



**The Royal New Zealand  
College of General Practitioners**

November 2009

**Notice of Consultation – November 2009 to April 2010  
2011 review of *Aiming for Excellence*, the New Zealand Standard for General Practice**

The fourth edition of *Aiming for Excellence* is due for publication in 2011. In preparation, the Royal New Zealand College of General Practitioners seeks your views on its third edition. We need to understand whether the measurements are still relevant and acceptable for use by general practices. The consultation period will run from November 2009 to the end of April 2010.

Practices using *Aiming for Excellence* are providing evidence of tangible shifts in the quality of services provided to patients. Its continuing use is assisting practice teams to build resiliency through improvements in internal communication processes, risk management, systems development, and whether they are providing safe, effective, efficient and continuing care.

In 2009, three quarters of all general practices have either achieved or are working towards CORNERSTONE accreditation. This means continued relevance of *Aiming for Excellence* is essential. Your advice is sought to help us understand whether:

- *Aiming for Excellence* still measures what it was intended to measure.
- It is still acceptable for assessing New Zealand general practice quality.
- The current format is fit for purpose in 2011.

Feedback from all stakeholders remains an essential element of continuing development. Advice is sought from all stakeholders, including patients and communities.

- The full version of *Aiming for Excellence* can be found on the RNZCGP website:  
<http://www.rnzcgp.org.nz/assets/Uploads/qualityprac/Aiming-for-Excellence-2009-including-record-review.pdf>
- Testing the new version of *Aiming for Excellence* will begin during 2010. The College would like to hear from practices, general practice networks and Primary Health Organisations who are interested in being involved in the process.

# Aiming for Excellence

## – Consultation Document

New evidence or information must always inform tools and processes developed for use in general practice because they impact directly on patient care. Your feedback will ensure *Aiming for Excellence* remains useful and relevant for general practice teams working in primary care.

We need to understand whether:

- Indicators and criteria are still accurate and relevant
- Standards for each criterion are set at the right level
- The structure of *Aiming for Excellence* still works

Things change rapidly in the health sector, have we missed anything you consider important?

### Instructions:

There are 4 questions for each criterion. We would like to know if the criterion is:

- Specific – is it easy to understand and accurately describes what is expected?
- Easy to measure – if not why not?
- Achievable – if not, what are the barriers?
- Relevant – is it applicable to general practice?

**Scoring:** Please tick the box to record your answer.

(Example)

<b>Indicator A.1.1</b>										
<b>The practice team demonstrates its commitment to the Code of Health and Disability Services Consumers' Rights 1996</b>										
No.	Criteria:	Are the criteria Specific?		Easy to measure		Are they achievable		Relevant to General Practice		Comments on the indicator or criteria
		Yes	No	Yes	No	Yes	No	Yes	No	
A.1.5 – 1 ★★	The practice has a documented complaints policy	✓		✓		✓		✓		.....

Thank you for taking time to complete this document. Feedback can be submitted on line or by mailing the document back to the College by 31 April 2010.

Maureen Gillon:  
RNZCGP  
PO Box 10440  
Wellington  
[mgillon@rnzcgp.org.nz](mailto:mgillon@rnzcgp.org.nz)

### Focus Groups

If your practice, faculty, network or PHO would prefer to hold a focus group in your area contact Maureen Gillon – [mgillon@rnzcgp.org.nz](mailto:mgillon@rnzcgp.org.nz) (04) 496 5964

# Aiming for Excellence

## **The standard for New Zealand General Practice – 3<sup>rd</sup> edition 2009**

---

The College uses new evidence or information to continually refine indicators and criteria in this document. It is committed to guiding improvements in the quality of care provided to patients and supporting general practices. To ensure relevance the College will continue to monitor feedback from patients, health professionals, and other health sector stakeholders.

Changes to *Aiming for Excellence* since the second edition have been responsive to feedback received during 2002 to 2006 and during the 2007 consultation phase. Testing and validation have ensured that *Aiming for Excellence* remains current, relevant, and useful for those who work in and use general practice services in New Zealand.

### **Acknowledgements**

This document builds on the work of the Royal New Zealand College of General Practitioners Professional Development Practice Sub-Committee, The New Zealand College of Practice Nurses NZNO, Practice Managers and Administrators Association of New Zealand (PMAANZ), Te Akoranga a Maui, the RNZCGP Consumer Liaison Committee, general practitioners, practice nurses, practice managers, assessors, Independent Practitioner Associations, Primary Health Care Organisations and practice teams that participated in the pre-test (1999), pilot study (1999), field trial (2000-2001) the implementation phase from 2003 to 2006, and the 2007 review and validation field trial.

This resource builds on the work of other international Colleges, particularly the Royal Australian College of General Practitioners, who have shared information and their experience of standards development and assessment. The Royal New Zealand College of General Practitioners has shared information with other international Colleges in particular, the Canadian Quality in Family Practice Programme.

Thanks are due to:

- Associate Professor, Stephen Buetow for his contribution as academic advisor to the redevelopment and validation of this practice assessment tool.
- Ministry of Health and ACC – funding assistance for the development and validation process.
- RNZCGP Board of Quality; Dr John Wellingham (Chair), Dr Kenneth Tong, Dr Chris Fawcett, Dr Harry Pert, Dr Jim Vause.
- *Aiming for Excellence* Working Group: Dr Kenneth Tong (Chair), Dr Tane Taylor (Te Akoranga a Maui), Dr Helen Bichan (Consumer representative, Bioethics Committee), Jane Ayling (CORNERSTONE Practice Nurse Assessor), Stella McFarlane (CORNERSTONE Practice Manager Assessor), Kevin Smith (PMAANZ), Waveney Grennell (RNZCGP CORNERSTONE Manager), Maureen Gillon (RNZCGP National Director Quality), Dr Peter Jansen (Mauri Ora), Kathleena Smith (Mauri Ora), Ida Faiumu-Isoako (Consumer Liaison Committee), Jo Rankin (Quality Manager, ProCare), Dr Henare Broughton, Lindsey Mitchem (Quality Manager, Pinnacle).

### **Disclaimer**

While this document has been developed after consultation with many people and the relevant laws, consideration should be given to the changing nature of the environment and law, and neither the RNZCGP nor any other person associated with the preparation of these standards accepts the responsibility for the results of any action taken, or not taken, by any person as a result of anything contained in or omitted from this publication.

Published by the Royal New Zealand College of General Practitioners, New Zealand

First printing January 2000, Second edition 2002, Trial version 2006, Third edition 2008, Revision of third edition, 2009.

© The Royal New Zealand College of General Practitioners, New Zealand, 2000, 2002, 2008, 2009.

The Royal New Zealand College of General Practitioners owns the copyright of this work and has exclusive rights in accordance with the Copyright Act 1991.

In particular, prior written permission must be obtained from the Royal New Zealand College of General Practitioners for others (including business entities) to: copy the work, issue copies of the work, whether by sale or otherwise, show the work in public, make an adaptation of the work as defined in the Copyright Act 1994.

# Contents

<b>Introduction</b> .....	5
<b>Section A: Factors affecting patients and enrolled populations</b> .....	11
Indicator Group 1 – Needs and rights of patients	
Indicator Group 2 – Access to practice services	
Indicator Group 3 – Absence of physical barriers to access	
<b>Section B: Physical factors affecting the practice</b> .....	18
Indicator Group 4 – Practice facilities	
Indicator Group 5 – Medical equipment	
<b>Section C: Clinical practice systems</b> .....	25
Indicator Group 6 – Comprehensiveness and coordination of care	
Indicator Group 7 - Disease prevention and promotion of health	
<b>Section D: Practice and patient information management</b> .....	30
Indicator Group 8 – Integration and continuity of care	
Indicator Group 9 – Content of medical records	
Indicator Group 10 – Information management	
Indicator Group 11 – Human Resource Management	
<b>Section E: Quality Improvement and Professional Development</b> .....	35
Indicator Group 12 – Continuous Quality improvement and professional development	
<b>Appendix</b> .....	38
1. History of development	

# Introduction

*Aiming for Excellence* is a reflection of ongoing improvements in the quality care provided by general practices. It contains indicators, criteria and standards for use in quality improvement activities such as the Cornerstone programme. It is used by general practice teams to review systems and processes that support care provided to patients. The standards included in this edition are by no means exhaustive. They recognise diversity in general practices and focus on what is needed to provide safe and effective services to support local populations in attaining their overall health goals.

*Aiming for Excellence* was first published in 1999. It was the beginning of a new millennium and also a new era in the quality movement in New Zealand general practice. This was the first time the Royal New Zealand College of General Practitioners (RNZCGP) had undertaken to develop a set of standards for general practices in New Zealand. They were developed in consultation with a wide range of stakeholders including general practitioners, practice nurses, practice managers, Maori, consumers and funders. More importantly it was a reflection of the College's commitment to improving health outcomes through high quality general practice. Those standards contained indicators that were regarded as best practice at the time. Following the validation and field trials, the second edition of *Aiming for Excellence* was released in 2002.

Subsequently, the assessment process using *Aiming for Excellence* as the instrument for practice assessment was formally branded as the Cornerstone General Practice Accreditation programme. By the end of year 2007, more than 520 practices throughout New Zealand had enrolled in the programme and 274 had achieved Cornerstone accreditation status.

Feedback on the process and instrument has been overwhelmingly positive and includes constructive suggestions for improvement. A significant finding reported by practices was the enhancement of the functioning of general practice teams, and hence their ability to become learning organisations. In recent years *Aiming for Excellence* has received both national and international recognition.

In this edition of *Aiming for Excellence*, about one third of the indicators have been significantly revised to reflect the changes that have taken place in the general practice environment. This provides new challenges on the path to continuous quality improvement. The content provides better guidance for practices contemplating or preparing to undergo accreditation for the first time.

The RNZCGP produced this document to guide its members to provide robust general practice services as part of primary health care, to achieve improved health outcomes and reduced health inequalities in a safe, accessible, effective and sustainable manner.

Improving quality in general practice shows commitment by the whole practice team. This edition of *Aiming for Excellence* provides guidance to teams to meet daily and ongoing challenges inherent in health care provision.

Lastly, standards do change with time and in keeping with the spirit of continuous quality improvement, the standard needs ongoing review and revalidation. To this end it is imperative that we receive, listen and be responsive to the feedback of users of *Aiming for Excellence*. The RNZCGP Board of Quality welcomes any comments and suggestions regarding this new edition.

Dr Kenneth Tong (Chair)  
RNZCGP *Aiming for Excellence* Working Party

Dr John Wellingham (Chair)  
RNZCGP Board of Quality

# Introduction

## ***Aiming for Excellence – Raising the bar in general practice***

---

To continuously maintain and improve high standards of general practice care, the College commits to the principle of putting patients first. To do that, its tools and processes use the best information available and are designed by those who work in and use general practice services.

*Aiming for Excellence* contains indicators and criteria that identify minimum legal and safety standards or those that pose significant risk as defined by the College. It also identifies other standards considered essential by the College to guide further improvements in practice systems and clinical care. General practice teams and the Cornerstone General Practice Accreditation programme use *Aiming for Excellence* to assess quality in general practices. Together *Aiming for Excellence* and *Cornerstone* meet the requirements of the New Zealand Public Health and Disability Act 2000 for the development, use and monitoring of a nationally consistent standard and quality programme for general practice services and patient safety.

## **The discipline and specialty of General Practice<sup>i</sup>**

---

*General Practice<sup>ii</sup>* is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity. It is a clinical specialty orientated to primary health care. It is a first level service that requires improving, maintaining, restoring and coordinating people's health. It focuses on patients' needs and enhancing the network among local communities, other health and non-health agencies. General practice:

1. Is personal, family and community oriented comprehensive primary care that continues over time, is anticipatory as well as responsive, and is not limited by the age, gender, race, religion or social circumstances of patients, nor by their physical or mental states.
2. Is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, gender, culture or any other characteristic of the person concerned.
3. Makes efficient use of health care resources through the coordination of care, working with other professionals in the primary health care setting, managing the interface with other specialities, and taking an advocacy role for the patient when needed.
4. Develops a person-centred approach, orientated to the individual, as well an approach that is responsive to the needs of their family/whanau and their community.
5. Has a unique consultation process that establishes a relationship over time, through effective communication between clinician and patient.
6. Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
7. Has a specific decision-making process determined by the prevalence and incidence of illness in the community.
8. Diagnoses and manages simultaneously both acute and chronic health problems of individual patients.
9. Diagnoses and manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
10. Promotes health and well-being through appropriate and effective intervention.
11. Has a specific responsibility for health in the community.
12. Deals with health problems in their physical, psychological, spiritual, social and cultural dimensions.

# Development of organised General Practice in New Zealand

The mission of the Royal New Zealand College of General Practitioners is to “improve the health of all New Zealanders through high quality general practice care”<sup>iii</sup>.

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

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

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

Providing high quality and safe primary health care within the context of general practice is essential to achieve best outcomes for patients. *Aiming for Excellence* describes the New Zealand standard for safe, high quality general practice care.

## General Practice Quality

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

- The WONCA definition best describes general practice quality:  
*The provision of best health outcomes that is consistent with patient values and preferences, given the available resources.*<sup>iv</sup>
- The New Zealand health sector definition of quality health care is also supported<sup>v</sup>. It describes multiple dimensions of quality, including access and effectiveness:  
*Quality of care is the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*<sup>vi</sup>

Taking the first step toward improvement requires commitment and active engagement by general practice teams<sup>vii</sup>. To assist the process, *Aiming for Excellence* brings together managerial, organisational and clinical processes to provide an assessment tool for teams to identify how to provide greater accountability, guide improvements and use the information to increase cooperation in general practice teams<sup>viii</sup>.

Leadership by all stakeholders in general practice has strongly influenced the development of a Quality Improvement programme for general practice, CORNERSTONE. Its purpose is to provide an external review and feedback on the outcomes of general practice quality. This process is best described by JACHO:

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

The approach assists practice teams to work together to design quality systems and processes. To do this it reinforces team processes through a CQI approach, incorporating Quality Assurance (QA) and Quality Improvement (QI) confirms and provides a basis for changes in services provided to patients. The model incorporates three dimensions of quality: *Patients, Professionals, Practice*.

## Continuous Quality Improvement (CQI)

---

CQI is a culture that seeks never-ending improvement of the whole system as part of normal daily activity, continually striving to act according to the best available knowledge.<sup>x</sup> Undertaking a quality improvement process reflects the desire and commitment of the team to find out, “**Are we doing what we should be doing?**”

Imagine yourself on a seven-metre yacht in the middle of the Pacific Ocean with no engine or modern navigational equipment. A logical question would be “Where am I?” Using a sextant allows you to put a cross on the map. Only then can another cross be marked at **where you want to go (indicators)** before making the next step to determine **how to get there (criteria)**.

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

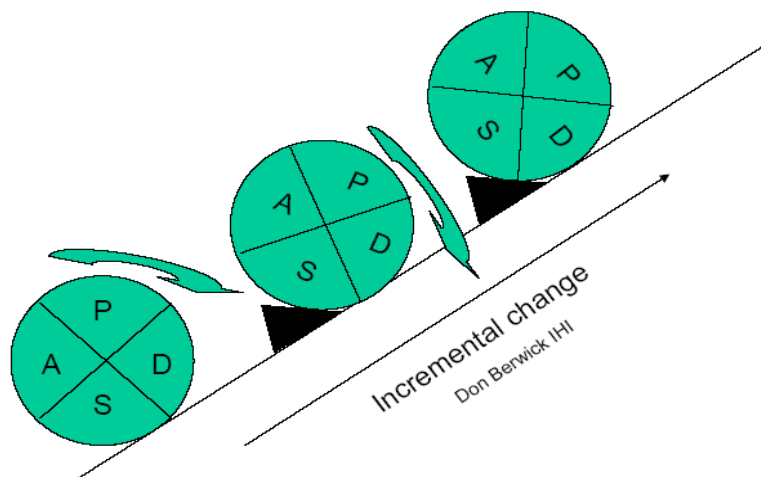
*Aiming for Excellence* is designed for the practice to put a cross on the map where your practice is and identifies **where you want to go**. The indicators in this document are a guide to best practice; they outline opportunities for the practice team to identify potential improvement in the quality of care offered to patients. They provide a basis to measure and assess the provision of care offered in general practice.

The College conviction is that **Aiming for Excellence** should be used primarily as a catalyst for continuous quality improvement operating within a practice and only secondarily for external measurement to ensure that contract obligations are being fulfilled. Inevitably the latter would be a minimum standard. We want to encourage practices to strive for the best. Only then can another cross be marked where you want to go before taking the next step of deciding how to get there.

Dr Tony Hanne  
Goodfellow QA Unit 2002

## Cycles of Continuous Improvement

To understand a practice's capacity to respond to patient need, a baseline is obtained to identify comparisons. To do this practice systems and processes are compared against criterion measurements in *Aiming for Excellence*. A process of reflection and action is then applied. It is a useful method to guide improvements and can be applied to any aspect of care.



Start	Compare the practice against <i>Aiming for Excellence</i> . <ul style="list-style-type: none"> <li>• Are we doing what we should be doing?</li> <li>• What could we do better?</li> </ul>
1. Plan	Use <i>Aiming for Excellence</i> to identify the expected standard of care expected by general practices. <ul style="list-style-type: none"> <li>• Where are we going?</li> <li>• Set markers for improvement (Indicators)</li> <li>• What are the questions? (Criteria)</li> <li>• What are the expectations? (Standards)</li> </ul>
2. Do	What information needs to be collected? <ul style="list-style-type: none"> <li>• Undertake a self-assessment.</li> <li>• Collect data from the practice and score against the criteria in <i>Aiming for Excellence</i>.</li> </ul>
3. Study	Were objectives met? <ul style="list-style-type: none"> <li>• Undertake a gap analysis.</li> <li>• What is the gap between the information obtained and the expectations in <i>Aiming for Excellence</i>?</li> </ul>
4. Act	What changes can be made to improve patient care as a result of the information obtained? <ul style="list-style-type: none"> <li>• Develop a quality action/management plan to address outstanding issues.</li> </ul>
Monitor	Undertake a regular review of progress against changes agreed.
<b>Key principle: the practice team must be involved at every stage</b>	

## Aiming for Excellence – the measurements

---

It is not possible or useful to assess every function in a practice. The indicators and criteria in *Aiming for Excellence* reflect a sample considered important by all stakeholders, including patients. Each indicator has been designed to consider patients first. Key considerations have been:

- *Is the practice safe, accessible, effective, efficient, responsive and sensitive to all cultural groups?*
- *Is the practice team actively committed to improving the quality of service provided?*

There are five sections in *Aiming for Excellence*.

- Factors affecting patients and enrolled populations
- Physical factors affecting the practice
- Clinical practice systems
- Practice and patient information management
- Quality improvement and professional development

Together they define the RNZCGP expectation for the quality of general practice care in New Zealand. Practices measure themselves against the indicators, criteria and standards in each section. This is followed by an external assessment to compare results of performance against the College standard

### Indicators, criteria and standards

#### a) Indicators

There are 49 indicators in this latest edition of *Aiming for Excellence*. Each indicator describes a measurable element of practice performance for which there is evidence that it can be used to assess the quality, and change in the quality, of care provided<sup>xi</sup> [3].

The indicators help practices to compare their level of performance against the College *standard*. They provide points along the way to meeting a standard. They identify measurable elements of practice performance for which there is evidence or consensus that it can be used to assess and produce a positive change in the quality of care provided. This standard or mark of success describes the College expectation for practices' to achieve each indicator. Together, the indicators define the RNZCGP standard for general practices in New Zealand.

#### b) Criteria

These are the elements of care that are so clearly defined that they can be counted or measured to help understand whether the indicator was met or not [3]. Criteria are discrete, definable, measurable and explicit<sup>xii</sup>.

#### c) Standards

The standard is a mark of success and specifies the acceptable level of care. To achieve RNZCGP Cornerstone General Practice Accreditation, each practice is required to meet every minimum and essential standard contained in *Aiming for Excellence*<sup>xiii</sup>.

There are three categories of standards (identified by a star)

- ★★ Those that identify legal and safety obligations or significant risk as defined by the College. (Minimum Standards)
- ★ Considered best practice and important by the College (Other essential standards)
- ☆ Those that identify opportunities for CQI (Desirable standards)

*An example of an Indicator that identifies criteria and levels of standards:*

#### Indicator A.2.1

**The practice makes provision to ensure patients are able to access 24 hour medical care**

##### Criteria:

- A.2.1 – 1 ★★ The practice population is provided with information on how to access 24-hour medical care
- A.2.1 – 2 ★ Patients can access the after hours service via a maximum of two calls
- A.2.1 – 3 ☆ A record of the patient after hours visit to a deputising service is sent back to the patients practice

# Section A - Factors affecting patients and enrolled populations

## Indicator Group 1 – Needs and rights of patients

### Indicator A.1.1

#### The practice team demonstrates its commitment to the Code of Health and Disability Services Consumers' Rights 1996

Criteria		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.1.1 – 1 ★★	The practice has a documented policy that describes how the Code of Health and Disability Services Consumers' Rights 1996 ('The Code') will be implemented									
A.1.1 – 2 ★★	All Practice team members have received training within the last three years to implement 'The Code'									
A.1.1 – 3 ★	Practice team members are able to describe their role in implementing 'The Code'									
A.1.1 – 4 ★★	The Code of Health and Disability Services Consumers' Rights 1996 is displayed									
A.1.1 – 5 ★★	Written information about the local health advocacy service is available to take away									
A.1.1 – 6 ★	The practice team can assist patients to access the support of a Health and Disability Advocate									

### Indicator A.1.2

#### The practice team ensures that patients are provided with information to enable them to make informed choices about their care

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.1.2 – 1 ★★	Information is available for patients to help them understand and exercise their right to make informed choices									
A.1.2 – 2 ★★	Informed consent is obtained from a patient or									

	legally designated representative, when agreeing to a treatment or procedure									
A.1.2 – 3 ★★	There is recording of informed consent for patients being screened for contentious issues									
A.1.2 – 4 ★	Support is available, or obtained, to assist patients to make informed choices and give consent about management of care									

**Indicator A.1.3**  
**The practice maintains the privacy of individual patient information in accordance with the Health Information Privacy Code 1994**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
A.1.3 – 1 ★★	The practice has a documented policy that describes how the requirements of the Health Information Privacy Code 1994 will be implemented									
A.1.3 – 2 ★★	The practice has a designated Privacy Officer to manage compliance with the Health Information Privacy Code 1994									
A.1.3 – 3 ★★	All Practice team members have received training within the last three years, on the principles of the Health Information Privacy Code 1994									
A.1.3 – 4 ★★	The practice collection, use, storage, disposal and disclosure of individual patient information complies with the Health Information Privacy Code 1994									

**Indicator A.1.4**  
**The practice layout enhances patient privacy in the reception and waiting area**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
-----------	--	--------------------	--	---------------------------	--	----------------------	--	--	--	----------

A.1.4 -1 ★★	There are adequate and effective safeguards in the reception area to ensure confidentiality of patient information (includes verbal, documented and electronic)									
A.1.4 -2 ★★	The practice has achieved a balance in the waiting area between the ability to observe the clinical condition of waiting patients and maintenance of confidentiality of information at the front desk/reception									

**Indicator A.1.5**  
**The practice upholds the patient's right to complain**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
A.1.5 – 1 ★★	The practice has a documented complaints policy									
A.1.5 – 2 ★★	The practice has a designated team member to manage compliance with Right 10 of The Code of Health and Disability Consumers Rights									
A.1.5 – 3 ★★	The designated team member can demonstrate that the complaints process complies with Right 10 of 'The Code'									
A.1.5 – 4 ★	Practice team members are able to describe their role in implementing the Complaints Policy									
A.1.5 – 5 ★	Complaints and their resolution are used as opportunities for learning and quality improvement									

**Indicator A.1.6**  
**The practice includes patient input into service planning**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
A.1.6 – 1 ★	The practice encourages patient feedback about service provision and									

	development								
A.1.6 – 2 ☆	Practice planning and development of services are responsive to concerns of the local community								
A.1.6 – 3 ★	The practice has obtained feedback from patients, which reflects the view of the practice population, to determine their satisfaction with the service within the last three years								
A.1.6 – 4 ★	Information about the practice's use of patient input is communicated to the practice team and patients								

### Indicator A.1.7

#### The practice demonstrates its commitment to recognising diversity of culture and background

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.1.7 – 1 ★★	The practice provides services that are responsive to the cultural needs of diverse patient groups									
A.1.7 – 2 ★	All practice team members have received training to maintain cultural competence within the last three years									
A.1.7 – 3 ☆	The practice provides evidence of engagement with diverse groups to identify health needs									
A.1.7 – 4 ★	The practice has identified appropriate local resources, people and organisations									
A.1.7 – 5 ☆	The practice has a process that is regularly reviewed for understanding and working positively with diverse patient groups									

### Indicator A.1.8

#### The practice acknowledges and is responsive to the special status, health needs and rights of Maori whānau

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.1.8 – 1 ★★	Members of the practice team have had training in the principles of the Treaty of Waitangi – Tiriti o Waitangi – Partnership, Participation and Protection									
A.1.8 – 2 ★	The practice has a documented Maori Health Plan that states how it implements measures to address the priority areas as stated in He Korowai Oranga Maori Health Strategy 2002									
A.1.8 – 3 ★	The practice effectively addresses the health needs of its enrolled Maori population									
A.1.8 – 4 ☆	The practice team has developed working relationships with local Maori organisations/providers and Maori groups									
A.1.8 – 5 ★	The practice collects, records and audits patient ethnicity data consistent with the Health Information Privacy Code 1994 and the MOH Ethnicity Data Protocols for the Health and Disability Sector in order to identify its enrolled Maori population									

## Indicator Group 2 – Access and availability of practice services

### Indicator A.2.1

#### The practice makes provision to ensure patients can access 24 hour medical care

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.2.1 – 1 ★★	The practice population is provided with information on how to access 24-hour medical care									
A.2.1 – 2 ★	Patients can access the after hours service via a maximum of two calls									

A.2.1 – 3 ☆	A record of the patient after hours visit to a deputising service is sent back to the patient's practice									
A.2.1 – 4 ★★	The practice acts on information received about patients seen after hours									
A.2.1 – 5 ☆	The practice reviews and is responsive to feedback about access to the after hours service									
A.2.1 – 6 ☆	The practice arranges for home visits during hours of opening									
A.2.1 – 7 ☆	Booking intervals during normal surgery hours are scheduled at least 10 minutes apart									

**Indicator A.2.2**  
**The practice identifies and responds appropriately to all patients with clinically urgent medical conditions**

Criteria		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.2.2 – 1 ★★	A flexible appointment system is used to meet practice and patient needs for urgent care									
A.2.2 – 2 ★★	Patients who present with an urgent condition are triaged for urgency									
A.2.2 – 3 ★★	Reception team members who interact with patients have received training to recognise and respond appropriately to urgent medical conditions									
A.2.2 – 4 ★★	All team members who may be required to administer CPR have current certificates to an appropriate level from certified trainers									

**Indicator A.2.3**  
**Information about practice services is available for patients**

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.2.3 – 1 ★	Practice information is displayed where it can be read by patients									
A.2.3 – 2 ★	Practice information is routinely given to new patients									

A.2.3 – 3 ☆	Information about practice services is available on request in languages other than English and other formats if necessary									
A.2.3 – 4 ★	Information about practice services is current									

**Indicator A.2.4**  
**Prescribing in the absence of direct patient contact is accurate, appropriate and timely**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
A.2.4 – 1 ★	The practice implements a documented policy for repeat prescribing.									
A.2.4 – 2 ★	The practice implements a policy on prescribing in the absence of a face-to-face consultation									
A.2.4 – 3 ☆	The practice team routinely informs patients when their prescriptions will be available for collection									
A.2.4 – 4 ☆	The practice routinely audits for non-collection of prescriptions held by the practice									
A.2.4 – 5 ☆	The practice is able to fax copies of prescriptions to pharmacies									
A.2.4 – 6 ☆	Prescriptions for non controlled drugs are computer generated									

**Indicator Group 3 – Absence of physical barriers to access**

**Indicator A.3.1**  
**Patients can easily access the practice using its telecommunications system**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
A.3.1 – 1 ★	The practice makes provision for hearing, sight or speech impaired people to communicate with the practice									
A.3.1 – 2 ★	A review of the practice telecommunications system has been undertaken within the last three years to identify ease of access for patients									
A.3.1 – 3 ☆	The practice offers patients direct telephone access to nominated clinical team members									

**Indicator A.3.2**

<b>The practice premises are physically safe, clearly signposted and accessible</b>										
Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
A.3.2 – 1 ★★	External practice signs are clear, visible and well placed to read from a distance									
A.3.2 – 2 ★★	There is access to practice premises for all people with mobility problems									
A.3.2 – 3 ★	There is adequate parking close to the practice with dedicated parking for disabled drivers									
A.3.2 – 4 ★★	Lighting outside the practice facilitates safe entry and exit to the practice									
A.3.2 – 5 ★★	There is a toilet on site with access for disabled people and with hand washing facilities									
A.3.2 – 6 ☆	A designated person monitors general maintenance of the building and acts on any issues arising									

## **Section B – Physical factors affecting the practice**

### **Indicator Group 4 – Safety of practice systems and facilities**

#### **Indicator B.4.1**

**The practice waiting area is comfortable and sufficient to accommodate patients who wait for services**

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
B.4.1 – 1 ★★	The waiting area has adequate space, seating, heating, lighting and ventilation									
B.4.1 – 4 ★★	The waiting area has appropriate seating for disabled patients									
B.4.1 – 3 ★	The waiting area has books and/or hard toys to meet the needs of children									
B.4.1 – 4 ☆	The waiting area has current reading material									

#### **Indicator B.4.2**

**Consultation areas for assessment and management ensure patient comfort and safety**

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
B.4.2 – 1 ★★	There are facilities to ensure hand hygiene in all									

	patient contact areas									
B.4.2 – 2 ★★	Examination couches are accessible, safe, and visually private									
B.4.2 – 3 ★	Each consultation room is maintained at a comfortable temperature and has adequate lighting, including task lighting									
B.4.2 – 4 ★	Each consultation room is free from excessive extraneous noise									
B.4.2 – 5 ★★	Patients are assured of auditory privacy during consultations or when any personal information is conveyed									

**Indicator B.4.3**

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

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
B.4.3 – 1 ★★	Documented practice policies and procedures outline infection control practices for cleaning, disinfection and sterilisation of equipment and facilities									
B.4.3 – 2 ★★	The practice maintains records to monitor the effective physical parameters for each sterilising cycle									
B.4.3 – 3 ★★	A current calibration and validation record is available									
B.4.3 – 4 ★★	The practice stores and handles sterile and surgically clean instruments in a manner that maintains the integrity of their sterility or surgical cleanliness									
B.4.3 – 5 ★★	Within the last year, appropriate members of the practice team have received training related to disinfection and sterilisation policies and practice									

**Indicator B.4.4**

**The practice safely stores and disposes of sharps, contaminated materials and hazardous waste**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
-----------	--	--------------------	--	---------------------------	--	----------------------	--	---	--	----------

B.4.4 – 1 ★★	The practice has appropriate puncture-resistant sharps containers, displaying a biohazard symbol NZS 4304:2002, in all areas where sharps are used									
B.4.4. – 2 ★★	Sharps containers are kept out of the reach of children									
B.4.4 – 3 ★★	Biohazardous waste is safely stored, collected and disposed of in accordance with the industry standard (NZS 4304:2002) for the management of health care waste									

**Indicator B.4.5**

**The practice has appropriate vaccine storage and maintains the Cold Chain in line with national guidelines**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
B.4.5 – 1 ★★	The practice has current national Cold Chain Accreditation as per the Ministry of Health (NZ) Protocol 2007									
B.4.5 – 2 ★★	Vaccines are stored as per the current Vaccine Storage and Distribution National Standards, including onsite and offsite immunisation and transport									
B.4.5 – 3 ★★	The practice monitors vaccine stock levels, and currency									
B.4.5 – 4 ★★	Team members who manage the Cold Chain hold a current Vaccinators Certificate, having passed a nationally recognised Vaccinator Training Course									

**Indicator B.4.6**

**Practice security is maintained to ensure there is only authorised access to medications and pharmaceutical products**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments

B.4.6 – 1 ★★	The practice stores medications, pharmaceutical products and clinical bags or portable emergency kits securely so that they are only accessible to authorised people									
B.4.6 – 2 ★★	If controlled drugs are stored on site, they are stored in line with current legislation									
B.4.6 – 3 ★★	A register is maintained for any controlled drugs kept on site									

**Indicator B.4.7**

**The practice demonstrates its commitment to Health and Safety in the workplace**

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
B.4.7 – 1 ★★	The practice has documented policies that describe how the Health and Safety in Employment Act 1992 and 2002 Amendment will be implemented									
B.4.7 – 2 ★★	The practice has a designated Health and Safety Officer to manage compliance with the Health and Safety in Employment Act 1992 and 2002 Amendment									
B.4.7 – 3 ★★	Members of the practice team comply with health and safety policies and procedures to identify and manage hazards									
B.4.7 – 4 ★★	The practice reviews health and safety procedures annually and makes amendments as necessary									
B.4.7 – 5 ★★	Health and safety accidents and incidents are recorded, investigated, followed up and reported									
B.4.7 – 6 ☆	The practice can demonstrate occupational health and safety in action									

**Indicator B.4.8**

**The practice has planned for fire, disaster or emergency preparation, response and recovery**

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	

B.4.8 – 1★★	The practice implements a fire safety and evacuation scheme or procedure									
B.4.8 – 2★	There is a plan for emergency management planning in the event of a disaster or event that would severely impair the practices ability to maintain normal services									
B.4.8 – 3☆	The practice has a continuity plan for readiness to support the community response to health needs during an emergency if required									

### Indicator Group 5 – Medical equipment

#### Indicator B.5.1

#### Medical equipment and resources are available and maintained

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
B.5.1 – 1★	There is an audit trail to monitor the servicing of all medical equipment according to relevant regulations, maintenance and operating instructions									
B.5.1 – 2★	All medical equipment and resources should be appropriate to ensure comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered.									
B.5.1 – 3★	All essential basic equipment is available <ul style="list-style-type: none"> <li>• Stethoscope</li> <li>• Auriscope</li> <li>• Ophthalmoscope</li> <li>• Sphygmomanometer – <i>Extra wide and paediatric cuffs</i></li> <li>• Spatulas</li> <li>• Reflex hammer</li> <li>• Tuning fork</li> <li>• Thermometer</li> <li>• Measuring tape</li> <li>• Height measure</li> <li>• Weight scale</li> <li>• Urine dipstick – protein, glucose, ketones –<i>expiry dates must be current</i></li> </ul>									

	<ul style="list-style-type: none"> <li>• Blood glucose test strips/glucometer –<i>expiry dates must be current</i> /Check calibration of glucometer to number on strip.</li> <li>• Pregnancy testing kit</li> <li>• Proctoscope</li> <li>• Visual acuity chart – at the correct distance</li> <li>• Eye local anaesthetic</li> <li>• Fluorescein dye for eyes</li> <li>• Ear syringe or suction</li> <li>• Peak flow meter</li> <li>• Nebuliser – via air or O2, or large spacer device</li> <li>• Cervical smear equipment</li> <li>• Gloves</li> <li>• Syringes and needles</li> <li>• Suture equipment</li> <li>• Surgical instruments appropriate for any procedures carried out</li> <li>• Dressings adequate to the services provided – <i>check expiry dates</i></li> <li>• Benchtop steriliser</li> <li>• Urinary catheter or other means for urgent catheterisation</li> <li>• ECG is readily accessible or within 10 minutes (if on site, staff are trained to use it)</li> </ul>														
<p>B.5.1 – 4 ★</p>	<p>All essential emergency equipment is available</p> <p>Emergency equipment: An ECG should be accessible within 10mins. If an ECG is held in the practice, clinical team members know how to use it.</p> <p>Emergency and resuscitation equipment:</p> <ul style="list-style-type: none"> <li>• Emergency bag/trolley</li> <li>• Airways varied sizes 00 to adult</li> <li>• Ambubag and masks (paediatric to adult)</li> <li>• IV equipment (set up and infusion)</li> <li>• Saline/plasma expander (any one of e.g. penpaspan/crystalloid) – <i>expiry dates are current</i></li> <li>• Tourniquet</li> <li>• Oxygen</li> </ul> <p>Rural practices: <i>Rural practices require a greater level of off site</i></p>														

	<p><i>equipment</i></p> <ul style="list-style-type: none"> <li>• Strobe lighting for aerial rescue</li> <li>• Full stretcher kit</li> <li>• Assortment of inflatable splints</li> <li>• Defibrillator (check weekly to 50 joule discharge), pads available, paper in machine, battery changed/charged</li> <li>• Portable oxygen supply with regulator, tubing, masks and replacement cylinder</li> <li>• Blood taking equipment</li> <li>• Portable suction</li> <li>• Intubation equipment</li> <li>• Oropharyngeal airways</li> <li>• Mobile phone/RT system</li> <li>• Manual defibrillator and/or automatic electronic defibrillator (AED) with annual function (AED alone without three lead ECG monitor is inadequate) – back up battery</li> <li>• Regional maps</li> </ul>														
<p>B.5.1 – 5 ★</p>	<p>All essential emergency medications are available</p> <p><i>In stock or in the doctor's bag/clinical bag or portable emergency kit</i></p> <ul style="list-style-type: none"> <li>• Adrenalin 1/1000</li> <li>• Aspirin tablets</li> <li>• Atropine inj.</li> <li>• Diazepam inj./rectal</li> <li>• 50% Glucose/glucagons inj.</li> <li>• Antihistamine inj.</li> <li>• Local anaesthetic</li> <li>• Penicillin inj. – some need refrigerating (<i>powdered version for offsite emergencies</i>)</li> <li>• An alternative for those allergic to penicillin</li> <li>• Corticosteroid inj.</li> <li>• Naloxone inj.</li> <li>• Antiemetic</li> <li>• NaCl to check IV route prior to administration of medicines</li> <li>• Water to mix powdered antibiotics</li> <li>• Analgesia – voltaren, pamol, panadol</li> </ul>														
<p>B.5.1 – 6 ★</p>	<p>A system is followed for medication maintenance and checking of the expiry dates of all drugs, including patients drugs stored in the practice</p>														

B.5.1 – 7 ★	A system is followed to check and maintain the contents of the clinical bag/portable emergency kit and emergency equipment – at least monthly																	
----------------	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## Section C – Clinical Practice Systems

### Indicator Group 6 – Comprehensiveness and coordination of care

#### Indicator C.6.1

#### Patients can access a broad range of services, either in the practice or through referral

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
C.6.1 – 1 ★	The range of services provided by the practice is sufficient to meet the general medical needs of patients.									
C.6.1 – 2 ☆	The practice coordinates referrals to other services									

#### Indicator C.6.2

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

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
C.6.2 – 1 ★★	There is a patient registration process that collects personal and health information as required by the practice									
C.6.2 – 2 ★★	At enrolment, the practice requests patients' written consent to transfer unidentifiable patient data to health agencies for contract requirements									
C.6.2 – 3 ★★	New patients have provided written consent to enable the practice to obtain their previous medical records									
C.6.2 – 4 ★★	Details of the transfer of medical records to and from the practice are recorded									
C.6.2 – 5 ★★	Requests for the transfer of medical records are acted on within 10 working days to facilitate continuity of care									

#### Indicator C.6.3

#### The practice maintains and uses effective databases to respond to patient needs and population health priorities

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	

C.6.3 – 1 ★★	The practice has an effective Patient Management System for maintaining a patient database									
C.6.3 – 2 ★★	The practice collects patient ethnicity data consistent with the Health Information Privacy Code 1994 and current Patient Management System standard for ethnicity collection protocol									
C.6.3 – 3 ★	The practice maintains a current database of enrolled patients									
C.6.3 – 4 ★	The practice database uses a disease coding system compatible with other commonly used data transfer systems									
C.6.3 – 5 ★	The practice database is used to identify the health needs of the practice population									
C.6.3 – 6 ★	The practice uses data from the Patient Management System to support the provision of services that are responsive to the targeted health needs of priority groups									

**Indicator C.6.4**  
**The practice has agreed policies for screening and recall**

Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
C.6.4 – 1 ★	Practice policies reflect evidence and best practice for disease screening and recall									
C.6.4 – 2 ★	Practice team members can describe their role in implementing screening and recall policies									
C.6.4 – 3 ★	The practice team has received training to implement screening and recall programmes									
C.6.4 – 4 ★	The practice uses a system to identify patients in screening and recall programmes									
C.6.4 – 5 ★	The practice annually reviews screening and recall policies for effectiveness in reaching eligible target populations									

<b>Indicator C.6.5</b>										
<b>The practice undertakes opportunistic screening</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
C.6.5 – 1 ★	Practice processes for opportunistic screening are evidence based									
C.6.5 – 2 ★	Clinical team members can describe their role in providing opportunistic screening									
C.6.5 – 3 ★★	There is evidence of linking screening activity with interventions									
C.6.5 – 4 ★★	Clinical team members document discussing contentious screening tests with eligible patients in relation to harm v benefit									
C.6.5 – 5 ☆	The practice annually reviews its opportunistic screening process									
<b>Indicator C.6.6</b>										
<b>The practice targets at risk patients identified in national or regional health priority areas</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
C.6.6 – 1 ★	The practice database is used to identify at risk patients in a range of health priority areas									
C.6.6 – 2 ☆	Patient family histories are routinely reviewed for risk factors									
C.6.6 – 3 ☆	Clinical team members audit people identified as at risk in one or more of the health priority area for engagement in and change in risk levels									
<b>Indicator C.6.7</b>										
<b>Appropriate clinical management guidelines are used to ensure consistent high quality health care</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
C.6.7 – 1 ★	The clinical team can demonstrate appropriate use of current evidence based clinical management guidelines									
C.6.7 – 2 ☆	Current clinical practice guidelines are used as a resource for clinical team education									

C.6.7 – 3 ☆	The clinical team annually reviews its use of clinical management guidelines for currency and consistency									
----------------	---	--	--	--	--	--	--	--	--	--

**Indicator Group 7 – Disease prevention and promotion of health**

**Indicator C.7.1**

**The practice offers services to improve quality of life through disease prevention and promotion of healthy lifestyles**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments	
C.7.1 – 1 ☆	Clinical team members can describe the brief intervention process.						
C.7.1 – 2 ★	Practice nurses are available for patient education and support						
C.7.1 – 3 ☆	The clinical team implements or refers patients to programmes to improve, maintain or restore patient health						
C.7.1 – 4 ★	A wide range of current health promotion material is accessible to patients						

**Indicator C.7.2**

**The practice has an effective immunisation programme**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments	
C.7.2 – 1 ★	The practice has a system to identify and recall all patients requiring immunisation						
C.7.2 – 2 ★★	The practice has a certified vaccinator responsible for review of immunisation procedures in accordance with current standards						
C.7.2 – 3 ★	The practice records the vaccine batch number and name, expiry date, site and route of administration						
C.7.2 – 4 ★	The practice can access the current version of the New Zealand Immunisation Handbook						
C.7.2 – 5 ★★	The practice effectively records adverse reactions to immunisations and reports these to the Centre for Adverse Reactions Monitoring (CARM)						

**Indicator C.7.3**

**The practice routinely identifies smokers and offers appropriate interventions**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
C.7.3 – 1 ★	The smoking status of newly enrolled patients is recorded					
C.7.3 – 2 ★	The practice uses a Patient Management System to identify and record the smoking status and history of patients over the age of 15					
C.7.3 – 3 ★	The practice actively promotes smoking cessation strategies and provides educational intervention programme information to patients					
C.7.3 – 4 ☆	The practice team has access to specific programmes that assist patients with smoking cessation					
C.7.3 – 5 ☆	There is a process to update the smoking status of patients					

### Indicator Group 8 - Integration and continuity of care

#### Indicator C.8.1

**The practice provides care that is integrated with other care agencies and community services to improve individual patient care**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
C.8.1 – 1 ★	Access to a directory and/or resources about local, regional, and national health, social and community agencies are available in the practice					
C.8.1 – 2 ☆	Clinical team members have developed working relationships with public health networks and other local resource people					

#### Indicator C.8.2

**The practice provides services to help patients and families with special care to meet end of life needs**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
C.8.2 – 1 ★	The practice has a system to identify patients that have special end of life needs					
C.8.2 – 2 ★	All patients should be able to access their doctor or an informed deputy at all times					
C.8.2 – 3 ☆	The practice can describe how it follows up patients, families or caregivers after a significant life event or bereavement if appropriate.					

# Section D – Practice and patient information management

## Indicator Group 9 – Content of medical records

### Indicator D.9.1

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

To complete the requirements for this indicator all doctors and practice nurses must use the RNZCGP Content of Medical Records Module – [rnzcgp@rnzcgp.org.nz](mailto:rnzcgp@rnzcgp.org.nz)

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
D.9.1 – 1 ★	GPs and practice nurses have completed an audit of 15 patient records each									
D.9.1 – 2 ★★	<i>Demographic data:</i> <ul style="list-style-type: none"> <li>Name of patient</li> <li>NHI number</li> <li>Gender</li> <li>Address</li> <li>Date of birth</li> <li>Contact phone no.</li> <li>Ethnicity</li> <li>Registration status</li> <li>Contact person in case of emergency</li> </ul>									
D.9.1 – 3 ★	<i>Other demographic data:</i> <ul style="list-style-type: none"> <li>Current occupation</li> <li>Principal caregiver/ contact person</li> <li>Significant relationships</li> <li>Hapu/iwi</li> <li>Aliases, maiden name</li> </ul>									
D.9.1 – 4 ★	<i>Medical records show:</i> <ul style="list-style-type: none"> <li>Clinically important drug reactions and other allergies (<i>or the absence thereof</i>)</li> <li>Directives by patients</li> <li>Problem lists (<i>Using a recognised system for disease coding</i>)</li> <li>Past medical history</li> <li>Current smoking status and history of all patients over age 15</li> <li>Disabilities of the patient</li> <li>Current medications</li> <li>Clinical management decisions made outside consultations e.g. telephone calls</li> </ul>									
D.9.1 – 5 ★★	<i>Consultation records:</i> <ul style="list-style-type: none"> <li>Relevant content of each patient contact with practice clinical staff, including consultations,</li> </ul>									

	<p>home visits and telephone advice</p> <ul style="list-style-type: none"> <li>• Each entry is dated</li> <li>• The person making the entry is identifiable</li> <li>• The entry is legible and could be understood by someone not regularly working at the practice (e.g. a locum)</li> </ul>									
D.9.1 – 6 ★	<p><i>Consultation records should also include:</i></p> <ul style="list-style-type: none"> <li>• Patient reason for encounter</li> <li>• Examination findings</li> <li>• Investigations ordered</li> <li>• Diagnosis and assessment</li> <li>• Management plans</li> <li>• Information given to patients, including notification of recalls, test results, referrals and other contacts (and ideally patient understanding, agreement and consent will be checked and recorded when necessary)</li> <li>• Medications (<i>name, frequency</i>) by indication Review appropriateness of long-term medications.</li> <li>• Intermediate clinical outcomes Screening and preventive care initiatives recommended</li> </ul>									
D.9.1 – 7 ★	<p><i>Risk factors are identified and appropriately acted upon:</i></p> <p>Alerts</p> <ul style="list-style-type: none"> <li>• Family history</li> <li>• Smoking and, where appropriate, offer of support for smoking cessation</li> <li>• Alcohol/drug use</li> <li>• Blood pressure</li> <li>• Weight/height/BMI</li> <li>• Immunisations</li> </ul>									
D.9.1 – 8 ★	<p><i>Referral letters contain:</i></p> <ul style="list-style-type: none"> <li>• Reason for referral</li> <li>• Background information and history</li> <li>• Current treatment</li> <li>• Key examination findings</li> <li>• Problem</li> <li>• Referral letter should contain long term medications and allergies.</li> </ul>									
D.9.1 – 9 ★	<p><i>Referrals and responses are easily accessible in clinical records:</i></p> <ul style="list-style-type: none"> <li>• Laboratory results</li> <li>• X-Ray</li> <li>• Other tests and health</li> </ul>									

	information									
D.9.1 – 10 ★	Screening: • Cervical Smears • Mammograms									
D.9.1 – 11 ★	Clinical records chosen for assessment show evidence of random selection									
D.9.1 – 12 ★	The last entry in the records is less than 12 months old									
D.9.1 – 13 ★	Records, referral letters and investigation reports are filed, or are available electronically, in the patient's medical record									
D.9.1 – 14 ★	Clinical management decisions are recorded									
D.9.1 – 15 ★	The practice team uses the results of the medical record audit to identify quality improvement opportunities									

### Indicator Group 10 – Information management

#### Indicator D.10.1

#### Medical records and documents are stored or filed safely and securely

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
D.10.1 – 1 ★★	The content of medical records and documents (paper or electronic) is not identifiable in public areas									
D.10.1 – 2 ★	Non-lockable files (or non-secure computers) are in non-public working areas only									
D.10.1 – 3 ★	Files are secure or password protected from unauthorised access, unless in active use by the practice team									

#### Indicator D.10.2

#### Electronic Health Records are used in the practice

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
D.10.2 – 1 ★	Members of the team have access to a computer for clinical use									
D.10.2 – 2 ☆	Members of the team can access the internet when needed.									
D.10.2 – 3 ★★	The Patient Management System can record and alert clinical team members to potential adverse events									
D.10.2 – 4 ☆	Clinical team members have access to electronic patient specific decision support tools									
D.10.2 – 5 ★	The practice implements a clearly defined policy for computer security,									
D.10.2 – 6 ★	The practice implements a clearly defined policy for backing up computer data;									

<b>Indicator D.10.3</b>										
<b>There is a system to manage patient test results and medical reports</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
D.10.3 – 1 ★★	There is a practice policy describing how patient test results, medical reports and investigations are tracked and managed									
D.10.3 – 2 ★★	All incoming medical reports are seen and actioned by the practice team member who requested them or by a designated deputy									
D.10.3 – 3 ★★	Patients are provided with information about the practice procedure for notification of test results									
D.10.3 – 4 ★★	There is a procedure to identify missing results of potentially significant cytology, histology tests and urgent referrals									
D.10.3 – 5 ★	A record is kept of communication with patients informing them about test results									
<b>Indicator D.11.1</b>										
<b>All members of the practice team are qualified or trained for their position</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
D.11.1 – 1 ★★	Clinical staff have current annual practising certificates demonstrating their competence and fitness to practise their profession under the Health Practitioners Competence Assurance Act 2003									
D.11.1 – 2 ☆	The practice manager has undergone formal management training by an external provider									
D.11.1 – 3 ☆	Medical staff in the practice are vocationally registered in general practice or working towards this									
<b>Indicator D.11.2</b>										
<b>All practice team members have employment agreements and current job descriptions</b>										
Criteria:		Specific Yes No		Easy to measure Yes No		Achievable Yes No		Relevant to general practice Yes No		Comments
D.11.2 – 1 ★	The practice has documented workplace policies – including recruitment and appointment procedures, disciplinary procedures and orientation									
D.11.2 – 2 ★★	Practice team members have written and signed employment agreements with terms and conditions									
D.11.2 – 3 ★	Practice team members have job descriptions that include key tasks, functional relationships and annual									

	review dates									
D.11.2 – 4 ★	Performance reviews are conducted annually and used to guide professional development for all practice team members									
D.11.2 – 5 ★★	Members of the practice team and others who have access to medical records have signed a confidentiality agreement									
D.11.2 – 6 ★★	Every member of the clinical staff is insured to cover liability									
D.11.2 – 7 ★	There is a practice information resource available to new practice team members and locums									

**Indicator D.11.3**  
**Practice meetings are used as a communication tool to enable all practice team members to participate effectively**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
D.11.3 – 1 ★	The practice has evidence of regular, meetings involving the practice team					
D.11.3 – 1 ★	Extra-ordinary meetings are held in the practice to address urgent matters					

**Indicator D.11.4**  
**Clear lines of communication, responsibility and accountability operate in the practice**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
D.11.4 – 1 ★	There is an understanding of the roles and responsibilities of the practice team within the practice					
D.11.4 – 2 ★	There are clear lines of accountability and reporting structures that include all team members					

**Indicator D.11.5**  
**The Practice contributes to the development of health promoting environments**

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
D.11.5 – 1 ★	There is a workplace policy that encourages the practice team to consider a healthy workplace					
D.11.5 – 2 ☆	Members of the practice team lead healthy action practices					
D.11.5 – 3 ☆	Members of the practice team implement work/life balance					
D.11.5 – 4 ☆	Practice team members are encouraged by practice management to register with a general practice					
D.11.5 – 5 ☆	The practice team is committed to environmentally friendly actions					

# Section E – Quality Improvement and Professional Development

## Indicator group 12 – Continuous Quality improvement and professional development

### Indicator E.12.1

#### The practice promotes Continuing Professional Development

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
E.12.1 – 1 ★★	Professional team members participate in continuing professional development to meet the requirements of the Health Practitioners Competence Assurance Act 2003									
E.12.1 – 2 ★	The learning needs of the members of the practice team are reviewed annually									
E.12.1 – 3 ★	There is planned professional development and peer review for the clinical team									
E.12.1 – 4 ☆	The practice keeps a record of continuing professional development for each team member									
E.12.1 – 5 ☆	Funds are available for professional development of individual practice team members									
E.12.1 – 6 ☆	Clinical team members are encouraged to attend structured clinical supervision									

### Indicator E.12.2

#### The practice promotes Continuous Quality Improvement

Criteria:		Specific		Easy to measure		Achievable		Relevant to general practice		Comments
		Yes	No	Yes	No	Yes	No	Yes	No	
E.12.2 – 1 ★	A designated person coordinates quality improvement activities in the practice									
E.12.2 – 2 ★	There is documented evidence that the practice team has implemented an action plan									
E.12.2 – 3 ☆	A review of the outcome of the Quality action plan									
E.12.2 – 4 ★	There is documented evidence of team involvement in a quality improvement process									
E.12.2 – 5 ☆	The practice undertakes an annual quality improvement activity related to improving the management of a targeted area of clinical care									

### Indicator E.12.3

#### The practice has a Significant Event Management system to address serious or potentially serious practice problems

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
E.12.3 – 1 ★★	There is a process to manage Significant Events					
E.12.3 – 2 ★★	The practice has a Significant Event Record in place					
E.12.3 – 3 ★★	The practice has a process to analyse and follow up Significant Events					
E.12.3 – 4 ★	The Significant Event process is used for potential incidents as well as actual incidents					
E.12.3 – 5 ★	The Significant Events process has been reviewed in the last year					
E.12.3 – 6 ☆	If a significant event has happened, the practice has defined and measured the event to reveal potential problems in practices, procedures or systems					

#### Indicator E.12.4

#### Educational resources and other learning materials are available to the practice team

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
E.12.4 – 1 ★	Current journals and resources are accessible to all practice team members					
E.12.4 – 2 ☆	Practice team members can demonstrate that they use a range of resources for improving their knowledge and clinical practice.					
E.12.4 – 3 ☆	The practice provides a learning environment for patients, practice staff, medical students, nursing students and other health professionals					

#### Indicator E.12.5

#### The practice has a documented Strategic Plan

Criteria:		Specific Yes No	Easy to measure Yes No	Achievable Yes No	Relevant to general practice Yes No	Comments
E.12.5 – 1 ★	The practice has a documented strategic plan with objectives and an identified date for review					
E.12.5 – 2 ★	The practice has a documented annual business plan six monthly including quality objectives					
E.12.5 – 3 ★	Practice team members have input into the strategic plan					
E.12.5 – 4 ☆	Patient input is gathered for strategic and annual planning purposes and considered in the planning processes					



# Appendix

## Aiming for Excellence – History of development

Year	Indicator, criteria, standards development,	Practice Accreditation pathway
1996	The Goodfellow Unit, University of Auckland, reviewed the literature to identify indicators that identified the scope of good quality general practice. A range of provider groups and consumer organisations then reviewed them for relevance.	
1998	<p>Initial paper on Key Performance Indicators in Primary Health Care. The College agreed that these indicators should be further developed for general practice [17].</p> <p>International and stakeholder leadership response to a need for increased accountability in general practice. Waikato Faculty proposal. Expression of interest by members of the RNZCGP and Independent Practitioner Associations (IPAs) at an IPA Conference.</p> <p>RNZCGP Practice Standards Committee was established to develop standards for general New Zealand practice. The Committee identified existing international standards and found the Royal Australian College of General Practitioner standards most relevant. However, differences between the Australian and New Zealand health systems and populations made the Australian standards difficult to adopt in the New Zealand setting.</p>	
1999	<p>The RNZCGP agreed to develop a standard specifically for New Zealand General Practice.</p> <p>Indicators were developed by a Goodfellow Unit project and released by RNZCGP Practice Standards Working Party in 1999 as Aiming for Excellence.</p>	
2000	<p>Early adopters.</p> <p>Aiming for Excellence in General Practice – Standards for General Practice (1st edition) was tested. Six assessors were trained. A pretest and pilot study of 20 practices was undertaken to determine its usefulness for general practice.</p>	
2001 - 2002	<p>RNZCGP Practice Standards Validation Field Trial. Indicators and criteria in the first edition of Aiming for Excellence were subjected to a rigorous evaluation in a field trial of 81 practices during 2000-2001 and found to be reliable, valid and feasible for use in measuring the quality of care provided by a general practice.</p> <p>Aiming for Excellence – An assessment tool for General Practice (2nd edition published)</p>	<p>RNZCGP began identifying the principles and key issues for future practice accreditation.</p> <p>The RNZCGP Professional Development Practice Sub-Committee agreed to identify and design the process for implementing the Key Performance Indicators in a learning environment and oversee the implementation of Practice Accreditation.</p> <p>Sixty-one GP, practice nurse, practice manager assessors trained in practice assessment.</p>
2003		<p>Early programme establishment. QIPNZ a subsidiary of RACGP/AGPAL were contracted to establish an accreditation programme for NZ general practice.</p>

2004	GDSL/MedAudit design online version of Aiming for Excellence was developed.	<p>Review of QIPNZ contract.</p> <p>RNZCGP establishes Cornerstone General Practice Accreditation Programme.</p> <p>RNZCGP contracts HDANZ to provide programme oversight and external validation of Cornerstone practice reports.</p> <p>Development of IT support for practice visits by GDSL/MedAudit.</p> <p>Ministry of Health funds implementation of practice accreditation – 85 practices.</p>
2005	Aiming for Excellence was reviewed by the RNZCGP Professional Development Practice Sub-Committee for continued relevance – this review drew on feedback that aided the development of a guide to help assessors interpret the accreditation instrument	<p>The Te Paea Marae Clinic in Auckland was the first general practice in New Zealand to become Cornerstone accredited.</p> <p>Cornerstone is established as a formal RNZCGP programme for practice teams.</p> <p>ACC funds 100 practices to enable refinement of the process.</p> <p>Pinnacle funds 100 practices to test a practice support process.</p>
2006	Aiming for Excellence – (Consultation version published) Consultation phase from July 2006 to January 2007	Implementation phase of Cornerstone is completed.
2007	Revision of Aiming for Excellence, informed by analysis of the consultation data; research evidence; and informal consensus building among local experts	At the end of 2007 520 practices had enrolled in the Cornerstone programme and 274 achieved Cornerstone General Practice Accreditation.
2008	Aiming for Excellence – (3 <sup>rd</sup> edition February 2008)	

## References

<sup>i</sup> New Zealand Gazette. Notice of prescribed scopes of practice and related qualifications for healthier practitioners. Supplement 9 September 2004. Wellington: Wednesday, 15 September 2004: Issue no. 120.

<sup>ii</sup> WONCA Europe. The European definition of the key features of the Discipline of General Practice, the role of the General Practitioner and a description of the core competencies of the general practitioner/family physician. 2002

<sup>iii</sup> RNZCGP – mission ...

<sup>iv</sup> WONCA Working Party on Quality in Family Medicine. Family Doctors' Journey to Quality. National Research and Development Centre for Welfare and Health. Gummerus Printing, Finland. 2001.

<sup>v</sup> Coster G, Buetow S. Quality in the New Zealand health system: Background paper to the National Health Committee. Wellington: National Health Committee, September 2001. (<http://www.nhc.govt.nz/publications/qualityreport/backgroundpaper.pdf>)

<sup>vi</sup> National Health Committee. Safe systems supporting safe care: A discussion document on quality improvement in health care. Wellington: National Health Committee, September 2001. (<http://www.nhc.govt.nz/publications/qualityreport/discussiondocument.pdf>)

<sup>vii</sup> Wellingham J, Gillon M. Outcomes of the implementation of the Cornerstone General Practice Accreditation Programme. NZFP 2007; Vol.34, No.4: 263-265.

<sup>viii</sup> Buetow S, Roland M. Clinical governance: Bridging the gap between managerial and clinical approaches to quality of care. Quality in Healthcare 1999; 8: 184-190.

<sup>ix</sup> The Joint Commission on Accreditation of Health Care Organisations (JACHO). From: [www.jacho.org/mainmenu.html](http://www.jacho.org/mainmenu.html).

<sup>x</sup> WONCA Working Party on Quality in Family Medicine. Family Doctors Journey to Quality. National Research and Development Centre for Welfare and Health. Gummerus Printing, Finland. 2001.

<sup>xi</sup>

<sup>xii</sup>

<sup>xiii</sup>