Interpretation Guide

RNZCGP Standard for New Zealand General Practice

2011–2014
CORNERSTONE General Practice Accreditation

This interpretation has been written to support practices in their journey to accreditation. CORNERSTONE General Practice Accreditation is awarded, by the Royal New Zealand College of General Practitioners on the recommendation of Health and Disability Auditing New Zealand Limited, a designated auditing agency. The process involves a self assessment by the practice and external validation against Aiming for Excellence, the standard for New Zealand general practice. It encourages practice teams to implement continuous improvement strategies in their practice systems and includes an assessment from peer reviewers to measure progress, identify areas for improvement and recommend change.

Accreditation is valid for four years.

Disclaimer

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.

Published by The Royal New Zealand College of General Practitioners, Wellington, New Zealand
First published in January 2012
ISBN: 978-0-9864536-5-6
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Aiming for Excellence measurements

Anecdotal evidence on its own is not sufficient as a measure of improvement, and access to consistent data over time produces robust information to inform reflection and health improvement activity. While it is not possible or useful to assess every function in a practice, Aiming for Excellence identifies measurements considered important by all stakeholders, including patients, for the development of structures and processes in patient-centred general practice settings. They are grouped into four areas with people as the focus (Figure 1). Practices that achieve the standards in this document can provide accountability for delivering safe, comprehensive, high quality services to patients.

Figure 1 – Sections in Aiming for Excellence

There are three categories of standards.

Key

★ ★ Essential standards
These are the essential, legal, safety standards or those that pose significant risk if not met. They determine the minimum level of service patients can expect.

★ College standards
These standards are considered important and best practice by the RNZCGP.

☆ Aspirational standards
These standards identify further opportunities for continuous quality improvement.

Practice Accreditation and Quality Improvement

The College uses the Joint Commission on Accreditation of Healthcare Organisations (JACHO) definition for Practice Accreditation:

Accreditation is a self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.

The College view on quality has been formed over time by best available evidence and practice. Leadership by all members of a general practice team has strongly influenced and supported a Quality Improvement (QI) approach to the General Practice Accreditation Programme.

The CORNERSTONE General Practice Accreditation Programme

The principles of JACHO and a strong commitment to CQI are firmly embedded in the College CORNERSTONE programme. It is a framework for practices to confirm the quality of care provided to patients.

Participation in the programme enables a practice to validate the quality of care against Aiming for Excellence – the Royal New Zealand College of General Practitioners, standard for New Zealand general practice. The publication provides a quality improvement framework for general practice teams to compare their practice and clinical systems against a recognised and acceptable standard. It outlines where a practice can focus their efforts to establish safe, transparent, accountable and high quality general practice. Practices can use the information for systems review, continuous improvement and to support the management of patient care.

Aiming for Excellence contains standards, indicators and criteria that identify minimum legal and safety standards or those that pose significant risk as defined by the College. It also identifies other standards...
considered essential by the College. The CORNERSTONE General Practice Accreditation Programme uses *Aiming for Excellence* to assess quality in general practice. Together, *Aiming for Excellence* and CORNERSTONE meet the requirement of the Public Health and Disability Act 2000 for the development, use and monitoring of a nationally consistent standard and quality programme for organised general practice services and patient safety.

CORNERSTONE assessors are peers who undertake an external assessment of the practice and systematically review the practice against indicators, criteria and standards in *Aiming for Excellence*. The assessors are trained to go beyond audit to identify whether members of the practice team have knowledge of the practice policies and systems and can describe how they apply them.

**Health and Disability Auditing New Zealand Limited (HDANZ)**

HDANZ provide oversight of the CORNERSTONE programme and independent verification of reports. They provide an analysis of the reports and recommend practices to the College for final accreditation.

Health and Disability Auditing New Zealand (HDANZ) endorse the CORNERSTONE general practice accreditation programme. They are a Designated Audit Agency and accredited as an independent certifying body.

Certification is the process by which organisations meet the standards of the Health and Disability Services (Safety) Act 2001. It is a legislative requirement. Standards cover both quality assurance and quality improvement activities. Audit agencies that have been designated by the Director-General of Health will undertake certification audits. The Health and Disability Service (Safety) Act 2001 includes a mechanism for updating the standards under it. One of the objectives of the Act is to encourage health and disability support service providers to continuously improve service quality.  

**Key principles for practice assessment**

The RNZCGP early pilot studies and field trials to test the standards, assessor consistency, assessment tool and the process of assessment discovered key principles that are important to the successful outcome for practice assessments.  

1. **Commitment of the whole practice**

The involvement of all members of the practice has been shown to be effective to improving quality. There must be commitment by the whole team to participate in the process for this to happen.

2. **Allocating a team member to manage the process**

The team leader can be any member of the practice team. The main requirement is that the person who manages the process has excellent communication skills, is respected and supported by the team, has a drive to continually improve services and a knowledge of continuous quality improvement or is keen to learn.

3. **Undertaking a self assessment**

A self assessment is an important part of the process. It provides baseline information about the practice, which should be used to prepare for the external assessment. This task should involve the whole team. Indicators can be allocated to team members to enable them to assess each criterion and score the results. They should also collect information about policies and procedures that will need to be sighted during the external assessment.

4. **Being prepared for an external assessment**

Preparation is the key to be well managed, stress free external assessment. An organised practice will have relevant material uploaded to the on-line system for the assessors to view, appointments and meeting times booked and the practice team should be well briefed, prepared and aware of the agenda for the assessment day.

5. **Involvement of Primary Health Organisation, Network, franchise holder, management organisation**

Regional quality facilitators may assist by coordinating local training and providing one-to-one with the practice to prepare for an assessment.

6. **Assessor contact with the practice coordinator prior to the external assessment**

Contact between the lead assessor and the practice before the assessment provide clarification about the timetable and the process, assisting with reducing practice apprehension about the visit and ensures that preparations are well managed. Two assessors will spend 6-8 hours in your practice.

7. **The whole practice team attendance at the debriefing session**

The purpose of a one hour debriefing session, at completion of the external assessment, is to assist the team to develop a quality action or management plan. The field trial results showed the greatest benefit was when the whole team made contributions, agreed to take responsibility for various tasks and set timelines.

8. **Timely written feedback to practice following the assessment**

The timing of the feedback report to practices is important to the practice commitment to ongoing improvement. The written report is a valuable record, or snapshot of the practice. It can be used as a baseline when developing quality plans or other practice activities.
<table>
<thead>
<tr>
<th>Access</th>
<th>The ability to obtain health care irrespective of income, physical location and cultural background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>A process of assessing a practice against an approved set of standards to determine whether or not they achieve those standards. If the requirements are met, they can be 'accredited'.</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>The relevance of care, intervention or action to a patient’s needs, based on established standards.</td>
</tr>
<tr>
<td>Brief interventions</td>
<td>A short discussion intended to provide people with information and help people to think differently about how to take responsibility for making changes to improve their health.</td>
</tr>
<tr>
<td>Calibration</td>
<td>Checking or adjusting the accuracy of a measuring instrument against a known instrument, standard or reading, with the purpose of ensuring consistent measurements.</td>
</tr>
<tr>
<td>Capacity</td>
<td>An individual’s or organisation’s ability to provide a service, based on skills, knowledge, and available resource.</td>
</tr>
<tr>
<td>Chronic condition</td>
<td>Is an ongoing, long term or recurring condition that can have a significant impact on people’s lives. Disabilities are not included in this definition although many people with a disability have one or more chronic conditions and they are sometimes causally linked.</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>The system which has responsibility for clinical health care decisions. It involves deciding who is accountable for clinical judgements and defining how decisions are passed on.</td>
</tr>
<tr>
<td>Continuity</td>
<td>Uninterrupted, coordinated care or service provided across programmes, practitioners and organisations over time.</td>
</tr>
</tbody>
</table>
| Disabilities | • An inability to walk  
• Walking difficulties  
• Reliance on walking aids  
• Partial sightedness or total blindness  
• Hearing disabilities  
• Lack of coordination  
• Reaching disabilities  
• Manipulation disabilities  
• Lack of stamina  
• Difficulties in interpreting and reacting to sensory information  
• Extremes of physical size  
• Learning difficulties |
| Disease coding | • Examples of Disease Coding Systems:  
• READ codes are a hierarchical coding system – each level provides a more specific diagnosis  
• SNOMED CT® (Systematized Nomenclature of Medicine—Clinical Terms) is the most comprehensive multilingual clinical health care terminology developed by the National Health Service in England and the College of American Pathologists in 1999  
• ICPC-2 PLUS (also known as the BEACH coding system) is a clinical terminology classified to the International Classification of Primary Care. |
| Effectiveness | The degree to which care, intervention or action achieves a desired outcome. |
| Efficiency | The degree to which results are achieved with the most cost-effective use of references. |
| Evidence-based practice | Is clinical decision-making based on a systematic review of the scientific evidence of the risks, benefits and costs of alternative forms of diagnosis and treatment. |
| Intermediate outcomes | The result of appropriate, effective and timely interventions that are proven to make a difference to patients’ quality of life and are a step on the way to a final outcome. |
Triage | The systems of ensuring people who need the most urgent help are dealt with first.
---|---
Practice team | Every team member in the practice.
Protocol | A protocol is a written procedure for an activity.
Quality | For general practices, quality is defined as meeting or exceeding patient expectations and relevant standards.
Reliability | The ability of a person or system to perform and maintain its function(s) accurately and consistently.
Self-management approach | Enables people with chronic conditions, and their family/whanau to manage their health condition and social functioning in partnership with health professionals and community resources. Self management promotes collaborative care planning, including decision-making and design of the care plan.
Significant results | Those results where follow-up is essential and the risks to patients of not following up are high.
Whanau | Is extended family, including kuia, koroua, pakeke, rangatahi and tamariki. The term recognises the wide diversity of families, represented within Maori communities.

**Maintenance of professional standards**

The triennial programme reflects the strong evidence that traditional methods of maintaining professional standards such as lectures and conferences are only marginally useful. The most effective methods of improving practise include educational initiatives that are based on the real work of the practitioner, use individual practitioner data to compare with peers, takes place in the working environment of the practitioner and produces individualised educational programmes based on identified learning needs.

Select activities undertaken for CORNERSTONE accreditation can be claimed by individual doctors as credits towards their maintenance of professional standards (MOPS) programme. In order for this to apply, activities must be performed by the individual and directed at individual improvement. This does not preclude all members of a practice undertaking the same activity as part of a team. Activities must have a focus on professional development.

The components of the MOPS programme include professional development plans; continuous quality improvement (CQI) activities; continuing medical education (CME) activities; and peer review activities. The MOPS programme requires the completion of a minimum number of credits in each of these areas over a three year (triennium) period. See the College website for further information.

Credits can be given for participation in CORNERSTONE General Practice Accreditation activities.

In this Interpretation Guide available credits are highlighted after each applicable indicator.

Additional credits may be claimed for the following:

**Peer review**

(a) To be eligible for credits the doctor must have attended the feedback session that is held at the completion of the external assessment.

15 credits

**Practice improvement activities**

(a) CORNERSTONE systems improvements

(b) CORNERSTONE self assessment against Aiming for Excellence

(c) Guidelines / protocols / resource development

1 credit per hour

**Collegial activities**

(d) Assessor role

(e) Training associated with assessor role

(f) General practitioner on College committee

1 credit per hour
Getting started on the journey to accreditation

This guide has been designed to assist practices to begin the journey to achieve CORNERSTONE General Practice Accreditation.

The journey will involve the practice team identifying ‘where you are now’, ‘where you want to be’ and plan ‘how to get there’ – this is the change process.

Incremental change improves systems over time and the process is designed to help practice teams work together to identify improvements, plan changes and take action to continually move forward.

CORNERSTONE is a continuous improvement process that uses the PDSA Cycle as a guide – PLAN, DO, STUDY, ACT

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**The CORNERSTONE General Practice Accreditation Journey**

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DO</th>
<th>STUDY</th>
<th>ACT</th>
<th>Health &amp; Disability Auditing New Zealand Limited Endorsement</th>
<th>CORNERSTONE General Practice Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A self-assessment against Aiming for Excellence</td>
<td>Measure the practice against criteria in Aiming for Excellence</td>
<td>What are the gaps identified and actions needed to improve?</td>
<td>Practice assessment by external assessors Report on findings of the assessment Post assessment dialogue</td>
<td>HDANZ assesses the final report and recommends the practice for accreditation</td>
<td>The College awards CORNERSTONE accreditation to the practice</td>
</tr>
</tbody>
</table>

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The Royal New Zealand College of General Practitioners

CORNERSTONE

®

The CORNERSTONE General Practice Accreditation Journey

Practice undertakes a self-assessment against Aiming for Excellence – using CQI (the PDSA cycle) to progress

External Assessment

Health & Disability Auditing New Zealand Limited Endorsement

CORNERSTONE General Practice Accreditation

Practice assessment by external assessors

Report on findings of the assessment

Post assessment dialogue

HDANZ assesses the final report and recommends the practice for accreditation

The College awards CORNERSTONE accreditation to the practice
Self-assessment – Where do you start?

Change does not happen without good planning. The purpose of the self-assessment is to measure the practice against the indicators, criteria and standards in Aiming for Excellence and take necessary action to ensure all minimum and essential criteria are met.

Early preparation

The practice should appoint a person to coordinate the self-assessment and preparation for an external assessment, and to be the main point of contact with the College.

Linking to Geethal Data Systems Limited (GDSL)

The online system contains a step-by-step presentation on how to carry out a self-assessment using the software. It contains a risk management plan and an action plan to assist you. The online system can be accessed either through the College website or directly using a hyperlink that will be emailed to the practice coordinator when the practice contracts to be accredited.

The system allows for an unlimited number of practice users. Please contact support@geethal.com if alternative access is required such as multiple site access in a group of practices, satellite practices or franchise holders.

The online guide in the use of the GDSL web based tool, ‘User Guide for Standard Users and Coordinator’ will provide you with full instructions. An online tutorial is also provided by GDSL.

The CORNERSTONE process

BEGIN Begin the CORNERSTONE journey

Aiming for Excellence, the standard for general practice in New Zealand is designed to enable the practice to put a cross on the map where the practice is now and identify where it wants to go. Continuous quality improvement is a culture that seeks never-ending improvement of the whole system as part of normal daily activity, continually striving to act according to the best available knowledge. Undertaking a quality improvement process reflects the desire and commitment of the team to find out, ‘Are we doing what we should be doing?’

Snapshot

A Snapshot is a very quick appraisal of your practice against the Aiming for Excellence criteria. The purpose is to record where the practice is at, prior to commencing the CORNERSTONE journey similar to taking photos before a house renovation or embarking on a weight loss programme. You must complete this section before you progress to the self-assessment phase.

The snapshot should be answered very quickly by the coordinator – it is expected to take no more than 20–30 minutes to complete and that some of your answers may change when you undertake a self-assessment of the practice.

Self-Assessment

The next step is to undertake a self-assessment, a more in-depth analysis. The purpose of the self-assessment is for the team to measure the practice against the criteria in Aiming for Excellence, identify any gaps and develop an action plan to work on these items, allocate tasks and complete them before the assessment by College assessors.

Once the Snapshot has been submitted, the view of the Aiming for Excellence question set changes in the Answer screen.

Self Assessment differs from Snapshot in the following ways:

• The coordinator can allocate questions to individual team members, to answer.
• The criteria are reviewed in a more thorough way. It is expected that some of your ‘Snapshot’ answers will change.

To achieve CORNERSTONE accreditation the practice must meet those criteria that identify legal and safety obligations or significant risk as defined by the College (Essential standards ★★) and those considered best practice and important by the College (Other essential standards ★).

PLAN Arrange a practice meeting

Appoint one member of the team to take overall responsibility and coordinate the process. This person will:

• Be the point of contact for the College
• Be responsible for the overall process and making sure the practice team keeps to the plan and timeline
• Set up and inform the team about meetings
• Develop a reporting plan
• Report progress against actions back to the team
• Develop an overall reporting plan and make modifications if behind targets
• Plan tasks to complete the self-assessment

Important:

• Identify a timeframe to complete the self-assessment; this will guide progress
• Ask members of the practice team to identify which criteria they will take responsibility for measuring (doctors, practice nurse, practice manager, administration staff)
• Identify who will collect the data for each criterion (Met, Partially Met, Not Met)
• Book regular meetings to report back on progress
DO  The audit
Audit – What information needs to be collected?
Important:
- Double star items are those that identify legal
  and/or safety obligations or significant risk as
  defined by the College – these are mandatory for
  accreditation ★★
- Single, solid star items are considered best
  practice and important by the College – these are
  mandatory for accreditation ★
- Open star items are those the College considers
  important but not essential; they are opportunities
  for improvement – these are not essential for
  accreditation ☆

CHECKLIST
Measure the practice against all the indicators, criteria
and standards in Aiming for Excellence
Record findings (Met, Partially Met or Not Met) on the
GDSL Practice Assessment Software

STUDY  The improvement process

What were the results of the audit?
- Assess the results of the audit
- How well does the practice compare against the
  expectations in Aiming for Excellence?

Arrange a team meeting

Sample Action Plan:
Preparing the practice for an EXTERNAL Assessment

Weekly meeting time: Tuesdays 9am–9.30am
Participants: All members of the practice

<table>
<thead>
<tr>
<th>Date</th>
<th>Agreed tasks</th>
<th>Actions</th>
<th>Person responsible</th>
<th>Complete by</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/08/11</td>
<td>Write complaints policy</td>
<td>Identify sample complaints policy</td>
<td>Alan</td>
<td>20/7/12</td>
</tr>
<tr>
<td>21/08/11</td>
<td>Appoint complaints officer</td>
<td>Plan team meeting to discuss and finalise</td>
<td>Claire</td>
<td>30/6/12</td>
</tr>
</tbody>
</table>

Does the practice need extra help to meet the required
criteria?
There are a number of sources that practices can go to
for extra assistance:
- Aiming for Excellence includes additional
  resources for each indicator
- CORNERSTONE folder of resources
- The regional PHO, Network or practice
  organisation/ franchise holder may provide extra
  assistance
- Medical Assurance Society – hyperlink from
  RNZCGP website
- Other accredited practices – see RNZCGP
  website
**Additional Tips**

Choose a date for the external assessment early in the process, at least six months out from the scheduled date. To do this send an email or phone the CORNERSTONE team at the College to add the name of the practice into the CORNERSTONE external assessment schedule.

Plan the full year’s programme in advance as other practice commitments and seasonal activities may impact on your timetable. These may include but are not limited to staff taking annual leave, rostering staff in rotation to attend courses, seasonal increases in patient load (winter illness/influenza vaccination programme) and public holidays.

Attach all the policies and documents into the online tool. (See ‘User Guide for Standard Users and Co-coordinators). This will allow the assessors to access the information in preparation for the CORNERSTONE assessment.

**Training Levels in Guidance Section**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Training requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1.3</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>Code of Health &amp; Disability Services Consumers’</td>
<td>All practice team</td>
</tr>
<tr>
<td>• 2.2</td>
<td>Level 1 or 2</td>
</tr>
<tr>
<td>Health Information Privacy Code 1994</td>
<td>All practice team</td>
</tr>
<tr>
<td>• 5.2</td>
<td>Level 1 or 2</td>
</tr>
<tr>
<td>Principles of the Treaty of Waitangi</td>
<td>All practice team</td>
</tr>
<tr>
<td>• 6.1</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>Cultural competence and cultural safety</td>
<td>All practice team</td>
</tr>
<tr>
<td>• 16.2</td>
<td>Level 1</td>
</tr>
<tr>
<td>Infection control and disinfection and sterilisation—appropriate members of the practice team</td>
<td>Appropriate team members</td>
</tr>
<tr>
<td>• 17.4</td>
<td>Level 1</td>
</tr>
<tr>
<td>Cold Chain Training</td>
<td>Appropriate team members</td>
</tr>
<tr>
<td>• 17.5</td>
<td>Level 1</td>
</tr>
<tr>
<td>Vaccinator training—team members who manage cold chain</td>
<td>Designated team members</td>
</tr>
</tbody>
</table>

Note: The assessors do not have access to the practice data in the snapshot or self assessment fields. The online tool limits the assessor view to the attachment field only.

Other areas to consider in preparation for the assessment visit:
- Training
- Third party evidence
- Record review

**Training**

A number of criteria require individual staff members or all the practice team members to have been ‘trained’ in certain aspects relevant to the indicator. Be aware of what training programmes are being delivered in your region. Do not leave the training of staff until the last few months.

A template for the collection of training details is available on the CD.
Record Review – Where do you start?

Indicator 22

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

For CORNERSTONE General Practice Accreditation the practice must undertake an audit of 15 medical records per doctor and practice nurse.

It is recommended the practice commence the record review at least six months before the assessment date. This will allow adequate time to implement the quality improvement plan to address any identified problems.

The instructions for the record review, recording sheets and reporting template are available on the accompanying CD. Further information is also on Page 66.

Checklist for accreditation

- The practice has audited 15 records per doctor/practice nurse
- The medical records chosen show evidence of random selection
- The last entry is less than 12 month old
- A report of the audit findings is available

Upload third party evidence to GDSL.

- Electromedical testing annually (six monthly or more frequently if equipment is in high use or subject to abuse)
- Inspection and testing of residual current devices and/or Body-Protected Electrical Area
- Cold chain accreditation - timeframe based on the Immunisation Advisory Centre findings at original assessment
- Fire evacuation scheme signed off by the National Commander, New Zealand Fire Service
- Feedback from patients – undertaken by the practice, for example RNZCGP Better Practice Patient Questionnaire
- Calibration and validation of the steriliser annually and every time significant changes are made as per AS/NZS 4815:2006 Office based health care facilities – reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment
The purpose of this indicator is to establish the practice commitment and its response to the Code of Health and Disability Services Consumers’ Rights 1996.

The rights are:
1. Consumers should always be treated with respect.
2. No one should discriminate against consumers, pressure them into anything, or take advantage of them.
3. Services should help consumers to live dignified, independent lives.
4. Consumers should be treated with care and skill and receive well-co-ordinated services
5. Service providers should listen to consumers and give them information in a way they understand and that makes them comfortable to ask questions if they don’t understand. This may require you to provide an interpreter.
6. Consumers should have any treatment to be provided to them explained, including benefits, risks, alternatives and costs, and have any questions answered honestly.
7. Consumers can make a decision about treatment, and are free to change their mind.
8. Consumers can have a support person with them at most times.
9. All these rights apply if consumers are asked to take part in research or teaching.
10. Consumers have a right to have a complaint about services taken seriously

The Code can be downloaded free of charge from the Health and Disability Commission website http://www.hdc.org.nz Additional resources are available through this website or the office of the Health and Disability Commissioner. Phone: 0800 11 22 33 Ext 5263. Most come in a range of languages at a nominal charge.
The Health and Disability Commissioner’s office provides training through the Advocacy Service. This is a free service. Phone 0800 11 22 33 Ext 5263 Provider DVDs can also be purchased through the HDC website:
For example: ‘Making it easy to do the right thing’ (Provider DVD)
‘Scenarios illustrating rights and advocacy services’
The role of the advocate is to assist the ‘consumer’ to resolve a complaint with a provider. You can expect the advocate to have a good understanding of the consumer’s rights and your obligations. Advocates from the Health and Disability Commission provide their services free of charge.

Guide to key documents
- Code of Health and Disability Services Consumers’ Rights 1996
- HDC training records – name of provider, date of delivery, names/certificates of persons attending
- HDC Poster/pamphlets
- HDC advocacy poster/pamphlets

Resources include:
Posters
Leaflets
Pocket cards
Audio tapes
Compact discs
Videos / DVDs
In addition several leaflets and poster are available to download free of charge.

A poster outlining the Code is displaying where patients can easily read it.

All members of the team have participated in training (Level 1 or 2) to assist them to understand their role and the purpose of the Code of Health and Disability Services Consumers Rights 1996. The practice team should be able to describe and demonstrate how they deliver health and disability services in keeping with the Code.
Examples may include but are not limited to:
How does the practice co-ordinate care?
How does a consumer obtain support?
What are advanced directives? - Also links to Indicator 22.

Notes
The code applies to health information relating to identifiable individuals. This means that while it covers, for example, information about an individual’s medical and treatment history, disabilities or accidents, contact with a health or disability service, service providers and information about donations of blood or organs, it does not apply to anonymous or aggregated information where the individual cannot be identified.

Health agencies and individual practitioners will need to ensure that their internal operational procedures apply with the code, for instance in the design of computer systems and the use of forms and internal procedures relating to collection, use and disclosure of health information. Compliance with privacy obligations is an integral part of good information handling procedures and closely linked to good clinical practice.

The code applies specific rules to agencies to better ensure the protection of individual privacy. With respect to health information collected, used, held and disclosed by health agencies the code substitutes for the information privacy principles in the Privacy Act.
In a nutshell from the Privacy Commissioner:

Protecting personal privacy with a PADLOCK

P  Purpose: Have a clear need for collecting and using personal information.
A  Accuracy: Personal information should be correct and accurately processed. Fix any mistakes promptly.
D  Data Minimisation: Collect only what is necessary; keep only what is necessary.
L  Lifecycle: Make smart choices about information use and flow while it is in your care. Dispose of information safely.
O  Ongoing responsibility: Encourage pro-privacy use of technologies now and in the future.
K  Knowledge: Tell people why information is being collected, and how it is being used.

A poster with this message is available from the Privacy Commissioner.

The code is technology neutral – it deals with health information in the same way regardless of what form it is held. Rule 5 addresses specific consideration related to health information stored in an electronic form.


All members of the team have participated in training (Level 1 or 2) to assist them to understand their role and the purpose of the Health Information Privacy Code 1994. Staff training is an essential element of operational procedures.

The practice team should be able to describe and demonstrate how they manage people’s health information.

The practice team should be able to describe and demonstrate their role in implementing the Code.

Examples include but are not limited to:

What are the practice requirements around disclosure?

Who owns the health information?

When do we need informed consent to use or disclose health information?

Who is the Privacy Officer?

Section 23 of the Act places a responsibility on each health agency to ensure that there is, within that agency, at least one individual (referred to as a ‘privacy officer’) whose responsibilities include:

• encouraging the agency to comply with the code;
• dealing with requests made to the agency under the Act and code;
• working with the Privacy Commissioner in relation to any investigations conducted under the Privacy Act in relation to the agency; and
• otherwise ensuring compliance by the health agency with the Act and the code.

The ‘privacy officer’ does not need to be a dedicated role. One or more persons may hold the responsibilities within an agency.

External training can be obtained through the Office of the Privacy Commissioner:
Email enquiries@privacy.org.nz
Phone Auckland 09 302 8655
Other areas 0800 803 909
A fee may be chargeable.

The Privacy Commissioner’s office also has an online training tool see: http://www.commissioner.com/2723701

On the Record – A Practical Guide to Health Information Privacy is not a substitute for good training however provides a comprehensive table of content as a quick reference guide to compliance with the code. The aim is to help agencies devise policies for:

• collecting, using and disclosing health information;
• dealing with requests by third parties for information about patients;
• dealing with requests by patients for access to and correction of their information.

Files are secure or password protected from unauthorised access, unless in active use by the practice team. The electronic Patient Management System should be secure and passwords should be of a moderate security. The longer the password the better – use a mixture of upper and lower case letters mixed with numbers and special characters. For example PASSword8!

Links with Criterion 13.5

The Privacy Commissioner asked for the following to be noted:

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. It does not specify exactly how this should be achieved. 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. In the context of complaints that she has received, the Privacy Commissioner has been of the view that having lockable cabinets in which to store sensitive personal information is an important component of secure information handling. Even where space is very limited, a range of lockable cabinets is now available to ensure information is secure.

NB: The Commissioner has notified an expectation that all practices are to have lockable cabinets for paper files. Storing files in an open area behind reception is not acceptable. The College noted that it may not be practical to meet this expectation, due to space and/or financial limitations. It has agreed to inform RNZCGP members that they should plan to fulfil this requirement by 2013.
Rule 9 provides that health information must not be kept longer than is required for the purposes for which it may be lawfully used. Health information must be kept for at least 10 years from the date of treatment or care.

It is an expectation that practices will have a robust process to dispose of health information in a manner which ensures confidentiality. Controlled physical destruction of the records by shredding or controlled incineration by a third party collection and disposal service with the correct level of information security, knowledge and experience. This will ensure records are not lost or parts removed during the process and that the process does not leave any readable waste.

Computerised records for disposal should be re-formatted to prevent reconstruction of the data from storage devices such as hard drives. Storage devices damaged prior to disposal will require physical destruction if they cannot be securely erased.

Inactive hardcopy files should be moved to an appropriate secure location.

The Health Information Privacy Code 1994 states: Retiring practitioners should take proper steps to ensure that relevant records are left with another competent practitioner, the individuals concerned, or an appropriate statutory or professional body.

Portable storage devices such as USB sticks, cellphones, iPods, personal digital assistants (PDAs) and smart phones such as Blackberrys and iPhones are now more widely used. While technology is advancing the way we work these devices may increase the likelihood of information being compromised. The Privacy Commission has issued guidance note on the use of portable storage devices – see http://privacy.org.nz/guidance-note-on-the-use-of-portable-storage-devices/

Key documents for accreditation
- Health Information Privacy Code 1994
- Training records – name of provider, date of delivery, names/certificates of persons attending

Additional Resources


The Privacy Commissioner website (includes training and education resources); on the record: A practical guide to health information privacy; Health privacy toolkit. Available from: www.privacy.org.nz

The health information privacy tool kit is available from Privacy Commissioner’s website at: http://privacy.org.nz/health-privacy-toolkit/


Health related privacy case notes http://privacy.org.nz/health-privacy-toolkit/

Health related privacy fact sheets http://privacy.org.nz/health-privacy-toolkit/

Notes
The practice upholds the patient’s right to complain

The practice 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. Complaints are important indicators of problems with clinical care or processes in the practice. Complaints may not be isolated incidents so practices need to establish whether there is a pattern to any complaints received. While most complaints can be dealt with at practice level, experiencing a problem can be distressing for patients, families, and affected team members or the practice team. Having a process in place to identify and manage complaints assists practices to understand the nature of problems and resolve them.

Under the Code all complaints must be taken seriously whether made orally or in writing. You are expected to facilitate a fair, simple, speedy, and efficient resolution of the complaint.

- See CD for example of policy
- See CD for example of complaints form

Under the Code you 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 you have 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.

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

The Commission states many of the complaints the Commissioner receives are about complaints not being taken seriously by providers, or complainants not being told what is being done about the complaint.

If the complaint does not get settled an advocate may report an unresolved complaint to the Commissioner. The complaint can also be taken directly to the Commissioner’s Office. Senior member of the Commissioner’s staff carefully review the complaint and the Commissioner decides the best way of dealing with it. This may include referral to another body (for example the Ministry of Health), advocacy, investigation or no action.

1. A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in the Code.
2. The onus is on the provider to prove that it took reasonable actions.
3. For the purpose of this clause ‘circumstances’ means all the relevant circumstances, including the consumer’s clinical circumstances and provider’s resource constraints.

The final decision is a written report on the case. You can view some of the Commissioner’s reports known as opinions on the Commissioner’s website at http://www.hdc.org.nz.

The practice team should be able to describe and demonstrate how they manage complaints in keeping with the Code. Examples may include but are not limited to:

- Reviewing and managing complaints is an important risk management activity that enables practices to reflect and respond constructively to complaints.

### Indicator 3

Complaints

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
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<tbody>
<tr>
<td>3.1 ★★</td>
<td>There is a documented policy that describes how complaints will be managed in line with Right 10 of ‘The Code’</td>
</tr>
<tr>
<td>3.2 ★★</td>
<td>The practice team is able to demonstrate their role in managing the complaints process</td>
</tr>
<tr>
<td>3.3 ★★</td>
<td>The Complaints Officer can demonstrate that the complaints process complies with Right 10 of ‘The Code’</td>
</tr>
<tr>
<td>3.4 ★</td>
<td>Complaints and their resolution are used as opportunities for learning and quality improvement</td>
</tr>
</tbody>
</table>

The complaintant can also take the complaint directly to the Commissioner’s Office. Senior member of the Commissioner’s staff carefully review the complaint and the Commissioner decides the best way of dealing with it. This may include referral to another body (for example the Ministry of Health), advocacy, investigation or no action.

1. A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in the Code.
2. The onus is on the provider to prove that it took reasonable actions.
3. For the purpose of this clause ‘circumstances’ means all the relevant circumstances, including the consumer’s clinical circumstances and provider’s resource constraints.

The final decision is a written report on the case. You can view some of the Commissioner’s reports known as opinions on the Commissioner’s website at http://www.hdc.org.nz.

The practice team should be able to describe and demonstrate how they manage complaints in keeping with the Code. Examples may include but are not limited to:

- Reviewing and managing complaints is an important risk management activity that enables practices to reflect and respond constructively to complaints.
Who is authorised to manage complaints?
Do all the team know who this is?
Who is authorised to receive complaints?
Is there a complaints form for patients to complete?
The practice has authorised a person to manage complaints. The designated Complaints Officer maintains a complaints register – this can be electronic.
The designated person can describe and demonstrate how they manage complaints in keeping with the legislated process and can produce documentation to validate compliance with timelines. A comprehensive record should be maintained of each complaint outlining the actions taken and outcome in chronological order.
The complaints process, including the resolution of complaints, is used as an opportunity for learning and to improve quality.

- See CD for example of PDSA cycle
- See CD for PDSA worksheet for testing change

Key documents for accreditation
- Code of Health and Disability Services Consumers’ Rights 1996
- HDC Poster/pamphlets
- Complaints policy
- Complaints register
- Complaints forms
- Meeting minutes
- Quality plan

Maintenance of professional practice credits
Criterion 3.4 – resolution of complaints
If the review of a complaint leads to the identification of an area for development, this plan can be included as part of the professional development plan for the individual doctor, to identify a relevant set of CME activities (event attendance or development of practice improvement activities; 1 credit per hour).
The complaints resolution process by itself does not attract credits – it is not a professional development activity.

Additional Resources
The Royal New Zealand College of General Practitioners. Managing complaints—process and strategies. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2009

Notes
Patients are provided with information to enable **Indicator 4** them to make informed choices about their health care

Informed consent occurs when the patient gains an understanding of what is involved in receiving a proposed procedure or treatment and, free from coercion, gives agreement. Clinicians must be able to support patients so that they can make informed choices about their care. Trust is a vital element in this approach and both patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. Clinicians need to inform the patient about potential risks and benefits of a proposed treatment and let the patient know that their welfare is the paramount concern. 

<table>
<thead>
<tr>
<th>CRITERIA</th>
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<tbody>
<tr>
<td>4.1 **</td>
<td>Information is available and accessible to assist patients to make informed choices</td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>4.2 ★</td>
<td>Patients are routinely informed of their right to have a support person or chaperone present during a consultation</td>
</tr>
<tr>
<td>• Patients need to know that they can ask to have someone to support them during a consultation. 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</td>
<td></td>
</tr>
<tr>
<td>4.3 ★★</td>
<td>Informed consent is obtained from a patient or legally designated representative when agreeing to a treatment or procedure</td>
</tr>
<tr>
<td>• Obtaining informed consent is an essential risk management activity. New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers’ Rights 1996</td>
<td></td>
</tr>
<tr>
<td>4.4 ★★</td>
<td>Informed consent is documented when there is variance between evidence and practice</td>
</tr>
<tr>
<td>• A record is important in areas where there is variance between evidence and some medical practice or an ethical dilemma about treatment</td>
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Consent law is patient centred in New Zealand and 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 basic to the individual’s freedom, right and self-determination.

It comprises of 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 the delivery 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.

Under the Code of Rights every consumer, including a child, has a right to the information they need to make an informed consent or give an informed consent. The law relating to the ability of children to consent to medical treatment is complex. There is no one particular age at which all children can consent to all health and disability services. The presumption that parental consent is necessary in order to give health care to those aged less than 16 years is inconsistent
with common law developments and the Code of Rights. 13

A child aged less than 16 years has the right to give consent for minor treatment, including immunisation, providing he or she understands fully the benefits and risks involved. This right has been tested in a 2001 case that went before the Health and Disability Commissioner – see http://hdc.org.nz (Commissioner’s Decisions 2002 01HDC02915)

Consent requirements for school programmes are different – refer to Immunisation Handbook 2011 page 54, MOH.

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:
http://www.everybody.co.nz
http://www.healthnavigator.org.nz

Patients can then come back if they have further questions.

Every consumer has a right to one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights may be reasonable infringed.

The practice may wish to advise patients by displaying a poster in the waiting area.

See CD for example of chaperone poster
See CD for example of chaperone policy

Consent is not a single act but a process involving communication between the consumer and the provider in which the provider openly and honestly provides full information in an environment and in a manner in which the consumer can understand it. The right to consent carries with it the right to refuse. The right is a negative; a right to be left alone, the right to choose whether to agree to receive a particular service or whether to decline it. It is not a right to demand or have a particular procedure or treatment. 14

Right 5 – Right to effective communication:
(1) Communication shall be in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Interpreter

It is preferable to engage the services of an experienced interpreter who has been trained in medical terminology and concepts. In reality, the use of trained interpreters is often not possible because of lack of access or high cost. Hence, friends and family members are frequently used as de facto interpreters for the patient. 15

Language Line, a telephone service offered by the Office of Ethnic Affairs, is available 9 – 6 pm weekdays and 9 – 2 pm Saturday. The service is available in 42 languages (costs are involved). The interpreter can be pre-booked. http://www.ethnicaffairs.govt.nz/oeawebsite.nsf/wpg_url/language-line-index

Right 6 – Right 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
– the results of 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.

The law has established that there is a duty to disclose expected risks, but determination of these will depend on the circumstances of individual cases. At common law there is duty to disclose material or substantial risks. 14

(2) Every consumer has a right to the information that a reasonable consumer in that consumers circumstances needs to make an informed choice and give informed consent.
(3) Every consumer has a right to honest and accurate answers to questions relating to services including questions about –
– a) the identity and qualifications of the provider; and
– b) the recommendation of the provider; and
– c) how to obtain an opinion from another provider; and
– d) the results of research

(4) Every consumer has the right to receive, on request, a written summary of information provided.

It is suggested written information such as pamphlets and brochures, should not replace verbal communication between the provider and the consumer because the onus of assessing whether the consumer actually understands the information that is being given to them is on the provider.

Right 7 – Right to Make an Informed Choice and Give Informed Consent.
(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.

Advanced directives

This term means the patient can make a choice in advance of a service. Directives, made in the event a person was in danger of death or incapable of decision making, must apply to a particular future healthcare procedure or service. The validity of advanced directives is unclear in New Zealand however is regarded as best practice by the College and a useful adjunct for patient care. The practice is advised to seek legal assistance in the preparation of an advanced directive. The Code states that ‘everyone has a right to refuse to undergo any medical treatment.’

Links to Indicator 22

Consent forms

Mandatory elements of a consent form according to Health Care and the Law:

- Name and full identification of client;
- Name of procedure agreed to;
- Name of place for carrying out of the procedure;
- (Optional) consent to specified associated treatments (these could presumably have been discussed as part of the procedure);
- (Optional) consent to or statement acknowledging possible emergency treatment;
- Statement of what information had been given, for example what the procedure involves, why it is required, why it is recommended in reference to alternatives (further items could be added as per those in statute);
- (Optional) list of specific risks and advantages which have been discussed;
- Some institutions and practitioners may wish to have additional statements to the effect that the client assumes all risks and acknowledges that benefits are not guaranteed or certain. This gives some protection to the professional(s) involved.

Clients should be wary of signing such conditions, and should at least insist on the above matters being included if they do.

- Agreement to another person carrying out the procedure, or any other necessary procedure, if circumstances require this.

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.

See CD for checklist for consent forms.

Consent forms are recommended for but not limited to;
- Minor surgery
- Other surgical procedures, for example circumcision, vasectomy
- Steroid injections into joints
- Insertion of intra-uterine contraceptive devices
- Insertion of intra-uterine progestin devices
- Insertion of long acting contraceptive implants

Doctors have a special duty of care when enrolling apparently healthy asymptomatic persons in screening. Particular attention must be paid to explaining the uncertainties and limitations of the screening and implications of the screening and limitations of false positives and false negative findings for your patients.

The decision to offer tests and investigations can be influenced by societal, political and economic factors. Screening in the face of uncertain evidence will remain a controversial issue.

Links to Indicator 29.
Key documents for accreditation

- Code of Health and Disability Services Consumers' Rights 1996
- Consent forms
- Evidence of signed consent
- Evidence (documentation) of verbal and/or implied consent
- Evidence of consent to be screened for a contentious issue – see also Indicator 29
- List or contact details for interpreter services
- Chaperone poster

Additional resources

CALD (Culturally and Linguistically Diverse)—training, development, resources for health professionals: www.cald.org.nz


The Health and Disability Commissioner’s office—videos, audiotapes, posters, pocket cards and pamphlets: www.hdc.org.nz


Department of Internal Affairs—Translation Service: www.dia.govt.nz

The Office of Ethnic Affairs—Language Line: www.ethnicaffairs.govt.nz


New Zealand Society of Translators and Interpreters (NZSTI)—a nationally representative body of translators and interpreters that provides a networking forum for its members, represents members’ interests, and promotes continued professional development, quality standards and awareness of the profession within government agencies and the wider community: www.nzsti.org

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

General practice commitment to Te Tiriti o Waitangi, the Treaty of Waitangi

The RNZCGP is committed to improving the health status of Māori, and recommends taking an evolutionary approach to improvement. This may include attending Te Tiriti o Waitangi (Treaty of Waitangi) training, collecting ethnicity data correctly, and conducting clinical audits of Māori and non-Māori. All audit data requires analysis by ethnicity for identifying ethnic health inequalities. These activities will assist practices to identify needs and work towards improved health and parity of outcomes for Māori people.

The RNZCGP supports the Crown commitment to ongoing development and refinement of services that recognise both the partnership status and the current health disparities of Māori. As such, there is a commitment to seeing that Māori are involved at all levels of health services delivery.

This indicator looks for evidence of practice responsiveness to Te Tiriti o Waitangi, the Treaty of Waitangi. It assesses whether practices reach, know the health needs of and have a plan to address the health needs of Māori in their population. For example, it looks for evidence that:

- the patient management system identifies Māori
- the practice uses an equity assessment tool, for example Ministry of Health, the Health Equity Assessment Tool, Whanau Ora Tool or Whanau Ora Health Impact Assessment Tool in their planning process
- the practice is aware of the special rights and health needs of Māori, and implements policies consistent with the Māori Health Strategy to ensure access to a fair share of the practice resources
- the practice conducts regular clinical audits reviewing data by ethnicity, and makes changes as indicated by the results of these audits
- practice teams proactively identify the health needs of Māori with the purpose of providing equity to Māori.

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<tr>
<th>CRITERIA</th>
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<tbody>
<tr>
<td>5.1 ★ The practice has a documented Māori Health Plan</td>
<td>Practice planning supports the Crown’s commitment to address inequalities between the health status of Māori and other New Zealanders. 17</td>
</tr>
<tr>
<td>5.2 ★★ All team members are trained in Te Tiriti o Waitangi (the Treaty of Waitangi), including the principles of ‘Partnership, Participation and Protection’</td>
<td>Training provides practice teams with accurate and consistent information about relationships with local Māori, and addresses indigenous rights and the Crown’s responsibility to Māori</td>
</tr>
<tr>
<td>5.3 ★ The practice addresses the health needs of its enrolled Māori population to reduce health inequalities</td>
<td>Successful engagement with Māori will help reduce disparities through better understanding about the determinants of health, healthy lifestyles, how to access appropriate health services early, and how to ensure Māori feel comfortable in mainstream health institutions. 18</td>
</tr>
<tr>
<td>5.4 ★ The practice team has developed active relationships with local Māori organisations, providers, groups, and whānau</td>
<td>Establishing relationships with tangata whenua*, iwi groups, marae, local Māori providers and/or Māori community organisations will enable the practice to develop services that are relevant for Māori</td>
</tr>
</tbody>
</table>

The RNZCGP recognises the diversity of understanding about Māori populations and Māori health issues throughout New Zealand and encourages practices to provide their own solutions.

Inequalities between the health status of Māori and other New Zealanders are well documented. 19 Research confirms Māori are disproportionately represented in almost all negative health and social

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*Tangata whenua is a Māori term referring to Māori being the indigenous peoples of Aotearoa (New Zealand) and means ‘people of the land’, from tangata, ‘people’, and whenua, ‘land’. In a particular tribal geographical area tangata whenua refers to the local Māori tribe.
statistics and are, in general poorer, sicker, and more socially deprived than non Māori. Māori do not access primary care services as often as or as early as non Māori and are not referred for secondary and tertiary procedures at the same rate as non Māori.

These findings have led government to identify a range of priority areas for improving Māori health and a reorganisation of the health services in an attempt to improve access to appropriate, affordable and acceptable primary health services. 17

A Māori Health Plan is an essential element of the Te Akoranga a Maui strategy.

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)
- implement measures to address priority areas as stated in He Korowai Oranga: Māori Health Strategy
- target services for the enrolled Māori population
- ensure ethnicity data on Māori is available and robust
- establish priorities for Māori in the practice and set goals that will benefit their health outcomes
- 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

Useful links
http://www.maorihealth.govt.nz/moh/nsf/About+Māori+Health
http://www.maorihealth.govt.nz/moh/nsf/pagesma/303

The RNZCGP has a cultural competence resource which was developed by Mauri Ora Associates with the assistance of Te Akoranga a Maui.

All members of the team should have participated in training (Level 1 or 2) in the principles of the Treaty of Waitangi and the government’s commitment to fulfilling the special relationship between iwi and the Crown. The principles of partnership, participation and protection underpin that relationship. This is important in addressing the body of evidence of significant disparities in health. Where possible, training should be recognised by Tangata Whenua.

Successful engagement with Māori will help reduce disparities through a better understanding about the determinants of health, healthy lifestyles, how to access appropriate health services early, and how to ensure Māori feel comfortable in mainstream health institutions.


The Medical Council states that ‘a reasonable pronunciation of Māori words, some understanding of the processes and rituals of engagement and a general sense of tikanga relevant to clinical practice will lead to solid and respectful relationships with Māori. Knowledge of, and an ability to work with, traditional practitioners in a collaborative way give Māori the best chance of benefiting from all paradigms of practice.’

What specific interventions has the practice put in place to address Māori health priorities? Ensure key strategies and action plans developed and initiated to reduce inequalities for Māori include measurable progress milestones.

The practice should identify and develop a contact list of Māori organisations, groups and providers of health services. Active relationships can be demonstrated through such documents as meeting minutes.

**Key documents required for accreditation**

- Māori health plan
- Training records – name of provider, date of delivery, names/certificates of persons attending
- Contact list of local Māori organisations, providers, groups and whanau
- Meeting minutes
- Ethnicity data collection policy
- Posters/health information in Te Reo

**Maintenance of professional practice credits**

An audit of health issues in relation to patients identifying as Maori could be devised and submitted
to the College for pre-approval as a CQI activity for the individual doctor or by the practice on behalf of a group of doctors, for example diabetes mellitus. 10 credits

Some registered providers deliver CME courses in Te Tiriti o Waitangi (Treaty of Waitangi) with endorsed credits

Additional Resources


Ministry of Health. The Health Equity Assessment Tool (HEAT); the Whānau Ora tool and the Whānau Ora Health Impact Assessment tool. Available from: www.moh.govt.nz


Notes
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.

All members of the team should have participated in training (Level 1 or 2) in cultural awareness and competency. Training ensures all team members, including locums, are provided with accurate and consistent information to deliver culturally safe care and be responsive to the cultural needs of patients.

### Indicator 6

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

Being responsive to diverse local communities in a practice population can help teams to better understand how to help patients manage their own care. Care provided must be appropriate to the practice population and the practice team must be aware of any specific requirements of its population groups. Personal, family and community-oriented comprehensive care continues over time, and is anticipatory as well as responsive. It is not limited by the age, gender, ethnicity, religion or social circumstances of patients, or by their physical or mental state.

## CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
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</table>
| 6.1 ** ▲** All members of the practice team are trained in cultural competence and cultural safety | • New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers’ Rights 1996 and Section 118 of the Health Practitioners Competence Assurance Act 2003  
• Training ensures all team members, including locums, are provided with accurate and consistent information to deliver culturally safe care and be responsive to the cultural needs of patients |
| 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 | • New Zealand legislation outlines the basic rights and entitlements of patients to information privacy under the Health Information Privacy Code 1994  
• Accurate collection, maintenance and auditing of patient ethnicity data enables the Crown and the practice to identify patient and population health needs |
| 6.3 ** ▲** The practice team can access interpreters and resources for people with limited English proficiency | • Patients should not be disadvantaged when language is a barrier to care  
• Patients need interpreting services when interpreting by family members is not appropriate (due to, for example, the seriousness of illness) to gain informed consent or to understand the nature of the clinical problem |
| 6.4 ** ▲** The practice makes provision for hearing, sight or speech impaired people to communicate with the practice | • Patient care and outcomes must not be compromised by a patient’s inability to communicate with the practice team  
• It is important to remember that language is not the only barrier to communication; disabilities (e.g. blindness, deafness etc.) may also impact on the ability to understand what is being communicated |
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 Waitemata District Health Board offers classroom and E-learning professional development training courses, CALD – Cultural and Linguistic Diversity. CALD on-line is currently (2011) available free to Waitemata DHB, Auckland DHB, Counties-Manukau CMDHB and NDSA employers and employees working in PHOs and GP practices funded by WDHB, ADHB and CMDHB http://www.caldresources.org.nz/info/CourseLanding.php

However CALD online resources such as booklets and toolkits are available free to all health professionals throughout New Zealand. http://www.caldresources.org.nz


Ethnicity data capture – this criterion has links with 6.2

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.

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 data must not be transferred from another form as it may have been incorrectly collected.

Ethnicity capture must align with Enrolment Requirements for Providers and Primary Health Organisations Version 3.0. See: http://www.moh.govt.nz. 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

The documentation of ethnicity must align with the Government classification codes including levels, groupings and special codes. A person can belong to more than one ethnic group – record up to a maximum of three. Most electronic systems will utilise a coding aid (for example, drop-down pick list or searches from the first letter of the ethnicity entered into the field) which can speed up the coding process. The ethnicities with which a person identifies can change over time.

Most electronic systems have an audit facility through additional software or a query builder menu. The team can demonstrate how they use the audit feature, for example for the quarterly reviews of the Age Sex Register.

Interpreter

It is preferable to engage the services of an experienced interpreter who has been trained in medical terminology and concepts. In reality, the use of trained interpreters is often not possible because of lack of access or high cost. Hence, friends and family members are frequently used as de facto interpreters for the patient. 15

Language Line, a telephone service offered by the Office of Ethnic Affairs, is available 9 – 6 pm weekdays and 9 – 2 pm Saturday. The service is available in 42 languages (costs are involved). http://www.ethnicaffairs.govt.nz/oeawebsite.nsf/wpg_url/language-line-index

How do staff identify patients with a hearing, sight or speech impairment.

How does the practice make provision for hearing, sight or speech impaired people to communicate with the practice.

Examples may include but are not limited to:

Mail
Fax
Email
Short message service – SMS – via computer, cell phone, smartphone
Teletypewriter TTY – via telephone line when one or more of the parties has hearing or speech difficulties
Support person / caregiver

Key documents required for accreditation

• Training records – name of provider, date of delivery, names/certificates of persons attending
• Ethnicity data capture form – registration form
• List or contact details for interpreter services

Maintenance of professional practice credits

A number of registered providers offer courses on cultural competency
1 credit per learning hour

Additional resources

The Royal New Zealand Foundation of the Blind—Braille translation: www.rnzfb.org.nz
CALD (Culturally and Linguistically Diverse)—training, development, resources for health professionals: www.cald.org.nz
Deaf Aotearoa: www.deaf.co.nz
Health Navigator: www.healthnavigator.org.nz
Department of Internal Affairs—Translation Service: www.dia.govt.nz
The Office of Ethnic Affairs—Language Line: www.ethnicaffairs.govt.nz
New Zealand Society of Translators and Interpreters (NZSTI). www.nzsti.org
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

Notes
24-hour health care is available to the practice population

Patients should be able to access 24-hour medical care, after-hours care or be directed to a service when they need it. Practices should use methods that take into account local situations and enable flexibility. Practices that do not provide 24-hour medical care must make after-hours arrangements for their enrolled patients.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 ***</td>
<td>The practice makes provision for 24-hour health care</td>
</tr>
<tr>
<td>7.2 **</td>
<td>Patients can access the after-hours service using a maximum of two calls</td>
</tr>
<tr>
<td>7.3 *</td>
<td>The practice acts on health information received about patients seen after hours</td>
</tr>
</tbody>
</table>

Patients must be able to access after-hours care, or be directed to the service 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, e.g. via Healthline or an alternative primary healthcare service.

Note: 111 calls to an emergency service are free from cell phones.

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 hour message on answer phone
• Addition to practice patient information brochure/ pamphlet
• Poster in waiting area about after hours service
• Poster in waiting area about Healthline

Telephone access to the after-hours service should require a maximum of two calls. If this is not technically possible the practice must provide an explanation to the assessors. Examples where two calls may not be possible include rural areas where ‘black spots’ may interfere with cell phone coverage.

The practice reviews information returned to the practice about enrolled patients, seen by another provider/service out of hours.

• How does this information come back to the provider/service out of hours.
• What is the process for reviewing this documentation?
• How often?
• Who has the authority and / or responsibility to enter this data in the patient’s clinical record?

Provide examples of actions carried out in response to an after hours consultation.

Examples may include but are not limited to:
• Prescribing of medications in response to abnormal test results
• Follow-up for wound management
• Clinical review to evaluate deterioration/improvement of the medical condition

Key documents required for accreditation

• After hours telephone message
• Poster/ signage
• Patient information brochure / pamphlet
• Contract with after hours provider
• Memorandum of understanding with alternate provider
The practice works with other agencies and community services to provide continuity of care

Integrated care is also known as case management, shared care, comprehensive care, or seamless care. It is an international trend in health care reforms and new organisational arrangements that focuses on more coordinated and integrated forms of care. Integrated care brings together care management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency. 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.

The practice team has 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.

The directory includes contact details and addresses. This can be in hardcopy or via an e-tool. Practice team members should link with the relevant services to build effective relationships. Examples include but are not limited to:

- Child health initiatives, for example Plunket
- Public Health
- Asthma Foundation
- Whanau Ora
- Tobacco and alcohol services
- Mental health services
- Age Concern

Active relationships can be demonstrated through such documents as:

- Minutes of meetings
- Documentation in medical records
- Allied health providers may visit practice on a regular basis
- Allied health providers may work from the same premises

Key documents required for accreditation

- Directory – electronic / hard copy
- Other resources such as pamphlets, handouts, brochure
- Meeting minutes
- Patient records

Maintenance of professional practice credits

A number of community service activities are recognised for MOPs credits such as running community workshops or providing medical knowledge and expertise for the benefit of a community group. 1 credit per hour under CME collegial activities.

Additional resources

Ministry of Health and Ministry of Social Development—for a list of local, regional and national agencies: www.moh.govt.nz and www.msd.govt.nz

New Zealand directories of the health sector: www.healthconnection.co.nz and www.healthpages.co.nz

Notes
The practice 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 and the size should be proportionate to the total practice population. The recommended number for RNZCGP Better Practice Patient Questionnaire (BPPQ) of 50 patients per practice should be regarded as a minimum. This number is a balance between giving a practice a reasonable idea about their care and not being too much of a burden to practices. It is recommended the practice target consecutive patients on one or more days.

The practice can choose to format their own survey or use the BPPQ available from the Royal New Zealand College of General Practitioners Ph. +64 4 496 5999 rnzcgp@rnzcgp.org.nz

Consider whether the patient's first language is English. The BPPQ is available in several languages including: English, Samoan, Māori, Chinese and Korean.

Or a practice may wish to look at international examples such as http://www.gpaq.info/

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

Postal surveys are also an option however this may prove a more expensive option.

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 how to use the information for transformational change within the practice. Not all suggestions may be 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. The use of the PDSA cycle allows the practice to start out with small incremental cycles of change and to measure and record the results in order to learn from the experience.

- P Plan
- D Do
- S Study
- A Act

See CD for example of PDSA worksheet for testing change
A simple patient feedback form with collection box may also encourage patients to comment on the service.

Service planning takes into account the characteristics of individuals and the enrolled practice population. This planning includes targeted services to address identified patient or carer needs. Examples include but are not limited to nurse-led clinics for specific conditions, longer opening hours, weekend clinics, extra influenza vaccination clinics and sexual health clinics.

Results from the survey can be communicated to patients through such examples as the practice newsletter, practice website, flyers on the front desk or notices in the waiting area. Major changes to the service such as hours of opening or seasonal additions such as influenza clinics may need to be advertised in the public notices of the local or community newspapers.

Feedback to the practice team can occur at meetings, additions to a practice intranet, huddles or via messages on notice boards or notebooks.

This indicator has links to 10.4

Key documents required for accreditation

- Survey form or other form of collection tool
- Survey methodology
- Survey results
- Satisfaction box / other collection tool e.g. electronic poll
- Population data - practice audits
- Meeting minutes
- Patient newsletters / flyers / posters

Maintenance of professional practice credits

The College’s Better Practice Patient Questionnaire (BPPQ) or Doctor’s Interpersonal Skills Questionnaire (DISQ) are available as a CQI activity for individual doctors.

10 credit per cycle, maximum of 2 audit cycles in a triennium

Other methods of obtaining patient feedback and improving practice in response could be devised by the individual doctor or by the practice team on their behalf and sent for pre-approval as a CQI activity.

Additional resources

The Royal New Zealand College of General Practitioners. Better Practice Patient Questionnaire (BPPQ)—available in English, Māori, Samoan, Chinese and Korean: Email: rnzcgp@rnzcgp.org.nz

Notes
The practice undertakes strategic planning to inform business and clinical activities in the practice.

Unless we learn something about what we are doing, we are unlikely to know what needs improving, or how to improve it. Continuous Quality Improvement (CQI) must be planned, organised and managed to be effective. It should be supported by regular evaluation to determine the effectiveness of improvements implemented. Practice plans should provide clear direction about what is happening across all areas of the practice, such as finance, professional development or information technology. Practices should identify what they are doing, what they want to achieve, how they will achieve it and how changes will be evaluated to determine whether there was an improvement. 11

The practice has developed a plan to identify and map the progress for quality improvement within the practice. The Quality Plan should include a systematic approach to improving targeted areas of the service including clinical outcomes. It should identify what areas require focused attention, how the practice will address the issues and how the practice will measure progress.

The use of the PDSA cycle allows the practice to start out with small incremental cycles of change and to measure and record the results in order to learn from the experience. New initiatives and activities can be added throughout the year.

See CD for example of Quality Plan

Practice team members contribute to service planning to identify what they are presently doing, what they want to achieve, how they will go about achieving the goals and how changes will be evaluated to determine whether there was an improvement. This can be through specific service planning meetings or as a permanent agenda item for regular meetings.

Indicator 10
Planning for Continuous Quality Improvement

STRATEGIC PLANNING

CRITERIA | RATIONALE
--- | ---
10.1 | The Strategic Plan is a living document that is reviewed every three to five years
- Strategic planning informs long-term sustainability and short-term goals, identifies business risk, and provides transparency. Plans should be reviewed regularly to identify whether progress is being made

10.2 | The practice has a current Quality Plan that outlines clinical goals for the year
- The Quality Plan is used to identify a planned and systematic approach to improving clinical outcomes. It should identify what needs improving and how the practice will address the issues identified

10.3 | Practice team members have input into service planning
- Engagement with team members in service planning is essential to enable them to ensure their views and experiences can influence service planning

10.4 | The practice identifies an annual quality improvement activity related to the management of a targeted area of clinical care
- Analysing and reflecting on clinical data ensures that quality processes result in improved quality outcomes for patients

Strategic planning is essential for prioritising and coordinating service and clinical improvement planning. It is part of a cycle called the PDSA Cycle. It is therefore never static but always ongoing.

Strategic plans should include:
- a vision
- a mission statement and purpose
- long-term and short-term strategic objectives
- a description of practice functions and range of services
- an analysis of strengths, weaknesses, opportunities and threats in relation to the practice (SWOT analysis) including both environmental and financial factors
- quality goals and objectives
- regular review dates
- risk management, including clinical and non-clinical, financial, reputation, and personnel risks

See CD for example of Strategic Plan

Plans must be reviewed regularly to identify whether progress is being made. The plan must be less than five years old at the time of your practice assessment.

For CORNERSTONE General Practice Accreditation the practice must undertake:

See CD for example of Quality Plan
• One clinical audit per year; and
• One audit of the practice’s choice per year – this can be a non clinical activity
Every year the practice identifies one or more areas of clinical care in order to determine how well you are meeting the needs of the practice population. Measuring, analysing and monitoring clinical care should enable the practice team to identify if they are meeting the health needs of their patients and to improve clinical outcomes.
This can be carried out by two methods:
• Focus groups using the annual quality plan to identify gaps; or
• Choosing a topic relevant to the patient population
See Appendix page 100 for further information.
This indicator has links to 9.3

Key documents for accreditation
• Strategic plan
• Quality plan
• Meeting minutes / methods for staff to have input
• Audit tool used to identify target area of clinical care
• Results of audit
• Evidence of improvement activities

Maintenance of professional practice credits
Quality improvement activities with a clinical focus can be used by individual doctors as the basis for continuous quality improvement (CQI) activities. These activities should be submitted to the College for pre-approval.
10 credits per cycle, maximum of 2 audit cycles in a triennium
In addition, continuing medical education (CME) practice improvement points can be claimed for activities undertaken by a doctor to enhance their patient care, such as
• Establishing new policies and procedures
• Undertaking strategic planning
• Writing a quality plan
1 credit per hour

Additional resources

Notes
Consider solar-powered low-level lights if continuous night lighting is required plus motion-triggered mains-powered spotlights.

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 enable patients with mobility difficulties to easily access the premises. This includes patients using mobility aids such as crutches, walking sticks, wheelchairs, 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.

Consider the seasonal effect of low temperatures on the surface texture of pavements, steps, and ramps in relevant areas of New Zealand – low winter temperatures may create a danger of slipping on frost, ice, and/or snow. The practice should consider slip-resistant materials.

There is parking for patients close to the practice with dedicated parking spaces for patients with mobility difficulties. Where a territorial authority will not permit a dedicated parking space on public land, the practice should obtain a letter of decline from the authority rejecting the application.

Many businesses and offices have a limited number of

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**CRITERIA** | **RATIONALE**
--- | ---
11.1 External signage is clear, visible, well placed and able to be read from a distance | • Clear signage allows people to identify the practice easily
11.2 External lighting facilitates security and safe access | • The safety of all people accessing the service is enhanced by well lit entrances with lighting that accounts for seasonal changes and winter daylight hours
11.3 People with mobility difficulties are able to access the practice premises | • Access must not act as a barrier if mobility is compromised due to a permanent or temporary physical disability, or illness
11.4 There is parking close to the practice with dedicated parking for patients with mobility difficulties | • Relevant legislation requires practices to provide sufficient parking for all patients including people with mobility difficulties

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**Signs have three functions.**

- Informative – advising about availability of facility or service;
- Directional – directing to specific facility;
- Locational – identifying the place where the facility is provided.

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. Failure to provide the services advertised may be in breach of Right 4 (1) of the Code.

See [www.hdc.org.nz](http://www.hdc.org.nz) Commissioners Decisions 00HDC8788

External lighting illuminates the practice and surrounds sufficiently to enable patients, visitors, and staff to safely enter and exit the premises. This includes doorways, parking areas, ramps, and pathways. Seasonal changes in length of daylight hours are considered.
parks available for their exclusive use. The Barrier Free Trust suggest they can be made available to anyone on a day to day basis provided that arrangements are made for them to be vacated when a person with a disability needs the parking space. Control of accessible parks in this situation becomes a matter for the building manager. They would probably act through the reception staff in the different tenancies. The use of accessible parks should be part of the contractual agreement between the owner and every tenant.

Car parks allocated to a building can sometimes be on another site. If this is the case, there must be an accessible route from the parking areas to the building it is associated with.

CCS Disability Action issues Mobility Parking Permits to people with specified disabilities. These permits are recognised under territorial authority bylaws as a permit for parking in marked accessible car parks on land and roads owned or administered by the territorial authority. Accessible car parks on private land are not subject to Mobility Parking Permits unless the property owner specifies that they must be displayed. In this case the sign at the park would say a Mobility Parking Permit is necessary.

### Additional resources

- **Barrier Free New Zealand Trust**: [www.barrierfreenz.org.nz](http://www.barrierfreenz.org.nz)
- **Department of Building and Housing—Building Code Compliance Documents**: Available from: [www.dbh.govt.nz](http://www.dbh.govt.nz)
- **Department of Building and Housing and Barrier Free New Zealand Trust. Accessible reception and service counters. Wellington, NZ: Department of Building and Housing; 2007. Available from: [www.dbh.govt.nz](http://www.dbh.govt.nz)
- **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). Available from: [www.standards.co.nz](http://www.standards.co.nz)**

### Key elements for accreditation

- External signage
- External lighting
- Building design
- Dedicated car parking
- Dedicated disabled parking
- Letter of decline from territorial authority (where applicable)

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

Practice facilities must be of a high standard to meet the needs of those who work in or use practice services. Consultation areas should be able to accommodate the needs, comfort and safety of patients and their families.

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<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>12.1 ★★</td>
<td>The waiting area has adequate space, seating, heating, lighting and ventilation</td>
</tr>
<tr>
<td>12.2 ★★</td>
<td>The waiting area has specialised seating for patients with mobility difficulties</td>
</tr>
</tbody>
</table>
| 12.3 ★★  | There are safeguards in the reception area to ensure confidentiality of patient information | • Legislation requires practices to ensure confidentiality of patient information  
• Patients should be assured that members of the practice team will be discreet and ensure their personal or medical information is not able to be identified in a public space |
| 12.4 ★★  | There is a toilet with mobility access on site | • Toilet availability on site facilitates patient comfort |
| 12.5 ★★  | There are facilities to ensure hand hygiene in all patient contact areas and toilets | • Patient and staff safety is enhanced by active infection control measures including hand hygiene |
| 12.6 ★★  | Each consultation room has adequate space, seating, ventilation, lighting and task lighting | • The consultation setting supports effective and safe clinical activity |
| 12.7 ★★  | Examination couches are accessible, safe and visually private | • Patients are entitled to privacy when being examined |
| 12.8 ★★  | Patients are assured of privacy during consultations or when any personal health information is conveyed | • Patients have a right to visual and auditory privacy to ensure their personal health information remains confidential  
Exception: It is possible that aspects of patient privacy may be compromised when treating patients who are acutely unwell |

The number of staff and their roles, the makeup of the practice population and the mix of chronic and acute care will influence the basic design of the premise.

Space - the waiting space must be large enough to comfortably accommodate patients and whanau. There must be adequate space to manoeuvre wheelchairs, push chairs and walking frames.

The recommendation is four seats per one full time equivalent doctor.

The waiting space must accommodate guide dogs out of high traffic areas or doorways. Guide dogs are trained to lie at their handler’s feet.

Heating – consider seasonal effects on the temperature of the waiting space. Ensure heaters are located in safe places and where applicable fitted with a guard to prevent inadvertent burns.

Lighting – if in doubt seek the guidance of a lighting designer

Reference Guide 24

<table>
<thead>
<tr>
<th>Type of Task or Interior</th>
<th>Recommended Service Illuminance (lux)</th>
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</thead>
<tbody>
<tr>
<td>Waiting Rooms</td>
<td>200</td>
</tr>
<tr>
<td>Consultation Rooms</td>
<td>500</td>
</tr>
<tr>
<td>Examination tables</td>
<td>800</td>
</tr>
<tr>
<td>Eye charts</td>
<td>600</td>
</tr>
</tbody>
</table>
As a guide to the installation of artificial lighting in a clean room of ‘normal’ proportions and light coloured walls and ceiling it will require approximately 0.25 watts of incandescent lighting to give an illumination of 1 lux over each square metre of working space. For example, to light a room of 5m x 3m (15m²) to 300 lux would require about 0.25 x 15 x 300 = 1125W of incandescent lamps.\textsuperscript{24}

Comparable illumination using the newer more energy efficient light bulbs will require conversion, for example a compact fluorescent CFL bulb of 20W is equivalent to a conventional 100W incandescent bulb. See www.rightlight.govt.nz

Ventilation – consider seasonal changes.

Air conditioner noise can be a source of irritation both indoors and at the site of the condensing unit. Poor placement, loose mountings and vibrations may cause unnecessary annoyance.

Ventilation should be adequate to exchange the air and discharge odours regularly – forced ventilation may be required in some buildings. It is particularly important to have adequate ventilation in the reception area where staff have continual contact with patients. To reduce the risk of cross infection from patients to staff it is recommended to have the airflow directed away from the reception areas. (This is a recommendation not a mandatory directive).

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.

AS/NZS 4121:2001 Design for access and mobility states seats should generally be 450 mm high but where a high proportion of elderly users are anticipated, heights up to 520 mm are preferred.

The Health Information Privacy Code 1994 applies to health information relating to identifiable individuals. This means that while it covers, for example, information about an individual’s medical and treatment history, disabilities or accidents, contact with a health or disability service, service providers and information about donations of blood or organs, it does not apply to anonymous or aggregated information where the individual cannot be identified.\textsuperscript{10}

Health agencies and individual practitioners will need to ensure that their internal operational procedures apply with the code, for instance in the design of computer systems and the use of forms and internal procedures relating to collection, use and disclosure of health information. Compliance with privacy obligations is an integral part of good information handling procedures and closely linked to good clinical practice.\textsuperscript{10}

Internal operational procedures for the handling of patient information must ensure confidentiality is maintained.

These methods may include but are not limited to:
- robust training of staff
- background music in the waiting space
- collection of personal information in hardcopy rather than verbally at the front desk
- architectural design such as an elevated front desk or purpose built service counters.

Patients must be assured that members of the practice team will be discreet and ensure their personal and medical information is not able to be identified by unauthorised personnel. This includes any exchange of information at the front desk or by telephonists located within the reception area. It is particularly important for frontline staff, such as receptionists and telephonists, to be trained in operational procedures to minimise the unauthorised release of health information.

Information which can be obtained from a publicly available publication such as a telephone directory, published report or public register (for example births, deaths and marriages) can be disclosed. This exception applies only if the agency has sourced the information from the publicly available publication. It is not sufficient that the information may alternatively have been obtained from the publically available publication.

The College regards a toilet on site and with access for the disabled as a mandatory standard and believes this aligns with reasonable patient expectations. Access for people with disabilities should not be seen as ‘special’ but as part of a safe and convenient environment for everyone.

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. Alternative sites will be considered on a case-by-case basis for CORNERSTONE accreditation. Patient safety, privacy, and the convenience and accessibility of the alternative site will be high priority.

Patient management areas and toilets have hand basins with hot and cold running water.

Liquid hand cleaning agents are available from pump packs. The dispensing unit is preferably wall mounted to prevent the person having to stabilise the pump pack with their soiled hands when dispensing the solution. This risks the transfer of micro-organisms to the exterior of the receptacle.

Best practice is to dispose of the empty pump pack as a single unit. The pump unit should not be ‘topped up’ as this can increase the risk of contamination and the growth of micro-organisms.

The type of cleaning solution may vary with the location of the pump, for example liquid soap with emollients and moisturiser in toilet and solutions with 4% chlorhexidine in treatment areas.

Soap bars or cakes are unacceptable as the wet, cracked surface can harbour micro-organisms.

The use of paper or cloth towels is acceptable however cloth towels can only be used for a single episode of hand drying.
Alcohol based hand sanitisers are positioned throughout the premises to give staff ready access to a hand hygiene product. Use hand rubs according to the manufacturer’s product directions.

Hand sanitisers must also be available for off site work.

Consultation rooms have adequate space.

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.

Privacy is enhanced by curtains or screens around the examination couches. Where this is not possible the practice has made provision to ensure patient privacy particularly for more sensitive procedures and examinations.

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.

It is not acceptable to have staff conveying identifiable patient information, such as the results of laboratory investigations, in public areas or where the information may be overheard by unauthorised persons.

The architectural design of consultation rooms enhances auditory and visual privacy. Examples include but are not limited to:

- doors on all consulting rooms
- robust internal wall construction
- opaque glass or window dressings on exterior windows

Internal partitions, that do not extend floor to ceiling, may compromise auditory privacy.

This indicator has links to Criterion 2.4

Notes

Key elements for accreditation

- Review layout of waiting space
- Seating for disabled
- On site toilet with access for disabled
- Hand basins or hand wash in contact areas and toilet
- Hand sanitisers
- Building design – ventilation, heating, lighting
- Review layout of consultation/treatment rooms
- Consultation beds/plinths/couches
- Easy access to premises
- Auditory privacy

Additional resources


Department of Building and Housing—Building Code Compliance Documents. Available from: www.dbh.govt.nz


Department of Building and Housing and Barrier Free New Zealand Trust. Accessible reception and service counters. Wellington, NZ: Department of Building and Housing; 2007. Available from: www.dbh.govt.nz

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). Available from: www.standards.co.nz

Indicator 13  The practice uses a Practice Management System

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 accurate, readily accessible, safely stored, and has an audit trail to meet Health Sector, Health and Disability Commission or other legal requirements. Accurate audit reports are heavily dependent on reliable information.

### CRITERIA & RATIONALE

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1 The practice information system is electronic</td>
<td>Electronic data provides precise, readily accessible information, for multiple users, that enables transportable patient care and provides an audit trail of activity to manage risk</td>
</tr>
<tr>
<td>13.2 All patient information generated in the practice is recorded electronically</td>
<td>The practice electronic Practice Management System (PMS) provides readily accessible data so it can be tracked, audited and enable practice teams to meet primary care objectives, Health and Disability or legal requirements</td>
</tr>
<tr>
<td>13.3 The practice can demonstrate implementation of its policy for security of electronic health information</td>
<td>An agreed and consistent approach to security will protect patient information</td>
</tr>
<tr>
<td>13.4 The practice has a reliable backup and retrieval system to protect electronic patient information</td>
<td>Patient information must not be compromised by uncontrolled events or disasters that cause loss of data or affect continuity of care</td>
</tr>
<tr>
<td>13.5 Files are secure or password protected from unauthorised access unless in active use by the practice team</td>
<td>Physical or electronic patient information must not be compromised by theft or unauthorised access</td>
</tr>
<tr>
<td>13.6 There is an Internet connection available to all clinicians to support clinical activity</td>
<td>Electronic connectivity to the Internet enables the practice to support the management of health care</td>
</tr>
</tbody>
</table>

The practice uses an electronic practice management system.

Personal and health information is stored electronically. The use of paper and electronic combinations of note keeping is not acceptable. A copy of the Health Information Privacy Code 1994 (incorporating amendments and including commentary) is available in the practice.


The code is technology neutral – it deals with health information in the same way regardless of what form it is held. Rule 5 addresses specific consideration related to health information stored in electronic form.

The Royal Australian College of General Practitioners has excellent resources outlining important aspects of computer security. http://www.racgp.org.au/ehealth/csg. NOTE: Please reference any material you use from the website and be aware of the differing legislation and, in some case, standards between New Zealand and Australia.

The Appendices contain information about:

- Practice computer security coordinator role description
- Computer security policies and procedures manual documents
- Contractual agreements with technical service providers
- Business continuity plan
- Internet and email policies
- Computer security terms

The internet will be as secure as the weakest link, i.e. the staff managing and using the system. The computer security policy should include:

What constitutes reasonable private use (use that does not interfere with work efficiency)

- What types of websites are not appropriate to
Key elements for accreditation

- Practice management system
- Security policy
- ‘Back-up’ and ‘restore from back-up’ process
- Staff password – comprehensive
- Internet connectivity

Additional resources


Health Act, Section 22F—Communication of information for diagnostic and other purposes. Available from: www.legislation.govt.nz


Privacy Commissioner website (includes training and education resources). On the record: A practical guide to health information privacy. Available from: www.privacy.org.nz


Standards New Zealand. SNZ HB 8169:2002 Health Network Code of Practice


Standards New Zealand. NZS 8153:2002 Health Records

Notes

view (for example pornography, offensive subject matter)
- What constitutes inappropriate personal use of email (for example offensive or sexually harassing content)
- How the system is protected from SPAM
- How the system is protected from viruses
- How the system is protected from hackers
- How the system is protected from theft of information
- How the system is protected from spyware
- How the practice backs up emails and internet favourites and bookmarks.

The practice has a system to backup essential electronic data on a daily basis.

Tapes: At any time there should be at least two complete backups stored on the premises (both less than four days old) plus two complete backups stored at other secure locations (both less than fifteen days old). Backup tapes should be stored with a high level of protection from physical and environmental risk.

The ‘verification function’ is run on a regular basis to ensure the practice data is being successfully stored and is also retrievable from the tapes.

‘Cloud storage’ is the new alternative to tapes. This enables an automated backup and a disaster recovery capability.

Files are secure or password protected from unauthorised access, unless in active use by the practice team. The electronic Patient Management System should be secure and passwords should be of a moderate security. The longer the password the better – use a mixture of upper and lower case letters mixed with numbers and special characters. For example PASSword8! Passwords are not shared.

Terminals and personal computers are positioned so the screen cannot be seen by unauthorised personnel. Password protected screensavers or automated privacy protection devices are enabled and activated in a timely manner.

This criterion links to 2.4

Clinical staff can access the internet to support clinical activity. It is recommended the clinical team identify relevant and reputable sites then bookmark the resources. This will assist the individuals to work as a team to deliver consistent information and health care, i.e. all ‘singing from the same songbook’.

See CD for example of IT Policy

Notes
Access to controlled drugs

Special responsibilities are placed upon pharmaceutical wholesalers, pharmacies and doctors in the stocking, distribution, issuing of prescriptions, supply and disposal of controlled drugs. Regulations have been tightened following incidents of misuse by health professionals. Controlled drugs must be stored in line with regulations.

**CRITERIA**

<table>
<thead>
<tr>
<th>14.1</th>
<th>Controlled drugs are stored in line with the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.2</td>
<td>A register is maintained for controlled drugs</td>
</tr>
</tbody>
</table>

**RATIONALE**

- Secure storage of controlled drugs reduces the risk of theft or misappropriation and is compliant with the Misuse of Drugs Regulations 1977 – 28 (a)
- Accurate documentation enables the practice to track the recipients of controlled drugs
- Tracking and monitoring of controlled drugs is for the prevention of theft or misappropriation


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
- each page is numbered consecutively
- each page identifies one form of controlled drug
- entries must be made no later than the ordinary business day following the day of the transaction


Controlled drug pads should be stored securely in the drug safe or a locked cupboard.

For prudent record keeping it is recommended that controlled drugs be prescribed and repeated through the Patient Rx field of the PMS. The hardcopy would not be printed as it would be invalid however the electronic record would enable the practice to audit the prescribing of controlled drugs and prescription details. The prescription will be hand written on a Controlled Drug pad and for best practice, the number of the prescription entered in the patient’s clinical record.

The script will be detached from the pad at the uppermost perforation – this ensures the copies in triplicate are kept intact on transit to the pharmacy. The practice may alternatively choose to fax the top copy to the patient’s pharmacy before giving the hardcopies to the patient. This will discourage and/or highlight criminal activity such as tampering with the original to procure greater amounts of the medication for illegal purposes.

This criterion links to 25.1
Guide to key elements

- Controlled drug safe
- Controlled drug register

Additional resources


Notes

The intent of the policy is to provide guidance on the management of healthcare waste to minimise potentially acute, long term or cumulative impacts on the environment and human health. Strategies should include but are not limited to:

- appropriately classifying and segregating waste to reduce the volume
- a review of healthcare practices
- a review of purchasing policies and products with a view to switching to environmentally friendly products and processes, by means of reusable products, recycling and other minimisation techniques.

Healthcare waste shall be categorised as hazardous, controlled or non hazardous

Healthcare waste is categorised by its properties and characteristics rather than the source of the waste, e.g. laboratory, home healthcare etc.²⁶

CRITERIA | RATIONALE
---|---
15.1 | Practice waste is correctly categorised, safely stored, collected and disposed of in accordance with the industry standard NZS 4304:2002
| • Ensuring practices manage health care waste they must meet the requirements of The Hazardous Substances and New Organisms Act 1966 will protect the environment, health and safety of people and communities and prevent or manage the adverse effects of hazardous substances and new organisms

15.2 | The practice has puncture resistant sharps containers displaying a biohazard symbol in accordance with NZS 4304:2002 in all areas where sharps are used
| • Using recognised puncture resistant sharps containers and positioning them in a suitable location protects the health and safety of people in the practice and enables safe disposal

15.3 | Sharps containers are kept out of reach of children
| • The health and safety of children must not be compromised when they are present in the practice

15.4 | The practice has an active waste management programme
| • There is a growing awareness that efficiencies can be obtained in the practice by reducing waste and improving energy efficiency

Indicator 15 There is safe storage and disposal of healthcare waste

Practices must provide safe storage and disposal of sharps, contaminated materials and hazardous waste. Due to differences in by-laws throughout New Zealand, practices should refer to local Council websites to find relevant regulations for storage, collection and disposal of contaminated waste.

See CD for reference paper Alison Carter
See CD for Waste Management template

Specific disposal units for scalpel blades are commercially available. Although this is an additional practice expense these units enhance occupational health and safety as the construction makes for safer and easier removal of used blades.

Sharps container 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. Handle all loose sharps with forceps. Every effort should be made to readily identify and find mislaid sharps. 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, 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.

Waste management includes recycling to channel product, packaging or parts thereof through an existing process so it can be processed and returned for reuse in the form of raw material or product.

Greening the practice
A toolkit has been developed to guide general practices on how to implement systems that produce benefits such as waste minimisation, improved time efficiencies and significant financial savings. The toolkit covers topics including lighting, appliances, computers, paper, waste minimisation, specialty waste, pharmaceutical wastage, and polystyrene.

Guide to key elements
- Waste management policy
- Waste collection units
- Waste storage area
- Method of waste disposal
- Biohazard units
- Biohazard unit holders
- ‘Greening the practice’ plan

Additional resources
Greening your Practice Toolkit. To obtain a copy of the toolkit, email: communications@rnzcgp.org.nz
Energy Efficiency and Conservation Authority: www.eeca.govt.nz

Notes
Indicator 16  The practice ensures effective infection control to protect the safety of patients and team members

Infection control

The principles of infection control are well established, and preventing the spread of infectious organisms is recognised as a means of safeguarding both patients and practice team members. In addition, training, monitoring, validation, maintenance, calibration, and cleaning are essential to ensure equipment and procedures meet regulatory requirements.

CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 ★★</td>
<td>The practice can demonstrate that its infection control policies and procedures align with the AS/NZS 4815: 2006 Standard</td>
</tr>
<tr>
<td>16.2 ★★</td>
<td>Appropriate team members have received infection control, sterilisation and disinfection training, within the last three years</td>
</tr>
<tr>
<td>16.3 ★★</td>
<td>The practice can demonstrate how it monitors the effectiveness of each sterilisation cycle</td>
</tr>
<tr>
<td>16.4 ★★</td>
<td>A current calibration and validation record is available for the steriliser</td>
</tr>
</tbody>
</table>

Control of infection is essential to prevent potential problems and is the centre of good clinical practice. 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.

See CD for Guide to Infection Control

See CD for infection control policy template

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

- antimicrobial usage
- outbreak management
- single-use items
- management of occupational exposure to blood/body fluids
- cleaning, decontamination, disinfection and sterilisation of instruments and equipment
- wound management
- linen services
- venepuncture
- cryotherapy
- cleaning and servicing of the steriliser
- laboratory specimens
- children’s toys

Reuse of medical equipment:
Managers take on responsibility to designate a product as single-use. If an employer directs an employee to re-use it, technically the employer becomes responsible under the law.

Single use medical device – A medical device intended by the manufacturer to be used on one patient during one procedure. The device is not intended for reprocessing and/or reuse on another patient or on the same patient at another time. Items include needles for injections, neurological testing, acupuncture and suturing, scalpel blades, lancets and stitch cutters.
Single patient use – A medical device intended by the manufacturer as being suitable for reuse on the same patient during a nominated episode of care, e.g. oxygen masks, nebulisers, peak flow meters. Some materials used in the manufacture of these items may not withstand the sterilisation process. This may result in failure to perform to the manufacturer’s specifications. Tubing is for single patient use and cannot be reprocessed. Spacers, nebulisers, masks and tubing are for single patient use and can be given to the patient for reuse at a later date or discarded.

Validation is a process to evaluate the reliability of the sterilisation process. It consists of Installation Qualification (IQ), Operational Qualification (OQ) and Performance Qualification (PQ).

IQ – demonstrates the steriliser is installed to set specifications, is safe and fit for purpose. It is performed on commissioning and following any major servicing to the steriliser. The practice owner must ensure that the steriliser and the area in which it is installed comply with the manufacturer’s specifications.

OQ – demonstrates the sterilisation is operating correctly.

PQ – demonstrates the steriliser attains the required steriliser conditions on a day-to-day basis throughout the load. PQ needs to be performed after commissioning or if the practice changes the packaging or loads. The PQ should be performed at least annually if none of the above events has occurred.

Calibration

OQ, PQ, recommissioning and PQ should be performed 12 monthly or more frequently, depending on the calibration history.

Validation and calibration should be performed on site.

It is recognised that rural and remote practices cannot reasonably access on-site service technicians. NOTE: Validation of the sterilisation process off-site may not accurately mimic the practice conditions and mishandling during the return of the machine may compromise the validity of the results.

Performance testing, monitoring and calibration for moist heat (steam) sterilisers:

- Conduct performance testing is carried out by an authorised operator in accordance with manufacturer’s instructions—special tests may apply for certain models. The practice is provided with documented evidence of the performance testing.

Cycle monitoring

- Print out of cycle parameters or direct observation and recording of cycle parameters or Class 4.5 or 6 chemical indicators (when there is no print out mechanism)
- Class 1 chemical indicator in each load of unwrapped items – piece of sterilising tape used to close paper packs
- Class 1 external chemical indicator on the outside of every packaged item in the load – steriliser tape

Optional

- Biological/enzymatic indicator
- Class 1, 4, 5 or 6 chemical indicators on tray or inside pack

For archival purposes, thermal print-outs should be copied as the recorded detail can fade over time. The date, identification of the load, cycle number and time of release should be documented in a results book along with the name of the person authorising the release of the load. The release will be dependent on evidence that the process has complied with all specified requirements.

Documentation enables identification of items should evidence of sterility problems or failure become available at a later date.

Although not yet mandatory, traceability between the patient, the cycle and the equipment from that cycle is important. This can be done by entering the date and cycle number into the patient’s clinical record or the patient’s name, date and cycle details in a procedure book.

Small vault sterilisers, i.e. gravity displacement or single vacuum bench top sterilisers, are only suitable for Class N cycles. They can only be used for instruments not required to be sterile at the time of use (‘flash cycles’), unwrapped solid instruments to be used immediately (no lumens) or to disinfect equipment. They cannot be used for wrapped or packaged items.

AS/NZS 4815:2006 Office-based health care facilities – reprocessing of reusable medical and surgical equipment and maintenance of the associated environment states that ‘Existing sterilisers without process recorders need to be upgraded or replaced to ensure automatic parameter recording’.

Ultrasonic cleaners do not sterilise or disinfect instruments. Cavitation is created by the alternating...
high and low pressure waves which generate high frequency (ultrasonic) sound.

Test performance daily using the foil or pencil test.

See CD for further information including occupational health and safety and choice of solutions.

Ultraviolet radiation is NOT suitable for the reprocessing of reusable medical and surgical instruments and equipment, i.e. UV stericabinets.

Guide to key documents

- Infection control policy
- Infection control training records – name of provider, date of delivery, names/certificates of persons attending
- Sterilisation documentation
- Calibration and validation records

Additional Resources


NQIP. Infection Prevention and Control: www.infectioncontrol.org.nz

Notes
Cold Chain Accreditation (CCA) is a process that allows providers of immunisation to demonstrate their management of vaccine stocks in the cold chain, as required by 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. Cold chain accreditation is available through the Immunisation Advisory Corporation (IMAC).

Cold Chain Accreditation (CCA) is a process that allows providers of immunisation to demonstrate their management of vaccine stocks in the cold chain, as required by 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. Cold chain accreditation is available through the Immunisation Advisory Corporation (IMAC).

CAA is based on a self-assessment followed by a review by an immunisation coordinator. See page 40 Immunisation Handbook 2011. The temperature of the vaccine fridge is regularly monitored according to the MOH protocols. Each immunisation provider should have an individualised and documented cold chain management policy. This should include details of the designated staff member, vaccine requirement estimations, vaccine ordering process, refrigerator operations, and maintenance and management processes, along with an emergency procedure for dealing with equipment failure.

If the practice delivers vaccines off site there are procedures for the management of the cold chain. See page 49 Immunisation Handbook 2011. Appropriate team members have participated in training (Level 1 or 2) to manage the cold chain. See page 38 Immunisation Handbook 2011. The team member can describe and demonstrate how they align process with the cold chain standards. The Certified Vaccinator can be identified. Identify how they review immunisation procedures in the practice. Note: The National Immunisation Handbook contains the current national standard.
The Vaccinator:
1. Is competent in the immunisation technique and has the appropriate knowledge and skills for the task.
2. Obtains informed consent to immunise.
3. Provides safe immunisation.
4. Documents information on the vaccine(s) administered and maintains patient confidentiality.
5. Administers all vaccine doses for which the vaccinnee is due at each visit and only follows true contraindications.
6. Reports adverse events following immunisation promptly, accurately and completely.
7. The organisation, which employs vaccinators to offer vaccination services, has links to comprehensive primary health care and the Well Child programme.
8. The organisation achieves high immunisation coverage of its population.
9. The organisation supports the vaccinator.
10. The service is readily available with no barriers to access.

Guide to key documents
- Cold Chain Certificate
- Records of cold chain temperature monitoring
- Cold chain training records – name of provider, date of delivery, names/certificates of persons attending

Additional Resources
Immunisation Advisory Centre—for Cold Chain references, education and vaccinator training: www.immune.org.nz
The Centre for Adverse Reactions Monitoring (CARM)—accessed through the NZ Pharmacovigilance Centre’s website: https://nzphvc-01.otago.ac.nz/carm-adr/

Notes
## Medical equipment and resources are available and maintained to meet patient needs

Indicator 18

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.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
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</thead>
<tbody>
<tr>
<td>18.1 ★★</td>
<td>There is an audit trail to monitor the servicing of all medical equipment according to relevant regulations (AS/NZS 3551), maintenance and operating instructions.</td>
</tr>
<tr>
<td></td>
<td>• Regular inspection, testing and servicing of all medical equipment to meet the AS/NZS 3551 will ensure they are safe and fit for the purpose of protecting patients and the practice team members.</td>
</tr>
<tr>
<td>18.2 ★★</td>
<td>Residual Current Devices (RCDs) are used to protect patients and members of the practice team in accordance with the Electrical (Safety) Regulations 2010.</td>
</tr>
<tr>
<td></td>
<td>Mains powered medical equipment must meet legislation requirements to protect patients and members of the practice team against electric shock.</td>
</tr>
<tr>
<td>18.3 ★★</td>
<td>All essential basic equipment is available, including:</td>
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<tr>
<td></td>
<td>• auriscope</td>
</tr>
<tr>
<td></td>
<td>• blood glucose test strips/glucometer – expiry dates must be current; check calibration of glucometer to number on strip</td>
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<tr>
<td></td>
<td>• cervical smear equipment</td>
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<td></td>
<td>• dressings adequate to the services provided</td>
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<td></td>
<td>• ear syringe/suction</td>
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<tr>
<td></td>
<td>• ECG – should be accessible within 10min; if held in the practice, clinical team members should know how to read the tracings</td>
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<tr>
<td></td>
<td>• eye local anaesthetic</td>
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<tr>
<td></td>
<td>• fluorescein dye for eyes</td>
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<tr>
<td></td>
<td>• gloves</td>
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<td></td>
<td>• height measure</td>
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<td>• monofilament</td>
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<td>• spacer device</td>
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<td>• ophthalmoscope</td>
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<td>• peak flow meter</td>
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<td></td>
<td>• pregnancy testing kit</td>
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<td></td>
<td>• proctoscope</td>
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<td>• sphygmomanometer – extra wide and paediatric cuffs – calibrated within the last year if aneroid; mercury sphygmomanometer needs only rubber pipes checked</td>
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<td></td>
<td>• Practices must have basic equipment that is appropriate for comprehensive patient care.</td>
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<tr>
<td></td>
<td>Note: if a defibrillator is held in the practice the clinical team members are trained to use it.</td>
</tr>
</tbody>
</table>
- spatula
- spirometer
- stethoscope
- surgical instruments appropriate for any procedures carried out
- suture equipment
- syringes and needles
- reflex hammer
- tuning forks – 256 Hz, 512 Hz
- thermometer
- urinary catheter and local anaesthetic gel for urgent catheterisation, e.g. referral in urban area
- urine dipstick – protein, glucose, ketones
- visual acuity chart – at the specified distance
- weight scales – adult, paediatric

| 18.4 | Emergency and resuscitation equipment is easily accessible and in a single location | Patients must be assured that practices have readily available equipment for timely resuscitation in the event of an emergency |
| 18.5 | The practice team conducts annual emergency drills to improve their response to medical emergencies | Annual exercises ensure that all team members are familiar with their roles during an emergency |

18.6 All essential emergency and resuscitation equipment is available and maintained

- airways and/or laryngeal masks – varied sizes 00 to adult
- ambubag and masks – paediatric to adult
- emergency bag/trolley
- IV equipment – set up and infusion
- oxygen
- saline – any one of e.g. penpaspan/crystalloid
- tourniquet

Rural practices require a greater level of off-site equipment.
- PRIME kit (St John)
- It is recommended that practices use the PRIME standard to build their emergency kits

- Practices must have equipment that is appropriate for emergency and resuscitation responses
- The adequacy and appropriateness of essential emergency equipment is determined by the location and circumstances of the practice. Any omissions should be able to be justified by the practice
- PRIME has its own equipment standards for its contract with rural practices
- If practices are linked to PRIME, they should be trained to use the emergency equipment. See PRIME Nation

18.7 All essential basic and emergency medicines are available

*In stock or in the doctor’s bag/clinical bag or portable emergency kit:
- 50% glucose/glucagon injection
- adrenalin 1/1000
- an alternative for those allergic to penicillin
- analgesia – e.g. paracetamol, voltaren
- antihistamine injection
- aspirin tablets

- The adequacy and appropriateness of essential emergency medicines is determined by the circumstances of the practice. Any omissions should be able to be justified by the practice
Medical equipment is 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. Owners and operators of electrical medical devices, must ensure the installations are periodically tested to determine electrical safety and compliance with the Electricity Act 1992, Electrical (Safety) Regulations 2010 and relevant standards.

Testing must be carried out by licensed operators who are obliged to complete prescribed forms and to provide the practice with a copy. The Department of Building and Housing advises that electrical medical devices should be tested in accordance with the Regulations and standards.

Regulation 26 (1) in part states:
This regulation applies to a fitting or appliance that is in use, or available for use,

(a) by an employee or contractor of the owner of the fitting or appliance;

(2) A fitting or appliance to which this regulation applies is deemed to be electrically safe if at the time it is first made available for use,

(a) it has a current tag issued in accordance with AS/NZS 3760; or

(b) it is supplied with electricity through a portable residual current device (RCD) that –

(i) provides protection from electrical shock; and,

(ii) has a current tag issued in accordance with AS/NZS 3760; or

(iii) it is supplied with electricity through a circuit protected by an electrically safe RCD that provides protection from electrical shock.


Periodic inspection and performance verification must take place on an annual basis. Failure to comply may result in a Grade B offence resulting in a fine.

Residual current devices

Residual current devices are sensing devices which constantly monitor the balance of current electrical flow from any permanently connected mains powered appliance or socket outlet wired to the unit which has the appliance plugged in. These are capable of tripping on occurrence of a.c. and pulsating d.c. leakage faults.

The device must be a 10 milli Amperes, Type A. The 30 milli Amperes used in domestic locations is not suitable for medical electrical equipment.
Residual Current Devices (RCDs)

Equipment for medical locations should comply with the AS/NZS 3200 series and be maintained in accordance with the recommendations of AS/NZS 3551.

Any electrical installations in patient areas must meet the testing requirements NZS 3003: 1: 2003.

**Essential basic equipment**

Basic medical equipment and resources must be suitable for supporting comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered. Equipment must be calibrated, in working order, and have current service dates. The adequacy and appropriateness of basic equipment is determined by the circumstances of the practice and any omissions must 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.

There should be a range of blood pressure cuffs including extra wide to paediatric. Research has demonstrated cuffs of the wrong size may increase an error in the recording of up to 50mm Hg. The bladder must encircle the circumference of the mid arm by at least 80%. ‘Alternate’ adult cuffs may also be in use for teenagers and older frail persons.

Aneroid and mercurial sphygmomanometer must be calibrated annually. Mercurial sphygmomanometers must also have the rubber piping and control valves inspected.

The correct distance for visual acuity testing is clearly identified. Visual acuity should be using either the standard Snellen wall chart, or a projector and screen. The chart should be well illuminated (a minimum of 500 lux at the screen – see Indicator 12) and at eye height from the floor. The chart should be viewed from 6 metres. If this distance is not available directly, a reversed chart may be viewed indirectly through a mirror, so that the total distance from subject to mirror to chart is 6 metres. The correct viewing distance of 6 metres from the chart should be marked on the floor or walls for easy identification by the staff and the patient.

**Access and location of emergency and resuscitation equipment**

Emergency and resuscitation equipment should be located in one site for ease of use.

Hazardous materials such as oxygen cylinders and liquid nitrogen in Dewar flasks should be stored securely to prevent accidental toppling when in use and during storage. Adequate precautions should be taken at all times to prevent damage to the cylinder during transportation, handling, storage or use.

Restraints, holders and carriers are available through commercial outlets.

Cylinders should be stored, handled and used in an upright attitude wherever possible, unless they are specifically designed for horizontal use.

**Annual emergency drills**

Annual exercises require a degree of advanced planning. A facilitator or operator should be identified from the practice team to plan, and coordinate the drill and evaluate the results.

Emergency and resuscitation equipment

The adequacy and appropriateness of essential emergency equipment is determined by the location and circumstances of the practice. Any omission should be able to be justified by the practice.

PRIME contracts require a greater level of equipment. Where applicable it is recommended the practice use the PRIME standard to build the emergency and resuscitation checklist.

Most types of resuscitators come in two sizes – adult and paediatric. The large size ambubag is used for the manual ventilation of adults and children with a body weight of down to 15 kgs (approximately 3 years). The small size is used for infants and children with a weight up to 20 kgs (4-5 years). NOTE: This is only a guide - the clinical team should make themselves familiar with the manufacturer’s instructions for the make and model available in the practice.

**Coroner’s Advice COR: Ref: CSU-2008-00043**

- GPs should be aware of, and vigilant for, symptoms of inherited cardiac conditions.
- AEDs are as effective with children as adults, and there should be no hesitation to use them in sudden, unheralded, pulseless collapse.
- Early defibrillation from direct current cardioversion provides the best chance for improving the rate of survival in these cases.
- Cardiac arrhythmias cause a significant proportion (approx. 15%) of cardiac arrests in otherwise fit, healthy young people.

The Coroner advises that he believes all health care practices, particularly rural, would benefit from having automated external defibrillators (AED).

**Essential and emergency medicines**

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.

See CD for essential and emergency medicines checklist template

See CD for clinical bag, portable emergency kits and emergency equipment checklist template

Medicines, pharmaceutical products and emergency equipment are stored so that they are not accessible to unauthorised people. Theft, misuse or vandalism of practice medicines, pharmaceutical products or equipment may compromise patient care. Patients, in particular children, are protected by secure storage of dangerous products and equipment.

Notes

Guide to key documents

- Annual electro-medical testing documents
- Monthly body protected area testing record and/or annual RCD testing
- Record of annual emergency drills
- Checklist of essential emergency and resuscitation equipment
- Checklist of essential and emergency medicines
- Documented record of inspection
- Checklist of content in clinical bag/s, portable emergency kit/s and emergency equipment
- Documented record of inspection

Additional Resources

PRIME National Standards 2008: www.stjohn.org.nz
RNZCGP Assessment Visit Module: Contents of the Doctor’s Bag: 2000
Standards New Zealand. AS/NZS 2500: 2004 Guide to the safe use of electricity in patient care
CRITERIA | RATIONALE
--- | ---
19.1 ★★★ The practice has a documented Evacuation Scheme or Evacuation Procedure as required by the Fire Safety and Evacuation of Buildings Regulations 2006 | • The Fire Safety and Evacuation of Buildings Regulations 2006 require a building owner, where there are 10 or more employees in the building at any one time, to have an evacuation scheme approved by the Fire Service
19.2 ★★★ The practice team is trained to evacuate the practice by participating in fire drills every six months | • Lessons learned from regular drills can be used to improve fire safety practices
19.3 ★ The practice has an Emergency Response Plan which identifies risk and formulates contingencies to address the practice response to disasters or events in the community | • Risk analysis and contingency planning maximise patient safety and continuity of care through coordinated delivery of health care and by participation in the local response in the event of a disaster or major incident
19.4 ★ The practice has a Business Continuity Plan that prioritises support and recovery of critical and non-critical functions of practice processes and activities | • Risk analysis and contingency planning maximises patient safety and continuity of care, and also mitigates practice or business financial loss

Indicator 19 The practice has planned response and recovery procedures for fires, disasters or emergencies

Practices must protect patients and the team during an emergency in the community, such as a fire in the practice, flood, extended power outage, earthquake or pandemic. The ability to deal with these situations during an emergency depends how well a practice has planned for an event or disaster that severely impairs its ability to maintain normal services. The three components of a robust emergency plan are business continuity planning, response planning, and major incident planning.

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
- inform the occupants about the:
  - route of travel to the place of safety
  - fire alarm signals used or available

- any fire fighting equipment available for use
- erect signs and notices at appropriate places within the building that clearly display the evacuation procedure

Under the Fire Safety and Evacuation of Buildings Regulations 2006 an Evacuation Scheme is required in buildings providing employment facilities for 10 or more persons. For application forms see www.evaonline.fire.org.nz

All other ‘medical and dental surgeries, and medical and paramedical and other primary health care centres’ require a Evacuation Procedure.

Procedures should include but are not limited to:
- how to raise the alarm if they discover a fire
- how to contact the fire brigade
- how to use the fire-fighting equipment
- how and where to evacuate the building
- where to assemble and who to report to
- participate in a fire safety and evacuation drill every six (6) months

Practice owners should review the Fire Safety
and Evacuation of Buildings Regulations 2006 to determine additional legislated requirement under the Regulations. This includes but is not limited to fire fighting equipment, buildings that have any type of sleeping accommodation, store hazardous substances in greater volumes than that set as the minimum under the Hazardous Substances (Classification) Regulations, the use of gas or open flame, and tenants.

The team take part in a six monthly fire drill to identify any faults or deficiencies that require remedial action.

For buildings with a fire alarm system that is monitored by the Fire Service contact your regional Fire Safety Officer for advice on trial evacuations. In some locations the Fire Service will attend the drill and provide you with a report.

See CD for Emergency Drill Reporting Form

Links to Criterion 18.5 – annual emergency drills for medical emergencies.

Major incident planning should outline how a practice fits into the overall local health response in an emergency situation. It should also set out what to expect in terms of information, coordination and support, and how communication channels will be impacted.

See CD for Emergency Business Continuity Planning Template

The practice has a contingency plan to maximise staff and patient safety.

Guide to key documents

- Documented fire procedure / scheme
- Fire drill records – six monthly
- Hand held fire hose or similar fire fighting equipment service record - annual
- Documented Emergency Response Plan
- Documented Business Continuity Plan

Maintenance of professional practice credits

CME credits can be claimed under Practice Improvement Activities for the development of an emergency response plan 1 credit per hour

Additional Resources

The Ministry of Health’s website has access to information, resources and the Regional Primary Care Emergency Planning Coordinators.


Ministry for the Environment. Climate change impacts in New Zealand: www.mfe.govt.nz

New Zealand Fire Service Evacuation Scheme: http://evaconline.fire.org.nz


Infection control and prevention


Notes
The practice team comply with the Health and Safety in Employment Act 1992 and the 2002 Amendment.  

The Act does not require an employer to prepare a formal written statement of health and safety policies. However, in some workplaces it may be good practice to obtain written confirmation of agreed safety and health policies and the way they are to be implemented as a basis on which to proceed. Usually, the larger the enterprise and the numbers of people involved, the more useful it will be to prepare a formal statement of health and safety policies and procedures.

Example of hazard record for small business  

Primary responsibility is placed on the employer, who has a general duty to provide a safe and healthy work environment.

There are other specific duties, including a requirement for employers to identify and actively manage hazards in the workplace. To do this, the Act sets out a hierarchy of action where employers must follow a process of identification, elimination and isolation. If a hazard cannot be eliminated or isolated, the effects of the hazard must be minimised.

What the Act sets out to do:
The object of the Health and Safety in Employment Act is to promote the prevention of harm to all persons at work and other persons in, or in the vicinity of, a place of work.

- Section 5 of the Act sets out the object, and lists various means contained in the Act to achieve it, including by:
  - Promoting excellence in health and safety management, in particular through being systematic;
  - Defining hazards and harm in a comprehensive way so that all hazards and harm are covered, including harm caused by work-related stress and hazardous behaviour caused by certain temporary

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**Indicator 20** The practice team is committed to ensuring health and safety in the workplace

**Health and Safety**

New Zealand legislation requires practices to comply with the Health and Safety in Employment Act 1992 to protect patients, their whānau, employees, employers, contractors and visitors. The practice has a responsibility to ensure the service has Health and Safety policies and procedures that describe how the practice aligns with the Act. All team members must be aware of health and safety policies, and a Hazard Plan and Risk Register must be used to identify and manage risk.

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<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
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<tr>
<td>20.1 ★★ The practice team is able to demonstrate how they comply with the Health and Safety in Employment Act 1992 and the 2002 Amendment</td>
<td>• Practices must be able to translate requirements of the Health and Safety in Employment Act 1992 and the 2002 Amendment into effective practice processes</td>
</tr>
<tr>
<td>20.2 ★★ The practice has a designated Health and Safety Officer who manages compliance with the Health and Safety in Employment Act 1992 and the 2002 Amendment</td>
<td>• A Health and Safety Officer assists practice teams to understand how to apply the requirements of the regulations in s19E and s19F of the Health and Safety in Employment Act 1992</td>
</tr>
<tr>
<td>20.3 ★★ The practice team conducts an annual health and safety review and makes policy amendments as required</td>
<td>• Practices which conduct an annual health and safety review will identify risk and meet the requirements in Regulation 4 of the Health and Safety in Employment (Prescribed Matters) Regulations 2003 which sets out the information that must be recorded or reported in a register</td>
</tr>
<tr>
<td>20.4 ★★ Health and safety accidents and incidents are reported, recorded, investigated and followed up</td>
<td>• Employers have a duty to investigate all accidents and occurrences of harm to determine whether it was caused by or arose from a serious hazard, regardless of whether or not the person exposed to the hazard was an employee (Section 25(1) of the Health and Safety in Employment Act 1992 and 2002 Amendment)</td>
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</tbody>
</table>
The practice has a designated person to assist the practice team to understand how to apply the requirements of the Act.

Development of employee participation system
An employee participation system must be developed where there are fewer than 30 employees, whether or not at a single location, and 1 or more of the employees, or a union representing them, requires the development or where there are 30 or more employees, whether or not at a single location.

The practice has a designated Health and Safety Officer.

Information for employees generally and health and safety representatives:

(1) Every employer shall ensure that every employee who does work of any kind, or uses plant of any kind, or deals with a substance of any kind, in a place of work has been given, and is provided with ready access to, information in a form and manner that the employee is reasonably likely to understand about—

(a) what to do if an emergency arises while the employee is doing work of that kind, using plant of that kind, or dealing with substances of that kind, in that place; and

(b) all identified hazards to which the employee is or may be exposed while doing work of that kind, using plant of that kind, or dealing with substances of that kind, in that place, and the steps to be taken to minimise the likelihood that the hazards will be a cause or source of harm to the employee; and

(c) all identified hazards the employee will or may create while doing work of that kind, using plant of that kind, or dealing with substances of that kind, in that place, and the steps to be taken to minimise the likelihood that the hazards will be a cause or source of harm to other people; and

(d) where all necessary safety clothing, devices, equipment, and materials are kept.

(2) An employer must ensure that all health and safety representatives in a place of work have ready access to sufficient information about health and safety systems and health and safety issues in the place of work to enable the representatives to perform their functions effectively.

The practice conducts an annual survey of health and safety systems and policy to identify any required changes. This includes but is not limited to:

• Natural emergencies
• Mannmade emergencies such as injury, armed robbery, power failure
• Workplace stress
• Accident recording
• Training of employees
• Examples of potential workplace hazards
• A workplace process (how an employee uses machinery or equipment)
• The physical environment (for example, working off site)
• The equipment used (for example, is electrical equipment properly used?)
• An external factor (for example, the possibility of robbery)
• An input to the work process (for example, toxic chemical used)
• The work organisation (for example, are shifts and breaks designed to minimise fatigue and disruptions to sleep?)
• Access to critical information (for example are instructions available at an appropriate literacy or language level for employees in the workplace?)
• The construction of the building (for example, are the floors safe when wet?)
• The impairment of the individual employee (for example, where a diabetic employee misses meals due to work pressures)

Similarly, an employee has a duty:

• Not to endanger themselves or others;
• Not to interfere with an accident scene; and/or
• To comply with notices, sampling or other requirements of health and safety inspectors and/or departmental medical practitioners.


The practice Health and Safety Manual has policies that describe how the practice aligns with the Health and Safety in Employment Act. The policies address patients, employees, employers, contractors and visitors.

This includes but is not limited to:

• Natural emergencies
• Mannmade emergencies such as injury, armed robbery, power failure
• Workplace stress
• Accident recording
• Training of employees
• Examples of potential workplace hazards
• A workplace process (how an employee uses machinery or equipment)
• The physical environment (for example, working off site)
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• The work organisation (for example, are shifts and breaks designed to minimise fatigue and disruptions to sleep?)
• Access to critical information (for example are instructions available at an appropriate literacy or language level for employees in the workplace?)
• The construction of the building (for example, are the floors safe when wet?)
• The impairment of the individual employee (for example, where a diabetic employee misses meals due to work pressures)
Task analysis
It may be useful to look at the tasks in each job and observe the actions of employees, while identifying the hazards involved.

Process analysis
This involves following the production or service delivery process from start to finish, and identifying the hazards involved at each stage.

Analysis of accident investigation details
This is mandatory under section 7(2) of the Act. Whenever there is an accident, “near miss”, or the incidence of harm, the employer must take all practicable steps to determine the cause and whether it was a significant hazard.

This corresponds with the requirement for employers to keep a register of every accident or incident.

Depending on the approach used and other factors, such as the type and size of the workplace, procedures may range from a simple checklist for a specific piece of equipment or substance, to a more open-ended appraisal of a group of related work processes.

Whichever method(s) is used, it may be useful to develop a hazard checklist for the particular place of work or process.

Information from designers or manufacturers, material safety data sheets, product labelling, or other sources of information should all be systematically reviewed as part of the hazard identification process.

Guide to key documents
- Health and Safety Policy
- Health and Safety Officer - role description in employment contract
- Evidence of annual review
- Evidence of amendments to Health and Safety Policy
- Hazard notices (where applicable)
- Record of accidents and incidents
- Record of investigation and follow-up

Additional Resources
Department of Labour: www.osh.govt.nz/order/catalogue/index.shtml
New Zealand Fire Service Evacuation Scheme: http://evaconline.fire.org.nz

Notes
SECTION 3 – Clinical Effectiveness Processes

General practices must be organised to support practice teams to manage clinical care effectively. This section outlines the structures needed to support and maintain safe, comprehensive and effective care for patients through improvements in continuity, coordination and integration of care.

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

Patients are identified through the registration and enrolment process. It is the first point of entry and links patients to health care services provided by a practice. The patient record remains an identifiable information source that records care provided and facilitates continuity of care.

<table>
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<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>21.1</td>
<td>There is a patient registration process that collects demographic and health information • Collection of personal and health information informs patient identification, clinical care and service planning, and assists the implementation of government health policy. It also provides data for clinical audits, population and preventive health activity, fulfilling contractual requirements and risk management</td>
</tr>
<tr>
<td>21.2</td>
<td>There is an effective and timely system that enables medical records to be obtained and transferred between practices within 10 days • Timely transfer of patient information from previous providers assists continuity of care</td>
</tr>
<tr>
<td>21.3</td>
<td>There is a system to manage tracking and retrieval of medical records to and from and within the practice • Tracking the transfer of patient information limits risk management and provides evidence of actions carried out by the practice</td>
</tr>
<tr>
<td>21.4</td>
<td>Receipt of records transferred from the practice is confirmed • Patients and practices need assurance that any hard copy health information transferred between providers reaches the intended recipient</td>
</tr>
</tbody>
</table>

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. There should be a policy that details which staff have the authority to enter the data in the clinical records and a standardised approach to where the information will be entered in the electronic patient record.

Core demographic data includes:

Links to Indicator 22

Ethnicity capture must align with Enrolment Requirements for Providers and Primary Health Organisations Version 3.0.

See: http://www.moh.govt.nz

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

Examples of proper authority to send or obtain the medical record may include but are not limited to documented authority on practice forms used for the transfer or request for medical records.

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.

Guide to key documents

- Registration form
- Registration policy
- Electronic or hardcopy record to track timelines for transfer of notes
- Electronic or hardcopy record to track the retrieval and/or transfer of medical records
- Electronic or hardcopy record to track receipt of medical records

Additional Resources

- Standards New Zealand. NZS 8153:2002 Health records.

Notes
CRITERIA | RATIONALE
--- | ---
22.1 | 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
Core demographic data includes:
- patient name
- NHI number
- gender
- address
- date of birth
- contact phone number
- ethnicity
- registration status
- contact person in case of emergency
- next of kin – where applicable
- primary language – where applicable
- whether or not an interpreter is needed
- Other demographic data:
  - occupation history
  - significant relationships
  - hapu, iwi
  - alternate names

Medical records show:
- clinically important drug reactions and other allergies (or the absence thereof)
- directives by patients
- problem lists that are easily identifiable
- disease coding
- past medical history
- disabilities of the patient
- English proficiency limitations
- identifiable current and long-term medication(s)
- reasons for changes to medication
- clinical management decisions made outside consultations, e.g. telephone calls

Consultation records:
- each entry is dated
- the person making the entry is identifiable
- the entry can be understood by someone not regularly working at the practice, e.g. a locum
Consultation records support continuity of care and record:
- the reason for encounter
- examination findings
- investigations ordered
- diagnosis and assessment
- management/treatment plans
- health information given to patients, including notification of recalls, test results, referrals and other contacts
- medications, including: drug name/ dose/ frequency/ amount/time / volume
- current and long-term medications
- intermediate clinical outcomes
- brief interventions
- screening and preventive care initiatives recommended
- a follow-up plan
- end of life needs where applicable
- name of interpreter used if applicable

Risk factors are identified, including:
- awareness alerts, e.g. deaf, blind, communication requirements, mental health issues
- family history
- current smoking status
- smoking history of patients 15 and over
- offer of smoking cessation where appropriate
- alcohol/drug usage
- blood pressure
- weight/height/BMI
- immunisations

Referral letters contain:
- special considerations: interpreter needed, language, disability, transport
- current problem
- current medical warnings
- long-term medications
- the reason for referral
- background information and history
- key examination findings
- current treatment
- appropriate investigations and results

Incoming information is filed or available electronically in the patient’s medical records. This includes:
- laboratory results
- radiology results
- other test results or health information, e.g. Mini Mental State Examination
- other health information
- discharge and outpatient information
- specialist letters

Screening is up-to-date, including:
- cervical smears
- mammograms
- cardiovascular risk assessment
- diabetes screening

See CD for Record Review instructions

Patient records should contain sufficient information to identify an individual patient and facilitate continuity of care.

For CORNERSTONE accreditation it is recognised patient records may not contain 100% of the recommendations 100% of the time. The record review activity, to be undertaken for accreditation, is a quality improvement activity. The review should be carried out by each individual not by a third party.

Core demographic data includes:
Ethnicity data capture - links with Criterion 6.2

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.

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 data must not be transferred from another form as it may have been incorrectly collected in the first instance.

Ethnicity capture must align with Enrolment Requirements for Providers and Primary Health Organisations Version 3.0.

See: http://www.moh.govt.nz. 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.

The documentation of ethnicity must align with the Government classification codes including levels, groupings and special codes. A person can belong to more than one ethnic group - record up to a maximum of three. Most electronic systems will utilise a coding aid (for example, drop-down pick list or searches from the first letter of the ethnicity entered into the field) which can speed up the coding process. The ethnicities with which a person identifies can change over time.

In some cases the person to contact in an emergency (ICE) will be the same person as the individual’s Next of Kin.

It is recognised that some practice management software do not include a specific field for the capture of the individual’s primary language and the need, and contact details, for an interpreter. Health agencies should have appropriate procedures to ensure this data is routinely entered in a consistent area of the PMS by all staff with authority to access patient records. This will assist to enhance continuity of patient care.

Clinically important drug reactions and other allergies are recorded and in addition, the absence of any known allergy. The entries alert the clinician to a future propensity to a serious reaction on future exposure to the substance. Regardless of the documentation it is prudent risk management to reconfirm the presence or absence of any drug reaction prior to the administration or prescription of a medication or vaccine. Where applicable, new drug reactions or other allergies should be reported to the Centre for Adverse Drug Monitoring.


Advanced directives

This term means the patient can make a choice in advance of a service. Directives, made in the event a person was in danger of death or incapable of decision making, must apply to a particular future healthcare procedure or service. The validity of advanced directives is unclear in New Zealand however is regarded as best practice by the College and a useful adjunct for patient care. The practice is advised to seek legal assistance in the preparation of an advanced directive. The Code states that ‘everyone has a right to refuse to undergo any medical treatment’.

Examples of other types of directives made by an individual may include but are not limited to:

- the decline to be recalled in accordance with recommendations for national screening; or
- the giving of permission to relay personal information to a partner (laboratory results – INR); or
- specific directives in association with religious or cultural beliefs

The New Zealand Medical Association has produced information about advanced directives in line with the Code and has sample forms that can be used by patients


Links to Indicator 4

The Mental Health Commission has produced information to allow people with mental illness to specify what treatment they agree to should they become unwell in the future.


Disease coding is an effective means to address the issue of having consistent clinical terminology. The practice should use a drop-down box functionality to avoid the confusion of free text.

The practice should use a nationally recognised coding system rather than invent their own. If coding is a new activity for a practice the staff may wish to start the process using a limited formulary for common conditions. This will assist the clinical team to become accustomed to entering a code at the time of a consultation. The standardisation of coding between providers is important for the accuracy of audit information.

http://www.nzhis.govt.nz/moh.nsf/indexns/snomed-educationresources

Medical records show:

English proficiency limitations (where applicable) – see paragraph above regarding primary language and interpreters.

Consultation records:

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. Various PMS software allows for further distinction of provider notes by the use of colour coding identifying individual
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.

A standardised communication process for the transfer of care to providers and services outside the practice is recommended. This might include but is not limited to templates for correspondence and checklists.

Links to Criterion 32.2

The practice has electronic links with secondary healthcare facilities. This will assist a smooth and seamless transition of patient information between the primary and secondary health care services. This may not be technically possible in all areas of New Zealand however will remain an aspirational target. In some regions limited connectivity will be in place, i.e. restricted to specific departments or services.

The practice has an agreed (and preferably documented) policy on the recording of risk factors. The data is consistently entered in defined fields of the PMS to facilitate continuity of care.

Links to Criterion 21.1

Referral letters - links to Criteria 32.2

The Medical Protection Society (MPS) has developed a referral and referral back checklist to help doctors manage the referral process. http://www.medicalprotection.org/uk/casebook-may-2011/the-risk-of-working-with-others

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.

Maintenance of professional practice credits

The Content of Medical Records is an existing College Continuous Quality Improvement (CQI) activity available for individual doctors in the practice. A resource for this purpose is available on the member’s page of the College website under ‘Information and Resources’

10 credits per cycle - maximum of two audits per triennium

NB: Retain the summary sheet for MOPS audit purposes.

A consultation record audit and a referral letter audit are also available as CQI activities.
Guide to Key Documents

- Record review for 15 records per doctor/practice nurse
- Audit completed in last 12 months
- Key to match data to individual patient record
  - NHI numbers
  - Patients name
- Audit results
- Individual or joint improvement plan

Notes

Resources

There are a variety of Health and wellness plans that can be accessed on the web, e.g. www.healthwellnessplans.org/category/exercise
Non-medical team members responsible for first-line interaction with patients (for example reception staff and telephonists) are trained to identify and respond to patients who present at the front desk, or who phone the practice, with urgent medical conditions. Non clinical staff can describe how they manage medical emergencies to ensure responsiveness to patients requiring urgent care.

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.

It is recommended to take staff through your policy in training sessions and give them the opportunity to practise by 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. The policy should also include a guide to the recognition of medical emergencies in patients who are phoning the medical centre and for putting callers ‘on hold’.

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

First aid or monitoring advice is not medical treatment or care but immediate action until clinical assistance is available. It may be as simple as reassuring the patient and keeping them on the line or, where a patient is not breathing or has no pulse, advising the caller to commence cardiopulmonary resuscitation, if they know it.

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.

### Indicator 23
The practice identifies and responds appropriately to all patients with clinically urgent health needs

#### Prioritising urgent health needs

All practice team members have a role to play in recognising and managing urgent need. It is important that front line team members understand their role and can alert clinical team members if they are concerned about a patient in the waiting room. Having a triage system in place to recognise and respond to an emergency is essential to monitor and assess patients, decide how urgent their illness or injury is and how soon treatment is required.  

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.1 Non-medical team members responsible for first-line interaction with patients are trained to identify and respond appropriately to patients with urgent medical conditions</td>
<td>Training provides non-medical team members with accurate and consistent information to enable a timely and appropriate response</td>
</tr>
<tr>
<td>23.2 Practice teams have systems in place to observe the clinical condition of patients</td>
<td>Early detection of change in a patient’s condition enables the practice to initiate a timely response to their medical need</td>
</tr>
<tr>
<td>23.3 There is a triage system to manage patients with urgent medical needs</td>
<td>Triaging by the clinical team ensures that patients assessed as having the most urgent needs are treated more quickly than those patients with less urgent needs</td>
</tr>
<tr>
<td>23.4 All team members who may be required to administer CPR must have current certification to an appropriate level from certified trainers</td>
<td>Training provides non-medical team members with accurate and consistent information to enable a timely and appropriate response</td>
</tr>
</tbody>
</table>
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.

Timely access to care may be:

- Emergency: Immediate
- Urgent: 5-20 minutes
- Interrupt doctor: As soon as possible
- Today: Same day
- Within 24 hours

Cardiopulmonary resuscitation (CPR) skills are essential for all members of the practice 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.

CPR 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 Continuing Professional Development, must 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. ACLS, St John, New Zealand Heart Foundation).

Guide to key documents

- Policy: how to manage urgent medical conditions
- Protocols for non-clinical team members
- Reference material: posters, algorithms
- Triage policy
- Current CPR certificates for applicable team members

Maintenance of professional practice credits

Participation in an approved RESUS course once per triennium is required for MOPS participants:

- Level 5 course: 8 credits
- Level 7 course: 12 credits

Additional Resources


Notes
Indicator 24  The practice has an effective system for the management of clinical correspondence, test results and other investigations

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.

<table>
<thead>
<tr>
<th>CRITERIA</th>
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</tr>
</thead>
<tbody>
<tr>
<td>24.1 ★★</td>
<td>There is a documented policy that describes how laboratory results, imaging reports, investigations and clinical correspondence are tracked and managed</td>
</tr>
<tr>
<td>24.2 ★★</td>
<td>All incoming test results or other investigations are sighted and actioned by the team member who requested them or by a designated deputy</td>
</tr>
<tr>
<td>24.3 ★★</td>
<td>Patients are provided with information about the practice procedure for notification of test results</td>
</tr>
<tr>
<td>24.4 ★★</td>
<td>The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals</td>
</tr>
<tr>
<td>24.5 ★★</td>
<td>A record is kept of communications with patients informing them about test results</td>
</tr>
</tbody>
</table>

The practice has a reliable, timely and consistent approach to the management of laboratory results, imaging reports, investigations and clinical correspondence. The principle is to establish a robust process to ensure requests for investigations or clinical opinion reach the intended recipient in timely manner particularly in an emergency or urgent situation. In addition, there is a process to determine whether the results or clinical correspondence have been returned to the clinician requesting the information within a timeframe identified by the practice.

Tracking methods may include:
- Automated electronic ‘flag’ to alert the requester at an identified period of time
- Track and trace in hardcopy – name/NHI of patient, test requested, by whom with date sent and date received

The Commissioner accepts that no system is infallible, but there is an expectation that important test results and referrals are tracked to ensure appropriate follow up.


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 tracking or 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 person 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.

The HDC 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 http://www.hdc.org.nz/publications/other-publications-from-hdc/articles/2008/managing-patient-test-results

Full information must be given to the patient in order for them to make an informed decision about the proposed tests and investigations.

Links to Indicator 28 & 29
Consent may be implied for repetitive testing such as

the international normal ratio (INR) for anticoagulant management. Other tests may require a greater amount of information such as the implications of liver function screening in patient with Hepatitis C.

Information (documented is strongly recommended) is given to patients or displayed for example posters, notices or patient information handouts. Members of the team explain to patients how they will be notified about their results and what to do if they do not hear from the practice.

Tracking – see above

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).

Guide to key documents

- Policy - how to manage and track laboratory results, imaging reports, investigations and clinical correspondence
- Protocols for management of incoming test results and other investigations
- Patient information - posters, notice, leaflet and/or brochure
- Policy – identification and tracking of significant investigation and urgent referrals
- Medical record to demonstrate communication of test results

Additional Resources

Health and Disability Commissioner: www.hdc.org.nz

There is an electronic record of all prescribed medicines in the patient’s medical record. This includes an electronic record of controlled drugs where the original prescription will be on a Ministry of Health Controlled Drug Prescription Form. The prescribing of the controlled drug will be recorded using the electronic patient medication software however the hardcopy of the prescription will not be printed from the computer. This will provide readily accessible data for continuity of care and an audit trail of activity.

Pharmaceutical samples, dispensed from the practice, are recorded in the patient’s record. This will assist with continuity of care and alert the clinician to possible drug interactions when prescribing new medications.

Links to Indicator 14

The purpose of this criterion is to identify the tracking and monitoring process used by the practice for repeat prescribing, including patient collection. The appropriateness or otherwise of long-term repeat prescribing and repeat prescribing without consultation will always be a matter of professional judgement. When assessed against accepted standards of best practice in the profession, prescribing must be capable of withstanding scrutiny.

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<tr>
<th>CRITERIA</th>
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<tbody>
<tr>
<td>25.1 ★</td>
<td>Prescriptions of all medicines including controlled drugs are recorded in the electronic record</td>
</tr>
<tr>
<td>25.2 ★★</td>
<td>The practice has a documented policy for repeat prescribing</td>
</tr>
<tr>
<td>25.3 ★</td>
<td>The practice team is able to demonstrate how the policy for repeat prescribing is implemented</td>
</tr>
<tr>
<td>25.4 ★</td>
<td>An audit of repeat prescribing has occurred within the last three years</td>
</tr>
<tr>
<td>25.5 ★</td>
<td>The practice routinely audits for non-collection of prescriptions held by the practice</td>
</tr>
</tbody>
</table>


The policy should include prescribing and dispensing by health professionals when other health professionals have prescribing rights. More and more, allied health professionals may work as part of the practice team. Some teams delegate to non-doctors the responsibility for initiating and/or changing drug therapy. If the person dispensing the medicine is working from
Standing orders, then the responsibility for the effects of the prescription rests with the doctor who signed the standing order. See the Ministry of Health’s ‘Guidelines for the development and operation of standing orders’.

The policy will comply with the Code of Health and Disability Services Consumers’ Right particularly Right 4 - Right to Services of an Appropriate Standard and Right 6 - Right to be Fully Informed.

The practice has a policy to reconcile a patient’s medication record on receipt of clinical correspondence such as antibiotics. Failure to collect a prescription may require more intensive tracking for non-collection as a follow-up to a laboratory result, for example cystitis, are routinely audited to determine if they have been casually prescribed. It should include a list of allergies and drug reactions.

For medicines under intensive monitoring:
Where applicable remember to tell patients that they have been prescribed a monitored medicine. This means the Intensive Medicines Monitoring Programme receives details of their prescriptions and that their doctor may be asked for clinical information on the patient’s experience whilst taking this medicine. If possible, an explanatory IMMP leaflet should be given to the patient (available from the IMMP, NZ Pharmacovigilance Centre, P.O. Box 913, Dunedin).

Team members involved in the repeat prescribing process can demonstrate how they translate the policy into practise.

Evidence may include but is not limited to:
• Medical records show evidence of prescribing in the absence of a face to face consultation.
• Front line staff know how to process requests that are made by phone, fax, email.
• Evidence of bring up systems to ensure tests and investigations associated with particular medications are performed at appropriate timeframes, for example TFTs with thyroxine, INR with anticoagulants.

The patient’s electronic medical record should include a list of ‘regular’ medications as well as those which have been casually prescribed. It should include a list of allergies and drug reactions.

An audit of repeat prescribing has taken place within the last three years to determine if there is adherence to the policy. In addition, the review may assist clinical and risk management (Indicator 33). Analysis can identify patterns leading up to incidents or near misses because of the prescribing process or prescriber habits.

See CD for repeat prescribing audit template

Prescriptions generated at the request of a patient, or as a follow-up to a laboratory result, for example cystitis, are routinely audited to determine if they have been uplifted by the patient, or designated representative, in a timely fashion. Some prescriptions may require more intensive tracking for non-collection such as antibiotics. Failure to collect a prescription is noted in the patient’s medical record. Continuity of care is enhanced by assuring that patient care is not compromised by the non-collection of prescriptions.

Standing orders
Where applicable, standing orders should be included in the repeat prescribing policy.

A person acting under an order must exercise their own professional judgement as to whether he or she administers medicines pursuant to the order. Responsibility could fall on one or both parties depending on the circumstances of the case.


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.

It is recommended that the standing order list the medicines by their ingredient name, rather than brand name, as every time a brand name changes, the standing order will need to be updated.

The policy should also include the:
• period for which the standing order applies
• documentation and monitoring in association with the order
• competencies of the provider
• audit and review details

See CD for standing order checklist

Reconciliation of medicines
Medicines reconciliation is listed as a current priority of the Health Quality and Safety Commission see www.safemedication.org.nz

It is about getting the medicines right at transition points and communicating this information accurately to the provider who is taking over care. Examples of transitions that relate to a general practice include the discharge from secondary to primary and admission from community to secondary care.

Medicine reconciliation is an evidence-based process involving three core steps:
• Collecting the ‘most accurate’ medicines list using at least two different information sources, the primary source being the patient
• Comparing the ‘most accurate’ medicines list against the current medication chart and clinical notes for any documented changes to medicines
• Communicating any discrepancies (i.e. undocumented changes, whether intended or not) to the prescriber to reconcile and action
The goal is to obtain the ‘most accurate’ list of all medicines that a patient is currently taking within 24 hours of admission to a hospital, transfer or discharge. The impact is to reduce any discrepancies that have the potential to become medication errors and cause medication-related harm to patients.

The practice must ensure any changes of medications are accurately transcribed into the patient's list of regular medicines.

There should be a defined time interval for patients to collect the repeat prescription after which it is considered ‘uncollected’ and arrangements made for secure disposal by shredding.

There should be an entry made in the patient's medical notes to document the non-collection of the prescription.

Guide to key documents
- Electronic record of prescribing
- Documented policy for repeat prescribing
- Telephone/fax/email request form
- Audit of repeat prescribing
- Policy for audit of non-collection of prescriptions

Maintenance of professional practice credits
There is an existing College CQI activity available on the member's page of the website under ‘Information and Resources’ (‘Assessment of Prescribing Habit’) 10 credits per cycle, maximum of 2 cycles per triennium

NB: Retain summary for MOPS audit purposes

Individual doctors or practices can format their own audit tool for CQI however this would require pre-approval to attract credits.

Additional Resources


Ministry of Health. Outlines the November 2010 changes to the Medicines Act www.moh.govt.nz

Medicines Act regarding electronic prescriptions, November 2010 Clause 40A of the Medicines Regulations 1984

Clause 41 of the Medicines Regulations 1984

Notes
The practice offers services for disease prevention and promotion of healthy lifestyles

Health promotion is distinct from education and information used to support diagnosis and choice of treatment, and occurs when practice teams work with patients to help them manage their own care to improve their quality of life. It may involve a range of activities such as meeting with internal or external teams to identify different approaches to care, using new evidence or influencing changes in practice. Some practices work with other primary health organisations, networks or public health units to develop health promotion and social marketing approaches to help people understand the importance of making healthier lifestyle choices. This is directly geared to achieving specific and measurable health goals over the short, medium and long term. Administering Green Prescriptions is one of many approaches that are proven to work.

### CRITERIA RATIONALE

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>26.1 ★ Practice teams deliver preventive care and promote healthy lifestyles</td>
<td>• Educating patients in preventive approaches helps them develop skills to manage their own health</td>
</tr>
<tr>
<td>26.2 ★ The practice database is used to identify the health needs of the enrolled population</td>
<td>• Collection of personal and health information informs patient identification, clinical care and service planning</td>
</tr>
<tr>
<td>26.3 ★ The practice team is able to demonstrate how they implement brief intervention processes</td>
<td>• Brief interventions are well-judged, brief comments or discussions with a patient intended to teach them how to self-manage their own care or consider changes beneficial for their health • Results of brief interventions have shown to have positive benefits for patient health, e.g. reduction in alcohol intake, smoking cessation, weight loss management, drug-using behaviour</td>
</tr>
<tr>
<td>26.4 ★ The clinical team is able to demonstrate how they provide or refer patients to programmes that improve, maintain or restore health</td>
<td>• Supporting patients with information and referring them to supportive programmes can be beneficial for achieving individual and measurable health goals</td>
</tr>
<tr>
<td>26.5 ★ A wide range of current health promotion material is available to patients in printed form</td>
<td>• Patients should be provided with quality and reliable health information, appropriate to the practice population, that supports effective clinical activity • Current smokers • Body mass index • Alcohol intake • Elevated blood pressure</td>
</tr>
</tbody>
</table>

Brief interventions are a well-judged brief comment or discussion with a patient to encourage them to consider changes beneficial for their health, for example reduction in alcohol intake, smoking cessation and weight loss management.

Clinical team members can demonstrate what preventative care and health promoting activities they deliver. Programmes to support patients may be conducted from the practice or from community based facilities.
In addition, the team can demonstrate how they refer patients to national or regional programmes, health professionals, social agencies and community representatives. Examples may include Green Prescription.

There is a wide range of patient information available to take away. The material is current and appropriate to the practice population. This may require practice teams to access information in different languages or formats and to contact interpreters and translators if needed.

Guide to key documents

- Audits
- Evidence of brief intervention in medical record/s
- Supportive programmes – delivered by clinical team
- Supportive programmes – delivered by local, regional or national provider
- Examples of patient information

Maintenance of professional practice credits

A range of CQI audit tools can be found on the members section of the College website. Examples include: Health for Young People, Preventative Care and Screening

10 credits per cycle, maximum of 2 audits per cycle in a triennium

Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources

CALD (Culturally and Linguistically Diverse)—training, development, resources for health professionals: www.cald.org.nz

Health Sponsorship Council—social marketing: www.hsc.org.nz

Ministry of Health—Green Prescriptions: www.moh.govt.nz

Health Literacy New Zealand: www.healthliteracy.org.nz

Notes
A chronic condition is any ongoing, long-term or recurring condition that can have a significant impact on people's lives.

The practice uses a recognised coding system to classify chronic and long-term medical conditions. All consultations for individuals with chronic and long-term conditions are coded to enable the practice to compare, prioritise and align activities with local, regional and national goals for disease management. The practice should format a limited list of codes in order to standardise data entry.

The coded data in the PMS is audited and analysed to identify the prevalence of certain conditions and the numbers of registered patients who have chronic and/or long-term conditions. Reviewing information can facilitate the practice to monitor a person's condition and assess when further intervention may be needed.

Chronic care models rely on effective electronic information systems for:

- information capability to support population healthy approaches: disease registers, patient databases, risk assessment tools
- information systems to support proactive primary care over time: contact of at-risk populations, monitoring and follow-up, performance feedback
- clinical decision-making support: evidence-based guidelines, electronic reminders in practice management system
- coordinated care systems to support timely quality treatment: accessible by the whole of a care team and the patient across providers, sharing of patient information across organisations, access to standardised information facilities coordination
- integrated systems capability: standardised e-referral, e-assessment processes and capability to access data across disciplines, institutions and providers: supporting electronic transaction processing, and integrated funding arrangements
- feedback and reporting to ensure quality service provision and improved patient outcomes.

Self-management approaches are an essential component of a care and coordination model. Self-management programmes and approaches enable:

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<tr>
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</thead>
<tbody>
<tr>
<td>27.1 ★</td>
<td>There is a system to code chronic or long-term conditions according to a recognised classification system</td>
</tr>
<tr>
<td>27.2 ★</td>
<td>Practices can provide information on the prevalence of chronic or long-term conditions recorded and classified on the database</td>
</tr>
<tr>
<td>27.3 ★</td>
<td>The clinical team audits its management of patients in the practice to align care with current health targets for chronic and long-term conditions</td>
</tr>
<tr>
<td>27.4 ★</td>
<td>The practice demonstrates use of evidence-based electronic clinical decision support</td>
</tr>
<tr>
<td>27.5 ★</td>
<td>Electronic clinical decision support tools are integrated into the practice management system (PMS)</td>
</tr>
</tbody>
</table>
• identification of symptoms
• knowledge of the condition and symptoms management
• understanding of the purpose of medication and using it effectively
• support and motivation to adopt a healthy lifestyle
• connection to support groups that understand the issues
• connection to organisations that will assist in managing a range of support (e.g. income) 34

Regular clinical audits will be conducted to demonstrate the extent to which clinical management aligns with national targets.

Electronic decision support tools are useful for tracking and managing diseases in the practice. Important prerequisites for patient treatment and management are patient demographic data, electronic notes and routine coding of conditions at source to enable assessment of disease prevalence in enrolled populations. This level of data provides information to clinical team members about any potential risk, e.g. allergies to medication, pharmaceutical products and/or vaccines. Outcomes of care provided can be used to identify any potential benefits from screening and whether it outweighs any physical and psychological harm (caused by the test, diagnostic procedure or treatment).

The criterion will remain an open star at this time as not all PMS programmes have electronic decision support tools. Therefore where possible the electronic support tools are integrated into the PMS software.

Notes
Screening occurs in two ways through screening programmes and opportunistically. (Opportunistic screening is covered in Indicator 29).

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
- population-based screening programmes involve 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.

See www.moh.govt.nz/nationalscreeningunit

The National Screening Unit (NSU) provides health screening programmes in New Zealand. A separate unit of the Ministry of Health, the NSU is responsible for the safety, effectiveness and quality of health and disability screening programmes.

The NSU is currently responsible for five screening programmes:
- Antenatal HIV Screening Programme (www.nsu.govt.nz) - screens pregnant women for HIV to reduce the chances of HIV being passed to the baby
- BreastScreen Aotearoa (www.nsu.govt.nz) - screens women for breast cancer
- National Cervical Screening Programme (www.nsu.govt.nz) - screens women for abnormal changes to cells on the cervix
- Newborn Metabolic Screening Programme (www.nsu.govt.nz) - screens newborn babies for certain metabolic disorders
- Universal Newborn Hearing Screening Programme (www.nsu.govt.nz) - screens newborn babies for hearing loss

Screening and recall can be undertaken if disease codes have been systematically recorded against patient encounters in the Practice Management System, e.g. READ, SNOMED. This enables auditing to identify outcomes for patients in national screening and recall programmes. Analysis of results will identify which patient populations benefit from being linked to programmes such as cervical screening. In addition, specific characteristics identified (e.g. age, gender or ethnicity) may be a precursor to diagnosis or treatment.

Guidelines for Cervical Screening

Informed consent to screening is not simple. This is because:
- individuals who participate in screening consider themselves to be healthy and do not have any symptoms
- screening is not just a test for a condition. A screening test is part of a pathway and may result in other interventions and treatment
- an individual may be harmed as a result of being screened, and may receive false negative or false positive results.
The New Zealand Medical Council’s statement on informed consent in screening published in 2002 states:

“Doctors have a special duty of care when enrolling an apparently healthy asymptomatic person in screening programmes, to make him or her aware of the limitations of screening and the uncertainties, in particular the chance of false positive and false negative results. Before obtaining consent the doctor should explain, or give information to the patient that explains the purpose of the screening:

- the uncertainties
- any significant medical, social or financial implications for which the screening is done and,
- follow up plans, including the availability of counselling and support services”.

The UK Medical Council has also issued a statement on informed consent in screening. Guidance from the UK’s General Medical Council as set out in the November 1998 paper entitled “Seeking Patient’s Consent: The Ethical Considerations” suggests the following key pieces of information need to be given to the person being asked to give their consent:

- information needs to be provided in the context of a person’s values, culture and background
- consistent and helpful advice needs to be given in an easy to understand systematic form
- information must be given to the person being asked to give their consent about the benefits and risks involved
- information leaflets and/or other publications should be given to the person involved to assist them understand what is involved
- ideally, a relative or friend should accompany the person involved in the consent discussion to assist them to understand the relevant issues
- distressing information should be explained in a sensitive way
- other members of the health team should be involved in the consent discussion if the need arises
- any questions the person “being consented” wishes to raise must be answered openly and honestly
- the person with whom the consent discussion takes place should be given enough time to digest the information they have been given and to ask questions before they are required to make a consent decision.

There should be agreed evidence based policies outlining which individuals should be offered treatment and the appropriate treatment to be offered. Clinical management of the condition and patient outcomes should be optimised, as far as practical, by all health care providers prior to participating in a screening programme. The practice should offer a pathway to effective treatment or intervention for patients identified through early detection.

Guide to key documents

- System used to identify patient for screening and recall – audit details
- Policy for review of efficacy of system
- Examples of clinical interventions as a result of screening results

Maintenance of professional practice credits

A range of CQI audit tools can be found on the members section of the College website. Examples include: RNZCGP Cervical Screening booklet.

10 credits per cycle, maximum of 2 audits per cycle in a triennium

Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources

BreastScreen Aoteoroa: www.nsu.govt.nz


Diabetes New Zealand: www.diabetes.org.nz


Ministry of Health—National Screening Unit (NSU): www.moh.govt.nz/nationalscreeningunit

National Cervical Screening Programme: www.nsu.govt.nz

Newborn Metabolic Screening Programme: www.nsu.govt.nz

New Zealand Guidelines Group: www.nzgg.org.nz

The Royal New Zealand College of General Practitioners.


Notes
There are established principles for screening and disease prevention that have been developed for New Zealand. They emphasise the rigorous standards of research evidence required to demonstrate effectiveness of screening. To ensure proposed screening is the most effective way of preventing long-term consequences for a patient, it is essential that clinicians understand the evidence for screening, and the natural history of a presenting problem.

With technological advances and early diagnosis it is possible to provide highly sensitive and specific tests. There are two elements to this process:

Opportunistic screening is only offered when clinical judgement confirms that a test is needed to detect the presence or confirm the absence of a specific condition. The quality of opportunistic screening can be improved through regular audit or peer review.

Clinical judgement must always define the need for opportunistic screening. Practitioners must always use their skills to identify the relevance of testing, and identify those likely to be helped rather than harmed by further tests or treatments to reduce the risk of disease or its complications.

Opportunistic screening includes:

- Screening for hearing impairment at school entry
- Antenatal screening:
  - anaemia
  - rhesus incompatibility (to avoid newborn haemolytic disease)
  - gestational diabetes
  - serology for syphilis, rubella, hepatitis B
  - ultrasound screening for anatomical abnormalities e.g. neural tube defects
  - risk factors for HIV
  - chromosomal abnormalities eg, Down syndrome (nuchal translucency +/- maternal serum screening)
- Newborn physical examination to screen for congenital hip dislocation, undescended testes, cardiac abnormalities, etc
- Well Child screening for developmental delays
- Screening for complications of diabetes (retinal, foot and kidney)
- Screening for breast cancer with clinical breast examination
- Mammographic breast screening outside of Breast Screening Aotearoa Programme
- Diabetes screening
- Colorectal cancer screening


Opportunistic screening includes:

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.1 ★</td>
<td>Practice opportunistic screening is evidence-based</td>
</tr>
<tr>
<td>29.2 ★</td>
<td>Clinical team members can demonstrate their role in providing opportunistic screening</td>
</tr>
<tr>
<td>29.3 ★</td>
<td>Clinical team members can show how screening interventions are applied to improve outcomes for patients</td>
</tr>
<tr>
<td>29.4 ★</td>
<td>The practice can demonstrate that screening is linked to early intervention</td>
</tr>
</tbody>
</table>

Indicator 29 The practice undertakes opportunistic screening

The burden of chronic disease is identified as a risk with very high severity to patients, populations, the health system and the economy. The World Economic Forum identified thirty six specific health areas where risk factors would be controlled better if detected early in their natural history. 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 in forms where to link people to care.

Screening is most useful for those with long-term conditions, and individuals or groups with a higher risk of a particular disease, e.g. familial polyposis risk for colon cancer.
- Prostate cancer screening
- Cardiovascular disease risk factor screening (smoking, serum cholesterol, hypertension)
- Screening for alcohol and drug misuse among adolescents and adults
- Osteoporosis risk factor screening (which may include bone mineral density scanning)
- Screening for congenital hearing impairment

Members of the clinical team can describe and demonstrate their role in the early detection of risk factors in presenting individuals. Which test is recommended depends on the patient’s age, family history and whether they have risk factors for a certain disease. For example, being overweight may increase the risk of developing diabetes.

How does the practice conduct screening activities?

Informed consent to screening is not simple. This is because:

- individuals who participate in screening consider themselves to be healthy and do not have any symptoms
- screening is not just a test for a condition. A screening test is part of a pathway and may result in other interventions and treatment
- an individual may be harmed as a result of being screened, and may receive false negative or false positive results.

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- distressing information should be explained in a sensitive way
- other members of the health team should be involved in the consent discussion if the need arises
- any questions the person “being consented” wishes to raise must be answered openly and honestly
- the person with whom the consent discussion takes place should be given enough time to digest the information they have been given and to ask questions before they are required to make a consent decision.

Members of the clinical team can describe and demonstrate how interventions are applied to prevent long-term consequences for a patient.

Interventions may include but are not limited to:

- Advice about diet, exercise, tobacco, alcohol and drug use, stress, accident prevention and the prevention of sexually transmitted diseases
- Immunisations for both children and adults

Guide to key documents

- Screening audit data
- Methods used to screening patients on an opportunistic basis
- Examples of interventions as a result of screening results
- Examples of early interventions

Maintenance of professional practice credits

A range of CQI audit tools can be found on the members section of the College website.

10 credits per cycle, maximum of 2 audits per cycle in a triennium

Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources

Ministry of Health. New Zealand Long-Term Conditions Programme: www.moh.govt.nz

The practice has an audit process to identify all eligible patients requiring immunisation under the National Immunisation Schedule. The national schedule is reviewed on a triennial basis but may also be subject to interim changes.

As at July 2011 the National Schedule is:

<table>
<thead>
<tr>
<th>Antigen</th>
<th>DTaP–IPV–Hep/Hib</th>
<th>PCV10</th>
<th>MMR</th>
<th>Hib</th>
<th>DTaP–IPV</th>
<th>Tdap</th>
<th>HPV</th>
<th>Td</th>
<th>Influenza</th>
</tr>
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<tbody>
<tr>
<td>6 weeks</td>
<td>♣</td>
<td>♣</td>
<td></td>
<td></td>
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<tr>
<td>3 months</td>
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<td>♣</td>
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<tr>
<td>5 months</td>
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<tr>
<td>15 months</td>
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<tr>
<td>4 years</td>
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<td>11 years</td>
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<tr>
<td>12 years (female only)</td>
<td>♣</td>
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<td></td>
<td>3 doses</td>
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<tr>
<td>45 years</td>
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<td></td>
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<tr>
<td>65 years</td>
<td>♣</td>
<td></td>
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<td></td>
<td></td>
<td>(annually)</td>
</tr>
</tbody>
</table>

Immunisation Handbook 2011
When planning a catch-up programme for eligible patients who have missed a scheduled vaccine focus on the antigens received versus the antigens required and not the vaccine combinations available or trade names. Follow the principles in Appendix 2 of the Immunisation Handbook 2011.

The Handbook contains guidelines for organisations offering immunisation on how to achieve high population coverage. This includes:

- having an effective communication strategy to target high-needs population groups
- using every attendance at the practice to remind individuals/parents/guardians of the importance of immunisations and where appropriate, to check and offer to administer the catch-up vaccine/s at that time
- routinely referring patients, who do not respond and have not declined to take part, to the outreach immunisation service, as per local protocols.

The practice reviews the recall process to identify whether it is effective in identifying and reaching patients who are due or overdue for immunisations on the national schedule. The review is conducted at least annually to identify gaps in service delivery and to formulate strategies to improve audit outcomes.

Guide to key documents

- Policy on recall process
- Immunisation audit data

Maintenance of professional practice credits

There are pre-approved CQI audits on immunisation.

- 10 credits per cycle, maximum of 2 audits per cycle in a triennium

Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources


National Immunisation Register: www.immune.org.nz

Notes
The New Zealand Smoking Cessation Guidelines 2010 recommends integrating the use of evidence-based interventions into the standard practice of health professionals. It has shown evidence of success in reducing harm caused by tobacco and improving health outcomes for (in particular) Māori, Pacific people, pregnant women, and people who use mental health and addiction services.

#### Disease prevention

**Indicator 31**  
The practice routinely identifies people who smoke and offers interventions

The practice collects the smoking history and current status of patients, aged 15 years and over, when they enrol with the practice. Additional fields to capture health information can be added to the enrolment form if applicable.


The smoking information is entered into the patient’s clinical record and coded to enable the practice to audit the data.

The MOH recommends the following coding:

1. Current smokers
2. Ex-smoker <12 months
3. Ex-smoker >12 months

As an example, someone who has successfully stopped for 3 months would be considered ‘ex-smoker<12 months’.

Once the patient has quit for one year then they would be considered ‘ex-smoker >12 months’. The MOH state ‘the reason for the 12 months milestone is that the chance of relapse is significantly less after this point’.

Data-recording and decision-support software tools are available through PMS providers. Examples of screenshots and a power point slideshow can be seen on http://www.hiirc.org.nz/page/26689/a-screen-shot-overview-of-the-data-recording/?tab=4207&section=10541. This site also includes other helpful keyboard shortcuts for those with Medtech software.

STEPS is a ‘Train the Trainer’ programme designed to strengthen New Zealand’s smoke free training workforce towards delivering effective, brief ABC training for registered health professionals within both secondary and primary care. At the time of writing training was available for both practitioners and those who work with practitioners to encourage smoking interventions – see http://www.hiirc.org.nz/page/26691/steps-training-a-train-the-trainer-approach/?section=10545&tab=822

General practice teams should give brief advice to stop smoking to all people who smoke, regardless of whether they say they are ready to stop smoking or not. In addition, practice teams should:

- provide evidence-based cessation support for those who express a desire to stop smoking
- only recommend smoking cessation treatments of proven effectiveness, as identified in the New Zealand Smoking Cessation Guidelines, to people interested in stopping smoking.

The guidelines promote the use of a memory aid, “ABC”, which provides prompts to:

- Ask about smoking status;
• give Brief advice to stop smoking to all smokers;
• provide evidence-based Cessation support to those who wish to stop smoking.

Ensure patients are aware of cessation options such as Quitline, Aukati Kaipaia and local DHB services through nicotine therapies and prescription medicines.


The team refers patients to regional smoking cessation services and/or national programmes. Knowledge about other allied health care providers, community services and national programmes enables teams to identify the best options and refer accordingly.

Guide to key documents
• Method of collecting smoking information
• Smoking data in medical records – coded
• In-house educational intervention programme information
• External intervention programmes
• Method to update smoking data

Maintenance of professional practice credits

There are pre-approved CQI audits on smoking cessation.
10 credits per cycle, maximum of 2 audits per cycle in a triennium
Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources


Nurse education and Quit Card Provider status. https://smokingcessationabc.org.nz


Notes
Indicator 32 The practice has processes to ensure continuity of care

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. Services will always vary over time and from place to place and patients must be able to rely on practice teams guiding them through the complexity of health care services and health contacts. 43

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.

Important: The Ministry of Health has a standing order that practice owners are ultimately responsible for continuity of care. Vicarious liability assumes the principal (owner) is responsible for the actions of those engaged by the practice.

The Medical Protection Society (MPS) has developed a referral and referral back checklist to help doctors manage the referral process. http://www.medicalprotection.org/uk/casebook-may-2011/the-risk-of-working-with-others

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

CRITERIA RATIONALE

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
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<tbody>
<tr>
<td>32.1 ✪ The practice can demonstrate continuity of care management by multidisciplinary teams in the practice</td>
<td>• The patient journey must not be compromised through loss of health information between team members</td>
</tr>
<tr>
<td>32.2 ✪ The practice can demonstrate its processes for transfer of care when transferring patients to providers and services outside the practice</td>
<td>• Practice processes and communication must provide a seamless connection to link patient information with other providers and services</td>
</tr>
<tr>
<td>32.3 ✽ The practice can provide evidence of effective electronic linkages between the practice and secondary care interfaces</td>
<td>• The patient journey is facilitated through sharing electronic patient information across primary/secondary interfaces</td>
</tr>
<tr>
<td>32.4 ✽ An electronic shared care record facilitates effective transfer of care</td>
<td>• An electronic record assists effective handover to facilitate seamless care across providers</td>
</tr>
<tr>
<td>32.5 ✽ Patient feedback of their experience is used to inform continuity improvements in clinical care</td>
<td>• Patient experience is an important consideration for developing existing and new services and understanding whether clinical care is making a difference to outcomes</td>
</tr>
<tr>
<td>32.6 ✽ All patients with palliative care needs can access their doctor or an informed deputy at all times</td>
<td>• Managing the complexities of terminal care ensures that patient care is not compromised</td>
</tr>
</tbody>
</table>
A standardised communication process for the transfer of care to providers and services outside the practice is recommended. This might include but is not limited to templates for correspondence and checklists.

The practice has electronic links with secondary healthcare facilities. This will assist a smooth and seamless transition of patient information between the primary and secondary health care services. This may not be technically possible in all areas of New Zealand however will remain an aspirational target. In some regions limited connectivity will be in place, i.e. restricted to specific departments or services.

The multidisciplinary teams of health providers, from primary and secondary facilities and community agencies, have full access to a patient’s medical record. This enhances effective communication for working across interfaces particularly for complex and chronic care. An electronic shared care record may not be technically possible in all areas of New Zealand however will remain an aspirational target.

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 under another provider’s name or initials. Some PMS providers allow for further distinction of provider by colour coding the clinical notes. One colour could then be allocated to a specific health professional group. This may be especially useful for medical centres with multiple providers working from one facility.

The practice obtains feedback from patients to identify gaps where continuity could be improved. This survey will link with activities under Criterion 9.1 and Indicator 10.

Patients with palliative care needs have access to their usual doctor or a deputy at all times. If a deputy is used they have been informed about the patient’s condition and care.


Palliative care is the total care of people who are dying from active, progressive diseases or other conditions when curative or disease-modifying treatment has come to an end. Palliative care services are generally provided by a multidisciplinary team that works with the person who is dying and their family/whanau.

Guide to key documents

- Transfer of care templates for letters
- Electronic records show primary/secondary interface
- Electronic records show evidence of transfer of care
- Patient survey
- Palliative care – policy on access to care

Additional Resources

The practice has a documented policy to outline the process for selection, reporting, management and investigation of incidents. The process is a positive approach to risk management.

Critical events (previously called ‘significant events’) include:

- Events that went well – these are important because they provide valuable information which can lead to improvements in other areas.
- Incidents – an undesired event, which under slightly different circumstances could have resulted in harm to people, damage to property, or loss to process.  
- Accidents – an undesired event that results in harm to people, damage to property, or loss to process.
- Sentinel events – events resulting for the management of the patient’s condition which have a significant effect on the patient, resulting in permanent disability or death.
- Complaints – patient complaints both verbal and written.

The practice maintains a record of incidents and near misses. Recording the events in a prescribed format assists with the robust management of incidents and near misses. Investigation and analysis can assist the team to improve quality and safety in the practice.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.1 ★★</td>
<td>The practice has an Incident Management Policy</td>
</tr>
<tr>
<td>33.2 ★★</td>
<td>The Incident Reporting Register records incidents and near misses</td>
</tr>
<tr>
<td>33.3 ★★</td>
<td>The practice uses a risk management process to analyse incidents and near misses</td>
</tr>
<tr>
<td>33.4 ★</td>
<td>The practice team can demonstrate how incidents are used as a learning opportunity to minimise risk</td>
</tr>
<tr>
<td>33.5 ★★</td>
<td>Adverse reactions to medicines and immunisations are recorded in the PMS and reported to the Centre for Adverse Reactions Monitoring (CARM)</td>
</tr>
</tbody>
</table>

The Incident Management process is a positive approach to risk management. It can be used for situations such as near misses or adverse outcomes. The ‘no blame’ approach helps practice teams consider ‘what is wrong’, rather than ‘who is wrong’. Alternatively, if something went well, the process encourages teams to identify the reason for success. The approach is useful as an early warning system, to prevent or minimise risk and improve safety in the practice.
looking to apportion blame.

UK studies have suggested that there can be some difficulties associated with Significant Events Management including:

- shortage of time
- frequency and timing of meetings
- appropriateness of issues
- naming and shaming
- outcomes difficult to implement and measure
- confidentiality and privacy
- shortage of congratulations
- individuals dominating groups

If your team is experiencing any of these difficulties, giving attention to the following may help:

- establish clear rules
- ensure general ownership
- carefully select topics
- use good facilitators
- protect and provide support to individuals.

It is important to set ground rules before these meetings such as around confidentiality, to assist the team members to engage in the discussion. The person/s reporting the event should ensure the event is well documented.

The members of the team can show how they have changed a process or practise as a consequence of analysing a previous incident or near miss.

See CD - Critical Events Management for more on the PDSA cycle and the use of root cause analysis.

Adverse events may occur as part of prescribing of medications or the administration of vaccines.

The Immunisation Handbook defines reportable adverse events as serious reactions that significantly affect a patient’s management, including reactions suspected of causing:

- death
- danger to life
- hospitalisation
- prolongation of hospitalisation
- interruption of productive activity in an adult recipient
- increased investigational or treatment cost
- birth defects

Adverse reactions to medications, vaccines, devices and all clinical events for the Intensive Medicines Monitoring Programme (IMMP) warrant reporting to the Centre for Adverse Reactions Monitoring.

For medications, vaccines and IMMP reporting use: http://www.medsafe.govt.nz/profs/adverse.asp

The patient or caregiver must give consent for personal information to be shared with CARM. If the patient does not give consent the report can however be sent without detail that would identify the patient, i.e. no name, NHI or address for the patient.

For medical devices use: http://www.medsafe.govt.nz/downloads/device.doc

Adverse events in relation to devices may include deficiencies in labelling, instructions, packaging, defective components, performance failure, poor construction or design.

CARM uses the reports to:

- Make entries of danger/warning against the patient’s name in the national database
- Identify new adverse reactions
- Change medicine data sheets
- Publish article for Medsafe Webpage and international medical literature
- Assess risk factors for adverse reactions
- Evaluate risk versus benefits for medicines
- Contribute to worldwide pool of adverse reaction data through New Zealand involvement in WHO programme

The adverse reaction is documented in the patient’s medical record and where applicable entered in the Medical Warning field.

Guide to key documents

- Incident Management Policy
- Incident reporting register
- Medical record – record of adverse reaction
- CARM form / bookmarked website

Maintenance of professional practice credits

There is a pre-approved CQI audit on incident management (previously called ‘significant events management’) available on the members section of the College website.

10 credits per cycle, maximum of 2 audits per cycle in a triennium

Retain summary sheets for MOPS audit

The individual doctor or practice can design their own quality improvement audit process however this must be submitted for pre-approval in order to attract credits.

Additional Resources

BPAC—CME references, patient resources, health practitioner resources: www.bpac.org.nz

The Centre for Adverse Reactions Monitoring (CARM)—accessed through the NZ Pharmacovigilance Centre’s website: https://nzphvc-01.otago.ac.nz/carm-adr/


SECTION 4 – Professional Development

Indicator 34 The practice team complies with the Health Practitioners Competence Assurance Act 2003

To meet the requirements of the Health Practitioners Competence Assurance Act 2003, all practice team members must demonstrate their competence and fitness to perform their duties. The intent is to ensure that all health professionals are engaged in a Maintenance of Professional Standards programme.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.1 ★★ All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003</td>
<td>• Practices must provide evidence that they meet the requirements of the Health Practitioners Competence Assurance Act 2003</td>
</tr>
<tr>
<td>34.2 ★ Medical staff employed long term in the practice are vocationally registered in general practice or working towards this</td>
<td>• Patients are provided with assurance that all permanent medical practitioners in the practice are vocationally trained and engaged in a Maintenance of Professional Standards programme</td>
</tr>
<tr>
<td>34.3 ★★ All clinical team members participate in Continuing Professional Development</td>
<td>• The practice meets the New Zealand Medical Council and the New Zealand Nursing Council requirement to maintain their commitment to Continuing Professional Development (CPD)</td>
</tr>
<tr>
<td>34.4 ★ The practice team can demonstrate how incidents are used as a learning opportunity to minimise risk</td>
<td>• The practice is committed to ensuring its clinical team is informed and skilled</td>
</tr>
</tbody>
</table>

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. Health Practitioners Competence Assurance Act 2003: www.legislation.govt.nz Medical Council of New Zealand: http://www.mcnz.org.nz/support-for-doctors/list-of-registered-doctors/ Nursing Council of New Zealand http://www.nursingcouncil.org.nz/index.cfm/1,32.html/Practising-Certificates For risk management it is recommended the practice maintains a record of certification including expiry dates.

General practice has been recognised as a medical specialty in law since 1995. http://www.rnzcgp.org.nz/assets/documents/News--Events/Statement-of-Vocational-Training.pdf The College leads, sets and reviews standards for general practitioner education and assessment as part of its commitment to high quality general practice in New Zealand. Education, examinations and assessments allow the College to verify the competence of individual medical practitioners and award them Fellowship of the Royal New Zealand College of General Practitioners (FRNZCGP). This enables practitioners to apply to the Medical Council (MCNZ) for registration in the vocational scope of General Practice. The College provides a range of options for doctors to gain vocational registration in addition to the main education pathway. These options include:

a. Recognition of Prior Learning (RPL) Doctors with significant experience in general practice can apply for consideration of recognition of prior learning. This experience has often been gained overseas. RPL enables doctors with competence in most areas to identify specific areas for attention and more quickly complete their vocational training without unnecessary repetition.

b. Experiential Interim Pathway From June 2010 until May 2013 an additional on-ramp to the pathway has been created which allows
Ensure all members of the practice team including practice partners participate in performance reviews and continuing education.

Information from the performance reviews will guide planned professional development for clinical team members. This may be in response to poor performance, new performance objectives or personal ambition.

**Guide to key documents**

- Practising certificates (MCNZ available online)
- Record of expiry dates (optional)
- See MCNZ website
- Evidence of CPD
- Peer reviews

**Maintenance of professional practice credits**

CME and peer review activities can be pre-approved or endorsed and would attract 1 credit per learning hour.

**Additional Resources**


New Zealand College of Primary Health Care Nurses NZNO—Accreditation: www.nzno.org.nz

Medical Council of New Zealand: www.mcnz.org.nz

Nursing Council of New Zealand: www.nursingcouncil.org.nz

New Zealand Medical Association: www.nzma.org.nz


The Royal New Zealand College of General Practitioners—Maintenance of Professional Standards Programme 2010–2012

**Notes**

Doctors who are experienced in general practice and are practising at a level expected of a vocationally trained registered GP, to be assessed as such and awarded Fellowship. They can then apply to the MCNZ for vocational registration.

A doctor working in general practice who is not in the training programme and has not completed vocational training must be in a “collegial relationship” with another general practitioner who is trained and vocationally registered.

The collegial relationship requires four to six face to face meetings between the two doctors each year. http://www.rnzcgp.org.nz/assets/documents/News--Events/Statement-of-Vocational-Training.pdf

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 the maintenance of professional standards.

For medical practitioners – see RNZCGP: http://www.rnzcgp.org.nz/continuing-professional-development

For nurses – see NCNZ: http://www.nursingcouncil.org.nz/index.cfm/1,193,html/Approved-Professional-Development-and-Recognition-Programmes-PDRP

The health professional maintains a record of their professional development. The practice may wish to retain a copy of training for taxation purposes particularly where the practice has funded the professional development.

To be read in conjunction with information for criterion 36.6.

Clinical team members are reviewed by a peer, at least, annually. This may be part of the annual performance review however it will be in addition to regular coaching and performance discussions.

There is a culture of teamwork in the practice

It's worth considering how team interaction and culture might influence patient outcomes or enable clinical improvement activity and engagement in other initiatives. The first step is to identify team culture. It cannot be created to order and takes time to evolve. As part of long-term plans for clinical governance, teams should begin by identifying how well they perform on communication, accountability, and responsibility for creating a culture of teamwork. 47 48

### CRITERIA RATIONALE

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.1 The practice undertakes a regular assessment of team functionality</td>
<td>• Use of team assessment tools identifies the culture of the team and their ability to work together effectively</td>
</tr>
<tr>
<td>35.2 The practice has evidence of regular meetings involving the practice team</td>
<td>• Mechanisms that support transparency, ability to contribute to discussion and two-way communication improves practice team involvement</td>
</tr>
<tr>
<td>35.3 There is a process to disseminate practice information to all team members</td>
<td>• Sharing ideas and information is inclusive and keeps everyone informed about practice activities or decisions</td>
</tr>
<tr>
<td>35.4 The practice can demonstrate the orientation process used for new team members and locums</td>
<td>• A planned approach to orientation ensures consistent information for new team members</td>
</tr>
<tr>
<td>35.4 There is a resource with information about the practice available to new team members and locums</td>
<td>• A Practice Induction Resource or Orientation Manual provides formal information and guidance to all new team members, including locums or casual staff</td>
</tr>
</tbody>
</table>

The practice undertakes a review of the culture of the practice team and their ability to effectively and efficiently work as a cohesive unit. A successful team culture is one in which members:

- are willing and able to acknowledge their problems
- work together to improve performance
- value personal development and education
- feel valued in their work
- recognise the importance of the patient’s experience of care
- seek ways of improving care as a matter of routine. 49

For an example of a Team Assessment tool see: www.mindtools.com/pages/article/newTMM_84.htm#Explanation

The practice retains minutes which demonstrate regular meetings of the practice team. The minutes may be in the form of electronic files or in hardcopy. There is evidence that information is disseminated to members of the practice to keep them all informed about practice activities and decisions. This enhances team culture and provides a shared and consistent approach to business and the delivery of health care. Examples include but are not limited to a practice intranet or in hardcopy forms like staffroom notices or notebooks.

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 induction process should include a checklist of required competencies that are signed on completion by both employee and manager and filed in the employee file. 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
Orientation will usually happen over several weeks although some places commence the ‘knowledge dump’ process by sending the new person an orientation package before they commence work.

A comprehensive and planned orientation process brings the new employee or locum ‘up to speed’ quicker and creates a positive impression. Conversely, a poor process can tarnish the person’s view of the practice, dent their motivation and severely affect job satisfaction.

Notes

Guide to key documents
- Team assessment audits
- Record of meetings – minutes
- Intranet / staff notice / notebook
- Orientation process
- Orientation resource
In accordance with legislation all team members must have signed employment contracts. http://www.dol.govt.nz/er/starting/relationships/agreements/builder.asp

In order for an individual employment agreement to meet the minimum requirements by law, it must contain at least the clauses listed below, or a derivation thereof.

• Employer and employee
• Position
• Duties
• Place of work
• Working hours
• Types of pay
• Public holidays
• Resolving employment relationship problems
• Restructuring due to transfer
• Negotiations with new employer
• No transfer or employment
• Rights in contracting out situation

The employment agreement builder in the DOL website can help you put together a draft employment agreement for your employee. This tool contains clauses that you must include in an agreement, as well as clauses that are voluntary.

Every employee must have a written employment agreement. This can be either an individual agreement or a collective agreement. Collective employment agreements are negotiated in good faith between an employer and a registered union on behalf of their members. Employers must not unduly influence employees to join or not join a union.

From 1 July 2011, employers are required to retain a signed copy of the employment agreement or the current signed terms and conditions of employment. The employer must retain the “intended agreement” even if the employee has not signed it. Employees are entitled to a copy on request.

Ensure the persons who own the practice have partnership agreements in group practices and position descriptions to clarify roles and responsibilities.

The employment agreement will include duties as set out in the job description.

The Employee shall perform the duties set out in the Job Description attached to the agreement. These duties may be modified and updated by the Employer from time to time following agreement with the
Employee. The Employee also agrees to perform all other reasonable duties and comply with reasonable instructions issued by the Employer.

The agreement includes a description of the functional relationships required by the employee.

The duties are reviewed at least on an annual basis.

Practice team members who have access to identifiable patient information are required to sign a confidentiality declaration. This is designed to protect confidential information from being misused by those to whom such information will be or has been disclosed.

For risk mitigation it may be prudent to extend the requirement for a confidentiality agreement to independent contractors such as cleaners and IT, business management or advisory services.

Ensure all members of the clinical team are covered by organisational or professional liability insurance. Examples include but are not limited to: Medical Assurance Society, Medical Protection Society, New Zealand Nurses Organisation, College of Nurses Aotearoa (NZ) Inc.

It is recommended the clinical team verify the insurance covers all services provided by the practice. For example, but not limited to, complementary medicine including reflexology, massage, acupuncture, and homeopathy. You can link to the following for information on the definition of complementary medicine. http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Complementary-and-alternative-medicine.pdf

Vicarious liability is an important legal principle. It is the liability an employer may have for the acts and omissions of an employee or some other individual for whose conduct they (the employer) are legally responsible. An employer can be vicariously responsible for the acts or omissions of employees. It is in the interest of the employer to ensure employees or independent contractors hold their own personal indemnity or insurance. This includes locums, nurses and allied health professionals employed by the practice. It is especially important where clinically trained staff hold a high level of autonomy.

Many doctors now form companies, or work within a group practice structure. It is recommended you seek legal advice about indemnity as the legal status of your practice may affect the apportionment of liability and, consequently, the contribution the insurance company may make towards a financial settlement.

Practice managers have access to continued education. The practice manager will retain evidence of a commitment to maintaining or expanding their knowledge. Evidence may include a record of self directed learning, certificates of attendance and recognised tertiary qualifications.

Performance Objectives

The employer shall, in consultation with the employee, set the employee objectives at least on an annual basis. These objectives shall be taken into account by the employer when assessing the employee’s performance.

Performance reviews

Links to Indicator 34.4

The employer shall conduct a performance review of the employee on at least an annual basis. This is in addition to regular coaching and performance discussions. The annual review shall be taken into account in any salary reviews. The review will also celebrate successes and deal with poor performance. See: http://www.dol.govt.nz/publications/big6/big6-performance.pdf

Ensure all members of the practice team including practice partners participate in performance reviews and continuing education.

Information from the performance reviews will guide continued education for all practice team members. This may be in response to poor performance, new performance objectives or personal ambition.

Guide to key documents

- Signed employment contracts for ALL practice team members
- Content includes mandatory clauses
- Confidentiality agreements
- Proof of liability insurance
- Evidence of continued education for practice manager
- Performance reviews for ALL practice team members

NOTE: The private nature of individual employment agreements and performance reviews will be respected when assessing a practice for CORNERSTONE accreditation.

Additional Resources


Department of Labour—Employment agreement builder: www.dol.govt.nz

Notes
Appendix — Develop practice-based activities to improve clinical outcomes for patients

Quality

The College view on general practice quality has been formed over time by best available evidence and practice. Good quality always puts patients first and has processes in place to support Quality Assurance and Quality Improvement, teamwork, and systems improvement.

- The WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) definition best describes general practice quality: *The provision of best health outcomes that is consistent with patient values and preferences, given the available resources.*

- The New Zealand health sector definition of quality health care is also supported. It describes multiple dimensions of quality, including access and effectiveness:

  Quality of care is the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Each general practice is unique and reflects the needs of the community it serves. Many practices have developed close working relationships with peers and colleagues in neighbouring practices. These general practice networks extend and enhance the capacity and capability of practice teams to improve delivery of care for patients through organised general practice, which is characterised by:

- working together with groups of general practices and managers in networks of cooperation and support, providing both individual and population oriented care for enrolled communities of patients
- embracing new opportunities, including (for example) activities in public health, screening, illness prevention, disease management and resource management
- accepting greater accountability for health outcomes and the best use of health resources
- delivering clinical and management excellence in services, at all levels, to ensure optimum effectiveness and efficiency.

This method of working involves cooperation and coordination by clinical and management teams. It encourages them to use their diverse knowledge to deal with health problems in the practice, as well as to educate and communicate with patients effectively, and to develop stronger links with other primary care services.

Clinical effectiveness

Leadership by all stakeholders in general practice has strongly influenced the development of a Quality Improvement programme for general practice. CORNERSTONE provides practices with a mechanism of external review and feedback on the outcomes of general practice quality. This process is best described by JCAHO (Joint Commission on Accreditation of Healthcare Organizations):

Accreditation is a self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.

The approach assists practice teams to work together to design quality systems and processes. It reinforces team processes using a Continuous Quality Improvement (CQI) approach, incorporating Quality Assurance (QA) and Quality Improvement (QI).

Taking the first step toward improvement requires commitment and active engagement by general practice teams. To assist the process, *Aiming for Excellence* brings together managerial, organisational and clinical processes to provide an assessment tool for teams to identify how to provide greater accountability, guide improvements and use the information to increase cooperation in general practice teams.
To understand the power of your practice systems and how well you are meeting the health needs of patients, clinical care must be measured and monitored. Undertaking regular quality improvement activities in clinical areas (e.g. asthma) will provide information about care provided to patients and whether there is a need to make changes that influence patient outcomes through innovations in clinical treatment, management and care provided to patients.

An annual quality improvement activity is now an expectation for practices in the CORNERSTONE programme. This requirement is outlined in criterion 10.4.

### CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.4</td>
<td>The practice identifies an annual quality improvement activity related to the management of a targeted area of clinical care</td>
</tr>
<tr>
<td></td>
<td>• Analysing and reflecting on clinical data ensures that quality processes result in improved quality outcomes for patients</td>
</tr>
</tbody>
</table>

This section outlines two different approaches to undertaking an annual quality improvement activity, but first the practice team must identify what it wants to achieve and then choose a topic to focus the activity.

1. **Meet with the practice team to discuss where they would like to focus clinical improvement activity**

Clinical activity should always encourage reflection and learning to improve outcomes for patients. A useful starting point to focus discussion is the practice Quality Plan. Reviewing the plan will help to identify progress made in the last year and help the team to consider what it wants to focus on next. Using a plan as a starting point will provide a systematic approach to topic selection, but may not be the only consideration. Using ideas from discussion with the practice team may provide greater insight into areas for consideration.

2. **Choose a topic**

A useful starting point for deciding where to identify a topic relevant to your practice and patient populations is the Quality Framework on page 109 of this document. The Quality Framework identifies where to target clinical effectiveness and practice improvement activity. It identifies quality activities under the areas of structure, process and outcome. Within these three broad areas, it depicts interconnected categories of practice activity relating to:

- the functioning of the practice and the practitioners
- the interventions and relationships necessary for the delivery of care
- the outcomes of the care provided.

3. **Identify the measures you want to achieve**

To develop the measures that are relevant for your topic there are a range of starting points that provide best practice or evidence-based indicators. A good starting point is the Healthcare Quality Measures NZ website: www.patientsfirst.org.nz/hqml/ . It provides measures developed for NZ, links to other sites or the ability to develop your own measures using the Indicator appraisal tool, 'the Sieve' on page 107.

4. **Change and improvement**

Use the Standard PDSA Cycle (see page 102) or the template for developing practice-based quality improvement activities (see page 104). Both are useful approaches to gain an in-depth look at:

- how the systems and processes in the practice function
- the issues
- any gaps.

They can both be used for reflection, learning and improvement opportunities, and peer review.
Next steps

PDSA cycles: a method to measure and improve clinical effectiveness

The quality process can be activated using PDSA cycles which are fundamental to clinical improvement activity. All RNZCGP quality activity is based on continuous cycles of change and improvement. PDSA cycles are a simple method for teams to identify and manage change. 54

PDSA cycles – PLAN, DO, STUDY/CHECK, ACT

The principle of all clinical quality activity is that it leads to improvement through change. PDSA cycles are useful because they outline a simple approach to systematic review and can be used by all members of the practice team.

The approach

Teamwork is essential and the approach should always involve or inform the whole team.

- PDSA cycles can be applied to any aspect of care or service.
- PDSA cycles work best if there is consideration of patients and whānau/families, or practice populations.
- PDSA cycles guide incremental and continuous change, gap identification and action. 55
- PDSA cycles facilitate reflection and learning.

PDSA cycles are useful to:

- target and plan improvement activities
- review any aspect of the practice service
- understand procedures used for care of patients
- understand the effect of care on outcomes
- develop improvements in the quality of life for patients. 56

The PDSA process is used to:

- analyse the effectiveness of practice systems and processes
- identify sources of variation causing safety or risk issues
- identify where to target changes or improvements in patient care.

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Incremental Change

Don Berwick (H)
## Standard PDSA Cycle

<table>
<thead>
<tr>
<th>Plan</th>
<th>Identify and develop measures</th>
<th>Prepare the team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop indicators and criteria based on the SMART principles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Specific – use clear, precise language.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Measurable – identify a target standard to measure the practice against.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Achievable – use measures that can be obtained in the practice.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Related to the aims and objectives of the activity and realistic within availability of resources, knowledge and time.</td>
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<tr>
<td></td>
<td>• Theoretically sound and achievable within a reasonable time frame.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Select audit sample</th>
<th>What data will you need to collect?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Develop the audit tool and method of data collection.</td>
</tr>
<tr>
<td></td>
<td>• Identify what data you will need to collect, e.g. demographic data, clinical data.</td>
</tr>
<tr>
<td></td>
<td>• Identify the data type, e.g. retrospective, prospective, concurrent.</td>
</tr>
<tr>
<td></td>
<td>• Identify where the data will come from and how it will be extracted, e.g. manual, electronic.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test methodology and tools</th>
<th>Will the audit tool collect the right information?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Seek comment from colleagues.</td>
</tr>
<tr>
<td></td>
<td>• Test the tool.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do Study</th>
<th>Data collection</th>
<th>What do you need to do to coordinate the activity or minimise poor data collection?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Develop a clear process for collecting and collating data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Analyse the data</th>
<th>What is the gap between standards and performance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Collate results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Analyse data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Describe the results (graphs and tables are useful).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review Interpret the results</th>
<th>Gap analysis</th>
<th>What information did you find?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• The team should interpret the results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Make comparisons.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify gaps or variance against standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prioritise problems.</td>
</tr>
</tbody>
</table>

| Act | Develop solutions | Develop an action plan to identify and manage your solutions |
|     | Action plan       | List all identifiable issues. |
|     |                  | Prioritise actions to address any problems or new ideas. |
|     | Test solutions    | Document any changes or actions required. |

<table>
<thead>
<tr>
<th>Implement solutions</th>
<th>Identify whether your solution will work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Involve the team.</td>
</tr>
<tr>
<td></td>
<td>• Trial solutions – did they work?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions to change</th>
<th>Implement changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Use information from trialling to implement changes.</td>
</tr>
<tr>
<td></td>
<td>• Involve all people or areas affected by changes.</td>
</tr>
<tr>
<td></td>
<td>• Communicate often.</td>
</tr>
<tr>
<td></td>
<td>• Identify any barriers or enablers to change, e.g. resources, skills.</td>
</tr>
<tr>
<td></td>
<td>• Identify how you will implement changes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check</th>
<th>Did change result in improvement?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Learning</th>
<th>Have the changes you implemented improved practice or patient outcomes?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Did you achieve the result you expected?</td>
</tr>
<tr>
<td></td>
<td>• Were any of the changes unsuccessful?</td>
</tr>
<tr>
<td></td>
<td>• Do you need to try a different solution?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reflection</th>
<th>What did you learn from the activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What you could have done differently?</td>
</tr>
<tr>
<td></td>
<td>• How can you put the learning into practice?</td>
</tr>
</tbody>
</table>

| Follow up | Set a date to re-audit the changes implemented |
A template for practice-based quality improvement activity

The new template is derived from the Quality Framework (see page 109) and provides a simple method for general practice teams or practitioners to develop a practice-based self-directed CQI activity. By working through each of the stages of the tool it will be possible to learn how systems or processes in the practice function, to identify any gaps and develop practical solutions. The tool incorporates the PDSA cycle (see page 102) and facilitates the ability of practice teams to plan, implement and audit a quality improvement activity.

Choosing a topic

Some activities or measures developed will only be of interest to an individual practice, and may not be useful to other practices. Others will be of use to regions, or practices with special interests, or have national applicability. Similarly, measures used to assess change may only be of relevance to a particular practice, while others may use indicators of performance that have been thoroughly investigated and exhaustively tested. Additionally it may be inappropriate to use some measures developed in a local setting in another context.

Involving the team

This tool is most effective when the entire practice team is involved in the analysis, defining the scope of the area of interest, describing what actually occurs, discussing possible solutions and choosing the solution. The team must also decide how it will evaluate the activity and what information it will gather as part of its day-to-day work in order to assess effectiveness of the activity.

Planning the activity

Define the topic area of interest and aspect of care or service delivery to be addressed:

(What is the problem?)

Define the activity:

(What do you want to do?)

Determine the drivers for undertaking the activity:

(Why do this?)

Determine the goal:

(What do you want to achieve?)

Determine the scope of the activity:

(What are realistic parameters?)

Determine the resources required:

(What do you need?) Consider:

- time – identify how the work to be done will fit into existing schedules or whether additional time is required
- people – identify roles, relationships and responsibilities; who needs to be involved?
- buy in – arrange to meet frequently; communicate activity with the whole practice and others involved outside the practice
- funding – can existing resources be utilised, or will external funding be needed?)
# Understanding the issues

<table>
<thead>
<tr>
<th>Description of current situation</th>
<th>Perceived problems or questions about the current situation</th>
<th>Potential solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify the setting in which the aspect of care or service delivery takes place</td>
<td>• Is the setting appropriate?</td>
<td>Identify what is needed and the processes required to achieve the required results</td>
</tr>
<tr>
<td>• Consider location, infrastructure, hours of operation, personnel</td>
<td>• Is the setting safe?</td>
<td></td>
</tr>
<tr>
<td>• What features about the setting can be improved?</td>
<td>• In what other settings does this activity occur?</td>
<td></td>
</tr>
<tr>
<td><strong>Capability of relevant professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify the competencies required by relevant practitioners</td>
<td>• Are the knowledge and skills of all relevant practitioners appropriate and sufficient?</td>
<td>As above</td>
</tr>
<tr>
<td>• Are additional educational activities provided by, e.g. RNZCGP etc., available?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capacity of the organisation and practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify relevant supporting systems and processes</td>
<td>• What other activities, support and resources are required at a practice or external organisational level to undertake the activity?</td>
<td>As above</td>
</tr>
<tr>
<td>• Consider the IT system in the practice but also systems in other organisations such as the PHO, and manual systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider both formal and informal systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Systems processes that affect the interface between the supporting systems and practitioner</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify processes that impact on practitioners when providing that aspect of care or service</td>
<td>• What structural and process gaps can be identified?</td>
<td>As above</td>
</tr>
<tr>
<td>• What are the issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What are the important relationships within the practice?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider formal and informal relationships necessary for providing the aspect of care or service</td>
<td></td>
<td>As above</td>
</tr>
<tr>
<td><strong>What are the important relationships with other providers?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider formal and informal relationships necessary for providing the aspect of care or service</td>
<td></td>
<td>As above</td>
</tr>
<tr>
<td><strong>What are the important relationships with patients?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider formal and informal relationships necessary for providing the aspect of care or service</td>
<td></td>
<td>As above</td>
</tr>
<tr>
<td><strong>What are the important relationships with the community?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider formal and informal relationships necessary for providing the aspect of care or service</td>
<td>• Are there other important community relationships?</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Suitable use of knowledge and skills by practitioners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider how all the above affects the application of knowledge by practitioners during the consultation with the patient</td>
<td></td>
<td>As above</td>
</tr>
</tbody>
</table>
Measuring change

Once a problem or issue has been identified, potential solutions need to be determined, and interventions implemented. Measuring change resulting from the introduced intervention is important to determine the effectiveness of the intervention. Measures must be focussed on information useful to the practice and be easy to collect as part of day-to-day activity.

<table>
<thead>
<tr>
<th>Baseline measures (pre-intervention)</th>
<th>Post intervention review (6 months)</th>
</tr>
</thead>
</table>

Define data to be collected and methods for data collection, collation and analysis. (May include both qualitative and quantitative information.)

### Additional Information

#### Critical events monitoring
- Is there a significant events monitoring system in place for this particular problem?
  - What information is currently available?

#### User evaluation
- How can we find out what patients think?
  - What information can be gathered and how?

#### Cost/benefit
- What is the cost/benefit to the service or patients?
  - What information can be gathered and how?

#### Equity
- Are there issues of equity and how can they be addressed?
  - What information can be gathered and how?

### Reflection, learning and improvement opportunities, peer review

#### Analysis of results
- Were the objectives met?
- What changes can be made to improve patient care as a result of the information obtained?

#### Identification of discussion points
- Knowledge gaps
- Areas for quality improvement
- Learning, education or upskilling highlighted, e.g. identification of severity:
- Assessment of risk and resilience
- Availability of tools in general practice for risk assessment
- Level of skill or comfort in using tools or in addressing health problems

#### Discussion of results
- What are the reasons for the results generated?
- What is the gap between the information obtained and the expectations?
- Feasibility, limitations etc.

#### Required changes at individual/organisational or systems level
- Systemic issues
- Practice resources
- Practice team issues and responsibilities
- Training requirements
- Link to educational material - are there any existing modules or educational material?

#### Prioritisation checklist
- What area will you address first?

#### Ongoing activity
- Develop a quality action/management plan to address outstanding issues
- Identify who takes responsibility for the actions
- Meet regularly to ensure actions being implemented are successful
- Discuss problems or benefits
- Report on activity
- Undertake a regular review of progress against changes agreed
Quality Tools

Develop your own clinical indicators using ‘the Sieve’

The Sieve can be found on the Patients First Website. www.patientsfirst.org.nz/hqml

The Sieve was developed following:
1) a review of the New Zealand and international literature
2) interviews with a range of key stakeholders from the New Zealand primary health care sector
3) synthesis of the information gained from the literature and interviews to create a functional tool.

1. ‘The Sieve’

The Sieve is a tool for undertaking critical analysis of clinical indicators in the New Zealand health sector. It is an evidence-based indicator appraisal tool that provides a formal accounting of the individual strengths and weaknesses of an indicator and outlines the parameters within which results may be used. It provides a useful platform for evaluating the selection and use of indicators for assessment of clinical quality, programme evaluation and planning.

It is essential that indicators are assessed for suitability, purpose, technical capability and the impact they may have on individuals or organisations. Robust indicators are necessary to monitor care, measure development or change in the quality of care, and make appropriate and evidence-based decisions. The Sieve provides the capacity to examine indicators in order to test suitability, and enable stakeholders to check, sort, distinguish and separate out functional, practical and valuable performance indicators.

2. How does ‘the Sieve’ work?

Under six subheadings, there is a set of 30 criteria against which indicators are measured. Components may be assessed using a combination of published evidence and technical judgement, and ranked as yes, no or no data identified/influenced by systems level factors. A summary statement for each indicator provides an appraisal of the main strengths and weaknesses of the indicator.

Use of the Sieve requires collating and analysing the international and local evidence pertaining to each indicator. Considerations include evidence relating to internationally available best practice, cost-effectiveness, and use as an indicator of good performance or quality in a primary care setting.

The Sieve is part of a web-based application which can be accessed by all stakeholders and used as needed. Any party interested in contributing to the pool of performance indicators should use the Sieve parameters to critique and appraise proposed indicators. Once an indicator or set of indicators is appraised through the use of the Sieve evaluation, it can be uploaded. For validation, it might need to be peer reviewed before it is put forward for implementation.

3. How useful is ‘the Sieve’?

Application of the Sieve helps to coordinate and avoid duplication of effort. It assists with the standardisation of clinical indicators for monitoring and evaluation processes across the health sector. It provides a process for the development of indicators through continuous dialogue and debate. This means all stakeholders will be able to participate in the selection and use of appropriate indicators for programme evaluation, policy development, and planning and implementation in health services. In summary, the Sieve can be used to:

• sort potential indicators in a systematic manner on the basis of 1) why the indicator was chosen and 2) its potential to give an accurate picture of performance
• enable debate about the relative merits of individual indicators
• understand the political and pragmatic reasons for including or excluding an indicator
• trace the likely impact of an indicator
• ensure coordination and synergy of efforts by various actors
• provide a yardstick for continuous quality improvement.

4. Who Can Use ‘the Sieve’?

The Sieve can be used at any level of the health system and stakeholders, including those listed below.
1. Individual practitioners
2. General practices
3. General practice networks
4. Primary health organisations
5. The public (individuals)
6. Professional organisations and associations
7. Universities and colleges
8. Health Quality and Safety Commission
9. ACC
10. Allied health services
11. Ministry of Health
12. District Health Boards
13. National Health Board
14. National Health IT Board
5. Limitations

The number of criteria under each subheading is not the same, and there is no set quantitative value or ranking assigned to each criterion. Therefore, determination of the minimum qualifying value to decide the extent or scale to which an indicator may be bad, good, very good or excellent, and the merits and demerits of the indicator is dependent on subjective judgement rather than a quantitative rating. Triangulation of opinion is therefore important in the use of the Sieve.

There is no inbuilt screen-in or screen-out factors to determine whether the selected performance indicator meets the minimum standards required. Decisions regarding whether an indicator under scrutiny has passed or failed is dependent on the comments noted in the summary statement. 59
The RNZCGP Quality Framework

The Quality Framework is a useful tool for planning, organising and informing practice and clinical quality activity. It may be used to facilitate the choice of a topic area to focus clinical effectiveness activity and in conjunction with PDSA cycles of improvement. It can also be used by practices and organisations as a practical tool for reviewing systems and processes, identifying quality gaps, choosing and prioritising new quality activities, or identifying the place and relevance of existing activities and programmes on a local or national level.

Evidence from published literature and practice was used in the development of the Quality Framework. A theoretical framework was first created, and each of the areas identified were mapped against practice activity. Existing sector programmes were then overlaid against categories within the framework. The sections and indicators in Aiming for Excellence are aligned with the categories of the framework.

The Quality Framework identifies areas of quality activity and groups them into three broad interrelated areas to use for assessment of practice or clinical performance.

1. **Structure, Process, Outcome (coloured red in the V2Q Framework diagram below)**

   Structure relates to activities which strengthen the environment within which care is delivered, and ensure operational safety. Some of these activities may be assessed using measures of access. Other aspects may be assessed or ensured by practice and practitioner accreditation. Development of practice protocols and sentinel event monitoring are separated out as important elements that contribute to structural quality activity.

   Process refers to what is actually done during the delivery of care and may be defined in terms of clinical and technical interventions and relationships. Structural attributes impact on process. Measures of process need to be linked to outcomes to be of value.

   Outcomes of care represent the ultimate objective of health care provision. They may be influenced either directly or indirectly by structural and process factors. The relationship between structure, process and outcome is key to assessing performance and understanding the various influences on health outcomes.

2. **Categories of quality activity in which practices are engaged (coloured green in the diagram below).**

3. **Ways of assessing performance or assuring quality (coloured light blue in the diagram below).**

The Quality Framework takes into account the distinction between comparative measurements (which use indicators to compare the quality of service provision) and organisational quality assessment and the use of external assessors to determine if a service meets the standards. Variables relating to age, gender, compliance, risk factors, lifestyle and environmental, may also influence the results obtained from quality assessment measures.

It is based on the definition of quality outlined by Campbell et al., which states that “quality of care is dependent upon the availability of access to a population of efficient and equitable services that are effective at an individual clinical and personal level.” In addition, they note that:

- **access** at an individual level is defined in terms of geographic and physical factors, as well as the affordability and availability of the services offered
- **effectiveness** covers clinical care and interpersonal care received in relation to need, health status and end-user evaluation
- **additional** factors of equity, efficiency and cost apply when viewed at a population level.

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Aiming for Excellence in a Quality system

Together, the indicators and criteria in Aiming for Excellence describe important components of a general practice system.

- The V2Q Quality Framework Overview (see below) shows how the system links to other interrelationships and activities that influence day-to-day clinical work, wider practice activity, health system activity and RNZCGP activity, including CORNERSTONE General Practice Accreditation.

- At the centre of the framework, Quality Improvement activities help practices to identify where practice teams engage in clinical effectiveness activities to improve outcomes. These can be utilised within a peer review environment to enable self-reflection and learning, or for quality assessment, professional development, continuing medical education (CME) or CORNERSTONE General Practice Accreditation.

RNZCGP Quality Framework Overview

The Quality Framework and Quality Framework Overview were developed for The Royal New Zealand College of General Practitioners by the Primary Health Care Quality Research Unit, University of Otago, Wellington

V2Q—Perera, Dowell, Morris

The Royal New Zealand College of General Practitioners

Primary Health Care Quality Research Unit

University of Otago
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