dipstick – protein, glucose, ketones
- visual acuity chart – at the specified distance
- weight scales – adult, baby

Emergency and resuscitation equipment:

- airways and/or laryngeal masks – varied sizes (e.g. paediatric to adult)
- Ambu bag and masks – paediatric to adult
- emergency bag/trolley
- IV equipment – setup and infusion
- oxygen
- saline – any one of e.g. Pentaspan/crystalloid
- tourniquet

All essential basic and emergency medicines are available in stock or in the doctor's bag/clinical bag or portable emergency kit:

- adrenalin 1/1000
- analgesia, e.g. paracetamol, Voltaren
- an alternative for those allergic to penicillin
- antiemetic
- antihistamine injection
- aspirin tablets
- atropine injection
- corticosteroid injection
- diazepam injection/rectal
- frusemide
- 50% glucose/glucagon injection
- local anaesthetic injection
- naloxone injection
- nitrolingual spray
- penicillin injection – some need refrigeration and in addition powdered version for off-site emergencies
- sodium chloride (NaCl) for injection
- sterile water for injection