Aiming for Excellence
The RNZCGP standard for New Zealand general practice

For Foundation and CORNERSTONE® practices

Version 1.0 – July 2016
Acknowledgements

This version of Aiming for Excellence with its guidance notes is the culmination of significant contribution from a wide range of people.

The working group for the review of the standard and its indicators and criteria was chaired by Dr John Wellingham and included Ms Jane Ayling, Ms Michelle Bayley, Dr Campbell Brebner, Mr Martin Carrell, Dr Chris Fawcett, Ms Shelley Frost, Ms Rosemary Gordon, Mr Matu Ihaka, Dr Campbell Murdoch, Dr Samantha Murton, Mr Mike Northmore, Dr Mick Ozimek, Dr Andrew Richardson, Ms Barbara Robson, Dr Ian Smiley, Dr Tane Taylor, Ms Fiona Thomson, and Dr Jim Vause.

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Our thanks also to Ms Vanita Hira, Energy Safety – WorkSafe New Zealand and the many others who contributed to this standard and its development and are not named above.

Disclaimer

This guide provides examples of what evidence practices can provide to demonstrate compliance with each of the criteria that comprise the Aiming for Excellence standard (including Foundation criteria).

The guide does not provide a full and final list of all evidence that may be used to demonstrate compliance. Practices may have additional or other evidence that is valid. Links to websites are provided to support understanding of what is expected from each criterion.

While this document has been developed after consultation with many people and external organisations, and in accordance with the relevant legislation, consideration should be given to the changing nature of the environment and law, and neither the RNZCGP nor any other person associated with the preparation of these standards accepts the responsibility for the results of any action taken, or not taken, by any person as a result of anything contained in or omitted from this publication.
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Quality is one of the College’s four strategic pillars. This much-used word has different meanings to different people, but for us, it’s about ensuring general practices are able to provide a high standard of care to their patients.

Of course the concept of what constitutes ‘good quality’ constantly evolves in response to new technologies, medicines, regulations and knowledge. This guide incorporates recent changes like the Health and Safety at Work Act 2015, the Vulnerable Children Act 2014, and technological advances such as eReferrals, ePrescriptions and patient portals.

As well as addressing these changes, the guide pulls together the College’s Foundation Standard and Aiming for Excellence criteria, resulting in one, easy-to-navigate guidance document. New criteria have been added, including new aspirational measures, which encourage advanced practices to extend their services and signal future development areas.

This guide has been produced in conjunction with a broad range of stakeholders, and it would be remiss of me not to acknowledge their contribution. We’ve sought input from organisations such as the Ministry of Health, WorkSafe New Zealand and the New Zealand Fire Service. Individuals from general practices, PHOs and the broader health sector (including patient representatives) also provided valuable feedback.

The advantage of taking such a collaborative approach, is that the final product is both relevant and robust. My sincere thanks to everyone involved.

Dr Tim Malloy
President
The Royal New Zealand College of General Practitioners
Introduction

Aiming for Excellence is The Royal New Zealand College of General Practitioners’ standard for New Zealand general practice.

Foundation Standard is part of the Aiming for Excellence journey. This version of Aiming for Excellence incorporates the Foundation criteria for the Foundation Standard (version 3.3 July 2016).

Foundation Standard

In establishing the Foundation Standard for General Practice, the College is providing all general practices throughout New Zealand with a consistent framework for demonstrating their commitment to the safety of their patients and general practice team.

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

However, there may be other legal and regulatory requirements for other purposes that general practices may need to comply with; we recommend general practices take advice from their primary health organisations or other business advisors about any local compliance issues in their area.

The overarching principles used to identify Foundation criteria included:

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

Aiming for Excellence

Aiming for Excellence is the College’s quality standard for general practices that want to embed continuous quality improvement in the way they provide care for their patients.

It sets out best practice criteria to achieve over and above the minimum legal, professional and regulatory requirements contained in the Foundation Standard.

In April 2015, the College Board approved the revised Aiming for Excellence standard. Since then, the College’s Quality Group, in consultation with many stakeholders in the sector, has been revising and updating the current interpretation guide, and developing guidance for the new indicators and criteria.
INTRODUCTION

Aiming for Excellence has continued to evolve since the last revision in 2011. A number of changes in the sector have taken place, including:

- new legislation, including the Health and Safety at Work Act 2015 and Vulnerable Children Act 2014
- processes that were once deemed aspirational have become more and more embedded in everyday practice throughout the country, like using electronic clinical decision support tools
- new advances in technology, such as eReferrals, ePrescriptions and patient portals.

All these changes have meant new criteria and guidance needed to be updated and developed to help guide practices through these new developments.

How to use these guidelines

The Interpretation Guide is a resource to help you understand what evidence is required to meet the requirements of the standard you are enrolled in.

This book includes all indicators and criteria for both the Foundation Standard and Aiming for Excellence (which is the standard used in the CORNERSTONE® accreditation programme).

The three levels of criteria are listed below. Which ones you choose depends on which programme you have enrolled in.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Which criteria you should complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation</td>
<td>Foundation criteria only – required</td>
</tr>
<tr>
<td>CORNERSTONE® programme</td>
<td>Foundation criteria – required</td>
</tr>
<tr>
<td></td>
<td>Advanced criteria – required</td>
</tr>
<tr>
<td></td>
<td>Aspirational criteria – optional</td>
</tr>
</tbody>
</table>

Resources

At the end of each indicator is a list of resources. The list is not exhaustive, and you may have other resources you prefer to use.

Some of these are the basis of the guidance developed in the indicator, and they also provide additional information if you wish to learn more.

New Zealand standards

There are links to Standards New Zealand standards in some places also. You are not required to buy these – we have summarised the key points in the guidance. The links are provided only if you do want to buy or refer to them. Where possible, a link to a free version or related information has been provided.
INDICATORS AND CRITERIA

Each indicator describes a high-level statement of performance it is expected a practice will meet, to meet the requirements of this standard (e.g. “The practice acknowledges and is responsive to the special status, health needs and rights of Māori”).

Criteria define the specific requirements that must be met to satisfy the indicator. Criteria are discrete, measurable and explicit (e.g. “The practice has a documented Māori Health Plan”).

This revision of Aiming for Excellence includes:

**Foundation criteria**
These criteria are the same as the Foundation Standard. They are mandatory, minimum quality assurance criteria and must be met by all practices.

*You must meet all Foundation criteria for Foundation Standard and CORNERSTONE®.*

**Advanced criteria**
This revision includes a number of advanced criteria. Some of these criteria have been taken from the current version of Aiming for Excellence. A number of new advanced criteria have also been developed.

*You must meet all advanced criteria for CORNERSTONE® accreditation.*

**Aspirational criteria**
This revision also includes a small number of aspirational criteria. Aspirational criteria allow advanced practices to extend their services and signal future development areas.

*Attainment of the aspirational criteria is voluntary.*

EVIDENCE OF COMPLIANCE

To meet the requirements of the Foundation Standard and CORNERSTONE® accreditation, you must demonstrate compliance with all relevant indicators and criteria.

We have provided some examples of evidence for each criteria.

These are examples only; your practice may have alternative and equally valid evidence to demonstrate compliance.
Training

Some indicators require your practice to train all your general practice team to ensure they are familiar with legislative or professional standards.

Where training is required, the College would expect you to consider (as appropriate):

a. Identification of all staff who require training.

b. New staff who may require training.

c. Retraining staff when there are changes made to standards or legislation.

These guidance notes do not include a full list of training providers. If you require assistance to identify a training provider, your primary health organisation (PHO) or the College may be able to assist with information or contacts.

Training records

You must keep dated and signed training records for all training for your general practice team.

Training levels

Level 1

Provided by an externally recognised training agency or provider.

Level 2

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

Frequency of training

Accurate and up-to-date records should be kept to show details of all training for your general practice team members.

The table below outlines the level and frequency of training required for each criterion listed. Evidence will be required that training occurs at the frequency listed below (at a minimum, more often is fine) and as a result of any significant changes (eg new legislation, changes in policy).
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Training requirement</th>
<th>Frequency of training (at a minimum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>The general practice team has received training to implement The Code.</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>2.2</td>
<td>The general practice team has received training on the requirements of the Privacy Act 1993, and Health Information Privacy Code 1994.</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>5.2</td>
<td>The general practice team is trained in Te Tiriti o Waitangi/The Treaty of Waitangi, including the principles of Partnership, Participation and Protection.</td>
<td>Level 1</td>
</tr>
<tr>
<td>6.1</td>
<td>The practice team is trained in cultural competence and cultural safety.</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>15.2</td>
<td>General practice team members responsible for managing infection control have received sterilisation and disinfection training within the last three years.</td>
<td>Level 1</td>
</tr>
<tr>
<td>22.1</td>
<td>Non-clinical team members responsible for first-line interaction with patients are trained to identify and respond appropriately to patients with urgent medical conditions.</td>
<td>Level 1 and/or 2</td>
</tr>
<tr>
<td>22.4</td>
<td>All practice team members who may be required to administer CPR must have current certification to an appropriate level from certified trainers.</td>
<td>Level 1</td>
</tr>
</tbody>
</table>

**Terminology used in this guideline**

**Clinical team** refers to clinical staff only.

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

Continuing professional development (MOPS programme)

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

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

CPD credits are gained from a combination of activities:

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

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

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

We have stated where specific indicators in the standards relate to activities that may be claimed for continuing professional development. Further information can be obtained in the Continuing Professional Development Programme 2014–2017 (MOPS) handbook.
SECTION 1

Patient experience and equity

The purpose of this section is to ensure that patients are aware of their rights as consumers, and the general practice team is suitably trained and equipped to provide services that meet patients’ rights.
### INDICATOR 1

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The practice displays a copy of the Code of Health and Disability Services Consumers’ Rights 1996 (the Code) poster prominently in the practice and brochures about the Code are available for patients to access.</td>
<td>Posters on prominent display in the reception area identifying the Code, and brochures are available.</td>
</tr>
<tr>
<td>1.2</td>
<td>The practice has a policy that describes how the Code is implemented.</td>
<td>A documented policy that describes how the general practice team is made aware of, and implements, the requirements of the Code. Open disclosure policy and procedures.</td>
</tr>
<tr>
<td>1.3</td>
<td>The general practice team has received training to implement the Code.</td>
<td>Evidence of general practice team training on how the Code is implemented. Training occurs every 5 years.</td>
</tr>
<tr>
<td>1.4</td>
<td>Information about the local health advocacy service is displayed where patients can view it.</td>
<td>Poster and/or brochures on display in the reception area identifying local health advocacy services.</td>
</tr>
</tbody>
</table>

**Guidance notes**

The Code can be downloaded free of charge from the Health and Disability Commissioner website.

The rights of patients are:

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

**Training requirements for Criterion 1.3:**

- **Level 1 and/or 2 training** every 5 years
Open disclosure

You should also consider how you will manage your open disclosure obligations. The Health and Disability Commissioner has set some guiding points that you should consider when developing your open disclosure policies and procedures.

Resources

- The Code of Health and Disability Services Consumers’ Rights 1996
- Health and Disability Commissioner
- Health and Disability Commissioner: open disclosure
- Training on the Code of Health and Disability Services Consumers’ Rights 1996
## INDICATOR 2

### The practice meets the requirements of the Health Information Privacy Code

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The practice has a privacy policy that complies with the Privacy Act 1993 and Health Information Privacy Code 1994.</td>
<td>A documented policy that describes how the general practice team is made aware of, and implements, the requirements of the Privacy Act 1993, and Health Information Privacy Code 1994.</td>
<td>F</td>
</tr>
<tr>
<td>2.2 The general practice team has received training on the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994.</td>
<td>Evidence of general practice team training on the Privacy Act 1993 and Health Information Privacy Code 1994.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>2.3 The collection, use, storage, disposal and disclosure of individual patient information comply with the Health Information Privacy Code 1994.</td>
<td>The general practice team can demonstrate/describe the process for the collection, use, storage, disposal and disclosure of individual patient information.</td>
<td>F</td>
</tr>
<tr>
<td>2.4 There are safeguards* in the reception area to ensure confidentiality of patient information.</td>
<td>Safeguards are identified and demonstrated.</td>
<td>F</td>
</tr>
</tbody>
</table>

### Guidance notes

**The Privacy Act**

The Privacy Act 1993 controls how ‘agencies’ collect, use, disclose, store and give access to ‘personal information’.

The privacy Codes of Practice do the same, but they apply to specific areas – in our case health. See below for the Health Information Privacy Code.

The Privacy Act has 12 information privacy principles. For the full text of each, click on its number.

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

**Training requirements for Criterion 2.2:**

**Level 1 and/or 2 training every 5 years**
As a brief guide:

**Collection of information**

**Principle 1, Principle 2, Principle 3, and Principle 4**

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

**Principle 12** governs how ‘unique identifiers’ – such as NHI numbers, IRD numbers, bank client numbers, driver licence and passport numbers – can be used.

**Storage and security of personal information**

**Principle 5** governs the way personal information is stored. It is designed to protect personal information from unauthorised use or disclosure.

**Access to information**

**Principle 6** gives individuals the right to access information about themselves.

**Principle 7** gives individuals the right to correct information about themselves.

**Disclosure of information**

**Principle 8** and **Principle 9, Principle 10, and Principle 11** place restrictions on how people and organisations can use or disclose personal information. These include ensuring information is accurate and up to date, and that it isn’t improperly disclosed.

**Health Information Privacy Code**

The **Health Information Privacy Code 1994** sets specific rules for agencies in the health sector. It covers health information collected, used, held and disclosed by health agencies and takes the place of the information privacy principles for the health sector.

This code applies to identifiable health information about individual patients. This code takes account of the characteristics of health information (such as its confidentiality, sensitivity and use by different health care providers) to protect individuals. Practices must identify measures needed to protect individual health information privacy that meet the legislative requirements set out in the Code.

Check out the **Health privacy toolkit** for more information.

**The Privacy Commissioner advises the following:**

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

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

- Office of the Privacy Commissioner:
  - On the record: a practical guide to health information privacy; health privacy toolkit
  - The Privacy Act 1993
  - Health information privacy fact sheet 1: overview
  - Free e-learning privacy training modules
- Health Act 1956 Section 22B-H
INDICATOR 3

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The practice has a policy that describes how complaints will be managed by the practice team.</td>
</tr>
<tr>
<td></td>
<td>A documented policy that describes how the general practice team is made aware of, and implements, its complaints process in accordance with Right 10 of the Code.</td>
</tr>
<tr>
<td>3.2</td>
<td>The practice has a designated complaints officer responsible for the implementation and management of the practice’s complaints policy.</td>
</tr>
<tr>
<td></td>
<td>A description of the role of the complaints officer in the practice; and</td>
</tr>
<tr>
<td></td>
<td>A current job description that identifies the appointment of a complaints officer; and</td>
</tr>
<tr>
<td></td>
<td>The complaints officer can describe the practice’s complaints process and the principles of Right 10 of the Code; and</td>
</tr>
<tr>
<td></td>
<td>Where available, current examples of complaints can be discussed that have been documented and processed in accordance with the practice’s complaints process.</td>
</tr>
<tr>
<td>3.3</td>
<td>Complaints and their resolution are used to look for opportunities for learning and quality improvement.</td>
</tr>
<tr>
<td></td>
<td>Complaints register; and</td>
</tr>
<tr>
<td></td>
<td>Evidence of current reports, findings, and improvement plans/activities.</td>
</tr>
<tr>
<td></td>
<td>Staff training records and resources.</td>
</tr>
<tr>
<td></td>
<td>Staff meeting minutes.</td>
</tr>
<tr>
<td></td>
<td>Quality, strategic plans, etc.</td>
</tr>
<tr>
<td>3.4</td>
<td>The practice team works with its primary health organisation/network to share learnings from complaints.</td>
</tr>
<tr>
<td></td>
<td>Evidence of reports and findings shared with PHO/network.</td>
</tr>
</tbody>
</table>

Guidance notes

Under the Code all complaints must be taken seriously whether made verbally or in writing. Your practice is expected to facilitate a fair, simple, speedy, and efficient resolution of all complaints.

Your practice’s complaints procedure must be managed to comply with relevant time frames and legal requirements under Right 10 of the Code of Health and Effective complaint handling is fundamental to the provision of a quality service.
Disability Services Consumers’ Rights 1996 (the Code). Your practice team will need to be able to describe and demonstrate how you do this.

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

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

See the Health and Disability Commissioner’s Complaints management guide for general practice.

Designing an effective complaints policy and process

The Code requires providers to have a complaints procedure, and sets out minimum requirements for keeping consumers informed about the progress of their complaint.

Your practice needs a policy and documented process that describes how your practice team will manage complaints, including responsibilities and timelines.

Each practice is different. Develop an effective complaints process that:

■ meets the particular needs of your practice
■ is in proportion to the number and types of complaints you are likely to receive
■ still meets the requirements under the Code.

Overview of an effective complaints process

To be effective, consider the following when developing a complaints process:

■ Have a user-friendly system for both patients and staff.
■ Hear and understand complainants.
■ Respect complainants.
■ Take action as soon as possible.
■ Provide explanations and apologies where appropriate.
■ Share information about the process with patients and staff.
■ Have clear responsibilities and delegations.
■ Have procedures for staff to deal with complaints and provide remedies.
■ Use a complaints register to record complaints data.
■ Use complaint data to identify problems and trends.
■ Show how you have improved service delivery in identified areas.
The three steps in an effective complaints process

Try using these types of questions to guide your process:

**STEP 1: Enabling complaints**

- Is your complaints process patient focused?
- Is it visible, easy to access and understandable for all patients?
- Can patients complain in a number of different ways (e.g., in person, by letter, fax or email)?
- Do you provide assistance for those having difficulty complaining (e.g., due to a disability or a language barrier)?
- Do you have information available about your complaints process (website, at reception, in leaflets or newsletters, on the noticeboard)?
- Do you have information and training available for staff?
- Is the process valued and supported by all staff and management?

See page 9 in *Effective complaint handling* for an example of how to present information for your patients.

**STEP 2: Responding to complaints**

- Do all your staff respond promptly to complaints?
- Are they handled objectively, fairly and in confidence?
- Are they able to be resolved at the earliest possible opportunity?
- Do you provide remedies where appropriate?
- How will you carry out the review of a complaint when required?
- How will you manage unreasonable conduct by a complainant (e.g., unreasonable persistence, demands, arguments etc) while still handling the complaint appropriately?
- When do complaints need to be in writing (you will still need to keep a record of verbal complaints)?
- How will you communicate any outcome, reasons and possible remedy?
STEP 3: Accountability and learning

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your process have clear responsibilities for complaint handling?</td>
<td></td>
</tr>
<tr>
<td>Who is your complaints officer?</td>
<td></td>
</tr>
<tr>
<td>Does the team know who to refer patients to?</td>
<td></td>
</tr>
<tr>
<td>Does your team use complaints to stimulate practice improvements?</td>
<td></td>
</tr>
<tr>
<td>How do you share your findings and lessons with other people (PHOs, peer groups, other practices)?</td>
<td></td>
</tr>
</tbody>
</table>

Resolving complaints

In resolving a complaint, any remedy should be fair and reasonable.

You can resolve complaints in a number of ways, including by:

- acknowledging what has happened
- providing an explanation, assistance or reasons
- providing an apology
- taking action if there has been a delay
- reconsidering or changing a decision
- changing policies, procedures or practices.

Complaints officer

You should have a person (or team in some cases) assigned to take primary responsibility for managing the complaints handling process. This person is called a complaints officer.

Complaints officers are the most important factor in ensuring that the complaints process works well. Make sure your staff, including locums, know who this is and let patients know too.

Your complaints officer must be able to describe and demonstrate how they manage complaints. This should be in keeping with any legal requirements, for example under the Code. They will need to be able to produce documentation to validate how they comply with the required timelines.

Write complaints down in a complaints register. This is a comprehensive record of complaints and how they are handled. For each complaint, write down the details and dates of any actions taken, along with any outcome (including reasons and remedies) in chronological order. You can record these electronically if you prefer.

Things to think about for complaints officers. You need to:

- be able to act sensitively and be impartial
- be trained to receive and deal with complaints about your practice
have access to staff at all levels of the practice so that complaints can be resolved quickly
have the authority to act to resolve a complaint or be able to refer the matter to someone who has the authority.

Opportunities for learning and quality improvement

Complaints and their resolution should be used to look for opportunities for learning and quality improvement.

A good complaints handling process allows your practice to learn from the problems that arise and take steps to improve internal processes. It is therefore important your team build in a system of review in order to do this. This will help you to reflect and respond constructively to complaints in the future. One way of identifying trends is to categorise complaints as they are recorded, so you can easily identify any common issues that need improvement.

Consider having complaints, their outcome, and any proposed improvements as a regular part of your practice’s ongoing reporting and planning processes. Any systemic issues, serious risks, and/or areas for improvement can then be identified by senior management for appropriate action.

You can use analysis to improve customer service by:
- highlighting any service failings that need to be fixed
- revealing problems and trends that can be acted on by management.

It is helpful to maintain a positive and proactive culture with your practice team when dealing with and responding to complaints. Encourage all members of your team to see complaints as learning opportunities. Use positive feedback to reinforce and recognise quality improvement also. Some practices use a regular agenda item for staff meetings to go over anything relevant to complaints and how to do better.

Sharing lessons from complaints

It is very helpful to share complaints data and lessons from complaints outside your practice; for example, to other practices, peer review groups, and PHOs. This allows you to discuss issues that have come up and to explore potential solutions. It also enables a wider range of people (including patients) to learn and benefit from your team’s experiences. You should keep any individual patient and staff information confidential.

Criterion 3.4 requires you to be able to demonstrate how you share your experiences and findings with your PHO/network, and in turn, how you incorporate any feedback into how your practice operates. For example, you can use this information to develop your strategic plan or your clinical goals (quality plan) for the year, develop some additional staff training education, devise a quality improvement activity, and so on.
Resources

- **The Code of Health and Disability Services Consumers’ Rights 1996**
- Health and Disability Commissioner: *Learning from complaints* leaflet and *Complaints* information
- *Complaints management guide for general practice* prepared by the Health and Disability Services Commissioner
- Office of the Ombudsman Tari o te Kaitiaki Mana Tangata: *Effective complaint handling*

Continuing professional development

- Contribution to the development of the practice complaints policy and process can be claimed as a CME practice improvement activity.
- If the review of a complaint leads to the identification of an area for development, this can be included as part of the professional development plan for the individual doctor, and used to identify a relevant set of CME activities.

*The complaints resolution process by itself does not attract credits – it is not a professional development activity.*
## INDICATOR 4

Patients can make informed choices about their health care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Information is available and accessible to assist patients to make informed choices about their health care.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- A copy of the Code of Health and Disability Services Consumers’ Rights 1996; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A variety of information on treatment, benefits and complications; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- List of, or contact details for, interpreter services; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patient record reviews (see Indicator 21).</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>The practice provides patients with information describing the services provided and any associated costs.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Practice signage or guidance sheets are provided describing services and associated costs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Website information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Notice in waiting room.</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Patients are informed of their right to have a support person present during a consultation.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Support person poster.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patient record notes the offer of a support person and the patient’s response.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Website information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Notice in waiting room and each clinic/consultation room.</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Informed consent is obtained from a patient or legally designated representative when agreeing to a treatment or procedure.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Consent forms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Evidence of signed consent where required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Evidence of verbal and/or implied consent.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patient record reviews (see Indicator 21).</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Informed consent is documented when there is variance between evidence and practice.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>- Evidence of information given.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Evidence of consent in the patient record.</td>
<td></td>
</tr>
</tbody>
</table>

### Guidance notes

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.

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**Indicator 25**

The practice maintains an effective screening and recall system.
The patient has the right to:
- consider the information given
- ask for clarification and ask for time to consider the information
- consult with family and others
- give consent or decline to give consent
- waive the right to discuss the details of treatment
- after having given consent, change his or her mind and withdraw the consent.

See Chapter 10 of Cole’s medical practice in New Zealand for more information.

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

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

1. **Competence:** The person giving consent for the service either for themselves or for others (eg 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.

2. **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.

3. **Full information:** All necessary information must be given to allow the consenting party to make an informed choice about their options.

4. **Full comprehension:** Information needs to be given in an environment that enables open and honest communication. There must be opportunities to freely ask questions about any aspects of service being offered. Interpreters should be used where necessary.

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

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

This list is not exhaustive and further issues may need to be included. In some circumstances it may be necessary and prudent for providers to also disclose the likely consequences of not having treatment.
Right 7 of the Code of Health and Disability Services Consumers’ Rights 1996 confers the right on consumers to make informed choice and give informed consent to receive health and disability services.

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

1. Services may only be provided if a consumer has made an informed choice and given consent (some exceptions apply – see the 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 the Code for details.
5. Consumers can use an advance 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. A 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 the Code for details.

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

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

The MCNZ states in Cole’s medical practice in New Zealand that the more major the procedure, and the more risks it involves, the more prudent it is to have the patient sign a consent form.

In the absence of a signed consent form it is necessary to add an annotation in the patient’s clinical record that the patient has consented to the treatment.
Compulsory written informed consent

Informed consent must be in writing if any of the following apply:
- the consumer is to participate in any research; and/or
- the procedure is experimental; and/or
- the consumer will be under general anaesthetic; and/or
- there is a significant risk of adverse effects on the consumer.

There may be other situations where informed consent is advised or required to be in writing (eg vaccinating in an offsite vaccination programme at a school).

Advance directives

An advance directive is a written or oral directive in which a person makes a choice about possible future health care treatment, and this choice is intended to be effective only when the person is no longer competent.

Advance directives enable patients to indicate in advance their objection to, or prohibition of, treatment which would otherwise be provided. They may also specify the type of treatment they would wish to undergo should they become incompetent. A ‘do not resuscitate’ (DNR) order is a type of advance directive.

The legal status of an advance directive rests with its validity, which should be established before it is given effect. The legal criteria that an advance directive needs to meet are:
- The person was competent to make the decision, when the decision was made.
- The decision was made free from undue influence.
- The individual was sufficiently informed to make the decision.
- The person intended the directive to apply to the present circumstances.
- The existence and validity of the advance directive must be clearly established.

If a valid advance directive exists, it is legally binding and treatment may either be given or not be given in accordance with the directive.

The direct application of an advance directive under certain circumstances may pose the following serious ethical and clinical challenges to your health care team and therefore may not be considered consistent with good medical practice (NZMA: Advance directive):
- The circumstances that existed at the time the advance directive was made may have changed. It may then be impossible to determine the extent to which the advance directive may still apply. Health care decisions arising from an advance directive are based on the information relevant to the medical condition (if any) and treatment options available, as well as the patient’s attitude and values around health care, at the time the advance directive was made.
Patients may use ambiguous terms in advance directives such as 'heroic measures' or 'extraordinary treatment' that make interpretation and application of the advance directive difficult. The patient’s view of what constitutes 'extraordinary treatment' may be quite different to that of their family members, surrogate decision-makers, and/or the health care team.

When preparing an advance directive, a patient cannot predict and account for every relevant future health care scenario; therefore, a patient’s advance directive may not be directly applicable to the actual circumstance at the time of losing decision-making capacity.

Doctors may have a conscientious objection or see the action as unethical. In such a circumstance, the doctor should explain to the medical team involved, and any appointed surrogate decision-maker, why they are not willing to follow the advance directive, and, where possible, the doctor should remove themselves from the treatment team and, if possible, recommend another practitioner.

**Declining to give consent**

In situations where a patient waives the right to discuss details or declines to give consent to a treatment or investigation, the clinician should carefully document this – including any options discussed, information given to patients, decisions made and reasons for them (MCNZ: Good medical practice).

See Chapter 10 of Cole’s medical practice in New Zealand for more information.

*This also relates to Indicator 25: The practice maintains an effective screening and recall system.*

**When there is variance between evidence and practice**

For any issues where the evidence is not clear and where there is variance between evidence and practice, you will need to provide and carefully document any information given to the patient and their consent (or otherwise).

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

The MCNZ's statement on informed consent in screening outlines a special duty of care when enrolling an apparently healthy, asymptomatic person into immunisation or screening programmes. This includes making them aware of the limitations of screening and the uncertainties, in particular the chance of false positive and false negative results. See Indicator 25 for more information.

In practice, it is not always easy to achieve the standard required for informed consent.

The provision of information, discussion and reflection may take considerable effort, time and skill, and many GPs are not able to easily fit this into the usual 15-minute consultation. This is where the provision of written information about testing in the form of patient information leaflets can be invaluable (eg pamphlets discussing the benefits and harms of PSA testing).
Resources

- The Code of Health and Disability Services Consumers’ Rights 1996
- MCNZ: Information, choice of treatment and informed consent
- Health and Disability Commissioner: Fact Sheet 1: Consent for consumers who are not competent
- Health and Disability Commissioner: Fact Sheet 2: “Do Not Resuscitate” (DNR) orders
- bpac®: Unapproved medicines and unapproved uses of medicines: keeping prescribers and patients safe
- bpac®: The use of screening tests
INDICATOR 5

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The practice has a documented Māori Health Plan.</td>
</tr>
<tr>
<td></td>
<td>A practice-specific Māori Health Plan.</td>
</tr>
<tr>
<td>5.2</td>
<td>The general practice team is trained in Te Tiriti o Waitangi/The Treaty of Waitangi including the principles of ‘Partnership, Participation and Protection’.</td>
</tr>
<tr>
<td></td>
<td>Evidence of training in The Treaty of Waitangi principles of ‘Partnership, Participation and Protection’ by all general practice team members.</td>
</tr>
<tr>
<td></td>
<td>Training is at level 1.</td>
</tr>
<tr>
<td></td>
<td>Training occurs every 5 years.</td>
</tr>
<tr>
<td>5.3</td>
<td>The practice addresses the health needs of its enrolled and geographic Māori population to reduce health inequalities.</td>
</tr>
<tr>
<td></td>
<td>Targeted services for the enrolled Māori population are documented.</td>
</tr>
<tr>
<td>5.4</td>
<td>The general practice team can explain how they work in partnership with local Māori organisations, provider groups and whānau.</td>
</tr>
<tr>
<td></td>
<td>Examples of how the general practice team work in partnership with local Māori organisations, provider groups and whānau.</td>
</tr>
<tr>
<td>5.5</td>
<td>The general practice team makes use of appropriate resources to assist staff to use correct pronunciation of te reo, particularly te reo Māori patient names.</td>
</tr>
<tr>
<td></td>
<td>Te reo resources are available for all the general practice team and staff can explain the importance of correct pronunciation of te reo Māori patient names.</td>
</tr>
</tbody>
</table>

Guidance notes

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

A Māori Health Plan describes how to reduce disparities. The plan must include the practice demographics for Māori. The plan can then be linked to the local district health board or other primary health organisation’s Māori Health Plan.

The Māori Health Plan

The Māori Health Plan must state how you will:

1. address Māori health priority areas and specific practice population issues for Māori (the Government has identified a range of priority areas in He Korowai Oranga: Māori Health Strategy for improving Māori health and to
improve access to appropriate, affordable and acceptable primary health services; and

2. implement measures to address priority areas as stated in He Korowai Oranga: Māori Health Strategy; and

3. target services for the enrolled Māori population; and ensure ethnicity data on Māori is available and robust; and establish priorities for Māori in the practice and set goals that will benefit their health outcomes; and

4. demonstrate that they are making additional efforts to address the needs of Māori. These efforts might include:
   - having specific targets and timelines, eg measure statins in Māori versus non-Māori
   - encouraging enrolment of Māori patients on specific programmes such as Ministry of Health (MoH) and district health board (DHB) programmes in chronic care management
   - identifying any barriers for Māori to access the practice services and addressing these, such as the percentage of Māori enrolled with the practice versus the percentage residing in the practice catchment area.

It is recommended the Plan include:

- the percentage of Māori enrolled with the practice
- health status of Māori enrolled with the practice
- key linkages (local, regional and national)
- strategies (both short and long term)
- how progress will be monitored and evaluated.

Resources

- Māori language resources
- Ministry of Health: Māori Health
- MCNZ: Best health outcomes for Māori: practice implications
- RNZCGP. Cultural competence – advice for GPs to create and maintain culturally competent general practices in New Zealand. Wellington, NZ: RNZCGP; 2007
- RNZCGP Māori Health Strategy

Continuing professional development.

- Contribution to the development of the Māori Health Plan can be claimed as a CME practice improvement activity or as a cultural competence activity.
- Any training or practice research undertaken is claimable as a cultural competence activity.
- Any audits undertaken can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence. Audits may also be claimed as cultural competence activities.
INDICATOR 6

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 The general practice team is trained in cultural competence and cultural safety.</td>
<td>□ Evidence of general practice team training in cultural competence and cultural safety. □ Staff training records and resources. □ Training is at level 1 and/or 2. Training occurs every 5 years.</td>
<td>F</td>
</tr>
<tr>
<td>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.</td>
<td>□ The enrolment form correctly records ethnicity data. □ Audits of ethnicity data from primary health organisations.</td>
<td>F</td>
</tr>
<tr>
<td>6.3 The general practice team can access interpreters and resources for people with limited English proficiency.</td>
<td>□ List of contact details for interpreter services.</td>
<td>F</td>
</tr>
<tr>
<td>6.4 The practice makes provision for hearing, sight or speech impaired people to communicate with and access the practice.</td>
<td>□ List of contact details for service providers for hearing, sight or speech impaired people to communicate with and access the practice. □ Patient information and resources (eg website, noticeboard, leaflets, etc).</td>
<td>A</td>
</tr>
<tr>
<td>6.5 The practice implements specific practice-wide activities to identify and address the needs of significant cultural groups within the practice.</td>
<td>□ Evidence of specific practice-wide activities to identify and address the needs of significant cultural groups within the practice. □ Audits of the practice population data, query builds, PHO data. □ Improvement plans and activities. □ Patient feedback and suggestions.</td>
<td>A</td>
</tr>
</tbody>
</table>

Guidance notes

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards.
The population of New Zealand is becoming increasingly more diverse. This has implications not only on the ethnic composition of the practice populations but also the medical workforce. One of the major barriers to culturally appropriate, accessible, safe and equitable health services is the lack of cultural awareness, knowledge and skills of health professionals.

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

Developing an understanding of cultural competency will allow you to:

- build strong relationships with patients
- find out more about the patient and their condition in order to make a more informed diagnosis
- more effectively explain the diagnosis, treatment and what the planned follow-up will be by using a patient-centric approach to the consultation
- improve cultural competence skills on a daily basis by incorporating these skills into daily practice
- understand each patient’s environment and make recommendations that are more realistic and likely to succeed
- significantly affect numerous patient outcomes, including emotional health, symptom resolution, function, physiologic measures (eg blood pressure and blood sugar level) and pain control
- increase doctor and patient satisfaction
- enhance continuity of care
- avoid unintentional offence.

**Ethnicity data capture**

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 inequities.

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

The registration form will include a field to capture ethnicity data. When collecting ethnicity, self-identification must be the process used to identify a patient’s ethnic group.

It is unacceptable for the collector to guess any patient’s ethnicity or to complete the questions on behalf of the patient based on what they perceive to be the respondent’s physical appearance.

Ethnicity capture must align with **Enrolment requirements for providers and primary health organisations**. The ethnicity question must be worded and set out exactly as specified in the MoH policy as this is the standard ethnicity question required by the **Ethnicity data protocols for the health and disability sector**.

A sample enrolment form is available in the policy, including a privacy statement, an explanation of PHOs for the patient, and model answers to frequently asked questions.
Training activities

Every staff member needs to be aware of the needs of your patient population. Aim for a good mix of cultures within your workforce where you can too. Every member of the practice – doctors, nurses, receptionists, etc – should be culturally competent.

Training ensures all team members are provided with accurate and consistent information to deliver culturally safe care and be responsive to the cultural needs of patients.

All members of your team should have participated in training (level 1 and/or 2) in cultural awareness and competency, and training records for each team member should be available. Their training should include any specific cultural groups you have identified in your practice (e.g., a specific ethnicity, migrants, refugees, people with disabilities, and so on).

There are a number of providers of cultural competence training. Some training is available online and some is free, for example Mauriora Health Education and Culturally and Linguistically Diverse (CALD) Working with Patients. All PHO workforces across New Zealand have access to free online and Auckland-based face-to-face ‘Working with CALD patients’ courses from 1 January 2016.

Interpreters and resources for people with limited English proficiency

Your team should be able to access interpreters and resources for people with limited English proficiency. Where possible try and engage the services of an experienced interpreter who has been trained in medical terminology and concepts. You should hold a list of contact details for interpreter services for your staff and patients.

In reality, the use of trained interpreters is often not possible because of lack of access or high cost. Friends and family members are frequently used as de facto interpreters for the patient. Any requirements and provisions you identify for each patient should be clearly documented and the need for any interpreter flagged in the patient’s clinical record.

Consider how staff can identify patients with a hearing, sight or speech impairment. Once these patients have been identified, you will need to make provision for these patients to communicate with the practice. For example, consider whether lip-readers can clearly see the receptionist’s face (e.g., they are not obscured by a computer monitor or high counter top).

These are some of the ways you can communicate with hearing, sight or speech impaired people (you may know others):

- Mail
- Fax
- Email
- Text
- Support person/caregiver
- Patient portals
- Language Line
- New Zealand Relay service (including TTY = Teletypewriter)
Identify and address the needs of significant cultural groups within your practice

New Zealand is an increasingly diverse nation, made up of many cultural groups, with many different customs and traditions. There are many ‘cultures’ to be aware of and they are not necessarily based on one’s ethnicity, race, nationality or religion.

Groups based on things like age, gender, socioeconomic status, language, occupation, interests and lifestyle, all have their own distinctive culture and practices. Your patients can and will often belong to multiple cultures simultaneously.

Your practice will have an enrolled population peculiar to you, with its own make-up of different cultural groups.

As health practitioners, the key is to determine those cultural connections by routinely asking about a patient’s ethnicity, hobbies, profession and other aspects of their life. In this way your practice can recognise, respect and make provision for the potential effects each culture may have them.

It is important that you implement specific practice-wide activities to identify and address the needs of the significant cultural groups within your practice. Your staff should be able to demonstrate and describe these.

You could consider:

■ posters and leaflets in other languages (these may be available through your DHB)
■ evening or weekend clinics for working parents
■ involving patients and using their feedback to come up with ideas

Resources

■ RNZCGP: Cultural competence – advice for GPs to create and maintain culturally competent general practices in New Zealand
■ Ministry of Health: Refugee health care: a handbook for health professionals, 2012
■ MCNZ: Statement on cultural competence
■ MCNZ: Best health outcomes for Māori
■ MCNZ: Best health outcomes for Pacific Peoples: practice implications
■ Ministry of Health: Ethnicity data protocols for the health and disability sector
■ eCALD training
■ Mauriora Health Education
■ Deaf Aotearoa
■ Health Navigator
■ Department of Internal Affairs: Translation Service
■ ‘The Code of Health and Disability Services Consumers’ Rights 1996
■ New Zealand Society of Translators and Interpreters (NZSTI)
- Language Line
- New Zealand Relay service
- How to use interpreters in general practice: the development of a New Zealand toolkit
- Health Quality and Safety Commission: Health Literacy

Continuing professional development
- Any cultural competence or safety training or practice research undertaken is claimable as a cultural competence activity.
- Any audits undertaken can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence. Audits may also be claimed as cultural competence activities. Self-designed audits should be pre-approved by the College.
INDICATOR 7

24-hour health care is accessible to the practice population

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 The practice makes provision for 24-hour health care.</td>
<td>Poster/signage (including on front door); and Patient information website/brochure/pamphlet. Contract with after-hours provider (if applicable); and Memorandum of understanding with alternate provider (if applicable).</td>
</tr>
<tr>
<td>7.2 Patients can access the after-hours service using a maximum of two calls.</td>
<td>After-hours telephone message and/or call diversion to after-hours provider. Poster/signage (including on front door). Patient information website/brochure/pamphlet.</td>
</tr>
<tr>
<td>7.3 The practice makes available electronic patient clinical summaries to out-of-hours health care providers.</td>
<td>Staff can describe and/or demonstrate how information is shared electronically with other providers. Tool(s) for sharing health information. Privacy and security of health information policies.</td>
</tr>
<tr>
<td>7.4 Urban practices ensure patients can access after-hours services using a maximum of one call.</td>
<td>After-hours call diversion to after-hours provider. Poster/signage (including on front door). Patient information website/brochure/pamphlet.</td>
</tr>
</tbody>
</table>

Guidance notes

After-hours primary health care is designed to meet the urgent needs of patients, which cannot be safely deferred until regular or local general practice services are next available.

If your practice does not provide its own 24-hour care, patients must be able to access after-hours care or be directed to an alternative provider when they need it. Access to the after-hours provider must use methods that take into account local situations and allow flexibility in the arrangements.
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 your practice. If your practice does not provide after-hours care, it must arrange for medical services to be covered 24 hours a day, seven days a week.

Patients should be advised of the name, address and contact details of the after-hours provider.

Examples include but are not limited to:

- a poster/signage on the front door/window in the event of a patient attending the premises when the practice is closed (include an address and preferably a map)
- an after-hours message on the answer phone
- an addition to the practice’s patient information pamphlet
- a poster in the waiting area about the after-hours provider
- the practice website includes information on the after-hours provider.

In some regions, especially urban areas, practices will be able to provide telephone access to the after-hours services using one call. At a minimum, patients must be able to access the after-hours service using a maximum of two calls.

Making it easy for patients to call an after-hours provider reduces the barriers to accessing care and enhances continuity of care. If this is not technically possible, you must provide an explanation.

Telephone advice can reduce the number of face-to-face consultations when it is safe to do so, easing after-hours workloads. However, it is not always suitable for patients who need to see a GP or a nurse urgently and some sort of provision for, or referral to, after-hours care should be made as appropriate (eg an after-hours provider, emergency department, call an ambulance).

Sharing information with other providers

Making electronic patient information available to an out-of-hours health care provider and other agencies helps maintain continuity of care. If health professionals have a fuller picture of a person’s medical history, then better, informed decision making and safer care can be provided as quickly as possible. Key elements include, for example, allergies and health alerts, laboratory tests, radiology reports, current medications, hospital referrals, discharge summaries, and the care they are receiving.

Your practice team should be able to describe and/or demonstrate the way in which they share electronic patient clinical summaries with out-of-hours providers, and be able to clearly articulate how they manage issues such as security and privacy.

See Indicator 40 for guidance on security.
INDICATOR 8
The practice works with other agencies and community services to provide integrated care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Directory – electronic/hardcopy; and</td>
</tr>
<tr>
<td></td>
<td>Other resources such as pamphlets, handout, brochures; and</td>
</tr>
<tr>
<td></td>
<td>Meeting minutes (if applicable); and</td>
</tr>
<tr>
<td></td>
<td>Patient records (demonstrating referral/advice).</td>
</tr>
</tbody>
</table>

Guidance notes

Your general practice team should have a compendium of regional and national health, social and community services applicable for case management and comprehensive care.

Opportunities to work collaboratively to provide seamless care for patients depend on understanding what other services are available. Your practice should identify where allied services might be available to fill service gaps. These efforts will contribute to improving continuity, reduce variation or disparities within care and contribute to improving the health of populations.

Resources

- Ministry of Health: Key health sector organisations and people
INDICATOR 9

The practice includes patients’ input into service planning

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>The practice includes feedback from patients when making decisions about the services provided in the practice.</td>
<td>■ Survey form or other form of collection tool; and ■ Survey methodology; and ■ Survey results; and ■ Evidence of changes made as a result of patient feedback; and ■ Patient newsletters/flyers/posters; and ■ Feedback sought from patients within last three years. ■ Patient experience survey (PES) results and improvement plan.</td>
</tr>
<tr>
<td>9.2</td>
<td>The practice informs patients and the general practice team about changes to services resulting from patient feedback.</td>
<td>■ Patient newsletters/flyers/posters. ■ Practice website. ■ Notices in waiting area. ■ Staff meetings minutes. ■ Notices on staff noticeboard. ■ Practice intranet. ■ Staff training resources.</td>
</tr>
</tbody>
</table>

Guidance notes

Understanding patients’ experience is vital to improving patient safety and the quality of care, and for improving your practice.

A planned approach to improvement ensures a better chance of success.

A patient satisfaction survey can also demonstrate that your practice is interested in quality and in doing things better.

Your practice should demonstrate it has surveyed patients to find out about their experience and to respond to any gaps they identify in the services you provide, or how you offer the service. This survey will need to be done within the last three years before your assessment visit. The survey should reflect a cultural and demographic mix of your practice’s population.
Ways to survey patients may include:

- focus groups
- a paper-based survey or questionnaire
- community groups
- online tool such as Survey Monkey
- telephone surveys
- touch poll.

When surveying your patients, consider whether the patients’ first language is English.

The Better Practice Patient Questionnaire (BPPQ) is available in several languages including English, Samoan, Māori, Mandarin and Korean. You can obtain copies of the BPPQ from The Royal New Zealand College of General Practitioners.

Encourage the patients to complete the form before leaving the surgery otherwise it becomes expensive supplying stamped, addressed envelopes for their replies.

Remember, surveys are only one way to gain patient feedback. The challenge is to use the information gained from the surveys to make meaningful changes within your practice.

Not all of your patients’ suggestions may be practical, so patients may need to be included in discussions about trade-offs between various elements.

Primary care patient experience survey

The Ministry of Health and the Health Quality and Safety Commission are introducing patient experience measures for primary care using online patient surveys.

The primary care patient experience survey, or PES, has been developed by the Commission to find out what patients’ experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists, and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

Practices will need to engage with the PES as part of the requirements for the new System Level Measures 2016/17 implemented from 1 July 2016.

The use of PES will be recognised as a source of evidence towards meeting this indicator. For CORNERSTONE® and other quality improvement activities you will also need a quality improvement plan based on the survey results.

Changes to services resulting from patient feedback

Your practice should inform patients and the general practice team about changes to services resulting from patient feedback. While improvement projects may focus on areas of weakness, this is also a good opportunity to celebrate your practice’s successes.
Results from the survey can be communicated to patients through tools such as a practice newsletter, practice website, flyers on the front desk, or notices in the waiting area.

Where you implement an improvement based on patient feedback, consider contacting the patient to let them know that their suggestion will be implemented.

Major changes to the service such as hours of opening or seasonal additions such as influenza clinics could be advertised in the public notices of the local or community newspapers.

Feedback to the practice team can occur at meetings, and via notices on the intranet, staff noticeboards, staff communication book, and so forth.

Resources

- Health Quality and Safety Commission:
  - Partners in care
  - Consumer engagement
  - Primary care patient experience
- Email to order the RNZCGP Better Practice Patient Questionnaire
- Family Practice Management: Measuring patient satisfaction: how to do it and why to bother

Continuing professional development

- Patient feedback surveys can be claimed as an AoMP (audit of medical practice) activity as long as at least 30 surveys are collected for the individual practitioner, and feedback is provided at this level. A patient survey reflection form completed by the practitioner should be kept as evidence.
- Surveys which are focused at the level of the practice only are not claimable as professional development activities.
SECTION 2

Practice environment and safety

The purpose of this section is to ensure that practice facilities meet the needs and safety of patients and the general practice team, that there is appropriate access for patients and their whānau, and that the privacy of patients is protected.
INDICATOR 10

The practice premises are safely accessible and clearly identifiable

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

Guidance notes

External signage must enable a patient or caregiver to readily identify your 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 your practice to provide the advertised services. For example, it is not acceptable to display opening hours as 9am to 5pm and then close over the lunchtime.

Access must not act as a barrier if mobility is compromised due to a permanent or temporary physical disability or illness. Where applicable, your practice must have ramps, rails or other structural design that enables patients with mobility difficulties to easily access the premises. This includes patients using mobility aids such as crutches, walking sticks, 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.

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

Resources

- Barrier Free New Zealand Trust:
  - Barrier Free Built Environments
  - Accessible reception and service counters
– Accessible car parking spaces
– Compliance schedule handbook
– The New Zealand Disability Strategy
– NZS4121:2001 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)

■ Department of Building and Housing: Building Code compliance documents and access
■ Office for Disability Issues: Built Environment
INDICATOR 11

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1 The waiting area has adequate space, seating, heating, lighting and ventilation.</td>
<td>The waiting area has adequate space, seating, heating, lighting and ventilation.</td>
<td>F</td>
</tr>
<tr>
<td>11.2 Each consultation room has adequate space, seating, ventilation, lighting and task lighting.</td>
<td>The consultation rooms have adequate space, seating, ventilation, lighting and task lighting.</td>
<td>F</td>
</tr>
<tr>
<td>11.3 Examination couches are accessible, safe and visually private.</td>
<td>Examination couches are accessible, safe and visually private.</td>
<td>F</td>
</tr>
<tr>
<td>11.4 The practice has made provision for patients who require a toilet with mobility access.</td>
<td>The practice has a toilet available which provides for patients who require mobility support.</td>
<td>F</td>
</tr>
</tbody>
</table>

Guidance notes

Your waiting area must be large enough to comfortably accommodate patients and whānau. There must be adequate space to manoeuvre wheelchairs, push chairs and walking frames.

Patient consultations must take place in private areas with visual and auditory privacy. Where treatment beds are separated by curtains, patients must be made aware of alternate options for a more private environment. This may take the form of a poster or notice.

Examination couches must be safe and accessible to all patients particularly the frail and elderly. The beds/plinths/couches should be at a comfortable working height with manual or hydraulic mechanisms or steps to enhance access. Portable steps must be safe and stable and not hazards to the visually impaired.

Access for people with disabilities is 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 certification/accreditation. Patient safety, privacy, and the convenience and accessibility of the alternative site will be high priority. Information about this should be given to patients at the time of registration, on the noticeboard or website, etc.
Resources

- Barrier Free New Zealand Trust:
  - Barrier Free Built Environments
  - Accessible reception and service counters
  - Accessible car parking spaces
  - Compliance schedule handbook
  - The New Zealand Disability Strategy
  - NZS4121:2001 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)

- Department of Building and Housing: Building Code compliance documents and access

- Office for Disability Issues: Built Environment

- RNZCGP: Policy for meeting premises-related criteria
## INDICATOR 12

The practice uses a practice management system

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
</table>
| 12.1 All clinical information generated in the practice is recorded electronically. | - A practice management system (electronic).  
- Patient record reviews (see Indicator 21). | F |
| 12.2 The practice can demonstrate implementation of its policy for security of electronic health information. | - The practice policy for security of information is provided and explained. | F |
| 12.3 The practice has a reliable backup and retrieval system to protect electronic patient information. | - Records of back-ups occurring.  
- There is a process for restoring from back-up. | F |
| 12.4 The practice has evidence of independent auditing of their electronic data systems and policies. | - Reports from independent auditing of electronic data systems and policies. | G |

### Guidance notes

**Recording clinical information**

Your practice must use an electronic practice management system (PMS).

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

Your PMS and other systems will provide:

- 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 PMS
Coordinated care systems to support timely quality treatment:
- accessible by the whole of a care team across providers
- sharing of patient information across organisations

Integrated systems capability:
- standardised eReferral
- ePrescriptions, patient portals, shared care records
- eAssessment processes and capability to access data across disciplines, institutions and providers
- supporting electronic transaction processing, and integrated funding arrangements
- transfer of health records (GP2GP)

Feedback and reporting to ensure quality service provision and improved patient outcomes.

Protecting health information in your practice

Rule 5 of the Health Information Privacy Code 1994 requires your practice to take reasonable security safeguards to protect health information. This means keeping the information safe from loss, as well as from unauthorised access, use, modification or disclosure.

To comply with rule 5 you’ll need to consider what risks there are for the health information you hold, make a plan to address those risks and do whatever is necessary to carry it out. You can use this to develop your policy for security of information.

Security of electronic health information

From the Patients First Baseline General Practice Security Checklist guide.

Most sensitive information in general practice is likely to be stored within your PMS.

Therefore the electronic PMS must be secure.

Most of these systems have a facility to assign roles to people, and to restrict the access of information at varying levels.

People with access to your PMS should be assigned an appropriate role based on their need within your practice. Custodial or cleaning staff should not have access to the PMS. Reception staff should only have access to the information that they need to do their jobs, which likely includes patient administration information but not clinical information.

By limiting the availability of patient health information, you limit the risk that it will be inadvertently or deliberately misused.

Access requires a password

Security and convenience are often at odds with each other. It would be far easier if we did not have to remember passwords and could simply turn computers on and gain access immediately without the use of such passwords. Not having passwords enabled on your computers is a risk, because it means that unauthorised personnel may be able to access them.
Files should be secure or password-protected from unauthorised access, unless in active use by a practice team member.

The longer the password the better – use a mixture of upper and lower case letters mixed with numbers and special characters. **Passwords must not be shared.**

Your terminals and personal computers should be positioned so the screen cannot be seen by unauthorised personnel or patients.

It is important that computers automatically require a password to access them after a period of inactivity (no more than 15 minutes). This protects against unattended access to computers if staff forget to log off or walk away and are longer than they expect.

Password-protected screensavers or automated security applications should be used for all computers when left unattended.

**General Practice ICT Security Checklist:**

Here is a link to a checklist for you to undertake both a self-assessment and quick independent assessment of the baseline ICT security within your practice. It is based on the baseline requirements discussed in the Health Information Security Framework.

Click here for [General Practice ICT Security Checklist](#).

**Backup and retrieval system**

From the Patients First [Baseline General Practice Security Checklist guide](#).

**Backups**

A backup is a copy of some or all of the files and information stored on a system.

The purpose of a backup is to be able to recover lost files or information if something happens to the original information. For your general practice, this should always include the PMS database, but may also include other computer files contained on your system.

Your practice must have (as a minimum) a system to backup essential electronic data on a daily basis (if not in real time).

Taking a backup of your most important files at least every day is important. In the event of a catastrophic loss of your system (perhaps a fire to your building that destroys it or a computer virus that renders the files or system unusable), the backup is used to retrieve important information. In order to retrieve information from backups, you use your most recent backup. This means that you will lose any information between the time you last have a backup of your system and when you wish to restore it.

**Store backups offsite**

Holding a copy of your backups and files offsite (or using a secure online service) is important to protect against events such as fire or theft, where both the original files and backups could be compromised.

For more information:
- Patients First: [Baseline General Practice Security Checklist guide](#)
- Indicator 40
  - Patients have access to a patient portal
Because your backups will almost always contain sensitive information, it is also important that the physical location in which the backups are being stored is secure. Generally staff storing backups in their homes is not considered to be a secure way of keeping offsite backups. There may be issues with staff having the potential to lose the backups en route to their home or having those backups stolen from their home. Both of these situations would compromise your information security. If you take physical backups, it is recommended that you use a professional service that can satisfy the requirement for secure transport and storage of those media.

**You’ll need retrieval and restoration too**

Backup of a system is only half of the equation needed to protect your important health information from loss. If your original information stored on your practice computers was lost, you would need to retrieve backups and successfully restore them.

It is possible that in some backup configurations you may not be undertaking a backup of all files required to get your system back into a working state quickly and easily.

You should occasionally check that it is possible to retrieve and restore your systems to a safe working state. It is recommended that you do this when your backup method is first established and at any time more than a minor change is made to that scheme.

Consider planning this backup test in conjunction with a third-party IT provider.

You would normally test the restoration process into an environment outside of your normal practice system (to simulate what may happen in a disaster situation). To undertake this test may require some time. We acknowledge that for most small businesses this task would only be undertaken sporadically.

**Independent auditing of your electronic data systems and policies**

Your practice should provide evidence of independent auditing of your electronic data systems and policies.

If you use a third-party IT support provider, your provider should be able to provide some independence in terms of audit and identifying information issues.

General practice systems are complex. They have many points of interconnection with other systems. They are responsible for transmitting health information. It is important that they are maintained in such a way that they are available most of the time and the way in which they operate does not compromise the security of the information that they hold.

There may be a temptation for practices to undertake the majority of this work themselves, but this is ill-advised. Having a specialist IT provider with knowledge of the systems and industry can help with maintenance of the systems and ensure that they are not configured in a way as to compromise the security of your system.

Your third-party IT specialist should be external to the practice. This excludes family or friends that complete IT work for you as a favour or in lieu of other non-cash payments. While not a guarantee, ensuring that you are paying for your IT services ensures that it is clear to those providing such services that they are providing a professional service. You should have a contract with your third-party
IT provider that covers all standard aspects of engaging a professional service. The contract may be on a time-and-materials basis, or have some retainer type component to it.

Refer here to the Patients First Baseline General Practice Security Checklist guide.

See also Indicator 40: Patients have access to a patient portal.

Resources

- Health (Retention of Health Information) Regulations 1996
- Health Information Privacy Code 1994 Incorporating amendments and including revised commentary
- MCNZ: The maintenance and retention of patient records
- The Privacy Commissioner: On the record: a practical guide to health information privacy
- The Privacy Commissioner: Health privacy toolkit
- Patients First: General Practice ICT Security Checklist and guide
- HISO 10029:2015 Health Information Security Framework
- Primary Health Care Practice Management Systems
INDICATOR 13

The practice prevents unauthorised access to controlled drugs and controlled drugs prescription pads

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
</table>
| 13.1     | Controlled drugs are stored in accordance with the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977.  
- Controlled drug safe;  
- Controlled drug register (consecutively numbered and balanced). |
| 13.2     | The practice can demonstrate their process for recording transactions of controlled drugs.  
- Evidence that the staff involved in managing controlled drugs are made aware of, and implement, the process for recording transactions of controlled drugs, and key accountabilities and responsibilities.  
- Staff involved in the signing in and signing out of controlled drugs can demonstrate the process for controlled drugs; and  
- Controlled drug register.  
- Patient record notes any prescribing and/or dispensing of controlled drugs. |
| 13.3     | The practice can demonstrate how they store and monitor the use of controlled drugs prescription pads.  
- Evidence that the staff involved in managing controlled drugs are made aware of, and implement, the process for storing and monitoring the use of controlled drugs prescription pads, and key accountabilities and responsibilities.  
- Staff involved in any transactions of controlled drugs can demonstrate how the practice stores and monitors the use of controlled drugs prescription pads; and  
- Controlled drug register; and  
- Controlled drugs prescription pads are kept in the controlled drugs cabinet or a locked cupboard. |

Guidance notes

The handling and prescribing of controlled drugs is more tightly controlled than prescribing of other medicines, reflecting the need to restrict access to, and minimise the misuse of, this type of medicine.
Storage and custody of controlled drugs

Any controlled drug that is not required for immediate use:

- 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
- 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
- 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.

Controlled drug prescription pads and forms must also be kept secure (usually in the controlled drugs cabinet or a locked cupboard) and recorded in the controlled drugs register. Your practice will need to be able to demonstrate how you store and monitor the use of controlled drugs prescription pads. There should be a process for notifying relevant authorities if prescriptions are found to be missing.

Controlled drug register

If you hold or dispense controlled drugs (CD) then you are required to keep a controlled drug register which documents the details of all transactions and includes a running balance of stock.

Accurate documentation enables your practice to track who receives controlled drugs and to prevent the theft or misappropriation of controlled drugs. Practices are encouraged to have a process for receiving, storing and disposal of controlled drugs returned by patients.

If you maintain a controlled drug register, you must:

- use an approved bound volume;
- keep that register or book in a neat and orderly manner in a secure place; and
- keep the register or book for a period of four years following the date of the last entry made in it.

All movements of a controlled drug, including those in the doctor’s clinical and/or emergency bag, must be recorded in the controlled drug register, legibly and indelibly.

The appropriate entries relating to any transaction regarding controlled drugs should be made in the register not later than the next ordinary business day following the day on which that transaction took place.

Any mistake in any entry may be corrected by a marginal note or footnote giving the correct particulars and containing, as part of the note, the date on which the note is written (and initials of the person making the entry).

Your practice should have a process for the identification and destruction/disposal of expired controlled drugs and the relevant actions must be documented in the controlled drug register.
The **following details are required** for each transaction in a controlled drug register:

1. Date of transaction (e.g., receipt, administration, stocktake or destruction of the medicine); and
2. Name and address of person from whom received; or name of patient; or name and address of person supplied; or form from which or into which the CD was made; or declaration ‘Physical stocktaking’; and
3. Prescription number; or order number; or time of administration or destruction of medicine; and
4. Number In; and
5. Number Out; and
6. Balance; and
7. Name of authority/prescriber; and
8. Received, issued, dispensed, or administered by; and
9. Initials/signature of person making entry or checking balance: preferably two signatures. It is recommended that controlled medicine administration be witnessed wherever possible – this means seeing the medicines being received, issued, dispensed, administered or destroyed, and signing as a witness.

It is good practice to keep a drug register even if the practice does not prescribe or dispense controlled drugs – particularly where the drug cabinet is jointly accessed by members of a group practice.

### Monitoring controlled drugs in an emergency bag

A small amount of controlled oral or injectable stock drugs (e.g., morphine) may be kept on hand in the clinical and/or emergency bag for *pro re nata* (PRN)/as required use.

Any medication stock of this nature should have concise records and is to be managed as usual for safety, transparency and auditing purposes. There should also be a system for checking the expiry dates of all drugs in clinical and/or emergency bags (see **Indicator 17**).

A clinical/emergency bag containing controlled drugs is acceptable provided it is in the personal possession of the clinician concerned.

All health care professionals in legal possession of controlled drugs have a professional duty of care to take all reasonable steps in maintaining safe custody of controlled drugs. When not in use, the bag must be kept out of vision to the public in a locked cupboard or vehicle.

If a clinician wishes to carry controlled drugs in his/her bag, the following should be considered:

- Another staff member should witness the stocking the bag from the controlled drug stock and record an entry in the controlled drug register.
- The controlled drugs should be stored in a lockable receptacle, which can only be opened by the person to whom the regulation applies. A digital combination lock is a convenient solution. Bags containing controlled drugs should not be left in a vehicle overnight, or for long periods of time.
- Each clinician must keep a record in the register for the controlled drugs carried in their bags. The clinician is responsible for those drugs.
Administration of a controlled drug to a patient should be recorded in the controlled drug register and in the patient record.

If a controlled drug has expired, the clinician should return it to the practice stock awaiting destruction. This should be recorded in the register. If there is no practice stock, then the expired controlled drug needs to be destroyed directly from the bag and witnessed by an authorised person. A record should be made.

ePrescriptions for controlled drugs

The New Zealand Electronic Prescription Service (NZePS) provides a secure messaging channel for prescribing and dispensing systems, to electronically exchange prescription information.

Eventually prescriptions for controlled drugs will no longer need to be handwritten on the triplicate controlled drugs form. The pharmacist will be able to dispense controlled drugs from an ePrescription provided it is:

- generated via NZePS and printed with a barcode on a separate piece of paper
- signed by the controlled drug prescriber
- downloaded from the NZePS broker – the barcode is either scanned or manually entered into the system if it can’t be scanned.

**Note:** This change will take effect over time, and the Ministry will advise when the change has taken effect.

The Ministry of Health will give practices the ability to use NZePS for controlled drugs on a practice-by-practice basis.

Stocktaking

Balances shall be undertaken on the last working day of June and December each year and at the time of obtaining new stock. The stock record, quantity stock account, and explanation of variations shall be entered on the page of the controlled drug register relating to the controlled drug or form of controlled drug to which the information refers.

Resources

- Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977
- Medicines Act 1981 and Medicines Regulations 1984
- Ministry of Health: Controlled drugs
- Frequently asked questions: Controlled drugs prescribing
- MCNZ: Good prescribing practice
- MCNZ: Prescribing drugs of abuse
- NZNO: Guidelines for nurses on the administration of medicines
- Pharmacy Guild of New Zealand: Pharmacy procedures manual app
- NZ ePrescription Service (NZePS)
- Medical Protection: Risk alert: controlled drugs
INDICATOR 14

There is safe storage and disposal of health care waste

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>Practice waste is correctly categorised, safely stored, collected and disposed of in accordance with the industry standard NZS 4304:2002.</td>
</tr>
<tr>
<td></td>
<td>Waste management policy; and</td>
</tr>
<tr>
<td></td>
<td>Waste collection units; and</td>
</tr>
<tr>
<td></td>
<td>Waste storage area; and</td>
</tr>
<tr>
<td></td>
<td>Method of waste disposal.</td>
</tr>
<tr>
<td></td>
<td>Local regional council bylaws.</td>
</tr>
<tr>
<td>14.2</td>
<td>In all areas where sharps are used, the practice has puncture-resistant sharps containers that are out of reach of children, and that display a biohazard symbol in accordance with NZS 4304:2002.</td>
</tr>
<tr>
<td></td>
<td>Sharps containers located out of reach of children, and marked in accordance with NZS 4304:2002.</td>
</tr>
</tbody>
</table>

Guidance notes

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

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

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

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

Hazardous waste

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

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

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

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

Non-hazardous waste

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

Segregation

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

Sharps must be placed in sharps containers.

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

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

Containers and packaging

Figure 1 shows the appropriate containers for packaging different categories of health care waste.
**Bags**

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

- have sufficient strength to contain waste
- comply with NZS 7603 (for plastic bags)
- conform to the colour coding and marking system (in Figure 1)
- be filled to not more than two-thirds of their capacity
- allow for the secure final closure when two-thirds full
- be secured with closure devices that do not have sharp protuberances (eg staples)
- not be made from paper if used for hazardous waste.

**Sharps containers**

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

Sharps containers should be in place in all clinical and treatment areas or where any hazardous waste may be generated such as sluice/sterilising rooms.

The disposal of sharps is the responsibility of the person generating the sharps. Used sharps should be disposed of directly after use, not left on work surfaces. Needles should never be bent, broken or recapped. Fill containers to the designated level only. When full, securely attach the well-fitting lid and dispose of through a licensed operator. These measures reduce the risk of inadvertent needle stick injuries.

**Holders**

Holders for the biohazard containers should preferably be wall mounted at chest height, out of doorways and high traffic areas. Loose biohazard containers (not wall mounted) in current use, should not be left on the floor, on trolley tops, on consultation desks or on any surface within easy reach of children.

**Rigid-walled containers**

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

If reusable rigid-walled containers are used for the disposable waste they must be lined in accordance with Figure 1 and identified as a biohazard.

**Packaging and labelling for transport**

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

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

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

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

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

Resources

- NZS 4304:2002 Management of Healthcare Waste
- bpac\textsuperscript{\textregistered}: Exposure to body fluids: keeping the primary healthcare team safe
**INDICATOR 15**

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1</td>
<td>The practice has infection control policies and procedures that align with the AS/NZS 4815: 2006 Standard.</td>
</tr>
<tr>
<td></td>
<td>Infection control policy; and</td>
</tr>
<tr>
<td>15.2</td>
<td>General practice team members responsible for managing infection control have received sterilisation and disinfection training, within the last three years.</td>
</tr>
<tr>
<td></td>
<td>Infection control training records – name of provider, date of delivery, names/certificates or persons attending.</td>
</tr>
<tr>
<td></td>
<td>Training is at level 1.</td>
</tr>
<tr>
<td></td>
<td>Training occurs every 3 years.</td>
</tr>
<tr>
<td>15.3</td>
<td>The practice can demonstrate how it monitors the effectiveness of each sterilisation cycle.</td>
</tr>
<tr>
<td></td>
<td>Sterilisation documentation.</td>
</tr>
<tr>
<td></td>
<td>Records of effective sterilisation cycles.</td>
</tr>
<tr>
<td>15.4</td>
<td>A current calibration and validation record is available for the steriliser.</td>
</tr>
<tr>
<td></td>
<td>Calibration and validation records.</td>
</tr>
</tbody>
</table>

**Guidance notes**

A wide variety of health care is delivered in primary and community care settings. Health care–associated infections arise across a wide range of clinical conditions and can affect patients of all ages. Health care workers, family members and carers are also at risk of acquiring infections when caring for patients (NICE guidelines).

It is important for you to provide a safe environment for staff, patients and other people in the practice. To ensure this, you should equip all team members with the requisite knowledge, skills and attitudes required for good infection control practices.

**Infection control policy**

You are required to document how you are going to manage infection control in your practice.

Your infection control policies and procedures must align with the AS/NZS 4815:2006 Standard.
The infection control policy should include but is not limited to:

- facilities, equipment, and procedures necessary to implement standard and additional (transmission-based) precautions for control of infections
- cleaning, disinfecting and reprocessing of reusable equipment
- cleaning schedule for the practice premises
- waste management
- special situations (eg influenza epidemics, norovirus)
- staff immunity and infections
- **hand hygiene**
  - prevention and management of infection by service providers
  - antimicrobial usage
  - single-use items
  - management of occupational exposure to blood and body fluids
  - cleaning, decontamination, disinfection and sterilisation of instruments and equipment
- wound management
- linen services
- venepuncture
- cryotherapy
- cleaning and servicing of the steriliser (where applicable – see below).

**Sterilisation processes**

Validation of the steriliser is important. You will need to be able to demonstrate how you monitor the effectiveness of each sterilisation cycle (eg printouts of every cycle, chemical indicator for every load, data logged directly to your computer).

If your practice has an older-style steriliser without an active drying cycle and/or process recorder you should consider:

- upgrading or replacing steriliser
- using prepacked disposable sterile supplies
- using an off-site sterilisation facility.

Calibration on site should be done (and documented):

- when steriliser is first installed
- annually
- when serviced or repaired.

For your steriliser (and/or the one used if you use an off-site service) you need a record of annual and current (within the last 12 months):

- servicing
- calibration
- validation.

You will also need to provide these if you use an off-site service.
Resources

- Hazardous Substances and New Organisms Act 1996
- WorkSafe New Zealand Health and Safety at Work Act 2015
- Standards New Zealand: AS/NZS 4815:2006 Office-based health care facilities— Reprocessing of reusable medical and surgical instruments and equipment and maintenance of the associated environment
- Standards New Zealand: NZS 4304:2002 Management of Health Care Waste
- RACP Infection Prevention and Control
- Hand Hygiene NZ
- bpac: Antimicrobial resistance in New Zealand: what is my role in primary care?

Continuing professional development

- Any training undertaken is claimable as a CME practice improvement activity.
INDICATOR 16

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1</td>
<td>The practice has Cold Chain Accreditation in accordance with the MOH protocol.</td>
</tr>
</tbody>
</table>

- Cold Chain Certificate; and
- Records of Cold Chain temperature monitoring.

Guidance notes

Cold Chain Accreditation (CCA) is a process that allows providers of immunisation to demonstrate their management of vaccine storage in accordance with existing national cold chain standards.

The CCA process aims to minimise the levels of vaccine wastage and ensures the provision of effective vaccines for the National Immunisation Schedule Vaccines.

All providers/clinics who store vaccines and/or offer immunisation services must achieve CCA.

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 CAA reviewer’s findings.

Resources

- Immunisation Advisory Centre
- Medicines Act 1981
- The Centre for Adverse Reactions Monitoring (CARM)
- Ministry of Health: National Immunisation Programme Cold Chain management
## INDICATOR 17

Medical equipment and resources are available and maintained

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17.1</strong></td>
<td>The practice has all the medical equipment and medicines listed in Appendix 1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Medical equipment and medicines are available.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- A signed list confirming the minimum requirements met.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Documented reasons for exceptions.</td>
<td></td>
</tr>
<tr>
<td><strong>17.2</strong></td>
<td>At least one set of emergency equipment and medicines are easily accessible in a single location.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Emergency equipment is centralised to one location in the case of an emergency.</td>
<td></td>
</tr>
<tr>
<td><strong>17.3</strong></td>
<td>There is a process to check and maintain all emergency equipment, medicines and impress items, including portable clinical/emergency kits, to ensure availability and expiry dates.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Documented process for the checking and maintenance of all emergency equipment, medicines and impress items.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Checklist showing (suggest monthly) checking that is signed and dated.</td>
<td></td>
</tr>
<tr>
<td><strong>17.4</strong></td>
<td>Medical equipment, medicines and pharmaceutical products are stored so that they are not accessible to unauthorised people.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Medical equipment, medicines and pharmaceutical products are stored so that they are not accessible to unauthorised people.</td>
<td></td>
</tr>
<tr>
<td><strong>17.5</strong></td>
<td>There is an audit trail to monitor the servicing of all medical equipment according to Electrical (Safety) Regulations 2010 Clause 60 &amp; 91 and relevant standards (AS/NZS 3000; 3003; 3551), maintenance and operating instructions.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Documented record of servicing, including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- evidence that shows annual, dated testing/servicing by the service company (eg tag/strip, electronic record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- annual electrical medical testing documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- records of calibration and validation.</td>
<td></td>
</tr>
<tr>
<td><strong>17.6</strong></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>
<td>F</td>
</tr>
<tr>
<td></td>
<td>- Medical grade 10mAmp Type 1 RCD are used with all electrical medical devices requiring an RCD.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Documented record of servicing and testing of all RCDs.</td>
<td></td>
</tr>
</tbody>
</table>

**Body Protected Areas:**

- Where the practice has deemed an area is a Body Protected Area, this area is to be certified and maintained in accordance with AS/NZS 3003.
- Documented record of assessment by an authorised person in accordance with AS/NZS 3003.
- Sign on wall to have correct, current stickers.
Guidance notes

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

The adequacy and appropriateness of basic equipment may be determined by your practice’s circumstances and you must be able to justify any omissions.

All essential medical equipment and supplies listed in Appendix 1 must be available when needed, and competency in the use of the equipment should be current.

If a defibrillator or an electrocardiograph is not available in your practice, an agreement should be in place for your practice team to access the equipment when needed. Clinical team members should be appropriately trained to use them.

An electrical medical device is any piece of medical equipment as defined by the Medicines Act 1981 that involves an applied part to a patient and that part is electrically connected to equipment that has a power source that is earthed.

When using or operating any type of equipment, including electrical medical devices, it is important to assess the following factors:

1. Environment:
   - Is the place you will be using the equipment configured for the purpose?

2. Equipment safety:
   - Is the equipment safe (demonstrated by acceptance testing before new equipment is released and maintenance activities like annual testing and performance verification, etc)?
   - The equipment needs to be in working order.
   - If using electrical medical devices, is appropriate RCD protection used?
   - If the equipment is from overseas, does it meet New Zealand and/or international standards and is it compatible with New Zealand power, 230 Volts 50 HZ?

3. Training and competence:
   - Does the operator know how to use the equipment?
   - Is the operator using the equipment safely?
   - Instructions and rules around its use are provided.

Using Residual Current Devices (RCDs) in your general practice

Residual Current Devices (RCDs) are commonly used as a safety device to minimise the risk of electric shock.

RCDs used to provide safety in medical procedures are more sensitive to reflect the bypassing of the skin’s resistance.

RCDs work by monitoring the flow of electricity out of the phase wire and returned up the neutral wire. The current in the wires must be balanced.

All electrical medical devices must be protected by medical grade 10mAmp (Type 1) RCDs.
If the RCD senses a fault to earth (i.e., an imbalance), the RCD shuts off the power supply to the electrical equipment. It works on the assumption that this imbalance is caused by some of the current taking an unintended route, such as through a person, causing an electric shock.

It is recommended that all electrical outlets supplying electrical equipment (other than electrical medical devices) in your practice (e.g., kitchen fridge, heaters, computers) are protected by standard 30mAmp RCDs. You should keep documentation for this.

Any items that are portable devices (i.e., not a computer that always sits on a desk) should be visually checked before each use. If it looks broken, the item should be removed from service following the practice’s procedures.

**Your options for RCD protection for general practice:**

There are a range of options to provide the appropriate RCD protection for electrical medical devices.

These include:

- Setting up designated Body Protected Area(s) in your practice.

- Installing 10mAmp Type 1 RCDs in locations where the electrical medical device may be used. You can:
  - Retrofit 10mAmp Type 1 RCD devices to standard wall-mounted power sockets
  - Use a portable or inline 10mAmp Type 1 RCD protector (pictured). This type of RCD can be hardwired into the cable of the electrical medical device ensuring you will always have the RCD protection wherever the device is plugged in. These RCDs need to be turned on every time the power is turned on. It is recommended that all users, after turning the power on, press the reset button and look for the red light/indicator, then press the test button (the RCD should click and trip and the red indicator disappear) then press the reset again. **If the RCD does not trip, then it should not be used.**
  - Fit 10mAmp Type 1 RCDs to the switchboard.

- Some electrical medical equipment (e.g., ECG) may already have protection built into them. Their ‘applied part’ (the part of the medical device which comes into physical contact with the patient) is separated from earth (called ‘floating’). When this is the case, the unit should display a BF or CF symbol indicating its safety standard. **If this symbol is displayed, you do not need sensitive 10mAmp RCD protection.**

Use caution as some of these items can be left attached to a patient while a defibrillator is in use and some can’t.
Look for these symbols:

- Type BF applied part
- Type CF applied part
- Defibrillation proof type BF applied part
- Defibrillation proof type CF applied part

Note that socket outlets protected by a Type 1 RCD, whether on the switchboard or the socket itself, should only have one device plugged into them.

If the RCD is remotely installed from the socket outlet, it is recommended that the socket outlet is readily identifiable to the user. This can be in the form of a label saying 10mAmp Type 1 protected or similar wording.

**Note for 10mAmp RCD:**

Schools also use 10mAmp RCDs, but they are of a different type. Ensure that when protecting medical equipment that your practice only uses 10mAmp Type 1 RCDs.

**Vaccine refrigerators**

The vaccine refrigerator should have an independent power point and surge protection. The switch should be of a type that has a flap that needs to be moved before it can be switched off. The surge protection can be provided on the switchboard, or a plug in type, or the power point can be changed to a surge protected type.

Make sure you check regularly (as part of your daily checks of temperature etc) that the power is on. Consider wiring the refrigerator in a manner that makes it immediately clear to your practice that the power is off (eg to the room lighting circuit). Then if the lights go off, you know there is a problem with the refrigerator.

See the [Immunisation handbook](#) for more detail.

**Electrical medical devices testing and servicing**

Electrical medical equipment/devices must be inspected, tested and serviced in accordance with AS/NZS 3551 (at least annually), other relevant standards and the manufacturer’s operating instructions.

**All electrical medical devices need to be inspected annually to specifications set out in AS/NZS 3551:2012.**

It is recommended that for other electrical devices such as examination task lighting, electric beds, sterilisers, heaters and office equipment, RCDs (30mAmp) are used to provide increased protection to patients and staff.
Calibration and validation

Calibration is the process that confirms the quantitative accuracy of instruments or equipment (eg scales, sphygmomanometers).

Validation is the process of confirming the effectiveness of the equipment that it is achieving the required outcomes (eg steriliser/autoclave).

You will need to keep records of annual servicing, calibration and validation of key pieces of equipment in your practice.

Testing RCDS

RCDs should be tested regularly to ensure that their capacity to ‘trip’ is still functioning. This is something that the practice staff can do.

You can test your socket outlet or portable RCDS by plugging in a small electric appliance (such as a lamp). Press the ‘test’ button. If the appliance turns off, the RCD is working. If it stays on, get your RCD checked by a licensed electrician. Make sure you press ‘reset’ once the test is complete.

It’s a good idea to test switchboard RCDS every six months by checking that it trips when the ‘test’ button is pushed. However, be aware that tripping circuits will turn off the power to any appliances on that circuit (be careful with your vaccine refrigerator). So appliances with electronic clocks will have to be reset. For this reason, it’s a good idea to test your switchboard RCDS when changing to and from daylight saving – when clocks have to be reset anyway and it will be about six months since the RCDs were last tested. See Residual Current Devices for more information.

In addition, all 10mAmp Type 1 RCDS should be regularly (annually) tested by an electrician with proper test equipment, and documented. The testing details can be sent by email for your records.

Make sure you keep a dated and signed record of any RCD testing – electronic is acceptable.

Your electrical testing records should include:
1. Who did the testing.
2. What equipment was tested (list what was tested).
3. What they are claiming (eg it is safe, it has been verified it is performing properly, etc).
4. What the basis/evidence for the claim is (eg test results, etc).

Body Protected Areas

Body Protected Areas need to be inspected annually by someone appropriately qualified. On each occasion the Body Protected Area signage will need to be updated with the latest inspection date.

Required documentation

The practice should hold:
- a register of the medical equipment with a schedule and reminder process to ensure everything is current
- a copy of the annual medical equipment servicing report (this should be certified and dated)
- a record confirming the date when RCDS have been tested.

Indicator 15

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

Make sure you keep a dated and signed record of any RCD testing.
This can be in electronic format and electronically signed.
Body Protected Area

In some situations the practice may decide to set up areas specifically dedicated for using electrical medical devices that are used to diagnose, treat, or monitor a patient. These areas are referred to as a Body Protected Area.

Specialised services such as X-ray, minor surgery (involving diathermy and monitoring) or even a plaster room may benefit from the use of Body Protected Areas.

The features of a Body Protected Area are:

1. They use isolating RCDs (10mAmp Type 1)
2. They use socket indicators (lights on/off), and
3. RCDs need to be accessible in the Body Protected Area/room or be labelled with lights on the switchboard in accordance with AS/NZS 3003.

The specific requirements for Body Protected Areas are described in a joint Australian/New Zealand standard AS/NZS3003 (2011).

A general practice may not need to set up Body Protected Areas to use electrical medical devices if they are following safety standards as outlined above.

However if a practice is setting up Body Protected Areas within the practice then it is essential that advice and direction is received from a suitably qualified person.

Where the practice has deemed an area is a Body Protected Area, this area is to be certified and maintained in accordance with AS/NZS 3003. Keep a documented record of assessment by an authorised person. You will need the correct sign on the wall with correct, current stickers.

It is the responsibility of each general practice to ensure they have checked their individual requirements to ensure compliance with the relevant legislation or standards.

Safe storage of medical equipment, medicines and pharmaceutical products

The Medicines Act 1981 – Section 47 states:

Storage and delivery of medicines

1. No person who is in possession or in 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 they have taken all reasonable steps to secure that building or vehicle, or the part of it in which the medicine is kept, against unlawful entry.
Resources

- AEDs in your community
- Electrical (Safety) Regulations 2010:
  - Clause 25: Specific installations, fittings, and appliances deemed to be electrically safe
  - Clause 60: Certain installations must comply with Part 2 of AS/NZS 3000
  - Clause 75: Periodic assessments of certain installations
  - Clause 91: Periodic assessment of electrical medical devices
- Worksafe NZ (Energy Safety)
- The Medicines Act 1981
- Residual Current Devices
- National Guidelines for Vaccine Storage and Distribution 2012

Additional resources

- AS/NZS 3000:2007 Electrical installations (known as the Australian/New Zealand Wiring Rules)
- AS/NZS 3003:2011 Electrical installations – Patient areas
- Electrical safety regulations 2010
- Standards New Zealand. AS/NZS 2500: 2004 Guide to the safe use of electricity in patient care
INDICATOR 18
The practice has planned response and procedures for fires, disasters or emergencies

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.1</td>
<td>Fire Service approval notification.</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>Records of six-monthly trial evacuation drills.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fire equipment/system maintenance register.</td>
<td></td>
</tr>
<tr>
<td>18.2</td>
<td>Detailed business continuity plan.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Asset register.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>List of utility provider contact details.</td>
<td></td>
</tr>
<tr>
<td>18.3</td>
<td>Documented practice-specific emergency procedures.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>List of emergency contacts for all staff.</td>
<td></td>
</tr>
</tbody>
</table>

Guidance notes

The Fire Service Act 1975 (and Regulations) requires a building owner providing nursing, medical or geriatric care to have an evacuation scheme approved by the National Commander of the Fire Service, irrespective of the number of employees.

Each practice needs to consider and document (and trial) evacuation procedures for their building to ensure that in the event of a fire (or other emergency situation) staff and patients can evacuate the building in a safe and rapid manner.

Clause 17 of the Fire and Safety Evacuation of Buildings Regulations 2006 outlines the requirements of an evacuation scheme. Applications can be made online using the Fire Service’s Online Services webpages.

The evacuation scheme online service lets you:

- submit an evacuation scheme – an online form
- view the status of any evacuation schemes that you have submitted using this service
- receive correspondence about your scheme (eg approval notification)
- maintain your contact and building details.

Note that once an evacuation scheme has been approved you must ensure everything described in the scheme is maintained. You will also need to nominate
how you will educate your staff team – using trial evacuations or an evacuation training programme. There are also requirements about ongoing maintenance requirements. Keep a record of your six-monthly trial evacuation drills.

Who applies for an evacuation scheme?

The building owner would normally apply to the Fire Service for approval of an evacuation scheme for any relevant building.

The building owner may authorise someone (eg a tenant) to act on their behalf (called an authorised applicant), provided the building owner gives written evidence of the authorisation to the applicant to submit with the application.

Use the Authorisation for approval of an evacuation scheme form to authorise someone to submit an evacuation scheme on behalf of the building owner.

The requirements of an evacuation scheme

An evacuation scheme describes the measures that have been put in place to enable safe and timely evacuation if there is a fire (or suspected fire).

The requirements for evacuation schemes (which do need Fire Service approval) are set out in Part 2 of the Regulations, and include:

- evacuation procedure (an evacuation procedure is a plan that describes how occupants will escape to a place of safety if there is a fire or suspected fire)
- training
- signs and notices (how to raise an alarm of fire and what to do if an alarm of fire is raised)
- firefighting equipment
- places of safety
- automatic sprinkler systems (if you have them)
- provision for persons with a disability
- means of warning
- maintenance of the evacuation scheme

No exemption from an evacuation scheme for general practices

The New Zealand Fire Service has advised that all medical centres require an approved Evacuation Scheme regardless of the number of staff they employ, even if they have a sprinkler system installed. As the place of medical care is listed under Section 21A(1)(f) the fact the premises have a sprinkler system is irrelevant – an approved Evacuation Scheme is still required.

Building owners

It is the responsibility of the building owner to take fire safety precautions in their building including having approved fire evacuation procedures.

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

The owner must have a procedure in place to:

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

**Business continuity planning**

Risk analysis and contingency planning help maximise patient safety and access to ongoing care through coordinated and continued delivery of general practice services in the event of a disaster or major incident.

Business continuity planning is not just about how the practice will operate during the disaster or significant event, but should also take into account viable alternatives to enable the practice to continue operating in the short to medium term after the significant event.

**A business continuity plan should address or include the following key elements:**

- Options for alternative premises should the emergency/significant incident mean the usual general practice premises are no longer usable (even in the short term).
- A list (including contact details) of all major utility providers used by the practice.
- A range of options for access to alternative utility services or work around should your practice’s normal provider be unable to supply any essential services when needed.

**Examples of essential services may include:**

- power (equipment, lighting, heating)
- water (service provision, cleaning, drinking, hygiene)
- IT solutions (PMS/patient information)
- phones (communications)
- medical supplies.

**Indicator 12**

The practice uses a practice management system
A copy of the practice’s business continuity plan should be maintained off-site in either an electronic or hard copy format that can be readily accessed and used when required.

It is also important as part of any business continuity planning that alternative resource options are checked out for reliability should they be needed. For example, an alternative to mains electricity may include the utilisation of a generator, so it will be important to hold discussions with an electrician to ensure that essential medical or other equipment requiring a power source can still be operated safely and effectively using the alternative power source.

The ability to access and maintain patient information may be important especially when moving into a re-establishment phase after a major event. The practice should have access to a valid and recent back-up of essential patient health information knowing that it is capable of being restored and used – see also Indicator 12.

It is recommended that you have a detailed list of practice assets that can be referred to should you need to re-establish any aspect of your practice resources after a significant event.

Emergency assistance

In situations when an emergency event such as a fire, flood, earthquake or prolonged power cut requires extraordinary actions, there should be a planned set of responses that all practice staff understand.

The plan should cover expectations of immediate responses covering staff roles and responsibilities, provision of services and allocation of resources for each type of emergency occasion or situation.

Other forms of emergency situations that should be covered may include bomb threats, hold-ups, prolonged computer outages, aggressive patients and significant incapacity of a staff member (eg through sudden illness or death).

The plan should cover responses to emergencies that may be confined to the immediate practice facilities as well as any responses that may be made externally to the local community when the emergency situation is of a greater scale.

Business continuity plans and emergency response documentation should be dated and include a review date and update process.

Resources

- Fire Service Act 1975
- Fire and Safety Evacuation of Buildings Regulations 2006
- New Zealand Fire Service Evacuation Scheme
- Evacuation Scheme Clause 17
- Ministry of Health:
  - Emergency management, disaster planning and business continuity in primary care
– Emergency management
– National Health Emergency Plan
– New Zealand influenza pandemic plan: a framework for action
– Pandemic influenza guidance for the health sector

■ Ministry of Civil Defence and Emergency Management
■ Ministry for the Environment: Climate change impacts in New Zealand
INDICATOR 19

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1</td>
<td>The general practice team is able to demonstrate how they comply with the Health and Safety at Work Act 2015.</td>
</tr>
<tr>
<td></td>
<td>▪ Hazard/risk register; and</td>
</tr>
<tr>
<td></td>
<td>▪ Incident register; and</td>
</tr>
<tr>
<td></td>
<td>▪ Health and safety policies and processes.</td>
</tr>
<tr>
<td></td>
<td>▪ Officers in the practice have been identified, and understand their obligations.</td>
</tr>
<tr>
<td>19.2</td>
<td>The practice has a designated health and safety coordinator who manages health and safety for the practice.</td>
</tr>
<tr>
<td></td>
<td>▪ There is a health and safety coordinator.</td>
</tr>
<tr>
<td></td>
<td>▪ They can describe their role and responsibilities.</td>
</tr>
<tr>
<td></td>
<td>▪ Position description.</td>
</tr>
</tbody>
</table>

Guidance notes

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

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

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

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

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

Key components of an effective health and safety system

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

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

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

**PCBU**

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

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

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

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

For more information on PCBU, see WorkSafe NZ: What is a PCBU?

**Officers**

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

Officers include:

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

The following people are not officers:

- health and safety managers
- team leaders, line managers, and supervisors
- workplace health and safety officers and advisors
- people whose job title includes ‘officer’, such as corrections officer, police officer or administration officer.

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

Officers have a duty because they make policy and investment decisions that can affect workers’ health and safety. People in senior leadership positions have an important role in leading health and safety culture throughout a PCBU.
An ‘officer’ under the Act is distinct from a Health and Safety Officer. This person helps the practice team understand how to meet regulatory requirements. Details should be in their employment agreement.

**Due diligence**

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

Due diligence includes taking reasonable steps to:

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

**The primary duty of care**

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

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

**Specific obligations:**

The primary duty of care includes:

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

**Working together on health and safety**

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

It’s about doing what is ‘reasonably practicable’ and proportional; balancing the level of risk, the likelihood of an incident happening, the impact on people, and how much influence or control the PCBU has to manage it.
Staff will know where the health and safety pressure points are. They can suggest practical, cost-effective solutions, and are more likely to make them happen when they are involved.

See WorkSafe NZ: Worker engagement, participation and representation good practice guidelines

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

Engagement is how a business involves its workers in decisions.

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

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

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

You should document how you will:

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

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

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

Managing hazards and risks in your practice
There are risky things in all practices big or small. The first step in managing health and safety is to identify these hazards in your practice and assess the likelihood or risk of them causing a serious injury or illness.
You will need to write hazards and risks down in a hazard/risk register. Try focusing on your people when you are looking for hazards/risks – you’re simply looking for all the things that could hurt the people that come into your practice.

This register should list all hazards to staff, visitors, patients and contractors along with a rating for the risk of each hazard and how you plan to control and manage them.

To help you, use tables like Worksafe NZ’s Risk rating table.

A common question is what the difference between a hazard and a risk is. **A hazard** is anything that can cause harm, like a hazardous substance, equipment, fatigue, repetitive movements on the computer, bullying, and so on. **A risk** is the likelihood that death, injury or illness might occur when exposed to a hazard. So for each hazard think about how likely it is to occur and write that down in your register.

**What you must do:**

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

**Incidents**

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

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

**Resources**

- RNZCGP: **Health and safety things to think about April 2016**
- WorkSafe New Zealand
- WorkSafe New Zealand: HSWA Guidance
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- Health and Safety at Work (Worker Engagement, Participation, and Representation) Regulations 2016
- Health and safety leadership: a guide for small to medium business owners and company directors
- HSWA terms and definitions
- Employers and Manufacturers Association
- WorkSafe New Zealand: **Emergency procedures**
- Environmental Protection Authority: Emergency procedures
- ACC: How to manage hazards: for small businesses
- Information for schools and ECE services, but with useful factsheets: Ministry of Education: Health and safety system for schools and ECE services
- MinterEllisonRuddWatts: Health and safety toolkit
SECTION 3
Clinical effectiveness

The purpose of this section is to ensure that there are structures to support and maintain safe, comprehensive and effective care for patients and manage continuity, coordination and integration of care across health and community interfaces.
INDICATOR 20
Continuity of care is facilitated by registration of new patients and timely transfer of health records

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.1</td>
<td>There is a patient registration process that collects demographic and essential health information.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Registration or enrolment form (including new patient medical questionnaire).</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Patient record reviews (see Indicator 21).</td>
<td>✔</td>
</tr>
<tr>
<td>20.2</td>
<td>There is an effective and timely system that enables health records to be obtained and transferred between practices within 10 working days.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Electronic or hardcopy record to track the retrieval and/or transfer of health records.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Records are transferred between practices within 10 working days.</td>
<td>✔</td>
</tr>
<tr>
<td>20.3</td>
<td>There is a system to manage tracking and retrieval of health records to, from, and within the practice.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Electronic or hardcopy record to track receipt of health records.</td>
<td>✔</td>
</tr>
<tr>
<td>20.4</td>
<td>The practice utilises an electronic system to transfer records from their practice to another practice in a format that meets practice management system standards.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Staff can describe/demonstrate the electronic system to transfer records from their practice to another practice; and</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>The format meets practice management system standards.</td>
<td>✔</td>
</tr>
</tbody>
</table>

Guidance notes

Patient registration process

Your practice is required to have a process to collect personal demographic and essential 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.

Your practice is advised to have a system that identifies these patients so your staff can complete their registration and medical history at another consultation.

Consistently recording data (the same terms and the fields data belongs in) makes it easier to provide reports and to spot if information is missing.

Work out a standardised way of entering information so that staff with the authority to enter data in clinical records know where to place it, so it is consistently recorded throughout your practice.
Entering ethnicity data

The ethnicity question must be worded and set out exactly as specified by the Ministry of Health (MoH) as this is the standard ethnicity question required by the Ethnicity data protocols for the health and disability sector.

For other resources see Enrolment requirements for primary health organisations, Enrolling with a primary health organisation.

Complying with the Health Information Privacy Code 1994

Make sure that the way you collect information about patients complies with the Health Information Privacy Code 1994, particularly Rule 3 and 4.

Rule 3: Collection of health information from individuals

The patient must be aware of:

- the fact the information is being collected
- the purpose for which the information is being collected
- the intended recipients of the information
- the name and address of the health agency that is collecting the information, and the agency that will hold the information
- whether or not the supply of the information is voluntary or mandatory and if mandatory the particular law under which it is required
- the consequences (if any) for that individual if all or part of the requested information is not provided
- the rights of access to and correction of health information provided by rules 6 and 7.

The collection of health information for care and treatment and the related routine administrative aspects (for example, billing) are usually clear and may require a brief explanation. The intended recipient of the information may not always be apparent, particularly where health information is sought to meet monitoring and funder requirements, and audit and research.

Some accident and medical centres send consultation information to a patient’s GP after the patient has received treatment at the centre. This should be done only with the individual’s knowledge and authorisation since he or she may not otherwise anticipate or agree to the disclosure.

Reasonable steps to inform include:

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

Rule 6: Access to personal health information

The rule does not determine ownership of documents. Rule 6 does not give patients the right to take away original records. Having said that, a request cannot be refused on the basis that the practice ‘owns’ the record or that they are not the requester’s property.
Under ‘Transfer of requests’, Privacy Act 1993 (s39), your practice is required to transfer the request promptly, and in any case within 10 working days, and to inform the individual accordingly. You and your staff need to understand the timelines and have appropriate procedures in place so that they are met. There should also be procedures to allow requests to be dealt with on an urgent basis if required.

Where a request for access is made, your practice should:

- satisfy itself as to the identity of the individual making the request
- ensure only the patient or his or her agent receives the information sought. This may involve registered mail or requiring the patient or agent to sign a receipt for the information.

Ensure that where an agent makes a request, the agent has a current written authority and is otherwise properly authorised to obtain the information. Your practice should set out policies for what evidence of authorisation will be acceptable and communicate those policies to staff (eg Enduring Power of Attorney (EPA), a signed note where the signature can be compared, anyone listed as an agent with prior permission).

**Tracking of clinical records to, from, and within the practice**

Patients and practices need assurance that any hardcopy health information transferred between providers reaches the intended recipient. Information management to track health records may be in an electronic or hardcopy format.

Examples of tracking receipt of health 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 and confirm receipt.

**Using an electronic system to transfer records**

In some practices, health records are still being mailed across the country as hardcopies and manually re-entered, if at all, every time a patient file is transferred. This requires a considerable administrative commitment in terms of time recording, printing and mailing an outgoing patient’s medical record, and re-entering an incoming patient’s record.

Ideally patient records should be presented in a format that is structured, easy to read and searchable so key pieces of information can be located efficiently. This helps increase efficiency and reduces errors and risk.

This can be achieved through a system like GP2GP, which has the capability to transfer a patient’s files electronically from one general practice system to another. It allows an individual to transfer their record with them when changing GP or moving location within New Zealand, reliably, securely and accurately.

**Resources**

- The Code of Health and Disability Services Consumers’ Rights 1996
- Health Information Privacy Code 1994

MCNZ. *The maintenance and retention of patient records*

MCNZ. *Good medical practice—A guide for doctors*

Ministry of Health. *Ethnicity data protocols*

Privacy Act 1993

Health Act 1956 Section 22B-H

Patients First: GP2GP

Additional resources:

- Standards New Zealand. *NZS 8153:2002 Health records*
- SNZ HB 8169:2002 Health Network Code of Practice
- HISO 10029:2015 Health Information Security Framework

**Continuing professional development**

Audits conducted by the individual doctor relating to transfer of medical records can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
## INDICATOR 21

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.1</td>
<td>Patient records contain information to identify the patient and document: the reason(s) for the visit, relevant examination and assessment, management, progress and outcomes (management/risk factors/screening/continuity/referral/tests/investigations).</td>
<td>■ Record reviews for 10 records per clinical practitioner; and&lt;br&gt;■ Internal audits completed within the last 12 months.&lt;br&gt;■ Quality improvement plan.&lt;br&gt;■ Report and Plan template from the Medical Record Review tool.</td>
</tr>
<tr>
<td>21.2</td>
<td>All incoming clinical records are reviewed by a practice clinician for identification of key clinical issues as soon as possible upon receipt of the records.</td>
<td>■ Process for review of clinical records.&lt;br&gt;■ Patient record notes review of record within 10 days of receipt of the records.</td>
</tr>
</tbody>
</table>

### Guidance notes

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

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

All entries in a patient’s clinical notes must clearly identify the person who has made the entry. **It is not acceptable to make entries in the electronic records under another provider’s name or initials.**

Your PMS software system may allow you to use colour coding to distinguish between individual groups of health professionals. This may be especially useful if your medical centre has multiple providers working from one facility.

Make sure that access to health records is limited to only those individuals in your practice who have a legitimate reason to access them.

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

Conducting a record review helps you to find out how your records compare to the requirements. This helps you and your team think about how to improve the quality of clinical records in your practice in order to support the safe care of patients.

Each clinician in the practice is required to complete record reviews for 10 records per clinician (that is each GP, nurse, etc).

An RNZCGP Medical Record Review Tool is provided on our website. You can use this for your self-assessment and review. You will need to complete Modules 1: Patient record systems and Module 2: Medical record review for both Foundation Standard and CORNERSTONE®. The requirements in the tool also link to the PHO services agreement.

The review must be completed within the 12 months prior to the assessment visit. Although an external audit is often useful to check progress, the review should be carried out by each individual, not by a third party.

How to select records

For Modules 1 and 2 of the tool you'll need a random audit of 10 patient records.

The patient records you use should be electronic. All records selected should have an entry in the past 12 months.

One of the easiest ways to generate a random sample is to select consecutive patient appointments, beginning at a random time, on a randomly selected day. You can also find apps online that can generate random numbers for you.

Non-clinical staff can help in the selection of these patients and in filling out the demographic section (after all, this is the section they’re often responsible for).

You should keep a key (a list of records reviewed) to match data to the individual patient record, that includes NHN numbers and patient names used. These may be checked by an assessor.

Quality improvement plan

In reality, patient records won’t contain 100 percent of the recommendations, 100 percent of the time. In any assessment, this is taken into consideration. Rather, the record review activity is a quality improvement activity.

Once the data is collected, you need to develop an individual or joint (maybe practice-wide) improvement plan based on the findings of the review.

A Report and Plan template is provided with the Medical Record Review tool. You can use this to summarise the findings and plan for any necessary improvements.
Patient record requirements

**NOTE:** Foundation Standard requirements for clinical records are in red. Additional Aiming for Excellence/CORNERSTONE® requirements are in blue (if you are a CORNERSTONE® practice you need to do all).

1. **Patient records are electronic, secure and traceable:**
   - **F** All clinical information is recorded electronically, password-protected and reliably backed-up.
   - **F** Clinical notes are dated and reliably identify the author.
   - **F** The date and author of any alterations made to the notes are recorded.

2. **Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements:**
   - **F** Information stored for each patient includes: name of patient, NHI number, gender, address, date of birth, ethnicity, registration status.
   - Information held for enrolled patients includes: contact phone number, contact in case of emergency (ICE), next of kin – where applicable
   - ...as well as significant relationships, hapū/iwi for Māori patients, primary language – where applicable.
   - **A** Any need for an interpreter is flagged for patients with English as a second language.

3. **The record is objective, contemporary and sources are identified:**
   - **F** Notes are made as soon as possible after contact and any delay is identifiable.
   - **F** When information is provided by other than the patient, the source is identified.

4. **Clinical notes can be understood by someone not working regularly at the practice:**
   - **F** The notes are ordered, intelligible, and sequential.
   - **A** The use of keywords or templates does not compromise the validity of the notes.

5. **Important medical warnings (or the absence of any) are displayed for all records:**
   - **F** Medical warnings, past medical history, and/or previous medication adverse reactions are recorded, where relevant.
   - **F** All important medical alerts available on the PMS are activated.
   - **F** Allergy status (allergies or the absence of known allergies) is recorded for each patient.
   - **A** Prescriptions cannot be generated unless allergies are recorded.

6. **Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point:**
   - **F** Patient needs and instructions recorded include, where applicable, directives by patient, disabilities of patient, drug dependencies, end of life needs, and special alerts (eg deaf, blind, communication requirements, mental health issues), and name of any interpreter used.

See Indicator 6 for more information on ethnicity data protocols
7. The recorded history is adequate for both safe management and evidential purposes:
   - The reason for the encounter is recorded or apparent from the notes.
   - Consultation records include date, place of consultation (if different from usual) and mode (if not face to face, such as teleconsultation or e-consultation).

8. The record of the examination includes all findings essential to diagnosis and management:
   - Sufficient positive and negative findings are present to justify management decisions.
   - Objective measurements (BP, pulse, temp, respiratory rate, etc) are recorded, where relevant.
   - Photographic evidence is included, where relevant (eg skin lesions).

9. The working diagnosis/differential is apparent and consistent with supporting information:
   - The diagnosis (and any differential) and level of certainty is clear from the notes.

10. The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent:
    - Patient notification of test results and other clinical findings is recorded.
    - There is evidence of advice given to support any necessary consent and its confirmation.
    - The record includes evidence of signed or verbal consent to procedures as required.
    - Informed consent is documented when there is variance between evidence and practice.
    - Notes include health promotion, preventative care information and referrals.

11. Clinical management decisions and any interventions provided are recorded:
    - The management/treatment plan is clear from the notes, including contingency plans and follow-up arrangements (safety netting) where necessary.
    - The notes include any clinical management decisions made outside face-to-face consultations (eg telephone calls and emails) and off-site consultations (home visit, aged care facilities, etc).
    - Any brief interventions provided are recorded, eg smoking cessation.

12. The record identifies all medication treatment provided including the type, dosage and total amount of any medications prescribed:
    - There is a record of all prescriptions issued including drug name/dosage/frequency/time/volume and total amount.
    - Any medications prescribed outside the practice have been recorded and reconciled in the PMS.
    - Current and long-term medications are differentiated and the status is clear.
    - Where long-term medications are changed, reasons for alteration or discontinuation are recorded.
    - All long-term prescribed medications are linked with a medical condition.
13. The record identifies all investigations requested and tracks high-risk tests:
   - F All tests and investigations requested are recorded.
   - F Tests (e.g., histology, cervical smears) are tracked for completion.

14. The record supports effective and timely referral for treatment and transfer/continuity of care:
   - F Copies of referral letters to and from the practice, certifications, referrals and responses, discharge summaries and test results are included in the patient PMS record or accessibly filed.
   - F Referrals include urgency, reason/expectation of referral, relevant findings, classifications, warnings and current treatment.
   - F The record confirms that all referrals are enacted in a timely way.
   - F The record confirms appropriate and timely action in response to incoming correspondence.

15. Follow-up arrangements are clearly documented and actions are recorded:
   - F Follow-up actions on test results and referrals are recorded.
   - A When transferring patients to providers and services outside the practice in potentially significant cases, there is evidence of tracking of referral status and safe transfer of clinical responsibility.

16. Screening history and results (or patient decline) are recorded:
   - F Screening history and results (or patient decline) is recorded for routine screening areas (this may vary with current national guidelines, but examples include cervical smears, mammograms, cardiovascular risk assessment, diabetes screening).
   - F Screening recall status can be easily tracked.
   - A There is evidence of patient risk assessment and opportunistic screening for high-risk conditions.

17. Immunisation history and status is recorded:
   - F There is evidence that immunisations are conducted and updated according to the national schedule.
   - A Records show advice given and immunisation status for non-scheduled immunisations.

18. There is a systematic record of individual risk factors:
   - A Diseases are classified for common chronic diseases, including all conditions for which the patient is on long-term treatment.
   - A Family history (or lack of history of note) for major risk factors, such as diabetes, early CVD, bowel and breast cancer etc.
   - A Current employment (where relevant) and any history of at-risk occupations.
   - A Blood pressure monitoring as clinically indicated.
   - A Baseline weight/BMI and monitoring as clinically indicated.
   - A Smoking status and history and cessation support offered, where relevant.
   - A Alcohol and drug usage.
   - A Regular diabetic review as clinically indicated.
Reviewing clinical records when records are received

A suitably qualified clinician in your practice should review all incoming clinical records for identification of key clinical issues as soon as possible upon receipt of the records – within 10 working days is considered to be best practice.

Suitably qualified staff members are those professionals in your practice (like GPs, nurse practitioners and nurses) who provide patient services (including clinical care or judgement) and who have qualifications and registration required by statute to practise, or individuals with experience in the provision of patient care or support and deemed competent to perform this function by a recognised representative body.

Resources

- RNZCGP. Medical Record Review Tool.
- MCNZ: The maintenance and retention of patient records
- NZS 8153:2002 New Standard Health Records

Continuing professional development

- Audits of patient records can be claimed as an AoMP activity if at least 10 records are collected for the individual practitioner. A completed RNZCGP AoMP summary sheet should be kept as evidence.
INDICATOR 22
The practice team identifies and responds to patients with clinically urgent health needs

Criteria | Evidence may include | Level
--- | --- | ---
22.1 Non-clinical team members responsible for first-line interaction with patients are trained to identify and respond appropriately to patients with urgent medical conditions. | - Training record for non-clinical members; and  
- Documented triage process that identifies non-clinical staff members' responsibilities; and  
- Reference material, including triage process posters and algorithms.  
- Training is at level 1 and/or 2.  
- Training occurs annually. | F

22.2 The practice has systems in place to observe the clinical condition of patients. | - Demonstrate a clear view of patients in the waiting room to monitor clinical status of patients. | F

22.3 There is a system to manage patients with urgent medical needs. | - Process on how to manage urgent medical conditions. | F

22.4 All practice team members who may be required to administer CPR must have current certification to an appropriate level from certified trainers. | - Current CPR certificates for applicable practice team members. | F

22.5 Patients with palliative care needs can access their doctor or an informed deputy at all times. | - Policy on access to care.  
- Process for contacting doctor or informed deputy.  
- Information for patient and family/whānau.  
- Handover process to informed deputy. | A

Guidance notes
Every general practice operates in a different way so make sure you design protocols or guidelines to meet the needs of your individual practice.

It is important that front-line team members understand their role in observing waiting patients and how to alert your clinical team members if they are concerned about a patient in the waiting room.
Ways you can observe patients:

- Direct observation
- Two-way windows
- Concave mirrors
- Closed circuit TV (consider Privacy and CCTV issues).

You’ll need to think carefully about asking patients to wait in secondary waiting areas, distant from the main waiting area. How will you detect a change in the condition of waiting patients in this area?

How will you manage patients with urgent medical needs?

It is essential that you have a triage system in place to recognise and respond to an emergency. This will assist your 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 your clinical team.

Levels of timely access to care may be:

1. Emergency – immediate
2. Urgent – 20 minutes
3. Interrupt doctor – as soon as possible
4. Today – same day
5. Within 24 hours.

Training

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

Your training programmes should also include:

- medical emergencies in patients who are phoning the medical centre and
- things to think about when putting callers ‘on hold’.

<table>
<thead>
<tr>
<th>Things to think about for your training and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it at a level appropriate for different team members?</td>
</tr>
<tr>
<td>Do you have reference material available from which to make a decision (eg posters, booklets, algorithms or flowcharts)?</td>
</tr>
<tr>
<td>Is your reference material readily available and accessible?</td>
</tr>
<tr>
<td>Do all relevant staff members know where to find this information?</td>
</tr>
</tbody>
</table>
Things to think about for your training and resources

<table>
<thead>
<tr>
<th>Do you have definitions and responses for potential problems including (but not limited to):</th>
</tr>
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<tbody>
<tr>
<td>■ pain</td>
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<tr>
<td>■ bleeding</td>
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<tr>
<td>■ slurred speech</td>
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<tr>
<td>■ altered level of consciousness</td>
</tr>
<tr>
<td>■ extreme concern</td>
</tr>
<tr>
<td>■ dehydration</td>
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<tr>
<td>■ fever?</td>
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</table>

Non-clinical team members must not diagnose the patient’s medical condition or make a clinical decision.

Is your training non-diagnostic (based on presenting problems and how to arrange timely access to care)?

Is it comprehensive and patient focused to include self-care, first aid and/or ongoing monitoring?

Does your training occur at least once a year?

Whereas it is not possible to cover every possibility that may arise, do try and cover as many possible situations as you can, especially those that may be specific to your practice and location (e.g., opens early, rural, isolated).

CPR training

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

In some locations non-clinical team members may be required to initiate CPR or to assist at a medical emergency. This may happen in the likes of solo and rural practices or where reception staff are working without any clinical team members available onsite (maybe your receptionist opens the medical centre before any clinical staff are in the practice or clinical staff are on meal breaks).

This includes:

- gathering appropriate personnel
- having defined roles and responsibilities and systems to ensure such rules are followed
- ensuring staff have a global overview of the crisis
- having appropriate communication between staff members, and
- ready access to organised and necessary equipment.

Responsibility for the management of any resuscitation lies with all team members.*

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

Your practice should carefully consider the risks associated with staff working alone, particularly around health and safety. The PCBU (person conducting a business or undertaking) has a primary duty of care to ensure there is no risk to the health and safety of staff (and others).

You should therefore have control measures in place to eliminate or minimise risks. This may include, but is not limited to, personal alarms, securing public access, panic buttons.

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

It is increasingly recognised that the management of an acute medical emergency is not simply about making a diagnosis or having appropriate knowledge, but instead relies on a coordinated approach to delivery of care (Crisis Resource Management).

Patients with palliative care needs

Well-coordinated palliative and end-of-life care provides people and their family/whänau with humane and dignified support and services as they face their life-limiting condition. This care is essential. Patients with palliative care needs should be able to access their doctor or an informed deputy at all times.

Your practice should work out how these patients can contact their GP and their designated representative within working hours and out of hours. Make sure this information is provided to the patient and family/whänau. If a deputy is used, this delegated representative must be well informed about the patient’s condition and care.

Resources

- New Zealand Resuscitation Council guidelines and flowcharts
- New Zealand Resuscitation Council training
- St John resuscitation courses
- Sydney Clinical Skills and Simulation Centre: Crisis Resource Management
- PRIME – St John
- Privacy Commissioner: Privacy and CCTV: a guide to the Privacy Act for businesses, agencies and organisations
- Te Ara Whakapiri: principles and guidance for the last days of life
Continuing Professional Development

ACLS training requirements:

- GPs participating in the RNZCGP Maintenance of Professional Standards are required to hold a current resuscitation skills certificate (which is not more than three years old) from an approved resuscitation course provider at New Zealand Resuscitation Council standards Level 5 or higher, appropriate to the situation.

- Practice nurses participating in Professional Development Recognition Programmes (PDRPs) and those who are authorised vaccinators should be certified to a minimum of Level 4.

- Practice CPR training records should show that all team members required to administer CPR are trained to the correct level (NZRC Core 1-7), as well as recording the certified trainer (e.g., NZRC, St John, New Zealand Heart Foundation).
INDICTOR 23

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

<table>
<thead>
<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>23.1 There is a policy describing how laboratory results, imaging reports, investigations and clinical correspondence are managed.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Policy on how to manage and track laboratory results, imaging reports, investigations and clinical correspondence.</td>
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<tr>
<td>- Level</td>
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<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>23.2 All incoming test results or other investigations are sighted and actioned by the practice team member who requested them, or by a designated deputy.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Policy for the management of incoming test results and other investigations.</td>
</tr>
<tr>
<td>- Patient record reviews (see Indicator 21).</td>
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<tr>
<td>- Level</td>
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<th>Criteria</th>
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<tbody>
<tr>
<td>23.3 Patients are provided with information about the practice procedure for notification of test results.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Policy on how to manage and track laboratory results, imaging reports, investigations and clinical correspondence.</td>
</tr>
<tr>
<td>- Patient record reviews (see Indicator 21).</td>
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<tr>
<td>- Level</td>
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<th>Criteria</th>
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<tbody>
<tr>
<td>23.4 The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Policy that describes how the practice identifies and tracks significant investigations and urgent referrals.</td>
</tr>
<tr>
<td>- Patient record reviews (see Indicator 21).</td>
</tr>
<tr>
<td>- Standardised process across the clinical team.</td>
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<tr>
<td>- Level</td>
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<th>Criteria</th>
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<tbody>
<tr>
<td>23.5 A record is kept of communications with patients informing them about test results.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Medical record to demonstrate communication of test results.</td>
</tr>
<tr>
<td>- Patient record reviews (see Indicator 21).</td>
</tr>
<tr>
<td>- Level</td>
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<th>Criteria</th>
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<tbody>
<tr>
<td>23.6 The practice has a clinical governance process to ensure all clinical correspondence has been actioned.</td>
</tr>
<tr>
<td>Evidence may include</td>
</tr>
<tr>
<td>- Documented process for ensuring all clinical correspondence has been actioned.</td>
</tr>
<tr>
<td>- Person(s) who takes responsibility for this process.</td>
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<tr>
<td>- Regular review of inboxes.</td>
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<td>- Level</td>
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</table>

Guidance notes

Managing patient test results in general practice is a complex task. It involves all members of the practice team, relies on the systems in the general practice and the outside provider, and requires the results to be communicated to the patient in a timely, clinically appropriate and meaningful manner.
The highly administrative nature of test result management can feel bureaucratic at times, but it is a critical part of a patient’s diagnostic work-up and the results often have significant implications for the care patients receive.

The complexity involved means that errors can occur, and these have sometimes resulted in patient harm.

**Have clear policies and processes**

Your practice 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 timeframes identified by your practice. For every report or test there must be a person in the practice responsible for management and tracking.

Good practice requires that your practice should keep a record of telephone conversations with patients about test results also, noting the date and who advised the patient.

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

**Guiding principles**

There are a number of steps you can take to minimise the risk of patient harm.

Your practice is encouraged to (from Managing patient test results: minimising error):

1. create a culture where patients and staff can raise concerns about problems with processes and errors, acknowledging that mistakes can happen. Be hard on systems, but easy on people.
2. develop a system to audit and improve the management of patient test results.
3. have a clear, documented policy covering:
   - patient notification
   - the process for tracking and managing tests ordered, including identifying missing results (particularly significant results)
   - staff responsibilities (including results interpretation)
   - actions and follow-up
   all in a clinically appropriate and timely manner.

**When proactive follow-up is necessary:**

Significant results are those where subsequent follow up is essential and the risk to the patient of not following up is high, for example breast biopsy results. A significant result could be either a normal or abnormal result – it depends on the clinical picture.
Practice recommendations

Dr St George, in his piece *The management of clinical investigations* in Cole’s, makes a number of recommendations, including the following:

1. If you request a clinical investigation, you should tell your patient why the clinical investigation is recommended and when and how they will learn the results.

2. All the relevant parties should understand their responsibilities clearly.

3. If you are responsible for informing the patient, you should:
   - inform the patient of the system for learning test and procedure results, and arranging follow up.
   - ensure staff and colleagues are aware of this system.
   - inform patients if your standard practice is not to notify normal results and obtain their consent to not notifying.
   - if other arrangements have not been made, inform the patient when results are received. This is especially important if the results raise a clinical concern and need follow up.

4. Identifying and following up overdue results is an essential, but difficult, office management task. Your PMS should ensure that test results are tracked successfully. Such a system might be a paper file or computer database that identifies:
   - high risk patients
   - critical clinical investigations ordered
   - dates of reports expected
   - date of expected or booked follow-up patient visits.

5. The patient’s clinical record itself might be flagged in some way to aid this tracking process.

6. It can sometimes be difficult to contact a patient by telephone, and sometimes they do not attend planned follow-up appointments:
   - The number and intensity of efforts to reach the patient by telephone should be proportional to the severity and urgency of the medical problem. All attempts to contact the patient should be documented.
   - If the patient fails to attend an appointment, or you have been unable to speak to them directly about test results that raise a clinical concern, then send a letter to the patient advising them of the action they should take.

7. If you order investigations it is your responsibility to review, interpret and act on the results. If you are not available to receive the results, you should alert a locum or deputising clinician in your practice. Further, you should check the results when you are next on duty.

*In addition:*

1. Use the task allocation system in your PMS to automatically add a task in the future to check a result has been received. This may be for all tests, or tests that you have determined to represent a higher risk (for example, cytology, radiology and troponin T).

2. Use a Patient Portal where appropriate to send results to a patient after filing. However, you should always use other systems to notify the patient of any
results requiring action. The consent process you use for the Patient Portal should be explicit about how it will be used with respect to results notification.

3. Ensure that any results requested by a locum are forwarded to a permanent staff member once the locum leaves.

Auditing your practice’s processes

Any medical investigations requested by your practice should have a clear pathway to an outcome (request, results, communicate results, record results, patient informed, action taken, dated, time limit identified).

Auditing these processes allows you to see where any improvements need to be made.

Key areas to focus on:

- Identify missing results, ie 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
- Appoint a clinical team member responsible for monitoring the review and action of all incoming test, results and medical reports (see clinical governance)
- Appoint a designated deputy, for example locum, to process the reports if that requester is not available or is on leave
- Track specialist referrals.

Tracking methods may include:

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

How you communicate results with patients

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

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

Make sure you reinforce your message by having information wherever possible (eg waiting room, consultation room, patient information, practice website etc).

Leaving patients to assume that silence means their test results are OK is not acceptable. See the Health and Disability Commissioner website.
Recording communication with patients about tests:

Communication (including phone calls and emails) 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)

Laboratory tests and diagnostic imaging services

For each referral for a laboratory test or a diagnostic imaging service issued by a health practitioner, whether electronic or hardcopy, it should include the following details (this aligns with the PHO services agreement):

a. The Practitioner Identification Number of the issuing practitioner
b. Health practitioner type (this tells the lab or person you are referring to you have the correct authority)
c. Health practitioner name (helpful if you add the name of the practice as well, especially if the referrer works across several practices, eg locums)
d. Health Practitioner Index number (gives a unique identifier for the practitioner)
e. Date of referral (useful to know because sometimes patients do not present to the labs until a long period of time has lapsed)
f. Patient’s full name and address (to differentiate between people with the same name and date of birth, which happens even in New Zealand) – consider adding preferred name as well
g. Patient NHI number
h. Patient date of birth
i. Patient gender (this impacts some tests performed, eg if the patient is transgender)
j. Name of test or test code
k. The purchaser, if it is not the DHB (as appropriate, eg for job placement screening or entry into study)
l. Health practitioner’s signature (or electronic equivalent).

Other useful tips to consider:

- Adding the patient’s preferred name
- Clinical details – what is the purpose of the test being ordered? This helps the labs to process the testing
- Start each new test on a new line (rather than in string/block text because it helps the lab staff to make sure they have each test)
- Make sure hardcopy referrals are legible and are not too small
- Ensure samples are in the correct containers
- Check referrals match samples.

Vicarious liability

General practices will not ordinarily be held liable for lapses in care or communication by an individual practitioner who they ‘employ’. However, if the lapse was attributable to poor systems or inadequate protocols at the practice, the practice may be held vicariously liable. In practice, general practices should have good, robust systems in place, provide appropriate training, guidance and support, and ensure ongoing audit and review.
Under the Health and Disability Commissioner Act 1994, ‘employing authorities’ will avoid vicarious liability if they can show that they took such steps as were reasonably practicable to prevent the acts or omissions that amount to a breach of the Code of Health and Disability Services Consumers’ Rights.

Clinical governance

Someone in your practice needs to take responsibility to ensure all clinical correspondence has been actioned. Some practices have one staff member (eg senior clinician) who reviews all inboxes and outstanding items. This can also be a regular agenda item at clinical meetings. The key thing here is that any issues are monitored and addressed quickly.

Resources

- Health and Disability Commissioner
- Managing patient test results
- RNZCGP Policy Brief: Managing patient test results
- Medical Protection: Handling test results

Continuing professional development

- Audits of test and investigation result management can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
## INDICATOR 24

**Prescribing is accurate and appropriate**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
</table>
| 24.1 Prescriptions of all medicines including controlled drugs generated within the practice are recorded in the electronic record and comply with all legislative and regulatory requirements. | ■ Electronic record of prescribing.  
■ Patient record reviews (see Indicator 21). | F     |
| 24.2 The practice has a documented policy for repeat prescribing.         | ■ Documented policy for repeat prescribing.  
■ Evidence that staff involved in managing repeat prescriptions are aware of, and implement, the policy. | F     |
| 24.3 Where utilised, standing orders are in place and comply with Ministry of Health guidelines. | ■ Sample practice standing order.  
■ List of standing orders used in the practice.  
■ Standing orders are kept in a place that is easily accessible by the practice nurse.  
■ Current standing order policy (including whether countersigning or auditing occurs).  
■ Evidence of countersigning or auditing.  
■ Sample audit tool.  
■ Evidence of annual review of the standing order by the issuer.  
■ Evidence of auditing of each RN working with the standing order.  
■ Record keeping in clinical notes.  
■ Staff training records. | F     |
| 24.4 Prescriptions of all medicines including controlled drugs (including those generated by the practice team outside the practice) are recorded in the electronic record and comply with all legislative and regulatory requirements. | ■ Electronic record of prescribing, including those generated by the practice team outside the practice (eg rest home).  
■ Patient record reviews (see Indicator 21). | ✅ |
### Criteria

#### 24.5 The practice audits prescribing to ensure that medicines, including controlled drugs, are prescribed in compliance with legislative requirements and practice policy.

- Evidence of current audit findings, reports and improvement plans/activities.
- Data source (eg from PMS/PHO query builds, bpacNZ).
- A documented practice policy that describes how the general practice team is made aware of, and implements, its medicine prescribing processes, including controlled drugs, and key accountabilities and responsibilities.
- Relevant staff can demonstrate an understanding of relevant requirements (eg Medicines Act 1981, the Medicines Regulations 1984, the Misuse of Drugs Act 1975, the Misuse of Drugs Regulations 1977, the Pharmaceutical Schedule and the DHB Pharmacy Procedures Manual).

#### 24.6 The practice audits prescribing appropriateness and patterns in comparison to regional and/or national prescribing.

- Evidence of current audits, findings, reports and improvement plans/activities.
- Data source, eg from PMS/PHO query builds, bpacNZ.
- Evidence of changes made as a result of audits.

#### 24.7 Results of practice audits are shared with the practice team to identify and action improvements in prescribing practice.

- Evidence of current audits, findings, reports and improvement plans/activities.
- Evidence of reporting of results and lessons in staff communications, training and/or meetings.

#### 24.8 The practice identifies opportunities to improve prescribing and patient safety by developing relationships with pharmacists.

- Examples of how the practice works in partnership with pharmacists.
- Evidence of changes made as a result of collaboration with pharmacists.
- Quality improvement plan.

#### 24.9 The practice utilises the New Zealand ePrescription Service.

- All team members involved in prescribing medicines can describe and show examples of prescribing using New Zealand ePrescription Service.
- Electronic record of prescribing.
### Criteria

<table>
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<th>Criteria</th>
<th>Evidence may include</th>
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| 24.10 All long-term prescribed medications are linked with a medical condition. | - Patient record notes link(s) between long-term prescribed medications and medical condition(s).  
- Patient record reviews (see Indicator 21). |
| 24.11 The practice develops a partnership with patients to identify ways to improve safety and adherence to prescribed medications. | - Evidence of patient input into, and informed decisions about, prescribed medications.  
- Patient record notes information shared with patient.  
- Examples of information about medicines.  
- Evidence of patient input into initiatives for improving safety and adherence to prescribed medications. |

### Guidance notes

Appropriate prescribing practice is fundamental to safe and ethical health care. Prescribing in your practice must conform to accepted practice and any relevant best practice guidelines, and be capable of withstanding scrutiny.

### Prescriptions

Prescriptions must be legibly and indelibly printed and personally signed by the prescriber. Therefore those issued by email or other electronic means do not meet New Zealand legislative standards under regulations 40–41 of the Medicines Regulations. See the section New Zealand ePrescription Service (NZePS) for new developments in this area.

Faxed or telephone prescriptions are permitted in cases where the prescriber requires a medicine to be dispensed urgently. In such cases you must forward the original prescription to the pharmacist within seven days; prescriptions for Class A and Class B controlled drugs must be sent to the pharmacy within two business days. See MCNZ: Good prescribing practice.

### Details of a prescription:

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

Each prescription for a pharmaceutical issued whether electronic or hardcopy, in indelible ink, should have (this aligns with the PHO Services Agreement Reference document, effective 1 July 2015, see also Medicines Regulations 1984 (41)):

- The Practitioner Identification Number of the issuing health practitioner  
- Health practitioner type
c. Health practitioner name, physical address and telephone number
d. Health Practitioner Index number
e. Full date prescribed (day, month and year)
f. Patient surname, given name and physical address
g. Patient NHI number
h. Patient date of birth, gender
i. The patient category code (co-payment) if patient is eligible for funded services, and any Special Authority number with current expiry date the patient has been allocated for the prescribed medicine
j. Community Services Card status (yes or no)
k. High Use Health Card status (yes or no)
l. Name of pharmaceutical
m. Dosage, strength and form of the drug
n. Frequency of dosage
o. Quantity
p. The period of supply, dispensing frequency (if any) and any other dispensing conditions/restrictions for at-risk patients.
q. Full instructions for use of the drug, including any special instructions (if applicable)*
r. In certain cases additional information should also be recorded such as the patient’s weight and/or age (for example where the patient is a child and where this information would affect dosage)†
s. Health practitioner’s signature (or electronic equivalent)
t. The funder, if it is not the DHB (eg Veteran Affairs)
u. Endorsement requirements (if required)
v. Recommending specialist and date of recommendation (if required)
w. If the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose; and if the medicine is for application externally, indicate the method and frequency of use.

Patient records

Recording prescribing information electronically provides accurate, readily accessible data for continuity of patient care and an audit trail of activity.

Your prescribers should keep a clear and accurate patient record containing all relevant clinical findings, decisions made, information given to the patient, and the medicines and any other treatment prescribed.

The patient record should include adequate patient medication history, including:

- current medical conditions
- any previous adverse reactions
- concurrent or recent use of medicines (including non-prescription, complementary and alternative medicines.

The Coroner has recommended that all medication alerts available on practice management software should be activated.‡

This electronic record of all prescribed medicines in the patient’s clinical record should include an electronic record of controlled drugs where the original prescription is on a Ministry of Health Controlled Drug Prescription Form (see below and Indicator 13 for requirements for controlled drugs).

Prescriptions for when required medications should ideally have a quantity expressed to avoid large quantities of medications being supplied (usually when variable doses and administration times are written).

* The Coroner has recommended that prescriptions should specify the day of the week medication is to be taken where the medication is to be taken weekly. Findings of Coroner C J Devonport COR REF: CSU-2012-DUN-000286
† MCNZ. Good prescribing practice; 2013.
‡ Findings of Coroner C J Devonport COR REF: CSU-2012-DUN-000286
Pharmaceutical samples, dispensed from the practice, and in-house dispensing should also be 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.

**Repeat prescriptions**

The appropriateness of long-term repeat prescribing and repeat prescribing without a consultation will always be a matter of professional judgement.

You are required to have a documented policy for repeat prescribing that outlines a reliable, safe and consistent approach to repeat prescribing.

- Before signing a repeat prescription, you must have secure procedures in place to ensure that:
  - the patient is issued with the correct prescription
  - each prescription is regularly reviewed so that it is not issued for a medicine that is no longer required
  - the correct dose is prescribed for medicines where the dose varies during the course of the treatment
  - any subsidy conditions that have changed since the last prescription are amended
  - all relevant information has been reviewed before completing the prescription, and that the patient record is maintained and up to date.

- Repeat prescriptions should include details about the period of supply and state if more frequent dispensing is required in the interests of patient safety. Pharmacists are required to use their professional judgement to determine if more frequent dispensing is appropriate, so liaising with the patient’s pharmacist can be helpful.

- Patients receiving repeat prescriptions should be assessed in a face-to-face consultation on a regular basis to ensure that the prescription remains appropriate. Your practice’s repeat prescription policy must include a definition of what constitutes ‘appropriate regular’ face-to-face consultation. This will take into consideration individual patients’ needs and specific medications.

- Patients who need a further examination or assessment should not receive repeat prescriptions without being seen by a doctor or nurse practitioner. This is particularly important in the case of medicines with potentially serious side effects.

**Standing orders**

The Ministry of Health has Standing order guidelines.

The guidelines cover the issuer, people working under standing orders, medicines, content of a standing order, period for which the standing order applies, record keeping, competency including training, countersigning and audit of standing orders, review of standing orders and availability of standing orders.

The Regulations require that the standing order list:

- the medicines that may be supplied or administered under the standing order
- the indications for which the medicines is to be administered and the recommended dose or dose range for those indications

The full details of what a standing order must contain are outlined in the Regulations.
■ the contraindications for the medicines, the validated reference charts for calculation of dose (if required)
■ the method of administration, and
■ the documentation required.

See also the section on standing orders in Guidelines for nurses on the administration of medicines.

Medications supplied to the patient under a standing order should be labelled appropriately. Liaising with the pharmacy providing the medication can ensure that legislative requirements are met.

**Auditing prescribing in the practice**

Appropriate prescribing practice requires that a prescriber’s customary prescribing conforms within reason to patterns established by their peers in similar practice. In order to establish that, your practice needs to have documented processes for monitoring and auditing various prescribing practices. Inappropriate prescribing is unacceptable, both clinically and ethically.

Reflecting on prescribing practice is extremely important. By comparing your prescribing with regional and/or national data, you can gain useful insight into whether it is suitable, and this can help inform and improve safe prescribing practices.

To ensure that prescribing is appropriate and responsible, prescribers should keep themselves informed of policy and legislation relating to the use and disposal of medicines, including the requirements of the Medicines Act 1981, the Medicines Regulations 1984, the Misuse of Drugs Act 1975, the Misuse of Drugs Regulations 1977, the Pharmaceutical Schedule and the DHB Pharmacy Procedures Manual.

**Some potential audit activities:**

■ Non-executable prescriptions that required the pharmacist to contact the prescriber
■ All medicines, including controlled drugs, are prescribed in compliance with legislative requirements and practice policy (Indicator 13, Indicator 24)
■ Prescribing appropriateness and patterns in comparison to regional and/or national prescribing (Indicator 24)
■ Repeat prescribing (Indicator 24)
■ Medicines reconciliation (Indicator 32)
■ Prescribing for long-term conditions (Indicator 24)
■ Long-term prescribed medications are linked with a medical condition (Indicator 24)
■ Polypharmacy – eg bpac™ clinical audit
■ Non-collection of prescriptions
■ Prescribing errors and other incidents (Indicator 24, Indicator 28)
■ Collaborate with community pharmacists to conduct an audit (eg reviewing returned prescriptions from a pharmacy to determine the reason for return and the amendment required to how many prescriptions got returned because they didn’t meet legislative or subsidy requirements, concerning patterns of prescribing, etc).
Share the results of your practice audits with the practice team so you can all identify and action improvements in prescribing practice.

You can get data for audits from different sources, including PMS query builds. Pharmaceutical utilisation reports from Best Practice Advocacy Centre New Zealand (bpac\textsuperscript{nz}) are no longer sent out by post, but you can get one for the practice and/or individual prescriber by logging onto the ‘My bpac’ section of the bpac\textsuperscript{nz} website.

**NZ ePrescription Service (NZePS)**

The NZePS provides a secure messaging channel for prescribing and dispensing systems, to electronically exchange prescription information.

Implementing NZePS is part of an evolving process for the way medicines are prescribed in New Zealand.

NZePS allows GPs to electronically generate and transmit a prescription for medicines to a pharmacy, and for the pharmacy to return a record of the dispensed medicines to the GP.

Closing the feedback loop between prescriber and dispenser through NZePS is a key change, and over time, will enable significant quality improvement in medicines management.

**Benefits of electronic prescribing and NZePS:**

While NZePS is an electronic prescription service (rather than allowing for full electronic prescribing), it is anticipated that NZePS will help to improve medicines safety and patient health outcomes.

Over time, the potential benefits of NZePS include improving the accuracy of prescribing and dispensing through the NZePS ‘closed loop’, and improving the efficiency of generating and processing prescriptions.

In particular:

- The patient’s clinical record is updated soon after dispensing, and shows GPs the medicines dispensed and any differences from the prescribed medicines.
- It reduces the need for pharmacists to make telephone calls to GPs for clarification or confirmation, which reduces the risk of oral miscommunication.
- It is easier for GPs to see feedback provided by pharmacists. Improving the ‘learning loop’ will lead to improved prescription quality and reduce the number of amendments made to prescriptions at the point of dispensing.
- The risk of selecting an incorrect medicine is reduced as medicines databases can be used more easily and consistently and so avoid incorrect interpretations of free-text prescriptions.
- GPs can electronically acknowledge unsigned and referred prescriptions (eg telephone prescriptions), medicine charts used in aged residential care facilities, and changes to prescriptions made by pharmacists.

NZePS also eliminates the need to use special safeguards against forgery by preventing multiple use and unauthorised alteration of a prescription.

For more information see RNZCGP Policy Brief: ePrescriptions in general practice: better medicines management.
Prescribing controlled drugs:

With NZePS, GPs are no longer required to handwrite prescriptions for controlled drugs on the triplicate form. A prescription for the supply of a controlled drug "on a paper form that is electronically generated by the controlled drug prescriber from [NZePS]" may be accepted if it is printed with a barcode on a separate prescription form to that of non-controlled drugs and signed by the prescriber.

The Ministry of Health will give practices the ability to use NZePS for controlled drugs on a practice-by-practice basis.

Alerts to medicines not dispensed:

NZePS has an optional feature that enables GPs to be notified electronically where a prescribed medication has not been dispensed within a specific timeframe. This feature could be a useful tool where a GP has concerns about medication adherence in a patient needing active monitoring and follow-up. The GP might confirm adherence with the patient at their next consultation or request practice staff to follow this up with the patient.

The College's view is that it would not be practicable or reasonable for GPs to follow up all prescriptions using this feature because:*  
- a large number of medicines in general practice are not dispensed – 13% in one study  
- practices should ideally develop a partnership with patients to identify ways to improve safety and adherence to prescribed medications. Patients are partners in deciding on their treatment and share responsibility for the agreed management plan. This includes the responsibility of the patient to get their prescription filled  
- if a pharmacy processes the prescription but it is not done electronically, then the medication status will not be updated and will result in an alert that is false.

If your practice utilises the NZePS, all team members involved in prescribing medicines should be able to describe and show examples of prescribing using this service.


Developing relationships with community pharmacists

Community pharmacists are an integral part of primary health care. Good, cohesive working relationships between your general practice and community pharmacists will help contribute to best outcomes for your patients.

Your practice should provide evidence to show how you collaborate with community pharmacists.

Potential ways of working together with pharmacists include:

- local networks of health services  
- medicines reconciliation  
- sharing health information and advice  
- shared public health initiatives  
- training and education sessions

* However, if a GP wishes to receive status notifications that can be viewed without a follow-up task, then specifying ‘999 days’ in the duration field allows status notifications to be received, but not reminders (where the prescription would have expired within 999 days).
Long-term prescribed medications are linked with a medical condition

The treatment of chronic illnesses commonly includes the long-term use of pharmacotherapy.

Each long-term medication should be linked with a diagnosis. Where there are multiple uses for the medication, it should be linked to the main condition being treated.

Improving safety and adherence to prescribed medications

Failing to adhere to medical treatment programmes, including failing to follow instructions for medication, has significant impacts for patients and the system. For your patients, these impacts may include reduced safety, longevity and quality of life. For the system, these impacts affect hospitalisation and treatment (medication) costs.

Communication is important in improving safety and adherence to prescribed medications

Medicines adherence, lifestyle management and symptom management are better supported through improved communication between all health professionals, in and outside the practice, and with patients.

Your practice should also demonstrate/describe how you partner with patients, their whānau and other providers, to improve safety and adherence to prescribed medications.

Some things to consider when working to improve safety and adherence to prescribed medications:

1. **Improved communication with patients**: Medicines information should be designed, produced and disseminated in ways that are appropriate for individual patients and that help advance their health literacy. Individuals and their family/whānau should be active partners equipped with the necessary knowledge, skills and tools to manage their own medicines and wellbeing.

   - **Make the most of every point of care.** Every contact with a patient is an opportunity for you to share health information, ensure it is understood, communicate about medicine adherence and other issues, and maximise the value of care you provide.

   - **Give information in manageable chunks.** Your practice team members should be careful not to overwhelm the person with too much information. If more information is required at a later stage, you should...
agree with the patient how to do this (eg a follow-up phone call, another appointment, text message, email, a website link, and so on).

- **Provide written information and multimedia applications to support face-to-face communication.** Your practice could provide patient newsletters, take-home information, brochures, posters, information on medicine safety and the importance of adherence to reinforce messages given at each contact point. Where possible this should be offered in the patient’s first language. These help build health literacy levels in your patient population.

- **Seek feedback and input from patients and whānau.** Your patients can help inform policies and pathways to better medicine management processes. Treat patients as active partners in treatment decisions, including which medicines are used and if they can take or use the medication in the form prescribed.

2. **Improved communication with other health care providers:**

- **Utilise electronic support tools.** An IT infrastructure that enables current and accurate information to be shared across providers and settings is a key enabler of integrated health care delivery. For example:
  - NZePS (see above) has an optional feature that enables GPs to be notified electronically where a prescribed medication has not been dispensed within a specific timeframe. **It is not expected that all prescriptions are followed up in this manner.**
  - Shared care platforms that support shared care planning to provide readily accessible and accurate information at all points of patient care.

- **Liaise with other providers to meet the patient’s needs.** Community pharmacists may be able to provide additional adherence support.

3. **Improved communication within your practice:**

- **Develop staff training and resources.** Develop documented policies that support medicine safety and adherence, and medicine adherence strategies in staff training and meetings. Provide time for your staff to share experiences and strategies with helping patients adhere to medicine programmes.

See also **Indicator 32**: The practice reconciles medicines, and **Indicator 34**: The practice offers shared care.

### Resources

- MCNZ: [Good prescribing practice](#)
- New Zealand Nurses Organisation: [Guidelines for nurses on the administration of medicines](#)
- Draft Pharmacy Action Plan 2015–2020
- NZ ePrescription Service (NZePS)
- Ministry of Health: 1 July 2014 changes to prescribing.
- The New Zealand Formulary
- Ministry of Health: [Implementing Medicines New Zealand 2015 to 2030](#)
- bpac.nz: *Piles of pills: prescribing appropriate quantities of medicines*
- Pharmacy procedures manual
- Dilemmas: principles of prescribing for elderly people
- Ministry of Health: [Standing order guidelines](#)
Continuing professional development

- Audits of prescribing and repeat prescribing can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
INDICATOR 25

The practice maintains an effective screening and recall system

Criteria | Evidence may include | Level
---|---|---
25.1 The practice demonstrates the system used to identify patients eligible for screening and recall. | ■ System used to identify patients for screening and recall. | F
■ Patient record reviews (see Indicator 21). |  
25.2 The practice regularly audits screening and recall activities to review its effectiveness in reaching eligible target populations. | ■ Evidence of current audits, findings, reports and improvement plans. | A
■ Activities to improve access for target populations. |

Guidance notes

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

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

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

The National Screening Unit

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

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

See also the National Bowel Screening Programme.
Opportunistic screening

In addition to the national screening programmes overseen by the NSU and Ministry of Health, some of your screening or testing may be opportunistic, such as for cardiovascular disease (CVD), diabetes and cancer.

See Indicator 37: The practice undertakes opportunistic screening.

Informed consent is important

In contrast to routine clinical practice where a patient seeks help from a service, screening is generally initiated by a provider.

This raises a number of ethical requirements for your practice:

- The need for robust evidence that screening is of benefit.
- Potential harms must be minimised.
- The need for informed consent (this issue is particularly important when there is variance between evidence and practice – Criterion 4.5).
- Equity of access and outcomes for all population groups.

Auditing screening and recall activities

At the root of all effective screening and recall activities is good information about your patients.

If you systematically use disease codes in your PMS (eg READ, SNOMED), this will help classify your patients so you can identify those eligible for screening and those requiring recall, and identify any issues for particular groups in your population.

Consider how you can:

- identify patients eligible for screening and recall (eg query builds on the PMS)
- identify gaps and those patients who have missed out
- communicate with eligible patients in a way that suits them (eg texts, telephone, letters, email)
- work with other organisations and agencies to come up with strategies to reach all your target populations (eg outreach services)
- improve uptake by eligible populations
- identify and reduce inequities for people in different groups in your population
- engage with and raise awareness in under-screened populations (eg education sessions, resources)
- help remove barriers for patients (eg by arranging transport, evening and weekend clinics, mobile services, outreach programmes). For an example see How to increase the uptake of cervical screening: a profile of success.

Having good data and using coding also enables you to audit your population to identify outcomes for patients in national screening and recall programmes. For example, have your patients benefited from being linked to programmes such as cervical screening? In addition, specific characteristics identified (eg age, gender or ethnicity) may be a precursor to diagnosis or treatment.
Click here for NSU’s Programme Information requests.

Important Quality principles to keep in mind are outlined by the NSU.

Informed consent and 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 (eg more tests, treatments, surgery)
- a patient may receive false negative or false positive results
- a patient may be harmed as a result of being screened (eg stress, unnecessary surgery).

The MCNZ’s statement on informed consent in screening outlines a special duty of care when enrolling an apparently healthy, asymptomatic person into immunisation or screening programmes.

This includes making them aware of the limitations of screening and the uncertainties, in particular the chance of false positive and false negative results.

Before obtaining consent, the clinician should explain, or give information to the patient, that explains:

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

The patient has the right to waive the right to discuss the details of treatment or investigation, decline to give consent and, after having given consent, change his or her mind and withdraw the consent. Any of these should be carefully documented in the patient record, along with any options discussed, information given to patients, decisions made and reasons for them (MCNZ: Good medical practice).

See also Indicator 4 about declining to give consent.

If a patient declines a particular screening test or investigation, then you should consider how you will flag this in the patient record so that they are not asked inappropriately again.

Addressing health inequities in your practice

The World Health Organization’s definition of equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.
Reducing health inequities is important because health is a fundamental human right and its progressive realization will eliminate inequalities that result from differences in health status (such as disease or disability) in the opportunity to enjoy life and pursue one’s life plans.

There is considerable evidence, both internationally and in New Zealand, of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females. Research indicates that the poorer you are the worse your health. Reducing inequalities is a priority for government. (Ministry of Health: Equity)

The New Zealand Health Strategy 2016 acknowledges the need to address health inequalities as a major priority requiring ongoing commitment across the sector. He Korowai Oranga sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori.

In addition, one of its aims of the Health Quality & Safety Commission’s Triple Aim Framework is improved health and equity for all populations.

There are a number of areas in which these inequities are particularly obvious in the health sector, such as screening and immunisations rates. Practices should undertake audits to identify inequities. For example, to monitor ethnic inequities in immunisation the practice could:

1. compare Māori and non-Māori ethnic groups, or
2. compare Māori and Pacific and non-Māori and non-Pacific groups

Your practice should plan how to address these.

Consider using the following set of questions (from The Health Equity Assessment Tool) to assist you to consider how particular inequalities in health in your practice have come about, and where the effective intervention points are to tackle them.

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

Practices may need to consider different approaches to care to meet the needs of members of their practice population who experience inequalities.

Resources

- National Screening Unit
- National Health Committee: An overview of screening in New Zealand; March 2015
Section 3
Clinical Effectiveness

- National Screening Unit. *Improving quality: a framework for screening programmes in New Zealand*. Auckland, NZ: National Screening Unit; October 2005 (currently being revised).


- Ministry of Health: *New Zealand Health Strategy 2016*
- Unsolicited Electronic Messages Act 2007
- MCNZ: *Information, choice of treatment and informed consent*
- *Equity of health care for Māori: a framework*
- *The Health Equity Assessment Tool: a user’s guide*

Additional resources

**Screening resources:**

- Report of the Parliamentary Review Committee regarding the New Zealand Cervical Screening Programme
- UK National Screening Committee: *Interventions to reduce inequity and inequality in accessing national screening programmes*
- Inequalities in cancer screening programmes

**Continuing professional development**

- Audits of patient screening and recall can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
- Learning activities taken to update knowledge in current screening requirements can be claimed as a CME activity.
INDICATOR 26

The practice maintains an effective immunisation programme

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<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
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| 26.1 The practice identifies and recalls all patients requiring immunisations on the national schedule. | Data showing rates of immunisation.  
Patient record reviews (see Indicator 21).  
Policy/process for recall.  
Documented informed consent. | F |
| 26.2 General practice team members responsible for performing immunisations hold current authorisation. | Documented current authorisation from Medical Officer of Health.  
Standing orders. | F |
| 26.3 The practice regularly reviews immunisation recall activities to identify effectiveness in reaching eligible target populations. | Immunisation audit data, including ethnic-specific results (Māori and non-Māori as a minimum).  
Evidence of current audits, findings, reports and improvement plans/activities. | A |

Guidance notes

Immunisations help minimise the risk of infection among at-risk populations.

Immunisation programmes help to control diseases at population level.

Identifying and recalling patients requiring immunisations

Success of these programmes relies on correct identification and recording to monitor effectiveness and reduce the risk of outbreaks.

Your practice should have an audit process that monitors monthly immunisation rates and identifies those overdue for immunisation. You will need to consider how you will follow these patients up.

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

Immunisation standards and authorisation for vaccinators

Vaccination should be undertaken in compliance with the Ministry of Health’s current regulations and standards for authorisation of vaccinators.
Your practice should ensure that all your vaccinators meet the quality levels required to ensure they can competently deliver safe and effective immunisation services. Your vaccinators must be competent in all aspects of the immunisation technique, understand Cold Chain requirements, and have the appropriate knowledge and skills for the task.

Your general practice team members responsible for performing immunisations must hold current authorisation and evidence of this should be available.

**Requirements of all vaccinators (from the Immunisation handbook):**

1. The vaccinator is competent in all aspects of the immunisation technique and has the appropriate knowledge and skills for the task.
2. The vaccinator obtains **Informed consent** to immunise.
3. The vaccinator provides safe immunisation.
4. The vaccinator documents information on the vaccine(s) administered, and maintains patient confidentiality.
5. The vaccinator administers all vaccine doses for which the patient is due at each visit and only follows true contraindications (unless the individual/parent/guardian does not consent to this).
6. The vaccinator reports adverse events following immunisation promptly, accurately and completely.

The *Immunisation Handbook* outlines the characteristics required of the vaccinator for each of these points. Note: the term ‘vaccinator’ used throughout these standards applies to both registered nurse vaccinators and pharmacist vaccinators.

**Reviewing immunisation recall activities**

Your practice should regularly review and document immunisation recall activities to identify how effective you are in reaching eligible target populations. It is recommended you conduct the review at least annually to identify gaps in service delivery and to come up with strategies to improve outcomes.

**Achieving high population coverage**

The *Immunisation Handbook* contains guidance for organisations offering immunisation on **how to achieve high immunisation coverage** of its population. This includes:

- The organisation has an effective, secure, NHI-based system for recording and reporting immunisations and identifying individuals requiring immunisation.
- Respecting the individual’s/parent’s/guardian’s rights to make an informed choice, the organisation takes all steps to ensure that an individual’s immunisation schedule commences on time and that subsequent events are administered on the due date.
- The organisation has electronic linkage to the National Immunisation Register (NIR) for registration and immunisation event notification, and uses the NIR to assist with follow-up. If electronic linking is not available, manual processes must be used.
- The organisation has a robust reminder (pre-call) system that encourages the delivery of on-time immunisation and timely follow-up for overdue immunisation.
The organisation has an effective communication strategy to target high-needs population groups.

Attendance at the practice/organisation is used as an opportunity to remind individuals/parents/guardians of the importance of immunisation, and, if appropriate, to check and offer to bring up to date the individual’s immunisation status.

Those who do not respond to recall and who have not declined to take part are appropriately and routinely referred to the outreach immunisation service, as per local protocol.

The **Handbook** also outlines the necessity for your immunisation service to be readily available, with no barriers to access. These measures will also help your practice to achieve high coverage of your population.

### Equity issues for immunisation

While New Zealand immunisation coverage has improved steadily over the years, there is persistent inequity between ethnic groups, with rates lower in Māori and Pacific people.

Your practice should undertake audits to identify inequities in immunisation coverage and evaluate the effectiveness of approaches to address identified issues.

See Indicator 25: **Addressing health inequities in your practice.**

### Resources

- Immunisation handbook 2014
- National Immunisation Register
- Immunisation Advisory Centre: [Information for health professionals](#)
- Well women and family trust
- Immunisation Advisory Centre: [Successful strategies towards BEST Practice for vaccination 2014](#)
- Ministry of Health: [National Immunisation Programme Cold Chain management](#)

### Continuing professional development

- Audits of identification and recall of patients requiring immunisation can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
INDICATOR 27
The practice has processes to ensure continuity and transfer of care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
</table>
| 27.1     | The practice can demonstrate continuity of care management for patients within the practice. | Practice policies and processes that support continuity of care, which may include:  
– team meeting minutes.  
– patient records.  
– patients have a nominated and named practitioner or mini-team of practitioners that they are assigned to. | F |
|          |                      | Patient record reviews (see Indicator 21). | |
| 27.2     | The practice can provide evidence of effective electronic linkages between the practice and secondary care interfaces. | Evidence of referrals and discharge summaries and follow-up. | F |
|          |                      | Evidence of referral letters showing continuity of care focus. | |
|          |                      | Evidence of electronic referrals (if available). | |
|          |                      | Patient record reviews (see Indicator 21). | |
| 27.3     | The practice can demonstrate its processes for safe and effective transfer of clinical responsibility when transferring patients to providers and services outside the practice. | Transfer of care templates for email, letters, etc. | A |
|          |                      | Evidence of transfer of clinical responsibility when transferring patients. | |
| 27.4     | The practice utilises a summary patient record to facilitate continuity of care between health providers. | Examples of summary patient record. | A |

Guidance notes

Continuity of care management for patients within the practice

It is important to work collaboratively with colleagues to improve care, or maintain good care for patients, and to ensure continuity of care wherever possible.

Patients and colleagues need to understand the responsibilities in the team and who is responsible for each aspect of patient care. The practitioner who is the patient’s principal health provider is responsible for maintaining this continuity of care (see MCNZ: Good medical practice).
Effective linkages between your practice and secondary care

Effective treatment of a patient’s illness often involves a coordinated effort between clinical staff in the primary and secondary/tertiary health care sectors.

Your practice has a shared responsibility for providing seamless care for a smooth transition between these primary and secondary or community interfaces.

Your practice team must also provide comprehensive care that recognises and acts on the full range of health-related needs in the patient population, and refer your patients on if specific services are not provided by your practice.

Effective communication is essential

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.

Your practice is required to provide evidence of effective electronic linkages between your practice and secondary care. More ways of linking will develop over time both regionally and nationally.

Examples include:

- eReferrals
- eDischarges
- electronic shared care records (eg HealthOne)
- radiology information and picture archiving systems (eg Radiology Information System (RIS), Picture Archiving Communications System (PACS))
- maternity clinical information system
- eMedicines reconciliation (eMR).

Transferring patients

Transfer of care involves transferring some or all of the responsibility for your patient’s ongoing care.

When your practitioners transfer care of a patient to another practitioner, they must ensure that the patient remains under the care of one of your practitioners at all times. The colleague should be provided with appropriate information about the patient and their care, and the chain of responsibility must be clear throughout the transfer. Where the transfer is for acute care, this information should be provided in a face-to-face or telephone discussion with the admitting doctor where possible.

All transfers must be appropriately documented. The patient should be aware of who is responsible for their care throughout the transfer, and how information about them is being shared (MCNZ: Good medical practice).
Referring patients

Referring involves transferring some or all of the responsibility for some aspects of your patient’s care.

Referring the patient is usually temporary and for a particular purpose, such as additional investigation, or treatment that is outside the clinician’s scope of practice. When a practitioner refers a patient, they should provide all relevant information about the patient’s history and present condition.

All referrals must be appropriately documented (MCNZ: Good medical practice).

When a clinician orders a test and expects that the result may mean urgent care is needed, the referral must include one of the following:

- The referring practitioner’s out-of-hours contact details.
- The contact details of another health practitioner who will be providing after-hours cover in their absence.

You should have a process for identifying and following up on overdue results.

It is recommended that you have a standardised communication process for the transfer of care to providers and services outside your practice. This might include (but is not limited to) templates for correspondence and checklists.

‘Referring a patient to a colleague’ checklist

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

‘Referring patient care back to a colleague’ checklist

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

See also Indicator 23: The practice has an effective system for the management of clinical correspondence, test results, urgent referrals and other investigations.
Summary patient record

Your practice should use a summary patient record to facilitate continuity of care between health providers.

The summary patient record is a copy of key information from the patient’s clinical record. It is not a full clinical record.

Some regions in New Zealand have electronic shared care records so that authorised medical services involved in a patient’s care can access up-to-date health information from your practice. The shared care record is available at any time, even if your medical centre is closed (for example, available to after-hours providers) or in the event of an emergency.

What appears in a summary patient record will differ between providers, but in general may include:

- Medical condition(s)
- Recent or long-term illnesses
- Surgeries
- Medications
- Allergies
- Radiology results
- Immunisations
- Recalls
- Laboratory and test results
- Discharge summaries
- Information about home care visits.

Resources

- MPS Transfer of health information between healthcare professionals
- MCNZ: Good medical practice
- RNZCGP Policy Brief: Managing patient test results

Continuing professional development

- Audits of referral letters can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
## INDICATOR 28

There is an effective incident management system

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
</table>
| **28.1** The practice has an incident management policy. | - An incident management policy. The policy outlines:  
  - the process for reporting, review and management of incidents;  
  - category of incidents; and  
  - a severity assessment code (SAC) risk matrix. | F |
| **28.2** The incident reporting register records incidents and near misses. | - A current incident recording register. The register shows:  
  - sequential records that include category of incident and severity assessment code;  
  - review, actions and outcomes, including closed date or ongoing monitoring.  
  - Electronic register.  
  - Reports to WorkSafe NZ if using the system to incorporate health and safety accidents/near misses. | F |
| **28.3** Adverse reactions to medicines and immunisations are recorded in the PMS and reported to the Centre for Adverse Reactions Monitoring (CARM). | - Evidence within the PMS if a report to CARM has occurred.  
  - Discussion with clinician(s) demonstrates that the team is aware of the reporting process. | F |
| **28.4** Incidents and their review are used for learning and quality improvement. | - Team meeting agenda includes incident reporting and learning as an agenda item.  
  - Evidence in team meeting minutes where incidents have been discussed and lessons are documented.  
  - Evidence of a mechanism for checking the implementation and impact of recommendations. | A |
| **28.5** The practice team works with its primary health organisation/network to share learnings from the review of incidents. | - Shared learning reports to and from the PHO and practices.  
  - Discussion about shared learning with colleagues (eg at peer review sessions and regional meeting). | ☑ |
### Guidance notes

#### Incident management

The purpose of incident reporting and management is to identify, analyse and correct hazards or incidents, including near misses, to prevent them happening again and to improve patient safety.

The term ‘incident management’ covers a range of other terminology that may be used in general practice, including sentinel events, significant events, adverse events, incidents, events or reportable events.

A clearly defined system for reporting and managing all levels of incidents is important.

The system for managing incidents should include continuous quality improvement (CQI) mechanisms to ensure:

- all reports are acted upon appropriately and within set timeframes
- feedback to team members happens
- the appropriate levels within the practice/organisation/sector are involved to support quality and safety of service provision.

#### What is an incident?

Often in our health system an incident is defined as any event that could have or did cause harm to a consumer (eg see HQSC); however, other incidents occur in general practice, such as staff accidents and injuries, fire or other damage to the facilities, loss or disruption to service delivery.

An incident is deemed to be any event that:

- could have or did cause harm to a health consumer, employee or visitor
- could have or did cause damage to property, and/or
- could have or did cause loss of process.

Near-miss events are often an early warning system that helps identify potential gaps in systems and processes before an event occurs.

#### Recording of incidents

You can use your practice’s incident management process for all forms of incidents/accidents/near misses, including health and safety accidents/near misses.

#### Incident reporting

Incident reporting and follow-up is an essential quality improvement activity that enables the use of actual or near-miss event learning to support the implementation of safe practice, to reduce risk and improve systems and processes within your practice.
Incident reporting, follow-up and management are all part of the process to reduce risk and promote best practice processes.

**Incident management process**

There are several components in incident management that help support and guide the process:

- Using a system to categorise events enables you to identify trends and patterns which then support CQI activities for system and process improvement.
- Using a risk level measurement (also referred to as the Severity Assessment Code (SAC)) will assist your practice in determining the level of risk of an incident and to assist in determining the level of investigation required. See HQSC Severity Assessment Code tables.
- Using a register or log (preferably electronic) enables you to monitor trends and processes in your practice that may need adjustment or change to reduce potential risk.

**Benefits of a good incident management system include:**

- greater support for individual general practices or business units to meet legislative, industry or best practice requirements for recording, investigating and reporting incidents as necessary.
- increased levels of understanding about key areas of risk that can be addressed to minimise harm/loss.
- shared lessons leading to greater patient safety (and safety of staff too).
- enhanced reputation and transparency of continuous improvement across the health sector.
- increased accountability to governance mechanisms through more comprehensive standardised reporting.
- mitigating risk of liability.

**Reporting of adverse drug reactions (ADR)**

Reporting adverse drug reactions (ADR) is a clinical responsibility that enables centralised national monitoring of medication reactions by the New Zealand Pharmacovigilance Centre. This includes several monitoring agencies such as CARM (Centre for Adverse Reactions Monitoring), MERP (Medication Error Reporting Programme), Psychoactive Substances, Recreational Substances and Legal Highs.

Reporting to these agencies can be done via several methods – online and hardcopy. See How to Report.

**Resources**

- The Centre for Adverse Reactions Monitoring (CARM) – accessed through the NZ Pharmacovigilance Centre’s website.
- HQSC: Adverse Events.
Continuing professional development

- Contribution to the development of practice policies and processes for incident management can be claimed as a CME practice improvement activity.
- Audits of incident management can be claimed as an AoMP activity. A completed RNZCGP AoMP summary sheet should be kept as evidence.
## GUIDANCE NOTES

Continuous quality improvement (CQI) for your practice must be planned, organised and managed to be effective. It should be supported by regular evaluation to determine the effectiveness of any improvements implemented.

Your practice plans should provide clear direction about what is happening across all areas of the practice, such as finance, professional development or information technology. You should identify what you are doing, what you want to achieve, how you will achieve it and how changes will be evaluated to determine whether there was an improvement.

Ideally you will give your practice team members opportunities to provide input into service planning. Engaging with your team members enables them to ensure their views and experiences can influence your practice’s goals and improvement activities. This can be through specific service planning meetings or as a permanent agenda item for regular meetings.
Quality planning and clinical goals

Your general practice team should have clinical goals for the year. Quality planning helps you to identify and develop a planned and systematic approach to improving clinical outcomes.

Your team should identify what areas require focused attention, how your practice will address the issues and how you will measure progress.

The use of the PDSA cycle allows you 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.

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

**Goals should be SMART:**

- Simple
- Measurable
- Achievable
- Realistic
- Timely.

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

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

Strategic planning

If you are a CORNERSTONE® practice, you will need a strategic plan that outlines service and clinical goals.

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

Consider these five steps in the strategic planning process:

1. Perform an assessment
2. Identify a strategy
3. Plan the strategy
4. Implement the strategy
5. Monitor the results.
Strategic plans should include:

- a mission statement that best describes the purpose of your practice
- a vision statement which identifies the overall goals for the future
- 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 (i.e. SWOT analysis) including internal conditions, environmental, market and financial factors
- quality goals and objectives
- regular review dates
- risk management, including clinical and non-clinical, financial, reputation, and personnel risks.

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

**Leadership responsible for practice improvements**

Your practice needs to identify someone (or a team of people) who can take responsibility for practice improvements in the safety and quality of clinical care.

Practice team members can also 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.

**Improvement activities and audits**

Quality improvement in general practice is concerned with the assessment of the quality of all aspects of health care, the efforts to improve the provision of care and the actions to ensure that good quality is maintained.

Undertaking a quality improvement process reflects the desire and commitment of the team to find out, “Are we doing what we should be doing?” and “How can we do better?” In defining where you want to go, it is important that a process is planned and asks the right questions in order to find the answer.

Your practice is required to undertake quality improvement activities related to the management of targeted priority areas of clinical care.

Every year you will identify one or more areas of clinical care in order to determine how well it is meeting the needs of your practice population. Measuring, analysing and monitoring clinical care should enable your team to identify if they are meeting the health needs of your patients and help to improve clinical outcomes.

For CORNERSTONE® accreditation your practice must undertake:

- one clinical quality improvement activity per year, and
- one quality improvement activity of the practice’s choice per year – this can be a non-clinical activity.
This can be carried out in a number of ways, including:

- focus groups using the annual quality plan and clinical goals to identify gaps, or
- choosing a topic relevant to the patient population.

See RNZCGP: Continuous Quality Improvement Activities from a quality perspective for more information on how to plan your projects.

**Suggested quality improvement topics:**

There are a number of functions of a practice and clinical care that can be used to undertake quality improvement activities.

Some of these include, but are not limited to:

1. **Structure (management quality):** The buildings, personnel, equipment and protocols that facilitate the process of care.
   
   Examples:
   
   - Does our practice layout enhance patient privacy in the reception and waiting rooms?
   - Are patient records and documents filed safely and securely?
   - Are the contents of the doctor’s/emergency bag current and complete?

2. **Process (professional quality):** Concerned with the technical aspects of clinical care, activities of a health system or practitioner in the provision of care.
   
   Examples:
   
   - Do the records in our practice contain enough information to identify the patient and to document the assessment, management, progress and outcomes sufficiently for another clinician to carry on management?
   - Are we familiar with the management principles for the treatment of tuberculosis?
   - Does our clinical management of patients with diabetes include appropriate observations that are recorded annually?

3. **Outcome (patient quality):** A change in a patient’s current or future health status (including physical, psychological, social health and behavioural) that can be attributed to previous care.
   
   Examples:
   
   - Can you develop new strategies for delivering care to patients (eg developing better communication skills), improving your knowledge of health conditions?
   - How good are our communication skills?
   - How do patients perceive the service provided in our practice?
Resources

- Medical office – 5 steps to a strategic plan
- SWOT analysis tools
- Mind tools – goal setting
- RNZCGP: Developing Continuous Quality Improvement activities from a quality perspective
- Safety in practice

Continuing professional development

- Involvement in clinical planning can be claimed on an hourly basis as a CME practice improvement activity.
- Quality improvement activities with a clinical focus can be used by individual doctors as the basis for AoMP activities. Self-designed AoMPs should be submitted to the College for pre-approval.
SECTION 4

Professional development

The purpose of this section is to ensure that all general practice team members demonstrate their ongoing competence to perform their duties and ensure that the general practice team is engaged in a continuing professional development programme.
INDICATOR 30

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.1 All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003.</td>
<td>■ Annual practising certificates. ■ Record of expiry dates (optional).</td>
<td>F</td>
</tr>
<tr>
<td>30.2 Medical staff employed long term in the practice are vocationally registered in general practice or working towards this.</td>
<td>■ Evidence of vocational registration (or working towards this).</td>
<td>A</td>
</tr>
</tbody>
</table>

Guidance notes

To meet the requirements of the Health Practitioners Competence Assurance Act 2003 (HPCA Act), all practice team members must demonstrate their competence and fitness to perform their duties. The main purpose of the HPCA Act is to protect the health and safety of the public.

It is an offence for a health professional to practise without a current practising certificate. Each health professional is responsible for maintaining competence to practise in accordance with the Health Practitioners Competence Assurance Act 2003.

For risk management it is recommended your practice maintains a record of certification, including expiry dates.

Vocational registration in general practice

The MCNZ requires that doctors employed long term in your practice are vocationally registered in general practice or working towards this. The College provides a range of options for doctors to gain vocational registration in addition to the main education pathway. See Why become a GP.

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 GP who is trained and vocationally registered.

The health professionals in your practice are responsible for maintaining competence to practise through continuing professional development (CPD) in accordance with the Health Practitioners Competence Assurance Act 2003.

See Criterion 31.4: All the general practice team participate in continuing professional development.
Resources

- Health Practitioners Competence Assurance Act 2003
- MCNZ: Doctors already practising in New Zealand
- Nursing Council of New Zealand
- New Zealand Nurses Organisation
- New Zealand College of Primary Health Care Nurses
- New Zealand Medical Association
INDICATOR 31

The practice has appropriate employment structures in place

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.1 All the general practice team members have current signed employment agreements and current position descriptions.</td>
<td>Current signed employment agreements and current position descriptions for all the general practice team.</td>
<td>F</td>
</tr>
<tr>
<td>31.2 All new general practice team members (including locums) are orientated to the practice when they commence employment.</td>
<td>Documented orientation programmes.</td>
<td>F</td>
</tr>
<tr>
<td>31.3 Each member of the clinical team is insured to cover liability.</td>
<td>Proof of liability insurance.</td>
<td>F</td>
</tr>
<tr>
<td>31.4 All the general practice team participate in continuing professional development.</td>
<td>Current CPD records for all practice team members.</td>
<td>F</td>
</tr>
<tr>
<td>31.5 The practice completes children’s worker safety checks in accordance with the Vulnerable Children Act 2014.</td>
<td>A child protection policy; and Practice process for safety checking of employees and contractors.</td>
<td>F</td>
</tr>
<tr>
<td>31.6 Practice team members and others who have access to identifiable patient information have signed a confidentiality agreement.</td>
<td>Signed confidentiality agreements.</td>
<td>A</td>
</tr>
<tr>
<td>31.7 Performance appraisals are conducted annually and used to guide continuing education for all practice team members.</td>
<td>Performance reviews for all practice team members.</td>
<td>A</td>
</tr>
</tbody>
</table>

Guidance notes

Employment matters are an important consideration for your practice. When you have good structures in place, with clear roles and responsibilities, this enables your team members to know where they fit in the team and to operate effectively.

Employment agreements and position descriptions

Good employment relationships begin with a good recruitment process that ensures everyone has clear expectations about the role, working conditions and
employment rights. A clearly written employment agreement can help reduce the risk of misunderstandings. You should also have something well documented for any staff engaged as contractors.

Every employee in your practice must have a written employment agreement and a current position description.

This can be either an individual agreement or a collective agreement (see below).

The employment agreement must be signed by both the employee and the employer.

Employers are required to retain a signed copy of the employment agreement or the current signed terms and conditions of employment. You must retain the ‘intended agreement’ even if the employee has not signed it. Employees are entitled to a copy on request.

**Collective agreements**

Some of your staff may need to have a collective agreement.

When there is a collective agreement negotiated by the employee’s union covering their work (eg Primary Health Care MECA), the employee’s minimum terms and conditions of employment must be those set out in the collective agreement. The employer and the employee may agree to (and must document) other terms that are additional to, or better than, the collective agreement, so long as those other terms can comfortably sit alongside those in the collective agreement.

When the employee is not a union member but there is a collective agreement covering their work, the employer and the employee can have an individual employment agreement based on the collective agreement. The employer and the employee may agree to other terms that are additional to, or better than, the collective agreement. However, the terms must comfortably sit alongside those in the collective agreement.

If the employee decides to join the union, they immediately join the collective agreement. If they don’t join the union, they stay on an individual agreement.

Employers must not unduly influence employees to join or not join a union.

**Mandatory clauses in individual employment agreement**

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 (Employment New Zealand):

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

The employment agreement builder in the Employment New Zealand website can help you put together draft employment agreements for your employees. This tool contains clauses that must be included in an agreement, as well as clauses that are voluntary.

Make sure your employment agreements include duties as set out in the position description.

**NOTE:** The private nature of individual employment agreements and performance reviews will be respected when your practice is assessed.

### Position descriptions

Developing a job description that clearly states the practice’s needs and expectations can assist both in recruiting and performance managing employees.

Job descriptions for your staff should:

- identify the business and its priorities
- be written at a level appropriate for the position your practice is filling
- clearly identify the core tasks and responsibilities
- describe the lines of responsibilities of the job – both to whom the person is responsible and (if appropriate) who reports to them
- describe any minimum legal or educational requirements
- describe ideal personal skills and attributes
- set out performance measures for the job.

Have a look at Employment New Zealand’s Checklist – job description. This covers items that employers would normally include, but there may be additional issues relevant to your practice (eg flexible working hours).

### Practice owners and partners

The people who own the practice should have partnership agreements in place in group practices to clarify roles and responsibilities.

Having a formal agreement for the ownership of your practice, including clear strategies for the entry and exit of partners or owners, is important. See Indicator 39 for more information.

### Induction and orientation programme

Your practice is required to have a documented workplace induction programme to orientate new employees and independent contractors, including locums, to your practice.

Good induction processes and ongoing training are critical to help your employees understand the job and perform well. Both set the tone and expectations for the relationship. A comprehensive and well planned orientation process brings your new employee or locum ‘up to speed’ quicker and creates a positive impression.

**Indicator 39**  
The practice identifies persons with practice management responsibilities

**Indicator 38**  
There is a culture of safety and teamwork in the practice
Orientation may happen over several weeks although some practices commence the process by sending the new person an orientation package before they commence work.

The benefits of providing a good induction programme are:

- to reinforce the positive first impressions employees have of your organisation
- making new employees feel welcome
- making sure they have all the resources and information they need.

Remember first impressions last, so make the first days on the job a positive experience.

The programme should take 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.

**Induction and orientation resources**

You should provide a resource with information about the practice to new team members and locums. See **Indicator 38**: There is a culture of safety and teamwork in the practice.

**Health and safety**

Health and safety matters should be included in your induction and orientation processes and resources. Use the **Health and safety things to think about** to help guide you.

This links to **Indicator 19**: The practice team is committed to ensuring health and safety in the workplace.

There are different ways of approaching an induction programme and what you include will depend on your practice, the number and mix of staff you have, and where you are located.

**Things to consider in your induction programme and resources:**

<table>
<thead>
<tr>
<th>An overview of the organisation, structure and culture</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>A list of key staff within the organisation</td>
<td>☐</td>
</tr>
<tr>
<td>If you have a large number of staff, consider having a buddy system to show a new person around and answer any questions</td>
<td>☐</td>
</tr>
<tr>
<td>Who to contact in case of absence or emergency (give them a copy of the contact details to keep at home)</td>
<td>☐</td>
</tr>
<tr>
<td>Paperwork to complete (eg staff details form, tax code declaration)</td>
<td>☐</td>
</tr>
<tr>
<td>Staff welfare facilities (eg toilets, changing rooms, first aid facilities, meal rooms)</td>
<td>☐</td>
</tr>
<tr>
<td>The practice policies and where to find them</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Details of their role and responsibilities within your practice</td>
<td></td>
</tr>
<tr>
<td>Start times, finish times and the duration of breaks</td>
<td></td>
</tr>
<tr>
<td>All aspects of the employment relationship, levels of quality, performance, expected behaviour and conduct in the workplace, contractual obligations, benefits schemes (if you have them), and so forth</td>
<td></td>
</tr>
<tr>
<td>Legislative and professional requirements (eg APC, safety checks for the Vulnerable Children Act 2014)</td>
<td></td>
</tr>
<tr>
<td>Health and safety issues including:</td>
<td></td>
</tr>
<tr>
<td>☐ their responsibilities for health and safety</td>
<td></td>
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<tr>
<td>☐ information about hazards, risks and control measures</td>
<td></td>
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<tr>
<td>☐ any safety or other equipment, eg personal protective equipment (PPE), and how to use it</td>
<td></td>
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<tr>
<td>☐ certification and training for specific pieces of equipment (eg steriliser)</td>
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<td>☐ fire and emergency procedures and equipment</td>
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<tr>
<td>☐ how to report incidents and accidents</td>
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<tr>
<td>☐ how they can participate in health and safety matters on an ongoing basis</td>
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<tr>
<td>☐ workstation set up</td>
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<tr>
<td>Financial allocations and arrangements if applicable</td>
<td></td>
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<tr>
<td>Environment/location information</td>
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</table>

**Record keeping**

You must set up a personal file and **keep accurate records** for your employees including a holiday and leave record and wage and time record. You might like to add copies of qualifications and certificates, a copy of their annual practising certificate (APC), CPR training, and training records.

Good record keeping makes sure that an employee’s pay and leave are correct, prevents misunderstandings and protects the employer and the employee if there is a dispute. Your employees have the right to know everything you are recording on their file and have the right to see these records.

You can keep records on paper or electronically (as long as the information can be accessed easily and converted into written form). You’ll need to keep wages and time records and holiday and leave records for six years (even if the employee has left).

**Liability insurance**

Your practice should 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 your practice. For example, complementary medicine including reflexology, massage, acupuncture, and homeopathy (you may provide others). You can link to the following for information on complementary and alternative medicine.

**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 practices seek legal advice about indemnity as the legal status of the practice may affect the apportionment of liability and, consequently, the contribution the insurance company may make towards a financial settlement.

**Continuing professional development**

It is the health professional’s responsibility to maintain competence to practise through CPD in accordance with the Health Practitioners Competence Assurance Act 2003.

All health professionals in your practice must be engaged in continuing professional development.

**Scope of requirements under the Vulnerable Children Act 2014**

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

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

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

‘Children’s workers’ are people providing a regulated service, and whose work may or does involve regular or overnight contact with children, and this takes place without a parent or guardian of the child being present. A ‘core worker’ is

Indicator 30
The practice team complies with the Health Practitioners Competence Assurance Act 2003
a children’s worker whose work requires or allows them to be the only children’s worker present, or who has the primary responsibility for, or authority over, children (section 23 of the VCA).

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

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

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

**The required checks**
The safety checks required for new children’s workers include:

1. **Identity confirmation**
   a. Through an electronic identity credential (eg the RealMe identity verification service), and a search of personnel records to establish the uniqueness of the claimed identity.
   b. Following the regulatory process to establish:
      (i) the identity exists by checking an original primary identity document (as listed in Part 1 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children’s Workers) Regulations 2015);
      (ii) the identity is a living identity and is used in the community by verifying an original secondary identity document (as listed in Part 2 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children’s Workers) Regulations 2015);
      (iii) the identity is linked to the presenter;
      (iv) the uniqueness of the identity by searching personnel records.

2. **An interview**, which should be face-to-face, but may be via telephone or other communications technology. The Children’s Action Plan Directorate suggests considering whether to conduct two interviews (to enable follow-up and clarification) and whether to have a small panel of interviewers. Interviewers should be chosen for their experience, knowledge and skill, with at least one having broad child protection knowledge. In addition to role-related questions, the interview should explore the children worker’s view on safe practice.
   The Directorate suggests that questioning elicit information such as:
   a. whether complaints have been made about the worker’s professional practice
   b. whether they have been convicted of an offence, and reasons for leaving previous employment
   c. how they have dealt with a situation (or what they would do if such a situation arose) where a child or young person disclosed abuse;
d. what they think constitutes professional practice when working with children;
e. other relationships they have with children outside the working environment;
f. the kind of relationships they hope to develop with children and families in the new role.

3. **Work history:** consider the previous five years.

4. **At least one referee:** consider the information from three referees where possible, which includes information on how the potential children’s worker relates to children. Referees must not be related or be part of the individual’s extended family.

5. **Seek information:** from any relevant professional organisation, licensing authority or registration authority, and confirmation that the person is a member of the organisation or registered by the authority.

6. **New Zealand Police vet**. To use the Police Vetting Service, agencies or individuals need to meet the required criteria and obtain approval from the New Zealand Police.

7. **Assessment of the risk** the potential children’s worker would pose to the safety of children if employed or engaged by evaluating the above information.

**Risk assessment**

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

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

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

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

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

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

**Relying on previous checks or checks done by others**

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

However, the Children’s Action Plan Directorate states that:

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

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

**Safety checking contractors and the self-employed**

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

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

**Confidentiality agreements**

Practice team members in your practice 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, you may want to make it a requirement for independent contractors such as cleaners and IT, business management or advisory services to sign confidentiality agreements.

**Performance objectives and appraisals**

You’ll need to think about how you will set objectives for your employees and conduct their performance appraisals.
You should, in consultation with the employee, set the employee’s objectives at least on an annual basis. You can take these objectives into account when assessing the employee’s performance.

A formal review at agreed times during the year ensures your employees have clear targets to aim for and can perform to agreed standards, both in terms of what is expected and how the results are achieved. The degree of formality of the review will vary depending on your practice.

You should conduct a performance review of your employees on at least an annual basis. This is in addition to regular coaching and performance discussions. You can use the annual review for any salary reviews and to deal with poor performance. Don’t forget to celebrate successes too.

All members of the practice team including practice partners should participate in performance reviews and continuing education.

You can use information from the performance reviews to help guide continued education for all your practice team members. This may be in a response to poor performance, new performance objectives or personal ambition.

Resources

Employment resources:

- Employment Relations Act 2000
- Employment New Zealand, including employment relations information on topics like:
  - Employment relationships
  - Employment agreement builder
  - Induction
  - Performance reviews
- Your employee’s first day or week
- HRINZ: Induction and HRINZ: Induction guide checklist
- Induction/orientation program for new GPs and staff
- Induction for GP locums—how to get it right
- Business.govt.nz: Performance appraisals
- NZMA: Primary Health Care MECA Frequently Asked Questions
- Healthy Practice (MAS)

Continuing professional development resources:

- RNZCGP: Continuing professional development
- Nurses – CPD programme

Vulnerable Children Act resources:

- Vulnerable Children Act 2014
- Vulnerable Children (Requirements for Safety Checks of Children’s Workers) Regulations 2015
- Safety checking (Children’s Action Plan website)
■ Children’s worker safety checking under the Vulnerable Children Act 2014 – this includes advice on interpreting and applying the VCA and regulations, sample interview questions, and a useful checklist

■ Safer recruitment, safer children: guidance for choosing safe people to work with children

■ Safer organisations, safer children (Children's Action Plan, February 2015)

■ Ask for Police vetting (New Zealand Police)

■ New Zealand Police Vetting Service: Purpose statement and agency approval criteria

■ RealMe
SECTION 5
Advanced and aspirational-only indicators

The purpose of this section is to provide advanced and aspirational criteria that are considered important and best practice by the RNZCGP, and to identify further opportunities for continuous quality improvement.
### INDICATOR 32

**The practice reconciles medicines**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>32.1</strong></td>
<td>The practice has a medicines reconciliation policy.</td>
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<tr>
<td></td>
<td>- A documented policy that describes how the general practice team is made aware of, and implements, its medicine reconciliation processes, and key accountabilities and responsibilities.</td>
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<td></td>
<td>- Staff training, induction and orientation processes include medicine reconciliation.</td>
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<td></td>
<td>- Staff training records and resources.</td>
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<tr>
<td><strong>32.2</strong></td>
<td>The practice undertakes regular reconciliation of prescribed medicines in accordance with practice policy.</td>
</tr>
<tr>
<td></td>
<td>- All team members involved in medicine reconciliation can describe and show examples of regular reconciliation of prescribed medicines in accordance with practice policy.</td>
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<tr>
<td></td>
<td>- Patient records show the collection, comparison and communication of medicines lists.</td>
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<tr>
<td></td>
<td>- Patient record notes any medicine discrepancies and actions taken for reconciliation.</td>
</tr>
<tr>
<td></td>
<td>- Patient record notes reasons for alteration or discontinuation.</td>
</tr>
<tr>
<td></td>
<td>- Patient record notes medicines prescribed outside the practice.</td>
</tr>
<tr>
<td><strong>32.3</strong></td>
<td>The practice audits patient records to ensure that:</td>
</tr>
<tr>
<td></td>
<td>- prescribed medicines are current and complete</td>
</tr>
<tr>
<td></td>
<td>- new or changed medicines are accurately recorded including reasons for alteration or discontinuation</td>
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<tr>
<td></td>
<td>- any notification of medicines prescribed outside the practice have been recorded and reconciled in the PMS.</td>
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<td></td>
<td>- Evidence of current audits, findings, reports and improvement plans/activities.</td>
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<tr>
<td></td>
<td>- Patient Record Reviews (see Indicator 21).</td>
</tr>
<tr>
<td></td>
<td>- Evidence of changes made as a result of audits.</td>
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<td></td>
<td>- Evidence of reporting of results and lessons in staff training and/or meetings.</td>
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</tbody>
</table>
Guidance notes

What is medicines reconciliation?

Medicines reconciliation is the process of collecting, comparing, and communicating the ‘most accurate’ list of medicines that a patient is taking, together with details of any allergies and/or adverse drug reactions (ADRs), with the outcome of providing correct medicines for a given time period (see HQSC: Medicine reconciliation standard).

The impact is to reduce any discrepancies that have the potential to become medication errors and cause medication-related harm to patients. It also contributes to the accuracy of repeat prescribing.

Once the most accurate list possible of patient medicines, allergies and adverse drug reactions is obtained, this information is used within and across the continuum of care to ensure safe and effective medicine use. The key to its success lies in accurate communication (verbal and written) of medicine-related information between health care services and practitioners.

When does medicines reconciliation occur?

Medicines reconciliation is important at vulnerable points of transfer of care (eg admission to hospital, and/or transfer or discharge to home, aged residential care facility or another service). There will be other circumstances where collaborative practice and accurate medicines lists are vital (eg when medical care is shared across a number of health care practitioners).

What is involved in medicines reconciliation?

Your medicines reconciliation process should be accurately documented and key staff should be able to describe their role, tasks, responsibilities and accountabilities clearly. Make sure all stages of the process remain patient-centred with an emphasis on patient safety.

The medicines reconciliation process involves three key steps (see below for more detail). The health practitioner:

1. collects the ‘most accurate’ medicines, allergies and ADRs list
2. compares the ‘most accurate’ list against prescribed information to identify any differences
3. communicates any discrepancies to the prescriber for reconciliation.

Medicines reconciliation helps you identify a number of potential issues, including, but not limited to:

- omissions
- temporarily stopped medicines
- medicines not restarted
- duplicated orders
- incorrect medicines
- dosage/route discrepancies
- up and down titration of medicines
inappropriate prescribing  
undocumented changes  
medicine non-adherence.

Any differences identified in the comparison phase, whether intentional or unintentional, should then be communicated to the prescriber to reconcile and action, all of which should be clearly documented.

Sources of information

There are three types of information sources (you’ll need to use a minimum of two for each reconciliation):

1. **Primary** – for example verbal information from the patient or patient’s family/caregiver, patient-held medication list (e.g. yellow card), patient’s own medicines (check date of supply and expiry date on each container).
2. **Secondary** – for example GP, community pharmacy, community health team (e.g. diabetic, mental health, child), lead maternity carers, rest homes, private specialists (document full name and contact details).
3. **Tertiary** – for example clinical notes, hospital medication charts, transfer letters, hospital pharmacy records, previous medicines reconciliation documentation.

A primary source is normally the principal starting point. The primary source should be verified using a secondary or tertiary source.

Patient’s medicines list

As a minimum you’ll need to gather information on:

- generic name, strength, form, dose and units, route and frequency of the medicine
- brand name for bioequivalence reasons (e.g. warfarin, diltiazem)
- known medical warnings, allergies and adverse drug reactions (ADRs).

Useful information:

- Indications for use
- Assessment of patient’s adherence (e.g. last medicine dose and time taken, date of last dispensed medicines, etc)
- details of new and/or discontinued medicines within last three months
- changes in form, dose, route, frequency within last three months
- side effects
- over-the-counter (OTC), alternative, complementary therapies being taken regularly.

Medicines reconciliation policy and procedures

The details for how your practice performs these steps and other important aspects of medicines reconciliation should be clearly documented in a medicines reconciliation policy.
Components of the medicines reconciliation policy

The following lists the components to consider when developing your practice’s medicines reconciliation policy and the associated procedures. Further information can be found on the HQSC: Medicines reconciliation webpage.

The policy should detail:

1. **Accountabilities and responsibilities:**

   - **Personal**
     
     *Who is responsible for medicines reconciliation in your practice?*
     
     Medicines reconciliation should be carried out by any qualified health practitioner involved in the prescribing, dispensing or administration of medications, such as GPs, nurse practitioners, other authorised/designated prescribers, pharmacists or registered nurses.
     
     Details should be provided about how each person involved in medicines reconciliation is responsible and accountable for the accuracy and quality of information provided to support the medicines reconciliation process at a given point in time. Includes roles and responsibilities during different points of transfer of care.

   - **Organisational**
     
     *How does your practice ensure each health care practitioner involved in the medicines reconciliation process is able to undertake their role and responsibilities competently?*
     
     Your practice should ensure that staff have the necessary resources, qualifications and documentation (eg annual practising certificates), adequate education and training, and that policies, measuring, evaluation and reporting guidelines are being followed.

2. **Medicines reconciliation processes:**

   - **Collect**
     
     *How are your health care practitioners going to collect the most accurate list of medicines, allergies, and adverse drug reactions (ADRs) using a minimum of two source types?*
     
     When (eg how soon after transfer of care) and how often will it be collected?
     
     The patient should always be consulted if able (primary source). Information provided by sources should cover at least a period of six weeks prior to the present day. Written or tertiary sources of information should not be used if older than three months and should be used with a primary source where possible.

   - **Compare**
     
     *How does the health care practitioner compare the collected medicines, allergies and ADR list against the prescribed information (such as the medical record)?*
     
     *How do they identify and document any discrepancies?*
     
     The patient’s notes, discharge summary etc should be reviewed for any explanations for the differences found. Any medicine discrepancies require action, for example given to the prescriber to reconcile and to make any clinical decisions necessary to resolve any issues.
Communicate

At each transfer point, how will all changes that have occurred to the patient’s medicines, allergies and ADR lists be documented, dated, and communicated by the health care practitioners involved to ensure the care of the patient is continued?

3. Education and training:

■ How are you going to train your staff?

Your practice will need to document its education and training processes for medicines reconciliation. A comprehensive medicines reconciliation education and training toolkit is available from the Health Quality and Safety Commission, which may be adapted for each practice’s individual needs.

Education and training materials should be reviewed and monitored on a regular basis. Accurate staff training records should be kept. Medicines reconciliation should be part of induction and orientation processes. Any lessons from ongoing practice, incidents and audits should be documented and communicated to the staff in training sessions and/or meetings.

(i) Documentation:

- Documentation

How will you ensure that any information associated with medicines reconciliation is complete, accurate, relevant and current?

The responsibility for this remains with the health care practitioners involved.

(ii) Measuring, evaluation and reporting:

- Measuring and evaluation

How are you going to review and audit your medicines reconciliation process?

You should have a process for reviewing your policy and processes, including that impact and balance measures (eg auditing), are undertaken at regular intervals for learning and improvement using a continuous quality improvement cycle (eg Plan, Do, Study, Act (PDSA) cycle).

- Reporting

How are you going to ensure reporting on medicines reconciliation meets local and national requirements?

Your practice should also document who, when and how it will regularly report the results and lessons to appropriate staff and, where appropriate, clinical, quality, governance and management teams and/or stakeholders groups (eg PHO).
Auditing

Your practice should have a process you use to audit patient records to ensure that:

■ prescribed medicines are current and complete
■ new or changed medicines are accurately recorded including reasons for alteration or discontinuation
■ any notification of medicines prescribed outside the practice has been recorded and reconciled in the PMS.

You may think of other activities to audit.

This is a continual improvement activity; therefore, results from each audit should be analysed, then used to develop an improvement plan. That information should then be communicated to the team involved in medicines reconciliation.

Resources

■ MCNZ: Good prescribing practice.
■ HQSC: Medicine Reconciliation Standard v3, 2012
■ HQSC: Medicine reconciliation guidance tools and training materials
■ Medicines care guides for residential aged care
■ NZNO: Guidelines for nurses on the administration of medicines

Continuing professional development

■ Any audits undertaken can be claimed as an Audit of Medical Practice activity. Self-designed audits must be pre-approved by the College. A completed RNZCGP AoMP summary sheet should be kept as evidence.
INDICATOR 33

The clinical team utilises clinical decision support tools

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
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<tbody>
<tr>
<td>33.1 The practice can provide information on the prevalence of chronic or long-term conditions recorded and classified on the database.</td>
<td>System to code/classify chronic and long-term conditions. Prevalence data for chronic or long-term conditions.</td>
<td>A</td>
</tr>
<tr>
<td>33.2 The clinical team audits its management of patients to align care with current health targets for chronic and long-term conditions.</td>
<td>Evidence of current audits, findings, reports and improvement plans/activities. Current health targets.</td>
<td>A</td>
</tr>
<tr>
<td>33.3 The practice demonstrates use of evidence-based electronic clinical decision support.</td>
<td>Evidence-based electronic clinical decision support tools available. Clinical team can describe/demonstrate use of tools.</td>
<td>A</td>
</tr>
<tr>
<td>33.4 Electronic clinical decision support tools are integrated into the practice management system (PMS).</td>
<td>Electronic clinical decision support tools are integrated into the PMS.</td>
<td>A</td>
</tr>
</tbody>
</table>

Guidance notes

Clinical management relies on information to inform decisions about patient care.

Once your practice has quality information about its population, targeted care and monitoring can help improve the services you offer, increase quality of care and reduce health inequities.

Electronic tools that gather information about patients and support clinical decision making and management provide information for the clinicians in your practice. Use of evidence and comparisons may depend on situational variables such as patient comorbidities and patient preferences.

Important prerequisites for patient treatment and management are:

- patient demographic data
- electronic notes
- routine coding of conditions at source to enable assessment of disease prevalence in enrolled populations.
Electronic information systems

A key component of effective chronic care models are effective electronic information systems. See Indicator 12: The practice uses a Practice Management System.

Information on the prevalence of chronic or long-term conditions

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

Analysis and use of data held in the system about your patients’ conditions enables your practice to learn about their needs and respond appropriately.

Classifying chronic and long-term conditions

A recognised coding system should be used to classify chronic and long-term medical conditions (e.g., READ, SNOMED codes).

Using recognised codes ensures that the recording of health information is the same across the health care system, and that this information can also be used for improving funding decisions and research.

Data for health targets and other system measures

When all consultations for individuals with chronic/long-term conditions are coded, this enables your practice to compare, prioritise and align activities with local, regional and national goals for disease management, including health targets.

You need to know what the health system measures are and what data the targets require so that the correct data gets exported from your PMS to your PHO in order to assess performance against health targets.

As part of this, you need to be aware of the codes that are used for the health system measures and targets. For example, recording patient outcomes and comorbidities is an important factor for the diabetes and ischaemic heart disease indicators. When the wrong codes are used or misused your practice’s performance will be inaccurate and you can miss out on achieving the targets.

Auditing

You can analyse the coded data in the PMS to identify the prevalence of certain conditions and the numbers of registered patients who have chronic and/or long-term conditions. The clinical team should also check its management of patients aligns with current best practice and/or national health targets for these conditions.

It is suggested that you audit your coding in your practice on occasion to check you are all using the correct codes.

Reviewing information can help your practice to monitor a person’s condition and assess when further intervention may be needed.

This level of data also provides information to your clinical team members about any potential risk, e.g., allergies to medication, pharmaceutical products.
and/or vaccines. You can also use outcomes of care provided to identify any potential benefits from screening and whether it outweighs any physical and psychological harm (caused by the test, diagnostic procedure or treatment).

Electronic decision support tools

Using evidence-based electronic clinical decision support tools in your practice allows your patients and clinicians to make key clinical decisions, jointly or separately, that are consistent with current evidence and best practice.

Integration of electronic clinical decision support tools into the PMS increases efficiency and improves data capture.

Electronic decision support tools are also useful for tracking and managing conditions in the practice.

There are many examples of clinical decision support tools and websites that practices in New Zealand use (some of which are available free of charge through bpac®).

Useful resources include:

- Adverse Reaction Reporting – reporting of adverse reactions to medications and vaccines with an online form (completed form is sent electronically to the Centre for Adverse Reaction Monitoring (CARM) while a copy is retained in the patient record)
- Hazardous Substances and Lead Poisoning Notifications
- Childhood asthma
- Childhood asthma – action plan – create an individualised action plan
- Depression (4 modules)
  - Depression in adults
  - Depression in young people
  - Ante/postnatal depression
  - Depression in the elderly
- INR – managing patients’ anticoagulant therapy
- Acne management
- Isotretinoin – a stand-alone module or as part of the acne management module
- TIA/stroke
- PREDICT in primary care – cardiovascular disease CVD/diabetes
- DermNet – skin diseases, conditions and treatment
- Local resources, eg HealthPathways
- Map of Medicine
- Patient.co.uk

Resources

See also Indicator 34: The practice offers shared care

- Ministry of Health:
  - Meeting the needs of people with chronic conditions
  - Publications on effective behaviour change in long-term conditions
– Health literacy interventions: a brief summary
– New Zealand primary care handbook resources
■ Resources for improving chronic care

Condition-specific information

■ Clinical audit: Stepping up treatment in people with poorly controlled diabetes
■ Clinical audit: Following up people with diabetes
■ Quality standards for diabetes care toolkit 2014
■ Ministry of Health: Eating and activity guidelines for New Zealand adults resources
■ Managing chronic kidney disease in primary care
■ General practice toolkit for more heart and diabetes checks and better help for smokers to quit
■ New Zealand framework for dementia care
■ Guidance for improving supportive care for adults with cancer in New Zealand
■ The Green Prescription (GRx) process
■ New Zealand clinical guidelines for stroke management 2010
■ Identification of common mental disorders and management of depression in primary care summary
■ Identification of common mental disorders and management of depression in primary care
■ Assessment and management of cardiovascular risk
■ Diagnosis and treatment of adult asthma
■ Resources for improving chronic care
■ Information on the resources, programmes, courses and guidelines available from the Heart Foundation for health professionals
■ The optimal management of patients with COPD – Part 1: The diagnosis
■ The optimal management of patients with COPD – Part 2: Stepwise escalation of treatment

☑ Continuing professional development

■ Any audits undertaken to improve the management of chronic and long-term conditions can be claimed as an Audit of Medical Practice activity. Self-designed audits must be pre-approved by the College. A completed RNZCGP AoMP summary sheet should be kept as evidence.
INDICATOR 34
The practice offers shared care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
</table>
| 34.1 The practice has a process to identify patients who would benefit from a shared care plan. | ■ A documented process to identify patients who would benefit from a shared care plan.  
■ Patient record.  
■ Resources for patients. | A |
| 34.2 The clinical team using the shared care process can demonstrate use of the shared care plan. | ■ The clinical team using the shared care process can demonstrate use of the shared care plan.  
■ Staff resources.  
■ Staff training records.  
■ Shared care tools if available. | A |
| 34.3 The clinical team have received training in shared care principles such as person-focused goal setting and action planning, behaviour change, health literacy and self-management support. | ■ Staff training records and resources cover shared care principles. | ★ |
| 34.4 Interdisciplinary electronic shared care plans are developed collaboratively with both patient and family (as appropriate). | ■ Evidence of electronic shared care plans; and  
■ Care plans have input from both patient and family (as appropriate). | ★ |

Guidance notes

What is shared care?

Shared care is a person-centric approach, which involves all health professionals with a role in the patient’s care, working to a common care plan and sharing information between them.

A shared care plan is a structured, comprehensive plan developed jointly by the patient and their family/carer, and their health professional(s). It may include a summary of personal health information, a person’s health goals, and the treatment and follow-up care they receive.
Self-management approaches are an essential component of a care and coordination model, particularly for the prevention and optimal management of long-term conditions (LTCs).

**Components of a care plan**

A care plan typically includes, but is not limited to:

- mutually agreed list of problems
- patient-defined goals
- medical management, including medications
- prioritised action plan/interventions/steps/tasks – based on self-management needs of patient and their carer
- key action plan in the person’s preferred language
- crisis or contingency planning with written information regarding early warning signs/red flags and action to take
- who is responsible for what with sharing of responsibility
- community education programmes or resources
- community support networks
- time for review and follow-up. This includes the flexibility to acknowledge and anticipate unexpected emergent events arising from comorbidity and/or increasing frailty and some direction as to what should be done in that circumstance.

The care plans you develop can range from very simple and brief for someone with mild disease or risk factors, through to comprehensive, multidisciplinary care plans for someone with significant illness or a life-limiting condition.

**Identifying patients who would benefit from a shared care plan:**

In New Zealand, shared care plans are being developed for patients with complex health needs and/or who have an LTC requiring multidisciplinary care. There are a number of initiatives in different regions.

Your practice needs to have a documented process to identify patients who would benefit from a shared care plan in your particular practice environment and region. Be prepared to show examples.

The clinical team using the shared care process should be able to demonstrate the use of the shared care tools that are used in your practice and region.

Consider also contacting your local pharmacists to help identify patients who would benefit from a shared care plan, like those patients who use blister packaging or who may have compliance issues.

**Shared care principles**

There are a number of shared care principles you can use to create an effective shared care planning process and to deliver person-centred care. Your clinical team should receive training in those aspects of shared care principles that help contribute to effectiveness.
These principles include, but are not limited to:

**Self-management support:**

Self-management refers to any way in which a person with an LTC manages their condition by themselves.

Self-management support is what you do to support this.

We recommend you see self-management support as any help given to people with LTCS to enable them to manage their health on a day-to-day basis.

The way you and other providers collaborate with the patient, and how the shared care team encourages patients to solve their health issues are crucial to the patient’s ability for sustained self-care.

Any self-management support you provide must *(Ministry of Health)*:

- be appropriate for the person with the LTC and their family and whānau
- be developed in partnership with the person with the LTC
- focus on reducing inequities in health.

Self-management programmes and approaches give you and the patient the tools for:

- identifying symptoms
- knowledge of the condition and managing their symptoms
- understanding the purpose of medication and using it effectively
- providing support and motivation to adopt a healthy lifestyle
- a connection to support groups that understand the issues
- a connection to organisations that can help manage a range of support (eg income).

See the *Self-Management Support Toolkit* for more detail.

**Person-focused goal setting and action planning:**

Working with patients to identify something they want to do is one of the simplest, yet most effective techniques health professionals can use to improve communication and behaviour change.

Goal setting enables specific and achievable targets for your patients to focus on. The process breaks down problems or behaviours that need to change into small achievable goals.

To ensure ownership and motivation, it is critical to ensure your patients help choose their own goals, rather than being given them by the health provider.

It is useful to use an easy-to-understand goal setting process, such as SMART or SMARTER:

- S – Specific
- M – Measurable
- A – Achievable
- R – Realistic
- T – Time bound
- E – Enjoyable and evaluate
- R – Record and reward
Health literacy:

Lots of things in health care require people to understand how to access and apply health information; for example, seeking medical care, taking medications correctly and following prescribed treatment.

It is the responsibility of the health care professionals in your practice to give patients their health information in a way they can understand.

Three steps for better health literacy are:

- **STEP 1:** Find out what people know. When you are talking to people, listen to what the person tells you and the words they are using. Acknowledge what they know.
- **STEP 2:** Build people’s health literacy (knowledge and skills) to meet their needs.
- **STEP 3:** Check you were clear.

For more information see: [Three steps to better health literacy – a guide for health care professionals](#).

Reducing health literacy demands does not mean ‘dumbing down’ or reducing information. In some cases it may result in more, rather than less, information being shared with patients.

You can help by:

- making it easier for patients to find their way into and through health services, systems and processes
- encouraging health conversations and helping people to identify and ask questions
- finding out what people know as the starting point of any health conversation
- tailoring the conversation to take into account what they already know
- making the amount of information or instructions passed on manageable for the patient and their whānau
- checking that you have been clear when talking to a patient by asking them to ‘teach-back’
- encouraging whānau involvement in health conversations
- going through written information with patients and whānau rather than handing it out to be read later
- making medication and treatment information clearer
- following up and monitoring prescribed medicines and instructions
- redesigning health education resources, letters and forms so they are clear to the people you are giving it to.

**Behaviour change:**

Health literacy education needs to be complemented by programmes to support your patients to change their health behaviour.

There are five essential elements to changing health behaviour within self-management programmes:

- Active involvement in problem solving, goal setting and written action plans
- Lifestyle changes, including diet, physical activity and smoking cessation
- Informed decision making
- Medication management
- Stress management/positive mental health
Collaborative interdisciplinary electronic shared care plans

Good communication and information sharing across an integrated health care team environment is required to ensure that a patient’s journey across settings is seamless, safe and high quality.

Shared health care needs shared health information. An IT infrastructure that allows current and accurate patient information to be shared between providers and settings and with patients is a key enabler of integrated health care delivery.

Interdisciplinary electronic shared care plans should be developed collaboratively with both the patient and their family/whānau (as appropriate).

Resources

- Self-management support for people with long-term conditions
- Long-Term Conditions Network
- Self-management support – for health providers
- Health Navigator: Self-management support toolkit
- Health literacy
- HQSC: Three steps to better health literacy – a guide for health care professionals
- bpac®, Upfront: understanding health literacy
- Health literacy universal precautions toolkit (US)
- Healthy living toolbox
- Open for Better Care: Let’s PLAN for better care resources
- Privacy Commissioner: Electronic Shared Care Records: elements of trust
- Ministry of Health: Effective health behaviour change in long-term conditions resources
- National Health Shared Care Plan Programme: shared care user manual
- National Health IT Board: Shared care plans for long term conditions
- Privacy impact assessment

Case study

- Shared health records online improve patient care

Continuing professional development

- The development of patient information materials can be claimed as a CME research activity. Shared care training can be claimed as a CME activity.
INDICATOR 35
The practice offers services for health education

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.1</td>
<td>Practice teams deliver preventive care and promote healthy lifestyles.</td>
<td>Evidence of programmes used. Patient information and resources.</td>
</tr>
<tr>
<td>35.2</td>
<td>The practice database is used to identify the health needs of the enrolled population.</td>
<td>Evidence of audits.</td>
</tr>
<tr>
<td>35.3</td>
<td>The practice team is able to demonstrate how they implement brief intervention processes.</td>
<td>Evidence of brief intervention in clinical record/s. Patient information and resources.</td>
</tr>
<tr>
<td>35.4</td>
<td>The clinical team is able to demonstrate how they provide or refer patients to programmes that improve, maintain or restore health.</td>
<td>Evidence of programmes delivered in the practice. Evidence of programmes delivered by local, regional or national providers.</td>
</tr>
<tr>
<td>35.5</td>
<td>A wide range of current health promotion material is available to patients in printed and/or electronic form.</td>
<td>Patient information and resources. Website.</td>
</tr>
</tbody>
</table>

Guidance notes

Health promotion and education are important aspects of primary health care.

The Ottawa Charter for Health Promotion states that health promotion is the process of enabling your patients to increase control over, and improve, their health.

Health promotion is distinct from education and information used to support diagnosis and choice of treatment. Health promotion is the term given to planning, implementing and evaluating activities that promote health and wellbeing in communities, and when practice teams work with patients to help them manage their own care to improve their quality of life.

PHOs are required to work with whānau, hapū, iwi, consumers, and other groups within their community, relevant public health service providers and regional public health units to plan and deliver health promotion programmes. Programmes are required to be consistent with population health objectives and public health programmes at national, regional and local levels.

Your general practice has a role to play. Effective health education and promotion help contribute to patient safety and improved health outcomes.
and empower patients and whānau to increase control over their health and wellbeing through increasing health literacy levels.

**Preventive care and promoting healthy lifestyles**

Your practice team should deliver preventive care and promote healthy lifestyles. Educating patients in preventive approaches helps them develop skills to manage their own health.

You can also work with 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.

**Preventive health topics:**

Here are some areas in which your general practice can work with your PHO, public health service providers and your community to integrate both health promotion and health protection activities (see Ministry of Health: Preventative health/wellness):

- Screening (opportunistic and national programmes)
- Immunisation and communicable disease control
- Early interventions for alcohol and drug dependence
- Health promotion like Well Child/Tamariki Ora
- Smoking cessation and tobacco control
- Health sector family violence programmes
- Sexual and reproductive health
- Nutrition and healthy eating
- Physical activity, for example:
  - Green Prescriptions
  - sponsoring and promoting a regular walking programme
  - organising an exercise session and having staff available during the programme
- Community initiatives, for example:
  - contributing to a community coalition working to get speed humps and other traffic calming measures in a neighbourhood where many patients live
  - developing a petition asking for a local sportsground to be made smokefree
- Mental health promotion programmes
- Healthy Families NZ.

**Using the practice database to identify the health needs of the enrolled population**

You can use data from your PMS to identify the health needs of your enrolled patients. Think about what data would be useful and how you can build and extract it from your PMS.
Examples of audits may include but are not limited to:

- current smokers
- body mass index
- alcohol intake
- elevated blood pressure.

Staff members responsible for audits should be able to demonstrate how you go about using the practice database to do this.

**Brief intervention processes**

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.

The purpose is to support the person to think about their behaviour, assisting them to make a connection between their behaviour and any associated risks and harms. From there the nature of the intervention depends on the level of risk and/or harm and the person’s readiness to change.

**Programmes that improve, maintain or restore health**

Your clinical team members should be able to demonstrate what preventive 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 should be able to demonstrate how they refer patients to national or regional programmes, health professionals, social agencies and community representatives. An example is [Green Prescriptions](#).

**Current health promotion material**

A wide range of patient information should be available to take away or to be accessed by electronic means, such as on the practice website. The material should be current and appropriate to your practice population. This may require your practice team to access information in different languages or formats and to contact interpreters and translators if needed.

**Resources**

- [Public health in a primary health care setting](#)
- Health Ed: [Free health resources](#)
- [Health Promotion Agency](#)
- Health Quality and Safety Commission: [Partners in care](#)
- Health Navigator
- RNZCGP Clinical Effectiveness Module: Implementing the ABC Alcohol approach in primary care

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**Case study**

- A prescription for good health: Green Prescriptions in action
Ministry of Health publications:

- Eating and activity guidelines for New Zealand adults
- Guidelines on physical activity for older people (aged 65 years and over)
- Are physical activity interventions in primary care and the community cost-effective? A systematic review of the evidence
- The New Zealand guidelines for helping people to stop smoking
- Contacting patients to offer brief advice to quit smoking
- Opportunities for alcohol and other drug advice in the GP consultation
- Child abuse and neglect: brief intervention

Resources for specific topics include but are not limited to:

- Alcohol and drugs
- The Asthma Foundation
- Cancer Society
- Children’s Health
- Diabetes
- Heart Foundation
- Immunisation Advisory Centre
- Māori health
- NZ Nutrition Foundation
- Quitline

Continuing professional development

- Audits of health promotion prescriptions and referrals can be claimed as an AoMP activity. Self-designed audits must be pre-approved by the College. An RNZCGP AoMP summary sheet should be retained as evidence.
INDICATOR 36

The practice routinely identifies people who smoke and offers interventions

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.1 The current smoking history and status of newly enrolled patients 15 years and over is recorded in the PMS.</td>
<td>✔ Method of collecting smoking information. Smoking data in health records – coded. Enrolment form.</td>
</tr>
<tr>
<td>36.2 Practice team members actively promote smoking cessation strategies and provide brief intervention programme information to patients.</td>
<td>✔ Examples of smoking cessation strategies. Examples of brief intervention programme information.</td>
</tr>
<tr>
<td>36.3 The practice team has access to programmes that assist patients with smoking cessation.</td>
<td>✔ Examples of smoking cessation programmes.</td>
</tr>
<tr>
<td>36.4 The practice team routinely updates the current smoking status of patients.</td>
<td>✔ Method to update smoking data.</td>
</tr>
</tbody>
</table>

Guidance notes

All health care workers play an important role in supporting New Zealand’s goal of becoming smokefree by 2025. General practices regularly see a large proportion of New Zealand’s smokers and are uniquely placed to provide expert advice on the merits of stopping smoking.

The New Zealand guidelines for helping people to stop smoking (the Guidelines) provide health care workers with advice they can use when dealing with people who smoke. These Guidelines replace the 2007 New Zealand Smoking Cessation Guidelines and are based on a recent review of the effectiveness and affordability of stop smoking interventions.

The ABC pathway

The guidelines use a memory aid, ABC. ABC is a simple and evidence-based approach to guide and support health care workers to help people to quit smoking. ABC is about providing good clinical practice with the best quality care for the patient.

The ABC pathway is:

- **Ask** about and document every person’s smoking status.
- **Give Brief advice** to stop to every person who smokes.
- Strongly encourage every person who smokes to use **Cessation support** (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it. Refer to, or provide, cessation support to everyone who accepts your offer.
Collection and maintenance of smoking data

Your practice should collect the smoking history and current status of patients, aged 15 years and over, when they enrol with the practice.

You can add fields about their smoking history and current status to your enrolment form. Then you need to enter this smoking information into the patient’s clinical record and code it so you can audit and analyse the data later.

This information you collect helps provide evidence of the effectiveness of national programmes. You can also use it as a basis for any health improvement activities you do as a practice.

Your practice team should also routinely update the current smoking status of patients to keep smoking data accurate and to enable early interventions if necessary.

Definitions of smoking status

See the Ministry of Health for definitions of smoking status.

READ codes can be used to classify and code smoking status.

Statistically, the risk of relapse reduces dramatically after 12 months after quitting. For that reason, it has also become common for clinicians helping patients to quit to distinguish between an ‘Ex-smoker < (less than) 12 months’ and an ‘Ex-smoker > (greater than) 12 months’ (Ministry of Health).

If you use ZCPI codes, the following classifications are available:

- Current Smoker
- Ex-smoker < 12 months
- Ex-smoker > 12 months
- Never Smoker.

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

Smoking cessation strategies and brief intervention

Brief advice to stop smoking and, most importantly, an offer of cessation support by a health professional can increase the number of people who attempt to stop smoking considerably.

Your practice team members should actively promote smoking cessation strategies and provide brief intervention programme information to patients.

Ideally, you should be providing smoking cessation support in the ABC format to every patient who smokes, at every consultation, regardless of whether they say they are ready to stop smoking or not. It’s helpful to understand why a patient’s previous quit attempts have failed and to encourage a wave of social support for their future attempts where possible, particularly in groups with high rates of smoking. This helps increase the chances that patients will be able to stop smoking long term.
In addition:

- **Cessation support is the most important aspect of the ABC approach:** You should provide evidence-based cessation support for those who express a desire to stop smoking.
- **Referral to a smoking cessation service is recommended:** You should only recommend recognised smoking cessation treatments to people interested in stopping smoking.

**Examples of cessation services:**

- **Quitline** is a smoking cessation service that offers a range of free and subsidised support to all people who want to quit smoking.
- **Aukati Kai Paipa** is a free face-to-face stop smoking service that is available in various locations around New Zealand and is based on a Māori framework.
- **Tala Pasifika** is a movement for Pacific peoples to live healthy and smokefree lives.
- **Asian Smokefree** services.
- **WERO:** teams of people quitting smoking together rather than individuals trying to go it alone.

**Quitcard providers**

Consider having one or more Quitcard providers. Quitcard providers offer face-to-face support for people who want to quit smoking and they can distribute Quitcards for subsidised nicotine patches, gum and lozenges. Quitline administers the Quitcards programme though a contract with the Ministry of Health.

**Stop smoking training and resources**

Examples of training for health professionals:

- eLearning with the Ministry of Health: [Helping people to stop smoking](#)
- Heart Foundation: [Stop smoking training](#)
- Ministry of Health: [General practice toolkit](#) (for more heart and diabetes checks and better help for smokers to quit)
- **Smokefree Nurses**
- **Quitline resources**

**Resources**

- Ministry of Health: [The New Zealand guidelines for helping people to stop smoking](#)
- **Definitions of smoking status**
- **bpac** has a number of articles on smoking cessation
- Referring to Quitline: [Primary care (PHOs)](#)

**Audit suggestion:**

Smoking cessation can be used as a CQI activity

- See the bpac® audit [Encouraging Smoking Cessation](#)
Continuing professional development

- Audits of patient smoking status and cessation support offered can be claimed as an AoMP activity. Self-designed audits must be pre-approved by the College. An RNZCGP AoMP summary sheet should be retained as evidence.
INDICATOR 37
The practice undertakes opportunistic screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.1</td>
<td>Practice opportunistic screening is evidence based.</td>
<td>Methods used to screen patients on an opportunistic basis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice database audits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening audit data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice policy for opportunistic screening.</td>
</tr>
<tr>
<td>37.2</td>
<td>Clinical team members can demonstrate their role in providing opportunistic screening.</td>
<td>Clinical team members can demonstrate their role in providing opportunistic screening.</td>
</tr>
</tbody>
</table>

Guidance notes

General practices frequently perform tests for screening purposes, whether for formal screening programmes, such as cervical screening, or less formalised opportunistic screening, such as cardiovascular risk assessment.

The primary purpose of screening tests is to detect early disease in apparently healthy individuals. With technological advances and early diagnosis it is possible to provide highly sensitive and specific tests.

Opportunistic screening includes:
- screening for hearing impairment at school entry
- pregnancy screening:
  - Down syndrome and other conditions
  - HIV testing
  - diabetes testing
  - ultrasound scans
- newborn screening:
  - newborn metabolic screening
  - universal newborn hearing screening
  - hip screening
- Well Child screening for developmental delays
- B4 School Check:
  - hearing screening
  - vision screening
  - behaviour assessment

Indicator 25
The practice maintains an effective screening and recall system
■ diabetes screening
■ 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
■ cardiovascular disease risk factor screening (smoking, serum cholesterol, hypertension)
■ screening for mental health issues, alcohol and drug misuse among adolescents and adults (e.g. HEEDSSS)
■ osteoporosis risk factor screening
■ bowel screening.

Screening tests are not ‘case finding’ or ‘diagnostic’ tests.

The purpose of a diagnostic test is to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen-positive individuals (confirmatory test); for example, taking a midstream urine (MSU) sample for evaluation of a urinary tract infection, or performing mammography for a suspicious breast lump.

Opportunistic screening testing may be 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. Therefore robust information about your patient population from your PMS is essential.

Which test you recommend 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.

Clinical judgement must always define the need for opportunistic screening and your practice should minimise practices that are not beneficial or have been proven to be harmful. Your clinicians 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.

The quality of opportunistic screening can be improved through regular audit or peer review.

**Screening issues to think about**

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 your clinicians understand the evidence for screening, and the natural history of a presenting problem.

Although intuitively it may appear to be a good idea to identify people early in the course of a potential disease process, screening is in fact a complex process that requires careful consideration of a number of issues.
**Key issues for you:**

- You need to understand and provide advice for patients on the role of individual screening tests.
- Although screening has the potential to improve quality of life, it also has the potential to cause harm (for example, overdiagnosis, causing needless anxiety, additional appointments, tests, drugs and even operations).
- Screening should be based on good quality evidence that can demonstrate more good than harm.
- **Informed consent for screening** is not simple and requires a special duty of care to provide adequate explanation or information (see Indicator 25).
- There are direct and indirect costs to you and your patients; therefore, you and your clinical team need to prioritise appropriate preventive health activities within your practice.
- You need to ensure equity of access for all people within your target population and minimise barriers to screening where possible.

**The roles of your clinical team**

Clinical team members can play various roles in providing opportunistic screening. For example, auditing your database and identifying those eligible for screening, contacting and following up with eligible patients, progressing treatment and management, and so forth. Consider having ‘champions’ for particular areas of testing.

Your team will need to be able to demonstrate how they contribute to the various screening processes in your practice.

**Resources**

- National Health Committee: [An overview of screening in New Zealand](#)
- MCNZ: Information, choice of treatment and informed consent
- Ministry of Health: General practice toolkit for more heart and diabetes checks and better help for smokers to quit
- Ministry of Health: [New Zealand primary care handbook 2012](#)
- RACGP: Guidelines for preventive activities in general practice (8th edition)
- Diabetes New Zealand: Information for health professionals
- Ministry of Health: Cardiovascular disease risk assessment and management guidelines (under review)
- Heart Foundation
- Prostate cancer management and referral guidance
INDICATOR 38

There is a culture of safety and teamwork in the practice

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.1 The practice undertakes a</td>
<td>▪ Team assessment survey.</td>
<td>A</td>
</tr>
<tr>
<td>regular assessment of the team</td>
<td>▪ Improvement plans.</td>
<td></td>
</tr>
<tr>
<td>culture and approach to patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>safety.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.2 There is a process to</td>
<td>▪ Staff meeting minutes.</td>
<td>A</td>
</tr>
<tr>
<td>disseminate practice information</td>
<td>▪ Staff training resources.</td>
<td></td>
</tr>
<tr>
<td>to all team members.</td>
<td>▪ Staff information (eg communications/ notebook, noticeboard, intranet).</td>
<td></td>
</tr>
<tr>
<td>38.3 There is a resource with</td>
<td>▪ Orientation/induction process.</td>
<td>A</td>
</tr>
<tr>
<td>information about the practice</td>
<td>▪ Orientation resource.</td>
<td></td>
</tr>
<tr>
<td>available to new team members and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>locums.</td>
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<td></td>
</tr>
</tbody>
</table>

Guidance notes

It’s worth considering how team interaction, culture and functionality might influence patient outcomes or enable clinical improvement activity and engagement in other initiatives.

A high-performing team is now widely recognised as an essential tool for constructing a more patient-centred, coordinated, and effective health care delivery system.

Assessing team culture and approach to patient safety

The first step is to identify your team culture. Culture is the way an organisation works and what it values.

Culture cannot be created to order and does take 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.

Your practice will need to carry out a review of the culture and approach to patient safety of your practice team and their ability to effectively and efficiently work as a cohesive unit. When you know the culture of a team or organisation, you can better understand its strengths, weaknesses and overall health, and work to improve it if necessary. Team functionality is also an important component of how well the team operates.
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.

One approach many practices in New Zealand use is the Team Climate Assessment Measure (TCAM) programme. The TCAM programme measures teamwork, particularly behaviours essential to the maintenance of patient safety and effective patient safety incident management in clinical settings. It also gives staff the opportunity to improve on their team working.

Another example is the Safety in Practice (SiP) Safety Climate Survey in the Auckland region, which is a tool for involving all staff in the practice in a discussion around safety culture and systems. It comprises five subject areas: communication, workload, leadership, teamwork and safety systems and learning.

**Principles of team-based health care**

Each health care team is unique – it has its own purpose, size, setting, set of core members, and methods of communication.

The following are some core principles of high-performing teams to consider for your practice team:

1. **Shared goals**: The team – including the patient and, where appropriate, family members or other support persons – works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

2. **Clear roles**: There are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimise the team’s efficiency and often make it possible for the team to take advantage of division of labour, thereby accomplishing more than the sum of its parts.

3. **Mutual trust**: Team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

4. **Effective communication**: The team prioritises and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

5. **Measurable processes and outcomes**: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. These are used to track and improve performance immediately and over time.

**Disseminating practice information to all team members**

Your practice will need to provide evidence that information is disseminated to members of the practice to keep them all informed about practice activities and decisions. Sharing ideas and information is inclusive and keeps everyone informed about practice activities or decisions. This enhances team culture.
and provides a shared and consistent approach to business and the delivery of health care.

Ways you can communicate with your practice team:

- Practice intranet
- Staffroom notices
- Staff notebooks or communication books
- Staff newsletter.

Staff meetings are also important. Staff meetings help support transparency, give staff the ability to contribute to discussion and enable two-way communication. These things can help improve practice team involvement and functionality.

You should retain minutes that demonstrate regular meetings of the practice team(s). The minutes may be in the form of electronic files or in hardcopy.

Resource for new team members and locums

Your practice is required to have a documented workplace induction programme to orientate new employees and independent contractors, including locums, to your practice.

As part of this you are required to provide an induction resource or orientation manual for your practice. This provides formal information and guidance to all new team members, including locums or casual staff.

See Indicator 31: The practice has appropriate employment structures in place for things to include.

Resources

- Core principles and values of effective team-based health care
- The Team Climate Assessment Measure (TCAM) programme
- Induction for GP locums – how to get it right
INDICATOR 39

The practice identifies persons with practice management responsibilities

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.1 The practice has one or more persons with the responsibility and authority to manage the practice.</td>
<td>■ Current position description for person(s) with the responsibility and authority to manage the practice; and ■ Employment agreement; and ■ Outline of role and responsibilities if role is shared.</td>
<td>A</td>
</tr>
<tr>
<td>39.2 The practice has a person who can identify and explain the practice’s legal business structure and contractual requirements.</td>
<td>■ Documents outlining the practice’s legal business structure and contractual requirements. ■ A person can identify and explain the practice’s legal business structure and contractual requirements.</td>
<td>A</td>
</tr>
</tbody>
</table>
| 39.3 The practice has an agreement covering entry and exit of partners or owners. | ■ Signed copy of Partnership Agreement, Practice Agreement or Shareholders Agreement or similar; and ■ Agreement covers entry and exit of partners/owners. | |}

**Guidance notes**

**The importance of practice management**

The business of general practice is becoming more and more complex. Many different things make the role of managing the practice extremely important, like:

- the shifting of services into the community
- increased integration between services
- growing compliance and management requirements
- complex legal and financial frameworks.

Non-clinical functions in your practice demand attention, expertise and significant resources in order to operate successfully.

Many small and rural practices have their own character and your practice may not have a dedicated practice manager. In this situation, you should have one or more designated staff members with the responsibility and authority to manage the practice.
Your practice should have clear and realistic guidelines, position description and employment agreement in place for your practice manager(s).

To avoid confusion if a number of people can manage the practice, there should be clear agreement and documentation of the different roles, expectations and responsibilities of each person. A clear reporting structure for staff should also be in place.

In addition, someone in the practice needs to be fully aware of your practice’s contractual obligations under the PHO Service Agreement and, where applicable, PHO membership agreements or back-to-back contracts.

**Responsibilities of a practice manager**

The tasks and skills required for the practice manager role are varied and critical to the success of the practice.

The following are some of the key responsibilities of a practice manager:

- **Effective and efficient administration** of daily clinic and business operations
- **Leadership** – developing strong working partnerships with clinical and administration staff
- **Human resources**, including recruitment and training, position descriptions and employment agreements, performance management, health and safety, professional development, IRD requirements
- **Business and financial management**, including finance, funding, reporting, operations, systems and protocols, planning and marketing, quality and risk management
- **IT management**, including disaster recovery, security, licenses, internet, PMS
- **Strategic and business development**, including strategic, quality and service planning
- **Communication and liaison**, including with PHO, patient relationships, working with suppliers, staff meeting, contact with other health sector organisations
- **Facilities management**, including property management, security, maintenance, equipment
- **Governance and compliance**, including reporting to the practice and PHO, Foundation/CORNERSTONE®
- **Reporting**, which includes financial, strategic, marketing, budgeting, compliance (eg MoH), governance, PHO, planning, and patient-based reporting.

As part of this, your practice should have a person who can identify and clearly articulate the practice’s legal business structure and contractual requirements.

The role and status of the practice manager is definitely increasing and the importance of this should be reflected in ongoing education and support for the person(s) undertaking this role.

**Practice agreement**

Having a formal agreement for the ownership of your practice, including clear strategies for the entry and exit of partners or owners, is important. This is a significant area of potential risk and dispute.
There are a number of components of an agreement that you need to consider. Make sure you discuss and clarify these if necessary. This will help achieve a well-structured, sustainable ownership structure that ensures continuity for patients and staff, and minimises future issues.

Here are some things for you to think about when you’re developing a practice agreement:

- Details of the ownership arrangement, including how each practitioner’s share in the practice is determined
- Alternative models of ownership, such as amalgamation and corporate investment
- Rights, responsibilities and obligations of the principals
- Entry opportunities for new doctors, partners and/or owners
- Succession planning
- Exit arrangements on leaving the practice, including procedures for the death or serious illness of a partner, compulsory exit and sale
- Financial considerations on exit from the practice; for example, releasing equity that existing partners or owners have created
- Process for dissolution or change of the partnership or ownership structure
- Arrangements for when one or more of the business owners are considering retirement
- How to enable the remaining partner(s) of retiring doctors to have confidence in the continuation of their business and sale in due course
- How to manage conflict among partners or owners, including an agreed dispute resolution process
- A remuneration model for the shareholders
- Cost allocation
- Governance and management structures, decision-making processes.

Make sure that you review the arrangements on a regular basis to ensure they are still current and relevant to your practice.

Resources

- The business of general practice
- Medical Assurance Society
- Health Practice
- ACC: For providers
- Ministry of Health
- WorkSafe NZ
- The Royal New Zealand College of General Practitioners
- Medical Protection Society
- New Zealand Nurses Organisation
- Practice Managers and Administrators Association of New Zealand
SECTION 6
Specialised indicators

PLEASE NOTE:

For each indicator in this section, the indicator only applies to those practices that provide the service covered by the indicator. If the indicator applies then all mandatory criteria for that indicator must be completed.

The purpose of this section is to ensure that all general practice teams that provide specialised services have the necessary competencies to do so, and have effective systems and processes in the practice to support them.
## INDICATOR 40
Patients have access to a patient portal

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.1</td>
<td>The practice’s patient portal meets the HISO 10029 Health Information Security Framework.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Evidence of HISO 10029 Health Information Security Framework compliance for the patient portal from vendor.</td>
<td></td>
</tr>
<tr>
<td>40.2</td>
<td>The general practice team receives education and training on use of their patient portal system.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Staff training records and resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff meeting minutes.</td>
<td></td>
</tr>
<tr>
<td>40.3</td>
<td>The practice has a policy on general practice staff access to patient portals, which complies with the Privacy Act 1993 and Health Information Privacy Code.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Documented information security policy; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The policy was created or last reviewed within the last three years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed General Practice ICT Security Checklist.</td>
<td></td>
</tr>
<tr>
<td>40.4</td>
<td>The practice patient portal registration process includes patient information to optimise patients’ safe use of the portal.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Examples of patient information eg brochures, website, posters.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient record notes information given.</td>
<td></td>
</tr>
<tr>
<td>40.5</td>
<td>The practice’s patient portal can provide:</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>◼ clinical summary (including medication lists)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◼ test results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◼ appointment booking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◼ repeat prescriptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◼ secure messaging.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient portal has key features available.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff can demonstrate functions and features of the patient portal system.</td>
<td></td>
</tr>
<tr>
<td>40.6</td>
<td>The practice uses the patient portal to provide access to consultation notes as agreed with each individual patient.</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Patient record notes access provision for individual patients.</td>
<td></td>
</tr>
</tbody>
</table>

**Guidance notes**

See also Indicator 2: The practice meets the requirements of the Health Information Privacy Code, Indicator 12: The practice uses a Practice Management System and Indicator 34: The practice offers shared care.

Patient portals give your patients online access to their health information, enable them to interact with you electronically and to manage aspects of their own...
health care. The goal of patient portals is to broaden the engagement between patients and their general practice to support better patient outcomes.

Currently this indicator is mandatory only for those practices that provide this service.

**Patient portal benefits**

- Enhanced communication between patients and your practice
- Encourages patient empowerment and self-care
- Greater accuracy of patient information and patient records.

**Privacy and confidentiality of health information**

For both patients and your practice, it is vital that privacy and confidentiality of health records is maintained.

**HISO 10029 Health Information Security Framework:**

The relationship of trust that exists between a patient and their health care practitioner is vital for good health care. Every health practitioner is obligated to treat personal health information with proper care and respect and to keep it secure. If such information is disclosed inappropriately, corrupted or lost, the consequences for both patient and practitioner are potentially very serious.

The Health Information Standards Organisation (HISO) is the expert advisory group for standards to the National Health IT Board. The Health Information Security Framework (HISF) is designed to support organisations and practitioners holding personally identifiable health information to improve the security of that information, so that it can be collected, stored, disposed of and shared in a way that ensures confidentiality, integrity and availability.

As with other aspects of electronic health information, patient portals must meet the HISO 10029 Health Information Security Framework.

See also **Indicator 2:** The practice meets the requirements of the Health Information Privacy Code.

Health care organisations must undertake the following three activities as a minimum to meet their responsibilities in managing health information (from HISF):

- Regularly undertake a (or review an existing) health information related risk assessment
- Develop and apply policies and procedures to address each of the identified risks
- Regularly monitor and report on the performance of the above policies/procedures.

**Meeting the Health Information Security Framework:**

In your practice, at least one senior person must take responsibility for managing health information security requirements. This role needs to be clearly defined and documented. All staff must be aware of the security responsibility completed by that nominated individual or individuals.
You should have an information security policy to meet the needs of your practice. The information security policy document must be approved by management and published, reviewed and communicated regularly to all employees and relevant external parties. The policy should be reviewed a minimum of every three years.

The key elements of the Health Information Security Framework have been distilled into a General Practice ICT Security Checklist to help you undertake a self-assessment and a quick independent assessment of your baseline ICT security. You can use this to guide policy development as well.

The full Health Information Security Framework is here.

Staff training and education

Your staff will need training to use the patient portal software. Your whole practice team can play a role in letting patients know about the portal and registering them. Those practice members using patient portals, either in full or in part, need to be comfortable navigating the portal so that they can guide patients.

In addition, information security is the responsibility of every staff member within your practice, not just the person managing the security policy. Therefore security protocols should be included in any education and training.

Effective training, education and orientation systems will help ensure awareness of how the patient portal works, of policies and procedures, and roles and responsibilities for each staff member with access to patient portals.

Informing patients about patient portals

Your practice’s patient portal registration process should include patient information to optimise patients’ safe use of the portal.

Key areas of information for patients:

- Portal use including security of information, risks, benefits and implications
- Important information (such as not sharing passwords and who the health information may be shared with) up front during the registration process, with more detail available elsewhere (eg on a webpage/brochure)
- The process to follow if the patients have security concerns about their records (eg someone has their password)
- That portals are voluntary and opt-in, and that they can opt out at any time
- The practice should keep records confirming that they have given patients this information. Also record any consent patients have given
- That portals should not be used to contact the practice in an emergency situation.

Managing online communication with patients:

Your practice should:

- Set clear expectations with the patient regarding portal communications
- Establish reasonable response times. Different enquiries may warrant different response times and should include consideration of your closure times.

Indicator 12
The practice uses a Practice Management System
Publicise instructions regarding emergencies or urgent situations, **it should be clear that patient portals are not appropriate for emergencies.**

- Respond to communications in a timely manner and indicate the protocol for your practice’s response.
- Limit the time required to read and respond to patient communications by encouraging/requiring limited text from patients, focusing communications on single or simple issues and encouraging/requiring practice visits for complex matters.

### Key features of the patient portal

Patient portals have a number of different functions and features. Opening up functions and health information gradually allows your practice to sort out work flow processes, new roles and responsibilities and adapt to this new way of working.

For each patient portal service, you should determine a process to be followed and decide who in your practice will receive each notification. See [Patient portals: Practical guidelines for implementation](#) for more details.

Your practice’s portal should be able to provide at a minimum:

- Clinical summary (including medication lists)
- Test results
- Appointment booking
- Repeat prescriptions
- Secure messaging.

### Providing access to consultation notes

Providing access to consultation notes is currently optional and something that will develop more over time. It may be activated as part of a practice wide process or done on a case by case basis.

If the clinician and patient decide together to make viewing consultation notes possible, then the patient should understand that the medical record may contain technical language. Ideally the patient will have information on what common abbreviations mean.

### Key terms

- **Confidentiality:** Information must not be made available or disclosed to unauthorised individuals, entities, or processes.
- **Integrity:** Data must not be altered or destroyed in an unauthorised manner and accuracy and consistency must be preserved regardless of changes.
- **Availability:** Information must be accessible and useable on demand by authorised entities.

### Resources

- Privacy Commissioner: [Health Information Privacy Code 1994](#)
- [Code of Health and Disability Services Consumers’ Rights](#)
- [HISO 10029:2015 Health Information Security Framework](#)
- MCNZ: Statement on use of the internet and electronic communication
- Patient portals: practical guidelines for implementation
- Patient access to general practice electronic health information and interaction with their health care team via patient portals
- Patient portal resources
- Sharing health information: toward better, safer care
- Privacy Commissioner: Electronic shared care records: elements of trust
APPENDICES

Appendix 1: Medical equipment register
All medical equipment and resources must be suitable for supporting comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered.

All essential medical equipment and resources must be available when needed, and members of your 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>Programme</th>
<th>Medical equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation</td>
<td>Foundation medical equipment – all required</td>
</tr>
<tr>
<td>CORNERSTONE® programme</td>
<td>Foundation medical equipment – all required</td>
</tr>
<tr>
<td></td>
<td>Advanced equipment – all required</td>
</tr>
<tr>
<td></td>
<td>Aspirational equipment – optional</td>
</tr>
</tbody>
</table>

*Status codes: F = Found, A = Accepted, * = Accepted with caveats.*
## All basic equipment is available including:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>auriscope</td>
<td>F</td>
</tr>
<tr>
<td>automated external defibrillator</td>
<td>F</td>
</tr>
<tr>
<td>blood glucose test strips/glucometer</td>
<td>F</td>
</tr>
<tr>
<td>cervical smear equipment</td>
<td>F</td>
</tr>
<tr>
<td>proctoscope</td>
<td>F</td>
</tr>
<tr>
<td>dressings adequate to the services provided</td>
<td>F</td>
</tr>
<tr>
<td>electrocardiogram</td>
<td>F</td>
</tr>
<tr>
<td>eye local anaesthetic</td>
<td>F</td>
</tr>
<tr>
<td>fluorescein dye for eyes</td>
<td>F</td>
</tr>
<tr>
<td>gloves</td>
<td>F</td>
</tr>
<tr>
<td>height measure</td>
<td>F</td>
</tr>
<tr>
<td>monofilament</td>
<td>F</td>
</tr>
<tr>
<td>ophthalmoscope</td>
<td>F</td>
</tr>
<tr>
<td>peak flow meter</td>
<td>F</td>
</tr>
<tr>
<td>spirometer</td>
<td>F</td>
</tr>
<tr>
<td>pregnancy testing kit</td>
<td>F</td>
</tr>
<tr>
<td>reflex hammer</td>
<td>F</td>
</tr>
<tr>
<td>spacer device</td>
<td>F</td>
</tr>
<tr>
<td>spatula</td>
<td>F</td>
</tr>
<tr>
<td>sphygmomanometer – extra wide and paediatric cuffs – calibrated within the last year if aneroid; mercury sphygmomanometer needs only rubber pipes checked</td>
<td>F</td>
</tr>
<tr>
<td>stethoscope</td>
<td>F</td>
</tr>
<tr>
<td>surgical instruments appropriate for any procedures carried out</td>
<td>F</td>
</tr>
<tr>
<td>suture equipment</td>
<td>F</td>
</tr>
<tr>
<td>syringes and needles</td>
<td>F</td>
</tr>
<tr>
<td>thermometer</td>
<td>F</td>
</tr>
<tr>
<td>tuning fork</td>
<td>F</td>
</tr>
<tr>
<td>urinary catheters and local anaesthetic gel or other means for urgent catheterisation (eg referral in urban area)</td>
<td>A</td>
</tr>
<tr>
<td>urine dipstick – protein, glucose, ketones</td>
<td>A</td>
</tr>
<tr>
<td>visual acuity chart – at the specified distance</td>
<td>A</td>
</tr>
<tr>
<td>weight scales – adult, baby.</td>
<td>A</td>
</tr>
</tbody>
</table>

## All advanced equipment is available including:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood taking equipment</td>
<td>A</td>
</tr>
<tr>
<td>digital camera</td>
<td>A</td>
</tr>
<tr>
<td>colour blindness book</td>
<td>A</td>
</tr>
<tr>
<td>electrocardiogram on site</td>
<td>A</td>
</tr>
<tr>
<td>Automated External Defibrillator (AED) on site.</td>
<td>A</td>
</tr>
<tr>
<td>Aspirational (optional) equipment includes:</td>
<td>Level</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>bedside ultrasound</td>
<td>⭐</td>
</tr>
<tr>
<td>dermatoscope</td>
<td></td>
</tr>
<tr>
<td>slit lamps.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All emergency and resuscitation equipment is available including:</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>airways and/or laryngeal masks – varied sizes, paediatric to adult</td>
<td>F</td>
</tr>
<tr>
<td>ambubag and masks – both paediatric to adult of both</td>
<td></td>
</tr>
<tr>
<td>emergency bag/trolley</td>
<td></td>
</tr>
<tr>
<td>IV equipment – set up and infusion</td>
<td></td>
</tr>
<tr>
<td>oxygen</td>
<td></td>
</tr>
<tr>
<td>saline – any one of eg Pentaspan/crystalloid</td>
<td></td>
</tr>
<tr>
<td>tourniquet.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All essential basic and emergency medicines are available in stock or in the bag/clinical bag or portable emergency kit:</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>adrenalin 1/1000</td>
<td>F</td>
</tr>
<tr>
<td>analgesia</td>
<td></td>
</tr>
<tr>
<td>an alternative for those allergic to penicillin</td>
<td></td>
</tr>
<tr>
<td>antiemetic</td>
<td></td>
</tr>
<tr>
<td>antihistamine injection</td>
<td></td>
</tr>
<tr>
<td>aspirin tablets</td>
<td></td>
</tr>
<tr>
<td>atropine injection</td>
<td></td>
</tr>
<tr>
<td>corticosteroid injection</td>
<td></td>
</tr>
<tr>
<td>diazepam injection/rectal</td>
<td></td>
</tr>
<tr>
<td>frusemide</td>
<td></td>
</tr>
<tr>
<td>50% glucose/glucagon injection</td>
<td></td>
</tr>
<tr>
<td>local anaesthetic injection</td>
<td></td>
</tr>
<tr>
<td>naloxone injection</td>
<td></td>
</tr>
<tr>
<td>nitrolingual spray</td>
<td></td>
</tr>
<tr>
<td>penicillin injection—some need refrigeration and in addition powdered version for off-site emergencies</td>
<td></td>
</tr>
<tr>
<td>sodium chloride (NaCl) for injection</td>
<td></td>
</tr>
<tr>
<td>sterile water for injection</td>
<td></td>
</tr>
</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC pathway</td>
<td>ABC is a simple and evidence-based approach to guide and support health care workers to help people to quit smoking.</td>
</tr>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>AED</td>
<td>Automated external defibrillator</td>
</tr>
<tr>
<td>Applied part</td>
<td>A part of medical electrical equipment that in normal use would come in contact with the patient.</td>
</tr>
<tr>
<td>Autoclave</td>
<td>Colloquial term for a steam-under-pressure steriliser (AS/NZS 4815:2006)</td>
</tr>
<tr>
<td>Business or undertaking</td>
<td>The usual meanings of these terms are:</td>
</tr>
<tr>
<td></td>
<td>■ Business: an activity carried out with the intention of making a profit or gain</td>
</tr>
<tr>
<td></td>
<td>■ Undertaking: an activity that is non-commercial in nature (eg certain activities of a local authority) (WorkSafe NZ).</td>
</tr>
<tr>
<td>Calibration</td>
<td>The comparison of a measurement system or device of unknown accuracy to a measurement system or device of a known accuracy to detect, correlate, report, or eliminate by adjustment, any variation from the required performance limits of the unverified measurement system or device (AS/NZS 4815:2006).</td>
</tr>
<tr>
<td>CARM</td>
<td>The Centre for Adverse Reactions Monitoring: The CARM database provides New Zealand–specific information on adverse reactions to medicines and vaccines.</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled drug</td>
</tr>
<tr>
<td>Chemical indicator</td>
<td>Dye, which can be impregnated into materials or contained within a device, and which changes colour when subjected to the sterilising process (AS/NZS 4815:2006).</td>
</tr>
<tr>
<td>Cleaning</td>
<td>The removal of soil and reduction in the number of microorganisms from a surface, by a process such as washing with water and detergent without prior processing (AS/NZS 4815:2006).</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing medical education</td>
</tr>
<tr>
<td>Cold Chain</td>
<td>The ‘Cold Chain’ is the system of transporting and storing vaccine at +2°C to +8°C from the place of manufacture to the point of vaccine administration (the individual) (Ministry of Health).</td>
</tr>
<tr>
<td>Control measure</td>
<td>A way of eliminating or minimising the risk of harm.</td>
</tr>
<tr>
<td>CORNERSTONE®</td>
<td>The accreditation programme for the Aiming for Excellence standard</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous quality improvement</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>DHB</td>
<td>District health board</td>
</tr>
<tr>
<td>Disinfection</td>
<td>The inactivation of non-sporing organisms using either heat and water (thermal) or by chemical means.</td>
</tr>
<tr>
<td>Ethnicity Data Protocols for the Health and Disability Sector</td>
<td>Procedures for the standardised collection, recording and output of ethnicity data for the New Zealand health and disability sector (Ministry of Health).</td>
</tr>
<tr>
<td>Evacuation procedure</td>
<td>An evacuation procedure is a plan that describes how occupants will escape to a place of safety if there is a fire (or suspected fire).</td>
</tr>
<tr>
<td>Evacuation scheme</td>
<td>An evacuation scheme describes the measures that have been put in place to enable safe and timely evacuation if there is a fire (or suspected fire) (NZFS).</td>
</tr>
<tr>
<td>GP2GP</td>
<td>GP2GP enables medical records to be electronically transferred from one GP to another.</td>
</tr>
<tr>
<td>GPG</td>
<td>Good practice guidelines</td>
</tr>
<tr>
<td>Hazard</td>
<td>Anything that can cause harm.</td>
</tr>
<tr>
<td>HDC</td>
<td>Health and Disability Commissioner</td>
</tr>
<tr>
<td>Health monitoring</td>
<td>Monitoring workers’ health to see if their work is harming their health and to assess ongoing effects.</td>
</tr>
<tr>
<td>HIPC</td>
<td>Health Information Privacy Code</td>
</tr>
<tr>
<td>HISF</td>
<td>Health Information Security Framework</td>
</tr>
<tr>
<td>HISO</td>
<td>Health Information Standards Organisation</td>
</tr>
<tr>
<td>HPCA</td>
<td>Health Practitioners Competence Assurance Act 2003</td>
</tr>
<tr>
<td>HQSC</td>
<td>Health Quality &amp; Safety Commission</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IMAC</td>
<td>Integrated Performance and Incentive Framework – now System Level Measures Framework</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Medical Council of New Zealand: The Medical Council registers doctors in New Zealand and carries responsibilities in the areas of standards, conduct and competence.</td>
</tr>
<tr>
<td>MECA</td>
<td>Multi-employer collective agreement</td>
</tr>
<tr>
<td>Medsafe</td>
<td>New Zealand Medicines and Medical Devices Safety Authority</td>
</tr>
<tr>
<td>MOPS</td>
<td>Maintenance of Professional Standards – The Royal New Zealand College of General Practitioners’ continuing professional development programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NIR</td>
<td>National Immunisation Register</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td><strong>Notifiable event</strong></td>
<td>When someone dies or when a notifiable incident, illness or injury occurs as a result of work (See sections 23 and 24 of HSWA).</td>
</tr>
<tr>
<td><strong>NSU</strong></td>
<td><strong>National Screening Unit:</strong> Responsible for the development, management and monitoring of nationally organised population-based screening in New Zealand.</td>
</tr>
<tr>
<td><strong>NZePS</strong></td>
<td><strong>NZ ePrescription Service:</strong> The New Zealand Electronic Prescription Service (NZePS) provides a secure messaging channel for prescribing and dispensing systems to electronically exchange prescription information.</td>
</tr>
<tr>
<td><strong>NZFS</strong></td>
<td><strong>New Zealand Fire Service</strong></td>
</tr>
<tr>
<td><strong>Officer (Health and Safety at Work Act 2015)</strong></td>
<td>An <strong>officer</strong> is a person who holds a very senior leadership position and has the ability to significantly influence the management of a PCBU. This includes, for example, company directors and chief executives (WorkSafe NZ).</td>
</tr>
<tr>
<td><strong>PCBU</strong></td>
<td><strong>Person conducting a business or undertaking</strong></td>
</tr>
<tr>
<td><strong>PES</strong></td>
<td><strong>Primary care Patient Experience Survey</strong></td>
</tr>
<tr>
<td><strong>PHARMAC</strong></td>
<td><strong>Pharmaceutical Management Agency</strong></td>
</tr>
<tr>
<td><strong>PHO</strong></td>
<td><strong>Primary health organisation</strong></td>
</tr>
<tr>
<td><strong>PMS</strong></td>
<td>Practice management system</td>
</tr>
<tr>
<td><strong>PPE</strong></td>
<td>Personal protective equipment – anything used or worn by a person (including clothing) to minimise risks to the person’s health and safety (eg mask, gloves).</td>
</tr>
<tr>
<td><strong>Primary duty of care</strong></td>
<td>A PCBU must ensure, so far as is reasonably practicable, the health and safety of its workers, and that other persons are not put at risk by the PCBU’s work. This is called the ‘primary duty of care’.</td>
</tr>
<tr>
<td><strong>PRIME programme</strong></td>
<td>The <strong>PRIME programme</strong> utilises the skills of specially trained rural GPs and/or rural nurses in areas to support the ambulance service where the response time for assistance would otherwise be significant or where additional medical skills would assist with the patient’s condition.</td>
</tr>
<tr>
<td><strong>RCD</strong></td>
<td>Residual current devices</td>
</tr>
<tr>
<td><strong>Reusable device</strong></td>
<td>A device designated or intended by the manufacturer as suitable for reprocessing and reuse. It is not a device that is designated or intended by the manufacturer for single use only (AS/NZS 4815:2006).</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Risk can be described as the likelihood certain consequences (death, injury, or illness) occur when a person is exposed to a hazard. Risks arise from people being exposed to a hazard (a source of harm).</td>
</tr>
<tr>
<td><strong>RNZCGP</strong></td>
<td>The Royal New Zealand College of General Practitioners</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tbody>
</table>
| SAC          | **Severity assessment code**:  
The method used by any person who has identified an incident to determine the appropriate action to take on that incident.  
The score is ascertained by rating the consequence of the incident and its likelihood of occurrence. The SAC allocates a numerical rating to every incident to ensure that appropriate management occurs. |
| SiP          | **Safety in Practice**                                                                                                                                                                                                                                                                                                                   |
| SNOMED CT    | **Systematized Nomenclature of Medicine – Clinical Terms**:  
A standardised, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.                                                                                                                                       |
| SWOT         | **Strengths, weaknesses, opportunities, and threats**:  
A structured planning method that evaluates those four elements of a project or organisation.                                                                                                                                                                                                                                           |
| TCAM         | **Team Climate Assessment Measure**                                                                                                                                                                                                                                                                                                        |
| The Code     | **The HDC Code of Health and Disability Services Consumers’ Rights 1996**                                                                                                                                                                                                                                                                  |
| Trial evacuation | An evacuation drill that is carried out when there are no signs of fire, for the purpose of evaluating the effectiveness of an evacuation procedure.                                                                                                                                                                                                                      |
| Type BF applied part | **Body floating applied part**:  
Equipment providing a particular degree of protection against electric shock, with an isolated or floating applied part (or parts) that contacts the patient and is separated from earth.  
Examples of this type of equipment are blood pressure monitors, incubators and ultrasound equipment.                                                                                                               |
| Type CF applied part | **Cardiac floating applied part**:  
Type CF applied parts are those parts suitable for direct cardiac application and where the applied part is in direct conductive contact with the heart or other applications as considered necessary. Provides a higher degree of protection against electric shock than type BF.                                                                                   |
<p>| Validation   | Documented procedure for obtaining, recording and interpreting the results required to establish that a process will consistently yield a product complying with pre-determined specifications (AS/NZS 4815:2006)                                                                                                                   |
| VCA          | <strong>Vulnerable Children Act 2014</strong>                                                                                                                                                                                                                                                                                                          |
| Volunteer    | A person who does work for an organisation but receives no payment. Volunteers may receive out-of-pocket expenses such as petrol or meals when traveling away from home. Payment beyond out-of-pocket expenses may indicate that person is an employee.                                                                                     |
| Warden       | A person who has specific responsibilities during an evacuation of a building during an emergency                                                                                                                                                                                                                                |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>Worker</strong></td>
<td>A worker is an individual who carries out work in any capacity for a PCBU. A worker may be an employee, a contractor or subcontractor, an employee of a contractor or subcontractor, an employee of a labour hire company, an outworker (including a homeworker), an apprentice or a trainee, a person gaining work experience or on a work trial, or a volunteer worker. Workers can be at any level (eg managers are workers too).</td>
</tr>
<tr>
<td><strong>Worker participation practices</strong></td>
<td>Worker participation practices are what the PCBU puts in place so that workers can help to improve work health and safety on an ongoing basis. These practices make it possible for workers to share ideas and information, raise issues, and contribute to decision making on an ongoing basis.</td>
</tr>
<tr>
<td><strong>Workplace</strong></td>
<td>A workplace is any place where a worker goes or is likely to be while at work, or where work is being carried out or is customarily carried out. Most duties under HSWA relate to the conduct of work. However, some duties are linked to workplaces.</td>
</tr>
<tr>
<td><strong>Workplace monitoring</strong></td>
<td>Involves measuring a hazard arising from work (eg noise, vibration).</td>
</tr>
<tr>
<td><strong>WorkSafe New Zealand (WorkSafe)</strong></td>
<td>WorkSafe is the government agency that is the work health and safety regulator. WorkSafe collaborates with PCBUs, workers and other duty holders to embed and promote good work health and safety practices, and enforce health and safety law. Other government agencies.</td>
</tr>
</tbody>
</table>