5th ed Accreditation Focus List

Self-assessment: Complete and submit

Patient Feedback:

- 30 surveys/1 FTE GP
- 60 surveys/2 FTE GP's
- 90 surveys/3 FTE GP's
- 100 surveys if more than 3 FTE GP's
- Use an RACGP approved questionnaire
- Validated questionnaire must be approved by RACGP
- RACGP Patient feedback guideline should be stored in computer
- If a complaint cannot be dealt within the surgery, patients should be referred to the **Health Care Complaints Commission 9219 7444.**
- Practices should communicate findings to patients in appropriate manner, eg. newsletter, poster, signage, etc.

Signage:

- Practice opening hours (external signage)
- After Hours contact details (external signage)
- List of fees for consultation
- Practice information sheet with required information
- Triage procedure wall chart – ideally it should be placed near the phone
- Translating services
- National Relay Service Calls
- Longer appointment available
- Recall and reminder system
- Identification of ATSI poster
- No smoking signs
- Zero tolerance
- Toilet signs – directional signs to the toilet
- Privacy of health information
- Sharps stick injury sign – should be placed near the yellow sharp disposable bins
- Exposure to blood or body fluid protocol
- Patient alert
- Cough etiquette
- Standard precautions
- Droplet precautions
- Hand washing signs – placed near any sink in the practice
- Vaccine temperature record charts – keep near vaccine fridge
- Strive for 5 Cold Chain breach protocol

Please contact your Practice Support Officer for more poster/signage.

Practices may also like to have Info-Med brochures http://www.tonichealthmedia.com.au/info-med/ and/or electronic health information to provide patients with ranges of health information and conditions.

General:

- Answering machine message is correct and working. Emergency details need to be at the start of the message.
- There need to be a flexible appointments system to accommodate patients with

urgent medical problems or patients who need longer consultations.
- GP's and staff can describe their roles within the practice.
- Document of any ethical dilemmas that have been considered, and the outcome or solution. **(NEW)**
- Maintain a business plan and goals aim at improving practice services. **(NEW)**
- All staff can describe the process of recall and reminder system.
- All staff can describe how they manage non-English patients.
- All staff should be able to demonstrate working towards self-identified cultural background details of patients in the practice, such as ATSI.
- Range of posters, leaflet and brochures are available.

Practice Information Sheet:

This should include:
- Practice's address and telephone numbers
- Consulting hours
- Outside normal opening hours care arrangements
- Practice's fees and billing principles
- Names of doctors in the practice, session times available
- Practice's communication policy, including when and how we receive and return telephone calls and electronic communications
- Policy for managing patient health information
- Complaints resolution process
- Range of services available
- Clause of practices privacy policy (recommended)
- Translated into the common languages of the patient population (recommended)

Autonomy of GPs:

- Doctors can exercise full autonomy in relation to clinical care of patients, referrals to other health professionals, requesting investigations, duration and scheduling of appointments
- Doctors needed to be satisfied with equipment and medical supplies provided by the practice.
- Face-to-face clinical meeting is highly recommended to distribute guidance and discuss range of issues.
- There should be a written policy confirming the autonomy in decisions made by the Doctors (not required for solo practices who do not use locum services)

Clinical handover:

- Effective clinical handover system documented in policy and procedure manual.
- Share-care arrangement between GPs and AHPs/external Doctors.
- Practice staff can describe timely handover of patient care. This can be face to face, in written, via telephone or electronic means, e.g. communication book/document recorded of handover on vaccination check, incoming mails, referral letters, etc.

Follow-up system:

- Have a process for managing high-risk (seriously abnormal and life-threatening) results identified outside normal opening hours *(eg. give diagnostic services the contact details of the practitioner who ordered the investigation and/or the contact details of the practice team member who have access to the patient's health record.* **(NEW)**
- Have a procedure for follow-up and recall of patients with clinically significant tests and results and clinical correspondence.
- A register of patients for reminders for preventative activities (recommended).

Patient health records:

- Hybrid practices should record clinical note for each consultant in both system
- Clinical notes, emergency contact and Indigenous status must be recorded in medical record system. ***(Tips: include emergency contact and Indigenous status question in new patient registration form. Ask patients randomly whether their emergency contact has changed or ask for emergency contact details update when sending a new referral. Ensure to mark "non-Indigenous" where applicable. Collect all ethnic backgrounds).***

- Patient health record must be well organised. Progress notes should contain date, reason, problem managed, plan, medication prescribed and referral documentation.
- 90% of active medical records must have allergies recorded. Practice must mark "no known allergies" where applicable ***(PEN CAT recommended and can be installed by PHN).***
- 75% of active patient medical records must contain health summaries including up-to-date medications, past medical history, family history and social history, allergies, immunisations and risk factors. (***Tip: using coded data as this will make creating health summary simpler).***
- Home and after-hours visits should be notated.
- Patient health record should include discussions or activities relating to preventive health (eg. hand out up-to-date pamphlets and brochures, remind patients of screening activities, run diabetic education or quit smoking groups, use preventive health guidelines and resources, etc.)
- Patient health record should include the treatment options and associated risks and side effects that have been explained and discussed.
- Patient health record should include the patient's refusal to obtain or follow any clinician's advice.
- Test results should be signed or initialled by doctor and appropriate action taken.
- Records are to be kept until the patient has reached 25, or for a minimum of 7 yrs.
- Inactivate patient records, this will make the following maintenance tasks easier.
- Evidence that sterilisation load numbers are recorded in the patient's health record when sterile items have been used (recommended). **(NEW)**

GP/Clinician Qualifications:

- All GPs and clinical team can provide evidence of current national Medical registration.
- Practice can provide evidence of participation in the RACGP QG&CPD programs.
- GP's have undertaken CPR training within the past 3 years.
- Evidence that the clinical team has been educated on the safe use of equipment. **(NEW)**

Staff Qualifications:

- All staff have undertaken at least one CPR within the past 3 years
- Triage training (highly recommended)
- Cold chain management
- Infection control training
- Sterilisation training (if applicable)

** GPA webinars:
https://www.gpa.net.au/general-practices/webinars/
** AGPAL E-Learning:
AGPAL Hub
** South Eastern Melbourne PHN Free Online Learning:
http://www.practicecoaching.com.au/
** Cold Chain Management online training:
https://www.health.nsw.gov.au/immunisation/coldchain/story_html5.html

Quality Improvement:

- GP's and staff should be able to describe aspects of the practice that have been improved in the last 3 years based on real practice data. Those areas may include appointment system, record keeping system, handling feedback & complaint, increase immunisation rate, etc.
- Evidence of practice has conducted a quality improvement activity, such as a PDSA cycle of clinical audit, at least once every three years. Practice can participate in SWSPHN Quality Improvement in Primary Care (QIPC) program and/or develop a PDSA cycle to improve the quality and efficiency of patient care. Whole-of-practice should engage in quality improvement process **(NEW)**
- Record of feedback from the practice team about quality improvement systems is in place **(NEW)**

Clinical Risk

- The practice has risk management process in place and develop procedures to

Management:	mitigate risks. **(NEW)** – The practice has near miss register, mistakes and deviations from standard clinical practice report. – The practice has contingency plan for adverse events. – At least two practice members are present during normal opening hours. – The practice share information about QI and patient safety within the team.
Information Security:	– Patient health records must not be accessible by other patients or visitors. – Different access level for different users, always use screensavers – Have a back-up procedure with a disaster recovery plan document. – Make sure anti-virus software & firewalls installed – Maintain an email policy and a social media policy. **(NEW)**
Pharmaceuticals:	– Practice needs to demonstrate their patients are informed of benefits, risks and purpose of prescribed medications. Providing Consumer Medicines Information will cover this. Some clinical software programs have this feature built in. – Accurate medication list. – Doctors must access to current and accurate medication information. – Referral letter should include current medication. – There should be no expired drugs in the surgery or doctors bags – A policy should be in place to ensure that this is reviewed regularly.
Schedule 8:	– State & territory legislation generally require that Schedule 8 medicines are stored in a locked cabinet or safe that is itself fixed to an immovable structure. – S8 medicines must be correctly recorded in numbered recorded book in accordance with State & territory and stored with dangerous drugs. – S8 medicines can only be destroyed by GP or RN under a local police officer's witness at the practice, or by the deputy pharmacist from **NSW Health Department (02) 9391 9000.**
Cold Chain Management:	– Practice can demonstrate cold chain management process, action to be taken when power cut, fridge door left open, or any breach occurred, e.g. contact **PHU on 1300 066 055** for advice regard to vaccines. – Practice staff can describe procedure for packing/unpacking of vaccine fridge, how to use the max-min thermometer, how to store vaccine, etc. – Practice has a documented policy for cold chain management procedure. – If using domestic fridge, plastic bottles filled with salt water in the fridge door and lower drawer will help to stabilise the fridge temperature. – Data logging recommended **(this service can be provided by PHN)**
Infection Control:	– Staff and doctors can describe procedures for cleaning, disinfection and decontamination of surfaces. – Practice is visibly clean and well maintained. – Evidence of cleaning schedule and staff immunisation log. – PPE and wear for infection control procedures (items suggested in blood spills kit) – Procedure for dealing with spillage's of blood and body fluids. – Practice should use appropriate alkaline detergent e.g. Sonidet, Clinidet (or ask their local medical supplier). – On-going staff education about infection control. – Patient education on diseases transmission (e.g. respiratory etiquette and hand hygiene posters available in the waiting room) – If using external cleaning contractor, the cleaning procedure should be documented and included in the agreement. Evidence of this should be provided in the policy and procedure manual. – Log or list that record the patient's name against sterilisation load numbers. **(NEW)**
Sharps:	– Yellow, puncture resistant sharps containers placed in all areas where sharps are generated. Containers are placed out of the reach of children. – Leak proof containers with bio-hazard symbol for disposal of hazardous waste.

- Practice needs to have a sharps injury protocol.
- Staff and GP can describe safe disposal of sharps
- A written policy for the disposal of sharps and contaminated waste including letter from a contractor providing the services.

Responsible Staff:

One staff member has been designated with main responsibility for the following areas, and their responsibility should be documented in their job description:

- Quality improvement and safety
- Information management and security
- Infection control and sterilisation
- Cold chain management
- Recall & Reminder follow-up
- Feedback and complaints management
- Practice operation and training

Practice Facilities:

- The practice has one or more height adjustable beds.
- The practice has at least one consulting room for every doctor working in the practice at any one time.
- Toilets and hand washing facilities are available.

Practice Equipment:

- Auriscope
- Blood glucose monitoring equipment
- Defibrillator (recommended) **(NEW)**
- Disposable needles and syringes
- Equipment for resuscitation- maintaining an airway (children and adults), equipment to assist ventilation (including bag and mask)
- Intravenous access
- Emergency medicines
- Examination light
- Eye examination equipment (eg flourescein staining)
- Gloves (sterile and non-sterile)
- Height measurement device
- Measuring tape
- Monofilament for sensation testing
- Ophthalmoscope
- Oxygen
- Patella hammer
- Peak flow meter
- PPE
- Pulse oximeter **(NEW)**
- Scales
- Spacer for inhaler
- Specimen collection equipment
- Sphygmomanometer with small, medium and large cuffs
- Stethoscope
- Surgical masks
- Thermometer
- Torch
- Tourniquet
- Urine testing strips, including pregnancy testing kits
- Vaginal specula
- Visual acuity charts
- X-ray viewing facilities
- Timely access to a spirometer and electrocardiograph

Doctor Bag

- Auriscope
- Disposable gloves

- Equipment for maintaining airways- children and adults
- In-date medicines for medical emergencies
- Opthalmoscope
- Practice stationery (including prescription pads and letterhead)
- Sharps container
- Sphygmomanometer
- Stethoscope
- Syringes and needles in a range of sizes
- Thermometer
- Tongue depressors
- Torch

Resources (can be electronic copy):

- The RACGP Standards – 5th edition
- RACGP infection prevention and control standards
- Managing emergencies and pandemics influenza in General Practice
- Managing pandemic influenza in General Practice – 2nd ed
- Pandemic flu kit implementation guide
- National guide to a preventive health assessment for ATSI people - 3rd edition
- Interpretive guide to the RACGP Standards for Aboriginal community-controlled health services -4th edition
- Service directory for older people & people with disabilities
- RACGP Computer and information security standards (CISS) – 2nd edition
- APP compliance indicators (CISS addendum)
- RACGP Information security in general practice
- Information security guide for small healthcare business
- RACGP Guide for the use of email in general practice **(NEW)**
- RACGP Guide for the use of social media in general practice **(NEW)**
- AHPRA For registered health practitioners: Social media policy **(NEW)**
- AHPRA-Guidelines for advertising regulated health services **(NEW)**
- Strive for 5 – 2nd edition
- RACGP Standards 5: patient feedback guide
- Australian Open Disclosure Framework **(NEW)**
- Implementing the Australian Open Disclosure Framework in small practices

Accreditation Helpful Tips

PRACTICE DOCTORS

- Surveyors will look at the data collected from patient feedback surveys. Make sure the practice has enough time to obtain the survey.
- GPs and staff must be able to describe their roles within the practice (refer to job description)
- The practice has a staff performance management program, where the performance of team members is monitored against the requirements outlined on the position description. **(NEW)**
- Evidence of participating in Continuing Professional Development (CPD) activities and CPR training in the past three years (certificates can be kept in Doctor's profiles to demonstrate that)
- GPs are required to provide current registration and authority to practice.
- Evidence of the clinical team has been provided with training on the safe use of equipment and be aware of the potential risks associated with the equipment used. **(NEW)**
- The practice plans and set business goals aiming at improving its services **(NEW)**
- Have a statement of the practice's ethics and values and maintain a business plan/ strategy/ action plan **(NEW)**
- Evidence of practice ethical dilemmas that have been considered, and the outcome or solution **(NEW)**
- Ensure all practice team undertaking regular education on Cold Chain Management and Infection Control.
- Describe the way patients are informed of purpose, importance, benefits and risks of proposed treatments, referrals and investigations.
- Inform and encourage patients participating in relevant local health promotion programs (posters, brochures, leaflets, etc.)
- Describe procedures for interaction with local medical services, AHPs and community services.
- Describe how to manage patients who refuse specific treatment or want a second opinion.
- 90% of active patient health record must have allergies recorded.
- 75% of active patient health records must contain health summaries including current problems, past history, allergies, risk factors, medications, immunisations, social and family history, and emergency contact details.
- The patient health record needs to be comprehensive and well organised. e.g. encounter date, encounter reason, problem managed, management plan, prescribed medication, referral documentation, evidence of referral to health and community services.
- Health summaries should include Family and Social history information. If patients did not provide relevant information, then Doctors need to record that the question was asked.
- Evidence that the practice routinely records Aboriginal and Torres Strait Islander (ATSI) in active patient health records.

- Have documented evidence of After Hours Care arrangement, and After Hours encounter notes are to be kept in medical records.
- Demonstrate how to access current information on medicines and prescribing patterns with best available evidence.
- Make sure no our-of-date materials in the practice. These include samples, consumables and items stored in doctor's bag. Staff must routinely check their stock.
- Record of dispersion of Schedule 8 must contain both Patient's and Suppliers' name and address.
- Describe how to communicate with patients who are nor proficient in English, or who have a communicative disability e.g. deaf, blind, etc.
- GPs need to inform patients of any associated costs before treatments, investigations or procedures ae performed. Patients should be informed of potential out-of-pocket costs for referred services.
- Describe the procedure for follow up and recall of patients with clinically significant tests and results and clinical correspondence. Results need to be initialed by a Doctor with date and appropriate action taken and incorporated into medical record.
- It is good idea to show the surveyor reminder system offered by other agencies e.g. local pathology companies or Government Pap Smear register.
- Demonstrate a timely handover of patient care in various situations including staff on leave, absence, between part time staff, after hours care or handover of care to an outside health provider or other services.
- Only one Doctors bag required per practice and available to be accessed by all Doctors. Make sure sharps container is not omitted in Doctors bag.
- Demonstrate available ranges of equipment that is sufficient for common procedures.
- Have access to spirometer and electrocardiograph (can be purchased or by arrangement with a pathology or nearby local hospital)
- Be able to describe practice policy for dealing with complaints.
- Describe three aspects that the practice has been improved in the last three years.
- Describe the process of identifying, monitoring and mitigating business risks in the practice **(NEW)**
- Has evidence that practice have conducted a quality improvement activity at least once every three years. **(NEW)**
- Maintain a record of feedback from the practice team about quality improvement systems. **(NEW)**
- Describe the process for identifying and reporting a slip, lapse or mistake in clinical care and an improvement made to prevent reoccurrence of mistakes (e.g record mistake, discuss at meetings and implement a system in place)
- Disaster Recovery Plan must be documented, understood by all staff and tested on regular basis.
- Maintain an open disclosure process and encourage all practice members to follow the process. **(NEW)**
- Evidence of clinical meetings and staff meetings.
- Describe the process of discussing administrative matters with other staff, GPs and owner of the practice

when necessary.

- Have a policy and procedure for the management of patient health information in the practice as per the National Privacy Principles (NPP) and state requirements. All staff including cleaners and IT contractors should sign a Confidentiality Agreement.

- Describe the practice policy about the use of email and social media **(NEW)**

CLINICAL STAFF

- Describe how leaflets, brochures and other information area used to help describe the diagnosis and management of conditions and about medicines and medicine safety for patients.

- Practice nurses are required to provide current registration and authority to practice.

- Evidence of the clinical team has been provided with training on the safe use of equipment and be aware of the potential risks associated with the equipment used. **(NEW)**

- Demonstrate how to access current information on medicines and prescribing patterns with best available evidence.

- Describe how to manage non-English patients, or who have a communicative disability e.g. deaf, blind, etc.

- Describe the procedure for follow up and recall of patients with clinically significant tests and results and clinical correspondence. Results need to be initialed by a doctor with date and appropriate action taken and incorporated into medical record.

- Evidence of participating in Continuing Professional Development (CPD) activities and CPR training in the past three years (certificates can be kept in staff profiles to demonstrate that)

- Demonstrate a timely handover of patient care.

- Describe three aspects of the practice that have been improved in the last three years.

- Be able to describe practice policy for dealing with complaints.

- Describe the process for identifying and reporting a slip, lapse or mistake in clinical care and an improvement made to prevent reoccurrence of mistakes (e.g record mistake, discuss at meetings and implement a system in place)

- Describe the process of discussing administrative matters with other staff, GPs and owner of the practice when necessary.

- Describe procedure for transport, storage and handling of vaccines according to the NHMRC guidelines (e.g. the Australian Immunisation Handbook, Strive for 5)

- Describe procedure for packing and unpacking of vaccine fridges, e.g. vaccine deliveries and cleaning of fridge.

- Describe how to use thermometer and record fridge temperatures

- Describe procedures for cleaning, disinfection and decontamination of surfaces

- Describe safe disposal of sharp

- Describe procedure for dealing with spillage's of blood and body fluids

ADMIN STAFF

- GPs and staff must be able to describe their roles within the practice (refer to job description)
- The practice team can identify the team leader with main responsibility for various areas of practice clinical governance including Feedback and complaints management, Safety and quality improvement, Electronic system and computer security, Cold chain management, Environment cleaning, Infection control. This responsibility should be listed in the person's job description.
- The practice has an induction program for new GPs and staff (not necessary if the practice has not employed new staff in the last 3 years but must be able to describe what they plan to do when employing new staff)
- The practice has a staff performance management program, where the performance of team members is monitored against the requirements outlined on the position description. **(NEW)**
- Evidence of regular staff meetings. This should be documented.
- Describe the process of discussing administrative matters with other staff, GPs and owner of the practice when necessary.
- Describe the process of identifying, monitoring and mitigating business risks in the practice **(NEW)**
- Has evidence that practice have conducted a quality improvement activity at least once every three years.
- Maintain a record of feedback from the practice team about quality improvement systems. **(NEW)**
- Describe how to identify urgent matters and how they get urgent medical attention (triage procedure)
- Maintain confidentiality and privacy of patients eg. all staff sign a confidential agreement, patient health records must not be accessible by other patients or visitors.
- Demonstrate a timely handover of patient care in various situations including staff on leave, absence, between part time staff, after hours care or handover of care to an outside health provider or other services.
- Describe how to manage non-English patients, or who have a communicative disability e.g. deaf, blind, etc.
- Describe how to identify Aboriginal and Torres Strait Islander (ATSI) patients.
- Describe practice policy for dealing with complaints.
- Remember to ask all patients (even ones well known to the practice team) their patient identification details for every occasion they present at the practice. Approved patient identifiers include Patient name, DOB, Address, Gender, Patient record number where it exists.
- Emergency contact person should be contained in patient health record.
- If a third party is to be present during their consultant, patient consent must be obtained when the patient make appointment or when they arrive at reception (should not in consulting room).
- Patients should be advised of delays in seeing the doctor.
- Describe the procedure for follow up and recall of patients with clinically significant tests and results and clinical correspondence. Results need to be initialed by a doctor with date and appropriate action taken and incorporated into medical record.

- Describe three aspects of the practice that have been improved in the last three years.
- Evidence of participating in CPR training, Triage training and other on-going training in the past three years (certificates can be kept in staff profiles to demonstrate that)
- Evidence that practice maintains a cold chain management policy and produce in place. **(NEW)**
- Describe procedure for transport, storage and handling of vaccines according to the NHMRC guidelines (e.g. the Australian Immunisation Handbook, Strive for 5)
- Describe procedure for packing and unpacking of vaccine fridges, e.g. vaccine deliveries and cleaning of fridge.
- Describe how to use thermometer and record fridge temperatures
- Establish a protocol for when the temperature range is NOT between 2 – 8 ^{0}C
- Describe procedures for cleaning, disinfection and decontamination of surfaces
- Evidence of cleaning schedules (daily and weekly e.g. treatment room – daily, waiting room – weekly)
- Describe procedure for dealing with spillages of blood and body fluids
- Describe safe disposal of sharp
- Evidence of ongoing education about infection control. Be able to explain how patients are educated on the transmission of communicable diseases (eg. cough etiquette, hand hygiene)
- Describe the practice policy about the use of email and social media **(NEW)**