



Policy and Procedure Manual

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1. Introduction

1.1. Mission statement

Our mission is to provide the highest standard of patient care whilst incorporating a holistic approach toward diagnosis and management of illness.

We are committed to promoting health, wellbeing and disease prevention to all patients. We do not discriminate in the provision of excellent care, and we aim to treat all patients with dignity and respect.

1.2. Practice background

My Family GP Medical Centre is a small general practice located in an area that has a mixed socioeconomic status. The practice premises are *shared with a blood collection centre*.

Our practice provides comprehensive general practice care and has special interests including chronic disease management, mental health, family health, and more.

Our practice profile

Name of practice	My Family GP Medical Centre
Street address	52 Simmat Avenue Condell Park
Postal address	As above
In-hours telephone number	8766 4366
After-hours telephone number	8724 6300
Facsimile number	8766 4367
Email address	reception@myfamilygpaustralia.com.au
Web address	myfamilygpaustralia.com.au

1.3. Our practice team

Medical	
General Practitioner	Dr Mahmoud Awad
General Practitioner	Dr Belel Ejje
General Practitioner	Dr Neale Gunning
General Practitioner	Dr Susan Harnett
Allied health	
Podiatrist	Darrel Cochrane
Nursing	
Registered Nurse	Farah Abdulhussein
Administration	
Senior Receptionist	Farah Abdulhussein
Receptionist	Adibe Bechara
Receptionist	Susan Borg

1.4. Practice services

In addition to general medical consultations, our practice offers the following services:

Immunisation	Pathology
Workers compensation	Women's Health
Paediatric health	Iron Infusion

There is a range of posters, leaflets and brochures about health issues relevant to the community available for all of our patients via the:

- Waiting room,
- Consultation rooms,
- Treatment room, and
- Practice website.

1.5. Practice hours

Monday to Friday	8am till 5pm
Saturday	9am till 2pm
Sunday	Closed
Public holiday	Closed

Home or other visits

Home or other visit appointments are made with the receptionist at the discretion of the general practitioner.

1.6. Practice consultation fees

Patients are made aware of the costs associated with accessing care at our practice through:

- Signage at reception
- Our website, and
- Our practice information sheet.

2. Human resources

Medical practices are advised to be continually informed and up-to-date in respect of workplace relations legislation, regulations and decisions of Fair Work Australia. In accordance with the *Fair Work Act 2009*, a *Fair Work Information Statement* is provided to all new employees as soon as possible after the commencement of employment and provides basic information on matters that will affect their employment.

We obtain a copy of the *Fair Work Information Statement* from the Fair Work Ombudsman website:

www.fairwork.gov.au/employee-entitlements/national-employment-standards/fair-work-information-statement.

Whenever our practice needs to seek more information about workplace relations and legislation, we contact the Fair Work Ombudsman information line on 13 13 94 or obtain information through the Fair Work Ombudsman website www.fairwork.gov.au.

2.1. Awards and entitlements

2.1.1. Policy

This practice complies with all its legal obligations towards its employees. These include:

- Provision of rates of pay, leave and other entitlements as set out in the relevant award or workplace agreement,
- A safe and healthy workplace,
- Equal opportunity and freedom from discrimination and harassment,
- Protection of employee and patient privacy, and
- Maintenance of appropriate employment records.

Additionally, this practice follows established procedures and policies for employment and management of staff and contractors, including:

- Clear communication of expectations and standards, using position descriptions and job specifications as well as codes for conduct and presentation,
- Recruitment procedures which are fair, thorough and facilitate selection of the best candidate,
- A formal induction procedure for all practice team members, to familiarise them with important practice procedures relating to patient care, workplace health and safety, emergencies, confidentiality and conduct, and
- Regular feedback and opportunities for development through performance appraisals.

Research from both general practice and other industries supports the importance of attention to human resources; for example, the alignment of role, competence and (where required) licensing was identified by authors of a study of high performing clinical teams as a common element.

2.1.2. Procedure

Under the *Fair Work Act 2009*, general practices are bound by Workplace Agreements or Federal Awards which set out minimum employee entitlements. If general practices are not bound by a workplace agreement, then they must abide by the relevant Awards.

Our practice follows the 10 National Employment Standards (NES), ensuring all Awards, Enterprise Agreements (EA), contracts of employment, and Individual Transitional Employment Agreements (ITEA) provide for the 10 NES as minimum conditions.

The NES applies to all employees covered by the national workplace relations system; however, only certain entitlements apply to casual employees.

Under the NES, employees have certain minimum conditions, and together with pay rates in modern awards and minimum wage orders, the NES makes up the safety net that cannot be altered to the disadvantage of the employee.

In addition to the NES, our employee's terms and conditions of employment come from a modern award and agreement based transitional instruments, minimum wage orders, and state or federal laws.

The NES involve the following minimum entitlements:

- **Maximum weekly hours of work** - 38 hours per week, plus reasonable additional hours.
- **Requests for flexible working arrangements** – for employees who have been employed for at least 12 months (continuous service) and meet at least one of the following criteria: a parent or carer of a child who is school aged or younger, a carer under the Carer Recognition Act 2010, has a disability, is aged 55 years or older, is experiencing family or domestic violence, or who provides care or support to a member of their household or immediate family who requires care and support because of family or domestic violence.

- **Parental leave and related entitlements** – any employee who has been employed for at least 12 months (continuous service) can access up to 12 months unpaid leave, and has a right to request an additional 12 months unpaid leave, plus other forms of maternity, paternity and adoption related leave. The Australian Government’s paid parental leave scheme is available to all employees who have been employed for at least 12 months.
- **Annual leave** - based on their ordinary hours of work, four (4) weeks paid leave per year, plus an additional week in accordance with the relevant awards where the employee is a shift worker and is regularly rostered to work on weekends (i.e. Sundays) and public holidays.
- **Personal/carer’s leave, compassionate leave and unpaid family and domestic violence leave** - based on their ordinary hours of work, 10 days paid personal/carer’s leave and two (2) days unpaid carer’s leave per year, two (2) days compassionate leave (unpaid for casuals) as required, and five (5) days unpaid family and domestic violence leave per year.
- **Community service leave** - unpaid leave for voluntary emergency activities, and an entitlement to be paid for up to 10 days for jury service.
- **Long service leave** - a transitional entitlement for employees who had long service leave entitlements before the National Employment Standards were implemented, and pending the development of a uniform national long service leave standard.
- **Public holidays** - a paid day off on a public holiday, except where reasonably requested to work.
- **Notice of termination and redundancy pay** - up to four (4) weeks’ notice of termination (up to five (5) weeks if the employee is over 45 and has at least two (2) years of continuous service), or payment in lieu of notice, and up to 16 weeks redundancy pay, both based on length of service.
- **Provision of a *Fair Work Information Statement*** - all employers covered by the national workplace relations system have an obligation to give each new employee a *Fair Work Information Statement* before, or as soon as possible after, the employee starts employment.

Employment under Awards

Awards provide for minimum rates of pay and a safety net of employment terms and conditions. Often, employers will negotiate additional over-award terms and conditions in order to attract, retain and reward their staff.

Awards applicable to medical practices

Health Professionals and Support Services Award 2020 (Award code MA000027) applies to our reception staff, practice manager, bookkeeper, payroll officers, and cleaners.

Nurses Award 2010 (Award code MA000034) applies to our practice nurses.

Medical Practitioners Award 2020 (Award code MA000031) applies to our general practitioners.

2.2. Position descriptions

2.2.1. Policy

Effective selection and management of the practice team is critical to the success of this practice. Our ability to care for patients and to operate a successful general practice depends on attracting, developing and retaining the right people.

All new positions are evaluated in terms of the current needs and future goals of the practice.

Practice team members need clarity regarding their role and responsibilities. A position description is developed to clearly communicate the responsibilities and expectations of the position and to establish the role of that person within the organisation. A position description also documents the parameters of the responsibilities and duties associated with that position and form the basis for evaluation and lines of accountability. Recruitment, training and development, performance evaluation, remuneration management and succession planning are all based on the parameters of the position description.

2.2.2. Procedure

General practitioners and other members of the practice team have documented position descriptions that outline and define their roles, responsibilities, expected behaviours and personal attributes.

Position descriptions are signed by the practice team member to indicate that they acknowledge and understand their roles and responsibilities and ultimately their accountability.

Included within our position descriptions are any specific areas of designated responsibility, detailed in **Section 8.9 - Governance and management**; however, all members of the practice team take responsibility for a multidisciplinary culture of safety, quality and open communication.

2.3. Recruitment process

2.3.1. Policy

During recruitment, the selection criteria is developed based on the position description. The selection procedure is conducted in a non-discriminatory manner with all candidates treated with courtesy and respect.

As an equal opportunity and diverse workplace, our practice ensures it adheres to the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987*. To support our practice to achieve this obligation, we use the information contained in the Australian Government Business website:

www.business.gov.au/People/Hiring/Equal-opportunity-and-diversity

When appointing a successful candidate, they are provided with an *Offer of Employment* letter prior to commencement, which must be signed by both the candidate and the employer. This ensures both parties have a clear understanding and a written record of the agreed terms and conditions of employment.

2.3.2. Procedure

Our recruitment process includes the following:

Position evaluation

When undertaking a position evaluation, we look at the position in relation to other staff, the future needs of the practice and consider the following:

- Is there an opportunity for existing staff to develop new skills?
- Can tasks be redistributed to increase efficiency, or even eliminate the need for this position?
- Are there additional skills that may be incorporated into this position to assist the practice to achieve its goals for the future?
- Is there space for a new practice team member at the practice, or can the position include some off-site work?

Where necessary, we speak with our Primary Health Network (PHN) about options that may be available, consult with current team members and include them in the decision-making process, and consider the long-term goals of the practice and use this as an opportunity to plan strategically towards achieving them.

Position description

To determine the key requirements of the position we consider which ones are essential and which are desirable. We then use this information to compile a position description with clear specifications for the position. Consideration is taken in relation to the following:

- Skills: what skills does the position require? Is training an option?
- Qualifications: what are the minimum requirements? Are there others that would be an advantage?
- Personal attributes: what personal attributes are needed? Are there physical requirements essential to the position such as the ability to lift and bend?
- Hours per week: is the position full-time or part-time? Is there weekend or night work required?
- Is the position permanent, casual or a fixed-term contract? How long is the qualifying or probationary period?
- Remuneration: what Award/agreement classification will the position be? What is the salary range or hourly rate? Are there any other benefits offered, such as flexible hours, family-friendly options, training, salary packaging or incentive payments?

Advertising the vacancy

When writing advertisements, we ensure it complies with equal employment opportunity legislation. Information in relation to duties, required skills, qualifications, hours and location, how candidates are to apply (e.g. by email, mail, facsimile, or telephone), and a closing date for applications is included within the advertisement.

For practice nurses, the Award requires that the salary grade classification be included in all job advertisements.

Vacancies can be advertised in a number of ways:

- In newspapers (local and/or state) on the internet or in professional journals.
- Professional association and network newsletters or websites, such as a Primary Health Network (PHN) or the Royal Australian College of General Practitioners (RACGP).
- For non-clinical staff, local job network organisations who can find candidates at no charge.
- Employment agencies and recruitment consultants who handle the entire recruitment process.
- For junior or graduate staff - local schools or educational institutions.

Selection of applicants to interview

For each role we compile a list of selection criteria based on the position description and other factors, making sure to comply with equal employment opportunity legislation.

We compare all applications received against the selection criteria, and select those who best fit the criteria.

We then contact the candidates selected and arrange an interview time. We ensure candidates are made aware of any documents that may be required to be brought to the interview, such as proof of qualifications or their right to work in Australia (for non-residents).

Prepare for interviews

Preparation is undertaken for any additional application forms and documents to be given to the applicants during the interview, such as the position description and information about the practice. We decide on interview arrangements, including the location and who will conduct the interview (i.e. an individual or panel), ensuring all interviews are conducted by the same people. A decision is made on the questions to be asked.

Conduct the interviews

When the candidate arrives, we provide them with an application form to complete (where required) and a copy of the position description.

Interviews are conducted by asking the pre-prepared questions, although it is acceptable to include additional questions related to the candidate's resume or in response to comments made in the interview. We allow the candidate to ask questions also.

We ensure we view original copies of qualifications, proof of membership of professional organisations, professional indemnity insurance or right to work in Australia if the candidate has been required to bring these to the interview. Information is noted down in reference to document numbers on the application form, or photocopies are taken of the documents to be attached to the form.

After the interview has concluded, and the candidate departs, the involved interviewers discuss the impressions of each candidate and make brief notes on their application form to record any employment arrangements or salary agreed upon. Notes that would be in breach of the equal employment opportunity legislation or are not relevant to the position are not taken.

Reference checks

An appropriate member of our team contacts the referees nominated by the best candidates to confirm information given in the interview or resume, and to find out about previous job performance.

Medical examination, police checks or other tests

If relevant to the position, candidates may be required to take a pre-employment medical examination, police checks and/or personality or skills tests. These tests must be conducted prior to the job offer, as they are used to confirm suitability to the position.

These tests must only examine characteristics which are directly relevant to the job, or they could be in breach of equal employment opportunity legislation.

Job offer

Once the successful candidate has been chosen, the appropriate member of our team may contact them by telephone to offer them the position and confirm their acceptance. This process must be followed up and confirmed in writing through a written letter of *Offer of Employment*.

Getting the contract or letter of appointment right in the first place means both parties are much less likely to have problems later on. As a minimum, our letter of offer states:

- Candidate's name and address,
- Position title and reference to the position description,
- Pay rate including which specific Award or workplace agreement, including classification or relevant qualifications/allowances,
- Whether it is full-time, part-time or casual, the details such as days, shifts, and minimum hours to be worked,
- Name of employer,

- Workplace location/campus/other work sites,
- Date of commencement, and
- Probationary period and any other special terms or conditions which have been negotiated outside the Award (e.g. acknowledgement of prior service/entitlements such as sick leave, long service leave etc.).

The letter of offer is to be provided prior to commencement, allowing the candidate time to read through the offer and to sign it to indicate their acceptance. Consideration should be taken to ensure the letter of offer is written carefully – a poorly worded phrase, a typing mistake or the omission of an important item may prove to be very costly to the practice. The official employment agreement should be provided upon commencement of employment and should refer to the Award which covers the employee and also any other items which are not listed within the Award.

We take a photocopy of the formal letter of *Offer of Employment* and keep it on file at the practice as a record of the contract until a signed copy is received from the candidate.

All terms and conditions of employment, introductory information about the practice and practice policies in relation to conduct, induction, privacy, workplace health and safety and termination of employment are included with the letter of *Offer of Employment*. This means the new employee is aware of all their key legal obligations and entitlements before commencement.

The letter of *Offer of Employment* also includes a section for the employee to sign and return to the practice indicating that they have read all contents contained and that they accept the terms and conditions stipulated.

Once the signed letter is returned it is to be filed in the employee's employment file.

Notification of unsuccessful applicants

We notify all unsuccessful interviewed applicants by telephone; this should be done as soon as possible after the position is filled. Care must be taken when advising unsuccessful applicants to ensure equal opportunity or discrimination legislation is not breached. In accordance with the *Privacy Act 1988*, any applicant details that are not being kept on file are to be disposed of in the confidential documents bin.

Prepare for the commencement of the new practice team member

Prior to commencement, ensure facilities and resources such as a computer, desk, chair, stationery and software access are prepared for the new team member. When setting up access to the practice's computer systems and software, ensure passwords and access levels are applied appropriately.

A *Staff Employment Record* is created for the new practice team member.

Induction of new staff member

Refer to **Section 2.4 – Induction**.

2.4. Induction

2.4.1. Policy

Practices need a system for assisting new members of the practice team (medical, clinical, allied health and administrative) to learn their role.

Our practice has an induction program for new general practitioners (including registrars and locums) and other members of the practice team that includes ongoing monitoring of progress in their new role. To ensure staff and patient safety, new members of the practice team must be able to demonstrate knowledge of the procedures contained in this Policy and Procedure Manual, in addition to key operating systems relevant to their role by the end of the induction period. In some cases, we also institute an induction program for other contractors using rooms within our practice.

All new members of the practice team complete a full induction program which includes details of workplace health and safety requirements, the practice's code of conduct, infection prevention and control, and the processes by which the privacy and confidentiality of patient personal health information is maintained. We utilise a detailed *Staff Induction Checklist and Record* to facilitate the induction process.

In-house training is provided to members of the practice team responsible for inducting new members to ensure they understand the requirements of the induction process and the importance of an effective induction program in relation to job performance, legal liability and workplace health and safety. This in-house training is documented and retained on file.

It is important for new members of our practice team to also have an understanding of the local health and cultural environment in which the practice operates. Our practice is located in an area with high levels of concerns caused by illicit drug use and, therefore, we ensure all members of the practice team understand the practice's policy regarding management of Schedule 8 medicine prescribing.

Members of the practice team (GPs in particular) are made aware of the key public health regulations that may affect how they work, such as reporting requirements for communicable diseases and cases of child abuse. General practitioners are also educated regarding our local health and community services including pathology services, hospitals and other ancillary services to which they are likely to refer patients during the course of a consultation.

The *Staff Induction Checklist and Record* is intended to be used for any position within our practice; however, position specific orientation and induction is also undertaken and documented.

New members of our practice team are not permitted to work independently until competency in specific areas of induction have been demonstrated and signed-off, such as infection prevention and control, confidentiality and workplace health and safety. As each stage of the induction program is completed, the inductee and their trainer sign and date the *Staff Induction Checklist and Record*. Once all areas of the induction program are completed and signed, the *Staff Induction Checklist and Record* is filed in the team member's employment or contract file. This written record of induction is important to protect the practice against legal liability and injury claims in the future.

2.4.2. Procedure

Our induction process includes the following:

Before the first day

- Assign a member of the practice team to be responsible for the induction of the new team member who is adequately trained.
- Ensure all other practice team members to be involved in the induction program are aware of their involvement and are also trained adequately.
- Prepare the *Staff Induction Checklist and Record*.
- Prepare a copy of the Policy and Procedure Manual and position description to refer to during the induction process.

First day

- Welcome the new member of the practice team.
- Provide an overview of the induction process and provide a copy of the induction program to the inductee.
- Commence **Section 1 – About us** of the induction program checklist.

First week

- Make time each day to go through key policies, procedures and other training needs identified on the *Staff Induction Checklist and Record*.
- Arrange induction and training with other team members involved in the induction program.
- Provide opportunities for the inductee to ask questions.
- Take opportunities as they present to provide feedback and encouragement.
- Sign and date each item on the *Staff Induction Checklist and Record* as it is completed.

First month

- Continue to provide the new practice team member with opportunities to ask questions, as well providing them with encouragement and support.
- Introduce the practice team member to local networks and professional organisations, such as the Primary Health Network (PHN).
- Continue to sign and date each item on the *Staff Induction Checklist and Record* as it is completed.

After three (3) months – end of probationary/qualifying period

- Review the induction and training plan and the new practice team member's performance.
- Determine if the new team member has satisfactorily completed the requirements of the induction program to be offered a permanent and ongoing position within the practice.
- Where the new team member has performed unsatisfactorily, terminate the employment status and re-commence the recruitment process.
- Where the new team member has satisfactorily performed, update their status in their employment record and advise accordingly.
- Create a training and development plan for any remaining training needs identified during the induction process.
- File the completed *Staff Induction Checklist and Record* in the inductee's employment record.

2.5.Privacy and confidentiality obligations

2.5.1. Policy

All information collected by this practice is deemed to be private and confidential. The right of every patient is respected.

This practice complies with federal and NSW privacy regulations including the *Privacy Act 1988* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012* as well as complying with standards set out in the *RACGP Privacy and managing health information in general practice*.

Under no circumstances are members of the practice team to discuss or in any way reveal patient conditions or documentation to unauthorised staff, colleagues, other patients, family or friends, whether at the practice or outside it, such as in the home or at social occasions. This includes patient's accounts, referral letters or other clinical documentation.

General practitioners and other practice team members are aware of confidentiality requirements for all patient encounters, and recognise that significant breaches of confidentiality may provide grounds for disciplinary action or dismissal.

Every member of the practice team is aware of our Privacy Policy and has signed a privacy statement as part of their terms and conditions of employment or contract. This privacy statement continues to be binding even after the employment or contract has terminated.

2.5.2.Procedure

All members of the practice team are issued with the practice's Privacy Policy and sign a privacy statement as part of their terms and conditions of employment or contract. The policies and procedures of the practice are further explained during the induction of new practice team members, and the induction form is signed by the new team member as confirmation that they understand and accept their obligations in relation to patient privacy and the confidentiality of personal health information.

2.6.Performance appraisal

2.6.1.Policy

Annual performance appraisals are conducted to ensure continuing high levels of work performance and to assist in job enrichment. The review is part of a continuous process of feedback to individual practice team members on their work performance and is extended to include performance improvement and career development.

Performance appraisals benefit the practice and its team members by:

- Ensuring all practice team members know what is expected of them and how their work is important to the practice.
- Providing practice team members with formal recognition and appreciation for their work.
- Providing an opportunity to review goals, celebrate achievements and set objectives for the future.
- Helping practice team members to develop their skills and performance to achieve practice goals and further their own career.
- Reviewing management of issues and grievances (also refer to **Section 2.12 - Grievances in the workplace**).

A review involves identifying, evaluating and developing the work performance of the practice team so that practice goals are more effectively achieved, and at the same time benefit the practice team in terms of recognition, receiving feedback, catering for work needs and offering career guidance and support.

The relevant position description forms the basis for evaluation and lines of accountability.

The performance appraisal document, including comments concerning current progress and future goals, is signed by both parties, with a copy retained by the practice team member; the original is filed in their employment or contact record.

Performance appraisals are not directly linked to salary reviews, nor are they the forum for seeking a pay increase. The performance appraisal should also not be the forum for managing issues which have occurred over the previous year – any such issues which may arise should be addressed immediately.

2.6.2. Procedure

A performance appraisal is conducted at least annually, and a *Performance Appraisal Checklist* is used to facilitate this process.

Our performance appraisal process includes:

Plan and prepare

An effective performance appraisal process can increase productivity, motivation and morale; however, a poorly handled appraisal can have a damaging effect on the practice team member and can result in decreased performance.

Practice team members responsible for conducting performance appraisals are provided with training in giving feedback, including using specific examples and evidence rather than vague comments. They are also provided with education regarding the legal restrictions on what can be said.

Notice of the impending review is provided at least two (2) weeks in advance, at which time a mutually convenient time is arranged for the meeting, allocating at least one (1) hour to be free from interruptions.

The practice team member is provided with a *Self-Appraisal Form* and a copy of their current position description to help prepare for the appraisal, and to have an opportunity to reflect on examples of their achievements, issues they have encountered, and areas they would like to improve. This encourages ownership and involvement in the process. The completed *Self-Appraisal Form* should be provided to the person conducting the appraisal at least one (1) week prior to the scheduled meeting.

The person conducting the appraisal is required to review the team member's position description, in addition to the completed self-appraisal, along with records of previous performance appraisals. If required and where appropriate, discussions are held with co-workers and others that the person has had contact with in the course of their work to gather feedback on their performance.

The person conducting the appraisal is to also use this time to plan what to say during the appraisal, and how to say it. Focus is given to providing details of productivity, quality of work, reliability and team work, and in being objective by providing supporting evidence, examples and documentation, especially in situations of poor performance. Positive reinforcement is to be used to encourage desired behaviours.

Conduct the appraisal

Performance appraisals are to be conducted in a quiet location away from distractions and interruptions.

It is recommended to begin with a description of the aim and process of the appraisal as described on the *Self-Appraisal Form*, to help the practice team member feel comfortable.

Performance appraisals give our team members an opportunity to receive appreciation and recognition for their achievements, raise issues and resolve grievances, set goals for the future and discuss the training and development opportunities needed to enhance their performance and further their career.

Performance appraisals provide practice management with a chance to motivate our team members, re-focus attention on practice goals and strategies, acknowledge achievements, manage issues, align the team member's goals with those of the practice, assess development needs, and determine those who are ready for additional responsibilities.

It is important to set a positive tone for the discussion by starting the review with a brief account of the team member's strengths, recognition of their achievements and appreciation for their contribution to the practice.

We discuss the team member's self-appraisal, listening carefully to show genuine interest. Do not disagree with their assessment, unless they have underestimated their performance. Ask them for suggestions on how they could improve their performance or develop their skills – even when they have performed well, there may still be opportunities for improvement.

If communication is regular and open there should be no surprises for either party during the performance appraisal. We manage any issues arising sensitively and constructively, and remain calm at all times, focusing on the facts and not personalities. If the discussion is becoming unmanageable, suggest taking a 10-minute break, or arrange another time to continue the appraisal.

If an issue is raised and one party is not prepared, listen carefully and ask for specific examples and evidence. Staff are encouraged to arrange to respond at a later time, once there has been an opportunity to consider the issue and conduct further investigations if required.

Review the position description and the targets or goals set during previous appraisals. Ask about the team member's plans and goals for the future, considering their career development. Discuss the future needs of the practice, seeking to find opportunities for the team member to achieve their goals in ways which will also add value to the practice.

We work together to set new goals for the future, using the SMART principle: **S**pecific, **M**easurable, **A**chievable, **R**elevant (to both the needs of the practice and the team member) and **T**imely. Establishing mutually agreed goals will result in greater ownership and commitment to the achievement of the goals.

Areas are identified where the team member's performance or career development would benefit from training, additional resources or equipment, allocation of responsibilities etc. For both parties, it is important to only make promises and commitments which can be kept.

Position descriptions are adjusted to reflect any new responsibilities or role changes. Agreed goals and targets are documented, as well as commitments to training or support made by the practice. Timelines are agreed on for completion of agreed tasks and for the next appraisal to take place. Generally, the next appraisal will be in 12 months; however, if a team member has been given new responsibilities or an improvement in performance is required, the next appraisal may need to occur sooner.

Details of discussions and any agreements made are recorded on the jointly completed *Appraisal Review Form*. Team members are allowed to read the record of the review carefully and to suggest any changes or additions. Once both parties are satisfied that the document is an accurate record of the discussions, both parties sign and date the form. A copy of the completed and signed *Appraisal Review Form* is provided to the team member, and the original is filed in their employment or contract record.

The performance appraisal is concluded by thanking the team member for their participation in the appraisal process, ending with a positive statement about what has been achieved and the benefits anticipated in the future.

Follow through

We ensure the practice keeps all commitments made during the performance appraisal process, including commitments for additional training and career development or consequences for continued poor performance. Any commitment to additional training is to be incorporated on the team member's personalised *Practice Team Training Plan*.

The practice team member is to be provided with a copy of their updated position description where required.

If unsatisfactory behaviour continues after our practice has taken all reasonable steps to address the possible causes, including a provision of adequate instructions, training, resources and time, disciplinary action may be required (refer to **Section 2.7 – Disciplinary action and termination process**).

2.7. Disciplinary action and termination process

2.7.1. Policy

The owners have the day-to-day responsibility for ensuring that practice team members meet the required standards for work performance and conduct. Generally, the focus is on positive ways of motivating the team, including:

- Communicating clearly what has to be done
- Setting joint goals or targets
- Coaching practice team members
- Resolving problems as they occur, and
- Informal feedback and counselling in situations of poor performance.

If this approach is not sufficient, or when a serious breach of policy occurs, the disciplinary process will be followed. The purpose of the disciplinary process is to:

- Avoid repetition of mistakes or unacceptable behaviour – it is corrective, not punitive,
- Ensure fairness in the treatment of all practice team members,
- Provide a clear, written statement about the expectations of the practice in relation to conduct and behaviour at work,
- Encourage an improvement in work performance and behaviour,
- Provide support or training to assist in improvement, and
- Advise of the consequences of failure to comply with expectations, including written warnings and termination of employment.

For the process to be effective the following points need to be considered:

- Listen carefully,
- Gather the facts,
- Remain objective,
- Do not avoid the problem,
- Document all discussions and evidence, and
- Be fair and reasonable, balancing the safety and privacy of patients and practice team.

Under the *Fair Work Act 2009*, an employee is eligible to make an application for unfair dismissal if they have completed the minimum employment period of:

- One (1) year – where the employer employs less than 15 full-time equivalent employees (a small business employer).
- Six (6) months – where the employer employs 15 or more full-time equivalent employees.

Employees are also entitled to sue for unlawful dismissal on the grounds of a breach of 'general protections' (e.g. discrimination, bullying or harassment, employee making a claim or joining a union etc.).

Treating all practice team members fairly and having appropriate systems in place is important for workplace morale. Research shows that perceptions of management unfairness decreases commitment, motivation and performance.

2.7.2.Procedure

Counselling and disciplinary action

Counselling or disciplining practice team members is a difficult component of any manager's role. This process is usually stressful and unpleasant for those involved, and can lead to anger and resentment. This can be minimised by:

- Treating the practice team members with respect and dignity, focussing on specific behaviours and not the person.
- Preserving the team member's self-esteem by acknowledging positive points (such as useful skills or pleasant personality) and recognising that the current job may not be a good match for their talents, interests and abilities. Success in any job is reliant on the right combination of attributes of the person, the position and the practice.
- Understanding that most people desire the satisfaction of performing their job well, and will not be happy in a position which does not suit their skill level or ability. Supporting them through the disciplinary process in a respectful and affirming way will provide a greater understanding of their strengths and limitations, and will assist them to find a more satisfying position in the future.
- Providing all reasonable assistance to help practice team members improve their performance.

Whilst recommended, there is no requirement to provide three (3) warnings; however, the practice team member must be given 'a fair go' and have an opportunity to improve within a reasonable timeframe. Any issues raised are documented.

The disciplinary process involves four (4) steps:

1. Counselling
2. First written warning
3. Second and final written warning
4. Termination.

At each step, the following procedure occurs:

- Problem arises or incident occurs.
- Investigation of facts, including collecting witness statements. In some circumstances, the practice team member may be stood down with pay while the investigation takes place.
- The allegations and supporting evidence are presented to the practice team member. During this meeting, the team member is entitled to have a representative present, such as another staff member or union representative. It is advisable for the manager to have a witness present in all interviews related to disciplinary procedure.

- The practice team member is given an opportunity to respond, including requesting any reasonable assistance which would prevent a recurrence.
- A decision is made – this could range from deciding to take no action, agreeing upon clear guidelines about expected future behaviour, or termination of employment.
- The *Employee Work Performance Counselling* form is used to document details of the issues, available evidence, the practice team member's response, and decisions made.

Step 1: Counselling

Counselling is usually the first formal step in the disciplinary process; it can be used to discuss poor performance, grievances raised by other members of the practice team (refer to **Section 2.12 - Grievances in the workplace**), or to deal with a breach of policy.

A timeframe for improvement and the next review date is agreed, allowing sufficient time for the practice team member to improve. We ensure any resources or assistance agreed during this meeting is promptly provided.

The content and outcome of the meeting must be documented using the *Employee Work Performance Counselling* form, with both parties signing it. A copy of the completed and signed form is provided to the practice team member, and the original filed in their employment record.

Step 2: First written warning

A written warning should outline:

- Details of the issues of work performance.
- Evidence arising from investigation, including statements from others where necessary.
- The practice team member's response to the issues.
- The agreed plan for improvement.
- Any assistance, support or training to be provided by the practice to facilitate improved performance. This could include reasonable requests for reduced hours or changes to duties.
- The timeframe for improvement and the next review date.
- The consequences of failure to improve (including the possibility of termination).

Step 3: Second and final written warning

The second and final written warning is issued when there has been no improvement or change following counselling and the first written warning. A meeting should be convened between the necessary parties to discuss the continued issues, before the second and final written warning is issued.

The content and outcome of the meeting must be documented using the *Employee Work Performance Counselling* form, with both parties signing it. A copy of the completed and signed form is provided to the practice team member, and the original filed in their employment record.

If there is still no improvement in work performance or behaviour after the end of the agreed timeframe, a *Notice of Termination of Employment* is issued.

Step 4: Termination

In our practice, we use the *Termination of Employment Checklist* when exiting an employee.

If unsatisfactory work performance or behaviour continues after counselling and two written warnings, termination may be necessary. When terminating an employee, our practice follows the procedures set out in the *Small Business Fair Dismissal Code* of the *Fair Work Act 2009* as found on the Fair Work Commission website

www.fwc.gov.au/about-us/legislation-regulations/small-business-fair-dismissal-code.

Summary dismissal (dismissal without notice)

Practice team members may be summarily dismissed for serious breaches of policies, misconduct or illegal activity.

As employees must be informed of behaviours which would justify summary dismissal, we have included this information in our *Terms and Conditions of Employment* that is signed and accepted at commencement of employment. Our summary dismissals include:

- Engaging in any act of commission or omission constituting serious misconduct in respect of their duties.
- Wilfully failing or neglecting to perform or carry out their powers, functions or duties in an agreed manner.
- Committing a serious or persistent breach or non-observance of any of the provisions of the agreement.
- Engaging in any conduct which may tend to injure the reputation or standing of the employer.
- Refusing or neglecting to comply with any lawful and reasonable order given to them by the employer or any other person duly authorised by the employer.
- Wilfully breaching the confidentiality of any client/customer/patient, employee or the employer.
- Attending for work under the influence of drugs and/or alcohol.

In many cases, an employee will be stood down on full pay while an investigation is undertaken prior to summary dismissal, to ensure the dismissal is warranted.

Redundancy

This occurs when a particular job or position is no longer required, or less people are needed to perform the quantity of work available.

It is a requirement of the *Fair Work Act 2009*, and the relevant Award, for the employer to consult with the employee prior to the redundancy occurring.

The position held by an employee who is made redundant cannot be re-staffed. In accordance with the National Employment Standards (NES), employees who are made redundant are paid up to 16 weeks redundancy pay; the total calculation being based on length of service.

When terminating employment as a result of redundancy, we send the employee a *Letter of termination of employment (redundancy)* when exiting an employee. We also use the *Termination of Employment Checklist* when exiting the employee.

Abandonment of employment

Abandonment of employment occurs when an employee fails to attend his/her place of employment for three (3) days or more without having prior authorisation for the absence and has not contacted the employer to explain the reason for the absence.

During the three (3) days our practice should attempt to contact the employee by telephone and, if this is unsuccessful, a letter is drafted using the *Abandonment of Employment Letter* template and is sent by registered mail to the employee's last known address requesting they contact the practice upon receipt of the letter to explain the reasons for their absence, and to advise of their expected date of return.

If there is still no contact from the employee within three (3) business days of receiving the registered mail, a second letter is sent (also by registered mail). This letter is drafted using the *Abandonment of Employment Letter – Second and Final Notice* template requesting they contact the practice to advise of their intentions in continuing their employment.

If there is still no contact from the employee within three (3) business days of receiving the second registered letter, a final letter is drafted using the *Abandonment of Employment Letter – Termination Notice* advising that as a result of the employee's failure to contact or return to his/her place of employment, the practice has concluded they have abandoned their employment and termination of their employment status will commence. Any personal effects left at the practice will be returned to them by post (or courier if required).

Employee initiated termination, such as resignation

All employees are required to notify the practice in writing of their intention to resign from their employment, giving at least the amount of notice required under their employment contract, relevant Award, or workplace agreement. Employees who fail to give the required notice may forfeit some of their entitlements.

Termination considerations

Regardless of the reason for the termination of employment, we need to consider the following as part of the termination process:

- *Notice period*: the practice can require an employee to work out their notice period, or it can be paid in advance, so they leave their employment immediately. If an employee refuses to work out their notice period, they may lose some of their entitlements. The required notice period upon termination will be determined by the details included in the employment contract, relevant Award, or workplace agreement.
- *Termination pay*: amounts payable on termination include accrued pay in lieu of notice (if applicable), redundancy pay, annual leave, outstanding wages, and long service leave entitlements. In some cases, such as summary dismissal, failure to give notice on resignation or abandonment of employment, employees may forgo some of these entitlements. The required entitlements upon termination will be determined by the details included in the employment contract, relevant Award, or workplace agreement.
- *Administrative matters*: A number of administrative matters should be attended to at the time of termination:
 - Arrangements for termination, including reason for the termination and notice. Arrangements should be documented.
 - All keys and other practice property need to be returned.
 - The components of the termination pay need to be explained.
 - It is advisable to obtain the employee's permission for the practice to provide written or verbal references on the employee's performance to future prospective employers.
 - The employee should be reminded about their continuing obligations under the practice's privacy policy.
 - Centrelink may need to be notified if the person wishes to register for unemployment, or there have been payroll garnishee arrangements in place, such as child support payments.

2.8. Code of conduct

2.8.1. Policy

We encourage an environment that fosters robust general practice teams. Our team members conduct themselves in a manner that promotes the attributes we believe are desirable characteristics of a general practice team:

- A just, supportive, transparent, cohesive and collaborative culture, which is associated with improved patient outcomes and enhanced patient safety.
- Defined goals, including an identifiable practice mission statement and specific, measurable operational objectives that are shared by all team members.
- A 'systems' approach that includes the development of both clinical systems and administrative systems.
- Division of labour, including the delegation of tasks and assignment of tasks among team members, based on our practice's principles.

- Effective training, both for the functions that people routinely perform and cross-training to substitute for other roles in cases of absences or changed/increased work demands.
- Excellent communication, including supportive interpersonal communication through well designed communication structures and processes.

2.8.2. Procedure

It is expected that all members of the practice team behave in a courteous manner, which portrays the image of the practice in a positive and professional way, while maintaining the levels of service and care which our patients expect. These including the following:

- Any person who interacts with patients, other visitors or team members is expected to behave according to acceptable professional and social standards at all times.
- Medical, clinical and non-clinical team members perform duties within their legal scope of responsibilities and maintain their knowledge, skills and attitudes through their professional specialty organisations such as the AMA, APNA, ANF, and AAPM etc.
- No team member discusses patients outside the practice, and they are mindful of the sensitive nature of patient's private medical information while at work.
- Practice team members are prohibited from making judgemental comments about patient's treatment by others, including the general practitioners, inside or outside work.
- It is expected that everyone acts in accordance with specific practice policies and procedures and/or the specific details contained in their position description or contract agreement.
- The entire practice team is committed to encouraging quality improvement and identifying opportunities to make changes that will increase the quality of care and safety for patients.
- Everyone has an individual responsibility to identify any potential infection risks within the practice and to be familiar with and implement the relevant infection prevention and control procedures of our practice.
- Everyone is required to be punctual when starting and finishing work each day.
- The consumption of food or drink is not permitted at reception.
- Practice team members failing to meet acceptable codes of conduct will be counselled or disciplined (refer to **Section 2.7 – Disciplinary action and termination process**).

2.9. Accessing the internet

2.9.1. Policy

The internet is a vast network that links electronic, wireless and optical technologies, comprised of interconnected networks and systems all around the world. This large global network allows us to communicate with each other while allowing for information sharing between users. It is important to adopt secure practices when accessing and using the internet.

2.9.2. Procedure

The internet can be accessed by all members of the practice team; however, excessive use of the internet is not acceptable.

Practice team members are encouraged to use the internet for research activities pertaining to their role; however, should be aware that usage statistics are recorded and submitted to management as required.

Practice team members have full accountability for internet sites accessed on their workstations, and are expected to utilise this tool in an acceptable manner. This includes, but is not limited to:

- limiting personal use of the internet,
- accessing only reputable sites and subject matter,
- verifying any information taken off the internet for business purposes prior to use,
- not downloading any unnecessary or suspect information,
- being aware of any potential security risks (i.e. access/viruses),
- not disclosing any confidential information via the internet without prior permission from the practice manager (i.e. credit card details),
- maintaining the practice's confidentiality and business ethics in any dealings across the internet, and
- observing copyright restrictions relating to material accessed/downloaded.

Our practice reserves the right to check individual's internet history as a precaution to fraud, viruses, workplace harassment or breaches of confidence by practice team members. Inappropriate use of the internet facility will be fully investigated and may be grounds for dismissal.

2.10. Staff presentation

2.10.1. Policy

It is expected that all members of the practice team maintain a clean, neat and tidy appearance and dress in a manner which is not likely to be offensive to the patients or visitors attending this practice. Jewellery and makeup, if worn, should not be excessive.

2.10.2. Procedure

Employed staff are required to wear the prescribed uniform whilst on duty. In cases where a uniform is not able to be worn, staff are required to wear neat clothing similar to the prescribed uniform, or clothing which conforms to acceptable standards of professional dress. Clothing should be ironed, clean and kept in good condition.

All members of the practice team should maintain high levels of personal hygiene, paying particular attention to excessive body odours and general cleanliness.

All practice team members with long hair should have it tied back neatly; and makeup and jewellery, if worn, should be kept to a minimum.

2.11. Equal opportunity, bullying and harassment

2.11.1. Policy

Our practice is committed to the principles of merit, fairness and respect for all people. We seek to provide a working environment in which all members of the practice team are able to perform their duties without being subject to discrimination or inappropriate behaviour.

Workplace discrimination, bullying and harassment can occur:

- During employment procedures such as recruitment, performance review and termination of employment.
- In the way people are treated at work and the allocation of resources such as training, privileges and responsibilities.
- At work-related functions.
- When calling a work colleague at home.
- Between people working in the same building, even if they have different employers.
- In the provision of goods and services – for example, it is illegal to discriminate against a patient or a supplier on the basis of an irrelevant characteristic.

Our practice complies with its legal obligations in accordance with the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987*, *Work Health and Safety Act 2011 (Cwth)*, *Work Health and Safety Act 2011 (NSW)*; criminal law, defamation and common law provisions such as negligence.

All persons working at this practice have the responsibility to:

- Treat all people in this workplace fairly and with respect.
- Refrain from behaviour which could constitute harassment, bullying or discrimination.
- Report any incidents of harassment, bullying or discrimination to Dr Belel Ejje.
- Maintain confidentiality if they are involved in complaints.

Additionally, Dr Belel Ejje is expected to:

- Follow appropriate procedures when a complaint is reported to them, making sure they are taken seriously, properly investigated, treated confidentially and resolved in a timely manner.
- Ensure all members of the practice team are aware of their obligations and the practice's policies and procedures relating to harassment, bullying and discrimination.

- Promote a work environment free from harassment, bullying and discrimination.

Any member of the practice team who is subjected to discrimination, bullying, harassment or intimidation by a colleague, manager or supervisor should notify Dr Belel Ejje. All concerns raised will be promptly and confidentially investigated using the practice's grievance procedure (refer to **Section 2.12 - Grievances in the workplace**).

2.11.2. Procedure

Bullying and harassment

Workplace bullying is defined by the *Fair Work Amendment Act 2013* as “repeated unreasonable behaviour by an individual towards a worker which creates a risk to health and safety”. Bullying behaviour can range from obvious verbal or physical assault to subtle psychological abuse.

Workplace discrimination, bullying and harassment includes, but is not limited to:

- Name-calling and insults directed at another member of the practice team.
- Writing of notes which are personally offensive to another.
- Practical jokes (this may also be a safety issue).
- Unwanted physical contact of any kind.
- Interfering with the personal property of any other practice team member.
- Remarks or written comments which are personally insulting or offensive to others based on their race, background, gender, religion, sexual preference, appearance or any other personal attribute.
- Unwelcome sexual advances, requests for sexual favours and other verbal or physical conduct of a sexual nature.
- Interfering with the equipment, property or work of another practice team member in a way which is outside the normal course of their duties (this may also be a safety issue).
- Isolating or excluding a person.
- Setting impossible deadlines or being overly critical.
- Using aggressive language.

Any form of bullying is totally unacceptable in this practice. Behaviour is inappropriate and may constitute harassment if it is offensive to another person, even if this was not the intention of the one initiating the behaviour. Bullying and harassment may be a once-off incident or a pattern of behaviour. My Family GP Medical Centre regards these actions, and any similar behaviour, as serious misconduct and any person found to be behaving in this manner may have their employment or contract terminated.

Anti-discrimination

Under discrimination law, it is unlawful to treat a person less favourably on the basis of particular protected attributes such as a person's sex, race, disability or age. Treating a person less favourably can

include harassing or bullying a person. The law also has specific provisions relating to sexual harassment, racial hatred and disability harassment.

This practice does not discriminate on the basis of:

- Race (including colour, nationality and ethnic origin)
- Family status including marital status or responsibilities as a carer
- Sexual orientation and lawful sexual activity
- Age
- Gender and gender identity
- Physical features
- Political opinions or activity
- Religious beliefs or activity
- Breastfeeding
- Impairment including physical, intellectual or psychiatric
- Pregnancy or potential pregnancy
- Criminal record
- Union membership or industrial activity, and/or
- Personal association with a person with any of the above characteristics.

Any behaviour which is discriminatory is unacceptable in this practice. Discriminatory behaviour will lead to disciplinary action and may result in termination of employment or contract.

Family-friendly workplace

This practice values its team members and aims to provide a family-friendly culture that promotes life-work balance with a management philosophy that fosters a sense of fun and camaraderie and promotes self-care for all.

This policy recognises that all members of the practice team have varying family responsibilities. It recognises a broad definition of family including family as defined by various legislative and industrial instruments, people in same-sex relationships, and other close personal relationships.

We are committed to ensuring that family-friendly policies are developed, endorsed, implemented and monitored.

We endeavour to work in partnership to identify work practices that support arrangements to find the best possible match between the interests of the organisation and those of individual. Open communication and co-operation are essential within our workplace for the achievement of a successful family-friendly organisation.

2.12. Grievances in the workplace

2.12.1. Policy

Grievances undermine morale and affect teamwork and need to be dealt with promptly.

If any member of the practice team is exposed to any form of behaviour which constitutes discrimination, bullying or harassment, the following procedure must be adopted. **Do not** ignore harassment – ignoring the behaviour could be interpreted as condoning the behaviour.

This procedure may also be used for the handling of other workplace grievances such as complaints about working conditions, wages or work colleagues.

2.12.2. Procedure

Our practice strongly encourages any member of the practice team who believes they have been discriminated against, bullied, harassed or victimised to take appropriate action by:

- Informing the offender that the behaviour is offensive and unacceptable.
- Seeking assistance in having the behaviour stopped by reporting the incident to Dr Belel Ejje and Dr Mahmoud Awad

Upon receipt of a reported incident, Either GP will conduct a detailed investigation of the incident(s) to assist in the resolution of the grievance, including collecting witness statements or other evidence as required.

For any investigation to be properly conducted, it must be impartial. The person reporting the incident must not be victimised or experience adverse repercussions, and the complaint must be dealt with as quickly as possible. At all times, confidentiality must be maintained.

Actions taken to resolve the grievance will depend on the circumstances and the results of the investigation. Generally, the main aim will be to ensure the incident does not occur again. Possible solutions may include:

- An apology.
- An undertaking that the behaviour will cease.
- Formal counselling of the alleged offender, using the disciplinary procedure (refer to **Section 2.7 – Disciplinary action and termination process**).
- Disciplinary action, including termination for serious misconduct (refer to **Section 2.7 – Disciplinary action and termination process**).
- Training for all members of the practice team to raise awareness of equal opportunity obligations.
- Covering costs consequent to the harassment, such as medical or psychology expenses.

- Notifying the police.

If the grievance cannot be substantiated when investigated, it must still be taken seriously, including attempting to find a resolution of the matter with the team members involved. It may also be appropriate to take action against a complainant who makes a serious allegation against a work colleague which is found to be false or frivolous after investigation. This could include termination of employment or contract.

A record is kept of the grievance, its investigation and actions taken.

After the initial resolution of a grievance, occasional monitoring and follow up actions may be required to ensure that those involved are satisfied with the outcome, and to verify the issue has not recurred.

If the matter remains unresolved, the grievance may need to be referred to an external complaints authority. The nature of the grievance will determine which external authority to refer the complaint to.

In summary, the following steps are followed by Either GP when handling reported incidents.

1. Listen with an open mind -
 - Listen, no matter how trivial the grievance may seem,
 - Be patient and show a sincere interest in the grievance, and
 - Do not argue.
2. Get all of the facts -
 - Encourage the person to repeat the substance of the grievance to ensure the facts are understood,
 - Discuss any solution the person reporting the incident may have to solve the problem,
 - Question any discrepancies,
 - Discuss with others if necessary,
 - Do not jump to conclusions, and
 - Consult other members of the management team if necessary.
3. Take action promptly -
 - Do not delay taking action,
 - Do not make any rash decisions,
 - Advise all relevant parties of the action, and
 - Do not use your authority to force a decision unless there is no alternative.
4. Follow up -
 - Check that those involved are satisfied with the outcome,
 - Consider whether preventative action can be taken to avoid a recurrence (this may include training, awareness education or changes to systems and procedures), and
 - Refer to an external party if the matter remains unresolved.

3. Work health and safety

3.1. Workplace health and safety

3.1.1. Policy

This practice is committed to preventing workplace injury and illness and ensuring a safe and secure working environment for general practitioners, staff, contractors, patients and all other visitors.

We recognise that health and safety is an integral part of every activity we perform, and as such, we maintain current knowledge of our obligations under NSW and federal workplace health and safety legislation, and we understand that non-compliance with these requirements can result in penalty.

All our workers have a duty of care to ensure that they work in a manner that is not harmful to their own health and safety or the health and safety of others.

Safe Work Australia (www.safeworkaustralia.gov.au) leads the development of national policy to improve work health and safety, and workers' compensation arrangements across Australia. It does not regulate or enforce workplace health and safety legislation. Our practice is regulated under the Work Health and Safety Act 2011 (NSW);

Procedure

In our practice, we have appointed Dr Belel Ejje as our workplace health and safety officer.

The workplace health and safety officer has responsibility to ensure due diligence in relation to the practice's workplace health and safety obligations.

'Due diligence' in relation to workplace health and safety is defined as taking reasonable steps to:

- Acquire and keep up-to-date knowledge of workplace health and safety matters,
- Understand the operations being carried out by the business they are employed by or contracted to, and the hazards and risks associated with the operations,
- Ensure that the practice has, and uses, appropriate resources and processes to eliminate or minimise health and safety risks arising from work being done,
- Ensure that the practice has appropriate processes in place to receive and respond promptly to information regarding incidents, hazards and risks,
- Ensure that the practice has, and uses, processes for complying with duties or obligations under the Act, and
- Verify the provision and use of these resources and processes.

If the workplace health and safety officer fails to exercise due diligence, they may be liable for penalties and/or imprisonment irrespective of whether there has been an injury or incident at the workplace.

To help support our practice and workplace health and safety officer in complying with workplace health and safety obligations, the workplace health and safety officer conducts a *Practice Safety and Security Assessment* on an annual basis.

All members of the practice team are aware of the person appointed as our workplace health and safety officer through signage on the staff notice board. Information relating to workplace health and safety issues are posted on the staff notice board and information is conveyed to all members of the practice team by the workplace health and safety officer during induction training, annually thereafter, or whenever there are changes or updates implemented.

We have current workers' compensation insurance, and keep a register of any work-related injuries, illnesses and incidents that are reviewed and monitored to prevent a recurrence.

To support the health, safety and wellbeing of our practice team we have policies and procedures in the following areas:

- Tasks involving manual handling are identified, and measures are taken to reduce or eliminate the risk of injury as far as reasonably practical.
- Incidents and all injuries involving all workers, patients and others that occur in the workplace are documented and managed professionally and ethically, according to relevant medical standards and guidelines.
- During induction, and periodically thereafter, all members of the practice team are instructed in safety and infection prevention and control protocols ensuring risks are known and precautions are taken, including immunisations.
- We maintain a safe, physical work environment that includes ensuring regular breaks are taken, adequate staffing levels, and a smoke-free environment.
- We have a duty of care to safeguard the health of our practice team members which covers psychological health as well as physical health.
- We strive to encourage consultation between management and the practice team on all matters pertaining to workplace health and safety matters as obligated under legislation.
- We endeavour to provide a working environment in which all general practitioners, staff, contractors, patients and visitors are not subject to unlawful discrimination, sexual harassment, violence or bullying.
- Audits are undertaken to ascertain that all practice and office equipment is appropriate for its purpose, and records of maintenance, including electrical safety checks and calibration schedules, are maintained.

- Records of updates and training provided to all members of the practice team in relevant equipment operation and maintenance, manual handling skills and compliance with workplace health and safety requirements are maintained.
- We strive to ensure the practice environment and facilities are adequate, and provide for the comfort, safety and security of general practitioners, staff, contractors patients and visitors.
- Non-medical emergency procedures and fire safety precautions are documented and designated members of the emergency team have a reference and a basis for their decisions and actions within that role.
- We have appointed one member of the practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures which include environmental cleaning.
- We have clear lines of accountability and responsibility for the delivery of safe and effective quality care.
- We have a requirement for two members of the practice team to be present during normal opening hours of the practice.
- New members of the practice team are to disclose any pre-existing injury that may be affected by certain working conditions required by the role before accepting the position.
- The workplace is maintained in a safe condition, such as ensuring fire exits are not blocked, emergency equipment is serviceable, and the work areas are generally tidy, with adequate facilities provided to workers, such as clean toilets and hygienic eating areas.

Chemicals and hazardous substances

Our practice conducts an annual audit for the safe use, handling, storage and transport of chemicals and hazardous substances.

Our practice recognises that chemicals and hazardous materials are not only found in cleaning products, for example, but can also be found in printer toner cartridges, liquid nitrogen, oxygen etc.

Safety Data Sheets (SDS) are retained for all chemicals and hazardous materials found in our practice, and are visible on equipment and hazardous substances. A safety data sheet is a document that describes the chemical and physical properties of a material, and provides advice on its safe storage, handling and use. It includes details of health and physicochemical hazards, exposure controls, personal protective equipment required, safe handling and storage instructions, emergency procedures and disposal advice.

A register of hazardous substances is kept and maintained by the practice, and we endeavour to control risks associated with the use of hazardous substances by:

- Storing the substances in labelled containers.
- Providing adequate training to members of the practice team on how to handle hazardous substances appropriately, including ongoing training, and ensuring this training is documented.

- Conducting a regular risk assessment in order to control risk associated with the use of hazardous substances.

Also refer to **Section 4.5 - Handling and use of chemicals**.

Manual handling

Manual handling is any activity requiring the use of force exerted by a person to lift, push, pull, carry, or otherwise move or restrain any animate or inanimate object. It includes activities involving awkward posture and repetitive actions.

Manual handling injuries account for nearly 50% of all WorkCover claims. The objectives of *Safe Work Australia* and Work Health and Safety Act 2011 (NSW) is to reduce the number and severity of musculoskeletal disorders associated with tasks involving manual handling.

Under these regulations, our practice aims to identify tasks involving hazardous manual handling and to undertake risk assessments to reduce or eliminate risk as far as practicable.

Risk factors likely to cause manual handling injuries are therefore included in our risk assessments and include:

- Force applied,
- Actions and movements used,
- Range of weights,
- How often and for how long manual handling is done,
- Where the load is positioned and how far it has to be moved,
- Availability of mechanical aids,
- Layout and condition of the work environment,
- Work organisation,
- Position of the body whilst working,
- Analysis of injury statistics,
- Age, skill and experience of workers,
- Nature of the object handled, and
- Any other risk factor considered relevant.

To mitigate these risks, practice team members are advised to avoid:

- Twisting, bending or extensive reaching,
- Repeated or prolonged stooped posture,
- Lifting requiring extended reach,
- Repetitive lifts from below mid-thigh, or using forceful movements,
- Prolonged bent neck posture when working on a low, flat bench,
- Repetitive tasks for a prolonged time, and

- Using excessive force to push, pull or hold an object.

To prevent injury, practice team members are advised to:

- Reduce the size or weight of objects to be lifted or carried (for ideal conditions and with a compact load held close to the body and with a short carrying distance, weight limits are: seated – 4.5 kg and standing – 16 to 20 kg),
- Wear appropriate footwear to prevent slips or falls,
- Ensure adequate lighting,
- Clean areas regularly and wipe any spills immediately, and
- Check equipment is in good working order and there is adequate space in which to work.

Before doing any type of manual handling, practice team members are required to assess the situation by asking the following questions:

- Should two people be lifting this or am I able to lift this safely and without risk or injury?
- Is my pathway clear of all objects?
- What distance am I going to be going?
- Can I see clearly?
- Can I split the load to make it lighter?
- Size up the load – if in doubt, seek assistance.

Our practice has 1 height adjustable examination bed(s) to assist in the care of patients with a disability, and to reduce the risk of injury when assisting patients on or off the examination bed. Where our practice facilities are inadequate for our team and visitors to safely assist patients with a disability, we make alternative arrangements, e.g. home or other visits (refer to **Section 5.3 – Home and other visits**).

Personal responsibility

It is the responsibility of each member of the practice to report any identified tasks, equipment, or work area that may pose a risk to the workplace health and safety officer. A further detailed risk assessment will then be conducted and, if necessary, changes will be made to reduce the risk of injury including additional training as needed.

3.2. Incidents and injury and adverse patient events

3.2.1. Policy

This practice has designated Dr Belel Ejje with primary responsibility for clinical risk management, including following up on incidents, injuries and adverse patient events and near misses.

It is a legal requirement under the Work Health and Safety Act 2011 (NSW) and for insurance purposes, to report any injury sustained or thought to be sustained in the workplace. Consideration is taken to ensure that thorough reporting also leads to effective prevention.

Our practice encourages the identification, analysis and prevention of errors, failure or inadequate systems that can potentially be a risk to patient safety. To assist with risk management strategies, our practice does not apportion blame.

Incidents that should be reported (regardless of whether harm has occurred) to assist with making improvements to minimise the risk of recurrence, include:

- Needle stick injury or mucous membrane exposure to blood or body-substance,
- Slip or fall,
- Drug or vaccine incident (loss, misplacement or other),
- Adverse patient outcome,
- Failure or inadequate patient handover or identification of a patient at the point of transfer of care,
- Delayed treatment or delayed follow up, or unnecessary repeat of tests,
- Medication errors, and
- Any deviations from standard clinical practice.

Accidents or incidents may involve the following:

- Staff (employed directly by this practice),
- Non-staff (patients, visitors, contractors), and
- Events (e.g. theft, non-patient assault, gas leak, bomb hoax, security breach, medication error or patient complication following medical intervention or breakdown in clinical handover).

Actual and potential risks are identified and actions are taken to increase the safety and improve the quality of care. The privacy of individuals involved is maintained.

3.2.2. Procedure

Reporting

In our practice, we use the *Adverse Outcome Event/Incident Report* form to report any slips, lapses or near misses in clinical care (including any breakdowns in the clinical handover system) or deviations in patient care that might result in harm. Where necessary, our medical defence organisation is contacted for events that might give rise to a claim.

In addition to the *Adverse Outcome Event/Incident Report* form, our practice team use the *Blood/Body-Substance Exposure Incident Report* form to report any needle stick injury or exposure to blood or body-substances as detailed under **Section 3.3 – Sharps injury management and other body-substance exposure**.

Completed *Adverse Outcome Event/Incident Reports* are:

- Completed as soon as possible after an incident occurs, preferably within 24 hours,
- Provided to the person with designated responsibility for clinical risk management to facilitate a review of current systems and processes to prevent a recurrence, and
- Filed in a designated 'clinical incident' file.

For injury occurring in the practice or during course of work, WorkCover reporting protocols must also be followed. It is a legal requirement to report all injuries sustained in the workplace.

Where there is a possible conflict of interest, for example a staff WorkCover claim being managed by the employing practitioner, the general practitioner should refer the patient to another practitioner.

Risk assessment

The person designated with primary responsibility for clinical risk management will conduct a thorough review of all hazards relevant to the cause(s) of any injury that has occurred, with a view to identify appropriate controls (also refer to **Section 8.2 – Risk assessment and management**).

Risk control

Risk control involves identifying and implementing all the practicable strategies to minimise subsequent and similar events or to eliminate/reduce the causes(s) of the injury or incident.

Practice team members are informed about any changes implemented, including why they have been implemented, to reduce the likelihood of recurrences. Depending on the circumstances, this will take place as soon as practicable following an incident, or during the next practice team meeting.

All documentation or evidence of the implementation of improvements is retained for periodic evaluation to ensure the successfulness of the improvement implemented.

Documentation

Documentation of the investigation process, agreed actions implemented, and the evaluation of the improvements implemented is retained using the *Clinical Near Miss and Mistake Register*.

3.3. Sharps injury management and other body-substance exposure

3.3.1. Policy

Our practice is responsible to ensure that all members of the practice team:

- Are familiar with the practice policy regarding management of blood and body-substance exposure,
- Consider the blood and body-substances of all patients as potential sources of infection,

- Understand how to prevent exposure to blood and body-substances,
- Have access to education and regular in-service training in infection prevention and control matters,
- Have received immunisations as recommended by the current edition of the *Australian immunisation handbook* and appropriate to their role, and that the immunisation status of the practice team members is documented, and
- Analyse any incidents and modify procedures as required to reduce the risk of recurrence.

In our practice, we understand that the management of occupational exposure to blood or body-substances includes:

- Rapid assessment of the practice team member and the source patient
- Documentation of the incident
- Counselling for the practice team member involved
- Timely administration of medications where appropriate, and
- Investigation of the incident to enable modification of procedures if required.

Occupational exposure to needle stick injuries and body-substances can be prevented by using standard precautions, wearing personal protective equipment and implementing safe work processes.

3.3.2. Procedure

Preventing blood and body-substance exposure

All members of the practice team are instructed to:

- Use standard precautions where there is a risk of blood or body-substance exposure,
- Implement safe work practices when handling sharps, specimens and waste, and when cleaning the practice environment and reusable instruments, and
- Assess and manage any blood or body-substance exposure immediately.

Following occupational exposure

In our practice, we follow this procedure after occupational exposure:

1. Decontaminate the exposed area

- Wound -
 - Do not squeeze or rub the injury site.
 - Gently encourage bleeding from the skin wound.
 - Wash the area thoroughly with soap and water (or waterless cleanser or antiseptic if water is unavailable).
 - Apply waterproof dressing as necessary and apply pressure through the dressing if bleeding is still occurring.
 - Do not use strong solutions such as bleach or iodine on the wound site.
- Skin -

- Wash the area thoroughly with soap and water (or waterless cleanser or antiseptic if water is unavailable).
- Do not use strong solutions such as bleach or iodine on the skin site.
- Eyes -
 - Remove contact lenses.
 - Rinse the eyes gently (but thoroughly) while they are open for at least 30 seconds with water or saline.
- Mouth -
 - Spit out any blood or body-substance that has entered.
 - Rinse with water and spit out (repeat several times).
- Clothing -
 - If any clothing is contaminated, remove and shower if necessary.

2. Report and document

- Report -
 - Report the exposure to an appropriate person (i.e. Dr. Belel Ejje to ensure prompt and appropriate commencement of treatment and investigation).
- Document -
 - Document the incident using the *Blood/Body-Substance Exposure Incident Report* form.

3. Blood Borne Virus (BBV) testing

- Source -
 - Take a history from the source to identify the risk of disease exposure, accounting for the following:
 - Unprotected sexual intercourse
 - Sharing needles, tattoos or body piercing
 - Sharing razor blades or toothbrushes
 - Blood or body-substance exposure of mucous membranes or non-intact skin
 - Blood transfusion before February 1990 (For HCV)
 - Infected with HIV, HBV, or HCV
 - Where the source is positive, likely positive, or unknown for BBV, testing must be performed. Consent must be obtained prior to performing any baseline serology testing.
 - Perform baseline tests for:
 - HIV
 - HBV
 - HCV
 - Request urgent testing and results from the laboratory.
- Exposed Person -

- Informed consent for BBV testing must be obtained prior to performing any baseline serology testing.
- Perform baseline tests for:
 - HIV
 - HBV
 - HCV
- Request urgent testing and results from the laboratory.

4. Risk assessment

- High risk / Massive exposure -
 - Injection of large volume of blood/body-substance (>1mL).
 - Parenteral exposure to laboratory specimens containing high titre of virus.
- Moderate risk / Definite exposure -
 - Injection of large volume of blood/body-substance (<1mL).
 - Skin penetrating injury with a needle contaminated with blood or body-substance.
 - Laceration or similar wound which causes bleeding, and is produced by an instrument that is visibly contaminated with blood or body-substance.
- Low risk / Possible exposure -
 - Superficial injury with a needle contaminated with blood or body-substance.
 - A wound not associated with visible bleeding, caused by an instrument contaminated with blood or body-substance.
 - Prior wound or skin lesion contaminated with blood or body-substance.
 - Mucous membrane or conjunctival contact with blood or body-substance.
 - Scratched/broken skin caused by a fingernail injury when there is blood evident on the source hands.
 - Human bites that break the skin (clinical evaluation should include the possibility that both the person bitten and the person who inflicted the bite were exposed to BBVs).
- Very low risk / Doubtful exposure -
 - Superficial injury with needle considered not to be contaminated with blood or body-substance.
 - Superficial wound not associated with visible bleeding, caused by an instrument considered not to be contaminated with blood or body-substance.
 - Prior wound or skin lesion contaminated with a body-substance other than blood (e.g. urine).
 - Mucous membrane or conjunctival contact with a body-substance other than blood.
- No risk / No exposure -
 - Intact skin visibly contaminated with blood or body-substance.

5. Initiate treatment

- Confidentiality must be maintained, especially if the exposed person is a practice team member.

- Offer the exposed person counselling if the source is known to be HIV positive, 'high risk' or is unknown for BBV.
- Where the source is unknown, post-exposure prophylaxis needs to be considered based on the outcome of the risk assessment.
- If the source's blood test results will not be available within 24 hours and the source is likely to be HIV positive, post-exposure prophylaxis needs to commence.
- If post-exposure prophylaxis is required, it is important the exposed person commences this as soon as possible (best given within 1-2 hours of exposure, recommended within 48 hours of the incident or, up to 72 hours as decided by a medical practitioner).
- If the source's HBV result will not be available within 24-48 hours, and the exposed person's HBV status is not known/documented, with consent give the exposed person:
 - Hepatitis B immunoglobulin
 - Hepatitis B vaccine (first dose)
 - Adult diphtheria and tetanus (ADT) if necessary.
- Advise the exposed person to practice safe sex until the blood test results and source history has been reviewed.
- Provide the exposed person with the contact details for the NSW health department communicable disease office.
- If there is a high risk of disease exposure, refer the exposed person to an infectious disease specialist.
- Re-assess treatment initiated once the results of the blood tests become available.

6. Reporting and analysis of the incident

We have appointed a member of the practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures (refer to **Section 4.1 - Principles of infection prevention and control**). Using the *Adverse Outcome Event/Incident Report* form our team is to report any exposure to this person or delegated authority, in addition to normal incident reporting protocols, incorporating:

- What procedure was being undertaken,
- How the injury happened and the name of anyone that witnessed it,
- The nature and extent of the injury,
- What caused the injury (e.g. specify the gauge of the needle),
- The body-substance involved,
- How much blood or body-substance was the health professional exposed to,
- What personal protective equipment was being used, and
- The full name and address of the source - if the source cannot be identified document "source patient not known".

3.4. Practice team immunisation

3.4.1. Policy

In our practice, we have appointed Farah Abdul Hussein with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures which includes immunisations (refer to **Section 4.1 - Principles of infection prevention and control**).

All members of the practice team are advised of the risks of infection and are encouraged to be immunised against vaccine-preventable diseases to prevent transmission of disease to and from other members of the practice team and patients. Practice team members are also offered additional vaccinations where appropriate, depending upon the likelihood of their contact with patients and/or blood supply substances. These vaccinations may include protection against Hepatitis A, Meningococcal B, Meningococcal C, Poliomyelitis and Tuberculosis.

The practice keeps an extensive and up-to-date record of the immunisation history of each practice team member (including any refusals of immunisation, serology testing, or disclosure of vaccination history), and this assists in identifying non-immune team members to ensure they are excluded from contact with patients during disease outbreaks.

3.4.2. Procedure

A vaccination history, including serology testing where required and consented, is sought from all new employees during commencement of their employment. Based on the outcome of this, any immunisations then recommended are to be received within the first three (3) weeks of commencement (with the exception of influenza which is to be administered annually between March and May).

Contractors and volunteers working in the practice must provide evidence of vaccination, or proof that they are not susceptible to specified vaccine preventable diseases, prior to engagement/commencement.

Immunisation histories are recorded using the *Practice Team Member Immunisation Consent/Refusal Record Form*, which is held in each individual's employment or contract file. Each team member's immunisation history is reviewed regularly, and updated as required.

Guidelines for immunisation

All members of the practice team are encouraged to obtain immunisations recommended by the current edition of the *Australian immunisation handbook* based on their duties and immunisation status. The recommended immunisations for workers in healthcare include:

- Influenza,
- Hepatitis B,
- Measles Mumps and Rubella,
- Pertussis (dTpa), and
- Varicella.

To determine which vaccine preventable disease each member of the practice team should be protected against, we use the following criteria to help form the basis of this determination. This list is not an exhaustive list, and other considerations may need to be made, which are determined by the infection prevention and control coordinator when discussing with the practice team member the risks and benefits of vaccination:

Influenza

Due to the highly transmissible nature of the influenza virus and possible serious consequences for the young and elderly, all practice team members are required to have the annual influenza vaccine.

Hepatitis B

Tasks that involve the possibility of exposure to blood or body-substances (direct patient contact or indirect contact with blood or body-substance):

- hands-on clinical work,
- collecting, transporting, handling or processing of pathology samples,
- providing clinical care or treatment of any kind,
- cleaning of spills that may contain blood or body-substances of any kind,
- bed making and cleaning,
- handling of soiled or contaminated linen,
- handling of clinical or laboratory waste, or waste receptacles,
- cleaning or maintaining equipment or surfaces or other items used in clinical areas,
- assisting patients in using the bathroom, or mobilising, and
- any manual handling of patients.

Measles, Mumps, Rubella, Pertussis, Varicella

Tasks or work settings that involve the possibility of contact that would allow acquisition and/or transmission of measles, mumps, rubella, pertussis or varicella (direct patient contact or indirect patient contact):

- interacting face-to-face with patients,
- the normal work location is an area where patients frequent, and
- the work frequently or regularly requires attending a clinical area (such as consulting room or treatment room).

In addition to the above vaccinations, our practice team members are offered and encouraged to receive the following vaccinations:

- Hepatitis A,
- Meningococcal B,
- Meningococcal C,
- Poliomyelitis, and

- Tuberculosis.

Immunisation consent/refusal records

Immunisation consent/refusal records are initiated for all members of the practice team and include:

- Confirmation that the risks of infection relevant to the team member's role have been outlined, and that the benefits of vaccination have been explained.
- Consent (or refusal) to discuss or disclose immunisation history (including undertaking serology testing).
- Consent (or refusal) to have the recommended vaccinations.
- Any known allergies (where immunisation consent is given).

These records remain confidential and secure and are accessible by authorised personnel only.

3.5. Smoking, drugs and alcohol

3.5.1. Policy

As a healthcare provider, our aim is to promote the health and wellbeing of all members of the practice team, patients and others whilst on our premises. Smoking is therefore not permitted in this practice and is discouraged on the premises or the surrounding area. The use of illegal drugs and alcohol is prohibited on and around the site.

No member of the practice team should present for work if under the adverse effects of alcohol or illegal drugs.

3.5.2. Procedure

Practice team members who are smokers should make an effort to remove any nicotine odour on or about clothing and self, prior to returning to duty.

No smoking signs are visible in the waiting and reception area and these signs are not to be removed, except to replace worn or frayed items.

Brochures and posters for 'QUIT' and related no smoking and drug free strategies are placed in the waiting room and visibly displayed to demonstrate our commitment to better health strategies.

3.6. Health and wellbeing

3.6.1. Policy

This practice is committed to providing and maintaining a safe and healthy workplace for general practitioners, staff, patients and all other visitors. This includes psychological as well as physical health.

Health and wellbeing are an integral part of every activity we perform, and as such, the health and wellbeing of general practitioners and practice team members is a priority of this practice.

Our practice has implemented strategies to ensure current information on programs and support services available to the practice team are readily available to help them identify and manage any pressures and stressors.

We recognise that regular breaks for general practitioners during consulting times can reduce fatigue as well as enhance the quality of patient care.

3.6.2. Procedure

- Regular breaks are scheduled for all practice team members, including general practitioners.
- When a work break has been organised; where possible, a relieving member of the practice team will complete the workload of the absent team member, in addition to their own workload.
- Strategies are implemented to manage workflow whenever a general practitioner or other team member is unexpectedly absent, or scheduled for leave. Unplanned leave will be covered by existing practice team members or by agency or locum staff as required (also refer to **Section 3.17 - Non-medical emergency response and business continuity**).
- To promote a healthy work environment, employed team members are encouraged to take leave when the balance of accrued leave is in excess of 20 days.
- Current information on programs and support services is available to the practice team, including general practitioners.
- Occasionally, our practice team may be confronted by stressful incidents or situations, including assisting with emergencies. The practice provides emotional debriefing and/or counselling in these situations as soon as practicable after the incident has occurred.

3.7. Self-Care

3.7.1. Policy

Our practice promotes, and is committed to, the health and wellbeing of all practice team members and embeds self-care within our culture.

Due to the work undertaken in primary healthcare, it is essential for all practice team members to actively look after their mental health and physical wellbeing in order to meet personal, relationship and professional commitments.

Self-care refers to activities that preserve and maintain one's physical, emotional and mental health. It is an ongoing commitment to look after oneself through helpful behaviours that protect one's health during periods of stress. In order to achieve the best effects, self-care must be practiced throughout everyday life. Self-care correlates with what an individual does at work and outside of work to look after their wellbeing. It includes many activities, such as eating well, getting enough sleep, celebrating wins, learning a new skill or partaking in exercise.

How individuals respond to stress will be different. There may be instances in the practice that challenge our ability to cope. Practicing self-care is an important part of professional development, and by putting one's health and wellbeing first, we can, more effectively, provide the best care and support to patients.

3.7.2.Procedure

Self-care is a personal matter and everyone's approach will be different. Listed below are different aspects of self-care and strategies that we engage in as a team and promote within our practice.

Workplace/professional self-care

Within our practice, we participate in/encourage our practice team to:

- Engage in regular consulting with other staff members/managers
- Participate in a peer-support group
- Take regular breaks/lunch breaks away from the desk
- Eat a nourishing lunch and drink plenty water throughout the day
- Maintain a work-life balance, using annual leave spread out throughout the year
- Attend professional development programs
- Schedule work days and be realistic with what can be achieved
- Celebrate wins with other team members
- Create a work self-care plan and encourage other team members to do the same

Physical self-care

We encourage our practice team to:

- Develop a regular sleep routine and get between 6-8 hours of sleep each night
- Aim for a healthy, balanced diet and know what foods work best for your body and health
- Take regular exercise, for example, gym classes, bike rides, yoga
- Not be afraid to use sick leave when needed
- Develop a personal hygiene routine

Psychological self-care

We encourage our practice team to:

- Partake in extracurricular activities or hobbies

- Ensure they are taking time for relaxation and even consider a digital detox
- Have regular contact and spend time with positive friends and family
- Make time for self-reflection and celebrate wins with others
- Before they start the work day, write down three things which they want to accomplish that day
- Ensure to voice any work concerns or stresses to supervisors and managers

Emotional self-care

We encourage our practice team to:

- Create professional boundaries that they are comfortable with
- Learn to say 'no' to things that they are not comfortable with
- Experience their emotions without judgment, guilt, or embarrassment
- Turn to other staff members when they are feeling overwhelmed
- Practice self-compassion
- Talk to trusted friends/family about how they are coping with work and life demands

Relationship self-care

We encourage our practice team to:

- Arrive to work and leave on time every day
- Be aware of and respect other staff members' boundaries and needs
- Attend the special events of family and friends
- Ensure diversification of relationships e.g. friends that are not associated with work
- Surround themselves and build relationships with people who have a positive impact on them
- Engage in regular team work, developing listening and communication skills

Self-care plans for practice team members

We encourage all team members to create an individual self-care plan, starting with assessing which self-care methods they already partake in, then planning improvements to their self-care routine. We supply new team members with a *Self-Care Planning Tool* upon induction to assist in this process.

3.8.Patient aggression and patient-initiated violence

3.8.1. Policy

Our practice is responsible for providing a safe working environment; however, patient aggression and patient-initiated violence in healthcare settings can be an issue.

3.8.2.Procedure

To mitigate the risk of patient aggression and patient-initiated violence, our practice has the following strategies in place:

- A duress alarm system is installed that the practice team can use if a patient is threatening or violent.

Where a patient displays aggression or violence, our general practitioners have the right to discontinue the care of that patient. This includes the practitioner ending the professional relationship during a consultation or by letter or telephone, depending on safety considerations. A record is kept of this process when undertaken, and of any subsequent contact that the patient has with the practice. Our practitioners will, however, provide emergency care to patients whose care has been ceased in accordance with their professional and ethical obligation (refer to **Section 7.13 – Refusal to treat a patient**).

3.9. Practice facilities

3.9.1. Policy

The practice premises comply with relevant building regulations and its facilities and equipment are safe and adequate to meet the needs of the practice team and patients.

3.9.2. Procedure

Every reasonable effort is made to make the environment safe and comfortable for all members of the practice team. The practice has heating and air conditioning to assist in providing comfort.

Our facilities make adequate provision for, and encourage, patient auditory and visual privacy. The physical conditions in our practice support patient privacy and confidentiality. Facilities are well maintained and visibly clean with surfaces accessible for cleaning.

Our practice displays a list of names of the practice's team members on duty.

3.10. Consulting rooms

3.10.1. Policy

Our practice has 5 dedicated consulting/examination rooms to accommodate every general practitioner who would be working at any one time. All areas where consultations or treatments occur are appropriate for the health and safety of general practitioners, other members of the practice team and patients; this includes having a height adjustable bed in each consulting/examination room in our practice.

3.10.2. Procedure

Our consulting rooms have sufficient space, are free from excessive extraneous noise and have adequate lighting for observation. The temperature in the consulting rooms is maintained at a comfortable level, particularly for situations that require patients to undress for an examination.

The practice ensures that both visual and auditory privacy is afforded to all patients in examination areas, treatment rooms and consulting rooms. Where patients are required to undress/dress, they are provided with a gown or sheet and the privacy curtain around the examination bed is drawn.

Privacy and confidentiality of patient information is considered at all times, including during telephone conversations between members of the practice team and patients.

Patient personal health information is treated with respect, and letters, forms or notes concerning patients are not readily visible to other patients. Computer screens are positioned to ensure the content on the screens are not visible to patients and visitors, and screensavers are activated.

We maintain adequate infection prevention and control procedures in the consulting and treatment areas, including:

- Cleaning examination beds regularly and as required,
- Ensuring linen (including gowns and sheets), curtains and screens are laundered regularly and as required,
- Ensuring the consulting and treatment rooms are maintained and visibly clean with surfaces accessible for cleaning, and
- Storage areas for sterile/non-sterile items are dust proof and dry.

The security of the practice (and the practice team members) is an important issue and strategies are in place in the event of a breach of security.

3.11. Hand washing facilities

3.11.1. Policy

Dedicated hand washing facilities with hot and cold water, liquid soap and single-use paper towels are readily available in every clinical management and treatment area, including the consulting rooms.

3.11.2. Procedure

Hand disinfectants designed for use without water, such as alcohol-based hand gels, are available in:

- The doctors' bags to use when hand washing facilities are inadequate or not available (e.g. home or other visits),
- All treatment and examination areas to encourage hand hygiene in addition to hand washing, and

- Common areas used by patients and practice team members to encourage hand hygiene.

All new members of the practice team are informed about our hand washing and hand hygiene procedures (refer to **Section 4.3 – Hand washing and hand hygiene**) and we provide regular updates and training in infection prevention and control.

3.12. Waiting area

3.12.1. Policy

Our practice waiting area is fit-for-purpose. The design and layout enables privacy and is sufficient to accommodate the usual number of patients and others who would be waiting at any one time.

3.12.2. Procedure

The safety of patients and visitors is considered when selecting seating, furniture and toys, and the area is kept tidy and clean to maintain a safe environment.

The practice is able to provide appropriate and respectful care for patients and others in distress, i.e. vomiting, upset or in severe pain. Privacy for such patients is provided by allowing them to sit in an unused room, staff room or other designated area, rather than waiting in the general waiting area.

Auditory privacy within the waiting area is enhanced by the use of a television to mask conversations at reception; and privacy and confidentiality of patient personal health information is considered when team members are discussing patients and their health information within the reception area. Computer screens are not readily visible and screensavers are used.

Our waiting area caters for the specific needs of children with play equipment or toys that are washed regularly. During an infectious outbreak, we remove the play equipment and toys to mitigate the risks of spreading infection.

The waiting room furniture is in good condition, without sharp edges, and the room is maintained in a clean and tidy state with surfaces easily accessible for cleaning.

A range of posters, leaflets or brochures about health issues is available in the waiting room for patients to self-select.

3.13. Toilets

3.13.1. Policy

Toilet facilities for patients and others are easily accessible and well signposted. To reduce the possible spread of infection and to encourage good hand hygiene, washbasins are provided within each facility.

3.13.2. Procedure

Toilet facilities for patients are located within the practice and are easily accessible and well signposted.

Hand washing facilities, including liquid soap and single-use paper towels are readily available for use by patients and visitors within the toilet facilities.

Our practice has separate toilets for staff and patients.

All toilet facilities are well maintained and visibly clean, with surfaces accessible for cleaning.

Telecommunication system

3.13.3. Policy

Our practice's telecommunication system facilitates patient access to the practice services and aims to adequately meet the needs of patients and team members. The auditory privacy and confidentiality needs of patients have been considered when locating our telephones and facilities for electronic communication.

3.13.4. Procedure

Our telephone system provides sufficient inward and outward call capacity and has the functionality for electronic communication (either email or facsimile). The practice has 3 lines dedicated for telephone calls and 2 lines for electronic communication.

It is recognised that the telecommunication needs of the practice may change over time, in-line with staffing changes and growth of the practice. Strategies are in place to monitor, review and make the appropriate changes to the telecommunications system as required, and this includes monitoring through feedback from patients and practice team members.

A telephone line is available for the practice team to summon assistance in an emergency.

3.14. Unauthorised access areas

3.14.1. Policy

General practitioners and other members of the practice team need to ensure the confidentiality and security of patient personal health information and other sensitive practice materials.

3.14.2. Procedure

Signage is displayed to prevent unauthorised public access to specified areas in the practice.

The presence of an additional person in the practice, in addition to the general practitioner(s) on duty, increases security and safety for patients, general practitioners and other team members, and also reduces the risk of unauthorised access to patient personal health information or sensitive practice materials.

The confidentiality and security of patient health records, prescription pads/paper, letterhead, administrative records and other official documents are maintained and stored on the computers or storage rooms, which are in a restricted access area. Patient personal health information is also stored in manner that is not accessible to unauthorised persons, and all sensible security measures are taken to prevent unauthorised access to medications and to the doctors' bags.

Facsimile machines, printers and other communication devices are not readily accessible to people other than the general practitioner(s) and authorised members of the practice team.

3.15. Security

3.15.1. Policy

Our practice ensures, as much as possible, that our facilities provide appropriate security for patients, practice team members and visitors. All practice team members are aware of, and are able to, implement protocols to ensure the safety and security of all persons within the practice.

3.15.2. Procedure

The premises are protected by a computerised alarm system that has motion detection sensors located at various points on-site; refer to the office floor plan available in the cupboard in the reception area. A duress alarm, linked to the security system, is located under the reception desk. Our security firm also patrols the site after-hours.

During routine practice hours, at least one other practice team member in addition to the general practitioner(s) is present in the practice. By having another member of the practice team present, this allows for practical help to be provided during an emergency situation; reduces the risk of unauthorised

access to patient personal health information and sensitive practice documents; and provides security and safety for patients, general practitioner(s) and other team members.

Rosters are checked daily and staffing is then planned for the next workday. Where possible, this same strategy is strongly encouraged to be implemented outside of normal working hours, for example, at weekends and on public holidays or when non-routine 'emergency surgeries' are conducted for patients needing urgent care.

Equipment on-site is engraved with the practice name and item number, and Sumayyah Mechraoui maintains the asset register that incorporates this information. Contracts and warranties for medical, office and other site equipment are securely locked, maintained and updated as required by Sumayyah. Confidential waste is placed in a locked storage box prior to shredding or secure destruction by a contracted document destruction company.

Security codes are routinely changed for computers and the security system, and patients, visitors and trades people are to report to the reception desk upon arrival. Where appropriate visitors and trades people are to wear an identification name badge on-site.

All practice team members are encouraged to be vigilant whilst on duty and to ensure the continuing safety of all general practitioners, patients, visitors and other team members.

Open and lock up protocol

At commencement of the working day:

- The premises are unlocked and the security alarm is deactivated using the practice team member's allocated and confidential security code.
- All exits are checked for unimpeded access, and windows are unlocked and opened as required for routine practice operation.
- Lights are turned on, as well as the heating/cooling system, computers and photocopier.
- The after-hours answering machine is turned off, and any messages are retrieved.
- The facsimile machine is checked for any incoming messages.
- Any unusual issues or missing items are reported to Dr Belel Ejje.

At the end of the day:

- All windows and doors are locked.
- A check is conducted to ensure the computer backup is complete (or scheduled after-hours as required).
- Designated computers, photocopier and heating/cooling system are turned off.
- Checks are performed to ensure the medicines cupboard and medicines safe are locked.
- Checks are performed to ensure all bins are empty.

- All office areas are checked to ensure there are no unsecured confidential documents, including medical and finance records.
- Prescription pads/paper, practice letterhead, health records, and other administrative records or official documents are stored away securely.
- The cash box is secured, and the answering machine is turned on.
- All lights are turned off, and the security lights turned on.
- The security system is activated.

3.16. Non-medical emergency response and business continuity

3.16.1. Policy

Non-medical emergencies may occur that will require a quick, informed and effective response from our practice team.

Types of non-medical emergencies include: failure of electricity supply, telephone or water; fire or false fire alarm; property damage; break-in; abusive or threatening telephone calls or persons at the practice; leakage of toxic chemicals; or bomb threats and letter bombs.

It is important that our practice has contingency plans for unexpected events such as natural disasters, national or local infection outbreaks or the sudden, unexpected absence of clinical team members or computer system failures (also refer to **Section 4.27 – Response to Pandemic Outbreaks, Section 8.2 – Risk assessment and management** and **Section 6.2 – Computer information security**).

In an emergency, especially one such as a pandemic, the demand for healthcare services generally increases, so it is crucial that our practice can continue to provide services during this time, if appropriate.

As unplanned absence of clinical team members can affect our practice's ability to provide quality patient care, we consider succession planning, and encourage the practice team to share their skills and knowledge among other members.

We have mechanisms in place to ensure the timely acquisition and dissemination of information (including regular updates) about alerts, emerging diseases, local disasters or emergencies.

The practice has appointed Dr Belel with primary responsibility for managing and executing our practice's non-medical emergency response and business continuity plan. Specific areas of responsibility can be delegated to other nominated members of the practice team and these responsibilities, where allocated, are documented in the relevant position descriptions.

3.16.2. Procedure

Our practice's *Emergency Response Business Continuity Plan* is located in the disaster box and details what the practice team could do to re-establish our practice's operations, when appropriate, if our practice needs to close due to an emergency.

The purpose of the *Emergency Response Business Continuity Plan* is to formalise emergency procedures, including fire safety precautions within the practice, so that those who are required to take actions related to the protection of life and property have a reference and a basis for their decisions and actions.

All members of the emergency response team are familiar with the procedures in the manual and are able to carry them out in times of emergency.

In an emergency, our practice may experience the following:

Patients:

- Increased demand for services.
- Disruption to the normal health system functioning (e.g. inability to transfer patients to hospital).

Infrastructure and systems:

- Minor or significant damage to the practice's infrastructure.
- Loss of access to vital information.
- Loss of access to essential systems, networks, and communication.
- Reduced capacity or loss of key members of the practice team.

Supplies and services:

- Loss of critical equipment and supplies.
- Loss of or disruption to power supply.
- Loss of or contamination to water supply.

To help reduce the impact of an emergency, our practice undertakes appropriate emergency planning and preparation, and frequently identifies, reviews, and updates the actions that need to be completed before and during an emergency. These actions include:

- Having a documented emergency response plan,
- Appointing an emergency management coordinator,
- Undertaking research to identify, for example, local emergency services, the local geography, and previous events that have affected the community,
- Providing the practice team with education and training that will help them effectively prepare for and respond to emergencies,
- Testing components of the emergency response plan (e.g. evacuation drills) once a year,

- Reviewing, monitoring and updating the emergency response plan every six (6) months, and
- Keeping the emergency kit fully stocked.

Our practice's emergency response plan contains:

- How to communicate with patients and other services,
- Contact details of all members of the practice team,
- Contact details for response agencies and other health services,
- Details about the practice such as accounts, service providers (e.g. insurers, lawyers, and providers of telephone, internet, and utilities) and insurance policy numbers,
- How the practice will triage and run clinical sessions during an emergency,
- Details of equipment needed to continue to operate in an emergency, and
- How to manage unplanned absenteeism of multiple practice team members.

4. Infection prevention and control

4.1. Principles of infection prevention and control

4.1.1. Policy

Because many infectious agents are present in healthcare settings, patients may be infected while receiving care. Healthcare workers and others, such as receptionists and cleaners, may be infected during the course of their duties or when working or interacting with patients and other people. Potential infection risks to the practice team and our patients need to be reduced.

Our practice has implemented systems that minimise the risk of healthcare associated infections.

We have appointed a member of our practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures. Specific areas of responsibility may be delegated to other members of the practice team (e.g. infection prevention and control processes, sterilisation process, environmental cleaning, immunisation, education) and these particular responsibilities are documented in the relevant position descriptions (also refer to **Section 8.9 – Governance and management**).

Our practice has written policies relating to key infection prevention and control processes which are reviewed and updated regularly (refer **Section 8.3 – Review of policies and procedures**).

All members of the practice team have an individual responsibility to identify any potential infection risks within the practice and to be familiar with and implement the relevant infection prevention and control procedures of our practice (refer **Section 2.8 – Code of conduct**).

New members of the practice team, including contracted or casual staff, are educated on the infection prevention and control policies that are appropriate to their duties as part of their induction to our workplace and their competency is assessed and recorded. Mechanisms are in place to ensure ongoing education and competency on a regular basis and when changes occur to our procedures (refer to **Section 8.4 – Training, qualifications and continuing education**).

Subject to informed consent, the immunisation status of our practice team members is known and recorded, including the documentation of any refusal. Clinical team members are provided with access to the current *Australian Immunisation Handbook* and our team members are offered the recommended immunisations in accordance with this handbook as appropriate to their duties (refer **Section 3.4 – Practice team immunisation**).

Our practice remains alert to changes to guidelines for infection prevention and control, and can implement them accordingly in a timely manner. We have a system for monitoring and obtaining information about national and local infection outbreaks, as well as about emerging new risks of cross infection. We have an effective mechanism for timely receiving and dissemination of any important communication or updates about emerging diseases or infection prevention and control measures to all relevant team members (refer **Section 8.2 – Risk assessment and management**).

4.1.2. Procedure

Our practice has designated Farah Registered Nurse with primary responsibility for coordinating and sustaining our infection prevention and control processes. This includes:

- Continually modifying and improving our procedures and written policies in accordance with the most recent evidence and guidelines, and adopting a risk management approach when implementing infection prevention and control measures,
- Ensuring the timely dissemination of information concerning changes to infection prevention and control procedures or information about national and local infection control outbreaks,
- Maintaining practice team members' knowledge, education and competency in infection prevention and control activities and ensuring the consistent implementation of our infection prevention and control policies and procedures,
- Ensuring the practice remains visibly clean and the environmental cleaning processes are documented,
- Appropriate delegation of infection prevention and control responsibilities and documentation of such delegation, and
- Educating patients on infection prevention and control activities.

To ensure consistency of workplace practices, our policy and procedure manual contains the following infection prevention and control protocols:

- Prevention of disease in the workplace by serology and immunisation (Section 3.4),
- Blood and body-substance spills management (Section 4.2),
- Blood and body-substance exposure and sharps injury management (Section 3.3),
- Hand hygiene (Section 4.3),
- Standard and aseptic procedures (Section 4.4),
- Environmental cleaning of clinical and non-clinical areas (Section 5.20),
- Provision of sterile instruments (Section 4.8),
- Safe storage and stock rotation of sterile products (Section 4.19),
- Procedures for waste management including the safe storage and disposal of clinical waste and general waste (Section 4.20),
- Procedures for the management of sharps (Section 4.21),
- The appropriate use and application of standard and transmission-based precautions, including the management of patients with potential communicable diseases (Section 4.22 and Section 4.23),
- Access for patients and practice team members to personal protective equipment including education on appropriate application, removal and disposal (Section 4.24),
- Safe handling of pathology specimens (Section 4.26) ,
- Ongoing education and training including (Section 8.4), and
- The mechanism for assessing staff competency in infection prevention and control procedures (Section 2.4 and Section 8.4).

4.2. Blood and body–substance spills

4.2.1. Policy

Our practice has management systems for dealing with blood and body-substance spills, and these include the following:

- Blood and body-substance spills include blood, vomit, urine, faeces, sputum and body tissue and are treated as potentially infectious substances that can transmit disease, should contact occur.
- General practitioners, nurses, other health professionals, practice team members and external contractors (e.g. cleaners) use standard precautions to achieve a basic level of infection prevention and control regardless of the known or perceived infection status of the blood or body-substance.
- Any spillage needs to be treated promptly to reduce the potential for contact with other patients, practice team members or visitors.
- Our nurse has primary responsibility for coordinating and sustaining our infection prevention and control processes, is responsible for ensuring all team members are familiar with the practice's policy and procedure for the management of blood and body-substance spills, that they receive adequate training on how to appropriately manage blood and body-substance spills, and that they are familiar with the actions to take in the event of exposure to blood or body-substance while cleaning a spill (refer to **Section 3.3 – Sharps injury management and other body-substance exposure**).

Our practice has a spills kit readily available, consisting of a rigid walled container with a lid containing:

- A laminated guide containing a list of the spills kit contents and the spills management procedure
- One (1) small bucket, with the water level marked,
- A pre-measured amount of detergent* in a labelled container ready to be made up when necessary,
- Non-sterile utility gloves,
- Goggles and a face shield,
- Masks,
- Disposable aprons,
- Paper towels,
- Scrapers (i.e. two pieces of firm cardboard),
- Hazard sign to quarantine the area,
- Plastic (clinical and general) bags, and
- Polymerising beads (or other absorbent material such as kitty litter).

**The detergent we use for our general cleaning is used for treating most spills. Where transmission-based precautions apply, a disinfectant that has label claims against the microorganism of concern is used.*

4.2.2. Procedure

As part of our practice's induction process, all members of the practice team are provided with information about our practice's protocol for managing spills of blood and body-substances including what to do in the event of a needle-stick injury or exposure to blood or body-substance (refer to **Section 3.3 – Sharps injury management and other body-substance exposure**).

In our practice, the spills kit is located in the treatment room.

It is the responsibility of Farah Registered nurse to maintain the spills kit by ensuring all perishable items contained are within their expiry date and that stock is replenished/replaced as required.

Our management of spills is flexible enough to cope with different types of spills, taking into account the following factors:

- Nature of the spill: for example, sputum, vomit, faeces, urine or blood,
- Pathogens most likely to be involved: for example, stool samples may contain viruses or bacteria, whereas sputum may contain *Mycobacterium tuberculosis*,
- Size of the spill: for example, a spot, small or large spill,
- Type of surface: for example, carpet or vinyl flooring,
- Area involved: for example, in a contained area such as a consultation room or in a public area such as the waiting area, and
- Possibility of some material remaining on a surface where cleaning is difficult (e.g. between tiles) and the possibility of bare skin contact with that surface.

The affected area must be left clean and dry. Disposable items in the spills kit must be replaced after each use and reusable items cleaned according to protocol.

Only those practice team members with their immunisation status and spills management training recorded are permitted to clean spills of blood or body-substances.

The method for cleaning spills in our practice is as follows:

1. Apply standard precautions.
2. Don personal protective equipment.
3. Prepare detergent and water.
4. Tear off enough paper towel to manage the spill.
5. Prepare the rubbish bag.
6. Commence cleaning of the spill.

If the spill is on a hard surface:

- Wipe up any solid matter and excess material.
- Clean with detergent and water using a clean piece of paper towel each time.
- Dry the surface.
- Dispose of contaminated material.

If the spill is on a soft fabric or carpet:

- Use polymerising beads or other absorbent material.
- Scrape up residue.
- Clean with detergent and water using a fresh piece of paper towel each time.
- Quarantine the area until dry.
- Consider arranging for the carpet to be 'steam' cleaned.
- A disinfectant may be used after cleaning.
- Dispose of contaminated material.

4.3. Hand washing and hand hygiene

4.3.1. Policy

Effective hand hygiene has been proven to reduce the spread of infection. This minimises the risk of cross-contamination through physical contact with patients and co-workers, and touching inanimate objects such as door handles and telephones.

Gloves are not a substitute for hand cleaning. Fingernails are to be kept short and clean, and jewellery to be at a minimum as these may harbour bacteria; nailbrushes are not to be used. Cuts and abrasions are to be covered with water resistant dressings.

Our practice is responsible for ensuring all members of the practice team have been educated on effective hand hygiene and hand care.

Hand hygiene must be performed:

- Before and after eating,
- After routine use of gloves,
- After handling any used instruments or equipment,
- After going to the toilet,
- When visibly soiled or perceived to be soiled,
- Before, after and between performing procedures (e.g. removal of moles, suturing lacerations, wedge resections, drainage of cysts), and
- Before examining neonates and patients who are immunocompromised.

Easy access to hand hygiene facilities is promoted by having dedicated hand washing facilities with hot and cold water, liquid soap and single-use paper towel readily available in every clinical management and treatment area, including consulting rooms.

Hand disinfectants designed for use without water, such as alcohol-based hand gel, is available in:

- The doctors' bags to use when hand washing facilities are inadequate or not available (e.g. home or other visits),
- All treatment and examination areas to encourage hand hygiene in addition to hand washing, and
- Common areas used by patients and practice team members to encourage hand hygiene.

The most appropriate hand hygiene product to be used is selected with consideration of the following factors:

- Type of hand hygiene required i.e. routine, aseptic (clinical), or surgical,
- The location of the product,
- Compatibility of agents if multiple agents are used e.g. hand creams, ointments, and
- Care and protection of the person's hands, and any sensitivities.

In our practice, we do not use soap bars under any circumstances. We have liquid hand wash dispensers with disposable cartridges, including a disposable dispensing nozzle available, and where these are not available, a pump pack is used. The liquid soap pump packs are discarded when empty; however, should they need to be re-filled, the container is washed and dried thoroughly prior to the re-fill (and not 'topped up').

Appropriate facilities for drying hands are provided. Single-use towels (paper or cloth) are available in all areas where hand washing facilities are provided; hot air dryers are not used in our clinical management and treatment areas. Disposable paper towels are used prior to aseptic procedures and hand moisturiser is made available for use.

4.3.2. Procedure

The methods of hand hygiene performed in our practice are as follows:

Type of hand hygiene	Technique	Duration	Drying	When
Routine hand cleaning for soiled hands	Washing: - Wet hands - Wash with neutral liquid soap - Rinse thoroughly - Use paper towel to turn off the taps if not 'hands free'	10-15 seconds	- Paper towel OR - Clean, dry, single-use cloth towel OR - Clean section of roller towel	- Before eating - After going to the toilet - Before and after patient contact - After removing gloves
	Skin disinfectants: - Remove soil first, using hand wipes or soap and water - Apply alcohol-based hand rub - Rub over all surfaces in the same manner as washing hands	10-15 seconds OR Until dry	Rub hands until dry, without wiping	- Before eating - After going to the toilet - Before and after patient contact when hands are not visibly soiled - After removing gloves
Hand washing for standard aseptic (clinical) procedures	Method: - Wet hands - Wash with neutral liquid soap or antimicrobial cleaner - Rinse thoroughly - Use paper towel to turn off taps if not 'hands free' - Alcohol based hand rub can be used in emergency situations outside the practice, provided hands are not visibly soiled	1 minute	- Paper towel OR - Clean, single-use cloth towel	Before any procedures requiring a clean or 'no touch' technique

Type of hand hygiene	Technique	Duration	Drying	When
Hand washing for surgical aseptic procedures	Method: ● Remove jewellery ● Wet hands and forearms ● Wash with antimicrobial cleaner (4% chlorhexidine or 0.75% detergent-based povidone or 1% aqueous povidone) ● Clean under nails only if needed (do not scrub hands with nail brush as they can break the skin and be a source of infection) ● Rinse carefully, keeping hands above elbows To turn off taps if not hands free: ● Ask another member of the practice team to turn off the taps or use sterile towelling.	First wash of the day: 5 minutes Subsequent washes: 3 minutes	Sterile towels	Before significant invasive surgical procedures

Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)

The location of our hand washing facilities and available hand hygiene products are as follows:

Location	Hand washing facilities	Equipped for routine hand washing	Equipped for aseptic hand washing	Equipped for Surgical hand washing
Patient toilets	● Liquid soap ● Paper towel/air dryer	Yes	No	No
Consulting rooms	● Liquid Soap ● Antimicrobial cleaner (2% Chlorhexidine) ● Paper towel	Yes	Yes	No
Treatment room	● Liquid Soap ● Antimicrobial cleaner (4% Chlorhexidine) ● Paper towel ● Sterile towel	Yes	Yes	Yes

4.4. Standard and aseptic procedures

4.4.1. Policy

Standard aseptic technique refers to work practices used by general practitioners and other healthcare professionals to minimise the risk of introducing and transmitting infection during clinical procedures. Standard aseptic technique is used during treatment of wounds such as lacerations and ulcers, as well as minor operative procedures such as removal of moles and biopsies and venepuncture.

Surgical aseptic technique refers to work practices that result in preventing or minimising microorganisms entering sterile body areas such as through surgical incisions during a procedure. Elements of this technique may be used in some settings for more invasive procedures.

We ensure all practice team members involved in procedures are adequately trained and educated to execute standard and surgical aseptic technique as required.

4.4.2. Procedure

Standard aseptic technique is achieved by:

- Using standard precautions, including hand hygiene and personal protective equipment where necessary,
- Using barriers (e.g. clean single-use gloves),
- Using water or saline to clean ulcers or lacerations,
- Using skin disinfectants to prepare operative sites,
- Using clean environmental surfaces,
- Using a no-touch technique – that is, no direct contact between the health professional's hand and the patient during the procedure, such as using forceps during dressings or clean single-use gloves if no-touch technique is not possible (e.g. probing a penetrating wound),
- Using drapes to form a 'clean field' dependent on situation and risk,
- Using sterile instruments and equipment, and
- Reprocessing reusable instruments and other equipment between each patient.

Surgical aseptic technique involves:

- Using a sterile operating field where everything within a defined radius is clean and sterile,
- Using sterile gloves, gowns, drapes and instruments,
- Using skin disinfectant on the patient, and
- Taking care to ensure that nothing unsterile comes within the sterile field.

4.5. Handling and use of chemicals

4.5.1. Policy

Our practice does not use cleaning agents or other chemicals which are known to be toxic to the user such as glutaraldehyde and chlorine-based products. Chemicals and cleaning agents used in our practice are used in accordance to the manufacturer's instructions and are disposed of in accordance with our waste management procedure (refer to **Section 4.20 – Management of waste**).

Cleaning solution (detergents) that is mixed with other liquids by our practice is made at the beginning of each working day and discarded at the end of each working day, with the container rinsed and left upside down to dry overnight. This is to avoid the spread of microorganisms, which may have contaminated the solution. To avoid wastage, only enough solution is made up for the day.

All containers of chemical agents are appropriately labelled. This is to ensure that the contents of the containers can be readily identified and used correctly. For this reason, labels must be kept fixed to the container at all times and clearly understood.

Specifically, it is our policy that a container with diluted cleaning agent states the following:

- Name, type and purpose of chemical agent
- Instructions on preparing and discarding the solution, and
- Warnings and/or health and safety instructions.

Safety Data Sheets (SDS) are made available for all chemicals and hazardous materials found in our practice, and are visible on equipment and hazardous substances. The use and handling of chemicals, including cleaning agents, complies with the manufacturer's instructions.

It is important that our practice stores chemicals in a safe area to prevent unauthorised access. Most of our containers of chemicals are stored in a designated cupboard that is out of the reach of children; however, we also use a cupboard that is below waist height and this cupboard is fitted with a child-proof lock.

We ensure all practice team members who are required to handle chemicals are trained in the correct and safe use of the chemical, and this includes correct use of personal protective equipment.

All chemicals and cleaning equipment used in our practice is used only for the purpose intended and in accordance with the manufacturer's instructions including ensuring dilution ratios are strictly adhered to.

4.5.2.Procedure

Our practice stores the following listed chemical and cleaning products for the following uses :

Product	Use	Storage location	SDS available
Aqium	Antibacterial Hand Gel	GP Desks	x
palmolive	Hand sanitiser	GP room	x
			☐
			☐
			☐

Safety data sheets (SDS) for each product are found in the accreditation folder.

4.6. Single-use items

4.6.1. Policy

Single-use items and devices must not be reprocessed.

4.6.2. Procedure

Single-use items and devices include, but are not limited to: oxygen masks and tubing, nebuliser sets, spacers, razors, spatulas, auriscope tips, liquid nitrogen applicators, pins for sensory testing, medications such as eye drops and ointment, lancets for blood testing, spirometer and peak flow mouthpieces, and disposable instruments.

Single-use is the only acceptable method in this practice for dressings, suture materials, suture needles, hypodermic needles, syringes and scalpels.

Single-use vials are used in preference to multi-dose vials of injectable substances due to the increased risk of an infection hazard of multi-dose vials if incorrectly used. If multi-dose vials are used, education and ongoing compliance with prescribed protocols are required to prevent the potential transmission of infectious diseases, minimise the potential risk of vial contamination, minimise the potential risk of medical errors, reduce potential wastage associated with the use of multi-dose vials and, in the case of vaccines, to ensure the delivery of a potent vaccine to the patient.

Where possible, saline solution and skin preparation agents are purchased in single-use sachets or containers; larger containers, if used, are dated when opened and changed regularly.

Some items may be reprocessed for use by the same patient where labelled by the manufacturer as “single-patient use” and, in this case, the manufacturer’s instructions for reuse is followed. This process may include specific cleaning requirements and/or limitations to the number of times the item can be reprocessed before needing to be disposed of.

Single-use items or equipment contaminated with blood or body-substance is disposed of in accordance with our waste management procedure (refer to **Section 4.20 – Management of waste**).

5. Storage of sterile items

5.1.1. Policy

All sterile items, including those processed in the practice facility and those procured from commercial supplies, shall be stored and handled in a manner that maintains the sterility of the packs and prevents contamination from any source.

Factors that influence shelf life are event-related (not time-related) and are dependent on storage and handling conditions.

5.1.2. Procedure

Instruments in our practice are stored:

- In a clean, dry and well-ventilated area,
- In an area free from draughts,
- In an area where there is reduced chance of contamination from dust and water,
- with dust covers should items be stored for a long period of time,
- In a manner which allows stock rotation, e.g. place recently used items at the back and take from the front, and
- With the contents of the package clearly visible to reduce handling of instruments.

Instruments and items used for procedures in other locations such as aged care facilities and home visits are transported to the facility in a separate rigid walled container with a lid labelled sterile items. Care is taken to maintain the sterility of these while transporting to the facility.

Waste and sharps or disposable single-use instruments are disposed of into the appropriate waste stream in accordance with **Section 4.20 – Management of waste**.

6. Management of waste

6.1.1. Policy

Clinical and related waste must be handled, stored, packaged, labelled and transported appropriately to minimise the potential for contact with the waste and to reduce the risk to the environment from accidental release.

The RACGP's *Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)* outline policies and procedures that assist our practice to safely manage waste. We are also aware of our local, state (NSW), and federal regulations that impact on our waste management and ensure that our processes align to the requirements of the Australian Standards AS 3816:2018.

All members of our practice team receive education regarding the management and handling of waste that is appropriate to their role, including the safe use and disposal of sharps (refer to **Section 4.21 – Sharps management**), the management of spills (refer to **Section 4.2 – Blood and body-substance spills**) and the management of blood and body-substance exposure (refer to **Section 3.3 – Sharps injury management and other body-substance exposure**).

Our waste policies include:

- Use of standard precautions when handling waste
- Segregation of waste into the correct category: 'clinical and related' and 'general' waste
- Safe storage of waste, and
- Safe disposal of waste.

Clinical and related waste is waste that has the potential to cause infection or disease, sharps injury or public offence and includes such things as: discarded sharps; human blood, fluids and tissue (excluding hair, teeth, nails, urine and faeces); waste from patients known to have (or suspected of having) an epidemiologically significant communicable disease or being colonised/infected with an antibiotic resistant organism; material that contains free flowing or expressible blood; and pharmaceutical, chemical or cytotoxic waste.

General waste is any waste that does not fall into the 'clinical and related' waste category and includes: office waste; kitchen waste; urine, faeces, teeth, hair and nails; disposable nappies; used tongue depressors; non-hazardous pharmaceutical waste (e.g. out of date saline); items contaminated with blood or body-substances (though not to such an extent that it would be considered clinical waste, i.e. not contaminated with 'expressible blood').

6.1.2. Procedure

All members of the practice team use appropriate personal protective equipment when handling waste including, at a minimum, wearing gloves. Clinical and related waste is only removed by trained practice team members, and waste, whether general or clinical and related, is not compressed by hand.

Our practice's waste management procedures include sharps disposal. Our sharps containers and designated biohazard and cytotoxic bins are located in each area where the applicable waste is generated, and are emptied at the end of each day or when full.

Farah Practice Nurse is delegated responsibility to ensure adequate stock levels of our waste containers are maintained and collection schedules are timely.

All clinical waste containers in our practice (with the exception of sharps containers - refer to **Section 4.21 – Sharps management**):

- Are yellow in colour and lined with a yellow clinical waste bag
- Are labelled 'clinical waste' and display the biohazard symbol
- Have rigid walls
- Are sealable with a secure lid
- Are easy handled and have hands-free operation, and
- Are positioned so as to be inaccessible to the public and particularly out of the reach of children.

While awaiting collection, our clinical waste is stored securely inside a locked yellow biohazard identified bin in an area that is separate from clean stores and with restricted access. Collection of our clinical waste is made only by a licensed transport and disposal company, and our practice contracts the services of 4Cyte to achieve this. The clinical waste bins are collected every month and final disposal of our clinical waste is by special burial or high temperature incineration, depending on the category of the clinical waste as determined by the contents (which can vary from time to time).

All cytotoxic waste containers in our practice:

- Are purple in colour and lined with a purple cytotoxic waste bag
- Are labelled 'cytotoxic waste' and display the cytotoxic symbol
- Have rigid walls
- Are sealable with a secure lid
- Are easy handled and have hands-free operation, and
- Are positioned so as to be inaccessible to the public and particularly out of the reach of children.

While awaiting collection, our cytotoxic waste is stored securely inside a locked purple cytotoxic identified bin in an area that is separate from clean stores and with restricted access. Collection of our cytotoxic waste is made only by a licensed transport and disposal company, and our practice contracts the services of 4cyte to achieve this. The cytotoxic waste bins are collected when required and final disposal of our cytotoxic waste is by high temperature incineration.

Hazardous and toxic waste, such as formaldehyde and glutaraldehyde, must be treated appropriately before being disposed of in landfill. Some chemicals are suitable for incineration, while others will need to be neutralised or fixed so that they cannot leach into the environment. 4Cyte, an approved regulated waste treatment company, is engaged to perform these services and collection is arranged as required.

All general waste produced in our practice is segregated at the point of use into recyclable, non-recyclable and shred-only waste according to local council regulations, privacy and confidentiality

requirements. Waste contaminated with blood or body-substance (that is not considered clinical waste) is placed into a bin, lined with a bag which is positioned so as to be inaccessible to the public and particularly out of the reach of children. The final disposal of this waste is made into the normal council waste collection bins. Waste containing sensitive information is shredded and disposed of in accordance with our privacy and confidentiality protocols.

6.2. Sharps management

6.2.1. Policy

Our practice makes every attempt to minimise the risk of injury to the practice team and patients, and to prevent the possible transmission of disease by discarded sharps.

Sharps represent the major cause of accidents involving potential exposure to blood-borne diseases. All sharp items contaminated with blood and body-substance is regarded as a source of potential infection. Safe handling and disposal of sharps is essential to protect the operator and other team members from injury and possible transmission of disease. Sharps may be defined as any object or device that could cause a penetrative injury.

Consideration is given to the use of devices that significantly reduce the risk of sharps injury.

The member of the practice team who generates or uses a sharp is responsible for the safe use and disposal of that sharp; this responsibility cannot be delegated.

Our practice is responsible to ensure all members of the practice team are familiar with the practice's policy and procedure for the safe handling and disposal of sharps and that they are also familiar with the actions to take in the event of a sharps injury (refer to **Section 3.3 – Sharps injury management and other body-substance exposure**).

6.2.2. Procedure

Sharps disposal containers are placed in all areas where sharps are generated. Where possible they are located between hip and shoulder height.

All sharps containers in our practice:

- Comply with Australian Standards AS 4031-1992,
- Are positioned so as to be inaccessible to children,
- Cannot be knocked over,
- Are located so that the neck is clearly visible to health professionals when disposing of items,
- Have scalpel blade removers securely mounted to the walls, and

- Are closed and replaced when the full indicator is reached.

The following procedures are undertaken when disposing of sharps:

- The person using the sharp is responsible for its safe disposal,
- Sharps are preferably disposed of immediately, but must be disposed of at the end of the procedure being performed,
- Used sharps must not be carried about unnecessarily,
- Injection trays must be used to transport the needle and syringe to and from the patient,
- Needles and syringes must be disposed of as one unit,
- Needles must not be recapped,
- Needles must not be bent or broken prior to disposal,
- Containers must not be overfilled as injuries can occur whilst trying to force the sharp into an overfilled container – close container securely when at the fill line,
- The lid must be securely closed once the contents reach the fill line,
- Sharps containers must not be placed on the floor or in areas where unauthorised access or injury to children can occur,
- Sharps containers must not be placed directly over other waste or linen receptacles, and
- Assistance must be obtained when taking blood or giving injections to an uncooperative patient or to a child.

While awaiting collection, sharps containers are never reopened and are stored with and managed as clinical waste (refer to **Section 4.20 – Management of waste**), ready for collection by 4Cytel.

Our practice assumes an active role in reducing the possibilities for sharps injury by purchasing safe equipment whenever such an option is available, without compromising the quality and safety of patient care. Examples include:

- Self-retracting single-use lancets for blood glucose testing,
- Self-retracting cannula insertion devices and needleless IV administration systems,
- Vacuum blood collection tubes,
- Scalpel blade removal devices, and
- Plastic ampoules.

6.3. Standard precautions

6.3.1. Policy

Standard precautions must be taken by all practice team members involved in patient care or who may have contact with blood or body-substances (including secretions and excretions but excluding sweat) regardless of the known or perceived infection status of the patient. The blood and body-substances of all patients must be considered potentially infectious at all times.

Standard precautions are work practices that are used consistently to achieve a basic level of infection prevention and control in all healthcare settings and all situations.

Standard precautions are designed to protect both patients and the members of the practice team, and comprise the following measures:

- Hand hygiene,
- Use of appropriate personal protective equipment, for example, heavy duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers,
- Respiratory hygiene and cough etiquette,
- Use of aseptic technique to reduce patient exposure to microorganisms,
- Safe management of sharps and waste,
- Appropriate immunisation of all general practitioners, clinical and healthcare professionals and administrative staff,
- Effective reprocessing of reusable equipment and instruments,
- Environmental controls such as design and maintenance, cleaning and spills management, and
- Support services such as waste disposal, laundry and cleaning services.

The RACGP's *Infection prevention and control standards for general practice and other office-based and community-based practices (5th edition)* recommends the use of heavy-duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste.

6.3.2. Procedure

All staff involved in patient care or who may have contact with blood or body-substances are required to understand and use standard precautions when they are likely to be in contact with:

- Blood,
- Body-substances including secretions and excretions (but excluding sweat),
- Non-intact skin, and
- Mucous membranes.

6.4. Transmission-based precautions

6.4.1. Policy

Transmission-based precautions are measures used in addition to standard precautions when extra barriers are required to prevent transmission of specific infectious diseases. Transmission-based precautions are used for patients known or suspected to be infected with highly transmissible pathogens.

Our practice team members are educated in how to triage and apply transmission-based precautions for patients known or suspected with a potential communicable disease.

Transmission-based precautions require:

- Isolation of the infectious source to prevent transmission of the infectious agent to susceptible people in the healthcare setting, and
- A means for alerting people entering an isolation area of the need to wear particular items to prevent disease transmission.

There are three (3) transmission-based precautions categories based on routes of infection transmission in a healthcare environment. These are:

- Contact precautions,
- Droplet precautions, and
- Airborne precautions.

6.4.2. Procedure

Transmission-based precautions are used for patients known or suspected to be infected with highly transmissible pathogens (e.g. influenza or other novel viruses such as coronavirus).

In general, it our practice's main goal to minimise exposure to others. This may be achieved through:

- The use of personal protective equipment,
- Distancing techniques (e.g. one and a half (1.5) metres between patients in the waiting room, isolating the patient in a separate room or in their car),
- Effective triage and appointment scheduling, including advancing these patients ahead of others,
- Hand hygiene,
- Encouraging cough etiquette and respiratory hygiene,
- Surface cleaning, and
- By avoiding touch to one's own nose and mouth.

To help prevent the transmission of communicable diseases, our patients are educated in respiratory etiquette, hand hygiene, our practice precautionary techniques (e.g. telephoning reception first if they suspect they may have influenza or coronavirus), and our distancing techniques by displaying posters and information leaflets in the waiting room and through our recorded 'on hold' message.

Where an emergency response is declared with a pandemic outbreak, whether globally, nationally or locally, our practice will follow the advice of the NSW government or health department and/or federal government in relation to the appropriate personal protective equipment respective to that pandemic situation.

To determine the appropriate personal protective equipment to be used where transmission-based precautions are required in situations less significant to that of a novel virus such as influenza, our practice follows the guidelines as described in the RACGP's *Infection prevention and control standards for general practice and other office-based and community-based practices (5th edition)*.

Requirement	Airborne transmission	Droplet transmission	Contact transmission
Gloves	No	No	For all manual contact with patient, associated devices and environmental surfaces
Impermeable gown, apron	No	No	Use when health professional's clothes are in substantial contact with the patient (including items in contact with the patient and their immediate environment)
Mask	Yes	Yes	Protect face if splash is likely
Goggles/face shield	Protect face if splash is likely	Protect face if splash is likely	Protect face if splash is likely
Special handling of equipment	Single use equipment or reprocess after patient use (includes all equipment in contact with patient)	No	Single use equipment or reprocess after patient use (includes all equipment in contact with patient)
Other	● Encourage patient to use respiratory etiquette ● Segregate patient if possible ● Give patient a mask to wear if segregation is not possible ● Communicate the patient's infectious status to other practitioners and health professionals involved in the case of the patient (e.g. ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained	● Encourage patient to use respiratory etiquette ● Segregate patient if possible ● Give patient a mask to wear if segregation is not possible ● Communicate the patient's infectious status to other practitioners and health professionals involved in the case of the patient (e.g. ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained	● Encourage patient to use respiratory etiquette ● Wash hands after removing gloves and gowns ● Communicate the patient's infectious status to other practitioners and health professionals involved in the case of the patient (e.g. ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained

Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)

6.5. Personal protective equipment

6.5.1. Policy

Our practice has personal protective equipment available, including gloves, gowns, aprons, masks, goggles, and face shields.

All members of our practice team have easy access to this personal protective equipment, receive education about the proper use of personal protective equipment, and have a clear understanding of the purpose of personal protective equipment and how to apply, remove and dispose of it.

6.5.2. Procedure

All members of our practice team have easy access to appropriate personal protective equipment; and in the areas where personal protective equipment is used, there are posters providing education on the appropriate application, removal and disposal of the items.

Personal protective equipment is located in the storage room, and the maintenance and re-ordering of the items is the responsibility of Hanna Chami.

Personal protective equipment is used in all cases where there is potential for contact with blood or body-substances including:

- Any examinations requiring contact with mucous membranes,
- Cleaning or dressing wounds, taking down bandages,
- Cleaning up after procedures,
- Preparing instruments and equipment for sterilisation,
- Assisting with or performing procedures,
- Cleaning of contaminated surfaces,
- Cleaning spills of blood and body-substances,
- Taking blood,
- Handling all pathology specimens, and
- Controlling bleeding.

Personal protective equipment is also used when handling chemicals such as liquid nitrogen.

Our practice ensures and documents that all members of the practice team receive education during their induction period and on an ongoing basis. This training focuses on the appropriate use of the various types of personal protective equipment and where to access this equipment.

Personal protective equipment includes:

- Gloves (sterile, non-sterile, general purpose utility, heavy duty puncture-resistant),
- Face masks (surgical and P2/N95 respirators),
- Goggles and face shields,
- Gowns (long and short sleeved, cuffed, disposable, reusable), and
- Plastic aprons.

All members of our practice team understand and are competent in:

- Determining the appropriate use and selecting the correct type of personal protective equipment for the presenting situation,
- Explaining the purpose of the different types of personal protective equipment, and
- Demonstrating the correct fitting and removal of personal protective equipment and the safe disposal of these items.

Disposable gloves should be used:

- When handling blood and body-substances or when contact with such is likely,
- When handling equipment or surfaces contaminated with such substances,
- During contact with non-intact skin, and
- During venepuncture – although needle stick injury may still occur, the presence of the glove layer could reduce the volume of any inoculum.

Sterile gloves should be used:

- During any surgical procedure involving penetration of the skin or mucous membrane and/or other tissue,
- When venepuncture is performed for the purpose of collecting blood for culture, and
- During procedures that require a sterile field.

Heavy duty gloves should be used:

- During general cleaning and disinfection,
- During instrument processing, and
- During cleaning of blood or body-substance spills.

Surgical masks can be used:

- During procedures or activities that might result in splashing and the generation of droplets of blood, body-substances or bone fragments,
- When there is a risk of droplet transmission of disease,

- To protect unimmunised members of the practice team and patients, and
- By the patient to prevent the spread of disease (suspected or known).

P2/N95 masks are to be worn by staff when there is a risk of airborne transmission of diseases (suspected or known) such as tuberculosis, pandemic influenza or coronavirus.

Protective eyewear should be used:

- To prevent splashing or spraying of blood and body-substances into the wearer's eyes such as during surgical procedures, venepuncture, or the cleaning of spills, contaminated areas or instruments, and
- When there is a risk of airborne/droplet transmission of disease (suspected or known).

Gowns and plastic aprons should be used when there is a risk of:

- Contamination of wearer's clothing or skin with blood and body-substances such as during surgical procedures, venepuncture, or the cleaning of spills, contaminated areas or instrument processing, and
- Airborne/droplet transmission of disease (suspected or known).

6.6. Laundry

6.6.1. Policy

All members of our practice team have received education regarding the management of soiled linen including when to change linen, storage of linen, and the use of appropriate precautions during the handling of linen.

6.6.2. Procedure

Linen needs to be changed if:

- A patient requires the use of contact precautions (e.g. known or suspected of having CA-MRSA, scabies or lice),
- Blood or body-substance has been spilt on the linen,
- It is visibly soiled, and
- Before an operative procedure.

When changing linen:

- Staff use personal protective equipment and standard precautions as required, and
- Take care to ensure sharps are not caught up in the linen.

This practice uses only disposable linen on all examination beds and patient treatment areas. Linen is changed regularly and, provided it does not contain expressible blood or body-substance, is disposed of

into the general waste bin. Any linen that is contaminated with expressible blood or body-substance is disposed of into the clinical waste bin.

6.7. Safe handling of pathology specimens

6.7.1. Policy

Laboratory investigation of specimens is integral to clinical care. Specimen collection involves the sampling of various body sites for laboratory examination which will allow for the detection and identification of micro-organisms that cause disease and, if appropriate, to determine their antibiotic sensitivity.

The quality of the specimen received in the laboratory can have a major impact on the subsequent microbiological and clinical diagnosis. Valid results rely on the specimen being of the required quantity, collected correctly and transported appropriately to the laboratory.

False results may occur if specimens are kept for prolonged periods before examination in the laboratory, as some organisms may outgrow others, whilst other delicate organisms may not survive. False results may also occur if specimens are not stored at the correct temperature.

As all specimens may contain microorganisms capable of causing disease, care must be taken to ensure that they are handled and transported in a safe manner. Although the processes of obtaining patient specimens and transporting these to the laboratory are considered to be routine practice, they are not without risk. Transmission of infection to a healthcare worker may arise from suboptimal practice.

6.7.2. Procedure

Our practice's procedures associated with the handling of pathology specimens is as follows:

- Containers are named and labelled before use to avoid the need for extensive handling after the specimen has been collected,
- After collection of blood and body-substances, these are to be placed in the appropriate specimen container, as specified by the testing laboratory,
- Wipe the container clean to remove any visible soiling and check the specimen is correctly identified,
- Securely seal the container to prevent any leakage during transport,
- Place the container upright in a waterproof bag or container,
- Take care to avoid contamination of pathology slips by keeping them separate from the clinical specimens,
- For transport between institutions and interstate, pack the primary specimen surrounded by sufficient material to absorb its contents in a sealable inner container and provide a sealable outer

container of waterproof, robust material before labelling in accordance with postal and other transport regulations, and

- Maintain any specimen to the temperature required so as to not compromise the laboratory investigation.

6.8. Response to Pandemic Outbreaks

6.8.1. Policy

A pandemic is an epidemic that occurs globally or over a widespread area, crossing international boundaries. A pandemic or public health emergency poses an imminent threat to human health as the present disease is contagious, meaning that it can be transmitted directly or indirectly by an infectious or toxic agent between sources. For a communicable disease to be considered as a pandemic, there must be little or no pre-existing immunity in humans; it must lead to illness, and it must have the capability to spread easily from source to source.

Pandemics are often, but not always, caused by influenza viruses. For the intent of the guidelines in the below procedures, the public health emergency shall be taken as contagious and posing a significant risk to human health, such as influenza or other novel viruses. These unexpected events require a quick, educated and efficient response from the practice team to minimise and eliminate risk where possible (also refer to **Section 8.2 – Risk assessment and management**)

During a pandemic, there is an increased demand for healthcare services and they are often working beyond capacity. It is critical that our practice can continue to operate during this time, where appropriate.

Our practice has appointed a member of the practice team with primary responsibility for managing and executing our pandemic response plan and sufficient training has been provided.

My Family GP response to the emergency will prioritise to the greatest extent possible, the health and safety of the organisation's practice team and the general public.

6.8.2. Procedure

Our practice has appointed Dr Belal with primary responsibility for managing and executing our pandemic response plan and sufficient training has been provided.

Our practice's *Emergency Response Business Continuity Plan* is located accreditation folder and details what measures the practice team should take to reduce risk and maintain the safety and wellbeing of team members and the public. It also details the best course of action for continuing practice's

operations, when appropriate, and the guidelines for the closure of the practice, if necessary. All practice team members are trained in our practice's pandemic response procedures.

In the event of a pandemic, our practice may experience illness of practice team members or immediate family, or the requirement of practice team members to isolate or self-quarantine. Personal issues may arise for team members, such as the need to care for children in the absence of childcare, or caring for ill family members. Other extenuating circumstances may arise, these can include but are not limited to practice team members suffering from mental anguish or autoimmune diseases, affecting their ability to be present in the practice.

All of the above may result in unplanned absences of clinical team members and as often there is an increased demand for healthcare during a pandemic, this may have an effect on the practices' ability to provide quality patient care.

In order to combat the effects of a pandemic, whilst ensuring team and patient safety, we try to prevent and minimise the spread, prepare for the impact and respond to the effects.

Preventing the spread

Preventing the surfacing of a novel virus is almost impossible; however, it is possible to limit the spread of the disease by taking rigorous precautionary measures. The control measures taken at *<insert practice name>* to limit the spread of viruses and diseases in the event of a pandemic are as follows:

- All practice staff members and patients/visitors, where appropriate, are provided with adequate personal protective equipment. This includes gowns, gloves, goggles and face masks/N95 respirators. All personal protective equipment is disposable, where possible, as viruses can remain infectious on surfaces for periods of time.
- Hand hygiene is a key standard for limiting the spread of infection year-round, and adequate hand hygiene is practiced and encouraged at all times. Staff wash their hands with warm soapy water on a regular basis and employ the use of hand sanitiser where appropriate.
- It is important to have communication with those experiencing symptoms of the occurring virus. We implement a recorded telephone message with advice for patients experiencing symptoms and erect signs on our front entrance to advise patients who are experiencing symptoms to return to their car and call the surgery for further advice.
- We limit the number of patients in the practice at any one time to 10. This ensures that patients can appropriately maintain social distancing. We encourage this by rearranging furniture, mapping out adequate spacing for patients waiting in queues, having strict appointment slots and encouraging patients to come to appointments alone, where possible.
- We have an increased cleaning schedule, including the repeat cleaning of door handles, lift buttons and hard surfaces. We also perform a thorough clean and disinfection of the practice teamwork area between shift rotations and hand sanitiser is readily available for all practice team members and patients entering the practice. (also refer to **Section 4.3 – Hand washing and hand hygiene**).

- There is no hand-shaking or unnecessary touching between team members and patients and the sharing of personal items is limited, where possible e.g. telephones, stationery.
- All children's toys are removed from the waiting area and patients are encouraged to stand instead of sit on chairs, where appropriate.
- There are temperature checks of patients and staff entering the building.

Unwell practice team members

Due to the nature of healthcare, it is not uncommon for employees to become unwell at work. If this situation occurs, its management is imperative. Our procedures for this are as follows:

- If an employee presents unwell or is showing signs of the symptoms of the virus, they are isolated from others and provided with personal protective equipment, including a disposable surgical type mask.
- They are seen by a medical practitioner in the first instance, then arrangements made for their transportation either to a hospital or to their home - public transport will not be an option.
- A record and contact details are kept of all personnel who become ill and leave the workplace and the people they have had contact with.
- Once the suspected infected person has vacated the premises, their work area and communal areas are thoroughly cleaned and disinfected.
- Unwell personnel cannot return to work until they have received approval by a medical professional or a negative test result.

Preparing for the impact

Planning and preparation in advance of a pandemic is likely to significantly reduce the number of people affected. Being prepared and having a plan to implement appropriate measures when a pandemic occurs not only improves the health outcomes of those affected, but can help to protect essential services including the practice and critical infrastructure.

These are the measures that we implement to reduce the effects of a pandemic:

- The minimum staffing levels required to operate the practice is 2 GPs, 1 nurses and 1 receptionist. We also analyse the composition of the workforce e.g. how many might be parents or have other caring responsibilities and have adequate procedures in place for unexpected absences
- At all times the practice is appropriately stocked with clinical and non-clinical supplies and ordering of extra essential supplies. Personal protective equipment is purchased when required and stock levels are maintained.
- Minor, non-urgent appointments are postponed in order to limit the number of people attending the practice.
- Telephone and video conferencing appointments are offered in the first instance where appropriate, as this significantly reduces the number of people attending the practice and minimises the risk of spreading infections/viruses (also refer to **Section 7.23 – Telehealth**).

- Communication is key in the midst of a pandemic, and we effectively keep in touch with our patients as well as other organisations, updating them with any relevant, critical information. We communicate with stakeholders by touching base with our patients via email communications, sending them updates about the practice, opening hours and services available.
- We have informative posters placed in the practice advising patients of relevant precautions and steps to take, including on our practice door we have displayed a poster which advises patients with any of the listed symptoms to remain outside the practice and call for further instructions.
- The use of our air conditioning system is avoided. We keep the practice well ventilated by increasing outdoor air intake.
- We hold daily practice team meetings, providing team members with regular updates and briefings on any procedural changes.
- All team members are extensively vetted in regards to working from home arrangements, and a thorough work health and safety assessment will be conducted before commencing such, ensuring the respective team members have an appropriate and safe workspace that allows them to perform their duties comfortably.
- We have a database in which all team members' home telephone numbers and email addresses are stored. This information is treated with high sensitivity and is only to be used in complete emergencies if the team member is uncontactable using usual work methods e.g. work email address, work telephone number. All team members are able to opt out of having these details stored on the pandemic plan contacts list.
- All employee vaccinations are up to date and appropriate seasonal vaccinations are offered to all staff in order to reduce the transmission of infectious diseases, limiting the risk of staff falling unwell.
- All practice team members have been appropriately trained in our pandemic response plan.

Respond to effects/recovery

As the pandemic subsides, there is a planned recovery phase to assist in normalising services and getting work activities back on track. In order to fully recover from the pandemic, consideration is given to the restoration of social, economic, physical and emotional wellbeing. Actions required during this stage will be dependent on the impact that occurred on the usual operations of the practice. Any control measures implemented should be loosened in accordance with the threat of the virus and broader public health measures.

In order to recover from the pandemic strategically and effectively, a pandemic recovery team should be established. The pandemic recovery team will be responsible for the development and coordination of the practice's recovery plan.

In our practice, the membership of the pandemic recovery team consists of the practice owners. Team responsibilities consist of:

- Keeping up to date with the evolving situation and determining the impact this may have on the practice, as well as the implementation and the safe removal of control measures.
- Reporting to senior staff members regularly on the effects on the practice and stages as well as the effectiveness of recovery.
- Ensuring that any affected practice staff condition is assessed regularly, determining when it is safe for them to return to work, and when working from home/leave arrangements should be continued.
- Tracking the status of practice staff who have become unwell and alerting those who they have been in contact with.
- Touching base with the clinical and administration teams regularly to monitor any loss of staff, the impact this has had on the team and arranging for stand in team members where possible.
- Determining the stages of the recovery plan, the continued duration of the plan, and when the plan is no longer required.

The pandemic recovery team will also take into consideration existing business continuity plans (also refer to **Section 3.17– Non-medical emergency response and business continuity**).

Pandemic Response Analysis

From the impact of a pandemic, it is important to assess and analyse the response measures that were taken and determine what worked well and how things can be improved if the situation were to occur again.

Evaluations of the weaknesses that occurred when handling the situation are crucial for determining improvements and minimising risk in the future. It is also critical to capture any strengths from the practice response and effective control measures as they may be permanently implemented into daily operations of the practice.

When reviewing the practice recovery systems and their ability to combat the impacts of the pandemic, the following is considered:

- Key lessons learned,
- Key strengths of response to the pandemic,
- Key weaknesses of response to the pandemic,
- Changes needed to improve the practice pandemic response,
- Updates required for business continuity plan in response to implemented changes, and

Support for Practice Team Members

Working in healthcare may produce anxiety among staff during a pandemic. We have control measures in place including promoting a supportive work environment, providing practice team members with up

to date, relevant critical information in regards to developments on the virus and other protective measures that have been taken in the work place.

During the midst of a pandemic, practice team members may experience unfamiliar work and increased workloads. In an effort to reduce stress in these circumstances, our practice sets clear performance expectations and promotes a supportive team environment, setting daily goals. We also closely monitor and supervise each practice team member with the employee assistance programs available, as required.

It is also common that some practice team members experience psychological strain due to fatigue and insomnia. At our practice, we support our practice team members by:

- Advising all team members that their health and wellbeing is our priority.
- Where possible, we allow practice team members to work from home in an effort to reduce the potential for their exposure to an infectious person.
- Giving up to date, accurate information to all team members on decisions or changes in processes, including the control measures being implemented.
- Offering counselling and support to all staff members that have been affected, physically, mentally or those who have experienced a loss due to the pandemic;
- Encouraging all team members to create a self-care plan and supporting them in this development (also refer to **Section 3.7 – Self-care**).
- When working from home, hosting daily catch-ups via video calls to keep visually connected.
- Providing advice from credible sources.

7. Practice management

7.1. Access and parking

7.1.1. Policy

Our practice recognises that access to our services and facilities is important to our patients. We make all reasonable efforts to facilitate physical access to the premises and services offered and are committed to considering how best to meet the needs of our patients with physical disabilities or other special needs.

Where possible, wheelchair access, suitable parking and pictorial signage are provided to assist patients with a physical or intellectual disability.

Where physical access is limited to the practice and its facilities, or where physically attending the practice could result in an adverse outcome for the patient, the practice provides off-site or home visits (refer to **Section 5.3 – Home and other visits**).

Car parking facilities are available within a reasonable distance from the practice for our team members, visitors and patients; and where possible, there are designated spots for disabled drivers.

External and internal lighting is sufficient to facilitate safe access for all members of the practice team, visitors and patients at night.

Sufficient signs are provided externally and internally to assist visitors and patients in accessing the practice facilities.

7.1.2. Procedure

Designated parking for our general practitioners and other members of the practice team is available behind the practice. All other parking areas are designated for patients and visitors.

This practice provides physical access to patients, visitors and practice team members via the main entrance or through the pharmacy.

Ambulance trolley access is provided to the practice reception and consulting/treatment rooms via front door.

Our practice has a height adjustable bed in each consulting/examination room to assist in the care of patients with a disability, and to reduce the risk of patients (or practice team members assisting) injuring themselves when getting on or off the examination bed.

Doorways and walkways are kept free of clutter to ensure a clear pathway for all persons and in an emergency.

Prominent signs at the front of the practice allow the public to easily locate our practice and the parking facilities from the street. External signage also displays the practice name, address, opening hours, and telephone numbers (both within and outside normal opening hours).

Any external lights noted not to be operating are to be reported to Dr Ejje or Dr Awad immediately.

Our practice has provisions for patients with disabilities to access our services and facilities through:

- Wheelchair accessibility to our reception, toilets and consulting rooms
- Installed ramps and railings in common patient entry and access areas, and
- Designated parking in close proximity to the entrance.

7.2. Appointments

7.2.1. Policy

Our patient scheduling system is flexible enough to accommodate patients with urgent, non-urgent, complex and planned chronic care, and preventative needs.

The individual preference of our general practitioners or other healthcare providers, such as our nurses, is accommodated and members of the clinical team are consulted about the length and scheduling of appointments.

Patients can request to see their preferred general practitioner or member of the health team.

The length of clinical consultations will vary according to individual patient needs. Our aim is to provide enough time for adequate communication between patients and their practitioners to facilitate preventative care, effective record keeping and patient satisfaction. Patients are encouraged to ask for a longer appointment if they think it is necessary.

Our practice endeavours to accommodate patients with urgent medical matters even when fully booked.

All practice team members are trained to have the skills and knowledge to assist patients in determining the most appropriate length and timing of consultations and to recognise and act accordingly for patients with urgent medical matters.

Where possible, information is provided in advance about the cost of healthcare and the potential for out-of-pocket expenses.

We endeavour to respect patients' cultural backgrounds and, where possible, meet their needs including providing privacy for patients and others in distress.

7.2.2. Procedure

Each general practitioner and other healthcare provider (such as nurses and allied health) have specific times allocated to their consulting sessions to accommodate the need for interval times, short and long consultations, diagnostic tests, procedures etc. Each general practitioner also has a designated time allocated for home or other visits to see patients that are unable to attend the practice.

Generally, no more than six (6) appointments are made for any one (1) hour period and we aim to ensure no appointment is scheduled for less than ten (10) minutes. Patients are advised that one appointment is required for each family member requesting to be seen where more than one family member needs to consult with a general practitioner.

Patients are able to request their preferred general practitioner when making an appointment and our practice team will endeavour to ensure that patients generally see the same practitioner. If patients are unable to obtain an appointment with the general practitioner of their choice, they are advised of the availability of other practitioners they can consult with. A patient can expect to see their practitioner, or an alternative as approved, within two (2) working days.

If a third party is to be present during a consultation/treatment, whether requested by the general practitioner or accompanying the patient, consent from the patient will be obtained prior to the consultation (refer to **Section 7.10 - Third party observing or clinically involved in the consultation**).

Our practice information sheet outlines the types of consultations that may require a longer consultation and the costs. Patients can readily request a longer time when making an appointment.

Our practice team members have the skills and knowledge to assist in determining the most appropriate length and timing of appointments. Should a longer consultation be requested or is determined by information received from the patient, our team will endeavour to allocate the appropriate time for a longer consultation.

Our practice aims to ensure patients do not wait past their appointment time; however, where patients will likely be waiting more than 30 minutes, we will communicate these delays. Wherever significant delays are expected, we aim to contact patients prior to them attending the practice to advise of the delay.

As a priority, practice team members are vigilant of the need to detect and place requests for urgent care for immediate or timely attention by a general practitioner; our practice accommodates urgent care even if we are fully booked (refer to **Section 5.9 - Medical emergencies and urgent queries**).

Cancellations and 'no-shows' are monitored and marked accordingly in the appointments schedule and these patients are followed up as appropriate. Attempts to contact patients that fail to attend appointments are documented in the patient's health record.

Appointments made for patients required to attend a recall or periodic medical review are flagged so that if a patient cancels the appointment the practice team are alerted to ensure another appointment time is scheduled. If the patient fails to attend the practice for the appointment, the general practitioner is alerted to determine the appropriate action to be taken (i.e. contacting the patient to arrange a re-scheduled appointment time) (refer to **Section 7.7 - Follow up of tests, results and referrals**).

When booking an appointment, our practice team members obtain the patient's name and correctly identify the patient using three (3) approved identifiers in accordance with **Section 7.6 – Patient identification** then:

- Determine the urgency of the appointment,
- Determine the length of the appointment required (i.e. does the patient have complex medical or communication needs or multiple health matters they want to discuss?),
- Annotate any appointments made for a periodic review (e.g. blood pressure check) or medical recall (e.g. abnormal pathology result) so follow up procedures can be instigated if the patient does not attend,
- Advise of any potential for additional or out-of-pocket costs associated with longer, urgent or missed consultations,
- If the general practitioner requested is not available at the preferred time, give the nearest available time/day before asking the patient if another general practitioner would be suitable,
- Provide suggested appointment times if needed,
- Record the patient surname and given name in the agreed timeslot for the chosen general practitioner, and
- Verbally re-confirm to the patient their name, scheduled appointment time and general practitioner being seen.

If the patient scheduling the appointment is new to the practice:

- Inform them of the practice location and parking arrangements,
- Outline consultation costs and payment methods,
- Obtain their contact telephone number/s, address and other demographics, and
- Ask the patient to bring list of current medications where applicable.

Cancellations and missed appointments

Patients who do not attend for their scheduled appointment are telephoned to determine if an appointment is still required and if another appointment is to be scheduled. If the patient cannot attend the same day, use computer program instructions to delete the appointment whilst enabling the tracking of the cancellation for medico-legal purposes.

Patients that fail to attend a recall or periodic medical review appointment

For appointments of significance, it is imperative every attempt is made to contact these patients and that such attempts are documented in the patient's health record.

In attempting to contact the patient, it is recommended that the telephone calls are made at different times of the day and should the patient not respond, a follow up letter is sent requesting the patient contact the practice (also refer to **Section 7.7 – Follow up of tests, results and referrals**).

Patients in distress

We respectfully manage patients and others in distress by providing privacy through placing them in a spare room.

7.3. Home and other visits

7.3.1. Policy

Where safe and reasonable, our practice makes visits to regular practice patients in their homes, aged or residential care facilities, or in hospitals within and outside of normal working hours. Our practice has decided upon a reasonable distance within which visits can be conducted.

All patients are made aware that home and other visits are a suitable care alternative that is available both within and outside normal opening hours and that the provision of a home or other visit is determined by the patient meeting pre-determined eligibility criteria.

For regular patients whose circumstances are deemed not safe and/or reasonable, the practice ensures that there is an alternate system of care that these patients can access.

There are documented arrangements in place to exchange clinical details about patients to general practitioners who perform home and other visits on behalf of the patient's regular practitioner, and to ensure that all off-site care provided is documented in the patient's health record held in the practice.

Home and other visits are provided by appropriately qualified health professionals who have received information and advice about safety and security when conducting off-site visits.

Any anticipated costs associated with home visits or alternative care systems are discussed with the patient in advance.

7.3.2. Procedure

A patient can arrange for a home or other visit or a general practitioner may request to see a patient in their place of residence if the following criteria are met:

- The patient is a regular patient of this practice,
- The patient resides in a location that is within 5km radius of the practice,
- Where it is safe and reasonable,
- The practice has the correct contact details for the patient on file, and
- The patient has the type of problem that necessitates a home visit such as:
 - Acutely ill
 - Immobile
 - Elderly
 - No means of transport
 - Unable to access the practice facilities due to disability

When receiving a request for a home or other visit from a patient, the practice team refer to our triage protocols to determine the urgency of the request. Where necessary, advice is sought from the patient's usual general practitioner when scheduling the visit (refer to **Section 5.9 – Medical emergencies and urgent queries**).

All home and other visits recorded in the appointments schedule are noted as such.

Where patients with regularly scheduled home or other visits request a visit outside of this time, the request is referred to the patient's general practitioner who will confirm if this additional visit is required.

Where home or other visits are performed by a service on behalf of our practice, documented arrangements exist that include the requirement for timely exchange of clinical information about the patient's care, how the service can access the patient's usual general practitioner in exceptional and emergency circumstances, and assurance that care will be provided by appropriately qualified health professionals.

Notes of all consultations conducted through a home or other visit, both within and outside normal opening hours, are documented in the patient's health records. If information about the patient is held in two separate records systems (e.g. electronic and paper-based) there must be a record made of every consultation in each system indicating where the full clinical notes of the consultation is recorded so that all general practitioners, including locums, who consult that patient know to look at both systems in order to access all relevant information.

All general practitioners and other healthcare professionals undertaking home or other visits are given information and advice about protecting their safety.

There may be occasions where it is unsafe or unreasonable to provide a patient requesting care at home with a home visit; this may apply after-hours or within opening hours. Our practice advises the following options: name, telephone number and location of the nearest emergency department of the local hospital. This advice is documented in the patient's health record.

7.4. Telephone

7.4.1. Policy

An incoming telephone call is the principal method for initial and subsequent communication by a patient and most other persons to this practice. As such, the telephone is recognised as a vital vehicle for creating a positive first impression, displaying a caring, confident attitude and acting as a reassuring resource for our patients and others.

Our aim is to facilitate optimal communication opportunities with our patients. Our general practitioners and other team members are aware of alternative modes of communication used by patients with a disability or a language barrier.

Some patients may be anxious, in pain or distracted by their own or a family member or friend's medical condition. Our practice team members provide a professional and empathetic service whilst attempting to obtain adequate information from the patient or caller.

Our practice team members are trained not to argue with, interrupt or patronise callers. Courtesy should be shown to all callers and allow them to be heard; every call should be considered important.

My Family GP prides itself on the high calibre of customer service we provide, especially in the area of patient security, confidentiality, and right to privacy, dignity and respect. Team members are mindful of confidentiality requirements to ensure patient names or clinical discussions about patients are not openly stated over the telephone when within earshot of other patients or visitors.

It is important for patients telephoning our practice to have the urgency of their needs determined promptly. Our practice team try to obtain adequate information from the patient to assess whether the call is an emergency before placing the caller 'on hold'. Our team members are trained during induction, and on an ongoing basis, to recognise urgent medical matters and the procedures for obtaining urgent medical attention, and when to escalate a telephone call to a member of the medical or clinical team.

Patients of our practice are able to access a member of our medical or clinical team by telephone to discuss their clinical care. When telephone communication is received, the urgency and nature of the call is gathered to determine if the call will be transferred immediately or if a message will be taken for the call to be returned. In non-urgent situations, patient calls should not interrupt consultations with other patients. Our practice team members are aware of each practitioner's policy on accepting and returning telephone calls.

Patient messages taken for follow-up by a general practitioner or other practice team member are documented for their attention and action or, in their absence, for the designated person who is responsible for that absent team members' workload. This is done by having a designated messages notebook for each practitioner.

Only a member of the medical or clinical team can provide treatment or advice over the telephone. Patients are advised through information contained in the practice information sheet and from the practice team member receiving the call, if a fee will be incurred for the telephone advice to be provided.

7.4.2. Procedure

All members of the practice team are familiar with each medical and clinical team's policy of receiving and/or returning telephone calls and each team member's preference is documented and available from reception desk.

Any personal calls received are kept brief so as to remain mindful of engaging the telephone lines.

A comprehensive telephone answering machine message, both during and outside normal opening hours, is maintained and activated to advise patients of our after-hours care arrangements and the advice to call '000' in an emergency.

All members of the practice team are aware of alternative modes of communication that may be used by patients with a disability or special needs, including the National Relay Service (NRS) for callers with hearing impairments, and Translating and Interpreter Service (TIS) for patients who do not speak the primary language of our practice team. We ensure their use is conducted with appropriate regard for the privacy and confidentiality of health information and that patients are made aware of any risks these modes may pose to the privacy and confidentiality of their health information or any additional out-of-pocket costs, e.g. the requirement for a longer appointment.

Important or clinically significant communications with or about patients are noted in the patient's health record, and we have provisions for patients' usual general practitioners to be contacted after-hours for life threatening or urgent matters or results.

All telephone messages received are returned in a timely manner.

When receiving an incoming telephone call, our practice team members follow this procedure:

- Pick up the telephone receiver within three (3) rings,
- Answer by stating "My Family Gp, this is [your name] speaking, how may I help you today?"
- If the caller has not identified themselves – ask their name,
- If the call is for an appointment, refer to **Section 5.2 – Appointments**,
- If the call is assessed as an emergency or urgent query, refer to the steps outlined in **Section 5.9 – Medical emergencies and urgent queries**,
- If the caller is inquiring about their results from recent tests or investigations performed, do not disclose any information and refer to **Section 7.7 – Follow up of tests, results and referrals**,
- If the caller requests to speak with a specific general practitioner, refer to the general practitioner's policy on receiving and returning telephone calls:
 - Reception staff will take the message and pass it onto the practitioner. If the matter is urgent, the patient will be put on hold, the practitioner will advise whether to transfer the patient's call or be given a call back.
- If taking a message or when assessing the caller's needs, do not hurry the caller - if necessary repeat your questions or re-state the message taken:

- telephone messages from patients and others are given to the person for whom they are intended on the day of receipt or in that person's absence, to the person who is managing that absent team members patients, e.g. place a note on the patient's health record, or in practitioner's in-tray or send an email etc
- Never attempt to diagnose or recommend treatment over the telephone,
- Encourage the caller to write down any instructions resulting from the telephone call,
- Have the caller repeat any instructions given to assess their understanding of what was said, and
- Ensure the caller's consent is obtained prior to placing them on hold in case the call is an emergency.

A log book is used to record all significant and important telephone conversations, including after-hours contact, medical emergencies and urgent queries. The log records the:

- Name and contact telephone number of the patient/caller,
- Date and time of the call,
- Urgent or non-urgent nature of the call,
- Important facts concerning the patient's condition,
- Advice or information received from the general practitioner or other healthcare team member (e.g. nurse), and
- Details of any follow up actions necessary.

Details of telephone or attempted telephone contact with a patient (whether initiated by our practice team or the patient) is recorded in their health record, including the:

- Reason for the contact,
- Advice and information given, and
- Details of the outcome of that attempt (e.g. message left on answering machine) where team members have attempted to contact the patient.

Calls 'on hold'

It is important to try to obtain adequate information from the patient/caller to assess whether the call is an emergency before placing the call on hold. If another incoming call registers and no other practice team members are available to answer the incoming call, ask to put the caller on hold or seek to terminate the call with an offer to call them back to continue the discussion.

Do not leave the caller on hold for long periods. Return to the caller periodically if there is a significant delay in managing their call (e.g. waiting to transfer the call to another member of the practice team who is not immediately available) to re-confirm the caller remains satisfied to wait or if they would rather a message for a return call be taken.

Our practice 'on hold' message provides the advice to call '000' in case of an emergency.

7.5. Communication with patients by electronic means

7.5.1. Policy

Our practice is mindful that even if patients have provided electronic contact details, they may not be proficient in communicating via electronic means and patient consent needs to be obtained before engaging in electronic communication. Electronic communication includes email, facsimile and Short Message Service (SMS).

Communication with patients via electronic means is conducted with appropriate regard to privacy.

7.5.2. Procedure

Our practice's primary reason for communicating electronically to patients is to issue appointment reminders and we verify the correct contact details of the patient at the time of the appointment being made.

Whilst not encouraged, our practice allows patients an opportunity to obtain advice or information related to their care by electronic means, but only where the general practitioner determines that a face-to-face consultation is unnecessary and that communication by electronic means is suitable. Our practice will only provide information that is of a general, non-urgent nature and will not initiate electronic communication (other than SMS appointment reminders) with patients. Any electronic communication received from patients is also used as a method to verify the contact details we have recorded on file are correct and up-to-date.

Communication with patients via electronic means is not conducted with appropriate regard to privacy.

Our practice also has an automatic email response system set up so that whenever an email is received into the practice, the sender receives an automated message reinforcing information regarding these risks.

When an email message is sent or received in the course of a person's duties, that message is a business communication and therefore constitutes an official record. Patients are informed of any costs to be incurred as a result of the electronic advice or information being provided, and all electronic contact with patients is recorded in their health record.

All members of the practice team are made aware of our policy regarding electronic communication with patients during induction, and are reminded of this policy on an ongoing basis. They are made aware that electronic communications could be forwarded, intercepted, printed and stored by others. Each member of the practice team holds full accountability for emails sent in their name or held in their mailbox, and

they are expected to utilise this communication tool in an acceptable manner. This includes, but is not limited to:

- Limiting the exchange of personal emails,
- Refraining from responding to unsolicited or unwanted emails,
- Deleting hoaxes or chain emails,
- Not opening email attachments from unknown senders,
- Virus checking all email attachments,
- Maintaining appropriate language within electronic communications,
- Ensuring any personal opinions are clearly indicated as such, and
- Confidential information (e.g. patient information) must be encrypted.

Our practice reserves the right to check an individual's email accounts as a precaution to fraud, viruses, workplace harassment or breaches of confidence by members of the practice team. Inappropriate use of the email facility will be fully investigated and may be grounds for dismissal.

The practice uses an email disclaimer notice on outgoing emails that are affiliated with the practice stating: The information enclosed with this transmission is the private, confidential property of the sender, and the material is privileged communication intended solely for the individual indicated. If you are not the intended recipient, you are notified that any review, disclosure, copying, distribution, or the taking of any other action relevant to the contents of this transmission is strictly prohibited. If you have received this transmission in error please notify us immediately at (02) 8766 4366.

7.6. Using social media in our practice

7.6.1. Policy

'Social media' is defined as online social networks used to disseminate information through online interaction.

Regardless of whether social media is used for business related activity or for personal reasons, the following standards apply to members of our practice team, including general practitioners. Practitioners and team members are legally responsible for their postings online. Practitioners and team members may be subject to liability and disciplinary action including termination of employment or contract if their posts are found to be in breach of this policy.

7.6.2. Procedure

Our practice has appointed Dr Belel Ejje as our social media officer with designated responsibility to manage and monitor the practice's social media accounts. All posts on the practice's social media websites must be approved by this person.

When using the practice's social media, all members of our practice team will not:

- Post any material that:
 - Is unlawful, threatening, defamatory, pornographic, inflammatory, menacing, or offensive
 - Infringes or breaches another person's rights (including intellectual property rights) or privacy, or misuses the practice's or another person's confidential information (e.g. do not submit confidential information relating to our patients, personal information of staff, or information concerning the practice's business operations that have not been made public)
 - Is materially damaging or could be materially damaging to the practice's reputation or image, or another individual
 - Is in breach of any of the practice's policies or procedures
- Use social media to send unsolicited commercial electronic messages, or solicit other users to buy or sell products or services or donate money,
- Impersonate another person or entity (for example, by pretending to be someone else or another practice employee or other participant when you submit a contribution to social media) or by using another's registration identifier without permission,
- Tamper with, hinder the operation of, or make unauthorised changes to the social media sites,
- Knowingly transmit any virus or other disabling feature to or via the practice's social media account, or use in any email to a third party, or the social media site,
- Attempt to do or permit another person to do any of these things:
 - Claim or imply that you are speaking on the practice's behalf, unless you are authorised to do so
 - Disclose any information that is confidential or proprietary to the practice, or to any third party that has disclosed information to the practice
- Be defamatory, harassing, or in violation of any other applicable law,
- Include confidential or copyrighted information (e.g. music, videos, text belonging to third parties), and
- Violate any other applicable policy of the practice.

All members of our practice team must obtain the relevant approval from our social media officer prior to posting any public representation of the practice on social media websites. The practice reserves the right to remove any content at its own discretion.

Any social media must be monitored in accordance with the practice's current policies on the use of internet, email and computers.

Our practice complies with the Australian Health Practitioner Regulation Agency (AHPRA) national law, and takes reasonable steps to remove testimonials that advertise our services (which may include comments about the practitioners themselves). Our practice is not responsible for removing (or trying to have removed) unsolicited testimonials published on a website or in social media over which we do not have control.

Any social media posts by members of our practice team on their personal social media platforms should:

- Include the following disclaimer example in a reasonably prominent place if they are identifying themselves as an employee of the practice on any posting: *'The views expressed in this post are mine and do not reflect the views of the practice/business/committees/boards that I am a member of'*, and
- Respect copyright, privacy, fair use, financial disclosure and other applicable laws when publishing on social media platforms.

Social media activities internally and externally of the practice must be in line with this policy.

7.7. Practice website

7.7.1. Policy

Our practice is committed to making information about our practice and its services readily accessible for all patients and the community. One way to achieve this is through our practice website.

7.7.2. Procedure

In complying with the *Privacy Act 1988*, our practice provides the following advice to users of our website about the collection, use and disclosure of personal information. The aim of this advice is to inform users of our website about:

- What personal information is collected by our practice,
- Who is collecting the personal information,
- How personal information is used by our practice,
- Access to personal information collected by our practice, and
- Security of personal information collected by our practice.

The practice's privacy policy is posted on the website and is available for download. The website is continually monitored to ensure it is kept current and up-to-date and contains at a minimum the information included on our practice information sheet (refer to **Section 5.18 – Practice information sheet**). Any changes to our practice information sheet are also reflected on the website.

As our website contains advertisements from time to time, we ensure any advertising complies with the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia* and includes a disclaimer on any advertising which states that the practice does not endorse the advertised services or products.

7.8. Visitors

7.8.1. Policy

Patients and other visitors are welcome to our practice. All members of our practice team value the principles of good relations whether it is in person, by written or electronic form, or on the telephone. Persons including all types of visitors, e.g. patients, relatives, friends, healthcare providers, students, pharmaceutical and other business service representatives, food service suppliers and tradesmen are shown friendly, courteous recognition and assistance.

7.8.2. Procedure

When a person presents at reception or lingers in the main entrance or other areas of the practice and remain unidentified, our team members ask the person if they require assistance to elicit the reason for their presence on our site. If they are found in other areas of the practice, ask the person to wait in the waiting room.

If the visitor looks suspicious, we are to call upon a general practitioner or other member of the practice team to assist.

If the person is not a patient but is booked to see a general practitioner or other member of the practice team, alert the relevant person that their visitor has arrived.

If the visitor is an unsolicited representative with no appointment pre-arranged, we are to schedule an appointment for the visitor to come back at that booked time.

Visitors who will require moving throughout the building are to sign the *Visitors Book* and enter the time of their arrival and departure; a visitor's badge is supplied whilst on the premises. The receptionist is to be advised whenever these visitors are in the practice.

7.9. Medical emergencies and urgent queries

7.9.1. Policy

This practice classifies patients seeking medical consultations according to priority of need. Our triage system ensures that clinical care is provided to patients with urgent medical problems as a priority.

Patients telephoning the practice have the urgency of their needs determined promptly. All members of our practice team know and use the triage process, a copy of which is accessible at reception.

Administrative staff and members of the medical and clinical team have the skills and knowledge to assess the urgency of the need for care and can describe our procedures for dealing with urgent medical matters, including when the practice is fully booked.

Our induction process includes an orientation to our triage system and all team members are given training to its effective use and are encouraged to regularly update their first aid skills, including undertaking training in cardiopulmonary resuscitation.

Our practice has a pandemic plan which outlines our response to and management of patients with possible communicable diseases such as influenza or other novel viruses (e.g. coronavirus).

When telephoning the practice, our practice team members ask the caller if their call relates to an emergency before placing them on hold. Our recorded telephone answering machine messages, both during and outside of normal opening hours, include a recommendation to call '000' if the matter is an emergency.

Our general practitioners and other members of the practice team provide appropriate care and privacy for patients and others in distress.

We have provisions for general practitioners to be contacted after-hours for life threatening or urgent matters or results.

7.9.2.Procedure

All members of our practice team, including general practitioners and other healthcare professionals (i.e. nurses and allied health) receive regular training and updates in cardiopulmonary resuscitation at least every three (3) years.

All team members receive information at induction and on an ongoing basis about our triage guidelines and protocols for medical emergencies and possible communicable diseases, e.g. pandemic influenza or coronavirus.

Documentation of all triage and medical urgency and emergency training is retained in each practice team member's employment or contract file.

In accordance with triage guidelines, our front desk team members aim to obtain adequate information from the patient to assess the nature and urgency of their problem. This occurs when making an appointment (for telephone calls or walk-ins), before placing a caller on hold, and while observing patients in the waiting room.

Patients are informed that they will be asked about the nature of urgent problems to assist with prioritising the scheduling of their appointment. Should the matter be urgent, patients are advised of any potential for out-of-pocket costs where the use of specific practice materials/equipment is required or a longer consultation is necessary.

A computer entry is used to record all significant telephone conversations or actions including medical emergencies and urgent queries incorporating:

- Name and contact telephone number of the patient/caller,
- Date and time of the call,
- Urgent or non-urgent nature of the call,
- Important facts concerning the patient's condition,
- Advice or information received from the general practitioner (or clinical team member), and
- Details of any follow up appointments.

7.10. After-hours service

7.10.1. Policy

This practice ensures reasonable arrangements for medical care, including the follow up of seriously abnormal and life-threatening pathology results for our patients outside our normal opening hours.

The arrangements for medical care outside normal opening hours including how to access this care and the possibility of out-of-pocket costs, is communicated clearly to patients of this practice.

In our practice, we offer after-hours care to patients of our practice by having formal arrangements with an accredited medical deputising service.

As our practice has a formal written arrangement with another service to provide care to our patients during the after-hours period, this arrangement details how we receive information about any care that is provided to our patients and how the general practitioner providing the care can contact the practice for clarification or help regarding background information relating to a patient, especially in an emergency.

Feedback about the quality and timeliness of after-hours care provided to our patients by the after-hours service provider is obtained, and patient satisfaction with our after-hours service is regularly evaluated and improvements implemented if necessary.

To facilitate continuity of care, we ensure any reports or notes pertaining to consultations occurring outside the normal opening hours, either by or on behalf of our practice, are incorporated into the patients' health records in a timely manner.

Our practice has provisions enabling pathology providers to contact a patient's general practitioner or other member of our medical team where significant and life-threatening pathology results are identified outside our normal opening hours.

7.10.2. Procedure

Our practice's normal opening hours are Mon-Fri 8:00-17:00, Saturday 9:00-14:00.

Advice to our patients on how to access care during the after-hours period, including the potential for out-of-pocket expenses, is available:

- By our telephone answering machine message
- In the practice information sheet,
- On a sign visible from outside the practice, and
- On our practice website.

For calls received after-hours, our practice has a comprehensive message on the answering machine that includes the practice's opening hours, details of the after-hours care arrangements in place (including a contact telephone number) and a recommendation to call '000' if the matter is an emergency.

In our practice, we offer after-hours care to patients of our practice by having formal arrangements with an accredited medical deputising service.

Sometimes our general practitioners may need to be contacted during the after-hours period by Sydney Medical Services or 4Cyte pathology service about a serious or life-threatening matter. We have provided these organisations with a list of the after-hours contact numbers of our general practitioners and, in the event they cannot be contacted, an alternative person to contact in their absence. This list is reviewed and updated on a regular basis to ensure the numbers and contacts remain current.

Any correspondence or notification received about after-hours care provided to a patient of our practice is documented in the patient's health record.

As our practice has a formal arrangement with another service to provide care to our patients during the after-hours period, the documented agreement includes:

- Adequate information to ensure the after-hours care provider is familiar with the practice's requirements, especially in regard to receiving urgent and life-threatening results for a patient or managing an emergency or complex problem,
- A defined means of access for the after-hours service provider to the patient's health record maintained at our practice and, for exceptional circumstances only, to the patient's usual general practitioner (or designated practitioner in their absence),

- A requirement for timely reporting of the care provided or a handover of care back to the patient's usual general practitioner,
- Evidence that the care will be provided by appropriately qualified health professionals, and
- Evidence of the accreditation status of the after-hours service provider.

7.11. Practice meetings

7.11.1. Policy

Regular discussions where all members of the practice team are encouraged to have input are important in building a high performing team. We aim to cultivate a just, open and supportive culture where individual accountability and integrity is preserved, but there is a whole-of-team approach to the quality of patient care.

Practice meetings are conducted on a regular basis or more frequently as required to facilitate the exchange of practice news, other general administration and protocol issues, complaints and to discuss risk management issues arising out of the practice. Matters pertaining to clinical care may be discussed at these meetings if appropriate, or during clinical meetings.

Urgent daily notices and other general items for immediate attention are written in a communication book which is kept at reception. All members of the practice team are required to read the notices in this book, and to initial the book to acknowledge they have read this information during each work session.

7.11.2. Procedure

Practice team meetings

It is important that all members of the practice team have the opportunity to discuss administrative issues with the practice directors and/or owners when necessary; they are, therefore, supported and encouraged to attend our practice team meetings.

Practice team meetings are held once every 2 months and minutes are recorded. Calls for items for the agenda are made at least two (2) weeks prior to the scheduled meeting, and may be submitted to the practice manager up to one (1) week prior to the meeting. All members of the practice team are expected to attend, unless they are on planned or unplanned (e.g. sick) leave.

Administrative and workplace health and safety procedures are regularly reviewed at these meetings, and discussion and suggestions for improvement to quality, patient safety or policies and procedures associated with risk management is a standing agenda item.

Practice discussions about near misses, slips or lapses, with the intention of identifying what went wrong and how to reduce the likelihood of it happening again, are included in the practice team meeting where appropriate.

Any decisions made during the practice team meetings are documented, along with the person responsible for implementing the related action.

Outside of these planned meetings, all members of the practice team are encouraged and supported to raise any matters for discussion with the practice owners/directors/practice manager when necessary.

Clinical team meetings

Good communication between members of the clinical team is important for ensuring a consistent approach to clinical care. All members of our medical and clinical team meet face-to-face on a monthly basis to formally discuss clinical matters. In between these scheduled meetings, a communication book and emails are used to consider and communicate clinical issues.

Dr Beleb Ejje as the person with designated responsibility for leading clinical improvement in our practice, is appointed Chair of the clinical team meetings. Practice protocols, near misses, lapses or mistakes are a standing item on the agenda, and latest literature reviews may also be discussed during these meetings. All clinical team meetings to be scheduled in the coming calendar year are disseminated in the month of January to ensure all members of the medical and clinical team can arrange to attend.

Patient care and case studies are discussed during clinical team meetings which help to facilitate consistency of care by all general practitioners, practice nurses, allied health professionals and other healthcare professionals within our practice in the diagnosis and management of our patients. There is also a standing discussion item about clinical issues, support systems, new guidelines and evidence. This includes a review of patient information brochures used for preventative activities and to support management or treatment choices to ensure they are of appropriate quality, and that all members of the team are giving consistent information.

Clinical issues, updates, case studies and reports of continuous quality improvement (CQI) activities, complaints and incident reviews are presented, discussed and action taken as required, helping to improve processes and patient outcomes.

8. Patient rights

8.1.1. Policy

Our practice respects the rights and needs of all patients.

8.1.2.Procedure

No patient is refused access to clinical assessment or medical treatment on the basis of gender, race, disability, Aboriginality, age, religion, ethnicity, beliefs, sexual preference or medical condition. Provisions are implemented to ensure patients with a disability can access our services.

The practice identifies important/significant cultural groups within our practice including non-English speaking background patients, religious groups and those of Aboriginal and/or Torres Strait Islander background. We endeavour to continue to develop any strategies required to meet their needs.

Our practice provides respectful care at all times and is mindful of our patients' personal dignity. We have a plan in place to respectfully manage patients in distress.

Visual and auditory privacy for patients is provided in the waiting room and during the consultation. The waiting room provides a television to assist patient auditory privacy. Each consulting and treatment room has a curtain around the examination bed for patient privacy, and the doors to the consulting rooms are closed for each consultation.

Patient privacy and confidentiality is assured for consultations and in medical and accounts records, appointments, telephone calls and electronic media including computer information. Our practice does not leave patient information in any format in areas of the practice or surrounds that would allow unauthorised access. All members of our practice team sign a privacy agreement upon acceptance of work, and risk immediate dismissal should a breach of this agreement occur. Information no longer required that contains any reference to patients, including diagnosis reports, specialist letters, accounts etc. is securely disposed of via shredding.

Patients have a right to access their personal health information and may request to view their record or obtain a copy.

Our privacy policy for the management of health information is displayed in the waiting room and also on the practice information sheet and practice website, and is readily presented to anyone who asks. This policy includes information about the type of information and data this practice collects, how we collect it, use it and protect it, and to whom we may disclose it to.

Patients have the right to refuse any treatment, advice or procedure. Our general practitioners discuss all aspects of treatment and will offer alternatives should a patient seek another medical opinion (refer to **Section 7.12 – Management of a patient refusing treatment or advice**).

For ongoing management of patients should they leave the area, our general practitioners will ask for the forwarding practitioner/practice address and facilitate a transfer of health information. A copy of the

patient's health record or health summary will be sent directly to the new location via secure priority post.

This practice acknowledges a patient's right to complain. We provide mechanisms to ensure that this feedback, as well as positive comments and suggestions, are freely received and implemented where possible.

Patients are provided with sufficient information about the purpose, importance, benefits, risks and possible costs associated with proposed investigations, referrals or treatments to enable patients to make informed decisions about their health.

Patients are provided with adequate information about our practice to facilitate access to care including our arrangements for care outside our normal opening hours.

Patient consent is also sought for participation in our health reminder systems and any research projects we may participate in. Patients are advised that any prior consent given can be withdrawn at any time.

8.2. Complaints

8.2.1. Policy

Opportunities are available for patients and other visitors to tell us, "how we are doing" and we collect systematic patient experience feedback at least every three (3) years.

The practice information sheet provides patients with information on how to provide feedback, including how to make a complaint.

We have a complaints resolution process which all members of the practice team can describe, and we also make the contact details for the NSW health complaints agency readily available to patients if we are unable to resolve their concerns.

Patients have a 'right to complain' and where possible, patients and others are encouraged to raise any concerns directly with the practice team who are all trained to make sure patients of the practice feel confident that any feedback or complaints made will be handled appropriately. We believe most complaints can be responded to and resolved at the time the patients or other people such as carers, relatives, friends, or other consumers make them known to our team.

Under national and state privacy laws, our practice provides and adheres to a complaints process for privacy issues and those related to the *Australian Privacy Principles (APPs)*.

All members of our practice team are educated to be prepared to address complaints as they arise. Depending on the nature of the complaint and any advice received from our medical indemnity insurers where required, complaints are recorded and actioned with a copy placed in the patient's health record if related to patient care.

All clinical and medical staff, as well as administration staff, are aware of the professional and legal obligations regarding the mandatory reporting of unprofessional conduct.

8.2.2. Procedure

Patients and others have opportunities to register their complaints either verbally, in writing (letter) or via our suggestion box. Patients or others are able to complain anonymously if desired.

All members of our practice team are educated to be prepared to address complaints as they arise.

When receiving complaints, our practice keeps in mind the following in order to minimise further patient anxiety and hostility:

- Handle all complaints seriously, no matter how trivial they may seem.
- Verbal complaints made in person should be addressed in a private area of the practice where possible.
- Use tactful language when responding to complaints.
- Do not blame others; patients may not have all the facts or they may distort them.
- Address the patient's expectations regarding how they want the matter resolved.
- Assure the patient that their complaint will be investigated and the matter not disregarded.
- Offer the person an opportunity to complete a formal complaint form (they may accept or decline).
- Document all complaints and other relevant information and place this in the complaint folder so the person designated to manage complaints is informed of the complaint (even if the matter appears to have been resolved).
- Alert the general practitioner about disgruntled or hostile patients so they can diffuse the situation immediately - often patients are reluctant to make a complaint directly to a general practitioner.
- Always inform the person designated to manage complaints if you become aware of any significant statements made by the patient or significant change in patient attitude.

The practice has appointed Dr Belal with designated responsibility for seeking, collecting, analysing, investigating, resolving and managing all feedback and complaints. Any investigation and resolution of complaints is undertaken using an open disclosure process, incorporating the following:

- Acknowledge the patient's right to complain.
- Acknowledge receipt of the complaint as soon as possible, but within two (2) working days using the *Acknowledgment of Complaint* letter template.

- Respond to all complaints as soon as reasonably practicable, but within thirty (30) days in an open and constructive manner including an explanation and, if appropriate, an apology.
- If a resolution of the matter is to take longer than thirty (30) days, an update of the resolution activities will be provided to the patient, with an anticipated revised timeframe for resolution.
- Work with the patient to resolve the complaint and communicate the outcome with the patient, including any changes made as a result of the complaint.
- As a routine, contact the practice's insurer when there is a complaint about a member of the medical or clinical team in order to seek advice on resolving the complaint before any action is taken (refer to **Section 8.7 – Management of potential medical defence claims**).
- Where a complaint is made against a practice team member, provide the team member with an opportunity to discuss the details in a private setting.
- Ensure the complaint does not adversely affect the patient's care.
- Record the complaint, investigation and actions in the dedicated complaints file and, if related to patient care, include a copy in the patient's health record.
- Ensure, where appropriate, complaints are reviewed at practice team meetings; analyse trends and discuss the methods of resolution.
- Review other types of patient feedback (i.e. feedback surveys, suggestion box) during practice team meetings.
- Keep a record of improvement(s) made in response to feedback or complaints.
- Where appropriate, inform the patient about practice improvements made as a result of their input.

If the matter cannot be resolved, the patient is advised about how to contact the external health complaints agency for our state.

New South Wales

Health Care Complaints Commission (HCCC)

Telephone: (02) 9219 7444 / 1800 043 159 (Toll Free in NSW)

Web: www.hccc.nsw.gov.au

Complaints that relate to privacy issues or concerns that cannot be resolved internally are to be directed to the Office of the Australian Information Commissioner (OAIC).

Office of the Australian Information Commissioner

Telephone: 1300 363 992

Postal Address: GPO Box 5218, Sydney NSW 2001

Web: www.oaic.gov.au

Members of the public may make a notification to the Australian Health Practitioner Regulation Agency (AHPRA) - www.ahpra.gov.au - about the conduct, health or performance of a practitioner or the health

of a student. Practitioners, employers and education providers are all mandated by law to report notifiable conduct relating to a registered practitioner or student to AHPRA.

8.3. Non-English speaking patients

8.3.1. Policy

Our general practitioners and other members of the practice team have a professional obligation to ensure they understand our patients and that the patients understand any verbal instructions or written information given to them.

Patients who do not speak or read English, who are more proficient in another language, or who have special communication needs are offered the choice of using the assistance of a language service to communicate with the general practitioner/clinical team member.

Our practice team is aware that alternative modes of communication may be used by our patients with a disability, and we endeavour to inform ourselves of how to access and use these services or technology to achieve effective communication with these patients.

The practice also considers the communication needs of carers and other relevant parties.

A contact list of translating and interpreter services and other communication services for patients with a disability is maintained, updated regularly and readily available to all members of the practice team. This includes the National Relay Service (NRS) for patients that are deaf and the Translating and Interpreter Service (TIS) Doctors Priority Line for patients from a non-English speaking background.

8.3.2. Procedure

Once we have determined that a patient may have special communication needs, patient consent to use communication assistance is obtained and this consent is documented.

The patient may consider that a family member or friend could interpret at the consultation; however, a member of the patient's family or a friend of the patient may not be a suitable translator, especially for sensitive clinical situations or where serious decisions have to be made. The use of children as interpreters is not encouraged.

Qualified medical interpreters are our preferred option and their use is encouraged. Some of our practice team members are bilingual and can act as an interpreter if the patient consents.

The patient's nominated interpreter or any professional services that have been used are noted on the patient's health record which provides for an alert to the practice team to make prior arrangements for future consultations and treatments.

The translating and interpreter services and other communication services commonly used by this practice include:

- Department of Social Services which provides free telephone interpreting services for general practitioners when providing Medicare claimable consultations in private practice:
 - Doctors Priority Line (available 24 hours a day, seven (7) days a week)
 - Translating and Interpreting Service (TIS National)
 - On-site interpreting service (subject to interpreter availability)(Information on these services is available by calling 1300 575 847.)
- www.healthdirect.gov.au which provides helpful educational material for patients on a range of clinical conditions in a variety of languages.

Each of our general practitioners is registered with the interpreter service and allocated a code number. Registrations are renewed annually to ensure quick access when an interpreter is required. Other clinical team members access the service via the treating practitioner.

Where the Translating and Interpreter Service (TIS) is the chosen option, an interpreter is booked by telephoning the Doctor Priority Line (1300 131 450). This 24-hour service is available via telephone at the time of consultation, or if appropriate advance notice is given (usually 48 hours) the interpreter can be on-site at the practice or at the patient's home during a consultation (subject to availability).

8.4. Culturally appropriate care

8.4.1. Policy

We aim to identify important and significant cultural groups within our practice and have implemented strategies to meet their needs. We also aim to accommodate the specific needs of patients who experience disadvantage and increased disease risk whether due to socioeconomic factors, educational or literacy issues, cultural background, or disability (refer to **Section 5.12 - Patient rights**).

In order to improve health outcomes, we encourage our:

- Patients to self-identify their Aboriginal and/or Torres Strait Islander origin or cultural background, and
- Practice team members to ask patients of their Aboriginal and/or Torres Strait Islander or other cultural background.

We are sensitive and aware that there may be many reasons why patients are reluctant to identify their Aboriginal and/or Torres Strait Islander or other cultural background, and equally there are reasons why practice team members are reluctant to ask about the cultural background of our patients.

The entry of information about the Aboriginal and/or Torres Strait Islander or other cultural background of patients into health records is undertaken in a standardised manner that enables the extraction of data.

When patients are distressed we provide appropriate care and privacy which also respects their cultural practices (refer to **Section 5.2 - Appointments**).

We know how to communicate with patients who do not speak the primary language of our practice team or who have communication impairment, and our practice has a list of contact details for interpreters and other communication services (refer to **Section 5.14 – Non-English speaking patients**).

8.4.2. Procedure

Our practice routinely obtains and records the cultural background of our new and existing patients. Cultural background and ethnicity, e.g. Aboriginal and/or Torres Strait Islander background, can be an important indication of clinical risk factors and can assist our general practitioners and other clinical team members in providing disease prevention and in delivering culturally appropriate care.

We have identified the main cultural groups in our practice and endeavour to provide culturally appropriate written health information.

We collect information about the country of birth, languages spoken and any other additional cultural information. We have a system to regularly update our patient information using a standard *Update Your Details Form*.

The standard indigenous status question asked is “Are you of Aboriginal or Torres Strait Islander origin?” This question is asked of all patients, irrespective of appearance, country of birth or whether our practice team members know of the patient or their family background. Our practice collects this information from patients initially as part of our *New Patient Information Form*.

Our clinical software has the option to input Aboriginal and/or Torres Strait Islander status or other cultural backgrounds; therefore, we use the drop-down options rather than free-text to assist with extracting the information for preventative activities.

To encourage Aboriginal and/or Torres Strait Islander origin patients to self-identify, we have self-identification posters in the waiting room, displaying the Aboriginal and Torres Strait Islander flags on brochures etc.

8.5. Directory of local health and community services

8.5.1. Policy

Our practice engages with a range of health, community and disability services to plan and facilitate optimal patient care to patients whose health needs require integration with other services.

A readily accessible computerised directory of health and community services utilised by patients within our area, including how to refer or contact these agencies, is maintained and updated regularly.

All members of our medical and clinical team are encouraged to coordinate patient care across the general practice setting with other health services and to build good working relationships with these providers to facilitate collaborative care.

8.5.2. Procedure

A computerised directory of health and community services is available in medical director. The GPs will notified of new providers to include on the list, and the contact numbers in the list are checked and updated annually or more often if required. All new members to our practice team are made aware of how to access this list during their induction to the practice.

Our directory of local health and community services list includes:

- Local medical/diagnostic services,
- Local hospitals and specialist consulting services,
- Primary healthcare nurses,
- Pharmacists,
- Disability and community services,
- Health promotion and public health services and programs,
- Relevant government departments in the region,
- Local allied health services,
- Community, social or self-help groups in the area, and
- Culturally appropriate services for non-English speaking background and Aboriginal and/or Torres Strait Islander patients.

A brief explanation about any fees applicable, contact numbers or names and procedures for interacting with these services is included on this list to facilitate a transfer of this information to the patient.

It is recognised that referral information may differ for public and private providers (refer to **Section 7.4 – Referral protocols**) and our practice team members ensure all requirements outlined in the chronic disease initiatives are met if these item numbers are to be claimed.

8.6. Provision of brochures, leaflets and pamphlets for patients

8.6.1. Policy

There is a range of posters, leaflets and brochures available or on display in the waiting room, reception area and in the consulting and treatment rooms. Where appropriate, these are available in more than one language and in formats to assist patients with physical or intellectual disabilities.

Leaflets, brochures and pamphlets can vary considerably in quality. The brochures used by this practice are carefully selected and screened to ensure they are culturally appropriate and contain current, evidence-based information.

The quality and accuracy of any audio-visual resources or internet sites recommended to patients or used to provide printed information to patients is also considered.

The brochures, posters, leaflets and pamphlets available include information about health promotion and illness prevention, specific diseases and medical procedures, and privacy and rights.

The general practitioners and clinical team members use written information during a consultation to support diagnosis and management of conditions and for health promotion and illness prevention.

Brochures and educational materials are also available for patients to self-select.

8.6.2. Procedure

We are selective about the leaflets and brochures we provide both in the waiting room for patients to self-select and for the medical and clinical team to use to support information provided during a consultation. To ensure they contain current and evidence-based information, items are obtained from reputable sources. Where possible, items are dated, contain the name of the source and references to supportive evidence.

An audit of our brochures, leaflets and patient information sheets is conducted at least bi-annually to ascertain if they are current or if better options are available.

Brochures and leaflets are displayed in the waiting room in brochure holders and are checked monthly (more frequently if new or altered information becomes available) to ensure stocks are sufficient and up-to-date.

New brochures (e.g. seasonal, influenza vaccines, etc.) are incorporated into the collection as required.

Information that is no longer current or any damaged brochures are promptly discarded.

Low stocks to be re-ordered are noted in an order book and a check is conducted for brochures in other languages if required.

The provision of specific written material to support advice given in consultations is encouraged to help patients remember the key messages from the consultation and to address individual patient's needs (refer to **Section 7.20 – Clinical guidelines, references and resources**).

Verbal and written information is provided to patients about health promotion and specific disease prevention, and to support a diagnosis and choice of treatment.

8.7. Practice information sheet

8.7.1. Policy

Our practice information sheet provides patients with information about our practice facilities and how to access care. It is also a useful way to inform patients of current practice information or changes to our services. We endeavour to ensure all patients, new and existing, are provided with the most up-to-date version to ensure the information they have is accurate.

If a patient is unable to read or understand our practice information sheet, an alternative method is used to supply this information (also refer to **Section 5.14 – Non-English speaking patients**).

Our telephone's 'on hold' recording and our website is used to reinforce some of the information about our practice and its services.

8.7.2. Procedure

The practice information sheet is kept at reception and is handed to each new patient on their first visit. A supply of information sheets is also available in the waiting room for existing patients to take.

Where patients are unable to read or understand our written information sheet, we use other means to communicate the essential information which may include:

- Verbal communication,
- Larger font versions of materials,
- Gaining support through the National Relay Service or AUSLAN for patients who are deaf,
- Gaining support through the Translating and Interpreter Service (TIS) for patients who speak languages other than English, and
- Having our information sheet translated into languages commonly used at our practice.

To maintain the accuracy of our information sheet, it is reviewed regularly and updated as required. When the information sheet is updated, the date is inserted in the footer to denote the latest version and our reception staff are encouraged to bring this new version to the attention of our patients.

Our practice information sheet contains at a minimum:

- Our practice address and telephone numbers,
- Consulting hours and arrangements for care outside normal opening hours, including a contact telephone number,
- The names and qualifications and special interests of our practitioners, nurses, allied health and other practice team members,
- The medical, clinical and other services available,
- Our billing principles such as bulk billing arrangements, accounts settlement and what services incur additional out-of-pocket expenses and details of these expenses,
- Our communication policy including receiving and returning telephone calls and electronic communication,
- Our policies for the management of patient personal health information, including details on how patients can obtain a copy of their health information and where our practice's full privacy policy can be obtained,
- The process for the following up of test results, and
- How to provide feedback or make a complaint to the practice, including the name of the person of the practice who is responsible for receiving feedback and complaints, and the contact details for the state health complaints agency.

Where information on the practice information sheet, website or in general interest health articles and posters contains advertising within our practice, we ensure any advertising complies with the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*. We include a disclaimer on the advertisement stating that the practice does not endorse the advertised services or products.

As a best practice process we also display patient friendly messages promoting our status of accreditation.

8.8. Office supplies

8.8.1. Policy

Supplies of stationery, other office and practice stores including prescription pads, letterhead, medical certificates, etc. are accessible only to authorised persons.

Sumayyah Senior Receptionist or delegate, checks and maintains this stock.

8.8.2. Procedure

Stock is checked monthly and items are re-ordered when supplies are low. Incoming goods are checked against orders and invoices.

When a member of the practice team takes a supply of stationery, the item is ticked against the in-stock checklist as having been removed from the stationery cupboard.

When extra supplies or new items are needed, this request is directed to the practice manager, or delegate.

8.9. Environmental cleaning

8.9.1. Policy

All areas of our practice environment are visibly clean.

Regular cleaning of work areas is necessary because dust, soil and microbes on surfaces can transmit infection. Cleaning of our practice's clinical and non-clinical areas must be regular and scrupulous.

We have cleaning procedures that set out a schedule and the responsibilities for cleaning all clinical and non-clinical areas of the practice in accordance with the requirements outlined in the *RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)*.

We have appointed a member of the practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures, which includes environmental cleaning (refer to **Section 4.1 – Principles of infection prevention and control**).

Specific areas of responsibility may be delegated to nominated members of the practice team and when these particular responsibilities are delegated, we document them in the relevant position descriptions.

The practice team member with delegated responsibility for environmental cleaning can describe the process for the routine cleaning of all areas of the practice.

A good, neutral detergent is used for most of our cleaning requirements, and this includes floors, walls, toilets and other surfaces. The use of disinfectants is discouraged because they are expensive, often toxic and require contact times to be effective.

All work surfaces are made of smooth, non-porous material without cracks or crevices to allow for efficient cleaning. Any gross soiling or body-substance spills are to be cleaned as soon as possible.

Sinks and wash basins must be either sealed to the wall or sufficiently far from the wall to allow cleaning of all surfaces.

Dry dusting and sweeping will disperse dust and bacteria into the air and will then resettle. It is potentially hazardous and inefficient, and this must be avoided in patient treatment or food preparation areas. Damp dusting and wet mopping is used in the cleaning of the environment.

All cleaning equipment is stored in a clean and dry condition, and in an area not accessible to the public.

Our practice engages commercial cleaners for environmental cleaning, and a written contract is in place that outlines the schedule of cleaning, suitable products to be used, and the areas to be cleaned. Our contract cleaners also record their work in a designated cleaning log that is kept at reception.

All members of the practice team involved in cleaning receive ongoing education in our infection prevention and control policies including hand hygiene and the correct use of personal protective equipment and waste management.

8.9.2.Procedure

Dr Mahmoud has been designated responsibility for the development and consistent implementation of our environmental cleaning processes. This includes the initial and ongoing education and training to all members of the practice team, and following up any issues with the quality of the environmental cleaning undertaken.

Our cleaning schedule below describes the frequency of cleaning, products to use and person responsible for cleaning specific clinical and non-clinical areas of the practice. We also maintain documented evidence of cleaning activities.

Where patients are known to have or are suspected to have highly transmissible agents (e.g. influenza, coronavirus) additional or specific cleaning may be required throughout the practice.

An external cleaning service Haytham Ismail is responsible for cleaning the premises as specified in the cleaning schedule detailed below.

This service is contracted to provide general cleaning in all areas of the practice on a daily basis when the practice is open.

Our contract with Haytham Ismail is negotiated and reviewed on a yearly bases of each year.

The cleaning service operates after 5pm. Spills that occur during normal opening hours are the responsibility of the practice team members with designated responsibility for managing spills, with this responsibility documented in their position description.

All persons responsible for cleaning our practice environment are trained and educated to adhere to the following principles:

- Don personal protective equipment such as gloves and a waterproof apron
- Make up water and detergent solution each day
- Use clean dry cloths and mops
- Wash and dry all surfaces
- Promptly dispose of used cleaning solution in the dirty utility area, not in hand basins or clinical sinks
- Wash and dry buckets, cloths, mops and personal protective equipment (if not disposable) after use, and
- Wash hands when each task is completed.

Areas that are only cleaned/managed by appropriately trained practice team members include:

- Spillage of blood or body-substances
- Medical instruments or items for reuse
- Treatment room benches and trolleys
- Consulting room benches containing medical equipment, and
- Infectious waste and sharps containers.

All practice team members and contract cleaners responsible for cleaning have been appropriately immunised as documented in their employment or contractor records.

Sumayyah Senior Receptionist, conducts routine audits to ensure a high standard of cleaning. Should cleaning not conform to expectations, this is to be reported to Dr Mahmoud.

Safety data sheets of cleaning solutions, disinfectants, etc. are kept on file in case of a medical emergency (e.g. swallowing, splashed in eyes).

The cleaning schedule detailed below contains descriptions of all areas to be cleaned and the frequency, method and person responsible.

Routine Cleaning Schedule

Surface	Product	Method	Frequency	Person Responsible
Smooth surfaces (e.g. bench tops, couches, sinks, toilets and floors) and high touch surfaces (e.g. door handles, light switches)	Detergent and water, damp cloth OR Disposable wipes	Wiping/rubbing with a damp cloth, or use disposable wipes. Dry the surface with a clean cloth.	daily	Dr Mahmoud
Smooth floors	Detergent and water, mop and bucket	Damp mopping to ensure dust is captured and not dispersed into the air (note: mops need to be cleaned and left to dry after use and not left wet in a bucket).	Daily	Dr Mahmoud
Other items (e.g. stethoscopes, tape measures)	Detergent and water, alcohol wipes	Clean thoroughly, wipe over with alcohol wipe but avoid on stethoscope tubing.	monthly	Dr Mahmoud

9. Privacy and security of personal health information

9.1. Privacy of personal health information

9.1.1. Policy

As an Australian-based organisation, any data and information collected is held, used and disclosed in accordance with the *Privacy Act 1988*.

‘Personal health information’ is a particular subset of personal information and can include any information collected about a person in order to provide a health service.

The information we collect about a patient can include medical details, family information, name, address, employment and other demographic data, past medical and social history, current health issues and future medical care, Medicare number, accounts details, and any health information such as a medical or personal opinion about a person’s health, disability or health status.

Personal health information also includes the formal health record (written or electronic) and information held or recorded on any other medium (e.g. letter, facsimile, electronic, verbal).

Our practice has appointed a designated person with primary responsibility for the practice’s electronic systems, computer security and adherence to protocols in accordance with **Section 6.2 - Computer information security**. This responsibility is documented in their position description. Specific tasks may be delegated to others and this person works in consultation with the privacy officer.

Our security policies and procedures regarding the confidentiality of patient health records and other personal information are documented and our practice team are informed about these at induction and when updates or changes occur.

The practice team can describe how we correctly identify our patients using three (3) patient identifiers in accordance with **Section 7.6 - Patient identification** to ascertain we have selected the correct patient record before entering or actioning anything from that record.

For each patient we have an individual patient health record containing all clinical information held by our practice relating to that patient. Our practice ensures the protection of all information contained within these files. Our patient health records are accessed only by an appropriate team member as required, and we ensure information held about the patient in different records (e.g. at a residential aged care facility) is available when required.

If a breach of privacy occurs within our practice, we have processes in place to ensure this breach is reported appropriately, handled quickly and effectively, and reviewed to prevent recurrence. Breaches occur if personal patient information held by the practice is accessed by or disclosed to unauthorised personnel (such as hackers, incorrect recipients or contractors visiting the practice), or is lost entirely by the practice.

9.1.2.Procedure

Our practice has appointed Dr Belal with designated responsibility for ensuring the privacy and security of personal health information held within our practice. This includes managing the practice’s electronic

systems, computer security and adherence to protocols as outlined and in accordance with **Section 6.2 - Computer information security**. Our general practitioners, clinical and allied health team members and all other staff and contractors associated with this practice have a responsibility to maintain the privacy of personal health information and related financial information; the privacy of this information is every patient's right.

The maintenance of privacy requires that any information regarding individual patients (including practice team members who may be patients) may not be disclosed either verbally, in writing or by copying it either at the practice or outside it, during or outside normal opening hours, except for strictly authorised use within the patient care context at the practice or as legally directed.

There are no degrees of privacy. All patient information must be considered private and confidential, even that which is seen or heard and therefore must not be disclosed to family, friends, members of the practice team not involved in that patient's care, or any other people without the patient's approval.

Details about a person's medical history or other contextual information such as details of an appointment can sometimes still identify them, even if no name is attached to that information. This is still considered personal information and as such it must be protected in accordance with the *Privacy Act 1988*.

Any information given to unauthorised persons will result in disciplinary action and possible dismissal. Each member of our practice team is bound by a confidentiality agreement, which is signed upon commencement of working at our practice (refer to **Section 2.5 – Privacy and confidentiality obligations**).

Notifiable Data Breaches

My Family GP understands the importance of protecting patient information at all costs. However, in the event that a data breach does occur, our practice complies with the Office of the Australian Information Commissioner's (OAIC) Notifiable Data Breach (NBD) Scheme where notification must be made where the breach is deemed 'eligible' for notification.

An eligible data breach is when there is evidence of unauthorised access, unauthorised disclosure, or loss of personal health information; the breach is likely to result in serious harm to one or more individuals; and the practice has not been able to prevent the risk of harm through remedial actions.

If all three of these criteria are filled, My Family GP reports the breach to the OAIC using the Notifiable Data Breach Form available from their website. We then ensure we have notified any patients or personnel affected by the breach, as well as our medical indemnity insurer and all practice GPs' personal insurance providers.

For breaches relating to My Health Record, the Australian Digital Health Agency will also need to be notified in addition to the notification made to the OAIC.

Upon notification of the breach and all possible remedial action being taken by the practice, our practice logs the incident within our incident register for review at the next practice team meeting or, if the data breach is significant, at a specifically arranged meeting as soon as possible.

Any changes to systems or processes as a result of a breach are communicated to the practice team and are regularly monitored to ensure the changes remain in place and are effective for preventing a recurrence of the incident.

More information on how to report a notifiable data breach can be found within our **Business Continuity Plan**, which can be located in the accreditation folder.

Access to Electronic Information

The management of all practice computers and servers comply with the RACGP's *Information Security in General Practice* guidelines and we have a sound backup system and a contingency plan to protect the practice from loss of data (refer to **Section 6.2 - Computer information security**).

Personal health information is kept where only those with authorisation can access it, and is kept out of view of and unable to be accessed by the public (i.e. not left exposed on the reception desk, in the waiting room or other public areas; or left unattended in consulting or treatment rooms). To minimise this risk, automated screensavers are activated on all computer screens.

Members of the practice team have different levels of access to patient personal health information as appropriate to their roles and, to maintain security all computer hardware and software passwords are kept confidential and are not disclosed to others (refer to **Section 6.2 - Computer information security**).

Any team members positioned in the practice common areas (e.g. reception and waiting areas) are made aware that conversations in these areas can often be overheard by patients and visitors and, therefore, they are to avoid discussing confidential and sensitive patient information in these areas.

Whenever sensitive documentation is to be discarded, our practice uses an appropriate method of destruction using a security bin.

Correspondence

There are risks associated with electronic communication in that the information could be intercepted or read by someone other than the intended recipient. Email communications with other healthcare providers is undertaken securely through the use of encryption. Email communication with patients is

discouraged; however, where initiated by the patient, the risks are communicated and patient consent is obtained.

Where patient information is sent by post, the use of secure postage or a courier service is determined on a case by case basis.

Incoming patient correspondence and diagnostic results are opened and viewed only by a designated practice team member.

Items for collection or postage are left in a secure area not in view of the public.

Facsimile

Facsimile, printers and other electronic communication devices in the practice are located in areas that are only accessible to the general practitioners and other authorised team members. Faxing is point to point and will, therefore, usually only be transmitted to one location.

All facsimiles containing confidential information are sent only after ensuring the facsimile number dialled is the designated receiver before pressing 'Send'.

Details of confidential information sent by facsimile are recorded in a designated logbook which incorporates the date of transmission, patient name, description of the contents and the designated receiver (name and facsimile number).

A copy of the transmission report produced by the facsimile is kept as evidence that the facsimile was successfully transmitted, and as evidence the information was sent to the correct facsimile number.

Facsimiles received are managed according to incoming correspondence protocols.

The words 'Confidential' are to be recorded on the header of the facsimile coversheet and a facsimile disclaimer notice at the bottom of all outgoing facsimiles affiliated with the practice.

Patient consultations

Patient privacy and security of information is maximised during consultations by closing the consulting room doors. When the consulting, treatment room or administration office doors are closed, practice team members must ensure they knock and wait for a response prior to entering.

Where locks are present on individual rooms, these should not be engaged except when the room is not in use.

It is the general practitioner/clinical team member's responsibility to ensure that prescription paper, patient health records and related personal information is kept secure if they leave their room during a consultation or treatment, or whenever they are not in attendance in the consulting/treatment room.

Patient health records

The physical health records and related information created and maintained for the continuing management of each patient are the property of this practice. This information is deemed a personal health record and while the patient does not have ownership of the record, he/she has the right to access under the provisions of the *Privacy Act 1988*. Requests for access to a patient's health record will be acted upon only if the request is received in written format.

Both active and inactive patient health records are kept and stored securely.

A patient health record may be solely electronic, solely paper-based, or a combination (hybrid) of paper and electronic records.

Our practice is considered paperless and has systems in place to protect the privacy, security, quality and integrity of the personal health information held electronically. Appropriate team members are trained in computer security policies and procedures.

Members of the practice team have different levels of access to personal patient health information as appropriate to their roles; and to maintain security, all computer hardware and software passwords are kept confidential and are not disclosed to others (refer to **Section 6.2 - Computer information security**).

9.2. Computer information security

9.2.1. Policy

Our practice has systems in place to protect the privacy, security, quality and integrity of the data held electronically. All members of our practice team are trained in computer use and in our security policies and procedures. Updates to any computer security requirements are communicated to each team member at the time of the change.

The management of all practice computers and servers comply with the RACGP's *Information Security in General Practice guidelines* including:

- A designated practice team member who is responsible for championing and managing computer and information security, including the definition of this role and its responsibilities in their position description,
- team training on computer and information security upon induction and when any relevant changes to legislation of practice processes occur,

- Undertaking an annual structured risk assessment of information security and identifying improvements as required,
- Documented policies and procedures for managing computer and information security including processes for team training in computer and information security,
- Well-established and monitored authorised access to health information,
- Documented and tested plans for business continuity and information recovery,
- Processes to ensure the safe and proper use of internet and email in accordance with practice policies and procedures for managing information security,
- Reliable information backup systems to support timely access to business and clinical information,
- Reliable protection against malware and viruses,
- Reliable computer network perimeter controls,
- Processes to ensure the safe and proper use of mobile electronic devices in accordance with practice policies and procedures for managing information security,
- Processes to ensure notifiable data breaches are managed and reported appropriately,
- Managing and maintaining the physical facilities and computer hardware, software and operating system with a view to protecting information security, and
- Reliable systems for the secure electronic sharing of confidential information.

9.2.2. Procedure

In our practice, we have appointed Abdelfattah with designated responsibility for overseeing and managing the practice's computer security and our electronic systems.

A risk assessment of information security is undertaken on an annual basis and is aimed at identifying improvements as required. Any improvements necessary are implemented as soon as they are identified, and information relating to the improvement is communicated to all members of the practice team.

Each member of the healthcare team (i.e. general practitioners, clinical and allied team members) has access to a computer to document clinical care. For medico-legal reasons, and to provide evidence of items billed in the event of a Medicare audit, all members of the healthcare team always log in under their own passwords to document care activities they have undertaken.

We have a sound backup system and a contingency plan to protect practice information in the event of an adverse incident, such as a system crash or power failure. This plan encompasses all critical areas of the practice's operations such as making appointments, billing patients and collecting patient personal health information. This plan is tested on a regular basis to ensure backup protocols work properly and that the practice can continue to operate in the event of a computer failure or power outage.

This practice reserves the right to check an individual's computer system history as a precaution to fraud, workplace harassment or breaches of confidence by practice team members. Inappropriate use of the

practice's computer systems or breaches of practice computer security, including email and internet use will be fully investigated and may be grounds for dismissal (refer to **Section 2.7 - Disciplinary action and termination process**).

Our practice has the following information to support the computer security policy:

- Current asset register documenting hardware and software including software licence keys,
- Logbooks/printouts of maintenance, backup including test restoration, faults and virus scans, and
- Warranties, invoices/receipts and maintenance agreements.

Our practice has documented other essential information needed to put in place effective computer and information security in our **Business Continuity Plan**, which is located in the treatment room.

In the event of a power or computer system failure, we have a designated 'Disaster Box' located in the reception which is stocked with items to enable the practice to continue to operate during the failure including: Torches,

- Paper prescription pads and medical certificates,
- Appointment schedule printed out the night before, and a manual appointment book to continue to take appointments,
- Practice letterhead,
- Consultation notes template,
- Manual credit card/payment/Medicare processing equipment,
- Emergency numbers, and
- Manual pathology/radiology referral pads.

9.3. Practice privacy policy

9.3.1. Policy

The *Privacy Act 1988* and the *Australian Privacy Principles* require our practice to have a document that clearly sets out our policies on handling personal information, including health information.

This document, called a Privacy Policy, outlines how we handle personal information collected (including health information) and how we protect this information.

Our practice has used the privacy policy template available from the RACGP and this has been adapted to reflect how our practice collects and uses personal information.

Our privacy policy is displayed in the waiting room and also on the practice information sheet and practice website, and is readily presented to anyone who asks.

Our collection of information statement informs patients about how their personal health information will be used, including by other organisations to which the practice usually discloses patient information to, and any law that requires the particular information to be collected. Patient consent to the handling and sharing of personal patient health information is sought and documented early in the process of clinical care, and patients are made aware of the collection statement when giving consent to share health information.

According to the *Privacy Act 1988* and the *Australian Privacy Principles*, an organisation may use or disclose personal health information for a purpose (the secondary purpose) which is directly related to the primary purpose of collection without seeking consent, but only if the individual would have a reasonable expectation that the information could be used or disclosed for that secondary purpose.

A directly related secondary purpose for the use and disclosure of personal health information in our practice includes the many activities necessary for the provision of a health service, such as management, funding and monitoring, as well as complaint-handling, planning, evaluation and accreditation activities.

It is essential to recognise the importance of 'reasonable expectation' as many individuals may be unaware of the range of activities for which their personal health information may be used and disclosed, such as the accreditation process. Our practice ensures we tell patients how, and for what purpose, personal health information collected about them could be used or disclosed. Patients are advised of this 'secondary purpose' in a number of ways, including:

- At the time of the consultation with a general practitioner,
- Via the practice privacy statement in the practice information sheet,
- Via the practice privacy statement on signage on the walls of the practice, and/or
- By reading, understanding and signing a new patient information form when first registering at the practice, which incorporates the practice privacy statement.

It is important we maintain a patient's right to 'opt out' of the secondary purpose through refusal to consent. If an individual expresses negative views or opposition when made aware of a proposed secondary use or disclosure of their personal health information, this would indicate that they have a reasonable expectation that their personal health information will not be used or disclosed in that manner, and their non-consent is recorded on file.

9.3.2.Procedure

We inform our patients about our practice's policies regarding the collection and management of their personal health information via:

- A sign at reception,
- Brochure(s) in the waiting area,

- Our practice information sheet,
- New patient information forms,
- Verbal means if appropriate, and
- Our practice website.

Our practice privacy policy states:

Prior to a patient signing consent to the release of their health information, patients are made aware that they can request a full copy of our privacy policy.

Patient consent for the transfer of health information to other providers or agencies involved in the patient's healthcare (e.g. treating practitioners and specialists outside the practice) is obtained at the patient's first visit to our practice through the *New Patient Information Form*. Once signed, this form is scanned into the patient's health record and its completion is noted.

9.4. Third party requests for access to personal health information

9.4.1. Policy

Requests for third party access to personal patient health information are initiated through receipt of correspondence from a solicitor or government agency or by the patient completing a *Request for Personal Health Information* form. Where a patient request form or signed authorisation is not obtained the practice is not legally obliged to release information.

Where our practice holds reports or other health information from another organisation, such as a medical specialist, we are required to provide access to this information in the same manner as for the records we create. We are also required to provide access to records which have been transferred to us from another health service provider.

General practice has a fundamental role in ensuring the privacy of personal patient health information. Our practice has access to and uses the RACGP's *Privacy and managing health information in general practice* handbook which aligns with current best practice and includes commentary on the *Privacy Act 1988*. It provides guidance to our practice on the management of health information in a general practice setting and includes examples of compliance with the various Health Records Acts and the *Australian Privacy Principles* (APPs), which regulate the handling of personal information by both Australian government agencies and businesses.

Requests for access to patient health records and associated financial details may be received from various third parties including:

- Subpoena/court order/coroner/search warrant,

- Relatives/friends/carers,
- External practitioners and healthcare institutions,
- Police/solicitors,
- Health insurance companies/workers compensation/social welfare agencies,
- Employers,
- Government agencies,
- Accounts/debt collection,
- Students (medical and nursing),
- Research/quality assurance programs,
- Media outlets,
- International parties, and
- Disease registers.

We only transfer or release patient information to a third party once the consent to share information has been signed and, in specific cases, informed consent has been sought from the patient.

Our practice team can describe the procedures for timely, authorised and secure transfer of patient personal health information in relation to valid requests.

9.4.2. Procedure

The practice team can describe how we correctly identify our patients using three (3) patient identifiers in accordance with **Section 7.6 – Patient identification** to ascertain we have selected the correct patient record before entering or actioning anything from that record.

Patient consent for the transfer of health information to other providers or agencies is obtained at the patient's first visit and is retained on file in anticipation of when this may be required.

As a rule, no patient information is to be released to a third party unless the request is made in writing and provides evidence of a signed authority to release the requested information, to either the patient directly or to the third party.

Written requests for the transfer of health information are noted in the patient's health record, and are also documented in the practice's *Transfer Request* register. Any request received is forwarded to the patient's usual general practitioner for action. The requested record is to be reviewed by the general practitioner whilst using the *Release of Health Information Checklist* prior to release to a third party to ascertain if the information being requested is suitable for release.

Where patient information is being transferred in hard copy (i.e. post or being collected by the patient/third party), only copies are provided; the original is to remain at the practice.

The security of any health information requested is maintained when transferring requested records. Electronic data transmission of personal patient health information from our practice is in a secure format.

Subpoena, court order, coroner search warrant

Where a request for patient information is being sought by subpoena, court order, or coroner search warrant, we note the date of the pending court case and the date the request was received in the patient's health record. Depending on whether a physical or electronic copy of the record is required, we follow the procedures as described above.

On occasions, a member of the practice team is required to accompany the patient's health record to court or, alternatively, a secure courier service may be adequate. If the original is to be transported, we ensure a copy is made in case of loss of the original document during transport and we ensure that the record is returned after review by the court (refer to **Section 8.7 – Management of potential medical defence claims**).

Relatives/friends

A patient may authorise another person to be given access to their health information if they have the legal right and a signed authority (refer to **Section 6.5 – Request for access to personal health information**).

If a situation arises where a carer is seeking access to a patient's health information, we contact our medical defence organisation for advice before such access is granted.

Significant court orders relating to custody and guardianship are recorded as an alert on the health records of children where appropriate to ensure no information is released to an unauthorised party.

External practitioners and healthcare institutions

Any requests received from general practitioners or other healthcare institutions, external to our practice, are directed to the patient's usual general practitioner.

Police/solicitors

All members of the practice team have been made aware of the requirement for police and solicitors to obtain case-specific signed patient consent (or subpoena, court order or search warrant) before any information relating to that patient is released. Any such requests received are directed to the patient's usual general practitioner.

Health insurance companies/workers compensation/social welfare agencies

Depending on the specific circumstances, information may need to be provided and any such requests received are referred to the patient's usual general practitioner.

Employers

If the patient has signed consent to release information for a pre-employment questionnaire or similar report, this request is referred to the patient's usual general practitioner.

Government agencies – Medicare/Department of Veterans Affairs

Depending on the specific circumstances, information may need to be provided and any such requests received are referred to the patient's usual general practitioner with a recommendation to discuss any issues with their medical defence organisation.

State registers of births, deaths and marriages

Death certificates are to be issued by the patient's usual general practitioner.

Accounts/debt collection

The practice must maintain privacy of a patient's financial accounts.

Accounts must not contain any clinical information. Invoices and statements are reviewed prior to forwarding to third parties, such as insurance companies or debt collection agencies.

Outstanding account queries or disputes are directed to the practice owners.

Students (medical and nursing)

This practice does not participate in medical or nursing student education.

Research and continuous quality improvement activities

Where our practice seeks to participate in human research activities and/or continuous quality improvement activities, patient confidentiality and privacy will be maintained. Only the information of patients who have provided their explicit consent for the practice to use their information for these activities in this manner will be used. A copy of the patient consent to any specific data collection for research or continuous quality improvement purposes is retained in their record.

All requests to participate in research are to be approved by the practice owners before commencing, and also must have approval from a Human Research Ethics Committee (HREC) constituted under the NHMRC guidelines. A copy of this approval is retained by the practice. Also refer to **Section 7.11 – Research projects**.

Media

No member of the practice team is permitted to release information to media outlets unless it has been authorised, and all enquiries are to be directed to Dr Ejje.

International

Where patients request and consent to have their information transferred overseas, this can be performed; however, where the request for transfer of information is received by international subpoena, our practice is under no obligation to comply.

Disease registers

This practice submits patient data to various diseases registers to assist with preventative health management (e.g. cervical, breast and bowel screening, etc.).

Consent is required and obtained from the patient to 'opt in' to have their information shared with these registers. This consent is obtained when the patient first attends the practice, and patients are reminded through signage in the waiting room and by information contained in the practice information sheet of the opportunity to revisit their previous consent/non-consent to this data sharing at any time.

9.5. Request for access to personal health information

9.5.1. Policy

Patients of this practice have the right to access their personal (and health) information under legislation. The *Privacy Act 1988* and *Australian Privacy Principles* (APPs) govern health service providers' and other organisations' obligations to give patients access to their personal health information on request, subject to certain exceptions and the payment of fees (if any).

This practice complies with the *Privacy Act 1988* and APPs adopted therein. These regulations give patients the right to know what information a private sector organisation holds about them, the right to access this information, and to also make corrections if they consider any data is incorrect.

We have a privacy policy in place that sets out how to manage personal health information and the steps an individual must take to obtain access to this information. This includes the different forms of access and the applicable timeframes and fees (refer to **Section 6.3 – Practice privacy policy**).

Where our practice holds reports or other health information from another organisation, such as a medical specialist, we are required to provide access to this information in the same manner as for the records we create. We are also required to provide access to records which have been transferred to us from another health service provider.

9.5.2. Procedure

A notice is displayed in our waiting room, on our website and in our practice information sheet advising patients and others of their rights of access to information we hold about them, and of our commitment to privacy legislation compliance. An information brochure is also available that provides further details if required.

Personal health information about a patient will only be released in accordance with the relevant privacy laws and at the discretion of the patient's usual general practitioner.

Although patients can request access to their personal health information verbally, we request that patients complete a *Personal Health Information Request Form* which outlines the type of information being requested, and in what format the patient requests to receive the information. Completion of this form ensures correct processing is undertaken and appropriate consent is obtained, particularly where the patient is requesting their information be sent to them through an unsecure method (i.e. facsimile, mail, email).

The completed request form is then forwarded to the patient's usual general practitioner to review and consider the request through the use of the *Release of Health Information Checklist*. In considering the request, it is important that the practitioner answers the following questions:

- Would access pose a serious threat to the life or health of anyone, including the patient?
 - If it is possible to provide the information in another form which would remove the threat, for example discussing in person with the applicant, then this could be an option.
- Will the privacy of others be compromised?
 - It may be possible to remove the other person's identification prior to release of information. Check remaining parts of the record to not reveal the person's identification. You can try to contact the other person for their consent to release information in the record. Consider if this contact may cause a privacy risk for the patient.
- Is the request frivolous or vexatious?
- Does the information relate to existing or anticipated legal proceedings?
- Would access prejudice negotiations with the individual, for example, regarding negligence or other claims?
- Would access be unlawful due to other legislation?
 - Where any Commonwealth or state law prohibits this or if it would breach any other statutory or common law (e.g. Adoption Act, Infertility Treatment Act).

Where 'yes' was answered for any of the questions, there may be grounds for denying access to the record or certain parts thereof. Where there is no reason to deny access, the general practitioner is to peruse the record to ascertain if all information being requested is still suitable for release.

When a patient requests access to their health record and related personal information, we document each request in the practice's *Transfer Request* register and in the patient's health record. We endeavour to assist patients in granting access where possible and according to the privacy legislation. Exemptions to access will be noted and each patient (or legally nominated representative) will have their identification checked prior to access being granted.

Where there are grounds to deny a patient access to their personal health information (all or part thereof), the reasons for denied access are provided to the patient in writing. An intermediary may operate as facilitator to provide sufficient access to meet the needs of both the patient and the general practice.

Patients may request to access their personal health information in the following ways:

- View and inspect (patient is to make an appointment),
- View, inspect and discuss contents (patient is to make an appointment),
- Obtain a copy – collect,
- Obtain a copy - send via mail.
- Obtain a copy - send via facsimile, and/or
- Obtain a copy - send via email.

We respect an individual's privacy and allow access to information via personal viewing in a secure private area in consultation with their general practitioner. A fee is not charged in this circumstance, and the patient may take notes of the content of their record. Fees will be charged when a photocopy of the information is requested.

A patient may ask to have their personal health information amended if they consider it is not up-to-date, accurate or complete. Our practice aims to correct this information as soon as reasonably practicable and any corrections made are attached to the original health record.

Where there is a disagreement about whether the information is indeed correct, we attach a statement to the original record outlining the patient's claims.

Once the request has been processed, the completed *Personal Health Information Request Form* and *Release of Health Information Checklist* are incorporated into the patient's health record.

Request by another person who is not the patient

An individual may authorise another person to be given access if they have the right (e.g. legal guardian) and if they have a signed authority.

The *Privacy Act 1988* defines a 'responsible person' for an individual as:

- A parent of the individual, or

- A child or sibling of the individual if the child or sibling is at least 18 years old, or
- A spouse or de facto partner of the individual, or
- A relative of the individual if the relative is:
 - At least 18 years old, and
 - A member of the individual's household, or
- A guardian of the individual, or
- A person exercising an enduring power of attorney granted by the individual that is exercisable in relation to decisions about the individual's health, or
- A person who has an intimate personal relationship with the individual, or
- A person nominated by the individual to be contacted in case of emergency.

Where a young person is capable of making their own decisions regarding their privacy, they should be allowed to do so. The general practitioner could discuss the child's record with their parent; however, each case is to be managed subject to the individual circumstances. A parent will not necessarily have the right to their child's information.

Deceased Persons

Privacy protections that are in place for personal patient health information applies even after a person's death; however, in some situations these privacy interests may be reduced, or there may be other factors that outweigh the privacy interests which favour disclosure of the information. A request for access may be allowed for a deceased patient's legal representative if the patient has been deceased for 30 years or less and all other privacy law requirements have been met; however, we recommend that the general practitioner contacts their medical defence organisation for advice when receiving these requests.

9.6. Privacy officer

9.6.1. Policy

This practice has a designated privacy officer who implements and monitors adherence to all privacy legislation in this practice.

The privacy officer acts as liaison for all privacy issues and requests for access to patient personal health information.

9.6.2. Procedure

Sumayyah is our practice's designated privacy officer.

The privacy officer is responsible for ensuring compliance with the *Privacy Act 1988* and the *Australian Privacy Principles* and for developing and maintaining our written protocols. The privacy officer liaises

with the person responsible for our computer security and systems to ensure our electronic systems remain compliant.

If any members of the public or of our practice team have any queries concerning privacy laws and how our practice manages adherence to these laws, these queries are directed to the privacy officer.

9.7. Privacy audit

9.7.1. Policy

In the event of any issues or complaints relating to privacy matters, this practice conducts a review of privacy policies and procedures. This review is also undertaken from time-to-time to ensure these policies and procedures are up-to-date.

9.7.2. Procedure

The privacy officer reviews the following items:

- What is the primary purpose of this practice?
- What data do we collect and document?
- How do we store this information?
- What data do we disclose and to whom?
- When and how do we obtain patient consent?

Information is collected from hard copy and electronic storage devices, and issues are discussed with the general practitioners and other practice team members to gain the most current information.

National and state privacy laws are referenced with any updates being noted and actioned.

During this time, our privacy policy and other policies and procedures associated with the management of personal health information are reviewed and updated for privacy items as required.

Forms related to accessing personal patient health information, including requests for access and access registers, are also reviewed.

9.8. Health records administration systems

9.8.1. Policy

Our practice maintains a patient health record system that suits the needs of our practice, and the administration of this system is such that ensures each patient has a dedicated health record that is complete, maintained, and facilitates the provision of safe and high-quality healthcare.

9.8.2. Procedure

Our patient health records contain an accurate and comprehensive record of all interactions with our patients.

The practice team can describe how we correctly identify our patients using three (3) patient identifiers in accordance with **Section 7.6 – Patient identification** to ascertain we have selected the correct patient record before creating, entering or actioning anything from that record.

Creating a new health record

New patients to our practice are requested to complete a *New Patient Information Form* that is used to gather the patient's:

- Contact information,
- Emergency contact details,
- Next of kin,
- Healthcare identifiers (i.e. Medicare/Department of Veterans' Affairs number),
- Cultural identity (including Aboriginal and Torres Strait Islander status),
- Health information (such as allergies, current medications, medical history, lifestyle risk factors), and
- Family health history information.

Once obtained, this information is used to create a health record for that patient.

Retrieving a health record for a current patient

Our practice is considered paperless and has systems in place to protect the privacy, security, quality and integrity of the personal health information held electronically. Members of the practice team have different levels of access to patient personal health information as appropriate to their roles.

Standardised clinical terminology

Clinical terminologies and classifications allow the details of a consultation to be recorded in a standardised way. This can include such things as why a patient comes to the practice, the problems managed during a consultation, referrals, and investigations requested. Data can then be retrieved regarding patient encounters for auditing, quality improvement and continuity of care.

Using recognised classification or terminology avoids confusion that can result from entering 'free text' descriptions in a patient's health record.

Most general practice clinical software systems in Australia use a recognised vocabulary such as DOCLE, PYEFINCH, SNOMED CT, ICPC and ICPC2+. These are effective in ensuring data is recorded consistently, and can be used across a range of settings including chronic disease registers and population health research.

In using Medical Director for the storage or management of patient health information, our practice uses docle the coding system.

Filing reports (pathology, x-ray, consultants, etc.)

Paper-based diagnostic test results and other incoming patient correspondence must be dated and passed on to the referring general practitioner, or delegate if that practitioner is not on duty, and actioned accordingly.

This practice scans all paper-based correspondence received about patients, with copies of this data securely stored. Original copies are not retained.

All results received electronically are reviewed by the referring general practitioner, or delegate if that practitioner is not on duty, and actioned accordingly. These results are then incorporated into the patient's electronic health record.

Errors in health record

Corrections in the electronic record are to be recorded by referring to the date of the original entry and the associated amendment.

Allergies and alerts

Alert notification may be required for allergic responses, drug reactions, previous aggressive behaviour, or guardianship/custody arrangements.

It is practice policy to ensure that all patients have their allergy status recorded, especially any allergies to medications to facilitate safer prescribing. Where a patient has no known allergies, this is annotated in the allergy field as such.

Any non-allergy or medication interactions alert notifications are documented in the designated 'Warnings' field of the patient's health record.

Backup of electronic health records

In order to avoid lengthy down time, disruption or medico-legal concerns, frequent backups are essential and form a critical component of the practice disaster recovery plan. A formal policy for the backup of the practice computer systems is therefore in place (refer to **Section 6.2 – Computer information security**).

Retention of records and archiving

Patient health records must be kept until the patient is 25 years of age, if a child, or a minimum of seven (7) years following the last year of the patient's attendance, whichever is greater.

In our practice, inactive electronic patient health records are retained indefinitely.

Patient account records are retained for a minimum of seven (7) years.

Records of Schedule 8 medicines incorporating their acquisition, use, and disposal is retained for a minimum of two (2) years.

Sterilisation cycle records and evidence of vaccine refrigerator temperature monitoring are retained in accordance with the timeframes associated with the retention of patient health records.

Where our patients have chronic conditions or genetic diseases, or at the general practitioner's discretion, these records are kept for a minimum of <insert> years.

Records of patients that have been sought for legal purposes are retained for <insert> years.

Records of deceased patients are kept for <insert> years following the year of their death.

Outdated paper-based test results that no longer have clinical relevance are culled to assist with storage. This is done in consultation with our medical defence organisation and in compliance with NSW legislation.

Our practice has a process in place to allow for the timely identification of information to be culled, stored or archived and to enable timely retrieval of records where required.

Where a general practitioner identifies a patient as 'inactive', but the record is to be retained for an extended period of time, a note will be made on the patient's health record indicating the number of years it is to be held.

Deceased records are marked DECEASED.

On an annual basis, we conduct a review of our patient health records to identify any records that have not been accessed within the last two (2) years. These records are then removed from the active filing

system and filed in the inactive file area. Patient account records are culled at the end of each financial year.

Privacy and confidentiality is maintained during the destruction process to ensure information contained in the records is not divulged or seen by unauthorised persons. Records will be destroyed by shredding or pulping in a secure environment. Where a contracted document destruction company is used to undertake this task, certificates of destruction are retained.

When reviewing the practice's policy with respect to the retention of records, or when we are unsure about culling or archiving personal health information, our practice seeks advice from our medical defence organisation.

9.9. Transfer of patient health records

9.9.1. Policy

The transfer of patient health records from this practice can occur in the following instances:

- Medico-legal reasons, e.g. record is subpoenaed to court,
- A patient asks for their health record to be transferred to another practice,
- A health record report is requested from another source, and/or
- The general practitioner is retiring and/or the practice is closing.

Our practice team can describe the procedures for timely, authorised and secure transfer of patient personal health information to other providers and in relation to valid requests.

9.9.2. Procedure

Receiving a request

In accordance with state and federal privacy legislation, any request received from another general practice/practitioner to transfer patient health records from our practice must be signed by the patient in giving authority to transfer their record.

The request from the receiving practice needs to contain the:

- Name of the receiving practitioner or practice,
- Patient's name, address (both current and former if applicable) and date of birth, and
- Reason for the request.

When fulfilling a request, this practice may choose to either:

- Prepare a summary letter (manually or via the clinical software) and include copies of relevant correspondence and results pertinent to the ongoing management of the patient, or

- Make a copy of the health record and dispatch the copy to the new practice, retaining the original.

The requesting practice is advised if we propose to transfer a summary or a copy of the full health record. If they have a preference, the format can be negotiated or they can choose not to proceed with the transfer and seek a copy through a separate access request.

If there is going to be any expenses related to the transfer, the requesting practice is advised prior to sending the records and, once the fee has been paid, the request will be processed. Our practice uses the fees associated with accessing information from the *Office of the Australian Information Commissioner* (OAIC) under the *Freedom of Information Act 1982* (FOI Act) as a guide when determining a reasonable fee for our practice to charge.

The request signed by the patient and a notation that a copy/summary of the patient's health record has been transferred is made on the patient's original health record. The notation includes the name and address of the receiving practice and the dispatch details (e.g. via priority mail or confidential courier or in an electronic form).

Electronic data transmission of patient personal health information from our practice is in a secure format.

All reasonable steps are taken to protect the health information from loss or unauthorised disclosure during the transfer.

This practice does not allow individuals to collect a copy of their health record to take to their new provider.

Making a request

Access to a new patient's previous health information can assist with the continuity of care of that patient.

When requesting records from another practice, a standard request for the transfer of patient health records letter template should be used.

This letter template incorporates provisions for the request to contain:

- The patient's name, address and date of birth
- Reason for request including the name of the general practitioner making the request
- Requested format for receiving the records (.xml format), and
- Signed consent from the patient to release their health information.

If the previous practice advises that the patient is likely to incur an out-of-pocket expense related to the transfer, the patient is to be advised of these expenses prior to our practice accepting the transfer of records.

10. Clinical management

10.1. Clinical autonomy

10.1.1. Policy

All general practitioners and other healthcare professionals in this practice are free to make decisions that affect the management of their patients in accordance with accepted clinical judgement, best available evidence and adherence to valid clinical care guidelines.

10.1.2. Procedure

Our general practitioners and other healthcare professionals exercise full autonomy in determining:

- The appropriate clinical care of their patients,
- Duration and scheduling of appointments,
- The health professionals including specialists, other general practitioners and para-medical practitioners to whom they refer,
- The pathology, diagnostic imaging or other investigations they order and the provider they use
- How and when to schedule follow up appointments with individual patients, and
- Whether to accept new patients (provided that this action is non-discriminatory and does not apply to emergencies).

The general practitioners and other healthcare professionals of our practice are consulted prior to the scheduling of appointments and the purchase of new equipment and supplies.

Feedback is sought from the general practitioners and other members of the clinical team (i.e. nurses and allied health) concerning the use of practice equipment, appointment scheduling and other matters relating to professional autonomy.

All members of the healthcare team comply with their professional and ethical obligations, and practise within the boundaries of their knowledge, skills and competence and their role within the practice.

10.2. Clinical content of patient health records

10.2.1. Policy

Patients at our practice have their own individual patient health record containing all health information held by our practice about that patient.

All patients that have attended the practice in the last two (2) years should have had the essential information recorded in their health summary and active patients (i.e. those who have attended the practice three (3) or more times in the last two (2) years) should have a comprehensive health summary recorded in their health record.

All members of the practice team endeavour to keep the information in the patient's health records up-to-date and, where possible, data is entered using accepted coding or drop-down selections (rather than free text) to assist with practice audits and chronic disease registers. Care is taken when entering sound-alike or look-alike medicines, particularly when using drop-down selections in electronic prescribing programs.

Patient health records are essential to providing evidence of services billed under the Medicare Benefits Schedule (MBS) and for the continuing care of our patients. The contents are confidential and are subject to the requirements of the *Privacy Act 1988*. Our general practitioners and other members of the practice team have a responsibility to maintain the confidentiality of every patient's health record.

Recording of personal patient health information should be to the standard that another practitioner could easily and efficiently take over the care of the patient. As a key component for the continuing management of our patients, contemporaneous, legible, accurate and complete records are kept.

To ensure optimum documentation of healthcare, and to meet our legal risk obligations, all members of the practice team involved in patient care document their care activities in the patient's health records using their individual login credentials. Training appropriate to their level of access is provided to all members of the practice team in recording clinical management in the patient health records or utilising the records for clinical management activities (e.g. reminders and recalls).

Our practice team members are also aware of the importance of recording the cultural background of patients since this background can be an important indication of clinical risk factors and can assist the general practitioners and other members of the clinical team in providing relevant and culturally appropriate care (refer to **Section 5.15 – Culturally appropriate care**).

An active patient health record is defined as the record of a patient that has attended the practice three (3) or more times in the last two (2) years. Our practice can demonstrate that:

- At least 75% of our active patient health records have a current health summary, and
- At least 90% of our active patient health records have an allergy status known.

To assist in the provision of optimum care to patients, our practice integrates with other services. Information, including referral arrangements for public and private providers, and contact details are maintained on a central register which is accessible to all members of the practice team. Details of referrals made are documented in the patient's health record.

Our patient health records contain evidence of a system to review and follow up test results.

We work towards a systematic approach to the entry of patient data in the health records system to facilitate the search, extraction and utilisation of patient information for our prevention and screening activities. This includes recording comprehensive patient health summaries and incorporating documentation of preventative activities in the records.

10.2.2. Procedure

The practice team can describe how we correctly identify our patients using three (3) patient identifiers in accordance with **Section 7.6 – Patient identification** to ascertain we have selected the correct patient record before entering or actioning anything from that record.

Each patient has a dedicated and individual health record containing all personal health information held by us about that person. Each health record incorporates, at a minimum (and where applicable):

- Identification, contact and demographic details:
 - The patient's full name
 - Date of birth
 - Gender (as self-identified by the patient)
 - Address
 - Telephone number(s), and
 - Cultural background, including Aboriginal and/or Torres Strait Islander status.
- Next of kin,
- Emergency contact information,
- Allergy status (including 'nil known' where applicable),
- Health summary information:
 - Adverse drug reactions
 - Current medicines list
 - Current health problems
 - Past health history
 - Immunisations
 - Family history
 - Social history, and
 - Health risk factors (e.g. SNAP - smoking, nutrition, alcohol, physical activity).

- Progress or consultation notes, comprising (and where applicable):
 - Date of consultation
 - Who conducted the consultation
 - Method of communication (e.g. email, telephone, other electronic means)
 - Reason for consultation
 - Relevant clinical findings
 - Allergies
 - Diagnosis (where appropriate)
 - Recommended management plan and, where appropriate, expected process of review
 - Medicines prescribed (including the name, strength, directions for use, dose, frequency, number of repeats, date the patient started/ceased/changed the medication)
 - Third party brought in by the patient (e.g. partner, carer), and
 - Any special advice or other instructions.
- Informed consent (third party presence, treatments/procedures etc.),
- Referrals to other healthcare providers/services including tests ordered,
- Medicines used but not prescribed or advised by the practice,
- Complementary and over-the-counter medicines used by the patient,
- Preventative care information (e.g. blood pressure, waist measurement, height, weight etc.),
- Advanced care plan,
- Care provided outside normal opening hours/home or other visits performed on behalf of the practice,
- Results, reports and clinical correspondence received following referrals or other tests ordered, and
- WorkCover or insurance information or legal reports.

Information is stored electronically in the practice's computer system. Computerised health records should be alterable only if an audit trail is automatically kept by the system; otherwise, once created, a lock-out facility must apply. Any corrections made must be done so by recording additional information separately. Data is entered using accepted coding or drop-down selections (rather than free text) where possible to assist with practice audits and chronic disease registers.

General practitioners, practice nurses, allied health professionals and authorised students of this practice are responsible for documenting the care provided by them to their patients. Reception and practice management staff are responsible for documenting significant telephone contacts, including any attempts made to contact patients.

Plans for the management of patients with complex or chronic conditions, that are consistent with best available evidence, are documented in the patient's health record to ensure there is a consistent and coordinated approach to care between the general practitioners, practice nurses or allied health professionals.

Patient health records also document the role the patient takes in their healthcare and evidence that education and counselling on illness prevention is provided.

Where the person making the entry is not identified by an electronic signature, entries are identified by initials, or the person's name, and date – this is particularly relevant to scanned documents or notes. All entries must be able to be read and understood by another practitioner should they need to review or take on the patient's care.

Information contained in the health record is not to be prejudicial, derogatory or irrelevant. It is to be legible, i.e. able to be read by other healthcare professionals for the ongoing management of the patient.

Each of our patient health records contains sufficient and understandable information about each consultation to allow another member of our medical or clinical team to safely and effectively carry on the management of the patient.

Reports or notes of consultations occurring off-site, such as home visits, whether by or on behalf of our practice, are notated as such and include identification of the place and time of the consultation and the details of the care provided.

Important or significant telephone or electronic communication between the practice and patient is recorded in the patient health records.

At the time of each consultation, or as soon as practical or when information becomes available (e.g. test results), the general practitioner or clinical team member (e.g. nurse) providing the care notes the necessary details, as indicated above, in the patient's health record.

Our patient health records contain evidence of patient referrals to other healthcare providers, such as diagnostic services, hospital and specialist consultation, allied health services, disability and community services and health promotion, and public health services and programs.

A current and up-to-date patient health summary assists in providing ongoing care, both within the practice and when referring to other healthcare providers.

Health summaries are developed progressively and need to be accessible during all consultations with our healthcare team. Care is taken to enter data using accepted coding or drop-down selections, rather than free-text to assist with practice audits, chronic disease registers or continuous quality improvement activities that require identifying patients with risk factors or particular chronic diseases.

Ninety percent (90%) or more health records of patients who have attended our practice on a regular basis (i.e. three (3) or more times in the last two (2) years) have an allergy status recorded in the health summary, and 75% or more have a comprehensive health summary that has been updated to reflect recent important events.

Our practice encourages the general practitioners to clarify a patient's current medicines list and known allergies at every patient contact, and patients on multiple medicines should be provided with the most recent list of their medicines where updates occur.

Pathology results, imaging reports, investigation reports and clinical correspondence received by the practice are reviewed by the general practitioner who ordered the investigation or test (or their delegate in absences) before being retained in the patient's health record.

Follow up of clinically significant results is documented in the patient's health record.

To help gather relevant and essential information for all new patients, our practice uses a *New Patient Information Form* that patients complete whilst waiting to consult with the general practitioner for the first time, which also incorporates a standard consent form for the collection and use of information.

The information provided by the patient in the information form is data entered by transferring information into the patient's health summary and/or health record. The completed form is then scanned into the patient's health record.

Additional information not collected on the new patient form is added to the patient's record during the first and subsequent consultations.

The standard Indigenous status question asked is "Are you of Aboriginal or Torres Strait Islander origin?". This question is asked of all patients, irrespective of appearance, country of birth or whether a member of the practice team knows of the patient or their family background. Our practice collects this information as part of our *New Patient Information Form*.

Our practice has implemented a system whereby patient information is updated regularly so that it remains current and accurate. To achieve this, patients are provided with a standard *Update Your Details Form* in addition to the systematic updates that occur during consultations.

10.3. Informed consent

10.3.1. Policy

Our general practitioners, nurses and other healthcare professionals inform their patients of the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments, including medicines and medicine safety. We believe that patients need to receive sufficient information to allow them to make informed decisions about their care.

Our general practitioners and other practice team members have a professional obligation to ensure they understand our patients and that the patients understand any verbal or written information they receive.

Patients who do not speak or read English, or who are more proficient in another language or who have special communication needs, are offered the choice of using the assistance of a specialised service to communicate with the practitioner or clinical team members (refer to **Section 5.14 – Non-English speaking patients**).

Our general practitioners and other practice team members use information that is clear and is given in a format that is easy to understand, with verbal information supported by a diagram with explanation, brochures, leaflets or posters, electronic information or website referral (refer to **Section 5.17 – Provision of brochures, leaflets and pamphlets for patients**).

The patient's competence to give consent is ascertained by establishing whether the patient is able to understand, retain and consider the information they have been given to arrive at an informed choice. Such a process is applied to all adults, mature minors (within the Gillick test), intellectually and mentally impaired patients or guardians, or power of attorney for the patient.

In situations where patients are dependent on a third party for their ongoing care, we endeavour to provide all appropriate information to the carer.

Issues of personality, personal fears and expectations, beliefs and values are also considered.

There is no coercion by our general practitioners, clinical team members or other healthcare workers (e.g. allied health). Our patients can choose to reject their advice or seek a second opinion. In the instance of a patient's refusal of treatment, this refusal is documented in the patient's health record (refer to **Section 7.12 – Management of a patient refusing treatment or advice**).

The cost of treatment or investigations is an important component of informed decision making. Patients are advised of possible costs involved, including additional out-of-pocket expenses for procedures, investigations and treatments conducted on-site prior to them being conducted. For referred services and where costs are not known, the patients are advised of the potential for out-of-pocket expenses and are encouraged or assisted to make their own enquiries. If the patient indicates that the costs pose a barrier to the suggested treatment or investigation, alternatives may need to be discussed (e.g. referral to public services).

Patients are asked to be open and to feel free to discuss all health issues and proposed treatments. Consent must be voluntary - the individual must have a genuine opportunity to provide or withhold consent; that is, they must be able to say 'yes' or 'no' without extreme pressure which would equate to an overpowering of will.

The *Privacy Act 1988* states that consent may be 'express' or 'implied'.

Express consent is given explicitly, either orally or in writing. This could include a handwritten signature, an oral statement, or use of an electronic medium or voice signature to signify agreement.

Implied consent arises where consent may reasonably be inferred in the circumstances from the conduct of the individual and the practice.

10.3.2. Procedure

To encourage patients to actively discuss their healthcare and to help create an understanding of shared responsibility between the patient and our practice, we use the publication *Top Tips for Safe Healthcare* to guide our discussion. *NB: this document is available via the Australian Commission on Safety and Quality in Health Care's website*

www.safetyandquality.gov.au/wp-content/uploads/2017/04/Top-tips-safe-care_web-version.pdf

Clear communication is provided about the potential for out-of-pocket expenses including any unexpected developments and the possible expenses of additional treatments or procedures before proceeding. A *Medical Treatment/Procedure/ Examination Consent Form* is used for patient consent for medical treatment, procedure or examination on-site within the practice. The treating general practitioner explains the form to the patient before signed patient consent is obtained.

Written consent does not take the place of the general practitioner's personal communication when dealing with the risks, benefits and alternatives of the procedure with the patient. This task should never be delegated to other members of the practice team and all patients should direct any questions regarding procedures to the general practitioner.

Other members of the practice team may witness a patient's written consent, provided they believe that the patient is competent (not confused or disorientated), the conversation with the general practitioner is acknowledged, and that the signature is that of the patient.

Where immediate treatment is necessary to preserve a life or prevent serious injury, all attempts are made to provide information and gain the patient's consent. This may not be successful in all cases prior to administering emergency care.

Using a range of brochures, leaflets or written information that is tailored to suit individual patient's needs to support the explanation of diagnosis and management of conditions, including medication safety; our general practitioners, clinical and allied health team members inform patients of the following issues concerning treatment and investigations:

- Possible nature of illness/disease,
- Proposed approach to investigation, diagnosis and treatment including describing if it is conventional or experimental, common side effects and the clinician undertaking the procedure/treatment,
- Purpose, importance, expected benefits and risks,
- Other options for investigations, diagnosis and treatment,
- Length of procedure/treatment,
- The costs involved, including the potential for additional out-of-pocket expenses where applicable,
- Degree of uncertainty of a) any diagnosis found and b) therapeutic outcome,
- Potential result of not undertaking the specified procedure/treatment or any other treatments, and
- Any significant long-term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention.

We recognise that patients need to understand the purpose and importance of medicines and this assists them to comply with the recommended treatment plan.

To assist patients to make informed decisions about their medicines or to understand any medication safety requirements, our practice team supports any verbal information with consumer medicines information (CMI) leaflets available from the NPS MedicineWise website www.nps.org.au/medical-info/medicine-finder.

The informed consent process (including the use of interpreters), consent form and details of any information or post procedure instructions provided to a patient, are documented in the patient's health record.

Patient consent regarding the expected benefits, possible risks and possible cost is obtained for the following:

- All procedural interventions on-site (written consent),
- Patient's participation in research projects (written consent),
- Clinical Training Program (through waiting room signage and written consent prior to entering the consulting room),
- Third party observation or participation in patient consultation (through waiting room signage, written or verbal consent prior to entering the consulting room), and
- Medical treatment or preventative activities (e.g. childhood vaccinations or prescribed medications).

At the time of childhood immunisations, careful documentation of parental consent needs to be considered, including details of National Immunisation Program (NIP) Schedule, recommendations discussed and the parent's decisions regarding these recommendations. The practice offers the recommended vaccines for whom they are applicable to, regardless of the cost to the patient. The decision to accept or reject the vaccine must be made by the parent, after receiving full details of the risks, benefits and costs from the general practitioner or immunisation nurse.

10.4. **Referral protocols**

10.4.1. **Policy**

Patients are referred for diagnostic testing or to another medical specialist, general practitioner or allied health professional when the other health professional may be better placed to deliver a service that may benefit the patient.

The practice has an up-to-date written and computerised directory of local allied health providers, community and social services and also local specialists to assist when choosing practitioners to facilitate optimal patient care. This information includes different referral arrangements and how to engage with these providers to plan and facilitate care.

Clinical handover needs to occur when all or some aspects of the patient's care is transferred to another provider, such as when a patient is referred. Patients are made aware that their personal health information is being disclosed in the referral documents.

Referral documents to other healthcare providers are legible and contain relevant and sufficient information to facilitate optimal patient care, which include having at least three (3) approved patient identifiers included along with an accurate and current medication list.

Our patient health records contain evidence of patient referrals to other healthcare providers, such as diagnostic services, hospital and specialist consultation, allied health services, disability and community services and health promotion, and public health services and programs.

10.4.2. **Procedure**

Suggesting a referral to a particular practitioner or allied health professional carries with it an implicit endorsement that the receiving practitioner or service provider is appropriately skilled and qualified to administer the treatment or service.

Our directory of local allied health providers, community and social services, and local specialists is available in medical director.

The patient is given information about the purpose, importance, benefits and risks associated with investigations, referrals or treatments proposed by their general practitioner to enable the patient to make informed decisions. The general practitioner may use leaflets, brochures or written information to support their explanation where appropriate.

Patients are advised of all possible expenses involved, including additional out-of-pocket expenses for procedures, investigations and treatments conducted on-site prior to them being conducted. For referred services where costs are not known, the patients are advised of the potential for out-of-pocket expenses and are encouraged or assisted to make their own enquiries. If the patient indicates that the costs pose a barrier to the suggested treatment or investigation, alternatives may need to be discussed (e.g. referral to public services).

Special care is taken to advise patients of the costs of consultations or procedures that do not attract a government subsidy.

Letters of referral may be paper or computer based. Referrals sent electronically are encrypted. Plain paper or practice letterhead is considered appropriate stationery - use of drug company notepads or prescription pads is unacceptable.

In the case of an emergency or other unusual circumstance, a telephone referral may be appropriate. A telephone referral, where made, is documented in the patient's health record.

It is a requirement of our practice that all referral letters generated:

- Are legible (preferably typed) on appropriate practice stationery,
- Include the name and contact details of the referring practitioner and the practice,
- Contain at least three (3) of the approved patient identifiers (e.g. name, date of birth and address),
- Explain the purpose of the referral,
- Contain enough information (relevant history, examination findings and current management) so that the other healthcare provider can provide appropriate care to the patient,
- Do not include sensitive patient personal health information that is not relevant to the referral,
- Include a list of known allergies, adverse drug reactions and current medicines,
- Identify the healthcare setting to where the referral is being made (e.g. the specialist consultancy),
- The name of the healthcare provider to whom the referral is being made (if known), and
- Any relevant information that will help other healthcare providers deliver culturally safe and respectful care (e.g. language spoken, the need for an interpreter or other communication requirements).

Requests for pathology, diagnostic or other investigations should:

- Be legible,

- Contain relevant clinical information, and
- Contain at least three (3) of the approved patient identifiers (e.g. name, date of birth and address).

For medico-legal and clinical reasons, copies of any referral letters generated; pathology, diagnostic or other investigation requested and especially those which contain significant clinical details, are retained by the practice and documented in the patient's health record.

Patients seeking a further clinical opinion from another healthcare provider are encouraged to notify their general practitioner to allow an opportunity to reinforce any potential risks of the decision. Any advice or actions taken when a patient seeks a further clinical opinion, or refuses recommended clinical management are documented in the patient's health record.

10.5. Clinical handover

10.5.1. Policy

Clinical handover is defined in the *RACGP Standards for general practices 5th edition* as 'the transfer of professional responsibility and accountability for some or all aspects of a patient's care, from one professional person or group to another'.

Failure or inadequate handover of care is a major risk to patient safety and a common cause of serious adverse patient outcomes. It can lead to delayed treatment, delayed follow up of significant test results, unnecessary repeat of tests, medication errors and increased risk of medico-legal action.

Clinical handover communications can be face-to-face, written, via telephone and also by electronic means.

All members of our practice team are informed about our policy on clinical handover to ensure standard processes are followed.

Clinical handover of patient care occurs frequently in general practice both within the practice to other members of the medical and clinical team, and to external care providers.

We have standard and documented processes for timely clinical handover with services that provide care outside normal opening hours.

10.5.2. Procedure

Clinical handover needs to occur whenever there is a change of care providers. Examples of clinical handover include a:

- General practitioner covering for a fellow general practitioner who is on leave or is unexpectedly absent,
- General practitioner covering for a part-time colleague,
- The transfer of patient care to another practitioner in our practice when a patient requests the transfer,
- General practitioner handing over care to another health professional, such as a practice nurse, physiotherapist, podiatrist or psychologist,
- General practitioner referring a patient to a service outside the practice, and
- Shared care arrangement (e.g. team care of a patient with mental health problems).

The clinical handover is documented in the consultation notes including that the patient has shared in decision-making and has been informed.

Written or verbal clinical handover amongst general practitioners occurs on a formal arranged basis when practitioners cover for those working on a sessional basis or when a practitioner or other clinical team member is away because of annual leave or illness. In addition to a formal handover, adequate clinical records (including a health summary) enable the routine care of patients to continue. Practitioners relieving for another should read the patient's preceding clinical records.

Our practice recognises that an accurate and current medication list helps to minimise errors and promotes safety when clinical handover occurs. Patients with multiple medications may be provided with a copy of their medication list and encouraged to show the list to other providers of healthcare.

Clinical handover of a patient's care outside the practice occurs in many ways. It includes, but is not limited to, referral for an investigation, to an ancillary healthcare provider, to a specialist and to a hospital as an outpatient or as an inpatient. Referral letters include sufficient information to facilitate optimal patient care, including details of the purpose of the referral and clarification of who will manage the follow up of investigations.

The practitioners ensure that sufficient information is provided to the emergency department about the clinical condition of an inbound patient to facilitate prompt and appropriate care. This may be directly to the ambulance service or to the hospital.

Our practice has arrangements in place with our pathology services to ensure abnormal and life-threatening results identified outside our normal opening hours can be conveyed to a general practitioner in a timely way.

Where complex or high-risk patients, such as suicidal patients, or patients on complex medication regimen, are handed over to another provider for all or part of their care, it is important for the general practitioner handing over care to request notification if the new provider ceases to care for the patient.

Equally, a provider treating a patient on a handover basis has an obligation to notify others in the treating team if they stop seeing the patient (particularly as this issue has been the subject of several coroners' recommendations seen in the media in the past).

Our general practitioners notify the deputising care provider of patients who they anticipate may need care and ensure the deputising service has a defined means of timely contact with the practitioner should they need to access more detailed health information. Handover of the care of a patient who has been seen in the after-hours period is conducted in a timely and appropriate manner through the provision of a report of the consultation no later than the day following the after-hours contact.

When errors in clinical handover occur, every member of the practice team is encouraged to report the incident so the event can be analysed and processes introduced to reduce the risk of a recurrence.

10.6. Patient identification

10.6.1. Policy

Correct patient identification is vital for patient safety and the maintenance of patient confidentiality. Our patients are correctly identified at each encounter with our practice team using three (3) approved patient identifiers. All members of the practice team are trained in how to correctly identify a patient using approved identifiers.

10.6.2. Procedure

Approved patient identifiers include:

- Patient name (family and given name)
- Date of birth
- Gender (as self-identified by the patient)
- Address
- Patient record number (where it exists), and
- Individual healthcare identifier.

Patients' identification using three (3) approved identifiers should be established or confirmed when:

- A patient makes an appointment,
- A patient presents to the practice for their appointment,
- Any member of the practice team communicates with a patient over the telephone or electronically,
- A patient telephones asking for a repeat of a prescription,
- A patient sees more than one practitioner or member of the healthcare team during a visit,
- A patient record is accessed, and

- Any member of the practice team collects and/or manages information (e.g. scanned documents, X-rays) about a patient.

When asking for patient identifiers, practice team members must ask the patient to state at least three (3) identifiers (e.g. their full name, date of birth, and address) while remaining mindful of privacy and confidentiality issues. Practice staff must ask the patient for the information, rather than provide the identifying information for the patient to confirm.

Patients are able to supply government-issued photographic documentation (e.g. their driver's licence or passport) to provide information for our records and to subsequently provide one or more identifiers.

When a patient is well known to our practice team, it may appear unnecessary or illogical to ask for identifiers every time they attend or call the practice; however, it is common for practices to have patients with identical or similar names, or dates of birth, and to therefore mismatch patients and patient health records. Our practice overcomes this by routinely asking patients to verify their address and other particulars each time they attend. This also helps our practice to maintain accurate contact details for each patient.

Any incidents arising from failing to correctly identify a patient are to be documented using the *Adverse Outcome Event/Incident Report* (refer to **Section 3.2 – Incidents and injury and adverse patient events**).

10.7. Follow up of tests, results and referrals

10.7.1. Policy

Our practice's system for the follow up of tests, results and referrals has a strong focus on risk management.

Our practice team is adequately educated, trained and is cognisant of the procedures associated with:

- How patients are advised of the process for follow up of results,
- The system by which pathology results, imaging reports, investigations reports and clinical correspondence received by our practice is reviewed by a general practitioner, signed, acted upon in a timely manner and incorporated into the patient's health record,
- How we follow up and recall patients when we order important or clinically significant tests or investigations or initiate important referrals, and
- How we follow up and recall patients with clinically significant tests, results or correspondence.

All test results, including pathology results, diagnostic imaging and investigation reports, and clinical correspondence received are reviewed, initialled (or electronic equivalent) and, where appropriate, acted upon in a timely manner and incorporated into the patient's health record.

The nature and extent of the practice's responsibility for following up test results, diagnostic imaging and investigation reports, and clinical correspondence/referrals depends on what is reasonable in the circumstance and the clinical significance of the test, referral or result.

Whether something requires follow up is determined by the:

- Probability that the patient will be harmed if follow up does not occur,
- Likely seriousness of the harm, and
- Burden of taking steps to avoid the risk of harm.

Important referrals for consultations or tests ordered are followed up by the referring practitioner (or delegated authority) in a timely manner. This may include checking the patient has attended the referred consultation or the expected investigation, that correspondence or test results have been received and reviewed, and that a record of any follow up and subsequent actions or recall process is incorporated into the patient's health record.

Sometimes our general practitioners may need to be contacted outside our practice's normal opening hours by the pathology service about a serious or life-threatening result, and we have provisions for allowing this contact to occur (refer to **Section 5.10 – After-hours service**).

Our patients (or their carers) are made aware of their obligations and responsibilities for their own healthcare. This includes being informed about how to obtain their results and the seriousness of not attending for ordered appointments/investigations and any recall or subsequent follow up. Where appropriate, this advice is documented in the patient's health record.

Where a patient indicates they do not intend to comply with a recommended test or referral, the patient is deemed to have refused medical treatment or advice and is managed in accordance with **Section 7.12 – Management of a patient refusing treatment or advice**.

In addition to an appreciation of the need for timeliness when following up and actioning referrals, tests and results, our practice team members are aware of the need for confidentiality and discretion with regard to referrals, diagnostic tests and results or correspondence.

10.7.2. Procedure

The procedures used by our general practice to review, follow up and recall patients are complex and varied. The system is designed in a way that anticipates that individual cases will require different levels of follow up depending on the clinical significance or importance of the case.

When ordering diagnostic tests:

- General practitioners at the practice requests tests, investigations or referrals via medical director through the patient file.
- All patients are advised at time of investigation, referral or test any feedback on the referral.
- Patients are advised at the time on information regarding the time of result and costs.

When reviewing all results, reports and clinical correspondence received:

- All results, clinical information is sent through to the medical director. Extra information results, reports, clinical correspondence via fax is incorporated to the holding file for all the GPs to review asap.
- All urgent results are advised immediately to the GP at the time of the holding file.
- All General practitioners will then demonstrate action for the documentation ie to recall, file etc
- The holding file is reviewed on a daily basis to ensure all patient recalls have been reviewed in a timely manner.
- All pathology, radiology companies have all the GPs phone numbers in case of an emergency.
- Farah Registered Nurse will follow up all the normal and abnormal results.
- All the pathology radiology results are sent to the holding file where all GPs can review all results.
- GPs can review results and advise the nursing team farah for any urgent recalls to be recalled immediately.

When communicating with patients about tests, results and referrals:

- Patients can only obtain results once they have attended the practice.
- Patients will be advised at time of the referral when to expect the time of the results to be received. An appointment is made immediately upon the test ordered.
- Recalls are documented in patient file to confirm the patient has received the result.

Identification for follow up of clinically significant investigations and referrals that have been ordered:

- General practitioners identify when referrals, tests, or investigations are clinically significant at the time of receiving the results.
- All results are placed in the holding file for the general practitioners to review them.
- All General practitioners will review their own tests, reports or correspondence with the receptionist and advised them to follow up.
- General practitioners at the practice will advise the staff who to monitor for recalls and reminders.

What is your system to recall patients with clinically significant results, reports and clinical correspondence?

- Receptionist will call 3 times at different times of the day and will send a registered letter if patient has not attended.
- If patient results are extremely urgent the police can be called or the General practitioner will visit the house if the emergency contact and next of kin cannot be contacted as well.

- Patients are advised to make a booking at the time of referral to ensure the patient will receive the results.
- all information regarding the recalls are documented in the patient file to ensure the medical record is up to date.

Reminder systems for preventative care

10.7.3. Policy

For the continuing management of our patient's health, we utilise a systematic reminder system to provide health promotion, preventative care and early detection of disease.

Our system is based on the best available evidence and, where possible, incorporates clinical guidelines.

All members of the practice team participate in continuous quality improvement (CQI) and Plan, Do, Study, Act (PDSA) activities to improve our systematic approaches to health promotion and prevention of disease.

Where opportunities exist, we also coordinate with other health professionals and key agencies to achieve health promotion and preventative care objectives.

Our reminder systems and notifications are mindful of protecting the privacy and confidentiality of patient information and we consider the needs of patients with a physical or intellectual disability. We also consider our responsibility to patients if we cease or significantly change our reminder systems.

We maintain a systematic approach to the entry of patient data in the health records to facilitate the search, extraction and utilisation of patient information for our prevention and screening activities. This includes comprehensive patient health summaries and documentation of preventative activities.

Consideration of a patient's individual circumstances is encouraged when providing information about health promotion and illness prevention for patients (and carers). Verbal and written information is provided to patients about health promotion and specific disease prevention and is distinct from the education and information that is provided to patients to support a diagnosis and choice of treatment.

10.7.4. Procedure

Patient presentations at the practice are used as an opportunity to identify risk factors and provide health promotion and illness prevention in the following ways:

- Pamphlets and brochures from a variety of sources are available for patients to self-select or to be provided by members of the medical or clinical team to reinforce health promotion messages arising from a consultation,

- Patients are encouraged to self-identify information that is recorded on the health summary to assist with early identification of the patient's main health issues or risk factors, e.g. Aboriginal and/or Torres Strait Islander status, family or social history,
- Clinical data is routinely and opportunistically collected by the practice and this is entered into the patient health records in a manner that assists with data extraction for preventative activities,
- Our practice seeks the patient's consent before including their details on a formal reminder system for preventative care - this consent is documented in the patient's health record, and
- Patients are advised of the availability of reminder systems and how to opt out through signage in the waiting room and through information contained in the practice information sheet.

Patient privacy and confidentiality is protected at all times, and patients are notified in writing when reminder systems in which they participate are discontinued.

Reminder system that are included are below:

Patient Selection

Patients are selected for reminders and recalls based on:

- GP and nurse clinical assessment.
- Preventative health assessments and health checks.
- Chronic disease management requirements.
- Immunisation schedules.
- Screening eligibility based on age, gender, family history, and identified risk factors.
- Abnormal pathology and diagnostic imaging results requiring follow-up.
- National screening program recommendations.

Collection of Information

Information is collected through:

- Patient medical history and consultations.
- Health assessments and care plans.
- Self-identification of risk factors.
- Pathology and diagnostic imaging results.
- Immunisation records.
- Specialist correspondence and hospital discharge summaries.

Documentation and Recording

All reminders and recalls are recorded in MedicalDirector using the reminder and recall functions.

Documentation includes:

- Reason for reminder or recall.
- Due date.
- Contact attempts and outcomes.
- Relevant clinical notes and coding.
- Patient responses and appointment attendance.

Screening Programs

The practice participates in preventative health and screening activities including:

- National Bowel Cancer Screening Program.
- Cervical Screening Program.
- Breast cancer screening referrals.
- Cardiovascular risk assessment.
- Diabetes risk assessment and monitoring.
- Chronic disease management reviews.

Communication Within the Practice

All members of the practice team are informed of preventative health activities through:

- Practice policies and procedures.
- Staff meetings.
- Clinical updates and education sessions.
- Use of MedicalDirector reminders and alerts.
- Quality improvement activities and audits.

Targeted Risk Factors and Conditions

The practice targets preventative care and recall activities for patients with:

- Diabetes.
- Cardiovascular disease.
- Hypertension.
- Chronic kidney disease.
- Asthma and COPD.
- Mental health conditions.
- Obesity.
- Smoking and tobacco use.
- High-risk alcohol consumption.
- Cancer screening eligibility.
- Immunisation requirements.
- Aboriginal and Torres Strait Islander health assessments.
- Patients identified as being at increased risk due to family history or other clinical risk factors.
-

Results Recall Procedure

For clinically significant results requiring patient follow-up:

- Clinical staff place a recall in MedicalDirector.
- Patients are contacted by telephone, SMS, or other approved methods.
- A minimum of three contact attempts will be made.
- If the patient cannot be contacted, a letter will be sent to the patient's last known address.

- All contact attempts and outcomes are documented in the patient's medical record.
- The responsible clinician is notified if contact is unsuccessful or if further action is required.

10.8. Notifiable communicable diseases

10.8.1. Policy

Our practice has a policy that outlines how we handle personal information collected (including health information) and how we protect this information. This policy is displayed in the waiting room and also on the practice information sheet and practice website, and is readily presented to anyone who asks for it (refer to **Section 6.3 – Practice privacy policy**).

It is a requirement of our practice, and allowable under the exemption clauses of the *Privacy Act 1988*, to report the communicable disease cases required by the Department of Health when identified in patients of our practice.

Our practice has a system in place to ensure the timely reporting of suspected or confirmed communicable diseases to the NSW health department, including reporting by telephone in some cases.

Although patient consent is not required when reporting the communicable disease, consent will be sought by the notifying general practitioner where the Department of Health requires more detailed information.

10.8.2. Procedure

Under the *Public Health Act 2010* and *Public Health Regulation 2012*, our practice is required to notify our Public Health Unit whenever we have a patient with suspected or confirmed communicable diseases.

Our practice has a system in place to ensure the timely reporting of suspected or confirmed communicable diseases to the appropriate authorities, including reporting by telephone in some cases.

A list of the notifiable communicable diseases and related conditions is located in medical director.

Although patient consent is not required when reporting the communicable disease, consent will be sought by the notifying general practitioner where the Department of Health requires more detailed information.

10.9. Third party observing or clinically involved in the consultation

10.9.1. Policy

Consent must always be obtained from patients prior to a third party observing or being clinically involved in the consultation.

A 'third party' is a person(s) other than the general practitioner and the patient, who observes or is involved in a consultation. Third parties can be interpreters; carers; relatives; friends; medical, allied health or nursing students on placement; general practice registrars; or chaperones.

In some circumstances the patient or the general practitioner may feel more comfortable if there is a chaperone present during the consultation. For medico-legal reasons, it is recommended to consider offering a chaperone for unaccompanied children.

All practice team members receive information and training at induction and on an ongoing basis on the requirements for obtaining and documenting prior patient consent whenever the presence of a third party is introduced into the consultation by the practice. Consent is also obtained on occasions where the third party is accompanying the patient.

10.9.2. Procedure

Our practice aims to seek patient consent to a third party being present during a consultation at the time the patient is making the appointment when that third party is being introduced by the practice. This consent is then re-confirmed when the patient presents to the practice for that appointment, and the consent is documented in the consultation notes by the general practitioner.

Our practice team members are aware that it is not acceptable to ask permission in the consulting room for a third party to be present, as some patients may not feel comfortable refusing consent in the presence of the third party, and therefore agree even if they would prefer not to.

It may be necessary to later identify any third parties that were present during a consultation. For this reason, details of the third party are recorded so that they can be linked back to the consultation and subsequently identified if required. For example, we identify the third party by reference to their role (e.g. nurse, medical student) and/or initials.

Our practice team members are mindful of the particular needs of people with intellectual disabilities who may not be able to provide consent. In such cases, a legal guardian or advocate may need to be appointed to oversee the interests of the patient.

10.10. Research projects

10.10.1. Policy

Our practice has a policy that outlines how we handle personal information collected (including health information) and how we protect this information. This policy is displayed in the waiting room and also on the practice information sheet and practice website, and is readily presented to anyone who asks (refer to **Section 6.3 – Practice privacy policy**).

Research activity, both within the practice and through reputable external bodies, is encouraged.

Patient consent is essential to our involvement in research projects. Whenever any member of our practice team is conducting research involving our patients, we ensure that the research has appropriate approval from an ethics committee and that the research is indemnified. The research protocol, consent procedures and process for resolving problems are retained by the practice.

Research activities are distinct from audits undertaken by the practice as part of continuous quality improvement activities.

Privacy and confidentiality are particularly important, especially when considering involvement in commercial market research activities. When conducting research, our practice ensures that the collection, use and disclosure of data comply with privacy laws. Even if our practice is using de-identified health information, there are still some situations where we must obtain informed patient consent.

Our practice considers the identifiable level of patient information using the following:

- Identifiable patient information – by which individual patients can be identified,
- De-identified patient information – which cannot be traced back to the individual, and
- Potentially identifiable information – could possibly be traced back to individuals or groups of individuals.

10.10.2. **Procedure**

Research projects involving patient care are to adhere to the following actions:

- Must have the explicit and documented written consent of the patient,
- The patient must receive a written and oral explanation about the research and be able to withdraw consent at any time,
- The project must be approved by a relevant Human Research Ethics Committee (HREC) established under the NHMRC guidelines, and
- Privacy laws must be adhered to.

Research projects involving research or clinical audits using de-identified data should ideally have patients' consent. This can be in more general terms such as by waiting room notice or through information contained in the practice information sheet.

Extreme care must be taken not to allow patient identification from small and/or unusual cohorts.

For QI&CPD activities that require the transfer of patient information outside the practice (e.g. NPS activities) we need to:

- Ensure the activity complies with relevant guidelines on QI&CPD (issued by an appropriate specialist medical college),
- Ensure the activity is approved by that college,
- Retain a copy of the QI&CPD approval for the activity,
- Obtain patient consent if transferring identifiable patient information, and
- Transfer data in accordance with **Section 6.4 - Third party requests for access to personal health information.**

The practice retains a record of the request for participation in any research project, including the research protocol, consent procedures and process for resolving problems.

Our practice also ensures that appropriate insurance is in place to indemnify our practice for research.

Where our practice is involved in a clinical trial, we will usually be indemnified by the sponsor (e.g. a drug company); however, our practice will make inquiries to ensure the indemnity covers our liabilities and where it does not, we will obtain a separate insurance policy or indemnity.

If the research is not a clinical trial, we ensure our practice insurance covers the research.

In all cases of research, the general practitioners need to ensure that their individual medical indemnity insurance covers their research activities.

10.11. **Management of a patient refusing treatment or advice**

10.11.1. **Policy**

This practice takes an active approach to ensure the best outcomes for patients at all times even if they choose to reject investigation and/or management advice.

Our practice endeavours to help our patients understand the importance of medicines and treatment advice to help them make informed decisions about their healthcare.

All members of our medical and clinical team are educated and trained and can demonstrate how we provide care for patients who refuse a specific treatment, advice or procedure.

10.11.2. **Procedure**

Our general practitioners and clinical team are to respect the right of all patients to make investigation and treatment choices or to seek a further clinical opinion.

Patients should be advised to notify the practitioner or clinical team member if they want to refuse a specific advice or procedure.

An appropriate risk management strategy to be followed when a patient expresses intent to refuse specific advice, procedure or treatment includes ensuring that:

- The patient has been provided with the full range of options available, including the risks and benefits of each to enable them to make an informed choice,
- The consequences of the choices made are explained, including those of non-investigation and treatment,
- The patient is offered continued monitoring, support or timely referral appropriate to their choices; this may be to another practitioner or clinical team member within our practice or to another practice, and
- Full documentation of the actions taken to the above and any referrals (including dates) to other healthcare providers are recorded in the patient's health record.

10.12. Refusal to treat a patient

10.12.1. Policy

Our practice or individual medical and clinical team members have the right to refuse to treat patients in defined circumstances. In these circumstances, our practice ensures arrangements are made for the timely transfer of the patients' care to another member of the medical or clinical team in our practice or to another practice.

10.12.2. Procedure

Any refusal to treat a patient is done for substantial reasons, not based on discrimination (gender, sexual preference, religion, race, illness type).

Patients in emergency situations will always be treated to the best of our ability. Emergency medical treatment is defined as treatment that is necessary to:

- Save a patient's life, and/or
- Prevent serious damage to health, and/or
- Prevent or alleviate significant pain or distress.

Reasons that may give rise for a general practitioner or a member of the clinical team to no longer consider it appropriate to treat a particular patient include a breakdown in the practitioner/patient relationship, patient threats or aggressive behaviour, overloaded practice or patients with conditions outside the range treated by the practitioner.

An appropriate risk management strategy to be followed when exercising the right to refuse to treat patients includes ensuring that:

- The patient has been provided reasons why they cannot have ongoing treatment by the practitioner/practice,
- The patient has been provided with alternative possible treatment locations,
- Any complaints that may arise are dealt with according to the complaints procedure, and
- Full documentation of the actions taken to the above is recorded in the patient's health record.

Our practice will endeavour to assist such patients with ongoing care, including the provision of a written referral to other healthcare providers and a transfer of any medical history.

10.13. **Practice equipment**

10.13.1. **Policy**

The medical equipment, furniture and resources of this practice are appropriate and adequate to ensure:

- Comprehensive primary care and resuscitation, and
- Patient, practice team member and visitor safety.

Any legislative requirements are met and complied with.

We maintain a register of equipment which includes the scheduling requirements for service or maintenance. Any maintenance and calibration requirements are undertaken on a regular basis in accordance with the manufacturer's instructions to ensure the equipment is maintained in good working order.

We ensure all members of our practice team are informed, educated and trained in all relevant standards or guidelines and requirements relating to the safe operation or use of specific practice equipment.

10.13.2. **Procedure**

All members of the practice team are instructed in the use of the practice equipment to ensure equipment is used and maintained in a competent manner.

Training requirements depend on the specific equipment, and the equipment's relevance to the practice team member's role. Practice team members are trained in how to use the practice's equipment safely in order to avoid any adverse events. Our practice's general practitioners assess whether specific training is required to use the practice's equipment, such as the height-adjustable bed, point-of-care testing equipment, and determine whether ongoing training is required. Appropriate training is undertaken by completing external courses where required; all other training is conducted through in-house programs, or 'on the job' training. Evidence of the training completed is retained in the practice team member's employment or contract file.

Electrical safety checks and biomedical checks are performed on the required equipment annually or as required.

Maintenance, repairs, electrical and biomedical checks are documented in the equipment register. This register is retained as proof of the practice's quality control and preventative maintenance program.

Furniture used by the practice team members and by patients is maintained in good condition, is ergonomically effective and can be easily cleaned and wiped down.

10.14. Medical equipment and resources

10.14.1. Policy

The practice has all basic equipment and emergency drugs expected in a general practice. The practice ensures that these are maintained, safe and in a serviceable condition at all times.

The available equipment is sufficient for the procedures commonly performed within our practice and meets the needs of our patients.

Our practice maintains our key equipment according to a documented schedule.

Members of the medical and clinical team are consulted about the equipment and supplies the practice uses or purchases.

10.14.2. Procedure

Our practice has the necessary medical equipment to ensure comprehensive primary care and emergency resuscitation incorporating the following:

- Auriscope,
- Blood glucose monitoring equipment,
- Disposable syringes and needles,

- Equipment for resuscitation, maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask),
- IV access,
- Emergency medicines,
- Examination light,
- Eye examination equipment (e.g. fluorescein staining),
- Gloves (sterile and non-sterile),
- Height measurement device,
- Height adjustable patient examination bed(s),
- Measuring tape,
- Monofilament for sensation testing,
- Ophthalmoscope,
- Oxygen,
- Patella hammer,
- Peak flow meter,
- Personal protective equipment,
- Pulse oximeter,
- 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, and
- X-ray viewing facilities.

Our practice also has timely access to a spirometer and electrocardiograph

Relevant members of our practice team are trained in the care, use and maintenance of equipment and, where appropriate, to analyse and interpret any results. As liquid nitrogen and oxygen are hazardous materials, they are stored securely and the team are trained in their safe use.

Our key clinical equipment is maintained in working order and is appropriately maintained in accordance with our register of equipment below, which includes the scheduling requirements for service or maintenance and reflects the recommendations of the manufacturers of the equipment. Maintenance of

the equipment is performed as required by suitably trained practice team members or qualified technicians where required.

Item	Servicing/Calibration	Monitoring/Checking	Parts/Supplies
Auriscopes	Monthly clean of viewing glass or as required.	Replace or recharge batteries when light dims.	Spare batteries (standard or rechargeable), globe.
Computer system including backups	According to the maintenance and servicing program.	Server temperature.	Backup media, spare computer.
Dermatoscope	Monthly clean of viewing glass or more frequently as required.	Replace or recharge batteries when light dims.	Spare batteries (standard or rechargeable), globe.
Electrical cords and all computers, printers and appliances	Annual testing and tagging by a qualified person.		
Fire Extinguishers	Biannual check by qualified technician i.e.: MFB or private service.		
Glucometer	Annual comparison of an actual blood sugar level with a glucometer reading of same blood sample.	Monthly.	Test strips, batteries.
Non-medical items e.g. door mats, floor surfaces	Yearly inspection and replacement as required.	Warning signs displayed when wet or fall risk is evident.	
Ophthalmoscope	Monthly clean of viewing glass or as required.	Replace or recharge batteries when light dims.	Spare batteries (standard or rechargeable), globe.
Oxygen	Annual servicing and checking by qualified technician.	Weekly check that cylinder at least ¼ full.	Spare cylinder available.
Panic Buttons		Monthly check.	
Printers			Spare cartridges.
Scales		Compare with a known weight.	
Smoke Alarms	Replace batteries annually.	Monthly check.	Spare battery.
Spirometer	Servicing and calibration according to manufacturer's recommendations.	Regular calibration using 3L syringe. Monthly clean or more frequent as required.	Disposable mouth pieces, preferably one way and preferably filtered.
Sphygmomanometer	Annual checking against a mercury device or		Cuffs various sizes

	recently checked aneroid device. Cleaning and checking of mercury by qualified technician if required.		Spare standard cuff and bladder, bulb and control valve.
Telephone System		Quarterly check of battery backup function.	
Thermometer	Compare against mercury oral thermometer or other electronic thermometer.		Batteries, covers.
Vaccine Storage	Annual logging of fridge temperature using a calibrated data logger. Replace batteries on min/max thermometer annually.	Twice daily min/max temperature recording.	Spare batteries.

10.15. Doctor's bag

10.15.1. Policy

All of our general practitioners have access to a fully equipped doctor's bag for emergency care and routine off-site visits. When not in use, the doctor's bag is stored securely.

In some instances, our practitioners may share a doctor's bag or items may be kept in two smaller bags. Required items may be added to the bag prior to use to avoid doubling up on equipment. Where this is the case, a note is attached to the outside of the bag to remind practitioners of the additional equipment required to be added prior to taking the bag off the premises.

The practice nurse, in conjunction with the general practitioner, regularly reviews the contents of the doctor's bag (refer to **Section 7.21 – Checking and rotating medical supplies**). In addition to checking the condition, stock levels and expiry date of items and equipment, consideration is given during this process to incorporating additional items depending on the practice location, clinical conditions encountered, the shelf life and climatic vulnerability of various medications and the size of the bag.

In addition to containing the required equipment, the doctor's bag also contains the recommended medications. Additional medications may also be added after consideration of the clinical conditions encountered or likely encountered.

Where a doctor's bag is shared, the arrangements are reviewed on an ongoing basis to ensure the practitioners have access to the bag when required. Additional bags are purchased if required.

10.15.2. Procedure

When attending routine off-site consultations or emergency care, each of our practitioners has access to a fully equipped doctor's bag containing:

- Auriscope,
- Disposable gloves,
- Equipment for maintaining an airway (in both adults and children),
- In-date medicines for medical emergencies
- Ophthalmoscope,
- Practice stationery (including prescription pads and letterhead),
- Sharps container,
- Sphygmomanometer,
- Stethoscope,
- Syringes and needles in a range of sizes,
- Thermometer,
- Tongue depressors, and
- Torch.

When selecting emergency drugs for the doctor's bag, our practice considers the:

- Types of clinical conditions and emergencies likely to be encountered,
- Practice location,
- Shelf-life and climatic vulnerability of medicines, and
- Availability of emergency drugs at the practice if the doctor's bag has been taken by another practitioner.

The following medicines have been considered as the most appropriate and necessary medicines and are, therefore, routinely included in the doctor's bag:

- Adrenaline,
- Benzotropine mesylate,
- Benzylpenicillin,
- Diazepam,
- Furosemide,
- Glucose 50% and/or Glucagon,
- Ergotamine maleate,
- Haloperidol or Chlorpromazine,
- Hydrocortisone sodium succinate or dexamethasone,

- Metoclopramide hydrochloride,
- Morphine sulphate or appropriate analgesic agent,
- Naloxone hydrochloride,
- Prednisone,
- Promethazine hydrochloride,
- Aspirin soluble (oral),
- Atropine sulphate,
- Glyceryl trinitrate spray or tablets, and
- Salbutamol inhaler.

To ensure patient safety, all general practitioners are familiar with the medicines that are included in their doctor's bag, including the general usage, suggested dosage and possible side effects.

The doctor's bag also contains the following items:

- Cannulas, iv bungs, tourniquet, butterfly needles,
- Alcohol swabs, specimen containers, urinalysis sticks,
- IV fluids and giving set,
- Peak flow meter,
- Bandages, tape and other dressings,
- MIMS,
- Pathology and radiology request forms,
- Medical certificates,
- Useful telephone numbers – hospitals, health hotlines, and
- Other medicines such as starter packs for antibiotics and analgesics.

Each general practitioner retains ultimate responsibility for maintaining the doctor's bag by replacing used items, and for keeping the supplies of medicines at optimum levels.

Quarterly reviews of the doctor's bag contents are undertaken by the Registered nurse Hanna Chami, in conjunction with the general practitioner, to ensure any perishable items are within their expiry date. Any out-of-date items are discarded appropriately and the stock replenished. To facilitate this process, a *Doctor's Bag Checklist* is used and records the identification of the person conducting the check and the date the check was conducted.

A list of the items that must be routinely included in the doctor's bag when in use is included within the doctor's bag contents and highlights those items of equipment that are not permanently stored with the doctor's bag, but are to be added by the general practitioner before leaving the practice. Such items include an auriscope and ophthalmoscope as these items are expensive to duplicate.

Annually, Hanna Chami works with all general practitioners to conduct a comprehensive review of the items for the doctor's bag to determine if current equipment is adequate based on accepted good clinical practice.

When not in use, the doctor's bag is stored securely in the practice or remains in the locked boot of the doctor's car. When kept in the boot of the car, the practitioner must ensure consideration is given to the possible temperatures within the boot and if the temperature could compromise the viability and integrity to any of the doctor's bag contents, especially to any medicines.

10.16. Vaccine management

Our practice has a dedicated Vaccine Management Policy and Procedure Manual located in folder Section 7 - Clinical Management. Please refer to this document for our vaccine management policies and procedures.

10.17. Medicine management (scheduled medicines)

10.17.1. Policy

It is imperative that our practice ensures all scheduled medicines (including sample medicines) are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and relevant jurisdictional requirements. Failure to comply may render individuals and practice entities liable to prosecution.

To ensure patients' safe use of medicines, our practice stores scheduled medicines appropriately and securely and does not use or distribute them beyond their expiry dates.

According to the *Standard for the Uniform Scheduling of Medicines and Poisons* (Poisons Standard July 2020), poisons are classified according to the Schedules in which they are included. The following is a general description of the Schedules of medicines held in our practice.

Schedule 2 - Pharmacy Medicine: The safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.

Schedule 3 - Pharmacist Only Medicine: The safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.

Schedule 4 - Prescription Only Medicine: Substances, the use or supply of which should be by, or on the order of, persons permitted by State or Territory legislation to prescribe and should be available from a pharmacist on prescription.

Schedule 8 - Controlled Drug: Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

10.17.2. **Procedure**

In our practice, we hold Schedule 2, 3, 4 and we ensure these scheduled medicines are acquired, stored, administered, supplied and disposed of in accordance with manufacturers' directions and the requirements of the

NSW

Poisons and Therapeutic Goods Act 1966

Poisons and Therapeutic Goods Regulation 2008

Acquisition

All scheduled medicines (including doctor's bag emergency medicines, samples obtained from pharmaceutical representatives and vaccines) are obtained by and only on the authorisation of a general practitioner.

Storage

All scheduled medicines held in our practice are stored within the manufacturer's recommended storage temperature range; and in any other environmental condition that is necessary to preserve the medicine's stability and therapeutic quality.

Our practice ensures that all Schedule 2, 3 and 4 medicines are stored in a manner that ensures public access is restricted by Hanna Chami having a key to the nurse.

Administration and supply other than vaccines

Depending on professional scope and competencies, registered nurses or medication endorsed enrolled nurses can only administer Schedule 4 or Schedule 8 medications when:

- There is a recent written instruction from a general practitioner identifying the patient, medication, dose, time, date and route of administration and date the order was written,
- An oral instruction from a general practitioner if an emergency exists with written confirmation 'ASAP' by the practitioner and nurse,
- On the written transcription of the oral instruction (given by a general practitioner in an emergency) by the nurse who received those instructions – this must be countersigned 'ASAP' by the practitioner, and,

- To the designated patient in accordance with the directions on the label when the medications have been dispensed to the patient by a pharmacist or general practitioner.

Registered nurses must document any medications administered in the patient's health records, and sign the entry or use their individual log in.

Only a person who is authorised under legislation may supply a scheduled medicine. In our practice, general practitioners, registered nurses who are authorised under state/territory regulations to supply each of the scheduled medicines are authorised to supply scheduled medicines.

When our practice supplies patients with scheduled medicines (including professional samples), we ensure the medicine is labelled in accordance with our *<select as appropriate> state/territory* regulatory requirements, and that a record of the supply is made. The general practitioner also ensures all reasonable steps are taken to ensure a therapeutic need exists before supplying or administering a scheduled medicine, and that the patient has no allergies or sensitivities to the contents of the medicine.

Schedule 2 and 3 medicines are to be labelled with the following particulars:

Name of medication patient name dose, name of GP and practice.

Schedule 4 medicines are to be labelled with the following particulars:

NB: some of the particulars as required by the regulations may already be included on the standard packaging; however, it is the practice's responsibility to ensure any particulars that do not conform to state/territory regulations or are omitted from the manufacturer's packing must be included by other means, such as affixing a custom-made label. It is important that this section include the types of warnings necessary for display such as a 'sedation' or 'external use only'

Vaccine administration

Prior to administering any vaccines, our practice ensures there are adequately trained staff, emergency equipment and medicines available to deal with serious adverse post-vaccination complications.

In our practice, our registered nurses who have completed an accredited nurse immuniser course are the nurses responsible for administering vaccines to patients.

Prior to administering a vaccine, the nurse ensures the patient does not have any allergies or sensitivities of concern and that a record of the vaccine administration is made.

Records

Records of all transactions (administration and/or supply) of scheduled medicines must be true and accurate and retained in a readily retrievable form for a minimum of two (2) years.

Schedule 4 records must:

- Record the name, strength and quantity of the substance supplied and the date of the supply
- Record the name and address of the patient, and
- Record the name of the general practitioner who issued the prescription, and
- Be retained for at least two years.

Disposal

When our stock of Schedule 2, 3 or 4 medicines reach their expiry date, disposal of the medicines is made into the sharps or clinical waste containers/via the adjacent pharmacy.

Schedule 8 medicines are destroyed in accordance with our state regulations by being witnessed by an authorised person such as pharmacist, other medical practitioner, or police officer. This destruction must be recorded in the Schedule 8 record book and signed by the person destroying the medicine, and countersigned by the witness.

10.18. Safe and quality use of medicines, including prescribing

10.18.1. Policy

If patients understand the reason for taking medications, and the benefits and risks associated with particular medicines, they can make informed decisions about their treatment and will be more likely to follow the recommended treatment plan.

Having access to current information about medicines enables practitioners to engage in best practice prescribing of medications for patient care. Our practitioners also ensure they share decision-making with patients during consultations by discussing the likely benefits, harms and risks of antibiotics.

Patients must not use medicines, samples or medical consumables that have been prescribed for other patients and/or after their expiry date.

10.18.2. Procedure

In our practice, we ensure:

- Patients are informed about the purpose, importance, benefits and risks of their medicines and treatment, and are made aware of their own responsibility to comply with the recommended treatment plan,

- All members of the medical and clinical team access current information on medicines and our practice reviews prescribing patterns in accordance with best available evidence,
- We work towards maintaining a current and accurate medication list for all patients, especially those on multiple medications,
- Other health providers to whom we refer to or handover patient care to receive an accurate and current medicines list,
- The used-by date of all medicines in stock is checked on a systemic basis, and
- We observe the principles of correct patient identification.

To assist patients to make informed decisions about their medicines or to understand any medication safety requirements, our practice team supports any verbal information with consumer medicines information (CMI) leaflets available from the NPS MedicineWise website www.nps.org.au/medical-info/medicine-finder.

To reduce the risk of errors when prescribing or referring, general practitioners ensure the patient's medication list is up-to-date. Prior to prescribing or changing treatment, general practitioners clarify a patient's current medicines list and known allergies. Single-use medications, including antibiotics, should be removed from patients' records when they are no longer required and care is taken with sound-alike or look-alike medicines, particularly when using 'drop-down' boxes in electronic prescribing programs.

We encourage practitioners to review the medicines list with the patient to provide an opportunity to assess the patient's compliance with a medication regime and to identify the need for any further education/support.

Where appropriate, general practitioners provide patients with a copy of their medicines list which is updated when their medicines are changed. It is useful to include all medicines (prescription and non-prescription medicines and complementary healthcare products, if known) on the medication list.

Our practitioners also ensure they share decision-making with patients during consultations by discussing the likely benefits, harms and risks of antibiotics. These patient-centred discussions focus on the following areas:

- Why antibiotics may not be appropriate,
- Antibiotic resistance, and
- Advice of self-management of conditions.

Discussions with patients regarding antibiotic resistance are supplemented through the provision of leaflets and the display of posters in the waiting room.

General practitioners are mindful of patient use of complementary medicines and the potential for side effects and drug interactions with conventional medicines. For this reason, they also should be noted on letters of referral, including those for hospital admissions.

All members of the medical and clinical staff ensure the correct patient and patient health record is used, by using three (3) approved patient identifiers in accordance with **Section 7.6 – Patient identification** before administering any medications, or writing any prescriptions. When patients ask for a repeat of their medications without attending the practice, we require the request in writing and it must contain their name, date of birth and address. We also correctly identify patients when they come to collect their prescriptions.

Our practice team helps patients to understand the medication purpose, options, benefits and risks, and where possible we use written material to support this.

Where patients cannot understand written language or where information is not available in the patient's language, the use of pictorial media or translators may be appropriate. It is particularly important that patients understand the difference between generic drugs and trade name drugs so dosage problems are avoided.

All members of the medical and clinical team access and use the Therapeutic Guidelines and other references where appropriate. Our practice also encourages the use of the Home Medicines Review for eligible patients.

Consumer information about the practice prescribing policy is available to patients and displayed in the waiting room.

The RACGP's *Prescribing drugs of dependence in general practice, Part A Clinical governance framework* is a starting place for our general practice to support solutions to problematic prescription drug use. General practitioners of our practice are reminded that they are not obliged to prescribe the maximum PBS quantity of a drug. A smaller quantity can often address an immediate need whilst minimising the potential risks associated with drug-seeking behaviour.

Our general practitioners are advised to refrain from prescribing medications for family members. Drugs of dependence must not be prescribed to family members except in an emergency.

Prescription pads and paper is stored securely in an area where patients do not have unrestricted access and in the same manner as our Schedule 4 medicines. Software for prescribing is secured by passwords that remain strictly confidential to individual prescribers.

When generated, we ensure prescriptions contain:

- The full details of the prescriber (including an address and telephone number),
- The name and address of the patient,
- The medication (unambiguously),
- The quantity and maximum number of repeats (written in words and figures for Schedule 8),
- The prescriber's signature (preferably in a manner that prevents a patient adding another item above the signature), and
- Precise directions (prescriptions for Schedule 8 and Schedule 4 medicines are not legal without these).

Computer generated prescriptions for drugs of dependence must also contain key elements in the prescriber's handwriting and include dosage amounts in figures and words.

Our general practitioners may be required to obtain permits from the NSW Department of Health prior to:

- Treating a drug dependent person with a Schedule 8 medicine,
- Prescribing dexamphetamine, methylphenidate or methadone (exemptions may apply e.g. paediatricians treating ADHD, patients in oncology or pain clinics at hospital), and
- Treating a person with any Schedule 8 medicines for a period greater than eight (8) weeks (except where specifically exempt).

These permits are to be filed/scanned into the patient's health record and the police and NSW Department of Health must be notified of:

- Lost or stolen drugs,
- Lost or stolen Schedule 8 records,
- When a practitioner has reason to believe a person has obtained Schedule 8 or Schedule 4 medicines (or prescription for the same) by false pretences,
- If a practitioner suspects a patient is attempting to procure a prescription under false pretences, and
- Loss or theft of prescription pads or paper.

For patients going overseas or who find it difficult to access a pharmacy, the PBS will allow repeats to be dispensed with the original supply. The general practitioner must endorse the prescription with the words 'Regulation 24' for this to occur.

Notwithstanding the above, our practice is aware that it is illegal to supply medications:

- To Australian citizens not within the country at the time the prescription is written,
- For use other than the designated purpose for which it was prescribed, and
- For anyone other than the person named on the prescription.

10.19. Clinical guidelines, references and resources

10.19.1. **Policy**

Consistency and quality of care can be assisted by the use of current resources, access to clinical guidelines and communication between the medical and clinical team members. This process is encouraged and facilitated by the practice clinical leader (refer to **Section 8.9 – Governance and management**).

Our practice provides medical, clinical and allied health team members access to a range of resources and materials for reference on clinical matters and items of interest for professional development. General practitioners access current information on medicines to enable best practice prescribing.

We are selective about the guidelines and resources our practice team use to support information provided during a consultation. We aim to ensure the guidelines and resources contain culturally appropriate, current and evidence-based information and are obtained from reputable sources. Where possible, these resources are dated, contain the name of the source and are referenced to supportive evidence.

Any references available contain information that is consistent with current practice guidelines or is based on best available evidence. In the absence of well conducted trials or other higher order evidence, the opinion of consensus panels of peers is acceptable. References and resources, including practice guidelines, are accessible at the point of care.

There is an organised system of access for all members of our practice team to journals, clinical guidelines and other reference material.

The clinical references available and any new additions, deletions or updated versions are communicated to all practice team members involved in patient care to assist with consistency in the approach to diagnosis and management of patients.

10.19.2. **Procedure**

Our practice has the following clinical guidelines, references and resources readily available to all members of the practice team involved in patient care, either in hard copy or electronically:

- in the accreditation folder on google drive.

At least annually, we conduct an audit of our clinical resources and references to ascertain if they still comply with current practices and are providing consistent management and information to patients across the practice team.

It is a standing item at our clinical meetings to discuss any new clinical issues, resources or clinical practice guidelines relevant to the services we provide.

10.20. Checking and rotating medical supplies

10.20.1. Policy

Perishable medical supplies including vaccines, pharmaceutical and medical consumables are correctly stored, stock rotated and discarded if they are past their expiry date.

Our practice has appointed a designated member of the team to take primary responsibility for the proper storage and security of medicines, vaccines and other healthcare products.

10.20.2. Procedure

Hanna Chami maintains a log that incorporates the areas to be checked such as the medicines cupboard, doctors' bags, vaccine refrigerator and other locations where perishable practice stock is kept, along with the date and initials of the practice team member checking the stock.

New stock is marked with a coloured dot to indicate the year of expiry, making checking quicker and to encourage easy identification of the oldest stock so that it can be used first. Stock is also rotated in a uniform manner with the oldest stock placed nearest to the front of the shelf/drawer etc.

Quarterly stock checks are undertaken and any items past their used-by date are to be withdrawn from active storage and disposed of immediately, and according to the manufacturer's instructions and practice procedures.

Necessary and regularly used items are re-ordered using a dedicated supply order form.

10.21. Ethical dilemmas

10.21.1. Policy

Clinical situations that raise ethical questions are a challenge to navigate. Often, there are multiple clinical facts to consider. In addition, patient values and preferences and the concerns and values of family must be taken into account. In some cases, a decision is needed quickly. Ideally, when faced with these difficult clinical situations, our team would use a systematic approach that ensures success in reaching an ethical decision or recommendation (Schumann and Alfandre, 2008).

Our practice considers and documents any ethical dilemmas that arise, and the outcome or solution.

10.21.2. Procedure

In our practice, we use the ‘Four Topics’ approach framework (below) to work through and gather data to facilitate decision-making in ethically difficult situations.

The ‘Four Topics’ approach helps to highlight areas of controversy and to clarify the principles underlying the circumstances of a clinical ethics case. This helps guide discussion among care team members, patients, and families toward achieving a resolution that respects the patient’s values and preferences (Schumann and Alfandre, 2008).

Medical indications	Patient preferences
Beneficence and non-maleficence - What is the patient’s medical problem? History? Diagnosis? Prognosis? - Is the problem acute? Chronic? Critical? Emergent? Reversible? - What are the goals of treatment? - What are the probabilities of success? - What are the plans in case of therapeutic failure? - In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?	Respect for patient autonomy - Is the patient mentally capable and legally competent? Is there evidence of capacity? - If competent, what is the patient stating about preferences for treatment? - Has the patient been informed of benefits and risks, understood this information, and given consent? - If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? - Has the patient expressed prior preferences (e.g. advance directives?) - Is the patient unwilling or unable to cooperate with medical treatment? If so, why? - In sum, is the patient’s right to choose being respected to the extent possible in ethics and law?
Quality of life	Contextual features
Beneficence, non-maleficence, and respect for patient autonomy - What are the prospects, with or without treatment, for a return to normal life? - What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? - Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life? - Is the patient’s present or future condition such that his or her continued life might be judged as undesirable? - Is there any plan and rationale to forgo treatment?	Loyalty and fairness - Are there family issues that might influence treatment decisions? - Are there provider (physician, nurse) issues that might influence treatment decisions? - Are there financial and economic factors? - Are there religious or cultural factors? - Are there limits on confidentiality? - Are there problems of allocation of resources? - How does the law affect treatment decisions? - Is clinical research or teaching involved? - Is there any conflict of interest on the part of the providers or the institution?

- | | |
|--|--|
| <ul style="list-style-type: none"> • Are there plans for comfort and palliative care? | |
|--|--|

Source: Schumann JH, Alfandre D. Clinical ethical decision making: the four topics approach. *Semin Med Pract* 2008;11:36–42.

Examples of situations that might create ethical dilemmas in our practice include:

- Patient–practitioner relationships (familial relationships, friendships, romantic relationship),
- Professional differences,
- Patients giving gifts to the practitioner,
- Emotionally charged clinical situations (e.g. when a patient has an unwanted pregnancy or terminal illness, or wishes to discuss euthanasia),
- Reporting to the state’s driver licensing authority that a patient is unfit to drive,
- A patient’s request for a medical certificate if the practitioner does not believe that the patient’s condition warrants one.
-

Whenever presented with an actual or potential ethical dilemma, our practice: *<amend and add as required>*

- Documents any ethical dilemmas that have been considered, and the outcome or solution,
- Discusses ethical dilemmas at clinical team meetings,
- Provides a buddy or mentoring system where ethical dilemmas can be discussed,
- Uses a clinical intranet or group email to pose common ethical dilemmas and solutions for the clinical team to consider and discuss, and
- Displays a notice in the waiting room listing ethical dilemmas that practitioners sometimes encounter, and how they generally deal with them (e.g. referring the patient to another practitioner or clinic, politely refusing all offers of gifts).

10.22. Telehealth

10.22.1. Policy

Telehealth refers to the use of information and communication technologies to deliver health services to patients of our practice, when face-to-face consultation is not possible or not appropriate due to geographical reasons, infection control management or other factors. Telehealth can take the form of telephone or video conferencing consultation between a GP and a patient.

As our practice is located in a NSW Condell Park area, it is unlikely that we would need to facilitate telehealth services for patients living remotely; however, where this might be required and the patient’s care does not meet the Medicare Benefits Schedule (MBS) eligibility criteria, the patient will be privately billed.

During a declared public health emergency, to help reduce unnecessary risk of community transmission and to provide protection for patients and our practice team, our practice will offer telehealth services to all patients. Face-to-face consultations will still be undertaken where it is considered the most appropriate method, provided it is safe to do so.

Our practice has appointed a member of the practice team as telehealth coordinator to monitor and adapt procedures associated with telehealth consultations, and the Medicare Benefits Scheme, in addition to monitoring and implementing the advice of the NSW health department or federal government, as required.

It is also the responsibility of the telehealth coordinator to ensure all members of the practice team are educated and kept up to date on the telehealth policies of this practice, including making changes as they occur, and these particular responsibilities are documented in the relevant position description (also refer to **Section 8.9 – Governance and management**).

10.22.2. Procedure

In our practice, we have nominated the General Practitioners as telehealth coordinators.

A telehealth consultation is only to be conducted in place of a face-to-face consult when it is clinically appropriate to do so. Examples of consultation types where telehealth is considered appropriate include:

- Routine check-ups that do not require updates to measured information such as height and weight
- Mental health treatment
- Chronic disease management
- Health assessments as guided by the Medicare Benefits Schedule (MBS)
- Support counselling (e.g. pregnancy)
- Repeat prescriptions where the patient is known to the practice
- Reviewing blood/other results

Examples of consultation types where telehealth is **not** appropriate include:

- minor excisions and procedures,
- wound management,
- spirometry,
- insertion and removal contraceptive implants,
- immunisations and other routine injections,
- Pap smears,
- check-ups requiring measured information such as height and weight or blood pressure,
- prescriptions for scheduled medications to patients not known to the practice,

When arranging a telehealth consultation, it must first be ascertained if the patient meets the Medicare Benefits Schedule (MBS) eligibility criteria, either by geographical location, demographic (e.g. aged care residents or Aboriginal and/or Torres Strait Islander peoples), or as instated by the state or federal government during a public health emergency.

If the patient is eligible for a Medicare Benefits Schedule (MBS) claimable telehealth consultation, the consultation can be booked in through our reception team or via our online booking system.

If the patient is ineligible for a Medicare Benefits Schedule (MBS) claimable telehealth consultation, the patient must be informed of the fees associated with accessing a telehealth consultation before the appointment is booked.

When booking a telehealth consultation, patients are informed of the risks and benefits of technology-based consultations, including their rights and responsibilities, and must provide consent to continue.

When a telehealth consultation takes place, wherever possible, it is conducted via video conferencing. Video conferencing allows the practitioner to observe symptoms, in addition to providing opportunity for the practitioner to pick up on other visual cues that might require further investigation or discussion. Video conferencing also allows for clearer communication with patients through practitioners being able to screenshare or demonstrate actions using models.

In our practice, we use Zoom, as it meets requirements for privacy and confidentiality by having end-to-end encryption, requiring a password to join the session, etc.

Where a video conference consultation cannot occur, such as in situations where the patient does not have access to the required technology or where internet connection may be unstable, a telephone consultation will be conducted. Aural cues are key for practitioners to be attentive to during telephone consultations, such as listening for shortness of breath, fatigue, etc.

For patient-end services with a specialist, our processes have been established to align with the RACGP *Telehealth video consultations guide, 2019* accessible via the RACGP website. Our practitioners are able to access the Medicare Benefits Schedule (MBS) where clinical support is provided during video consultations where the patient:

- is located outside of Australian Standard Geographical Classification – Remoteness Area (RA) 1 classification (major cities), or
- accesses care from an eligible Aboriginal medical or health service, or
- lives in an eligible residential aged care facility, and
- is located more than 15 kilometres from the specialist who is providing the treatment.

When telehealth consultations are implemented as part of a pandemic response plan, the telehealth coordinator ensures all physical requirements are in place to offer extended telehealth services, such as having sufficient inward and outbound telephone lines, call diversion where clinical team members are working from home or off-site, video conferencing software installed on all computers, remote access to the practice software systems enabled for off-site workers, and access to printers and facsimile machines for the clinical team members working off-site or from home.

At the commencement of a telehealth consultation, in accordance with **Section 7.6 – Patient identification**, the patient's identity is verified and verbal consent is obtained from the patient to proceed; this consent is particularly important in situations where it is evident that the patient is not in a private location, or is not alone.

In situations where a third party is involved in the consultation, whether requested by the general practitioner or present with the patient, consent from the patient will be obtained in accordance with **Section 7.10 – Third party observing or clinically involved in the consultation**.

General practitioners are responsible for documenting the care provided by them in accordance with **Section 7.2 - Clinical content of patient health records**, in addition to ensuring all other protocols are followed in relation to **Section 7 – Clinical management**.

11. Continuous improvement

11.1. Plan set and review business goals

11.1.1. Policy

A business needs to operate successfully to create an environment where quality clinical care can be delivered. To operate a business successfully, strategic thinking and business planning is as important as financial budgeting and reporting. A documented business plan (that is linked to our business strategy and includes how it will be implemented) is an effective way of measuring our practice's progress, and increases the likelihood of achieving our practice's objectives.

Having a plan helps to get the team working together towards a common goal. It gives our team the ability to evaluate progress and helps the practice achieve consistency and quality in its operations, while achieving continuous quality improvements.

Our practice defines our governance structures relative to our own requirements.

In our practice, we have a merging of governance and management responsibilities.

11.1.2. Procedure

Our practice has an action plan that sets out our business goals and progress, instead of a strategic plan.

We regularly evaluate our practice's progress against our business goals in a number of ways, such as:

- Including it as an agenda item in our team meetings,
- Scheduling business planning and evaluation meetings at defined intervals,
- Reviewing the practice's patient population data and outcomes,
- Seeking patient feedback,
- Holding a team planning meeting, and
- Maintaining progress reports against the business' *<select as appropriate> strategic/action plan.*

11.2. Risk assessment and management

11.2.1. Policy

Risk assessment and management is a process of identifying and monitoring preventable and predictable risks, and developing accessible strategies and good practice systems that promote best practice and reduce risk.

Our practice has a system of risk assessment and management that ensures proper systems and procedures are in place within our practice. These systems and procedures are documented and regularly reviewed.

The aim of these systems and procedures is to:

- Identify all strategic risks using a risk management process
- Ensure risk management becomes part of day-to-day management
- Provide our practice team with policies and procedures necessary to manage risk
- Ensure all members of the practice team are aware of risks and how to manage them
- Assign accountability for risk
- Monitor our risk profile and implement continuous improvement approaches to risk management, and
- Ensure successful implementation of changes and improvements made to our risk management systems.

Our practice undertakes regular risk assessment and management in the areas of financial services, human resources, facilities (computers, telephones, storage, and infection prevention and control), clinical services and patient services.

As near misses and mistakes which are not appropriately dealt with may expose patients to an increased risk of adverse outcomes and practitioners to an increased risk of medico-legal action, our practice implements and maintains a risk management system following a significant event/incident (refer to **Section 3.2 - Incidents and injury and adverse patient events** and **Section 3.3 - Sharps injury management and other body-substance exposure**). This is done in addition to regular monitoring of systems and processes to prevent and reduce risk.

Our practice also has an emergency response plan for non-medical emergencies such as failure of electricity supply, telephone or water, fire or false fire alarm, property damage, break-in, abusive or threatening telephone calls to persons at the practice, leakage of toxic chemicals, bomb threats and letter bombs, natural disasters, and the sudden unexpected absence of key practice team members (refer to **Section 3.17 – Non-medical emergency response and business continuity**).

11.2.2. Procedure

In our practice, it is the responsibility of Dr Belel Ejje to undertake regular risk assessments in the areas of financial services, human resources, facilities, clinical services and patient services.

The risk assessment review is conducted on a yearly basis.

In addition to regular risk assessments, a review of significant events/incidents occurs with every incident, near miss or mistake in clinical care or practice procedure. If a large extraordinary event occurs, a meeting is scheduled immediately. If a smaller event or risk is identified, items are discussed at the next scheduled practice or clinical team meeting.

Improvements/actions are applied as a result of the significant event so as to prevent a recurrence, and any improvements/actions implemented are reviewed to determine if the improvement was successful or if further improvements/actions are necessary.

Additional tools and strategies used in this practice to manage risk include:

- Adherence to the *RACGP Standards for general practices* via the accreditation process,
- Regular practice and clinical team meetings and effective communication with all team members,
- Ensuring appropriate qualifications, induction and training for all members of the practice team,
- Patient feedback obtained via surveys/suggestion box/logbook of complaints/comments,
- Documentation of sterilisation procedures including servicing, details of individual loads/cycles and team training,
- Comprehensive patient health records and backup of electronic data,
- Documentation/tracking of abnormal results,
- Logging/recording of telephone exchanges with patients,

- Ensuring correct identification of patients at each face-to-face, telephone and electronic encounter and on correspondence, and
- Maintaining a risk register.

11.3. **Review of policies and procedures**

11.3.1. **Policy**

Policies and procedures relating to the administration of this practice are formally reviewed on an annual basis or when any changes occur to our systems and processes, prompting earlier review or revision (e.g. equipment changes).

Our practice encourages and promotes sharing of information about quality improvement and patient safety, including protocol and policy/procedure review or suggestions.

11.3.2. **Procedure**

Discussion and suggestions for improvements specifically around quality, patient safety or policies and procedures is a standing item on our practice team meeting agenda.

All members of the practice team may informally approach the practice owners with suggestions for new policies and procedures or with revisions to existing policies and procedures.

Our practice has appointed Zoe Taleb with designated responsibility for coordinating and sustaining our policies and procedures. This includes continually modifying and improving our procedures and written policies in accordance with the most recent evidence and guidelines, while ensuring the timely dissemination of information concerning changes to any policies and procedures.

Sumayyah Mechraoui, in consultation with Zoe Taleb, or other practice team members, as appropriate, approve all policies and procedures. Once approved, documentation is amended in this manual and elsewhere as necessary.

Analysis of practice data may also inform any changes to services or other practice activities to improve the health outcomes of our patients. These quality improvement activities may necessitate a new or revised written protocol.

Formal revision and final approval of all new and revised policies and procedures are presented at practice team meetings.

To ensure all members of the practice team are aware of new policies and recent changes, we establish a distribution plan whenever new or changed policies are executed.

11.4. Training, qualifications and continuing education

11.4.1. Policy

Administrative and other non-clinical practice team members have a vital role in the provision of safe and quality care, and therefore require training appropriate to their role.

Having medical, clinical and other healthcare providers who are suitably qualified reduces the risk of medical errors and means that our practice provides patients with safe and quality care.

Administrative and other non-clinical practice team members must complete training appropriate to their role, and to our patient population. This process commences at induction and proceeds on an ongoing basis with commitment from both the practice and the practice team member.

Our practice team members involved in the medical and clinical care of patients have the responsibility to maintain their relevant national registrations, have proof of their credentialing, and comply with their ongoing continuing professional development requirements. All medical, clinical and other healthcare providers must:

- Have appropriate current national medical or nursing registration,
- Be suitably qualified and trained,
- Maintain the knowledge and skills that enable them to provide quality clinical care,
- Comply with the professional development requirements and code of conduct of the relevant professional organisation, regardless of whether they are a member of the organisation, and
- Work within their scope of practice and competencies.

Copies of records showing current registration (where required), training and qualifications, competency and continuing professional development activities for each member of the practice team (including general practitioners) are provided to the practice to be retained in the team member's employment or contract file.

Our practice encourages team members to maintain their knowledge, skills and a professional attitude by maintaining membership with their professional specialty organisations (e.g. RACGP, AMA, APNA, AAPM).

Both in-house and external training programs are utilised for our staff. Practice team members are requested to obtain a certificate of attendance or evidence of participation and completion for all training (including informal training sessions) undertaken, allowing for this information to be retained on file.

It is acknowledged that some crucial areas for training exist, depending on the team member's role and responsibilities. These training requirements are met according to the team member's training schedule.

Education is not limited to professional technical skill updates, but includes a variety of training and educational activities in areas of need as they arise.

All members of the practice team are encouraged to identify any training needs they may have and seek to find training to meet these needs. Usually, this occurs in consultation with the team member's supervisor and this process should be documented.

Methods for training opportunities include:

- Education at formal institutions,
- Attendance of educational seminars,
- Online training,
- In-service education given by company sales representatives or other team members, and
- Reading of journals, evidence-based guidelines or researching information for the practice.

11.4.2. Procedure

Our practice's general practitioners, nurses and other healthcare professionals involved in clinical care must provide evidence of current national registration each year and we retain this information on file.

Copies of training and qualifications, competency and continuing professional development activities for each member of the practice team (including general practitioners) is also to be provided to the relevant practice team member at least annually, so that this information can be retained in the team member's employment or contract file.

If a member of the practice team identifies a course, education session, workshop, or a meeting that they wish to attend, they are to alert their supervisor who will discuss this with the practice manager/practice principal to seek approval for attendance. In seeking time off to attend external sessions, team members should consider workload to ensure adequate coverage. An application for study/conference leave should be lodged with as much advance notice as possible.

Once an education/training session is approved, details of the session are recorded within the team member's *Practice Team Training Plan*.

Training schedule

It is acknowledged that to maintain competency required for the efficient and smooth running of this practice, and for medico-legal reasons, all practice team members are required to undertake ongoing

training and upskilling and, where appropriate, competency assessment. The type of training and upskilling that is to occur will be dependent on that person's position and role within the practice.

A *Practice Team Training Plan* is developed for each member of the practice team, and is adhered to and reviewed during the annual performance appraisal process.

11.5. Accreditation and continuous improvement

11.5.1. Policy

This practice is committed to attaining and, where possible, exceeding the *Standards for general practices 5th edition* as defined by RACGP and as such, AGPAL is our chosen accreditation provider.

The Practice owners have primary responsibility for our quality improvement systems and processes.

Our practice team is committed to encouraging quality improvement and identifying opportunities to make changes that will improve the clinical care of patients and activities to promote health in the overall practice population. Further, the practice has a process for the practice team to provide input, suggestions and to escalate issues.

Our practice uses patient and practice data to identify opportunities for improvement and to monitor evidence of improvement occurring.

Quality improvement or clinical audit activities, for the purpose of seeking to improve the delivery of a particular treatment or service offered by our practice, is considered to be a directly related secondary purpose for collection of information; therefore, we do not need to seek specific consent for this use of patients' health information, however, we do need to include information about quality improvement activities and clinical audits in our patient consent form for the collection, use and disclosure of health information.

Our practice regularly implements improvements in response to the analysis of patient (and others) feedback, including complaints. Where appropriate, we provide information to patients about improvements made as a result of their input or feedback.

Our practice undertakes quality review activities such as audits, routine data checks, accounts reviews and health record reviews.

Our practice has a planned approach for improvements using the Plan Do Study Act (PDSA) cycle.

11.5.2. Procedure

Our practice has appointed Dr Belel Ejje with primary responsibility for our quality improvement systems and processes.

Discussion and suggestions for improvement to quality and patient safety is a standing item on our practice meeting agenda and our practice has a process for the practice team to provide input, suggestions and to escalate issues both within these meetings and on an ad hoc basis.

Accreditation via a peer assessment of our performance against the *RACGP Standards for general practices 5th edition* is a driver of quality improvement. Patient feedback is also an essential component of our quality improvement activities.

Our practice utilises information management techniques that allow us to collect and analyse our data. Consistent data coding systems are used to facilitate this process including using 'drop-down box' functionality where possible instead of 'free text' entries. We also use the search tools in our clinical software and the data extraction tool.

Our team utilise national registers to assist with quality improvement activities, including our quarterly Practice Incentive Program (PIP) statements, reports from the Australian Immunisation Register and Pap screening data.

Quality improvement is a team activity and provides opportunities for all members to contribute to achieving improvements.

Our practice has a planned approach for improvements using the Plan Do Study Act (PDSA) cycle. The PDSA cycle is a tool that provides a framework for developing, testing and implementing changes.

The four (4) steps in the PDSA cycle are as follows:

Step 1: Plan

Planning the improvement activity involves identifying:

- What the improvement activity is,
- Who needs to be involved, or made aware of the activity,
- When will the activity take place,
- Where the activity will take place,
- What outcomes are predicted, and
- What data will be collected to measure the outcomes of the activity.

Step 2: Do

Implementing the improvement activity includes:

- Involving the appropriate practice team members,
- Documenting the steps taken, and
- Seeking feedback from all involved.

Step 3: Study

Studying the improvement activity involves:

- Analysing and reflecting on the results,
- Reviewing whether the activity was successful,
- Determining if the results meet expectations, and
- Identifying whether further improvements need to be implemented.

Step 4: Act

Acting on the improvement involves identifying:

- What will be taken forward from this cycle, and
- Whether something else will be tested using a new PDSA cycle

If the continuous quality improvement activity has been successful, our practice looks at:

- How new policies or procedures will be incorporated into the way the practice team works,
- How the practice team members will be made aware of the change,
- Where the new activity will be documented, and
- How the new activity will be monitored to ensure all team members are participating.

If the continuous quality improvement activity has been unsuccessful, our practice looks at:

- What the activity has shown, and
- What different improvements might be able to be made.

11.6. Patient feedback

11.6.1. Policy

Our practice encourages patients and other people to give feedback, both positive and negative, as part of our partnership approach to healthcare. We have specific processes in place for responding to feedback.

In order to respond to patient feedback and make improvements, our practice has appointed a person with primary responsibility for examining issues raised and for facilitating improvements in the practice.

Opportunities are available for patients and other visitors to tell us 'How we are doing'. We have a 'suggestion box' available in the waiting room which allows patients to give us personal feedback on a day-to-day basis. We aim to follow up ideas and acknowledge notes of appreciation where we can.

Patients are encouraged to raise any concerns directly with the practice team and attempts are made for a timely resolution of such concerns within the practice in accordance with our complaints resolution process (refer to **Section 5.13 – Complaints**).

Our practice team seek structured/systematic patient experience feedback at least once every three (3) years and the data collected is analysed and the findings, including any improvements made, are communicated back to our patients.

As part of our risk management activities, a record of incidents, including complaints from patients, is maintained.

11.6.2. Procedure

Our practice has appointed reception and GP's with responsibility for examining issues raised and facilitating improvements in the practice.

At any time, patients can provide feedback or make a complaint. They are advised of the processes for providing feedback through:

- A notice displayed in the waiting room and information contained in the practice information sheet,
- Our practice website advising how to provide feedback or make a complaint,
- Provision of a 'suggestion box' in a common patient area (i.e. waiting room), and
- Adequate training provided to all practice team members to ensure patients of the practice feel confident that any feedback or complaints made at the practice will be handled appropriately.

We seek structured/systematic patient experience feedback at least once every three (3) years which meets the requirements outlined in the RACGP's *Patient feedback guide*.

Feedback collected includes, but is not limited to, the following six (6) categories that are considered critical to patient experiences within healthcare facilities:

- Access and availability,
- Provision of information,
- Privacy and confidentiality,
- Continuity of care,
- Communication and interpersonal skills of the clinical team, and
- Communication and interpersonal skills of the administrative team.

Data collected by our practice is analysed to identify potential opportunities for quality improvement. These findings are communicated back to our patients through a poster in the waiting room, newsletters and via our website, or individually as appropriate.

11.7. Management of potential medical defence claims

11.7.1. Policy

Our practice notifies our medical defence organisation immediately if there is suspicion that a claim will be initiated by a party against any practitioner(s) or our practice, or upon receipt of an impairment certificate served upon the practice or practitioner. This practice understands that the organisation or person against whom the claim is made has only 60 days from receipt of the impairment certificate to accept or challenge the claim.

11.7.2. Procedure

All members of the practice team should forward any legal documents delivered to the practice or any complaints that could result in a claim directly to Dr Ejje or Dr Awad, who will notify the parties concerned.

The case is not discussed with anyone other than the relevant medical defence organisation, and personal notes and communication with the insurance organisation are not to be kept in the patient's health record.

Upon receipt of a subpoena to produce records:

- Check the description of what is to be produced,
- Ensure original records are provided, but keep a photocopy,
- Place the original records in an envelope with the patient's name clearly identified, the court number (which will be shown on the subpoena) and the envelope marked 'Confidential Medical Records',
- Seal the envelope and attach a copy of the subpoena to the envelope,
- Arrange for a courier to deliver the records to the court (not to the requesting solicitor):
 - if the solicitor who served the subpoena does not provide the courier, our practice is entitled to charge for the courier service,
- Discuss courier arrangements with the solicitor who has served the subpoena, and
- Wait for the court to return the records in due course.

Should an impairment certificate be served, the state insurance authority and our practice's medical defence organisation will be notified and forwarded a copy of the impairment certificate.

Members of the public may make a notification to Australian Health Practitioner Regulation Agency (AHPRA) about the conduct, health or performance of a practitioner or the health of a student. Practitioners, employers and education providers are all mandated by law to report notifiable conduct relating to a registered practitioner or student to AHPRA.

11.8. Continuity of care

11.8.1. Policy

This practice aims to encourage patients to develop a positive relationship with their general practitioner and other practice team members over time to enhance the provision of high quality and comprehensive patient care, including effective health promotion and strategies for the early detection of disease.

Our practice has strategies and policies that encourage continuity of comprehensive care by facilitating:

- Relational continuity: the sense of affiliation between the patient and the general practitioner; ‘my doctor’,
- Management continuity: consistency of care by various people involved in the patient’s care, and
- Informational continuity: maintenance of information across healthcare events through documentation, handover and review.

Our medical notes demonstrate relational, management and informational continuity of comprehensive care. In addition, and at a minimum, 50% of our active patient health records have entries extending back over two (2) years.

11.8.2. Procedure

Relational continuity

All members of the practice team appreciate that it is important for our patients to have an opportunity to develop an ongoing relationship with the practice, incorporating the general practitioners, nurses, allied health team members and others. Strategies to achieve this include the following:

- Our appointment schedule has a separate appointment list for each general practitioner, nurse or allied health team member,
- Patients are able to request their preferred general practitioner or other healthcare provider when making an appointment and this request is accommodated if possible,
- Where possible ‘walk-ins’ are able to see the general practitioner of their choice, or the practitioner they saw on previous visit(s),
- Should a general practitioner be retiring or leaving or taking extended leave, our practice endeavours to minimise the disruption to care by providing patients at least four (4) weeks’ notice and by informing them of who will take over their care in the absence of their usual practitioner,
- Ensuring adequate clinical handover, either written, face-to-face or via the telephone is provided in all cases, and
- Special consideration is given to patients with high needs and, in the event of practice closure or should these patients be taking a vacation, we endeavour to assist these patients with finding alternative appropriate care and consideration is given to measures to make their health records available.

Management continuity

General practitioners, nurses and allied health team members coordinate the management of individual patient care and endeavour to maintain a consistent and cohesive approach through the following:

- Plans for the management of patients with complex clinical conditions are documented in the patient health record to ensure consistent clinical care and advice is provided to the patient,
- Clinical handover occurs when a patient's care is handed over to another health professional both within and external to the practice,
- Patient resources to support preventative activities or to assist with providing information about specific diseases or management choices are shared by all members of the medical and clinical team to ensure, as much as possible, patients receive consistent information and advice from all involved,
- To ensure clinical care is consistent with the best available evidence, culturally sensitive and consistent throughout the practice, all members of the medical and clinical team regularly attend clinical meetings or in-service together,
- Health summaries are updated to reflect recent significant events as information is gathered by those providing clinical care, so that care remains responsive to individual patient needs,
- Issues raised in consultations are documented in the patient health record to enable others providing subsequent clinical care to follow up previous problems,
- Patients are enrolled in disease prevention and health promotion activities where eligible and receive reminders for health checks,
- Children receiving immunisations are recorded on the practice immunisation reminder schedule and notified when future vaccinations are due, and
- Where preventative activities, such as Pap screening or immunisation are provided, the patient is bulk billed.

Informational continuity

General practitioners, clinical and allied health team members involved in the care of patients within the practice, have access to the patient's health record and a clinical handover occurs whenever there is an interface of care by different providers:

- Clinical care administered by members of the practice team is documented in the patient health records by the health professional administering the care,
- Letters and correspondence from other external care providers (e.g. allied health, specialists) can be read by all members of the practice team providing care,
- External care providers are notified should the planned management of a patient change or be reviewed, and
- Clinical handover of patient occurs both within the practice, to other members of the team and to external care providers whenever there is an interface of care by different providers; this may be face-to-face, written, via telephone or by electronic means.

11.9. Governance and management

11.9.1. Policy

Our practice has integrated governance and management systems that maintain and improve the quality of care provided to patients.

Practice governance relates to the principles, methods and processes that clinicians and health service managers follow in order to support patient safety and quality care. It also helps to set, measure and achieve social, fiscal, legal and human resources objectives.

Good management and leadership foster a culture that is based on mutual respect. When we have this, the entire practice team will be supported to achieve excellence in all areas of the practice and participate in just and open discussions about how the practice can improve.

The *RACGP Standards for general practices 5th edition* describe clinical governance as a “framework through which clinicians and health service managers are jointly accountable for patient safety and quality care”.

We recognise that good clinical leadership is required to engage the entire practice team in a commitment to excellence by nurturing a culture of openness and mutual respect that allows just and open discussions about areas for improvement.

We aim to develop an organisational culture where participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded, and all members of the practice team feel accountable and involved in monitoring and improving care and services.

To promote clear lines of accountability and responsibility for encouraging improvement in safety and quality of clinical care, and the sharing of information about quality improvement and patient safety within the practice team, we have appointed leaders who have designated areas of responsibility for safety and quality improvement systems within the practice.

Our leaders promote a multidisciplinary team approach to endorse a climate of safety and quality that does not blame, but rather seeks to solve problems.

Our practice leaders oversee the delegation of tasks to others but retain accountability for quality and safety.

Roles and responsibilities are specified in our position descriptions and all members of the practice team are aware of the designated leadership responsibilities and who has these appointments.

Our leaders promote compliance with the *RACGP Standards for general practices 5th edition* and relevant jurisdictional legislation or accepted industry requirements.

11.9.2. Procedure

We have nominated key members of the practice team with primary responsibility for the management of specific areas. Our leaders are resourced and supported to make improvements in their specified areas of responsibility through the coordination of practice activities such as:

- Education and information sharing,
- Clinical audits/research/data analysis,
- Promoting evidence-based practices,
- Risk management analysis – clinical and general,
- Openness to suggestions and feedback, and
- Policy and procedure development and review.

Our leaders can delegate specific areas of responsibility to other nominated members of the practice team and these particular responsibilities are documented in the relevant position descriptions. All members of our practice team can identify each person and their primary or delegated responsibility.

Areas of responsibility and their delegated authority are:

- Clinical risk management systems including receiving and disseminating any important communication or updates (e.g. health alerts) and contingency plans - Reception
- Business risk management systems -Dr Belel
- Quality improvement and risk management (non-clinical and business related) - Dr Ejje & Dr Awad
- Clinical care - GP's
- Telehealth services - GP's
- Information management -Dr Belel
- Human resources - Dr Belel and Dr Mahmoud
- Feedback and complaints - Reception, GP's
- Workplace health and safety - All staff
- Privacy - All staff
- Electronic systems and computer security - Abdelfattah
- Safe storage and security of medicines - GP's and Nurse
- Vaccine management - Farah
- Infection prevention and control (incorporating the sterilisation process, immunisation, and practice team education) - All staff
- Environmental cleaning -Dr Belel