The Royal New Zealand College of General Practitioners

Aiming for Excellence

RNZCGP Standard for New Zealand General Practice

2011–2014

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Aiming for Excellence 2011
—The Standard for New Zealand General Practice

Any changes to *Aiming for Excellence* since the first edition have been in response to feedback from general practice teams or other stakeholders in primary care. New evidence and information continually inform refinement of the indicators and criteria so they remain relevant to New Zealand general practices. The Royal New Zealand College of General Practitioners (the RNZCGP or the College) regularly monitors performance of the measurements to ensure the standard remains acceptable to general practice.

Acknowledgements

Disclaimer

Contents

Introduction

Aiming for Excellence 2011 is the RNZCGP Standard for New Zealand General Practice. It builds on previous editions and contributions by general practitioners, practice nurses, practice managers, Māori and consumers to develop indicators of best practice that are valid and relevant for use by general practice teams. Its purpose is to provide a standard to measure and to compare quality of care. It promotes continuous quality improvement through reflection of current practice, learning and making changes where required. The intent is to encourage critical thinking and questioning that influences systematic approaches to improvement through positive change.

Use of *Aiming for Excellence* by practice teams has had a measurable and positive effect on general practice quality and continued relevance is essential. It has provided a focus for practice teams who want to develop new methods of care and to work with other primary care organisations to organise and deliver incremental improvements to patient care.

This version of *Aiming for Excellence* reflects the changing general practice and primary care landscape. It blends academic investigation with pragmatic approaches that extend and facilitate seamless care for patients.[1] It provides an important platform for practice teams to develop activities that manage increasing diversity and complexity, and to set aspirational targets for quality improvement.

Aiming for Excellence reinforces the unique character and contribution of New Zealand general practices.[2, 3] Its use makes explicit the values of general practice and facilitates:

- person-centred approaches
- involvement of patients and their whānau in the management of their care
- a culture of safety, accountability and continuous quality improvement
- multidisciplinary teams networking to coordinate and facilitate continuity of care
- provision of individual and population care for communities of patients
- developing new opportunities, including public health, screening, illness prevention, disease management and resource management
- acceptance of greater accountability for health outcomes and best use of health resources
- delivery of clinical and management excellence in services, at all levels, to ensure optimum effectiveness and efficiency.

As the foundation standard used by the CORNERSTONE® General Practice Accreditation Programme and other College programmes, *Aiming for Excellence* combines quality assurance and quality improvement standards. It sets the scene for clinical improvements in patient care through assessment, reflection and learning, and encourages practice teams to deliver the best possible care to patients.

Aiming for Excellence Expert Advisory Group

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General Practice

General Practice[4,5] is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity. It is a clinical specialty oriented to primary health care. It is a first-level service that requires improving, maintaining, restoring and coordinating people's health. It focuses on the needs of patients and their whānau, enhancing networks among local communities, other health and non-health agencies.

General practice:

1. provides personal, family and community-oriented comprehensive primary care that continues over time, is anticipatory as well as responsive, and is not limited by the age, gender, ethnicity, religion, belief system or social circumstances of patients, nor by their physical or mental states

2. is normally the point of first medical contact within the health care system, provides open and unlimited access to its users, and deals with all health issues regardless of the age, gender, culture or any other characteristic of the person concerned

3. makes efficient use of health care resources through the coordination of care, working with other professionals in the primary health care setting, managing the interface with other specialities, and taking an advocacy role for the patient when needed

4. develops person-centred approaches to care which are oriented to the individual as well as being responsive to the needs of their whānau and their community

5. has a unique consultation process that supports a continuous relationship over time, through effective communication between clinicians and patients

6. is responsible for the provision of longitudinal continuity of care as determined by the needs of patients

7. has specific decision-making processes determined by the prevalence and incidence of illness in a community

8. diagnoses and manages both acute and chronic health problems of individual patients

9. diagnoses and manages illness which presents in an undifferentiated way at an early stage in its development, and which may require urgent intervention

10. promotes health and wellbeing through appropriate and effective intervention

11. has specific responsibility for health in the community

12. deals with health problems in their physical, psychological, spiritual, social and cultural dimensions.

Aiming for Excellence and the CORNERSTONE® General Practice Accreditation Programme

Together *Aiming for Excellence* and CORNERSTONE® meet the requirements of the New Zealand Public Health and Disability Act 2000 for the development, use and monitoring of a nationally consistent standard and quality improvement programme for general practice services and patient safety.

Aiming for Excellence in 2011

The mission of the RNZCGP is to improve the health of all New Zealanders through high quality general practice care. It believes the provision of safe, high quality general practice services in a primary care environment is essential to achieve the best outcomes for patients. *Aiming for Excellence* is the College standard for safe, high quality general practice care.

Aiming for Excellence provides a quality improvement framework for general practice teams to compare their practice and clinical systems against a recognised and acceptable standard. It outlines where practices can focus their efforts to establish safe, transparent, accountable, high quality general practice. Practices can use the information for systems review, continuous improvement and to support management of patient care[6,7] to improve outcomes for patients (*figure 1*).

Figure 1—Sections in *Aiming for Excellence*

Features of a general practice system

a. A focus on people

Providing person-centred care is the right thing to do.[8] It encourages practitioners to consider collective responsibility through shared thinking, shared information, deliberation and clinical effectiveness.[9] When combined with the core set of values, behaviours and relationships that underpin patient trust,[10] it results in practice teams and patients using information to navigate their way through the system and working together to achieve improvements in outcomes.[11]

b. Continuous Quality Improvement (CQI)

A culture of CQI seeks never-ending improvement of the whole system as part of normal daily activity. Continually striving to act according to the best available knowledge[12] and undertaking a quality improvement process reflects the desire and commitment of the team to find out, *"Are we doing what we should be doing as well as we could?"* and *"In what areas could we do better?"*

Imagine yourself on a 7m yacht in the middle of the Pacific Ocean with no engine or modern navigational equipment. A logical question would be "Where am I?" Using a sextant allows you to put a cross on the map; only then can another cross be marked *where you want to go,* before you can take the step of determining *how to get there.*

The assumption behind quality measurement is that unless we learn something about what we are doing, we are unlikely to know what needs improving, or how to improve it. The most effective way to learn is to ask the right questions. The *indicators* are the questions. They provide a baseline to help your practice team develop an accurate picture of where you stand.

Aiming for Excellence is designed to identify where you are in order to plan *where you want to go*. The indicators in this document are a guide to best practice; they provide a basis to measure and assess care to identify potential improvements in the quality of care offered to patients.

While *Aiming for Excellence* can be used as a minimum standard to fulfil external requirements, the intent is that it should be used primarily as a catalyst for CQI. We want to encourage practices to strive for the best. Only then can another cross be marked at *where you want to go* before taking the next step of deciding how to get there.[13]

c.   Teamwork

Teamwork is an essential element of the RNZCGP CQI approach and it builds on the work of other international organisations, in particular The Joint Commission on Accreditation of Healthcare Organizations (JCAHO),[14] which emphasises team engagement and processes as an essential element of quality improvement.[12] Effective teams provide coordinated, accessible, longitudinal and comprehensive care for patients and populations. Seamless care is achieved by working across health, allied health and community interfaces.

Measurement alone is not useful and synergies occur when all team members are involved in improvement processes. *Aiming for Excellence* provides a focus for problem solving and making tangible improvements in general practice systems. This approach is proven to support the development of a culture of quality in teams.[15]

d.   Comprehensive primary care

The case for primary care–oriented systems is strong and there are tangible benefits for patients.[16] Clinicians have explicit responsibilities and accountability to patients.[17, 18] Comprehensive care is person-focused and includes first contact and ongoing care that meets the health-related needs of people, is provided over time, and includes coordinating care when people need to be referred to other services. Only those cases that cannot be dealt with in a general practice are referred. Comprehensive primary care influences continuity, improves health outcomes, and produces greater efficiency and equity in health.[19, 20]

General practice teams are multidisciplinary teams that work together to manage issues in a complex environment within diverse populations, and constantly respond to societal trends and advances in knowledge and information technology.[21] In this mix, patients are no longer passive recipients of care. They are learning to self-manage and contribute to service planning and design.[22] To do so, they must have relevant information and support.

e.   Improving health for all, and Māori in particular

There is much to learn from whānau approaches to health. Improving health for Māori will benefit future generations. Potential within whānau has never been greater as they support and involve each other to improve chances of successful recovery and management.[23] General practice teams are encouraged to work with whānau across primary care and other whānau-centred services where possible.

Aiming for Excellence measurements

Anecdotal evidence on its own is not sufficient as a measure of improvement, and access to consistent data over time produces robust information to inform reflection and health improvement activity.[24, 25] While it is not possible or useful to assess every function in a practice, *Aiming for Excellence* identifies measurements considered important by all stakeholders, including patients, for the development of structures and processes in patient-centred general practice settings. They are grouped into four areas with people as the focus (*figure 1*). Practices that achieve the standards in this document can provide accountability for delivering safe, comprehensive, high quality services to patients.[19]

Aiming for Excellence contains indicators, criteria and standards. The measurements are used by practice teams to identify where they are doing well or where there are gaps. Results are used to identify where additional resources or improvements are needed to meet the needs of patients, their whānau[26] or other external stakeholders.

Indicators, criteria and standards

Indicators

Each indicator describes a measurable element of practice performance for which there is evidence or consensus that it can be used to assess quality, and be used to produce a positive change in the quality of care provided.[27]

Criteria

Criteria are discrete, definable, measurable and explicit.[27] These are the elements of care that are so clearly defined that they can be counted or measured to help understand whether the indicator was met or not.[27]

Standards

The standard is viewed as a mark of success and specifies the acceptable level of care. Each criterion guides improvement and provides a clear separation of external standards from developmental or aspirational standards.[28]

There are three categories of standards.

Key

★★   *Essential standards*

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

★   *Standards considered essential by the RNZCGP*

These standards are considered important and best practice by the RNZCGP. Meeting these standards signals an intent by practices to provide patients with continuity of care during their health journey.

☆   *Aspirational standards*

These standards identify further opportunities for continuous quality improvement.

Section 1—Patient Experience and Equity

Needs and rights of patients

General practice teams must provide care that meets the needs and rights of patients, and be accountable. New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers' Rights 1996. It was amended in 1999 and 2004, and specifies the obligation of practice teams to show that they have taken "reasonable actions in the circumstances to give effect to the rights, and comply with the duties [in the Code]".

Indicator 1

> ### The practice team complies with the Code of Health and Disability Services Consumers' Rights 1996

Criteria		Rationale
1.1 ★★	There is a copy of The Code of Health and Disability Services Consumers' Rights 1996 (The Code) in the practice	• New Zealand legislation outlines the basic rights and entitlements of patients when receiving health and disability services
1.2 ★★	The Code of Health and Disability Services Consumers' Rights 1996 is displayed where patients can view the content	• 'The Code' must be displayed so that patients can be aware of their rights when using health and disability services
1.3 ★★	The practice team has received training to implement 'The Code'	• Training provides practice teams with accurate and consistent information
1.4 ★★	The practice team is able to demonstrate their role in implementing 'The Code'	• Translating knowledge into effective practice enables the requirements of the legislation to be met
1.5 ★★	Information about the local health advocacy service is displayed where patients can view it	• Practices must make it easy for people to access advocacy information

Further information

The rights of patients under The Code of Health and Disability Services Consumers' Rights 1996 are to:

1. be treated with respect
2. be provided with fair treatment
3. be treated with dignity and independence
4. receive proper standards of care
5. participate in effective communication
6. be provided with information
7. decide about treatment and care
8. have a support person of their choice
9. decide about involvement in health teaching and research
10. make complaints

Consumer advice to practices

- The practice team should recognise individual values and beliefs, and culture. This includes ethnicity, spirituality, disability (physical, psychological, intellectual and sensory), gender, sexual orientation, social status and age.
- Information for patients should cover: hours, fees, services, after-hours arrangements, doctors, practice personnel, special information needs. A translation should be available when needed.
- Disability should not be a reason to curtail the process of informed consent. Extra time and resources should be made available if necessary to fulfil this right. Note: exemptions in legislated areas e.g. emergencies.

- Any other relevant information should be noted, such as professional, ethical, legal and other relevant standards.
- Patients have the right to decline or change their mind about treatment and services at any time.
- Interpreters or advocates should be available to assist patients who need extra help with communication and making decisions about their care e.g. people who are deaf, those for whom English is a second language or those with intellectual disabilities.
- Patients have the right to have a support person or chaperone present during a consultation.
- Receptionists need to be trained in dealing with the public and handling difficult situations that may arise at the desk.

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

Health Navigator: www.healthnavigator.org.nz

St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. www.mcnz.org.nz

Health Information Privacy

The Health Information Privacy Code 1994 applies to identifiable health information about individual patients. The Code takes account of the characteristics of health information (such as its confidentiality, sensitivity and use by different health care providers) to protect individuals. Practices must identify measures needed to protect individual privacy that meet the legislative requirements set out in the Health Information Privacy Code 1994.

Indicator 2

The practice maintains privacy of patient information in accordance with the Health Information Privacy Code 1994

Criteria		Rationale
2.1 ★★	There is a copy of the Health Information Privacy Code 1994 in the practice	• New Zealand legislation outlines the basic rights and entitlements of patients to information privacy under the Health Information Privacy Code 1994
2.2 ★★	The practice team has received training to implement the principles of the Health Information Privacy Code 1994	• Training provides practice teams with accurate and consistent information
2.3 ★	The practice team is able to demonstrate their role in implementing the Health Information Privacy Code 1994	• Translating knowledge into effective practice enables the requirements of the legislation to be met
2.4 ★★	The collection, use, storage, disposal and disclosure of individual patient information complies with the Health Information Privacy Code 1994	• Legislation requires practices to ensure security of health information throughout the patient's health care journey

Further information

In some circumstances practices have an obligation to disclose patient information, and the Health Act includes an expectation of cooperation between providers. It notes other Acts that override the Privacy Act. Section 23 of the Act places a responsibility on practices to ensure there is a dedicated privacy officer who is responsible for maintaining compliance.

The Office of the Privacy Commissioner advises that notice of disclosure can be provided through posters, brochures, enrolment form declarations or face-to-face discussions.

Consumer advice to practices

- Patients wanting to access notes from their consultation would be assisted by practices providing a simple *Request for Information* form.
- Practices should take steps to make sure people know what is being done with their information.

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

The Health Information Privacy Code 1994 (including commentary). www.privacy.org.nz

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

Complaints

The practice complaints procedure must meet relevant time frames and legal requirements under Right 10 of the Code of Health and Disability Services Consumers' Rights 1996. They can be important indicators of problems with clinical care or processes,[21] and may not be isolated incidents. Practices should establish whether there is a pattern to complaints received. Most complaints can be dealt with at practice level and experiencing a problem can be distressing for patients, families, and affected team members or the practice team. Having a process in place to identify and manage complaints helps practices understand the nature of problems and resolve them.

Indicator 3

The practice upholds the patient's right to complain

Criteria		Rationale
3.1 ★★	There is a documented policy that describes how complaints will be managed in line with Right 10 of 'The Code'	• A documented policy provides an agreed and consistent approach to a method for fair, simple, speedy and efficient resolution of complaints
3.2 ★★	The practice team is able to demonstrate their role in managing the complaints process	• Translating knowledge into effective practice enables the requirements of the legislation to be met
3.3 ★★	The Complaints Officer can demonstrate that the complaints process complies with Right 10 of 'The Code'	• The complaints procedure must be managed to comply with relevant timeframes and legal requirements under Right 10 of 'The Code'
3.4 ★	Complaints and their resolution are used as opportunities for learning and quality improvement	• Reviewing and managing complaints is an important risk management activity that enables practices to reflect and respond constructively to complaints

Further information

To meet the requirements of 'The Code', practices must ensure that:

- quality systems are in accordance with legislative requirements
- practice systems enable patient feedback and response
- people know that they have the right to make a complaint, and know to whom complaints can be made
- the team understands the method to implement a fair, simple, speedy and efficient resolution of complaints
- complaints are managed within the timeframes under 'The Code'
- complaints are used to inform clinical governance activity in the practice.

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. www.mcnz.org.nz

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

Informed choices

Informed consent occurs when the patient gains an understanding of what is involved in receiving a proposed procedure or treatment and, free from coercion, gives agreement. Clinicians must be able to support patients so that they can make informed choices about their care. Trust is a vital element in this approach and both patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. Clinicians need to inform the patient about potential risks and benefits of a proposed treatment and let the patient know that their welfare is the paramount concern.[29]

Indicator 4

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

Criteria		Rationale
4.1 ★★	**Information is available and accessible to assist patients to make informed choices**	• 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
4.2 ★	**Patients are routinely informed of their right to have a support person or chaperone present during a consultation**	• Patients need to know that they can ask to have someone to support them during a consultation. Right 8 of the Code of Health and Disability Services Consumers' Rights 1996 states that every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed
4.3 ★★	**Informed consent is obtained from a patient or legally designated representative when agreeing to a treatment or procedure**	• Obtaining informed consent is an essential risk management activity. New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers' Rights 1996
4.4 ★★	**Informed consent is documented when there is variance between evidence and practice**	• A record is important in areas where there is variance between evidence and some medical practice or an ethical dilemma about treatment

Further information

The Code of Health and Disability Services Consumers' Rights 1996 provides guidance on informed consent processes. In particular, refer to:

- Right 5—effective communication between the provider and the patient
- Right 6—disclosure of adequate information to the patient
- Right 7—the competent patient's voluntary decision.

Consumer advice to practices

- Practice teams should be trained to access information for patients in different languages and formats.
- Patients and their whānau must receive communication in a form, language, and manner that enables them to understand the information provided. This includes, for example, patients and whānau who are deaf, blind, or not proficient in English.

- Support must be made available to assist patients with understanding information provided and to enable them to make informed choices so they can give consent about their care and treatment. This support might include interpreting services, family members/whānau, patient advocate, clinical team members, counsellors.
- Practices should note whether an interpreter was used to explain any information, and the name of the interpreter.
- Practice members must be able to identify signs (e.g. body language) that people might need assistance.
- The use or offer of a chaperone should be routinely recorded in the clinical records, even if the offer is declined by the patient. Possible records might be COD for 'Chaperone offered: declined', or CP for 'Chaperone present'.

Resources

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

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

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

St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. www.mcnz.org.nz

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

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

Medical Council of New Zealand—Information and consent (2002); Legislative requirements about patient rights and consent (2005). www.mcnz.org.nz

Ministry of Health. Consent in child and youth health: Information for practitioners. Wellington, NZ: Ministry of Health; 1998. www.moh.govt.nz

Ministry of Health. Refugee health care: A handbook for health professionals. Wellington, NZ: Ministry of Health; 2001. www.moh.govt.nz

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

Te Tiriti o Waitangi

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

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

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

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

- the patient management system identifies Māori
- the practice uses the Health Equity Assessment Tool, Whānau Ora Tool or Whānau Ora Health Impact Assessment Tool in their planning process
- the practice is aware of the special rights and health needs of Māori, and implements policies consistent with the Māori Health Strategy to ensure access to a fair share of the practice resources
- the practice conducts regular clinical audits reviewing data by ethnicity, and makes changes as indicated by the results of these audits

Practice teams are expected to proactively identify the health needs of Māori with the purpose of providing equity to Māori. *Te Akoranga a Maui, 2011*

Indicator 5

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

Criteria		Rationale
5.1 ★	The practice has a documented Māori Health Plan	• Practice planning supports the Crown's commitment to address inequalities between the health status of Māori and other New Zealanders[30]
5.2 ★★	All team members are trained in Te Tiriti o Waitangi (the Treaty of Waitangi), including the principles of 'Partnership, Participation and Protection'	• Training provides practice teams with accurate and consistent information about relationships with local Māori, and addresses indigenous rights and the Crown's responsibility to Māori
5.3 ★	The practice addresses the health needs of its enrolled Māori population to reduce health inequalities	• Successful engagement with Māori will help reduce disparities through better understanding about the determinants of health, healthy lifestyles, how to access appropriate health services early, and how to ensure Māori feel comfortable in mainstream health institutions[31]
5.4 ★	The practice team has developed active relationships with local Māori organisations, providers, groups, and whānau	• Establishing relationships with tangata whenua,* iwi groups, marae, local Māori providers and/or Māori community organisations will enable the practice to develop services that are relevant for Māori

* Tangata whenua is a Māori term referring to Māori being the indigenous peoples of Aotearoa (New Zealand) and means 'people of the land', from tangata, 'people', and whenua, 'land'. In a particular tribal geographical area tangata whenua refers to the local Māori tribe.

Further information

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

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

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

- address Māori health priority areas and specific practice population issues for Māori (the Government has identified a range of priority areas in He Korowai Oranga: Māori Health Strategy for improving Māori health and to improve access to appropriate, affordable and acceptable primary health services)
- implement measures to address priority areas as stated in He Korowai Oranga: Māori Health Strategy
- target services for its enrolled Māori population
- ensure ethnicity data on Māori is available and robust
- establish priorities for Māori in the practice and set goals that will benefit their health outcomes
- demonstrate that they are making additional efforts to address the needs of Māori. These efforts might include:
  – having specific targets and timelines e.g. measure statins in Māori versus non-Māori
  – encouraging enrolment of Māori patients on specific programmes such as Care Plus, Diabetes Get Checked, 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

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

Resources

The Royal New Zealand College of General Practitioners. Cultural competence—Advice for GPs to create and maintain culturally competent general practices in New Zealand. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2007.

Ministry of Health. He Korowai Oranga—Māori Health Strategy. Wellington, NZ: Ministry of Health; 2002. www.moh.govt.nz

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

Durie M. Cultural competence and medical practice in New Zealand. Discussion Paper. Wellington, NZ: School of Māori Studies, Massey University, Palmerston North; 2001. www.massey.ac.nz

Medical Council of New Zealand. Best health outcomes for Māori: Practice implications. Statement on best practices when providing care to Māori patients and their whānau; 2006.

Ministry of Health. Ethnicity data protocols for the health and disability sector. Wellington, NZ: Ministry of Health; 2004. www.moh.govt.nz

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

Cultural competence and responsiveness

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

Indicator 6

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

	Criteria	Rationale
6.1 ★★	All members of the practice team are trained in cultural competence and cultural safety	• New Zealand legislation outlines the basic rights and entitlements of patients under the Code of Health and Disability Services Consumers' Rights 1996 and Section 118 of the Health Practitioners Competence Assurance Act 2003 • Training ensures all team members, including locums, are provided with accurate and consistent information to deliver culturally safe care and be responsive to the cultural needs of patients
6.2 ★★	The practice collects, documents and audits patient ethnicity data consistent with the Health Information Privacy Code 1994 and the MoH Ethnicity Data Protocols for the Health and Disability Sector	• New Zealand legislation outlines the basic rights and entitlements of patients to information privacy under the Health Information Privacy Code 1994 • Accurate collection, maintenance and auditing of patient ethnicity data enables the Crown and the practice to identify patient and population health needs
6.3 ★	The practice team can access interpreters and resources for people with limited English proficiency	• Patients should not be disadvantaged when language is a barrier to care • Patients need interpreting services when interpreting by family members is not appropriate (due to, for example, the seriousness of illness) to gain informed consent or to understand the nature of the clinical problem
6.4 ★	The practice makes provision for hearing, sight or speech impaired people to communicate with the practice	• Patient care and outcomes must not be compromised by a patient's inability to communicate with the practice team • It is important to remember that language is not the only barrier to communication; disabilities (e.g. blindness, deafness etc.) may also impact on the ability to understand what is being communicated

Further information

Cultural competency is a requirement of the HPCA Act. It is also recommended that all practice team members learn about Whānau Ora, how it would be applied in practice, and that all professional development activities include relevant cultural aspects (Te Akoranga a Maui 2010). For example, practice audits should include analysis by age, gender, ethnicity and other sociodemographic factors

The Code of Health and Disability Services Consumers' Rights 1996 states that every consumer has the right to be:

- treated with respect, and have services provided to them that take into account their needs, values, and beliefs, including the beliefs of different cultural, religious, social and ethnic groups (Right 1)
- free from discrimination, coercion, harassment, and exploitation (Right 2)
- provided with services in a manner that respects the dignity and independence of individuals (Right 3).

Patient surveys such as the RNZCGP Better Practice Patient Questionnaire (BPPQ) provide information about patient experiences of using general practice services.

Consumer advice to practices

- Patients need to feel safe in the practice and the warmth of greeting is considered important. The face of the practice should be friendly and welcoming.
- Reception teams should provide information about how to access a support person, an interpreter or transport if needed.

Resources

The Royal New Zealand Foundation of the Blind—Braille translation: www.rnzfb.org.nz

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

Deaf Aotearoa: www.deaf.co.nz

Health Navigator: www.healthnavigator.org.nz

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

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

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

Medical Council of New Zealand. Best health outcomes for Pacific Peoples: Practice implications; 2010. www.moh.org.nz

Durie M. Cultural competence and medical practice in New Zealand. Discussion Paper. Wellington, NZ: School of Māori Studies, Massey University, Palmerston North; 2001. www.massey.ac.nz

Medical Council of New Zealand. Statement on cultural competence. Wellington, NZ: Medical Council of New Zealand; 2006. www.mcnz.org.nz

Medical Council of New Zealand. Best health outcomes for Māori: Practice implications. Statement on best practices when providing care to Māori patients and their whānau; 2006. www.mcnz.org.nz

Medical Council of New Zealand. Best health outcomes for Pacific Peoples: Practice implications; 2010. www.mcnz.org.nz

Ministry of Health. Ethnicity data protocols for the health and disability sector. Wellington, NZ: Ministry of Health; 2004. www.moh.govt.nz

Ministry of Health. Kōrero Mārama: Health Literacy and Māori—Results from the 2006 Adult Literacy and Life Skills Survey. Wellington, NZ: Ministry of Health; 2010. www.moh.govt.nz

Ministry of Health. Refugee health care: A handbook for health professionals. Wellington, NZ: Ministry of Health; 2001. www.moh.govt.nz

Ministry of Health. He Korowai Oranga—Māori Health Strategy. Wellington, NZ: Ministry of Health; 2002. www.moh.govt.nz

New Zealand Society of Translators and Interpreters (NZSTI). www.nzsti.org

The Royal New Zealand College of General Practitioners. Cultural competence—Advice for GPs to create and maintain culturally competent general practices in New Zealand. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2007

Access and availability

Practices provide 24-hour medical care, after-hours care or can direct patients to a service. Practices should use methods that take into account local situations and enable flexibility. Practices that do not provide 24-hour medical care must make after-hours arrangements for their enrolled patients.

Indicator 7

24-hour health care is available to the practice population

Criteria		Rationale
7.1 ★★	The practice makes provision for 24-hour health care	• Patients must be able to access after-hours care or be directed to the service when they need it by using methods that take into account local situations and enable flexibility if the practice does not provide its own 24-hour care
7.2 ★	Patients can access the after-hours service using a maximum of two calls	• Reducing difficulties with telecommunications enhances continuity of care
7.3 ★	The practice acts on health information received about patients seen after hours	• Continuity of care is maintained by ensuring timely transfer of patient information from after-hours visits, emergency services, or specialist services so that medically important actions identified are acted on

Further information

Consumer advice to practices

- If a practice does not provide after-hours care, it must arrange for medical services cover 24 hours a day, seven days a week e.g. via Healthline or an 0800 number.
- If a doctor cannot provide after-hours care, they must make provision to redirect a patient to the nearest after-hours service, hospital, or the on-call service in the area, or to dial 111.
- Call diversion and voice messaging must provide explicit information about which service is providing access to care if after-hours care is not provided at the practice.
- The 111 service is free on cell phones.
- Barriers for people with limited English proficiency, disability or other factors must be identified.
- If a patient has been at the after-hours, emergency or specialist service provider, their information should be communicated back to the practice.
- Practice information could direct people to interpretation services.

Resources

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

Integration of care

Integrated care is also known as case management, shared care, comprehensive care, or seamless care. It is an international trend in health care reforms and new organisational arrangements that focuses on more coordinated and integrated forms of care. Integrated care brings together care management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.[32]

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

Indicator 8

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

Criteria	Rationale
8.1 ★ **The practice team has identified relevant health, social and community services available locally, regionally and nationally**	• Knowledge about other allied health care providers and/or community services enables teams to identify relevant services and refer appropriately
8.2 ★ **The clinical team can demonstrate relationships and linkages with other organisations and community services to coordinate patient care**	• Establishing effective relationships and communication between patients and other agencies enables the practice to improve continuity of care and delivery of services

Further information

Consumer advice to practices

- Patients would like to be able to identify who are looking after them. Name badges and photo boards can help achieve this.
- Practices can help patients to access resources such as handouts, directories, pamphlets, or internet sites.
- Practice teams should build local networks and attend meetings with providers of educational programmes such as: child health initiatives, arthritis field officer, Plunket, care coordination services, Whānau Ora providers
- ACC provides services to assist people to recover from injury caused by accident. The website includes information for patients.

Resources

ACC—resources and information on making claims or requesting entitlements: www.acc.co.nz

Citizens Advice Bureau: www.cab.org.nz

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

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

Patient involvement

Many practices have developed relationships with their local communities to gain insight into the experience of using practice services. This provides better understanding of the needs of its communities and an appreciation of any unique characteristics or dynamics and complexity that can affect health outcomes. Teams that use patient feedback to inform and improve practice services can be more responsive to patient and/or carer needs, which may require different approaches or special skills.[21]

Indicator 9

The practice includes patient input into service planning

Criteria		Rationale
9.1 ★	The practice obtains feedback from patients at least once every three years	• Canvassing patients on a regular basis enables the practice to understand patient experiences and to respond to any identified gaps in service delivery
9.2 ★	The practice can demonstrate how it incorporates patient feedback into service planning	• Patient experience and stories are a valuable source of information for developing services that are relevant to the practice population
9.3 ★	The practice uses population data for targeted service planning	• An awareness of the characteristics of individuals and practice populations contributes to targeted service planning
9.4 ★	Information about the use of patient feedback or any changes to services is communicated to patients and the practice team	• Communicating changes made in response to patient input provides tangible evidence of the value of patient engagement and awareness of changes made to services

Further information

Consumer advice to practices

- Use consumer participation and feedback.
- Keep it simple and flexible.
- Establish a culture of consumer participation.
- Patient feedback or participation should reflect the cultural and demographic mix of the practice population.
- Methods used to invite the views of patients and their whānau about practice services can include: community liaison, advisory groups, including a delegate on a practice committee, focus groups, hui, surveys, one-on-one feedback, and informal complaints or comments.
- Input from patients should be communicated to the practice team for improvement activity and any improvements should then be fed back to patients.

Resources

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

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

Planning for Continuous Quality Improvement

Unless we learn something about what we are doing, we are unlikely to know what needs improving, or how to improve it. Continuous Quality Improvement (CQI) must be planned, organised and managed to be effective. It should be supported by regular evaluation to determine the effectiveness of improvements implemented. Practice plans can provide clear direction across all areas of the practice, such as finance, professional development or information technology. Plans are useful for practice teams to identify what they are doing, what they want to achieve, how they will achieve it and how changes will be evaluated to determine whether there was an improvement.[21]

Indicator 10

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

Criteria		Rationale
10.1 ★	The Strategic Plan is a living document that is reviewed every three to five years	• Strategic planning informs long-term sustainability and short-term goals, identifies business risk, and provides transparency. Plans should be reviewed regularly to identify whether progress is being made
10.2 ★	The practice has a current Quality Plan that outlines clinical goals for the year	• The Quality Plan is used to identify a planned and systematic approach to improving clinical outcomes. It should identify what needs improving and how the practice will address the issues identified
10.3 ★	Practice team members have input into service planning	• Engagement with team members in service planning is essential to enable them to ensure their views and experiences can influence service planning
10.4 ★	The practice identifies an annual quality improvement activity related to the management of a targeted area of clinical care	• Analysing and reflecting on clinical data ensures that quality processes result in improved quality outcomes for patients

Further information

Strategic planning is essential for prioritising and coordinating service and clinical improvement planning. The practice could make use of existing tools to identify how to address the health needs of population groups within the practice. For example, use the Health Equity Assessment Tool (HEAT), the Whānau Ora Tool or the Whānau Ora Health Impact Assessment Tool to identify service needs for Māori patients. These tools encourage consideration of interventions to address and to evaluate success in reducing health inequalities.

Strategic plans should include:

- a mission statement and purpose
- long-term and short-term strategic objectives
- a description of practice functions and range of services
- a SWOT analysis (including both environmental and financial factors)
- quality goals and objectives
- regular review dates
- risk management, including clinical and non-clinical, financial, reputation, and personnel risks.

Resources

Standards New Zealand. (1) AS/NZS 5050:2010 Business continuity—Managing disruption-related risk; (2) HB 266:2010 Guide for managing risk in not-for-profit organizations. www.standards.co.nz

Section 2—Practice Environment and Safety

Physical access to the practice

Practice facilities must be of a high standard to meet the needs of those who work in and use general practice services. There must be good access for patients and their whānau, and the facilities must protect patient and practice team safety.

Indicator 11

The practice premises are safely accessible and clearly identifiable

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

Further information

Consumer advice to practices

- To make practices safe for patients, the practice must consider the internal and external environment.
- Consider people with mobility problems, impaired vision and other potential difficulties. Parking and heavy entrance doors may prove difficult for people who are frail, older or unwell, or who use wheelchairs or walking frames.
- Dedicated disabled parking or alternative arrangements must be available.
- Practices must be safe; they must enable all people to access the premises and find their way without difficulty.
- There should be equipment available to assist all people and those with disabilities if needed. This includes: railings, ramps, lighting, lifts or other relevant equipment.

Resources

Barrier Free New Zealand Trust: www.barrierfreenz.org.nz

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

Department of Building and Housing and Barrier Free New Zealand Trust. Accessible car parking spaces. Wellington, NZ: Department of Building and Housing; 2008. www.dbh.govt.nz

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

Standards New Zealand. NZS 4121:2001 Design for access and mobility: Buildings and associated facilities. (Code of practice for design of access, use of buildings and facilities by disabled persons and others—this applies to new buildings and in some cases alterations to existing buildings). www.standards.co.nz

Practice facilities

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

Indicator 12

<table>
<tr><td colspan="2">The practice facilities meet the comfort, safety and privacy needs of patients</td></tr>
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Criteria		Rationale
12.1 ★★	**The waiting area has adequate space, seating, heating, lighting and ventilation**	• Patients should be provided with a space that is comfortable and safe to accommodate them and their whānau while waiting for an appointment
12.2 ★★	**The waiting area has specialised seating for patients with mobility difficulties**	• Modified seating addresses the special needs of patients who have mobility difficulties
12.3 ★★	**There are safeguards in the reception area to ensure confidentiality of patient information**	• Legislation requires practices to ensure confidentiality of patient information • Patients should be assured that members of the practice team will be discreet and ensure their personal or medical information is not able to be identified in a public space
12.4 ★★	**There is a toilet with mobility access on site**	• Toilet availability on site facilitates patient comfort
12.5 ★★	**There are facilities to ensure hand hygiene in all patient contact areas and toilets**	• Patient and staff safety is enhanced by active infection control measures including hand hygiene
12.6 ★★	**Each consultation room has adequate space, seating, ventilation, lighting and task lighting**	• The consultation setting supports effective and safe clinical activity
12.7 ★★	**Examination couches are accessible, safe and visually private**	• Patients are entitled to privacy when being examined
12.8 ★★	**Patients are assured of privacy during consultations or when any personal health information is conveyed**	• Patients have a right to visual and auditory privacy to ensure their personal health information remains confidential Exception: It is possible that aspects of patient privacy may be compromised when treating patients who are acutely unwell

Further information

Consumer advice to practices

- Identifiable information about patients must not be seen or heard in public areas.
- When capturing patient information, methods must be used to ensure confidentiality is maintained. These methods might include playing background music, an elevated front desk, and training in telephone etiquette.
- The waiting room must be able to accommodate guide dogs comfortably. (Guide dogs are trained to lie at the handler's feet.)
- The waiting room must be large enough to accommodate patients and families comfortably, away from foot traffic areas and doorways.
- There should be enough seats to accommodate waiting patients.
- Seats should be available in a range of chair heights and include armchairs.
- There should be elevated seating with arms to assist patients with disabilities such as arthritis or hip problems.

- There must be adequate space to manoeuvre wheelchairs, push chairs or walking frames.
- Be aware of hazards for patients e.g. make sure footstools in the consultation room are not in the way of patients and there are no electric sockets without safety plugs.
- It is recognised that when treating or observing patients who are acutely unwell, some aspects of patient privacy may be compromised.
- Patients have the right to a mutually acceptable third party to be present during internal/intimate examinations.
- Consultation rooms should be maintained at a comfortable temperature and be private for patients who need to undress or hold a discussion in private.
- Examination couches must be accessible and safe for disabled or frail patients e.g. they should be a safe height, and have hydraulic or portable steps available.
- Be aware of privacy issues regarding access to information by third parties e.g. interpreters, carers, relatives, medical or nursing students on placement.
- Practices could consider consulting with disabled patient/s or groups to identify any needs not being met.

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

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

Department of Building and Housing and Barrier Free New Zealand Trust. Accessible car parking spaces. Wellington, NZ: Department of Building and Housing; 2008. www.dbh.govt.nz

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

Standards New Zealand. NZS 4121:2001 Design for access and mobility: Buildings and associated facilities. (Code of practice for design of access, use of buildings and facilities by disabled persons and others—this applies to new buildings and in some cases alterations to existing buildings). www.standards.co.nz

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. www.standards.co.nz

Information management

Electronic records are essential for managing and auditing patient information. Continuity of care requires that information is robust and available when needed so that practice teams can manage and track conditions. Effective electronic data is accurate, readily accessible, safely stored, and has an audit trail to meet Health Sector, Health and Disability Commission or other legal requirements. Accurate audit reports are heavily dependent on reliable information.

Indicator 13

The practice uses a Practice Management System

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

Further information

The Privacy Commissioner expects all practices to have lockable cabinets for paper files. The College notes it may not be practical to meet this expectation due to space and/or financial limitations and agreed to inform its members that they should plan to fulfil this requirement before the 2013 timeframe set by the Privacy Commissioner.

Rule 5 of the Health Information Privacy Code requires that health agencies, such as general practices, take reasonable steps to keep the health information that they hold secure against loss, misuse and unauthorised access. It does not specify exactly how this should be achieved. What is 'reasonable' depends on the circumstances, such as the nature of the information, the possible harm if it is lost or inappropriately accessed, and the practicality (including space and cost) of securing it. In the context of complaints that she has received, the Privacy Commissioner has been of the view that having lockable cabinets in which to store sensitive personal information is an important component of secure information handling.

Resources

Health (Retention of Health Information) Regulations 1996. www.legislation.govt.nz

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

The Health Information Privacy Code 1994 (including commentary). www.privacy.org.nz

Medical Council of New Zealand. The maintenance and retention of patient records (2005); Statement on use of the internet and electronic communication (2006); Information and consent (2002); Confidentiality and Public Safety 2002. www.mcnz.org.nz

Government Communications Security Bureau. New Zealand Information Security Manual; v1.0 December 2010. www.gcsb.govt.nz

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

Standards New Zealand. AS/NZS ISO/IEC 17799:2006 A1 Information technology—Security techniques—Code of practice for information management: Amendment 1

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

Standards New Zealand. SNZ PAS 8170:2005 Primary Healthcare Practice Management Systems: Publicly Available Specification

Standards New Zealand. NZS 8153:2002 Health Records

Access to controlled drugs

Special responsibilities are placed upon pharmaceutical wholesalers, pharmacies and doctors in the stocking, distribution, issuing of prescriptions, supply and disposal of controlled drugs. Regulations have been tightened following incidents of misuse by health professionals.[33] Controlled drugs must be stored in line with regulations.

Indicator 14

The practice prevents unauthorised access to controlled drugs

Criteria		Rationale
14.1 ★★	Controlled drugs are stored in line with the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977	• Secure storage of controlled drugs reduces the risk of theft or misappropriation and is compliant with the Misuse of Drugs Regulations 1977–28 (a)
14.2 ★★	A register is maintained for controlled drugs	• Accurate documentation enables the practice to track the recipients of controlled drugs • Tracking and monitoring of controlled drugs is for the prevention of theft or misappropriation

Further information

- The Misuse of Drugs Regulations 1977–28 (a) Keep 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.
- Controlled drugs registers have the following characteristics:
  - bound volume
  - each page is numbered consecutively
  - each page identifies one form of controlled drug
  - entries must be made no later than the ordinary business day following the day of the transaction
  - balances shall be undertaken
  - entries should be legible, indelible and in the format specified in the Regulations.

Resources

Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977. www.legislation.govt.nz

Medical Council of New Zealand. Good prescribing practice (2010). www.mcnz.org.nz

The Medicines Act 1981 and Medicines Regulations 1984. www.legislation.govt.nz

Sharps, contaminated materials and hazardous waste

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

Indicator 15

There is safe storage and disposal of healthcare waste

Criteria		Rationale
15.1 ★★	Practice waste is correctly categorised, safely stored, collected and disposed of in accordance with the industry standard NZS 4304:2002	• Ensuring practices manage health care waste they must meet the requirements of The Hazardous Substances and New Organisms Act 1966 will protect the environment, health and safety of people and communities and prevent or manage the adverse effects of hazardous substances and new organisms
15.2 ★★	The practice has puncture resistant sharps containers displaying a biohazard symbol in accordance with NZS 4304:2002 in all areas where sharps are used	• Using recognised puncture resistant sharps containers and positioning them in a suitable location protects the health and safety of people in the practice and enables safe disposal
15.3 ★★	Sharps containers are kept out of reach of children	• The health and safety of children must not be compromised when they are present in the practice
15.4 ☆	The practice has an active waste management programme	• There is a growing awareness that efficiencies can be obtained in the practice by reducing waste and improving energy efficiency

Further information

A toolkit[34] has been developed to guide general practices on how to implement systems that produce benefits such as waste minimisation, improved time efficiencies and significant financial savings. The toolkit covers topics including lighting, appliances, computers, paper, waste minimisation, specialty waste, pharmaceutical wastage, and polystyrene.

Resources

Greening your Practice Toolkit. To obtain a copy of the toolkit, email: greeningyourpractice@gmail.com

Energy Efficiency and Conservation Authority: www.eeca.govt.nz

Standards New Zealand. NZS 4304:2002 Management of Healthcare Waste

Infection control

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

Indicator 16

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

Criteria		Rationale
16.1 ★★	**The practice can demonstrate that its infection control policies and procedures align with the industry standard**	• Effective infection control measures protect the health and safety of people using and working in the practice, and implementing them is a prudent risk management activity
16.2 ★★	**Appropriate team members have received infection control, sterilisation and disinfection training, within the last three years**	• Training provides new and existing team members with accurate and consistent information
16.3 ★★	**The practice can demonstrate how it monitors the effectiveness of each sterilisation cycle**	• Monitoring provides data about the effectiveness of the sterilisation process
16.4 ★★	**A current calibration and validation record is available for the steriliser**	• Performance testing, monitoring, calibration and operational qualification indicate the reliability of the sterilisation process

Further information

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

Infection control practices should cover:
- facilities, equipment, and procedures necessary to implement standard and additional (transmission-based) precautions for control of infections
- cleaning, disinfecting and reprocessing of reusable equipment
- waste management
- special situations e.g. flu epidemic
- staff immunity and infections
- hand hygiene
- prevention and management of infection by service providers
- antimicrobial usage
- outbreak management
- single-use items
- management of occupational exposure to blood/body fluids
- cleaning, decontamination, disinfection and sterilisation of instruments and equipment
- wound management
- linen services
- venepuncture
- cryotherapy
- cleaning and servicing of the steriliser
- laboratory specimens
- children's toys

Resources

Department of Labour. An introduction to Employers' Rights and Responsibilities under the Health and Safety in Employment Act; 2003. www.workinfo.govt.nz

Hazardous Substances and New Organisms Act 1996. www.legislation.govt.nz

Health and Safety in Employment Act 1992. www.legislation.govt.nz

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. www.standards.co.nz

Standards New Zealand. NZS 4304:2002 Management of Healthcare Waste

World Alliance for Patient Safety. WHO guidelines on hand hygiene in health care (Advanced Draft): A summary. Geneva: World Health Organization; 2005. www.who.int/patientsafety

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

Cold Chain management

Effective immunisation management minimises the risk of infection among at-risk populations. The Immunisation Handbook, published by the Ministry of Health (MoH), contains the current national standard. Practices' immunisation programmes should support high immunisation coverage to control disease at population levels through robust management of the Cold Chain, including identification, administration, recording results and taking action.

Indicator 17

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

Criteria		Rationale
17.1 ★★	**The practice has Cold Chain Accreditation as per the MoH protocol**	• There is a statutory obligation to store vaccines in line with the MoH protocol
17.2 ★★	**The practice can demonstrate monitoring and maintenance of the Cold Chain in accordance with the protocol**	• Maintaining and monitoring the physical parameters of the Cold Chain provides confidence about the effectiveness of storage
17.3 ★★	**If off-site immunisation is undertaken, the practice can demonstrate Cold Chain procedures**	• Cold Chain procedures provide confidence about the effectiveness of transportation processes
17.4 ★	**Team members who manage the Cold Chain have received training**	• Training provides the team member with accurate and consistent information to manage the Cold Chain process effectively
17.5 ★	**Team members responsible for managing the immunisation programme hold a current Authorised Vaccinator Certificate**	• The integrity of the immunisation programme must be maintained and any risks to patients managed

Further information

The Certificate of Cold Chain Accreditation is measured against the current MoH protocol.

Resources

Immunisation Advisory Centre—for Cold Chain references, education and vaccinator training: www.immune.org.nz

Medicines Act 1981. www.legislation.govt.nz

Ministry of Health. Immunisation Handbook 2011. Wellington, NZ: Ministry of Health; 2011. www.moh.govt.nz

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

Medical equipment

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

Indicator 18

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

Criteria		Rationale
18.1 ★★	There is an audit trail to monitor the servicing of all medical equipment according to relevant regulations (AS/NZS 3551), maintenance and operating instructions	• Regular inspection, testing and servicing of all medical equipment to meet the AS/NZS 3551 will ensure they are safe and fit for the purpose of protecting patients and the practice team members
18.2 ★★	Residual Current Devices (RCDs) are used to protect patients and members of the practice team in accordance with the Electrical (Safety) Regulations 2010	• Mains powered medical equipment must meet legislation requirements to protect patients and members of the practice team against electric shock
18.3 ★★	All essential basic equipment is available, including: • auriscope • blood glucose test strips/glucometer—expiry dates must be current; check calibration of glucometer to number on strip • cervical smear equipment • dressings adequate to the services provided • ear syringe/suction • electrocardiogram—should be accessible within 10min; if held in the practice, clinical team members should know how to read the tracings • eye local anaesthetic • fluorescein dye for eyes • gloves • height measure • monofilament • spacer device • ophthalmoscope • peak flow meter • pregnancy testing kit • proctoscope • sphygmomanometer—extra wide and paediatric cuffs—calibrated within the last year if aneroid; mercury sphygmomanometer needs only rubber pipes checked • spatula • spirometer • stethoscope • surgical instruments appropriate for any procedures carried out	• Practices must have basic equipment that is appropriate for comprehensive patient care Note: if a defibrillator is held in the practice it is recommended that clinical team members are trained in its use.

Criteria	Rationale
• suture equipment • syringes and needles • reflex hammer • tuning forks—256 Hz, 512 Hz • thermometer • urinary catheters and local anaesthetic gel or other means for urgent catheterisation e.g. referral in urban area • urine dipstick—protein, glucose, ketones • visual acuity chart—at the specified distance • weight scales—adult, paediatric	
18.4 ★★ **Emergency and resuscitation equipment is easily accessible and in a single location**	• Patients must be assured that practices have readily available equipment for timely resuscitation in the event of an emergency
18.5 ★★ **The practice team conducts annual emergency drills to improve their response to medical emergencies**	• Annual exercises ensure that all team members are familiar with their roles during an emergency
18.6 ★★ **All essential emergency and resuscitation equipment is available and maintained** **Emergency and resuscitation equipment:** • **airways and/or laryngeal masks—varied sizes 00 to adult** • **ambubag and masks—paediatric to adult** • **emergency bag/trolley** • **IV equipment—set up and infusion** • **oxygen** • **saline—any one of e.g. penpaspan/ crystalloid** • **tourniquet** **Rural practices require a greater level of off-site equipment.** • **PRIME kit (St John)** **It is recommended that practices use the PRIME standard to build their emergency kits**	• Practices must have equipment that is appropriate for emergency and resuscitation responses • The adequacy and appropriateness of essential emergency equipment is determined by the location and circumstances of the practice. Any omissions should be able to be justified by the practice • PRIME has its own equipment standards for its contract with rural practices • If practices are linked to PRIME, they should be trained to use the emergency equipment. See PRIME National Standards 2008 for more information
18.7 ★ **All essential basic and emergency medicines are available** **In stock or in the doctor's bag/clinical bag or portable emergency kit:** • **adrenalin 1/1000** • **an alternative for those allergic to penicillin** • **analgesia e.g. paracetamol, voltren** • **antiemetic** • **antihistamine injection** • **aspirin tablets** • **atropine injection** • **corticosteroid injection** • **diazepam injection/rectal** • **frusemide** • **50% glucose/glucagon injection** • **local anaesthetic injection** • **naloxone injection** • **nitrolingual spray** • **penicillin injection—some need refrigeration and in addition powdered version for off-site emergencies** • **Sodium Chloride (NaCl) for injection** • **sterile water for injection**	• The adequacy and appropriateness of essential emergency medicines is determined by the circumstances of the practice. Any omissions should be able to be justified by the practice

	Criteria	Rationale
18.8 ★	There is a documented process to check and maintain all essential basic and emergency medicines	• Patients must be assured that their care is not impeded by expired or compromised medicines
18.9 ★	There is a documented process to check and maintain the contents of all clinical bags/ portable emergency kits and emergency equipment	• Patients must be assured that their care is not impeded by expired or compromised medicines and/or missing or faulty equipment
18.10 ★ ★	Medicines, pharmaceutical products and emergency equipment are stored so that they are not accessible to unauthorised people	• Theft, misuse or vandalism of practice medicines or equipment may compromise patient care • Patients, in particular children, are protected by secure storage of dangerous products or equipment

Further information

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

Coroner's Advice COR: Ref: CSU-2008-000434

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

Residual Current Devices (RCDs)

- Equipment for medical locations should comply with the AS/NZS 3200 series and be maintained in accordance with the recommendations of AS/NZS 3551.
- Any electrical installations in patient areas must meet the testing requirements NZS 3003: 1: 2003.

Resources

AEDs in your community: www.aedlocations.co.nz, http://itunes.apple.com/us/app/aed-locations/id424094430?mt=8&1s=1

PRIME National Standards 2008: www.stjohn.org.nz

RNZCGP Assessment Visit Module: Contents of the Doctor's Bag: 2000

Standards New Zealand. AS/NZS 3551: 2004 Technical management programs for medical devices and Amendment 1: 2005

Standards New Zealand. AS/NZS 2500: 2004 Guide to the safe use of electricity in patient care

Disaster response

Patients and team members must be protected during an emergency in the community, such as a fire in the practice, flood, extended power outage, earthquake or pandemic. The ability to deal with these situations during an emergency may depend on how well a practice has planned for an event or disaster that severely impairs its ability to maintain normal services. Three important components of a robust emergency plan are business continuity planning, response planning, and major incident planning.

Indicator 19

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

	Criteria	Rationale
19.1 ★★	**The practice has a documented Evacuation Scheme or Evacuation Procedure as required by the Fire Safety and Evacuation of Buildings Regulations 2006**	• The Fire Safety and Evacuation of Buildings Regulations 2006 require a building owner, where there are 10 or more employees in the building at any one time, to have an evacuation scheme approved by the Fire Service
19.2 ★★	**The practice team is trained to evacuate the practice by participating in fire drills every six months**	• Lessons learned from regular drills can be used to improve fire safety practices
19.3 ★	**The practice has an Emergency Response Plan which identifies risk and formulates contingencies to address the practice response to disasters or events in the community**	• Risk analysis and contingency planning maximise patient safety and continuity of care through coordinated delivery of health care and by participation in the local response in the event of a disaster or major incident
19.4 ★	**The practice has a Business Continuity Plan that prioritises support and recovery of critical and non-critical functions of practice processes and activities**	• Risk analysis and contingency planning maximises patient safety and continuity of care, and also mitigates practice or business financial loss

Further information

- Practice plans should provide information and guidance about what to do immediately after an event has occurred. They should also identify relationships and networks needed to support local or regional action in an event.

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

Resources

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

Ministry of Health. National Health Emergency Plan. Wellington, NZ: Ministry of Health; 2008. www.moh.govt.nz

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

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

Ministry of Health. New Zealand Influenza Pandemic Plan: A framework for action. Wellington, NZ: Ministry of Health; 2010. www.moh.govt.nz

Infection control and prevention

Ministry of Health. Infection prevention and control during an influenza pandemic. Wellington, NZ: Ministry of Health; 2006. www.moh.govt.nz

Health and safety

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

Indicator 20

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

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

Further information

When thinking about health and safety, consider:

- man-made emergencies such as injury, armed robbery, power failure
- workplace stress
- accident recording
- training of employees
- ensuring sick team members stay at home
- a smoke-free environment
- the physical environment
- workplace processes and how equipment is used e.g. proper use of electrical equipment
- external factors e.g. robbery
- the impact of work processes e.g. toxic chemicals
- work organisation e.g. shifts and breaks designed to minimise fatigue and disruptions to sleep
- access to critical information e.g. instructions available at an appropriate literacy or language level for employees in the workplace
- impairment of individual employees e.g. when a diabetic employee misses meals due to work pressures.

Resources

Health and Safety in Employment Act 1992. www.legislation.govt.nz

Civil Defence Emergency Management Act 2002. www.legislation.govt.nz

Civil Defence Emergency Management Regulations 2003. www.legislation.govt.nz

Fire Safety and Evacuation of Buildings Regulations 2006. www.legislation.govt.nz

Department of Labour: www.osh.govt.nz/order/catalogue/index.shtml

Department of Labour. An introduction to Employers' Rights and Responsibilities under the Health and Safety in Employment Act; 2003. www.workinfo.govt.nz

Hazardous Substances and New Organisms Act 1996. www.legislation.govt.nz

Health Act 1956. www.legislation.govt.nz

Ministry of Economic Development. Influenza Pandemic Planning: Business Continuity Planning Guide 2009. www.med.govt.nz

Ministry of Health. National Health Emergency Plan: Infections diseases. Wellington, NZ: Ministry of Health; 2004. www.moh.govt.nz

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

Resource Management Act 1991. www.legislation.govt.nz

Standards New Zealand: Business Continuity Plan AS/NZS HB221: 2004

Section 3—Clinical Effectiveness Processes

Managing effective clinical care requires good organisation. This section outlines the structures to support and maintain safe, comprehensive and effective care for patients and manage in continuity, coordination and integration of care across health and community interfaces.

Patient enrolment

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

Indicator 21

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

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

Further information

See Rule 11 of the Health Information Privacy Code—Permitted Disclosure:

When a patient has requested their notes be sent to another practice, the transfer of medical records must be recorded in a register or on the Patient Management System and should include:

- the name of person who requested transfer
- the date the transfer was requested
- where records were transferred, to or from
- how records were transferred (courier, post)
- the date of delivery
- a confirmation of receipt of records (electronic and hard copy).

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

Health Information Privacy Code 1994: www.privacy.org.nz

Privacy Commissioner. On the record: A practical guide to health information privacy. Wellington, NZ: The Office of the Privacy Commissioner; 2011. www.privacy.org.nz

Medical Council of New Zealand. The maintenance and retention of patient records (2005). www.mcnz.org.nz

St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. www.mcnz.org.nz

Medical Council of New Zealand. Good medical practice—A guide for doctors. Wellington, NZ: Medical Council of New Zealand; 2008. www.mcnz.org.nz

Privacy Act 1993. www.privacy.org.nz; or www.legislation.govt.nz

Standards New Zealand. NZS 8153:2002 Health records.

Standards New Zealand: Code of Practice for Information Security Management: AS/NZS ISO/IEC 17799:2002

Standards New Zealand. SNZ PAS 8170:2005 Primary Healthcare Practice Management Systems: Publicly Available Specification

Patient records

To provide effective patient care records must accurately describe and support the management of health care. Information contained must identify the patient and facilitate continuity of care. Assessment, management, progress and outcomes must be documented to enable other team members to carry on with coordination, management of care, and referral to other services.

Indicator 22

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

Criteria

22.1   **Patient records contain sufficient information to identify the patient and document: the reason(s) for**
★   **a visit, relevant examination and assessment, management, progress and outcomes**
Core demographic data includes:
- **patient name**
- **NHI number**
- **gender**
- **address**
- **date of birth**
- **contact phone number**
- **ethnicity**
- **registration status**
- **contact person in case of emergency**
- **next of kin—where applicable**
- **primary language—where applicable**
- **whether or not an interpreter is needed**

Other demographic data:
- **occupation history**
- **significant relationships**
- **hapū, iwi**
- **alternate names**

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

Consultation records:
- **each entry is dated**
- **the person making the entry is identifiable**
- **the entry can be understood by someone not regularly working at the practice e.g. a locum**

Consultation records support continuity of care and record:
- **the patient's reason for encounter**
- **examination findings**
- **investigations ordered**
- **diagnosis and assessment**
- **management/treatment plans**

Criteria

- **health information given to patients, including notification of recalls, test results, referrals and other contacts**
- **medications, including: drug name/dose/frequency/amount/time/volume**
- **current and long-term medications**
- **intermediate clinical outcomes**
- **brief interventions**
- **screening and preventive care initiatives recommended**
- **a follow-up plan**
- **end of life needs where applicable**
- **name of interpreter used if applicable**

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

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

Incoming information is filed or available electronically in the patient's medical records. This includes:
- **laboratory results**
- **radiology results**
- **other test results or health information e.g. MMSE**
- **other health information**
- **discharge and outpatient information**
- **specialist letters**

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

For CORNERSTONE® General Practice Accreditation requirements:

- all doctors and practice nurses, including permanent locums and regular part-timers, have completed an audit of fifteen (15) patient records each
- the audit has been conducted in the last twelve (12) months
- medical records chosen show evidence of random selection
- the practice uses the results of the medical record audit to identify quality improvement opportunities (Continuous Quality Improvement).

Further information

A legally defensive record:

- is not altered, disguised or added to
- records all house calls and phone calls
- is kept for a minimum of 10 years
- uses no abbreviations without an explanation
- if written, is in ink, not pencil
- is legible
- is signed and dated (including times) after being checked for accuracy.

Consumer advice to practices

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

Resources

There are a variety of Health and wellness plans that can be accessed on the web e.g. www.healthwellnessplans.org/category/exercise

Prioritising urgent health needs

All practice team members have a role to play in recognising and managing urgent need. It is important that front line team members understand their role and can alert clinical team members if they are concerned about a patient in the waiting room. Having a triage system in place to recognise and respond to an emergency is essential to monitor and assess patients, decide how urgent their illness or injury is and how soon treatment is required.[35]

Indicator 23

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

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

Further information

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

CPR training requirements

- General practitioners participating in the RNZCGP Maintenance of Professional Standards and General Practice Education Programme must have current certificates to a minimum of level 5.
- Practice nurses participating in Continuing Professional Development must be certified to a minimum of level 4.
- Practice CPR training records should show that all team members required to administer CPR are trained to the correct level (NZRC Core 1–7), as well as well as recording the certified trainer (e.g. ACLS, St John, New Zealand Heart Foundation).
- Practice teams must be able to demonstrate effective assessment of urgent conditions.
- Observing body language or signs of distress is important.
- Practice teams must know how to manage an emergency drill.

Resources

St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. www.mcnz.org.nz

Medical Council of New Zealand. Good medical practice—A guide for doctors. Wellington, NZ: Medical Council of New Zealand; 2008. www.mcnz.org.nz

Clinical investigations

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

Indicator 24

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

Criteria		Rationale
24.1 ★★	There is a documented policy that describes how laboratory results, imaging reports, investigations and clinical correspondence are tracked and managed	• There is an agreed and consistent approach to the tracking of health information to manage and assist continuity of care
24.2 ★★	All incoming test results or other investigations are sighted and actioned by the team member who requested them or by a designated deputy	• Facilitation of patient results and investigations improves continuity of care and ensures a clear pathway to an outcome
24.3 ★★	Patients are provided with information about the practice procedure for notification of test results	• Patients must be notified about important test results and referrals • Patients have rights and responsibilities for their own health care and must be provided with information so that there is a shared understanding about the process
24.4 ★★	The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals	• There is an agreed and consistent approach to the tracking of health information to manage and assist continuity of care • The HDC considers that the need for tracking is especially important where serious pathology is suspected
24.5 ★★	A record is kept of communications with patients informing them about test results	• Documenting communications about test results is essential record keeping for continuity of care, and helps mitigate risk

Further information

Reports must be processed to ensure the right people get the right information within the time frames identified by the practice.

- Nominated members of the practice team should take responsibility for ensuring all incoming test results and medical reports are acted upon.
- For advice on notification of patient test results, see the Health and Disability Commissioner (HDC) opinion C01H-DC00389—www.hdc.org.nz

Resources

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

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

Medicine management

Putting processes in place to prevent differences in prescribing is essential to protect patients. The risks of prescribing errors and the risks inherent in having different practices between primary and secondary systems can be mitigated through prudent management. The appropriateness of long-term repeat prescribing and repeat prescribing without consultation will always be a matter of professional judgement. When assessed against accepted standards of best practice in the profession, prescribing must be capable of withstanding scrutiny.

Indicator 25

Prescribing is accurate, appropriate and timely	

Criteria		Rationale
25.1 ★	Prescriptions of all medicines including controlled drugs are recorded in the electronic record	• Recording prescribing information electronically provides accurate, readily accessible data for continuity of patient care and an audit trail of activity
25.2 ★★	The practice has a documented policy for repeat prescribing	• A documented policy outlines an agreed and consistent approach to ensuring prescribing practices are appropriate and do not endanger patients • New Zealand legislation (including Right 4, Code of Health and Disability Services Consumers' Rights 1996, and Clause 41 of the Medicines Regulations 1984) outlines the requirement to deliver services of an appropriate standard to minimise potential harm to patients
25.3 ★	The practice team is able to demonstrate how the policy for repeat prescribing is implemented	• Translating policy directives into effective practice enhances safe prescribing
25.4 ★	An audit of repeat prescribing has occurred within the last three years	• Auditing repeat prescribing patterns to identify continuity of care is an efficient way of monitoring patient safety and managing risk
25.5 ★	The practice routinely audits for non-collection of prescriptions held by the practice	• Continuity of care is enhanced by assuring that patient care is not compromised by non-collection of prescriptions

Further information

Prescribing requires cooperation amongst providers to ensure quality and continuity of services.

Prescribing in the absence of a consultation should:

- be provided with reasonable care and skill
- comply with legal, professional, ethical and other relevant standards
- be provided in a manner consistent with needs
- minimise potential harm and optimise the quality of life
- include cooperation among providers to ensure quality and continuity of services.

Risk mitigation

- Increase awareness of potential risks by recording them (e.g. allergies to medication, pharmaceutical products or vaccines) in the patient's record.
- Ensure there is an alert system in place to highlight the potential risk of an adverse drug reaction e.g. allergies to medication, pharmaceutical products and/or vaccines.
- Provide evidence of any changes made as a result of evaluating an audit of medication.
- If a patient has been admitted to secondary care, an accurate list of all medicines that a patient is taking should be provided within 24 hours of admission or discharge back to primary care.
- Identify the appropriateness of medication. Is it required? Is the patient known to the practice? Be aware of drug seeking behaviour.
- Undertake a regular Record Review to identify medicine reconciliation or continuity of care issues.
- Review records to assess whether there was an accurate and timely assessment of the need for medicines.

Resources

The Code of Health and Disability Services Consumers' Rights 1996. www.hdc.org.nz

Health Quality and Safety Commission New Zealand. Safe Medication Management Programme. Medicine Reconciliation Toolkit; 2011.

Medical Council of New Zealand. Good prescribing practice (2010). www.mcnz.org.nz

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

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

Clause 41 of the Medicines Regulations 1984

Health promotion

Health promotion is distinct from education and information used to support diagnosis and choice of treatment, and occurs when practice teams work with patients to help them manage their own care to improve their quality of life. It may involve a range of actvities such as meeting with internal or external teams to identify different approaches to care, using new evidence or influencing changes in practice.[21] Some practices work with other primary health organisations, networks or public health units to develop health promotion and social marketing approaches to help people understand the importance of making healthier lifestyle choices. This is directly geared to achieving specific and measurable health goals over the short, medium and long term.[36] Administering Green Prescriptions[37] is one of many approaches that are proven to work.

Indicator 26

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

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

Further information

When patients and their families understand why and how to participate in their care, and feel empowered to do so, their involvement can help to prevent medical errors and enhance safety.[38]

Consumer advice to practices

- Practice teams should be trained to access information for patients in different languages or formats and to contact interpreters and translators if needed.
- Identify approaches to inform people about shared responsibility.
- Work collaboratively with other health professionals, social agencies and community representatives.
- Use interdisciplinary approaches on priority health issues.
- Offer people a range of options e.g. have an appointment system with practice nurses.
- Offer social marketing or whānau initiatives where it is difficult for patients to make or sustain changes on their own.
- Find out about Whānau Ora approaches. A key concept in Whānau Ora approaches is to support families to work proactively across services.

- Identify high-risk patient groups.
- Offer brief interventions.
- Provide patient education.
- Reduce inequalities in patient populations through the use of guidelines and case studies to inform best practice.
- Social marketing or whānau initiatives support people to manage change.
- Practices can use different methods to improve, maintain or restore patient care, and can offer them as a practice initiative or by referral to an external provider. Methods include arthritis care, Green Prescriptions, Chronic Care Management.
- If a practice is working to develop interventions, it could meet with other local networks to design and share ways of developing solutions.

Resources

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

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

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

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

Clinical support

Clinical management relies on good information to inform decisions about patient care. Use of evidence and comparisons may depend on situational variables such as patient comorbidities and patient preferences. Electronic tools that support clinical decision-making and management provide instant results and information for clinicians.

Indicator 27

The clinical team utilises clinical decision support tools

Criteria		Rationale
27.1 ★	There is a system to code chronic or long-term conditions according to a recognised classification system	• Coding long-term conditions enables practices to compare, prioritise and align activities with local, regional and national goals for disease management
27.2 ★	Practices can provide information on the prevalence of chronic or long-term conditions recorded and classified on the database	• Analysis and use of data held in the system about patients' conditions enables practices to learn about their needs
27.3 ★	The clinical team audits its management of patients to align care with current health targets for chronic and long-term conditions	• Regular clinical audits by the practice team demonstrate the extent to which clinical management aligns with current best practice or national targets
27.4 ☆	The practice demonstrates use of evidence-based electronic clinical decision support	• Use of evidence-based electronic clinical decision support tools allows patients and clinicians to make key clinical decisions, jointly or separately, that are consistent with current evidence and best practice
27.5 ☆	Electronic clinical decision support tools are integrated into the practice management system (PMS)	• Integration of electronic clinical decision support tools into the PMS increases efficiency and improves data capture

Further information

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

Identifying patients that are at risk of poor health outcomes

- Data that identifies high-risk groups provides clinical information that enables targeting care e.g. the delivery of influenza vaccines to patients over 65 years.
- Data informs effective patient management so that the practice can use the information to identify and respond to patient needs and population health priorities.
- Data used to inform case studies and Quality Improvement.
- PDSA cycles are a useful way for practices to identify whether guidelines or electronic decision support is used effectively for patient care.

Resources

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

Centre for Clinical Excellence: www.healthnavigator.org.nz/centre-for-clinical-excellence

Screening and recall

Screening is a complex process that spans education, invitation, disease detection, diagnosis and management, as well as long-term follow-up to determine outcomes.[39] It occurs when members of a defined population are identified by the clinician. Patients may not know they are at risk, or they may already be affected by a disease or its complications. Systematic implementation to defined, identifiable populations requires a method to identify and invite target populations registered with the practice, and specific characteristics such as age, gender or ethnicity provide essential information as a precursor to a diagnosis or treatment.[40]

Indicator 28

The practice maintains an effective screening and recall system	

Criteria		Rationale
28.1 ★★	The practice demonstrates the system used to identify patients eligible for screening and recall	• Patients who are linked to the National Screening Unit (NSU) must be able to access programmes designed to improve equity of care and early treatment
28.2 ★	The practice regularly audits screening and recall activities to review its effectiveness in reaching eligible target populations	• Identifying gaps and working with other agencies to formulate strategies to reach target populations will improve uptake by eligible populations
28.3 ★	The practice uses screening results to implement clinical interventions	• Changes in clinical practice may result from undertaking an audit

Further information

Screening and recall can be undertaken if disease codes have been systematically recorded against patient encounters in the Practice Management System e.g. READ, SNOMED. This enables auditing to identify outcomes for patients in national screening and recall programmes. Analysis of results will identify which patient populations benefit from being linked to programmes such as cervical screening. In addition, specific characteristics identified (e.g. age, gender or ethnicity) may be a precursor to diagnosis or treatment.[41]

Screening audit data is used to:

- build queries to audit enrolled patients and disease prevalence
- analyse by ethnicity to identify, address and monitor ethnic health inequalities
- manage opportunistic screening e.g. taking blood pressure or measuring weight
- show results of clinical team activity e.g. results that are positive for Chlamydia and received treatment and follow-up testing
- obtain an overall picture of trends to inform planning of practice activity, alignment of plans, or funding requirements,to support patient care
- identify practice population trends and links to national objectives.

Resources

BreastScreen Aoteoroa: www.nsu.govt.nz

Sherwood J. Chlamydia screening in New Zealand: Report for the National Screening Unit July 2006. Wellington, NZ: Ministry of Health; December 2006. www.moh.govt.nz

Diabetes New Zealand: www.diabetes.org.nz

Privacy Commissioner. On the record: A practical guide to health information privacy. Wellington, NZ: The Office of the Privacy Commissioner; 2011. www.privacy.org.nz

Health (Retention of Health Information) Regulations 1996. www.legislation.govt.nz

National Health Committee. HIV screening in pregnancy. A report to the New Zealand Minister of Health. Wellington, NZ: National Advisory Committee on Health and Disability (National Health Committee); October 2004. www.nhc.health.govt.nz

National Screening Unit. Improving quality: A framework for screening programmes in New Zealand. Auckland, NZ: National Screening Unit; October 2005. www.moh.govt.nz

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

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

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

The Royal New Zealand College of General Practitioners. Cervical screening: Information and continuous quality improvement activities to aid in the provision of quality cervical screening in general practice. Wellington, NZ: The Royal New Zealand College of General Practitioners; 1996. Revised 2001.

The Royal New Zealand College of General Practitioners. Preventive care and screening: A systems approach to improving preventative care and screening in general practice. Wellington, NZ: The Royal New Zealand College of General Practitioners; 1993. Revised 2001, 2006, 2010.

The Royal New Zealand College of General Practitioners. Developing Practice Review Activities from a quality perspective. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2000.

National Health Committee. Screening to improve health in New Zealand. Criteria to assess screening programmes. Wellington, NZ: National Advisory Committee on Health and Disability (National Health Committee); April 2003. www.moh.govt.nz

The Assessment and Management of Cardiovascular Risk. Wellington, NZ: New Zealand Guidelines Group; 2003. www.moh.govt.nz

The New Zealand Health Strategy. Wellington, NZ: Ministry of Health; December 2000. www.moh.govt.nz

Unsolicited Electronic Messages Act 2007. www.legislation.govt.nz

Opportunistic screening and equity

The burden of chronic disease is identified as a risk with very high severity to patients, populations, the health system and the economy.[42] The World Economic Forum identified 36 specific health areas where risk factors would be controlled better if detected early in their natural history. Offering screening to presenting individuals rather than populations is an important risk management approach that can enable early detection of disease in a preclinical state and in forms where to link people to care.

Indicator 29

The practice undertakes opportunistic screening	

Criteria		Rationale
29.1 ★	**Practice opportunistic screening is evidence-based**	• Ensuring the efficacy of opportunistic screening minimises risk and ensures patients receive appropriate and safe tests
29.2 ★	**Clinical team members can demonstrate their role in providing opportunistic screening**	• Undertaking opportunistic screening provides clinical team members with information to progress treatment and management of patient care
29.3 ★	**Clinical team members can show how screening interventions are applied to improve outcomes for patients**	• Interventions that occur as a result of screening results in appropriate, effective and timely treatment and management that is proven to make a difference to patients' quality of life
29.4 ★	**The practice can demonstrate that screening is linked to early intervention**	• Outcomes of care show that patients are receiving the care they need and have benefited from early intervention and treatment

Further information

There are established principles for screening and disease prevention that have been developed for New Zealand.[43] They emphasise the rigorous standards of research evidence required to demonstrate effectiveness of screening. To ensure proposed screening is the most effective way of preventing long-term consequences for a patient, it is essential that clinicians understand the evidence for screening, and the natural history of a presenting problem.[44]

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

- Clinical judgement must always define the need for opportunistic screening.[45] Practitioners must always use their skills to identify the relevance of testing, and identify those likely to be helped rather than harmed by further tests or treatments to reduce the risk of disease or its complications.[46]
- Opportunistic screening is only offered when clinical judgement confirms that a test is needed to detect the presence or confirm the absence of a specific condition. The quality of opportunistic screening can be improved through regular audit or peer review.

Resources

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

National Health Committee. Screening to improve health in New Zealand. Criteria to assess screening programmes. Wellington, NZ: National Advisory Committee on Health and Disability (National Health Committee); April 2003. www.moh.govt.nz

National immunisation programmes

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

Indicator 30

The practice maintains an effective immunisation programme

Criteria		Rationale
30.1 ★★	**The practice identifies and recalls all patients requiring immunisations on the national schedule**	• Clinical data provides a practice with information required to improve immunisation coverage and prevent disease
30.2 ★	**The practice regularly reviews immunisation recall activities to identify effectiveness in reaching eligible target populations**	• An annual review process assists with identifying gaps in service delivery and formulating strategies to improve audit outcomes for eligible populations

Further information

Immunisation can protect people against harmful infections, which can cause serious complications, including death. It is one of the most effective, and cost-effective medical interventions to prevent disease. Clinical team members must be able to show:

- how they identify and recall all eligible patients requiring immunisation
- how they identify at-risk populations or those who have risk factors which are likely to predispose them to disease
- their level of awareness of risk factors such as lifestyle, socioeconomic, personal medical history and family medical history, which may predispose to disease
- measures taken to improve immunisation rates for their patients.

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

- death
- danger to life
- hospitalisation
- prolongation of hospitalisation
- interruption of productive activity in an audit recipient
- increased investigation or treatment costs
- birth defects.

Resources

Ministry of Health. Immunisation Handbook 2011. Wellington, NZ: Ministry of Health; 2011. www.moh.govt.nz

National Immunisation Register: www.immune.org.nz

Disease prevention

The New Zealand Smoking Cessation Guidelines 2010[41] recommends integrating the use of evidence-based interventions into the standard practice of health professionals. It has shown evidence of success in reducing harm caused by tobacco and improving health outcomes for (in particular) Māori, Pacific people, pregnant women, and people who use mental health and addiction services.

Indicator 31

The practice routinely identifies people who smoke and offers interventions

Criteria		Rationale
31.1 ★	**The smoking history and status of newly enrolled patients 15 years and over is recorded in the PMS**	• Routine identification and collection of smoking status aligns with the national programmes to provide evidence of effectiveness and use as a basis for health improvement activity
31.2 ★	**Practice team members actively promote smoking cessation strategies and provide educational intervention programme information to patients**	• Systematic approaches to providing interventions are proven to make a difference to patients by reducing avoidable hospitalisations
31.3 ★	**The practice team has access to external programmes that assist patients with smoking cessation**	• Knowledge about other allied health care providers, community services and national programmes enables teams to identify the best options and refer patients appropriately
31.4 ★	**The practice team routinely updates the current smoking status of patients**	• Effective and regular data capture enables early interventions

Further information

The New Zealand Smoking Cessation Guidelines (2010) promotes the use of a memory aid, "ABC", which provides prompts to:

- **A**sk about smoking status
- give **B**rief advice to stop smoking to all smokers
- provide evidence-based **C**essation support to those who wish to stop smoking.

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

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

Practice processes to support smoking cessation
- The practice registration form must capture smoking status.
- Smoking status must be recorded on the Patient Management System.
- Smoking status must be coded so data can be audited.
- Clinical team members must know about local and national programmes e.g. Quitline 0800 number.
- Clinical team members must have a system for updating smoking status of patients.

Resources

Ministry of Health. New Zealand Tobacco Use Survey 2006. Wellington, NZ: Ministry of Health; 2007. www.moh.govt.nz

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

Ministry of Health. New Zealand Smoking Cessation Guidelines. Wellington, NZ: Ministry of Health; 2007. www.moh.govt.nz

The Royal New Zealand College of General Practitioners. Preventive care and screening: A systems approach to improving preventative care and screening in general practice. Wellington, NZ: The Royal New Zealand College of General Practitioners; 1993. Revised 2001, 2006, 2010.

Continuity

Practices have a shared responsibility to provide seamless care to assist a smooth transition between primary, secondary or community interfaces, provide comprehensive care that recognises and acts on the full range of health-related needs in a patient population and refer patients if specific services are not provided by the practice. Services will always vary over time and from place to place and patients must be able to rely on practice teams guiding them through the complexity of health care services and health contacts.[3]

Indicator 32

The practice has processes to ensure continuity of care

Criteria		Rationale
32.1 ★	**The practice can demonstrate continuity of care management by multidisciplinary teams in the practice**	• The patient journey must not be compromised through loss of health information between team members
32.2 ★	**The practice can demonstrate its processes for transfer of care when transferring patients to providers and services outside the practice**	• Practice processes and communication must provide a seamless connection to link patient information with other providers and services
32.3 ☆	**The practice can provide evidence of effective electronic linkages between the practice and secondary care interfaces**	• The patient journey is facilitated through sharing electronic patient information across primary/secondary interfaces
32.4 ☆	**An electronic shared care record facilitates effective transfer of care**	• An electronic record assists effective handover to facilitate seamless care across providers
32.5 ☆	**Patient feedback of their experience is used to inform continuity improvements in clinical care**	• Patient experience is an important consideration for developing existing and new services and understanding whether clinical care is making a difference to outcomes
32.6 ★	**All patients with palliative care needs can access their doctor or an informed deputy at all times**	• Managing the complexities of terminal care ensures that patient care is not compromised

Further information

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

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

Mitigating risks to patients through unresolved conditions being missed

- Implement systems and processes to support the coordination and integration of care.
- Patient care must not be compromised by the loss of information.
- The content of referral letters provides essential information to facilitate continuity of care.
- Referrals must be recorded, tracked and followed up.
- Identify gaps and where continuity could be improved.
- Deafness, dementia, intellectual disability etc. may not be apparent to recipients of a referral letter.

Resources

Ministry of Health. Guidelines for the development and operation of standing orders. Wellington, NZ: Ministry of Health; 2002. Revised in 2006. www.moh.govt.nz

Clinical and practice risk management

The Incident Management process is a positive approach to risk management. It can be used for situations such as near misses or adverse outcomes. The 'no blame' approach helps practice teams consider 'what is wrong', rather than 'who is wrong'.[47] Alternatively, if something went well, the process encourages teams to identify the reason for success. The approach is useful as an early warning system, to prevent or minimise risk and improve safety in the practice.

Indicator 33

There is an effective Incident Management System	

Criteria		Rationale
33.1 ★★	The practice has an Incident Management Policy	• Early warning systems that outline the process for reporting, management and follow-up help prevent adverse outcomes and promote excellence in practice
33.2 ★★	The Incident Reporting Register records incidents and near misses	• Recording incidents assists with the management of incidents or near misses, and enables learning opportunities for team members
33.3 ★★	The practice uses a risk management process to analyse incidents and near misses	• Analysis can identify patterns leading up to the event and can be used to review how to prevent incidents or near misses for patients and team members
33.4 ★	The practice team can demonstrate how incidents are used as a learning opportunity to minimise risk	• Lessons learned from incidents or near misses can be useful learning opportunities for practice teams and Quality Committees, enabling them to plan for and minimise risk in the future
33.5 ★★	Adverse reactions to medicines and immunisations are recorded in the PMS and reported to the Centre for Adverse Reactions Monitoring (CARM)	• Reporting adverse reactions assists with understanding more about why there was an adverse outcome or why there is a risk to patients

Further information

An incident is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. The Immunisation Handbook defines reportable adverse events as those that significantly affect patient management, including reactions suspected of causing significant harm.

Risk mitigation

- Document events for preventive activity and education.
- Use consistent methods of recording adverse reactions to medication to enable trend analysis and the management of the risk areas identified.
- Communicate with and involve all members of the team.

Resources

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

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

The Royal New Zealand College of General Practitioners. Incident and Risk Management – A general practice guide. Wellington, NZ. 2010

Ministry of Health. Immunisation Handbook 2011. Wellington, NZ: Ministry of Health; 2011. www.moh.govt.nz

Section 4—Professional Development

Continuing Professional Development

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

Indicator 34

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

Criteria		Rationale
34.1 ★★	All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003	• Practices must provide evidence that they meet the requirements of the Health Practitioners Competence Assurance Act 2003
34.2 ★	Medical staff employed long term in the practice are vocationally registered in general practice or working towards this	• Patients are provided with assurance that all permanent medical practitioners in the practice are vocationally trained and engaged in a Maintenance of Professional Standards programme
34.3 ★★	All clinical team members participate in Continuing Professional Development	• The practice meets the New Zealand Medical Council and the New Zealand Nursing Council requirement to maintain their commitment to Continuing Professional Development (CPD)
34.4 ★	There is planned professional development and peer review for the clinical team	• The practice is committed to ensuring its clinical team is informed and skilled

Further information

- The New Zealand Medical Council requires maintenance of Continuing Professional Development (CPD).
- Practices must provide evidence that each clinical team member has a current Practising Certificate and the Annual Practising Record is checked annually.
- Practices must be aware of whether medical practitioners working in the practice are registered in the general scope. This will be recorded on the Annual Practising Record and include the name of the supervisor and NPI number. Also, see Vocational Registration—(34.2–RNZCGP decision: 4 May 2011)

Resources

Health Practitioners Competence Assurance Act 2003. www.legislation.govt.nz

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

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

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

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

The Royal New Zealand College of General Practitioners—Fellowship pathway regulations; April 2010. www.rnzcgp.org.nz

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

Teamwork

It's worth considering how team interaction and culture might influence patient outcomes or enable clinical improvement activity and engagement in other initiatives. The first step is to identify team culture. It cannot be created to order and takes time to evolve. As part of long-term plans for clinical governance, teams should begin by identifying how well they perform on communication, accountability, and responsibility for creating a culture of teamwork.[48, 49]

Indicator 35

There is a culture of teamwork in the practice

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

Further information

The Team Climate Assessment Tool measures teamwork, particularly behaviours essential to the maintenance of patient safety and effective patient safety incident management in clinical settings. 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.[50]

Resources

The Team Climate Assessment Tool: www.mindtools.com/pages/article/newTMM_84.htm#Explanation

Human resources

Employment matters must be given due consideration to enable team members to operate effectively. Each team must have a structure that provides role clarity and shows team members how they fit in the team.

Indicator 36

All practice team members have employment agreements and current position descriptions

Criteria		Rationale
36.1 ★★	**Practice team members have signed employment agreements with terms and conditions**	• Position descriptions provide clear direction to practice employees
36.2 ★★	**Practice team members have position descriptions that include key tasks, functional relationships and annual review dates**	• Practice team members need clear lines of accountability and reporting structures to work effectively
36.3 ★★	**Practice team members and others who have access to identifiable patient information have signed a confidentiality agreement**	• Practice team members understand that patient information is protected
36.4 ★★	**Each member of the clinical team is insured to cover liability**	• Professional members of the team must be covered by organisational and professional insurance
36.5 ★	**There is evidence of continuing education for the practice manager**	• Supporting continuing education provides evidence of a commitment to maintaining an informed and skilled workforce
36.6 ★	**Performance reviews are conducted annually and used to guide continuing education for all practice team members**	• Performance reviews based on position descriptions and feedback ensures learning needs are identified for all team members

Further information

Every employee must have a written employment agreement. It may be an individual agreement or a collective agreement. From Juy 2011, employers are required to retain a signed copy of an employment agreement or the current signed terms and conditions of employment. The purpose is to clarify roles and responsibilities.

Risk mitigation

- Ensure all members of the practice and professional team are covered by organisational and professional insurance e.g. New Zealand Nurses Organisation, College of Nurses Aotearoa (NZ) Inc, Medical Assurance Society, Professional Indemnity Insurance.
- Ensure there is a practice induction resource or orientation manual that provides formal documentation for all new team members, locums or casual staff.
- Ensure GPs who own their practice have partnership agreements in group practices and position descriptions to clarify roles and responsibilities.
- Ensure all members of the practice team including practice partners participate in performance reviews and continuing education.

Resources

Employment Relations Act 2000. Available from: www.ers.dol.govt.nz or www.legislation.govt.nz

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

Use your quality system to improve quality, safety and effectiveness of patient care

The College view on general practice quality has been formed over time by best available evidence and practice. Good quality always puts patients and teamwork first.

The WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) defines general practice quality as:

> The provision of best health outcomes that is consistent with patient values and preferences, given the available resources.[12]

The New Zealand health sector definition of quality health care is also supported.[51] It describes multiple dimensions of quality, including access and effectiveness:

> Quality of care is the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[12]

Each general practice is unique and reflects the needs of the community it serves. Many practices have developed close working relationships with peers and colleagues in their communities and there are general practice networks that extend and enhance the capacity of practice teams to improve delivery of care for patients through organised general practice. This is characterised by:

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

Cooperation and coordination by clinical and management teams encourages them to use their diverse knowledge to deal with health problems in the practice. Good systems support teams to educate and communicate with patients and to develop stronger links with other primary care services.

CORNERSTONE® General Practice Accreditation

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

> Accreditation is a self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.[14]

The CORNERSTONE® approach enables practices to compare the quality of their systems and processes against measures in *Aiming for Excellence*. It reinforces team processes using a Continuous Quality Improvement (CQI) approach, incorporating Quality Assurance (QA) and Quality Improvement (QI).

Taking the first step toward improvement requires commitment and active engagement by general practice teams.[52] *Aiming for Excellence* brings together managerial, organisational and clinical processes to provide an assessment tool for teams to identify how to provide greater accountability, guide improvements and use the information to increase effectiveness of care by general practice teams.[18]

To understand the power of your practice systems and how well you are meeting the health needs of patients, clinical care must be measured and monitored. Undertaking regular quality improvement activities in clinical areas (e.g. asthma) will provide information about care provided to patients and whether there is a need to make changes that influence patient outcomes through changes in clinical treatment and management of care provided to patients. An annual quality improvement activity is now an expectation for practices registered in the CORNERSTONE® programme.

Quality Improvement Activities

All College tools and processes encourage learning from outcomes to improve results. This requires time, commitment and reflection involving the whole practice team. Templates 1 and 2 provide guidance on an approach for practice-based solutions, and guide systematic investigation of a problem. The process requires teams to have an understanding by learning from data and information, reflecting on practice, understanding what caused the problem and identifying where better process, organisation or clinical management of care might improve outcomes.

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

PDSA cycles provide a practical approach for practice teams to systematically review an area of practice. They can be applied by practice teams to any topic of interest, including practice, organisation or clinical activities.
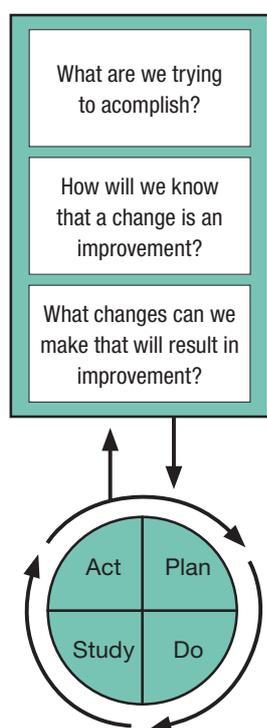
PDSA Cycles

The principle of all quality activity is that it leads to improvement through change. PDSA Cycles are useful because they outline a simple and systematic approach to review which involves all members of the practice team. They guide incremental and continuous change, through identifying actions to close gaps in care.[1]
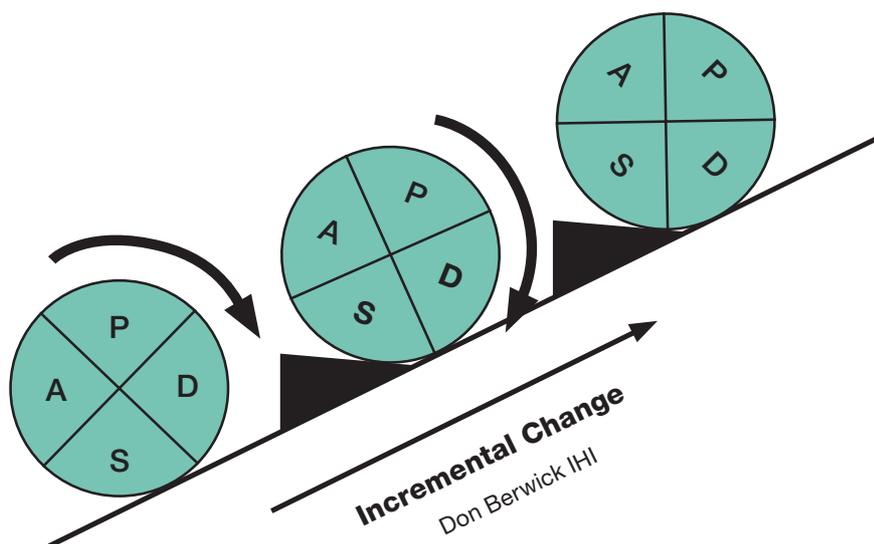
The approach

- Teamwork is essential and should always involve or inform the whole team
- The method can be applied to any aspect of patient care or practice service
- Considers patients and whānau/families, or practice populations
- Uses learning and reflection to understand the effect of care on outcomes
- Guides process improvement to improve quality of life for patients[2]

CORNERSTONE® & MOPS quality improvement requirements

This section contains templates for practices registered in the CORNERSTONE® General Practice Accreditation Programme to meet their annual requirements to complete an annual quality improvement activity in the management of a practice area or a targeted area of clinical care.

Aiming for Excellence: Criterion 10.4

The practice identifies an annual quality improvement activity related to the management of a targeted area of clinical care

Template 1 – A practice or clinical audit

- This template is a simple PDSA cycle. It has been tested and refined over time and can be applied to any aspect of practitioner or practice activity to help identify 'where you are now', 'where you could do better' and 'how to get there'. It is useful for encouraging reflection and action by using the best information available to improve practice.
- It can be used by individual practitioners in MOPS or to meet the requirements of a practice or clinical activity in CORNERSTONE®. While any area of activity can constitute the subject matter for a PDSA activity, to be eligible for MOPS points it must have a clinical focus and impact on the individual's practice.

Template 2 – Clinical Effectiveness Activity

- This template has been developed to help practices understand effectiveness of clinical care provided to patients in an integrated setting. It is used to explore the breadth of clinical issues in greater depth and understand the impact of care provided across practice and health interfaces.
- The approach provides an overview of environmental barriers or risks for patients, what to consider for integrated care and where working with other health teams or involving families/whānau might improve clinical outcomes for patients.

Important

- Choose a topic that is relevant to your practice or practice population. It could be a personal interest or the result of a critical or adverse event.
- Work systematically through the process to understand actual and potential problems.
- Analyse current processes and use PDSA Cycles to make sense of any complex components of health and community interfaces.
- Patients should be the focus. Use the process to understand outcomes of clinical care and where improvements in technical interventions would make a difference.
- Understand the global picture and break down the layers to map problems, understand linkages and discover where integration might help improve continuity of care.

Measures

Measuring quality helps to understand a situation and is the basis of the PDSA quality improvement cycle. The assumption is that unless we learn from evidence or information, it is unlikely that we will know what, or where, improvement is needed. The most effective way to learn is to ask questions to provide better understanding of a situation.

The team should identify measures that enable them to understand where to best target activity, and this will provide data and information to understand where to target improvement.

Useful references for identifying measures

- Healthcare Quality Measures NZ library. Access to measures relevant for NZ: www.patientsfirst.org.nz/hqml/
- The Health Quality and Safety Commission provides links to other sites: www.hqsc.govt.nz
- The Ministry of Health New Zealand Primary Care Handbook 2012, measures considered important to improving health outcomes in NZ: http://www.health.govt.nz/publication/new-zealand-primary-care-handbook-2012
- Institute for Healthcare Improvement, Boston, USA. www.ihi.org
- Centre for Clinical Excellence. www.healthnavigator.org.nz/centre-for-clinical-excellence/

Template 1 – A practice or clinical audit

Topic	First identify your topic • Are you doing what you should be doing? • What is the practice concerned about? • What is the problem? • What are the drivers? • Why is it an issue?
Plan	Identify what you want to achieve • What should you be doing? • Identify changes that will result in improvement • Identify measures • Develop an action plan for collecting data and prepare the team (what, when, how, who)

Plan (action plan table)

ACTION PLAN: List the tasks				
No.	Actions	How	By when	Who
1	Collect investigations requested in the last month	Search on PMS for investigations requested	14 March	David

If the area to be investigated is complex, it is a good idea to run a pre-test

DO	Discover what you are doing now • Minimise poor data collection by developing a systematic and clear process for collecting and collating data
STUDY	Analyse what the results tell you • Analyse the data • Identify the gap between expected standards and performance • Describe the results (graphs and tables are useful) • Summarise and reflect on what was learned • Identify solutions
ACT	• Meet with the team • Refine changes based on what was learned from the test • Identify any barriers or enablers to change e.g. resources, skills, IT • Implement changes **Learning and reflection** • Did you achieve the result you expected? • Is the change an improvement? • How can you put the learning into practice? • Plan a review date to follow up changes

Important

The practice quality improvement plan is useful for recording actions identified for ongoing review and monitoring, and learning and reflection.

Template 2 – A clinical effectiveness activity

First	**Involve the team** This tool is most effective when all members of the team are involved in analysis, defining the scope of interest, describing what actually occurs, discussing possible solutions and choosing the solution. Members must also decide how they will evaluate the activity and what information should be gathered to assess effectiveness of the activity. **Then choose a topic** Define the topic area of interest, aspect of care or service delivery to be addressed: • What is the problem? Define the activity: • What do you want to do? Define the drivers for undertaking the activity: • Why do this?
Step 1 – PLAN	**Understand the practice environment and other interfaces: How do they affect what we should be doing?** Understanding the underlying issues and scope helps to provide the right solutions. To make sense of the breadth of a current situation it is useful to review practice or clinical issues from the perspective of: • **Structure**: The characteristics of the setting where care takes place • **Process**: Identify what is actually done during the delivery of care • **Outcome**: The effects of care on the patient Some of these areas are interlinked or there may be a cross over. Understanding the issues in greater detail will assist with developing solutions. **Consider practice structures** Structural practice activities are those which strengthen the practice environment and assure operational safety. They fall into four sub categories, as shown in the boxes below.

"Competent" and appropriate setting within which care occurs	Competence of the professional providing the care	Organisational and practice supporting activity and resources	Functional interface between practitioner, management, resources, technology

Identify the current situation and perceived problems or any questions

1. Practice setting
• A description of the current situation
• Perceived problems or questions
• Practice population of interest
• Location of care
• Personnel
• Infrastructure
• Is the practice/care safe, what could be improved, in what other settings does this activity occur?

2. Capability of relevant health professionals
• Current knowledge, skills experience available
• Education and training requirements
• Additional educational activities identified

Step 1 – PLAN	**3. Capacity of the organisation and practice** • Relevant supporting systems and processes • IT systems, links to other organisations e.g. PHO, manual systems, technological support • Formal and informal systems • Other activities, support or resources **4. Interfaces** • Identify processes that impact on practitioners when providing the identified aspect of care or service • What structural gaps and process gaps can be identified? • What are the issues? **5. Resources** • Time – identify how the work to be done will fit into existing schedules or whether additional time is required • People – identify roles, relationships and responsibilities, and who else needs to be involved • Team buy in – arrange to meet frequently; communicate activity with the whole practice and others involved outside the practice • Funding – can existing resources be utilised, or will external funding be needed? **6. Important relationships required to provide an aspect of care or service** • Within the practice – formal and informal • Other providers – formal and informal • Patients – formal and informal • Community relationships – formal and informal • Are any resources required? • What structural and process gaps can be identified? • Are there any other important community relationships? • What are the issues? **7. Consider:** • How does all of the above information affect the application of knowledge by practitioners during a consultation with a patient? **Identify solutions needed and the processes required to achieve the required results** Once a problem has been identified, potential solutions need to be identified, and interventions implemented. Measuring change resulting from an intervention is also important to determine the effectiveness of the intervention. • Identify measures based on information useful to the practice and easy to collect as part of day-to-day activity • Consider effectiveness, access, health status, feedback, cost, equity • Develop a plan for collecting baseline measures • Pre-test if the area to be investigated is complex

Step 2 – DO	**Measuring change** • Define data to be collected and methods for data collection, collation and analysis (may include qualitative and quantitative) **Additional information** **Incidents** • Is there an incident management system in place? • What information is available to the practice? **User evaluation** • How can we find out what patients think? **Cost/benefit** • What is the cost/benefit to the service or patients? **Equity** • Are there any equity issues? How can they be addressed? **Feedback** • What information is available?
Step 3 - STUDY	**Reflection, learning and improvement opportunities, peer review** • What did we do as a result of knowing the information? **1. Analysis of results** • Were the objectives met? • What changes can be made to improve patient care as a result of the information obtained? **2. Identification of discussion points** What type of information/results was generated? e.g. whether selection of measures was suitable for purpose, any issues for data extraction and analysis, feasibility, potential inaccuracies in data collection or ability to verify accuracy of data. • Knowledge gaps • Areas for quality improvement • Learning, education or upskilling needed e.g. identification of severity • Assessment of risk and resilience • Availability of tools in general practice for risk assessment • Level of skill or comfort in using tools or in addressing health problems **3. Discussion of results** Reasons for the results obtained, e.g. appropriateness of systems and behavioural changes introduced. What are the reasons for the results generated? What is the gap between the information obtained and the expectations? Feasibility, limitations etc **4. Required changes at individual, organisational or systems level** What is the extent of knowledge and skills gaps highlighted? • Systemic issues • Practice resources • Practice team issues and responsibilities • Training requirements • Link to educational material - are there any existing modules or educational material? Note: For the activity to be eligible for MOPS points, changes at the level of individual practice must be examined. **5. Prioritisation checklist** Development of a checklist for change, e.g. resource availability or constraints, practice team communication and responsibilities, educational and training requirements, practice systems. • What area will you address first?

	6. Ongoing activity Planning for ongoing review and improvement, e.g. institute education/feedback cycles, development of additional measures required, review of progress against agreed changes, or progression of practice-based improvement. • Develop a quality action/management plan to address outstanding issues • Identify who takes responsibility for the actions • Meet regularly to ensure actions being implemented are successful • Discuss problems or benefits • Report on activity • Undertake a regular review of progress against changes agreed
Step 4 – ACT	**Institute and assess change** **Learning – What was the result of improvements made?** **Reflection – What did you learn from this activity?** **Post intervention** • Plan to review again, e.g. after 6 months, to determine whether improvement has occurred following changes instituted • To institute these changes the team will need to determine the effectiveness or otherwise of potential solutions by undertaking a complete PDSA cycle • Identify the impact of actions **Post intervention and feedback** Quality improvement is a cyclical process. If practice teams follow the steps described it provides a systematic process to identify current and potential problems, propose and action solutions, and determine whether the interventions put in place have made a difference to improvements in the practice, or for patient care.

The RNZCGP Quality Framework

The Quality Framework[3] is a useful planning tool for organising and informing practice and clinical quality activity. It can be used to identify topics and target areas for improvement. It can be used by clinicians, practices or organisations for understanding connections between systems, processes and outcomes, and for identifying gaps. It shows relationships between practice activities and other quality activities or programmes at a local or national level.

The Quality Framework groups quality activity into three broad interrelated areas to use for assessment of practice or clinical performance.

1. Structure, Process, Outcome *(red in the Quality Framework diagram)* [4] [5].
   Structure relates to activities which strengthen the environment within which care is delivered, and ensure operational safety. Some of these activities may be assessed using measures of access. Other aspects may be assessed or ensured by practice and practitioner accreditation. Development of practice protocols and sentinel event monitoring are separated out as important elements that contribute to structural quality activity.

   Process refers to what is actually done during the delivery of care and may be defined in terms of clinical and technical interventions and relationships. Structural attributes impact on process. Measures of process need to be linked to outcomes to be of value.[6]

   Outcomes of care represent the ultimate objective of health care provision. They may be influenced either directly or indirectly by structural and process factors. The relationship between structure, process and outcome is useful for assessing performance and understanding the various influences on health outcomes.

2. Categories of quality activity in which practices are engaged, e.g. equity (*Green in the Quality Framework diagram*).

3. Ways of assessing performance or assuring quality e.g. measures of access, effectiveness or performance (*Light blue in the Quality Framework diagram*).

   The Quality Framework outlines the difference between comparative measurements, which use indicators to compare the quality of services provided, and organisational assessment. It also includes variables that relate to age, gender, compliance, risk factors, lifestyle and environment.

References

1   Berwick D, Institute of Healthcare Improvement (IHI), Boston, USA

2   Ministry of Health. Toward Clinical Excellence. An introduction to clinical audit, peer review and other clinical practice improvement activities. NZ, Wellington, 2002

3   Perera R, Morris C, Dowell T. Voyage to Quality. Summary of Work. Report to the Royal New Zealand College of General Practitioners. February 2009-August 2010

4   Donabedian A. Evaluating the quality of medical care. Millbank Memorial Fund Quarterly. 1966;44:166-204

5   Donabedian A. Editor. An introduction to Quality Assurance in Health Care. New York: Oxford University Press;2003

6   Mant J. Process versus outcome indicators in the assessment of quality of health care. International Journal for Quality in Health Care. 2001;13(6):475-80

RNZCGP Quality Framework (V2Q)

STRUCTURE

PROCESS

OUTCOME

OUTCOME

- EQUITY
- COST OF THE SERVICE
- USER APPRAISAL
- HEALTH STATUS

PROCESS

- PRACTICE RELATIONSHIPS
  - EXTERNAL
  - INTERNAL
    - CORNERSTONE®
- CLINICAL CARE/ TECHNICAL INTERVENTIONS
  - Suitable use and ethical application of knowledge and skills by practitioners

OTHER ORGS / COMMUNITY / STAFF / PATIENTS

STRUCTURE

- PRACTICE ENVIRONMENT
  - 'Competent' and appropriate setting within which care occurs
  - Competence of the professional providing the care.
- OPERATIONAL SAFETY
  - Organisational and practice supporting activity and resources
  - Functional interface between practitioner, management, resources, technology

CORNERSTONE®

Practice systems

Variables
Demography
Case-mix
Severity
Govt policies
Behaviour of patients and families
Other

MEASURES OF EFFECTIVENESS/ PERFORMANCE

PPP

SENTINEL/ ADVERSE EVENTS REPORTING

PRACTICE PROTOCOLS

PRACTICE AND PRACTITIONER ACCREDITATION

Aiming for Excellence

MEASURES OF ACCESS

PPP

For theoretical underpinning see Perera G.A.R Panning for Gold. The assessment of performance indicators in primary health care. PhD thesis University of Otago 2009
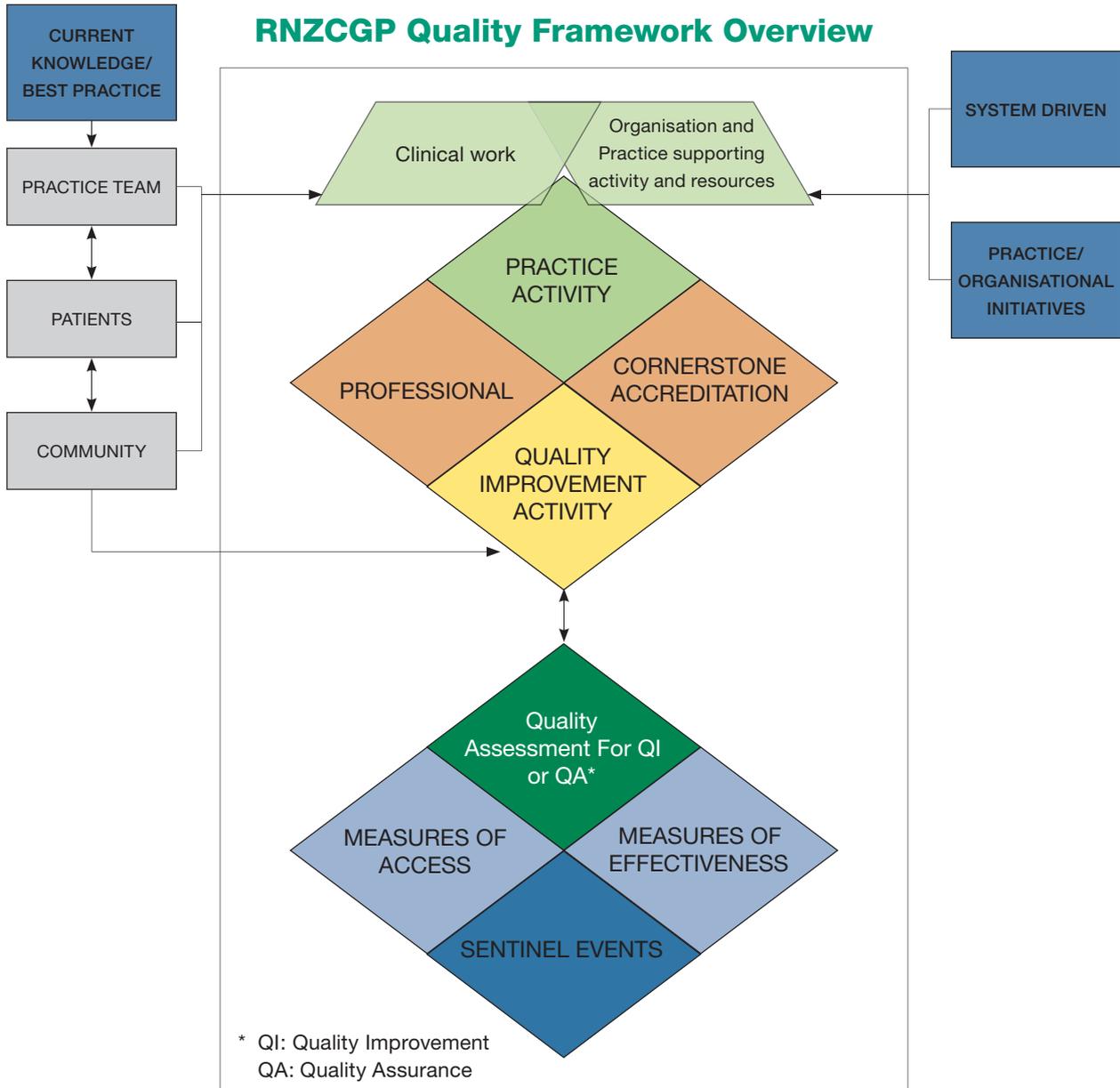
V2Q—Perera, Dowell, Morris

Aiming for Excellence in a quality system

Together, the indicators and criteria in *Aiming for Excellence* describe important components of a general practice system.

The RNZCGP Quality Framework Overview (see below) shows how the system links to other interrelationships and activities that influence day-to-day clinical work, wider practice activity, health system activity and RNZCGP activity, including CORNERSTONE® General Practice Accreditation.

At the centre of the framework, Quality Improvement activities help practices to identify where practice teams engage in clinical effectiveness activities to improve outcomes. These can be utilised within a peer review environment to enable self reflection and learning, or for quality assessment, professional development, continuing medical education (CME) or CORNERSTONE® General Practice Accreditation.

RNZCGP Quality Framework Overview

*   QI: Quality Improvement
    QA: Quality Assurance

The Quality Framework and Quality Framework Overview were developed for The Royal New Zealand College of General Practitioners by the Primary Health Care Quality Research Unit, University of Otago, Wellington

V2Q—Perera, Dowell, Morris

The Royal New Zealand
College of General Practitioners

Primary Health Care
QUALITY RESEARCH UNIT

UNIVERSITY OF OTAGO
Te Whare Wānanga o Otākou
NEW ZEALAND

Glossary

Access	The ability to obtain health care irrespective of income, physical location and cultural background
Accreditation	A process of assessing a practice against an approved set of standards to determine whether or not they achieve those standards. If the requirements are met, they can be 'accredited'.
Appropriateness	The relevance of care intervention or action to a patient's needs, based on established standards.
Brief interventions	A short discussion intended to provide people with information and help people to think differently about how to take responsibility for making changes to improve their health.
Calibration	Checking or adjusting the accuracy of a measuring instrument against a known instrument, standard or reading, with the purpose of ensuring consistent measurements.
Capacity	An individual's or organisation's ability to provide a service, based on skills, knowledge, and available resource.
Clinical governance	The system which has responsibility for clinical health care decisions. It involves deciding who is accountable for clinical judgements and defining how decisions are passed on.
Continuity	Uninterrupted, coordinated care or service provided across programmes, practitioners and organisations over time.
Disease coding	Examples of Disease Coding Systems: • READ codes are a hierarchical coding system—each level provides a more specific diagnosis • SNOMED CT® (Systematized Nomenclature of Medicine—Clinical Terms) is the most comprehensive multilingual clinical health care terminology developed by the National Health Service in England and the College of American Pathologists in 1999 • ICPC-2 PLUS (also known as the BEACH coding system) is a clinical terminology classified to the International Classification of Primary Care.
Effectiveness	The degree to which care, intervention or action achieves a desired outcome.
Efficiency	The degree to which results are achieved with the most cost-effective use of references.
Intermediate outcomes	The result of appropriate, effective and timely interventions that are proven to make a difference to patients' quality of life and are a step on the way to a final outcome.
Triage	The system of ensuring people who need the most urgent help are dealt with first.
Practice team	Every team member in the practice.
Protocol	A protocol is a written procedure for an activity.
Quality	For general practices, quality is defined as meeting or exceeding patient expectations and relevant standards.
Reliability	The ability of a person or system to perform and maintain its function(s) accurately and consistently.
Significant results	Those results where follow-up is essential and the risks to patients of not following up is high.

Aiming for Excellence
—History of development & quality journey

	The Structure—the standard	The Process—an accreditation programme	Outcomes—improving outcomes for patients
Year	Development of *Aiming for Excellence*, the NZ standard for general practice	CORNERSTONE® General Practice Accreditation development—an assessment process for practices to compare themselves against *Aiming for Excellence*	Clinical indicators development
1996	• The RNZCGP explored the literature and feasibility of standards for New Zealand general practice. • In a separate exercise, the Goodfellow Unit, The University of Auckland, reviewed the literature to identify indicators of good quality general practice. • A range of provider groups and consumer organisations reviewed the indicators for relevance. • A paper on Key Performance Indicators (KPIs) in primary health care was produced with advice on their use in New Zealand.[65]		
1998	• International Colleges and New Zealand leadership response for increased accountability in general practice. • The Waikato Faculty proposal, expression of interest by members of the RNZCGP and Independent Practitioner Associations Conference prompted an urgent response by the RNZCGP to consider development of a standard for general practice in NZ. • The RNZCGP Practice Standards Committee was established to review the applicability of existing international standards for use in New Zealand practices. • The RNZCGP considered the RACGP standard most relevant, but differences between the Australian and New Zealand general practice structures, health systems and populations made it difficult to adopt the standards. • The Committee agreed to adopt the structure provided by the Australian Standard but populate with the KPIs developed by the Goodfellow Unit.		

	The Structure—the standard	The Process—an accreditation programme	Outcomes—improving outcomes for patients
Year	Development of *Aiming for Excellence*, the NZ standard for general practice	CORNERSTONE® General Practice Accreditation development—an assessment process for practices to compare themselves against *Aiming for Excellence*	Clinical indicators development
1999	• The RNZCGP Practice Standards Working Party continued development work and identified a subset of the KPIs and developed to produce the first set of standards for New Zealand general practice. • *Aiming for Excellence* (1999) was introduced for consultation and testing.		
2001–2002	• The RNZCGP Practice Standards Validation Field Trial sought to validate *Aiming for Excellence* (2000), assessor training and the process of assessment. They were subjected to a rigorous evaluation in a field trial of 81 practices during 2000–2001 and found to be reliable, valid and feasible for use in measuring the quality of care provided by a general practice. • *Aiming for Excellence*—An assessment tool for general practice (2002, 2nd edition) was published.	General practice accreditation development • With the validation field trial complete, the RNZCGP began identifying principles and key issues for practice accreditation. • The RNZCGP Professional Development Practice Sub-Committee was established to provide oversight of design and development of an accreditation process for practices to enter into a continuous quality improvement programme and assess themselves against *Aiming for Excellence*. The purpose of the process was to inform learning and improvement by general practice teams. • 61 GPs, practice nurses and practice manager assessors were trained to undertake assessments. • A business model was developed to establish operations for the new programme.	
2003		• Early programme establishment. QIPNZ, a subsidiary of RACGP/AGPAL, was contracted to establish an accreditation programme for NZ general practice.	
2004		• Review of QIPNZ contract. • RNZCGP established the CORNERSTONE® General Practice Accreditation Programme. • HDANZ was contracted to provide external validation of CORNERSTONE® process. • GDSL/MedAudit developed a fully automated IT system and support for CORNERSTONE® programme and practices. • Ministry of Health funded implementation of practice accreditation—85 practices.	

	The Structure—the standard	The Process—an accreditation programme	Outcomes—improving outcomes for patients
Year	Development of *Aiming for Excellence*, the NZ standard for general practice	CORNERSTONE® General Practice Accreditation development—an assessment process for practices to compare themselves against *Aiming for Excellence*	Clinical indicators development
2006	• Consultation phase *Aiming for Excellence* (2002) from July 2006 to January 2007.	• The RNZCGP endorsed the CORNERSTONE® General Practice Accreditation Programme as a formal quality programme leading to accreditation.	• qi4gp—linking quality and information • General Practice Leaders Group—Study Tour to review the UK Quality Outcomes Framework—October 2006.
2007	• *Aiming for Excellence* (2000) was reviewed by the RNZCGP Board of Quality and informed by the rollout of CORNERSTONE®, analysis of consultation data, research evidence, and consensus building among local experts.	• By the end of December 2007, 520 practices had enrolled in the CORNERSTONE® programme and 274 achieved CORNERSTONE® General Practice Accreditation.	• Development of the RNZCGP Quality Agenda, Voyage to Quality, a high level strategy for improving clinical effectiveness and patient outcomes.
2008	• *Aiming for Excellence* (2008, 3rd edition)	• By December 2008, 335 practices achieved • CORNERSTONE® General Practice Accreditation.	• Consultation about the components of a clinical effectiveness programme with other primary care stakeholders.
2009	• *Aiming for Excellence* (2009) revised third edition. • The RNZCGP Board of Quality undertook a further review following feedback from general practices, CORNERSTONE® assessors and other organisations. • The high uptake of the CORNERSTONE® programme showed the bar had been raised too high for the majority of practices. • Relevance of some new indicators were found to be of no value and were removed, and others reverted back to previously validated indicators.	• By December 2009, 381 practices achieved CORNERSTONE® General Practice Accreditation.	• Primary Care Quality Research Unit, Wellington School of Medicine commissioned to continue develop capacity in the clinical outcomes area: – Review the Quality Landscape in New Zealand – Develop the evidence base for quality and indicators – Build a Quality Framework – Develop quality tools and processes for use by general practices – Further develop the 'Indicator Sieve' for use by general practice clinical teams – Develop a suite of clinical indicators – Develop clinical improvement capacity in CORNERSTONE®
2011	• *Aiming for Excellence* (2011, 4th edition)	• May 2011: 751 practices participating in CORNERSTONE® and 600 Accredited	2012—Development of an enhanced CORNERSTONE® programme to include clinical effectiveness activity

References

1 Perera R. Voyage to quality: Mapping the quality landscape. Interim report to The Royal New Zealand College of General Practitioners. Wellington School of Medicine and Health Sciences, University of Otago. Wellington, NZ; 31 August 2009.

2 Perera R. Voyage to quality. Background literature review. Department of General Practice and Primary Health Care, Wellington School of Medicine and Health Sciences, University of Otago. Wellington, NZ; 31 March 2009.

3 Buetow S. Advice to the RNZCGP. Review of *Aiming for Excellence*. University of Auckland, Department of General Practice and Primary Health Care; 2007.

4 WONCA Europe. The European definition of the key features of the discipline of general practice, the role of the general practitioner and a description of the core competencies of the general practitioner/family physician; 2002.

5 New Zealand Gazette. Medical Council of New Zealand scope of practice and prescribed qualifications for the practice of medicine in New Zealand. Supplement 29 January 2010. Wellington: Issue no. 8.

6 Scally G, Donaldson L. Clinical governance and the drive for quality improvement in the new NHS in England. BMJ. 1998;317:61–65.

7 Halligan A, Donaldson L. Implementing clinical governance: Turning vision into reality. BMJ. 2001;322:1413–1417.

8 Epstein R, Fiscella M, Lesser M, Stange K. Why the nation needs a policy push on patient-centered health care. Health Aff (Millwood). 2010 Aug;(29)8:1489–95

9 Sullivan WH. Repairing medicine's social contract: whose responsibility? Unpublished paper given at a joint meeting of the Royal Society of Medicine and New York Academy of Medicine, New York; 2002.

10 Medical Professionalism Project. Medical professionalism in the new millennium: a physicians' charter. Med J Aust. 2002;177:263–265.

11 Irvine DH. Time for hard decisions on patient-centred professionalism. Med J Aust. 2004 Sep 6; 181(5):271–4.

12 WONCA Working Party on Quality in Family Medicine. Family Doctors' Journey to Quality. National Research and Development Centre for Welfare and Health. Finland: Gummerus Printing; 2001

13 Hanne T. Statement on continuous quality improvement. Goodfellow QA Unit. University of Auckland; 2002.

14 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). www.jointcommission.org/

15 Continuous Improvement. www.c2econsulting.co.uk/services_continuous.asp

16 Starfield B. Starfield, Primary Care: Balancing Health Needs, Services and Technology. OUP 1998, Starfield et al, Health Policy 2002; 60:201–18.

17 Ministry of Health. The Primary Health Care Strategy. Wellington, NZ: Ministry of Health; 2001.

18 Buetow S, Roland M. Clinical governance: Bridging the gap between managerial and clinical approaches to quality of care. Qual Health Care. 1999;8(3):184–190.

19 Starfield B. The primary solution. Put doctors where they count. Boston Review. Nov/Dec 2005. Available from: www.bostonreview.net/BR30.6/starfield.php

20 Buetow S. To care is to coprovide. *Ann Fam Med*. 2005;3(6):553–5.

21 Roland M, Baker R. Clinical governance – a practical guide for primary care teams. National Primary Care Research and Development Centre, University of Manchester, Clinical Governance Research and Development Unit, University of Leicester, UK; 2006.

22 The Kings Fund. Inquiry into the Quality of General Practice. http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/patient_engagement.html

23 Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives to Hon Tariana Turia, Minister for the Community and Voluntary Sector. New Zealand.

24 The New Zealand, Quality Improvement Committee (QIC) – reporting to the Minister of Health.

25 Pert H, Wellingham J, Barnett P, Stenson A. qi4gp – A quality and information perspective for general practice. General Practice Leaders Forum. July 2007.

26 Ministerial Task Group on Clinical Governance: Dr Jeff Brown (Chair), Dr Andrew Connolly, Ron Dunham, Dr Anne Kolbe, Dr Harry Pert, Helen Pocknall. Wellington, NZ; 2009.

27 Marshall M, Roland M, Campbell S, Kirk S, Reeves D, Brook R, et al. Measuring general practice. A demonstration project to develop and test a set of primary care clinical quality indicators. Manchester: NPCRDC; 2003.

28 Department of Health. Standards for better health. UK; 2004. [Cited 2010 July 12] Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf 20.10.7.12

29 Medical Council of New Zealand. Information and consent. Available from: www.mcnz.org.nz/portals/0/Guidance/Information%20and%20Consent.pdf

30 St George I. Cole's medical practice in New Zealand. Wellington, NZ: Medical Council of New Zealand; 2009. Available from: www.mcnz.org.nz

31 Medical Council of New Zealand – Māori Culture and Health. Cole's Medical Practice in New Zealand (2008): Available from: www.mcnz.org.nz

32   Wikipedia. Integrated care. Available from: www.en.wikipedia.org/wiki/Integrated_care

33   New Zealand Misuse of Drugs Act 1977. www.legislation.govt.nz/act/public/1975/0116/latest/DLM436101.html Wikipedia. Controlled Drugs. Available from www.en.wikipedia.org/wiki/Controlled_Drug

34   Randerson R, Phipps R. Greening your practice toolkit. greeningyourpractice@gmail.com

35   Ministry of Health. [Cited 2011 Jan 11]. Available from: www.moh.govt.nz/moh.nsf/indexmh/ed-about-triage

36   Health Sponsorship Council; New Zealand. [Cited 2010 Aug 25]. Available from: www.hsc.org.nz/socialmarketing.html

37   Ministry of Health. Green Prescriptions. Wellington, New Zealand. [Cited 2010 Aug 26]. www.moh.govt.nz/greenprescription

38   McGreevey M. Patients as Partners: How to Involve Patients and Families in Their Own Care. Oakbrook Terrace, Illinois: Joint Commission on Accreditation of Healthcare Organizations, 2006.

39   Peckham CS, Dezateux C. Issues underlying the evaluation of screening programmes. Br Med Bull. 1998; 54(4):767–78.

40   Commonwealth Department of Health and Aged Care. General Practice in Australia. Canberra: Department of Health and Aged Care; 2000.

41   Ministry of Health. New Zealand Smoking Cessation Guidelines 2010. Available from: www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines.

42   Ministry of Health. New Zealand. Long-Term Conditions Programme. Available from: www.moh.govt.nz/moh.nsf/indexmh/longtermconditions-news-march09update#collaboratives

43   National Health Committee. Screening to improve health in New Zealand. Criteria to assess screening programmes. Wellington, NZ: National Advisory Committee on Health and Disability (National Health Committee); April 2003.

44   Low N, Egger M. What should we do about screening for genital chlamydia? Int J Epidemiol. 2002;31(5):891–893. doi: 10.1093/ije/31.5.891

45   The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice 7th ed. Melbourne, Australia: The Royal Australian College of General Practitioners; 2009. Available from: www.racgp.org.au

46   National Steering Committee. 2000. Second Report of the UK National Screening Committee. Department of Health, The Scottish Executive, Department of Health and Social Services and Public Safety, Northern Ireland and the National Assembly for Wales. Available from: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014560.pdf

47   Berwick DM. Continuous improvement as an ideal in health care. N Eng J Med. 1989;320(1):53–6.

48   Elwyn G. Rhydderch M, Edwards A, Hutchings H, Marshall M, Myres P, Grol R. Assessing organizational development in primary medical care using a group based assessment: the Maturity Matrix. Qual Saf Health Care. 2004;13(4):287–94. doi:10.1136/qshc.2003.008540

49   National Patient Safety Agency. The Team Climate Assessment Questionnaire. 2006.

50   Roland M. Holden J. Campbell S. Quality Assessment for General Practice: Supporting Clinical Governance in Primary Care Groups. Manchester, UK: National Primary Care Research & Development Centre, University of Manchester; 1998. Available from: http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/Publications/QualityASSESS.pdf

51   Coster G, Buetow S. Quality in the New Zealand health system: Background paper to the National Health Committee. Wellington: National Health Committee; September 2001. Available from: www.nhc.health.govt.nz/moh.nsf/pagescm/715/$File/backgroundpaper.pdf

52   Wellingham J, Gillon M. Outcomes of the implementation of the Cornerstone® General Practice Accreditation Programme. N Z Fam Physician. 2007;34(4):263–265.

53   Deming E. The PDCA cycle. In: Gabor A. *The man who discovered quality*. Penguin; 1990.

54   Berwick D. Institute of Healthcare Improvement (IHI). Boston, USA.

55   Ministry of Health. Toward clinical excellence. An introduction to clinical audit, peer review and other clinical practice improvement activities. Wellington, NZ: Ministry of Health; 2002.

56   Fawcett C, Perera R, Gillon M. Template for a Quality Plan for a practice based QI Activity. Wellington, NZ: The Royal New Zealand College of General Practitioners; 2011.

57   Perera GAR. Panning for gold. The assessment of performance indicators in primary health care. PhD thesis. Wellington, NZ: University of Otago, Primary Health Care and General Practice; 2009.

58   Perera R, Dowell T, Crampton P et al. Panning for gold: an evidence-based tool for assessment of performance indicators in primary health care. Health Policy. 2007;80(2):314–27.

59   Diressie D. Summary of the Sieve. Report for The Royal New Zealand College of General Practitioners. Wellington, NZ; 2011.

60   Perera R, Morris C, Dowell T. Voyage to quality. Summary of work. Report to The Royal New Zealand College of General Practitioners. February 2009–August 2010.

61   Donabedian A. Evaluating the quality of medical care. Millbank Mem Fund Q. 1966;44(3):Suppl:166–206.

62   Donabedian A. Editor. An introduction to quality assurance in health care. New York: Oxford University Press; 2003.

63   Mant J. Process versus outcome indicators in the assessment of quality of health care. Int J Qual Health Care. 2001;13(6):475–80

64   Campbell S, Roland M, Buetow S. Defining quality of care. Soc Sci Med. 2000:51(11):1611–25.

65   Wellingham J, Hanne T, McFarlane S, Buetow S, Coster G. Identification of an appropriate quality measurement tool for use in New Zealand general practice. Report to the Northern Regional Health Authority. Auckland: Goodfellow Unit, University of Auckland; 1998.