2

**Foundation Standard**

**Draft for piloting and feedback**

*The Foundation Standard represents the requirements a general practice must meet as part of providing safe, effective and equitable care.*

“Kia tika a runga, kia tika a raro, ka puta ai ki waho”

**April 2019**

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1. Introduction

During 2018 the Royal New Zealand College of General Practitioners (the College) announced a review of its quality standard *Aiming for Excellence* and CORNERSTONE® quality improvement programme.

*Aiming for Excellence* and CORNERSTONE® have been in place for about 20 years. While they have evolved during that time, changes in the sector, and in New Zealand as a whole, have happened faster.

College members, general practice teams and Primary Health Organisations (PHOs) also advised they wanted quality standards that support general practice with the delivery of safe and equitable care.

This resulting draft Foundation standard is the first module that contributes to the College’s new quality programme.

1. Purpose

This draft Foundation standard module is the output of a series of workshops with expert advisors to review and improve the current Foundation standard. This Foundation standard module also incorporates suggestions for improvement received from College members, practice teams, PHOs and other primary health care providers.

This draft standard will be:

* Piloted with a representative sample of practices; and
* Made available on the College’s website so all general practices have an opportunity to provide feedback; and
* Provided to key external stakeholders (e.g. the Ministry of Health, Medical Council of New Zealand, Medsafe and relevant professional associations) for their feedback.

Feedback from the pilot, practices and stakeholders will be incorporated into a final Foundation standard module to be implemented in October 2019.

1. Background
   1. The College’s role in quality

A quality general practice is one of the five focus areas for the College.

As stated in the College’s recently released Statement of Strategic Intent: 2019-2024:

*It’s important for the College to set quality standards for general practice, and this includes developing and administering programmes to improve their workplace and clinical systems for the benefit of practices and patients.*

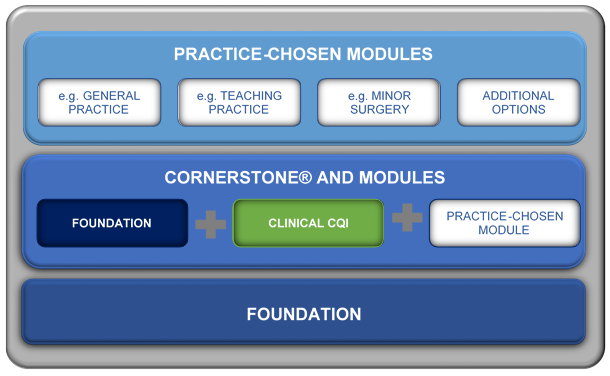
*We’ll know we’ve achieved this if we:*

* *Have 80 percent of practices join the CORNERSTONE® programme and attain and maintain accreditation to the CORNERSTONE® standard.*
* *Consistently receive positive feedback about the perceived value and simplicity of our quality programmes and our wrap-around support.*
  1. College Board decisions

Board decisions to support change to the College’s quality framework are:

* To retire the current quality standard – *Aiming for Excellence; and*
* To separate the Foundation and CORNERSTONE® standards and programmes; and
* To standardise the Foundation certification and CORNERSTONE® accreditation to four years; and
* To retire the CORNERSTONE® annual programme; and
* To introduce an online, summative mid-cycle review for the Foundation and CORNERSTONE® programmes;
* That CORNERSTONE® comprise a combination of mandatory and optional modules; and
* To trial the simplified programme with a range of practices for six months, so we can test that the new programme is simpler in real life and not just simpler in theory, and to test what effect the programmes changes might have on how the College runs the programme.
  1. Modular design of new quality framework

The new quality framework will be modular.



To achieve CORNERSTONE® accreditation, practices will need to be accredited against the Foundation Standard module, the Continuous Quality Improvement (CQI) module and one other module of their choice. Initially, practices will have three modules to choose from:

* General practice
* Teaching practice
* Minor surgery

Additional modules will be developed overtime.

1. How to use the Foundation Standard indicators and criteria

The Foundation Standard comprises 28 indicators. All are compulsory.

Each indicator describes a high-level statement of performance expected by a practice to meet the requirements of the Foundation standard. Each indicator has criteria. Criteria define the specific requirements that must be met to satisfy the indicator. Criteria are discrete, measurable and explicit.

Criteria are listed in the left-hand column under the heading of the indicator. The right-hand column describes evidence that can be used to demonstrate the practice meets the requirements of the criteria and states how the criteria can be assessed.

Guidance notes provide information about the indicator.

Some indicators require the practice to undertake training to ensure that all the general practice team are familiar with legislative or professional standards. Where training is required, the College would expect the practice to consider (as appropriate):

* Identification of all staff who require training
* New staff that may require training
* Retraining staff when there are changes made to standards or legislation

These guidance notes do include some training providers. If a practice requires further assistance to identify a training provider, the PHO or College may be able to assist with information or contacts.

# Draft Foundation Standard Module

# Section 1: Tikanga tūroro | Patient rights

Indicator 1: Code of Health and Disability Services Consumers’ Rights 1996.

**Our practice team have a working knowledge of the Code of Health and Disability Services Consumers’ Rights 1996.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 1.1 | Ensure team members are trained to understand and implement the Code of Health and Disability Services Consumers’ Rights 1996. | Staff training records demonstrate completion of required training by team members. |
| 1.2 | Ensure a poster(s) and brochures about the Code of Health and Disability Services Consumers’ Rights 1996 are available for patients to access. | A poster of the Code of Health and Disability Services Consumers’ Rights 1996 is displayed in languages, including te reo Māori, sign language, and others that reflect the practices enrolled patient population. |
| 1.3 | Inform patients of their right to have one or more support persons present during a consultation. | A poster and/or brochure are displayed in all clinical and waiting rooms advising patients they can have a support person(s) present. |
| 1.4 | Provide information about the local health advocacy service and ensure it is understood by the team. | Poster and/or local health advocacy brochures for patients are displayed in all clinical and waiting rooms. |
| 1.5 | Ensure interpreters and resources suited to your enrolled patient population can be accessed. | Demonstration of the process to access interpreter services. |
| 1.6 | Ensure patients with hearing, sight or speech-impairment can communicate with and access your practice. | Demonstrate how people with impairments are supported and enabled to communicate with and access your practice. |

**Required training**

A designated member(s) of the practice team is required to be familiar with the Health and Disability Commissioner’s and the Nationwide Health & Disability Advocacy Service’s guidance and resources available for training.

The practice team must have received training to implement the Code of Health and Disability Services Consumers’ Rights 1996.

* This training is required once and is to be updated either when the Code of Health and Disability Services Consumers’ Rights 1996 has been updated or there has been a Code of Health and Disability Services Consumers’ Rights 1996 related issue within your practice.

**Guidance notes**

[The Code](https://shop.hdc.org.nz/category/publications-for-free-download/) can be downloaded free of charge from the [Health and Disability Commissioner’s website](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)).

The rights of patients are:

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

**Resources**

[Health and Disability Commissioner](https://www.hdc.org.nz/)

[Health and Disability Commissioner: Free publications (including the Code of Health and Disability Services Consumers’ Rights 1996)](https://shop.hdc.org.nz/category/publications-for-free-download/)

[Health and Disability Commissioner: Making it Easy to Do the Right Thing](https://shop.hdc.org.nz/product/128-provider-dvd--making-it-easy-to-do-the-right-thing/)

[Health and Disability Commissioner: Advocacy Leaflet](https://www.hdc.org.nz/media/2759/advocacy-leaflet.pdf)

[Nationwide Health & Disability Advocacy Service: Advocacy Service education and resources](https://www.advocacy.org.nz/advocacy-service-education-and-resources/)

[Nationwide Health & Disability Advocacy Service: Arranging for an advocate to provide an education or a rights promotion session](https://www.advocacy.org.nz/advocacy-service-education-and-resources/arranging-for-an-advocate-to-provide-an-education-or-a-rights-promotion-session/)

[Health Navigator New Zealand: Interpreter services](https://www.healthnavigator.org.nz/languages/i/interpreter-services/)

[Health Navigator New Zealand: NZ Sign Language Interpreters](https://www.healthnavigator.org.nz/languages/n/nz-sign-language-interpreters/)

[Office for Disability Issues: Guidance and resources](https://www.odi.govt.nz/guidance-and-resources/?tg18%5B0%5D=19&start=11)

[Office for Disability Issues: Disability Etiquette](https://www.odi.govt.nz/home/about-disability/disability-etiquette/)

[Office for Disability Issues: Be. Accessible Business Toolkit](https://www.odi.govt.nz/guidance-and-resources/be-accessible-business-toolkit/)

Indicator 2. Open Disclosure

**Our practice has and applies an open disclosure policy and process.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 2.1 | Acknowledge and implement the open disclosure guidance provided by the Health and Disability Commissioner. | A documented Open Disclosure Policy and Procedure.  Examples of disclosures having been made with patients in line with the policy. |

**Required training**

The practice can self-determine the training required to achieve this Indicator and Criteria.

**Guidance notes**

The practice team should consider how you manage your open disclosure obligations. The Health and Disability Commissioner has developed guidance on open disclosure policies.

**Resources**

[Health and Disability Commissioner: Guidance on open disclosure policies](https://www.hdc.org.nz/resources-publications/search-resources/leaflets/guidance-on-open-disclosure-policies/)

[Medical Council of New Zealand: Disclosure of harm following an event](https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Disclosure-of-harm.pdf)

[Health Quality & Safety Commission New Zealand: National Adverse Events Reporting Policy](https://www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/)

Indicator 3. Privacy Act 1993 and Health Information Privacy Code 1994.

**Our practice meets the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 3.1 | Ensure team members are trained to understand and implement the Privacy Act 1993 and Health Information Privacy Code 1994. | Staff training records demonstrate completion of required training by team members. |
| 3.2 | Follow the guidance on privacy as provided by Privacy Commissioner. | A documented practice Privacy Policy and Procedure that includes team members, locums and contractors signing confidentiality agreements.  Demonstrate how team members comply with the requirements of Privacy Act 1993 and Health Information Privacy Code 1994.  A designated Privacy Officer role and responsibilities are written into a position description and stated in the Privacy Policy. |

**Required training**

A designated member(s) of the practice team is required to be familiar with the Privacy Commission’s guidance and ensure resources are available for training.

The practice team must have received training to implement the Privacy Act 1993 and Health Information Privacy Code 1994.

* This training is required once and is to be updated either when the Privacy Act 1993 or the Health Information Privacy Code 1994 has been updated or there has been a related issue within your practice.

**Guidance notes**

*The Privacy Act 1993*

The Privacy Act 1993 controls how ‘agencies’ collect, use, disclose, store and give access to ‘personal information’. The privacy Codes of Practice do the same, but they apply to specific areas – in our case health.

*Health Information Privacy Code*

The Health Information Privacy Code 1994 sets specific [rules](https://www.privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/) for agencies in the health sector. It covers health information collected, used, held and disclosed by health agencies and takes the place of the information privacy principles for the health sector.

*Rules of the Health Information Privacy Code*

The Health Information Privacy Code has twelve rules:

* Rule 1, Rule 2, Rule 3 and Rule 4 govern the collection of health information. This includes the reasons why health information may be collected, where it may be collected from, and how it is collected.
* Rule 5 governs the way health information is stored. It is designed to protect health information from unauthorised use or disclosure.
* Rule 6 gives individuals the right to access their health information.
* Rule 7 gives individuals the right to correct their health information.
* Rule 8, Rule 9, Rule 10 and Rule 11 place restrictions on how people and organisations can use or disclose health information. These include ensuring information is accurate and up-to-date, and that it isn't improperly disclosed.
* Rule 12 governs how "unique identifiers" - such as IRD numbers, bank client numbers, driver's license and passport numbers - can be used.

**Resources**

[Office of the Privacy Commissioner](https://privacy.org.nz/)

[Office of the Privacy Commissioner: Health Information Privacy Code 1994](https://privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code-1994/)

[Office of the Privacy Commissioner: Health Privacy Toolkit](https://www.privacy.org.nz/assets/Files/Health-toolkit/On-The-Record.pdf)

[Office of the Privacy Commissioner: Free e-learning privacy training modules](https://privacy.org.nz/further-resources/online-privacy-training-free/)

Indicator 4. Complaints

**Our practice has an active and effective complaints process.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 4.1 | Ensure the practice has a Complaints Policy and Procedure that aligns to Right 10 of the Code of Health and Disability Consumers’ Rights. | A documented practice Complaints Policy and Procedure. |
| 4.2 | Ensure team members are trained to understand and implement the Complaints Policy and Procedure. | Staff training records of completion of the required training. |
| 4.3 | Have a Complaints Officer. | A designated Complaints Officer role and responsibilities are written into a position description and stated in the Complaints Policy. |
| 4.4 | Have and actively use a complaints register. | A current and active complaint register. |
| 4.5 | Share learnings and quality improvements within your team members. | Demonstrate how learnings are shared, and improvements are made within the practice. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Timeframes*

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

Your practice’s complaints procedure must be managed to comply with relevant time frames and legal requirements under [Right 10 of the Code of Health and Disability Services Consumers’ Rights](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)) which are:

1. A provider must acknowledge any complaint in writing within 5 working days (Right 10(6)(a)).
2. A decision on whether the complaint is justified or not, or whether more time is needed to investigate the complaint, must be made by the provider within 10 working days of giving written acknowledgement of receipt of the complaint (Right 10(7)).
3. If the decision is that more time is needed to investigate the complaint, and that more than 20 additional working days will be required, the provider must inform the consumer of that (with reasons) within the 10 working days timeframe (Right 10(7)(b)(ii)).
4. If the decision is whether or not the complaint is justified, the consumer must be informed of that decision (with reasons, any proposed actions, and any appeal procedure) “as soon as practicable” after making the decision (Right 10(8)).
5. The provider must give progress updates to the consumer at intervals of not more than one month (Right 10(4)) where a complaint is ongoing.

*Complaints officer*

You must have a person designated as a complaints officer (or team) assigned to take responsibility for managing the complaints process.

All practice staff, including locums, must know who this is.

Your complaints officer must be able to clearly explain the policy and procedure and demonstrate how they manage complaints.

*Complaints Register*

Have a complaint register. This is a comprehensive record of complaints and how they are handled. Document the dates and details of any actions taken, any outcome (including reasons and remedies) in chronological order.

**Resources**

[Health and Disability Commissioner: The Code of Health and Disability Services Consumers’ Rights 1996](https://www.hdc.org.nz/disability/the-code-and-your-rights/)

[Health and Disability Commissioner: Complaints management guide](https://www.hdc.org.nz/resources-publications/search-resources/disability/complaints-management-guide-for-disability-service-managers/)

[Health and Disability Commissioner: Timeframes for Responding to Complaints under Right 10 of the Code (Fact Sheet 3)](https://www.hdc.org.nz/resources-publications/search-resources/fact-sheets/timeframes-for-responding-to-complaints-under-right-10-of-the-code-fact-sheet-3/)

[Office of the Ombudsman Tari o te Kaitiaki Mana Tangata: Effective complaint handling](http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/427/original/effective_complaint_handling.pdf?1349121913)

[Health and Disability Commissioner: Learning from complaints leaflet](https://shop.hdc.org.nz/product/174-learning-from-complaints/)

Indicator 5. Informed decision making

**Our practice provides and explains relevant information to patients to enable them to make informed decisions about their health care.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 5.1 | Document in the Patient Management System (PMS) when and what clinical information is provided. | Clinical notes review of 10 patient records in the 12 months prior to an onsite assessment completed by all clinicians. |
| 5.2 | Ensure informed consent is obtained in writing where there is significant risk associated with a treatment/procedure. | Written consent forms and/ or a written record of verbal agreement including the stating of risks. |
| 5.3 | Document when there is variance between any patient request, evidence-base and intervention. | Clinical notes review of 10 patient records in the 12 months prior to an onsite assessment completed by all clinicians. |
| 5.4 | Ensure patients with known literacy difficulties are recorded it in your PMS. | Demonstration of the process to record patients with literacy issues in the PMS and solutions to enable patients to make informed decisions. |
| 5.5 | Provide patients with information describing your practices services and fees. | Pamphlets, posters or information available on the practice website. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Informed consent*

Informed consent occurs when the patient gains an understanding of what is involved in receiving a proposed procedure or treatment and, free from coercion, gives agreement.

The patient has the right to:

* Consider the information given.
* Ask for clarification and ask for time to consider the information.
* Consult with family and others.
* Give consent or decline to give consent.
* Waive the right to discuss the details of treatment.
* After having given consent, change his or her mind and withdraw the consent.

*Compulsory written informed consent*

Informed consent must be in writing if any of the following apply:

* The patient is to participate in any research.
* The procedure is experimental.
* The patient will be under general anaesthetic.
* There is a significant risk of adverse effects on the consumer.

There may be other situations where informed consent is advised or required to be in writing (e.g. vaccinating in an offsite vaccination programme such as at a place of work or at a school).

**Resources**

[RNZCGP: Clinical record review self-audit checklist](https://oldgp16.rnzcgp.org.nz/assets/New-website/Quality/Draftv1RecordReviewAUGUST2018.pdf)

[The Code of Health and Disability Services Consumers’ Rights 1996](http://www.hdc.org.nz/the-act--code/the-code-of-rights/)

[Medical Council of New Zealand: Information, choice of treatment and informed consent](https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf)

[Ministry of Health: Advance care planning: A guide for the New Zealand health care workforce. Wellington, 2011](https://www.health.govt.nz/system/files/documents/publications/advance-care-planning-aug11.pdf)

[National Ethics Advisory Committee: Ethical challenges in advance care planning. Wellington, Ministry of Health, 2014](http://neac.health.govt.nz/system/files/documents/publications/Ethical%20Challenges%20in%20Advance%20Planning%20FINAL_pdf.pdf)

[Health and Disability Commissioner: Fact Sheet 1: Consent for consumers who are not competent](https://www.hdc.org.nz/resources-publications/search-resources/fact-sheets/consent-for-consumers-who-are-not-competent-fact-sheet-1/)

[Health and Disability Commissioner: Fact Sheet 2: “Do Not Resuscitate” (DNR) orders](https://www.hdc.org.nz/resources-publications/search-resources/fact-sheets/do-not-resuscitate-dnr-orders-fact-sheet-2/)

[New Zealand Medical Association: Advance directive](https://www.nzma.org.nz/patients-guide/advance-directive)

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# Section 2: Tikanga haumaru | Premise accessibility, safety and comfort

Indicator 6. Premise accessibility

**Our premise is safe and accessible for team members and patients.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 6.1 | Provide external signage that is clear, visible, well placed, and readable from a distance. | Demonstrate premise meets criteria requirements and are fit for purpose. |
| 6.2 | Ensure the practice has adequate space, seating, heating, lighting and ventilation. |
| 6.3 | Provide appropriate seating for patients with mobility and/or other needs. |
| 6.4 | Ensure there are disability accessible entrances and doorways. |
| 6.5 | Provide examination couches that are accessible and safe. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

The practice premise is required to be safe and accessible for team members and patients. It is however the business owner’s responsibility ensure all legislative requirements and patient’s rights are complied with.

Compliance with legislative requirements includes meeting Building Code requirements and the Fire and Emergency NZ (Fire Safety Evacuation Procedures and Evacuations Schemes) Regulations 2018.

Practices are particularly encouraged to ensure they are compliant with Building Code access requirements and have, as far as is practical, provided mobility parks and accessible toilets.

**Resources**

[Ministry of Business, Innovation and Employment: Building Code compliance](https://www.building.govt.nz/)

[Ministry of Business, Innovation and Employment: Building Code access guidance](https://www.building.govt.nz/building-code-compliance/d-access/)

[Ministry of Business, Innovation and Employment: Building Code compliance schedule handbook](https://www.building.govt.nz/building-code-compliance/building-code-and-handbooks/compliance-schedule-handbook/)

[Standards New Zealand, Design for Access Mobility – Buildings and Associated Facilities.](https://www.standards.govt.nz/assets/Publication-files/NZS4121-2001.pdf?utm_source=MBIE-BarrierFree&utm_medium=link&utm_content=NZS4121-2001&utm_campaign=downloads)

[Fire and Emergency New Zealand, evacuation scheme guidance](https://onlineservices.fire.org.nz/home/evacuationschemes)

[Fire and Emergency New Zealand (Fire Safety, Evacuation Procedures, and Evacuation Schemes) Regulations 2018](http://www.legislation.govt.nz/regulation/public/2018/0096/latest/LMS46332.html?src=qs)

# 

# Section 3: Wheako whaiaro | Patient experience

Indicator 7. Patient experiences

**Our practice uses patients’ experiences information to improve services.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 7.1 | Participate in the Health Quality and Safety Commission’s (HQSC) Primary Care Patient Experience Survey (PES) to understand patients experience of care. | Survey results. |
| 7.2 | Analyse survey data and other patient feedback to identify service improvement opportunities to develop and implement an improvement plan. | Analysis of results and record of discussions with the team on the patient experience of care.  A documented improvement plan and evidence the plan is being implemented. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Primary care patient experience survey*

The primary care patient experience survey (PES) is to find out what patients’ experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists, and/or hospital staff.

*Changes to services resulting from patient feedback*

Your practice should inform patients and the general practice team about changes to services resulting from patient feedback.

Results from the survey can be communicated to patients through tools such as a practice newsletter, practice website, flyers on the front desk, or notices in the waiting area.

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

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

**Resources**

[Health Quality & Safety Commission:](https://www.hqsc.govt.nz/)

* [Patient Experience](https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/)
* [Primary Care Patient Experience](https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/)

[Ministry of Health, System Level Measures Framework](https://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework)

# Section 4: Tikanga Tangata | Māori rights, health needs and equity

Indicator 8. Rights and health needs of Māori

**Our practice recognises, understands and is responsive to the rights and health needs of Māori as Tangata Whenua.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 8.1 | Understand the health needs of Māori and, in partnership with local Māori organisations, provider groups and whānau, actively improve access and care to achieve equity. | A Māori Health Plan which includes examples of how the practice has identified and is addressing inequities in healthcare.  A list of local Māori organisations, provider groups and whānau that the practice works in partnership with, including explaining the context of the partnership.  Minutes or file notes of partnership meetings with local Māori organisations, provider groups and whānau, including outcomes of the partnership activity. |
| 8.2 | Educate all team members in Te Tiriti o Waitangi/Treaty of Waitangi including the principles of *Partnership, Participation and Protection “and its application in a health context.* | Staff training records that demonstrate completion of required training. |
| 8.3 | Ensure all team members are supported with pronouncing Māori patient, clinic, service provider and local place names. | Te reo Māori signage and resources.  Activities / resources to assist staff to use correct pronunciation of te reo, particularly Māori patient names. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria however training options include:

* [Ministry of Health Foundation Course in Cultural Competency](https://learnonline.health.nz/course/category.php?id=84)
* [Mauriora Health Education Research: Foundation Course in Cultural Competency (Māori)](https://members.mauriora.co.nz/course/foundation-course-in-cultural-competency-maori/)

**Guidance notes**

*Māori Health Plan*

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

The Māori Health Plan should state how you will:

1. Address Māori health priority areas and specific practice population issues for Māori (the Government has identified a range of priority areas in He Korowai Oranga: Māori Health Strategy for improving Māori health and to improve access to appropriate, affordable and acceptable primary health services).
2. Implement measures to address priority areas as stated in He Korowai Oranga: Māori Health Strategy.
3. Target services for the enrolled Māori population; and ensure ethnicity data on Māori is available and robust; and establish priorities for Māori in the practice and set goals that will benefit their health outcomes.
4. Demonstrate that you are making additional efforts to address the needs of Māori. These efforts might include:

* Having specific targets and timelines, e.g. measure statins in Māori versus non-Māori.
* Encouraging enrolment of Māori patients on specific programmes such as Ministry of Health and District Health Board programmes in chronic care management.
* Identifying any barriers for Māori to access the practice services and addressing these, such as the percentage of Māori enrolled with the practice versus the percentage residing in the practice catchment area.

It is recommended the Plan include:

* The percentage of Māori enrolled with the practice
* The health status of Māori enrolled with the practice
* Key linkages (local, regional and national)
* Strategies (both short and long term)
* How progress will be monitored and evaluated

The plan should be updated annually.

*Te Tiriti o Waitangi / The Treaty of Waitangi*

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

*Rongoā Māori / Traditional Māori methods of healing*

The Ministry of Health has, in collaboration with representatives from the rongoā sector, developed a voluntary standard that provides clear requirements for providers that defines a benchmark of excellence to deliver safe and quality rongoā services.

It encourages and supports consistency of quality rongoā care and the ongoing development of the rongoā workforce. Guidance is provided in separate toolkits on how these requirements can be achieved.

**Resources**

Ministry of Health: Māori Health

Ministry of Health: He Korowai Oranga: Māori Health Strategy

[RNZCGP Māori Health Strategy: He Ihu waka, he ihu whenua, he ihu tangatai](https://oldgp16.rnzcgp.org.nz/assets/New-website/Advocacy/Maori-Strategy-Documentv17WEB.pdf)

[MCNZ: Best health outcomes for Māori: practice implications](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf)

[Te Taura Whiri i te Reo Māori/Māori Language Commission](http://www.tetaurawhiri.govt.nz/the-landscape-of-aotearoa-will-resonate-with-our-indigenous-language/)

[Ministry of Health: Rongoā Māori / Traditional Māori methods of healing](https://www.health.govt.nz/publication/tikanga-rongoa)

# Section 5: Tikanga ahurea | Population diversity

Indicator 9. Responsiveness to diversity

**Our practice identifies the diverse groups in our enrolled and geographic population and offers services that are responsive to their needs.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 9.1 | Have knowledge of the diverse groups within your enrolled and geographic populations and plan and provide for their health care needs. | Collated data and information on diverse groups within your enrolled and geographic populations and demonstration of the implementation of a plan to provide for their health care needs.  Examples of practice-wide initiatives to embrace diversity, inclusion and equity. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria, informed by an understanding of the diverse groups within your enrolled and geographic populations.

**Guidance notes**

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

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

Training options include:

*CALD*

CALD stands for “culturally and linguistically diverse’ and refers to people who are migrants and refugees from Asian, Middle Eastern and African backgrounds.

eCALD (an agency of the three Auckland DHBs) delivers a range of courses for practitioners who have knowledge and orientation in the New Zealand health system, and who work with CALD patients. They are available face to face in the Auckland region and online outside of the region.

* [CALD Cultural Competency “Courses for Working with CALD”](https://www.ecald.com/courses/cald-cultural-competency-courses-for-working-with-patients/)

*Diversity Works NZ*

Diversity Works NZ is a national membership organisation, aiming to help business develop diverse and inclusive workplaces. Diversity Works provides public and customised training in a range of diversity respect and inclusion related areas.

* [Diversity works](https://diversityworksnz.org.nz/about-us/)

*Rainbow Tick*

Rainbow Tick is an organisation that offers tools to help organisations become innovative and inclusive. They assist with policies and processes that will drive a supportive and productive workplace that specifically recognises and welcomes sexual and gender diversity.

* [Rainbow Tick](http://www.rainbowtick.co.nz/)

*Rainbow YOUTH*

RainbowYOUTH provides a number of services for queer and gender diverse youth and their wider communities all across Aotearoa. One of their professional development workshops is entitled Gender and Sexuality 101.

* [Rainbow YOUTH](https://www.ry.org.nz/what-we-do/pd)

*Life Unlimited*

Life Unlimited is a charitable trust that offers health and disability information, advice and equipment to enable people to live the life they choose. The Trust provides disability training workshops to businesses, local authorities, government or other community organisations and offers access to up-to-date information on disability issues.

* [Life Unlimited](https://www.lifeunlimited.net.nz/disability-information/disability-start-workshops/)
* [Learning cloud: Disability Awareness – Working with People with Disabilities](https://learningcloud.nz/courses/1263/disability-awareness-working-with-people-with-disabilities)

*Diversity in the population*

The [Health Practitioners Competence Assurance Act 2003](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards.

The population of New Zealand is becoming increasingly more diverse; there are many ‘cultures’ to be aware of and they are not necessarily based on one’s ethnicity, race, nationality or religion. In addition to these, the concept of diversity takes into account human differences in many different dimensions, including indigeneity, gender, gender identity, sex characteristics, sexual orientation and expression, age, ability, impairment and disability. Some groups of people with common lived experience consider their way of life to be a specific culture – and as such there are shared values, language, norms and practices (all elements of culture) that inform and shape their daily lives. Your patients can and will often belong to multiple cultures simultaneously.

There are implications not only on the demographic composition of the practice populations but also the health workforce. One of the major barriers to culturally appropriate, accessible, safe and equitable health services is the lack of cultural awareness, knowledge and skills of health professionals – current thinking around these matters describes cultural competence and cultural safety,

*Cultural competence and cultural safety*

Cultural competence refers to the skill-base of your general practice staff that enables them to recognise issues of cultural difference that may lead to miscommunication and inappropriate treatment. Cultural competence training will help them to take positive actions to help maintain a strong rapport, a clear understanding and practice that is consistent with the culture of the patient and their whānau or family. Cultural safety can be defined in many ways; the term is grounded in the experience of the patient. Factors other than the cultural competence of practitioners can contribute to the presence or absence of cultural safety for a patient, for example, environmental factors.

It is important to realise that simply knowing the information is insufficient; to achieve cultural competence, and for patients to experience cultural safety within your practice, general practice teams must integrate the knowledge into specific practices and policies that are applied to appropriate settings.

Developing an understanding of cultural competence will allow you to:

* Build strong relationships with patients.
* Find out more about the patient and their condition in order to make a more informed diagnosis.
* More effectively explain the diagnosis, treatment and what the planned follow-up will be by using a patient-centric approach to the consultation.
* Provide an environment within your general practice setting that is not inconsistent with the values, language, norms and practices of your patients.
* Understand each patient’s own environment and make recommendations that are more realistic and likely to succeed.
* Significantly affect numerous patient outcomes, including emotional health, symptom resolution, function, physiologic measures (e.g. blood pressure and blood sugar level) and pain control.
* Increase doctor and patient satisfaction.
* Enhance continuity of care.
* Avoid unintentional offence.

*Ethnicity data capture*

Providing quality ethnicity data will ensure the government is able to track health trends by ethnicity and effectively monitor its performance to improve health outcomes and reduce health inequities.

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

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

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

Ethnicity capture must align with [Enrolment requirements for providers and primary health organisations](http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation). The ethnicity question must be worded and set out exactly as specified in the Ministry of Health policy as this is the standard ethnicity question required by the [Ethnicity data protocols for the health and disability sector](http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector).

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

*Interpreters and communication resources for people with limited English proficiency*

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

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

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

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

* Mail
* Fax
* Email
* Text
* Support person/caregiver
* Patient portals
* [Language Line](http://ethniccommunities.govt.nz/browse/language-line)
* [New Zealand Relay service](http://www.nzrelay.co.nz/) (including TTY = Teletypewriter)

*Identify and address the needs of significant cultural groups within your practice*

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

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

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

You could consider:

* Posters and leaflets in other languages (these may be available through your DHB).
* Evening or weekend clinics for working parents.
* Involving patients (maybe on an advisory panel, or by focus group or surveys) and using their feedback to come up with ideas.

**Resources**

[Ministry of Health: Refugee health care: a handbook for health professionals; 2012](http://www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals)

MCNZ[: Statement on cultural competence](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf)

MCNZ: [Best health outcomes for Māori](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf)

MCNZ: [Best health outcomes for Pacific Peoples: practice implications](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf)

[Ministry of Health: Ethnicity data protocols for the health and disability sector](http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector)

[eCALD training](https://www.ecald.com/courses/cald-cultural-competency-courses-for-working-with-patients/)

[Mauriora Health Education Research](https://members.mauriora.co.nz/)

[Deaf Aotearoa](http://deaf.org.nz/)

[Health Navigator](http://www.healthnavigator.org.nz/)

[Department of Internal Affairs: Translation Service](https://www.dia.govt.nz/Translation-Service)

[The Code of Health and Disability Services Consumers’ Rights 1996](https://www.hdc.org.nz/your-rights/)

[New Zealand Society of Translators and Interpreters (NZSTI)](http://www.nzsti.org/)

[The Office of ethnic communities: Language Line](http://ethniccommunities.govt.nz/browse/language-line)

[New Zealand Relay service](http://www.nzrelay.co.nz/)

[Auckland Regional Public Health Service: Refugee Health](http://www.arphs.health.nz/health-professionals/refugee-health/)

[Health Quality & Safety Commission: Health Literacy](https://www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/health-literacy/)

[Be. Accessible](http://www.beaccessible.org.nz/the-movement/about-be-accessible)

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# Section 6: Pārongo tūroro | Patient information

Indicator 10. Patient information system

**Our practice manages patient information in a secure electronic information system.**

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| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 10.1 | Securely manage the use and security of patient health information including having a practice policy aligned to Health Information Security Framework standard HISO 10029:2015. | A documented Patient Information Policy and Procedures. |
| 10.2 | Formally appoint the role of Information Security Officer. | A designated Information Security Officer role and responsibilities are written into a position description and stated in the Patient Information Policy. |
| 10.3 | Use a Patient Management System that is securely deployed, backed up daily and can be restored. | Demonstrate how all patient information is securely stored.  Evidence of regular verification reviews of the effectiveness, resilience and security of all systems, back-ups and policies.  A [General Practice Information and Communication Technology (ICT) Security Checklist](http://www.patientsfirst.org.nz/services-products/general-practice-ict-security-checklist/) that has been completed in the last 6 months. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria. However, it should include all staff with access rights to information systems being trained on practice information security, privacy policies and standards.

**Guidance notes**

*Recording clinical information*

Your practice must use an electronic Patient Management System (PMS) that meets the requirements for digital health information security.

*General Practice ICT Security Checklist:*

This covers the essentials of digital security. The practice must meet these requirements and therefore should undertake both a self-assessment and quick independent assessment of the baseline ICT security within your practice. It is based on the baseline requirements discussed in the Health Information Security Framework. Click here for [General Practice ICT Security Checklist](http://www.patientsfirst.org.nz/services-products/general-practice-ict-security-checklist/)

*Third party access*

In order to ensure patient confidentiality clear documentation is required from patients for a third party (e.g. family member, spouse, or friend) to access records, results or request and/or collect prescriptions. Discretion may be applied if the patient is incapacitated, cognitively or physically impaired, in difficult social circumstances or a child. Youth records should be reviewed to ensure their confidentiality is maintained.

*Protecting health information in your practice*

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

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

*Security of electronic health information*

Most sensitive information in general practice is likely to be stored within your PMS therefore the electronic PMS must be deployed in an up-to-date, secure and fit-for-purpose IT environment.

Most PMS systems have a facility to assign roles to people, and to restrict the access of information at varying levels. People with access to your PMS should be assigned an appropriate role based on their need within your practice. Custodial or cleaning staff should not have access to the PMS. Reception staff should only have access to the information that they need to do their jobs, which likely includes patient administration information but not clinical information. By limiting the availability of patient health information, you limit the risk that it will be inadvertently or deliberately misused.

It is essential that access to the PMS system requires a personal password and the system automatically requires a password to access the computer/terminal or the PMS after a period of inactivity (no more than 15 minutes). An alternative is Password-protected screensavers or other automated security applications This protects against unattended access to computers if staff forget to log off or walk away and are longer than they expect. Consider shorter timeout periods for computers in consultation rooms or other locations where patients may be left alone even for short periods of time.

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

*Backup and retrieval system*

A backup is a copy of some or all of the files and information stored on a system. The purpose of a backup is to be able to recover all patient information stored in your computer system. This should always include the PMS database and other patient information e.g. photos, scanned documents not in the PMS. It may also include other computer files contained on your system e.g. HR records, financial data, emails, business records.

Your practice must have (as a minimum) a system to backup essential electronic data on a daily basis (if not in real time). Taking a backup of your most important files at least every day is important. In the event of a catastrophic loss of your system (perhaps a fire to your building that destroys it or a computer virus that renders the files or system unusable), the backup is used to retrieve important information. Be aware that you will lose any information between the time you last have a backup of your system and when you wish to restore it. Best practice is a backup that allows restoration of the complete “in practice” computer system

Holding a copy of your backups and files offsite (or using a secure online service) is important to protect against events such as fire or theft, where both the original files and backups could be compromised. Because your backups will almost always contain sensitive information, it is also important that the physical location in which the backups are being stored is secure and/or protected by secure password. Generally staff storing backups in their homes is not considered to be a secure way of keeping offsite backups. There may be issues with staff having the potential to lose the backups en-route to their home or having those backups stolen from their home. Both of these situations would compromise your information security. If you take physical backups, it is recommended that you use a professional service that can satisfy the requirement for secure transport and storage of those media.

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

Consider planning your backup and restore test in conjunction with a third-party IT provider. You would normally test the restoration process into an environment outside of your normal practice system (to simulate what may happen in a disaster situation). To undertake this test may require some time. It is acknowledged that for most small businesses this task would only be undertaken sporadically.

*Independent auditing of your electronic data systems and policies*

It is recommended that your practice can provide evidence of independent auditing of your electronic data systems and policies. If you use a third-party IT support provider, your provider should be able to provide some independence in terms of audit and identifying information issues.

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

Having a specialist IT provider with knowledge of the systems and industry can help with maintenance of the systems and ensure that they are not configured in a way as to compromise the security of your system.

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

**Resources**

[Ministry of Business, Innovation and Employment: Protecting Business Data](https://www.business.govt.nz/risks-and-operations/it-risk-and-avoiding-scams/protecting-business-data/)

[Patients First: General Practice ICT Security Checklist & Guide](http://www.patientsfirst.org.nz/services-products/general-practice-ict-security-checklist/)

[Patients First: Security Checklist Guide](https://www.patientsfirst.org.nz/downloads/gp-security-checklist-guide.pdf)

[Patients First: Security Checklist](https://www.patientsfirst.org.nz/downloads/gp-security-checklist.pdf)

[Standards New Zealand: Primary Healthcare Practice Management Systems](https://shop.standards.govt.nz/catalog/8170%3A2005%28SNZPAS%29/view)

[Ministry of Health: HISO 10029:2015 Health Information Security Framework](https://www.health.govt.nz/publication/hiso-100292015-health-information-security-framework)

[Ministry of Health: eHealth](https://www.health.govt.nz/our-work/ehealth)

[The Privacy Commissioner: On the record: a practical guide to health information privacy](https://www.privacy.org.nz/assets/Files/Health-toolkit/On-The-Record.pdf)

[The Privacy Commissioner: Health privacy toolkit](https://privacy.org.nz/news-and-publications/guidance-resources/health-privacy-toolkit/)

[Health Information Privacy Code 1994 Incorporating amendments and including revised commentary](https://privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-incl.-amendments-revised-commentary-edit.pdf)

[Health (Retention of Health Information) Regulations 1996](http://www.legislation.govt.nz/regulation/public/1996/0343/latest/DLM225616.html)

Indicator 11. Registration and enrollment

**Our practice has a patient registration and enrolment process that is timely and effective.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 11.1 | Collect enrolment information adhering to the Ministry of Health requirements. | Patient enrolment form consistent with current Ministry of Health guidelines, including a privacy statement. |
| 11.2 | Provide patients with a health information privacy statement. |
| 11.3 | Enable health records to be securely transferred between practices within 10 working days via a monitored tracking system. | A documented records transfer policy, procedure and tracking system, including timeframes for records transfer in and out of the practice. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

The practice is required to complete [Enrolment requirements for primary health organisations](http://www.health.govt.nz/publication/enrolment-requirements-primary-health-organisations), [Enrolling with a primary health organisation](http://www.health.govt.nz/system/files/documents/pages/enrolling-with-a-pho-jul14.pdf).

*Entering ethnicity data*

The ethnicity question must be worded and set out exactly as specified by the Ministry of Health as this is the standard ethnicity question required by the [Ethnicity data protocols for the health and disability sector](http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector).

*Complying with the Health Information Privacy Code 1994*

You should be familiar with the requirements of the Health Information Privacy Code 1994, particularly Rules 3 and 4 relating to the collection of health information and Rule 6 relating to the access, including transfer, of health information.

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

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

Examples of tracking receipt of health records by another authorised agency may include the inclusion of a fax-back form, the use of registered mail or courier packs with a signature required to authorise release and confirm receipt. The transfer of hardcopy notes between practices should only take place using track and trace services such as courier. The use of standard postal services is not considered secure.

*Using an electronic system to transfer records*

A system like GP2GP, which has the capability to transfer a patient’s files electronically from one general practice system to another, allows the transfer of records reliably, securely and accurately.

**Resources**

[Ministry of Health, Enrolment in a primary health organisation](https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation)

[Ministry of Health, National Enrolment Service](https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/national-enrolment-service)

[MCNZ, The maintenance and retention of patient records](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf)

[Ministry of Health, Ethnicity data protocols](https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols)

[Patients First: GP2GP](http://www.patientsfirst.org.nz/services-products/gp2gp/)

Indicator 12. Patient records

**Our practice has electronic patient records that describe and support the management of the health care provided.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 12.1 | Ensure that electronic patient records contain information to identify the patient and document:   * + - The reason(s) for the encounter.     - Relevant examination and assessment.     - Management.     - Progress and outcomes (management / risk factors / screening / referral / tests / investigations).     - Follow-up and safety netting. | A clinical notes review of 10 patient records in the 12 months prior to an onsite assessment is completed by all clinicians |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

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

Your PMS and other systems must provide:

* Information capability to support population healthy approaches:
  + Disease registers
  + Patient databases
  + Risk assessment tools
* Information systems to support proactive primary care over time:
  + Contact of at-risk populations
  + Monitoring and follow-up
  + Performance feedback
* Clinical decision-making support:
  + Evidence-based guidelines
  + Electronic reminders in PMS
* Coordinated care systems to support timely quality treatment:
  + Accessible by the whole of a care team across providers
  + Sharing of patient information across organisations
* Integrated systems capability:
  + Standardised eReferral
  + ePrescriptions, patient portals, shared care records
  + eAssessment processes and capability to access data across disciplines, institutions and providers
  + Supporting electronic transaction processing, and integrated funding arrangements
  + Transfer of health records (GP2GP)
* Feedback and reporting to ensure quality service provision and improved patient outcomes.

**Resources**

[MCNZ: The maintenance and retention of patient records](http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf)

# Section 7: Manaaki haumanu | Clinical care

Indicator 13. Management of clinical correspondence

**Our practice has an effective system for the management of clinical correspondence.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 13.1 | Have an effective system for managing internal and external clinical correspondence. | A documented policy and procedure on to how to manage and track, laboratory results, imaging reports, investigations and clinical correspondence. |
| 13.2 | Ensure newly enrolled patient records are reviewed by a clinician. | A documented policy and procedure on the handling of newly received patient records. |
| 13.3 | Ensure all incoming investigation results are sighted and actioned by the clinician who requested them, or by a designated clinician.  Significant results are prioritized and actioned. | Clinical notes review of 10 patient records in the 12 months prior to an onsite assessment is completed by all clinicians |
| 13.4 | Identify and track potentially significant investigations and urgent referrals. |
| 13.5 | Provide patients with information about your practice procedures for notification of test results. | Patient information e.g. provided: verbally and/or in writing (e.g. leaflet or brochure), by poster, by notice, on the patient portal or the practice website. |
| 13.6 | Keep a record of communications with patients informing them about test results. | Clinical notes review of 10 patient records in the 12 months prior to an onsite assessment is completed by all clinicians |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

Managing patient test results in general practice is a complex task. It involves all members of the practice team, relies on the systems in the general practice and the outside provider, and requires the results to be communicated to the patient in a timely, clinically appropriate and meaningful manner.

The highly administrative nature of test result management can feel bureaucratic at times, but it is a critical part of a patient’s diagnostic work-up and the results often have significant implications for the care patients receive.

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

*Have clear policies and processes*

Your practice must operate a reliable and defined process for recording and managing clinical investigations. There should be a clear indication of what action was initiated on all reports to enable correct tracking and management.

The principle is that patient reports are not lost in the system and are processed to ensure the right people get the right information within the timeframes identified by your practice. For every report or test there must be a person in the practice responsible for management and tracking.

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

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

A number of the requirements of this indicator can be met through correct usage of your practice’s PMS system and patient portal such as tracking of important test results, viewing of incoming new patient records and recording of notifications of results to patients. This capability can greatly reduce the workload impact of these criteria, although different PMS systems have varying capabilities in this regard, Demonstration of your practice IT implementation will facilitate assessor evaluation.

*Auditing your practice’s processes*

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

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

Key areas to focus on:

* Identify missing results, i.e. not received from the laboratory, or ordered but information not complete.
* Provide information about what has happened to medical investigations that have been returned to the practice.
* Appoint a clinical team member responsible for monitoring the review and action of all incoming test, results and medical reports (see clinical governance).
* Appoint a designated deputy, for example locum, to process the reports if that requester is not available or is on leave.
* Track specialist referrals.

Tracking methods may include:

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

*How you communicate results with patients*

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

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

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

Leaving patients to assume that silence means their test results are OK is not acceptable. See the [Health and Disability Commissioner](http://www.hdc.org.nz/publications/other-publications-from-hdc/articles/2008/managing-patient-test-results) website.

*Recording communication with patients about tests:*

Communication (including phone calls and emails) about tests should be recorded in the electronic health record with:

* The date.
* The person identified who provided the result to the patient.
* A brief record of what information was conveyed.
* A record of what method was used to convey the information – telephone, letter, email, SMS (consider security of message system – [Health Information Privacy Code 1994](https://www.privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/)).

Other useful tips to consider:

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

*Vicarious liability*

General practices will not ordinarily be held liable for lapses in care or communication by an individual practitioner who they ‘employ’. However, if the lapse was attributable to poor systems or inadequate protocols at the practice, the practice may be held vicariously liable. In practice, generalpractices should have good, robust systems in place, provide appropriate training, guidance and support, and ensure ongoing audit and review.

Under the Health and Disability Commissioner Act 1994, ‘employing authorities will avoid vicarious liability if they can show that they took such steps as were reasonably practicable to prevent the acts or omissions that amount to a breach of the Code of Health and Disability Services Consumers’ Rights.

*Clinical governance*

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

**Resources**

[RNZCGP: Managing patient test results](https://oldgp16.rnzcgp.org.nz/assets/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf)

[Medical Protection: Handling test results](http://www.medicalprotection.org/newzealand/casebook-may-2015/handling-test-results)

[MCNZ: The management of clinical investigations](https://www.mcnz.org.nz/assets/Uploads/Layout-draft-times-new-Roman.pdf)

[Health and Disability Commissioner](https://www.hdc.org.nz/)

Indicator 14. Continuity of care

**Our practice provides continuity of care for patients.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 14.1 | Have an effective referral system to other primary or secondary care providers (an electronic referral system where available). | Demonstrate how the referral system works between primary and secondary care. |
| 14.2 | Have a process for the safe and effective transfer of clinical responsibility when transferring patients to clinicians within your practice (e.g. to and from a locum) or to providers and services outside your practice (handover). | Demonstrate the process for the transfer of clinical responsibility. |
| 14.3 | Ensure patients with palliative care needs can always access their primary care provider or an informed clinician. | Practice policy and procedure |
| 14.4 | Give patients the option to see their preferred clinician(s). | Demonstrate a system that aims to accommodate a patient’s choice of clinician and appointment time, considering the medical urgency of the issue |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Continuity of care management for patients within the practice*

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

Patients and colleagues need to understand the responsibilities in the team and who is responsible for each aspect of patient care. The practitioner who is the patient’s principal health provider is responsible for maintaining this continuity of care (see MCNZ: [Good medical practice](https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf)).

*Effective linkages between your practice and secondary care*

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

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

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

*Effective communication is essential*

Effective communication and robust information is essential for working across interfaces and preventing patients getting lost in the system.

This is particularly important where information is shared across systems, in multidisciplinary teams and in networks. Lapses in continuity of care have occurred when patient information is not well documented, or when the pathway forward is not clear to other clinicians.

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

Examples include:

* [eReferrals](http://healthitboard.health.govt.nz/our-programmes/common-clinical-information/clinical-data-repository-and-clinical-workstations-0)
* [eDischarges](http://healthitboard.health.govt.nz/our-programmes/common-clinical-information/clinical-data-repository-and-clinical-workstations-1)
* Electronic shared care records (e.g. HealthOne)
* [radiology information and picture archiving systems](http://healthitboard.health.govt.nz/our-programmes/shared-health-information/common-clinical-information/radiology-information-and) (e.g. Radiology Information System (RIS), Picture Archiving Communications System (PACS))
* [Maternity clinical information system](http://healthitboard.health.govt.nz/our-programmes/shared-health-information/maternity-information-systems-programme/maternity-clinical)
* eMedicines reconciliation (eMR)

*Transferring patients*

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

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

All transfers must be appropriately documented. The patient should be aware of who is responsible for their care throughout the transfer, and how information about them is being shared ([MCNZ: Good medical practice](https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf)).

*Referring patients*

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

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

All referrals must be appropriately documented ([MCNZ: Good medical practice](https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf)).

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

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

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

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

*‘Referring a patient to a colleague’ checklist*

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

*‘Referring patient care back to a colleague’ checklist*

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

*Summary patient record*

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

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

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

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

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

*Give patients the option to see their preferred clinician(s).*

When a patient makes an appointment with the practice they must be offered an option to choose the clinician they prefer, with information as to likely time frame of this option verse other available clinician.

**Resources**

[MPS Transfer of health information between healthcare professionals](https://www.medicalprotection.org/newzealand/casebook-resources/factsheets/factsheets/nz-transfer-of-health-information-between-healthcare-professionals)

[MCNZ: Good medical practice](https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf)

[RNZCGP Policy Brief: Managing patient test results](https://oldgp16.rnzcgp.org.nz/assets/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf)

Indicator 15. Responsiveness to urgent health needs

**Our practice team identifies and responds to urgent health needs.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 15.1 | Train non clinical team members to identify and respond to patients with urgent medical conditions. | Staff training records of completion of the required training. |
| 15.2 | Ensure that team members who may be required to administer CPR have current certification to an appropriate level from certified trainers. | CPR Certificates. |
| 15.3 | Display signage for waiting patients detailing urgent situations and ensure reception staff can visually monitor all waiting areas. | Signage and staff training undertaken to monitor waiting areas. |
| 15.4 | Conduct annual clinical emergency scenario drills to support your practice’s responsiveness to urgent health needs. | Emergency drills that demonstrate all team members are familiar with their roles and responsibilities.  Documented analysis and debrief of the emergency scenario drill. |

**Required training**

Non-clinical team members responsible for first-line interaction with patients are trained / retrained, annually, to identify and respond appropriately to patients with urgent medical conditions.

**Guidance notes**

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

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

Ways you can observe patients:

* Direct observation
* Two-way windows
* Concave mirrors
* Closed circuit TV (consider [Privacy and CCTV](https://www.privacy.org.nz/news-and-publications/guidance-resources/privacy-and-cctv-a-guide-to-the-privacy-act-for-businesses-agencies-and-organisations/) issues)

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

*How will you manage patients with urgent medical needs?*

It is essential that you have a triage system in place to recognise and respond to an emergency. This will assist your staff to monitor and assess patients, decide how urgent their illness or injury is and how soon treatment is required. The triage system will be managed by your clinical team.

Levels of timely access to care may be:

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

*Training*

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

Your training programmes should also include:

* Medical emergencies in patients who are phoning the medical centre
* Things to think about when putting callers ‘on hold’

**Things to think about for your training and resources**

* Is it at a level appropriate for different team members?
* Do you have reference material available from which to decide (e.g. posters, booklets, algorithms or flowcharts)?
* Is your reference material readily available and accessible?
* Do all relevant staff members know where to find this information?
* Do you have definitions and responses for potential problems including (but not limited to):
* Pain
* Bleeding
* Slurred speech
* Altered level of consciousness
* Extreme concern
* Dehydration
* Fever
* Non-clinical team members must not diagnose the patient’s medical condition or make a clinical decision.
* Is your training non-diagnostic (based on presenting problems and how to arrange timely access to care)?
* Is it comprehensive and patient focused to include self-care, first aid and/or ongoing monitoring?
* Does your training occur at least once a year?

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

*CPR training*

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

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

This includes:

* Gathering appropriate personnel
* Having defined roles and responsibilities and systems to ensure such rules are followed
* Ensuring staff have a global overview of the crisis
* Having appropriate communication between staff members
* Ready access to organised and necessary equipment

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

**Resources**

[New Zealand Resuscitation Council: Guidelines](http://www.nzrc.org.nz/guidelines/)

[New Zealand Resuscitation Council: Training](http://www.nzrc.org.nz/training/)

[St John: First aid courses](https://buy.stjohn.org.nz/first-aid/first-aid-courses/)

[Privacy Commissioner: Privacy and CCTV: A guide to the Privacy Act for businesses, agencies and organisations](https://www.privacy.org.nz/news-and-publications/guidance-resources/privacy-and-cctv-a-guide-to-the-privacy-act-for-businesses-agencies-and-organisations/)

Indicator 16. 24-hour, 7-day/week health care

**Our practice makes provision for 24-hour, 7-day/week face-to-face health care.**

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| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 16.1 | Provide patients with information on how to access after-hours care. | Signage, including a patient portal notice, website information, social media page information, patient information sheets and an answer phone service. |
| 16.2 | Ensure patients can access your practice’s after-hours service using a maximum of two calls. | Demonstrate After-hours telephone message and/or call diversion to after-hours provider. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

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

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

Call diversion and voice messaging must provide explicit information about which service is providing access to care if after-hours care is not provided at your practice. If your practice does not provide 24-hour after-hours care, it must arrange for medical services to be covered 24 hours a day, seven days a week.

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

Examples include but are not limited to:

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

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

Making it easy for patients to call an after-hours provider reduces the barriers to accessing care and enhances continuity of care.

Telephone advice can reduce the number of face-to-face consultations when it is safe to do so, easing after-hours workloads. However, it is not always suitable for patients who need to see a GP or a nurse [urgently](http://www.oag.govt.nz/2014/after-hours-services) and some sort of provision for, or referral to, after-hours care should be made as appropriate (e.g. an after-hours provider, emergency department, call an ambulance).

Indicator 17. Screening and recall

**Our practice maintains an effective screening and recall system.**

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| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 17.1 | Meet the screening and recall requirements for both the enrolled and eligible population as per the national screening programme guidelines. | Demonstrates referral to and / or enrollment in the national population-based screening programmes. |
| 17.2 | Have one or more team members responsible for and trained in the recall procedure. | Identify persons responsible and the training they have received. |
| 17.3 | Ensure opportunistic screening is evidence-based. | Demonstrate where opportunistic screening is being delivered, how it has been verified and how it aligns with best practice. |
| 17.4 | Audit screening and recall activities to review effectiveness in reaching eligible target populations. | Practice audits of enrolled and eligible populations and screening, recall and uptake . |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

Screening is testing of asymptomatic patients. Opportunistic screening is screening outside of an organised program, either national or regional.

Practices should update the patient dashboard (if used) and recalls as required.

Offering appropriate screening to presenting individuals in addition to population-based screening may enable early detection of disease in a preclinical state. It may also cause harm through detection of conditions that are not clinically significant or are untreatable. Therefore opportunistic screening should be based on good evidence that benefit outweighs harms.

*The National Screening Unit*

The [National Screening Unit (NSU)](https://www.nsu.govt.nz/) is a separate unit of the Ministry of Health, and is responsible for the safety, effectiveness and quality of health and disability screening programmes:

* [Antenatal HIV Screening Programme](https://www.nsu.govt.nz/pregnancy-newborn-screening/hiv-testing-pregnancy) – screens pregnant women for HIV to reduce the chances of HIV being passed to the baby
* [Newborn Metabolic Screening Programme](https://www.nsu.govt.nz/pregnancy-newborn-screening/newborn-metabolic-screening-programme-heel-prick-test) – screens newborn babies for certain metabolic disorders
* [Universal Newborn Hearing Screening Programme](https://www.nsu.govt.nz/pregnancy-newborn-screening/universal-newborn-hearing-screening-programme) – screens newborn babies for hearing loss
* [Breast Screen Aotearoa](https://www.nsu.govt.nz/breastscreen-aotearoa) – screens women for breast cancer
* [National Cervical Screening Programme](https://www.nsu.govt.nz/national-cervical-screening-programme) – screens women for abnormal changes to cells on the cervix
* [National Bowel Screening Programme](http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/bowel-cancer-programme/national-bowel-screening-programme)

*Auditing screening and recall activities*

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

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

Consider how you can:

* Identify patients eligible for screening and recall (e.g. query builds on the PMS)
* Identify gaps and those patients who have missed out
* Communicate with eligible patients in a way that suits them (e.g. texts, telephone, letters, email)
* Work with other organisations and agencies to come up with strategies to reach all your target populations (e.g. outreach services)
* Improve uptake by eligible populations
* Identify and reduce inequities for people in different groups in your population
* Engage with and raise awareness in under-screened populations (e.g. education sessions, resources)
* Help remove barriers for patients (e.g. by arranging transport, evening and weekend clinics, mobile services, outreach programmes). For an example see [How to increase the uptake of cervical screening: a profile of success](http://www.bpac.org.nz/BPJ/2013/October/cervical.aspx).

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

Click here for NSU[’s Programme Information requests](https://www.nsu.govt.nz/health-professionals/tools-and-resources/information-requests).

Important [Quality principles](https://www.nsu.govt.nz/system/files/page/qualityprinciples25june14.pdf) to keep in mind are outlined by the NSU.

**Resources**

[National Screening Unit](https://www.nsu.govt.nz/)

[MCNZ: Information, choice of treatment and informed consent](https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf)

[Inequalities in cancer screening programmes](http://www.otago.ac.nz/wellington/otago019738.pdf)

Indicator 18. Healthy lifestyle

**Our practice promotes healthy lifestyles.**

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| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 18.1 | Promote patient centered self-management. | Document in the patient record any advice or activities discussed relating to health lifestyles. |
| 18.2 | Provide or refer patients to programmes that improve, maintain or restore health. | Document in the patient record any referrals to programmes that improve, maintain or restore health. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

Health promotion, education and self-management and self-management support are important aspects of primary health care.

The [Ottawa Charter for Health Promotion](http://www.who.int/healthpromotion/conferences/previous/ottawa/en/) states that health promotion is the process of enabling your patients to increase control over, and improve, their health.

Health promotion is distinct from education and information used to support diagnosis and choice of treatment. Health promotion is the term given to planning, implementing and evaluating activities that promote health and wellbeing in communities, and when practice teams work with patients to help them manage their own care to improve their quality of life.

PHOs are required to work with whānau, hapū, iwi, consumers, and other groups within their community, relevant public health service providers and regional public health units to plan and deliver [health promotion programmes](http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/health-promotion-primary-health-care). Programmes are required to be consistent with population health objectives and public health programmes at national, regional and local levels.

Your general practice has a role to play. Effective health education and promotion help contribute to patient safety and improved health outcomes, and empower patients and whānau to increase control over their health and wellbeing through increasing health literacy levels.

*Preventive care and promoting healthy lifestyles*

Your practice team should deliver preventive care and promote healthy lifestyles. Educating patients in preventive approaches helps them develop skills to manage their own health.

You can also work with primary health organisations, networks or public health units to develop health promotion and social marketing approaches to help people understand the importance of making healthier lifestyle choices. This is directly geared to achieving specific and measurable health goals over the short, medium and long term.

Preventive health topics:

Here are some areas in which your general practice can work with your PHO, public health service providers and your community to integrate both health promotion and health protection activities (see [Ministry of Health: Preventative health/wellness](http://www.health.govt.nz/our-work/preventative-health-wellness))

*Using the practice database to identify the health needs of the enrolled population*

You can use data from your PMS to identify the health needs of your enrolled patients. Think about what data would be useful and how you can build and extract it from your PMS.

Examples of audits may include but are not limited to:

* Current smokers
* Alcohol and drug intake
* Elevated blood pressure

**Resources**

[Public health in a primary health care setting](http://www.health.govt.nz/system/files/documents/pages/publichealthprimaryhealthcaresetting.pdf)

[Health Ed: Free health resources](https://www.healthed.govt.nz/home)

[Health Promotion Agency](http://www.hpa.org.nz/)

[Health Quality & Safety Commission, Partners in care](http://www.hqsc.govt.nz/our-programmes/partners-in-care/)

[Health Navigator](http://www.healthnavigator.org.nz/)

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# Section 8: Whare haumanu | Practice team members

Indicator 19. Health and safety

**Our practice actively works to support the health and safety of our team, patients, contractors and visitors.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 19.1 | Support a healthy and safe environment for your team, patients, contractors and visitors. | A documented Health and Safety Policy and Hazard and Risk Register which are reviewed and updated annually.  A record of any health and safety incidents and resultant actions taken.  A register of hazardous substances including substance, quality and location.  Data safety sheets for hazardous substances.  Certification of any required training. |
| 19.2 | Ensure the practice team is trained to evacuate the practice by participating in a fire drill every 6 months. | Demonstrate all team members are familiar with their roles and responsibilities during a fire drill.  Documented analysis and debrief of the fire drill scenario. |

**Required training**

Training may be required in line with the requirements of current Health and Safety at Work Act 2015 and/or Hazardous Substances Regulations 2017. Actual requirements will depend on number of staff engaged and the type and quantity of hazardous substances held on site. This potentially introduces training in handling and disposal requirements.

**Guidance notes**

The purpose of this indicator is to assist with ensuring that practices provide a healthy and safe environment for team members, patients, contractor and visitors. It is however the business owner’s responsibility to ensure all legislative requirements, including the requirements of the Health and Safety at Work Act 2015 and Regulations, are complied with.

*Managing hazards and risks in your practice*

The first step in managing health and safety is to identify these hazards in your practice and assess the likelihood or risk of them causing a serious injury or illness.

You will need to write hazards and risks down in a hazard/risk register. As a start point focus on your people and patients when you are looking for hazards – looking for all the things that could hurt the people that come into your practice.

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

A **hazard** is anything that can cause harm, like a hazardous substance, equipment, fatigue, repetitive movements on the computer, bullying, wear and tear as some examples. **Risk** is the likelihood that injury, illness or even death might occur when exposed to that particular hazard. For each hazard think about how likely it is to occur and the possible impact and record that in your register against each hazard.

What you must do:

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

*Incidents*

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

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

*General*

To support a healthy and safe environment it is recommended that practices:

* Know staff immunity status and offer appropriate vaccinations as required.
* Service electric equipment in accordance with the Electrical (Safety) regulations 2010 Clause 60.
* Ensure Residual Current Devices (medical grade 10mAmp RCDs) are used where required, and tested, to protect patients and team members in accordance with the Electrical (Safety) Regulations 2010.

**Resources**

[WorkSafe New Zealand](https://worksafe.govt.nz/)

[Worksafe New Zealand: Managing health and safety](https://worksafe.govt.nz/managing-health-and-safety/)

[Worksafe New Zealand: What the Hazardous Substances Regulations mean for you](https://worksafe.govt.nz/topic-and-industry/hazardous-substances/managing/what-the-hazardous-substances-regulations-mean-for-you/)

[Ministry of Business, Innovation and Employment: Working Safely With Hazardous Substances](https://www.hazardoussubstances.govt.nz/)

[RNZCGP: Health and safety things to think about April 2016](https://oldgp16.rnzcgp.org.nz/assets/New-website/Quality/Health-and-safety-things-to-think-about-April-2016-1.pdf)

[Institute of Directors: Health and Safety leadership: A guide for small to medium business owners and company directors](https://www.iod.org.nz/Portals/0/Publications/Health%20and%20Safety%20Guide%20for%20SME.pdf)

Indicator 20. Employee and contractor safety checking procedures

**Our practice has appropriate safety checking procedures.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 20.1 | Have and apply a Child Protection Policy and Safety Checking Procedure in accordance with the Vulnerable Children Act 2014. | A documented Child Protection Policy and Safety Checking Procedure.  Documented safety checks, including Police vetting, for employees and contractors. |
| 20.2 | Ensure clinical team members maintain their annual practicing certificate (APC). | Current annual practising certificates for clinical team members as required under the Health Practitioners Competence Assurance Act 2003.  A system for monitoring clinicians who are practising under conditions on their APC and ensuring clinicians are working within their scope of practice. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Scope of requirements under the Vulnerable Children Act 2014*

Under the Vulnerable Children Act 2014 specified organisations are required to undertake safety checks of all staff they employ or engage. Most GPs and practice nurses will be children’s workers and will need to be safety checked.

Public hospitals, publicly funded medical practices or facilities, medical practices belonging to PHOs, and other publicly funded providers of health services provide regulated service and are recognised as specified organisations.

*The required checks*

The safety checks required for all staff require a practice to do more than simply complete a Police vetting process. You are required to:

1. **Identity confirmation:**
2. Through an electronic identity credential (e.g. the RealMe identity verification service), and a search of personnel records, establish the uniqueness of the claimed identity.
3. Following the regulatory process to establish:

(i) The identity exists by checking an original primary identity document (as listed in Part 1 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children’s Workers) Regulations 2015).

(ii) The identity is a living identity and is used in the community by verifying an original secondary identity document (as listed in Part 2 of the Schedule of the Vulnerable Children (Requirements for Safety Checks of Children’s Workers) Regulations 2015).

(iii) The identity is linked to the presenter.

(iv) The uniqueness of the identity by searching personnel records.

1. An interview, which should be face-to-face, but may be via telephone or other communications technology. Consider whether to conduct two interviews (to enable follow-up and clarification) and whether to have a small panel of interviewers. Interviewers should be chosen for their experience, knowledge and skill, with at least one having broad child protection knowledge. In addition to role-related questions, the interview could explore the new staff members view on safe practice.

It is recommended that questioning elicit information such as:

* Whether complaints have been made about the worker’s professional practice.
* Whether they have been convicted of an offence, and reasons for leaving previous employment.
* How they have dealt with a situation (or what they would do if such a situation arose) where a child or young person disclosed abuse.
* What they think constitutes professional practice when working with children.
* Other relationships they have with children outside the working environment.
* The kind of relationships they hope to develop with children and families in the new role.

1. Work history: consider the previous five years at least.
2. At least one referee: consider the information from more than one referee where possible, which includes information on how the potential staff member relates to children. Referees must not be related or be part of the individual’s extended family.
3. Seek information: from any relevant professional organisation, licensing authority or registration authority, and confirmation that the person is a member of the organisation or registered by the authority.
4. New Zealand Police vet. To use the Police Vetting Service, agencies or individuals need to meet the required criteria and obtain approval from the New Zealand Police. Ministry of Justice records are not acceptable as evidence.
5. Assessment of the risk the potential staff member would pose to the safety of children if employed or engaged by evaluating the above information.

*Risk assessment*

It is important to follow the correct process, including the completion of a risk assessment of the potential staff member, and to keep accurate records. All relevant information gathered during the safety checking process must be considered to inform the final decision.

Decision making needs to be reasoned, based on evidence, and to put the child at the centre. Principles to follow include:

* Use professional judgement to identify patterns of concerning attitudes or behaviours. People conducting safety checks should consider the information holistically.
* Always consider indicators in context. Give people the opportunity to respond to concerns about their suitability.
* Follow up on potential indicators (e.g. by asking for evidence).

Moreover, safety checking must always be done in accordance with existing legal protections such as the Privacy Act 1993 and the Human Rights Act 1993. The final decision may be based on a range of factors, and ultimately the decision maker should be satisfied that the staff member poses no undue risk to the safety of children if employed or engaged. Decision makers should also consider whether they need to seek outside expert advice and further referees, and to raise any issues with the staff member.

Periodic rechecking every three years is required and should cover: confirmation of any changes of an officially recorded name, updating the checks with the relevant professional registration body or licensing authority, a fresh New Zealand Police vet, and a risk assessment based on these checks.

*Relying on previous checks or checks done by others*

Organisations may rely on checks that meet the standard (i.e. have met or exceeded all of the regulatory requirements) that they conducted up to three years previously (for previous employees or contractors starting in a new role/contract), and on checks done by individuals or organisations on behalf of the specified organisation.

It is recommended that:

* It is good practice to recheck previous employees or contractors if there has been a significant period of absence
* For all workers, their New Zealand Police vet needs to have been done to the required standard
* Where relying on a check done by a third party on their behalf, organisations should have a process in place to confirm that the person they are employing or engaging is the person whom the third party has checked. This should include an identity verification process.

**Responsibility for safety checking rests with the employing or contracting organisation, and they should exercise due diligence when relying on checks undertaken by others.**

Safety checking contractors and the self-employed

The Vulnerable Children Act 2014 applies to some, but not all, self-employed persons or sole practitioners. If a self-employed person or sole practitioner is contracted by a State service, then they will need to be safety checked by that State service.

Similarly, if a self-employed person or sole practitioner is contracted by an organisation or individual that is funded by a State service to provide regulated activities, the funded organisation or individual is required to ensure that a safety check of the practitioner is done. This situation includes self-employed or sole practitioners who have formed separate legal entities and are employed or engaged by them.

*Liability insurance*

Professional liability insurance is not a requirement of the Foundation standard. It is, however strongly recommended by professional associations that practices and clinicians take professional advice on their potential liabilities and insurance options.

**Resources**

*Vulnerable Children Act resources*

[Orangatamariki, Children’s Act Requirements](https://www.orangatamariki.govt.nz/working-with-children/childrens-act-requirements/)

[Ministry of Health, Children’s Action Plan: Children’s worker safety checking and child protection policies](https://www.health.govt.nz/our-work/health-workforce/childrens-action-plan-childrens-worker-safety-checking-and-child-protection-policies)

*New Zealand Police Vetting Service*

[New Zealand Police, Vetting Service: Purpose statement and agency approval criteria](http://www.police.govt.nz/sites/default/files/publications/new-zealand-police-vetting-service-approval-criteria.pdf)

[New Police, Vetting Service](https://www.police.govt.nz/advice/businesses-and-organisations/vetting)

[RealMe](https://www.realme.govt.nz/what-it-is/)

*Annual Practising Certification*

[MCNZ: Doctors already practising in New Zealand](https://www.mcnz.org.nz/home/doctors-already-practising-in-new-zealand/)

[Nursing Council of New Zealand](http://www.nursingcouncil.org.nz/)

Indicator 21. Staff induction, reviews and development

**Our practice inducts, supports and guides all permanent and temporary team members.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 21.1 | Provide new team members / locums with practice information resources - including role specific information and a supportive induction. | A documented role specific position description.  Induction checklist for each new employee / locum.  Practice information / resources to support induction. |
| 21.2 | Regularly communicate practice information to all team members. | Demonstrate how practice information is shared with all team members. |
| 21.3 | Perform annual (or more often if needed) performance and development reviews and use them to support/guide/educate team members. | Documented annual performance and development reviews. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Induction and orientation programme*

Your practice is required to have a documented workplace induction programme to orientate new employees and independent contractors, including locums and GP Registrars, to your practice.

Good induction processes and ongoing training are critical to help your employees understand the job and perform well. Both set the tone and expectations for the relationship. A comprehensive and well-planned orientation process brings your new employee or locum ‘up to speed’ quicker and creates a positive impression.

Orientation may happen over several weeks although some practices commence the process by sending new employees or contractors an orientation package before they commence work.

The benefits of providing a good induction programme are:

* To reinforce the positive first impressions new staff, have of your organisation.
* Making new staff feel welcome.
* Making sure they have all the resources and information they need to fulfil their roles professional and effectively.

The orientation programme should take into account the new staff member’s duties and responsibilities as well as their previous education and work experience. The workplace induction programme must be commenced in the first week of employment.

*Induction and orientation resources*

You should provide a resource with information about the practice to new team members

There are different ways of approaching an induction programme and what you include will depend on your practice, the number and mix of staff you have, and where you are located.

Things to consider in your induction programme and resources:

* An overview of the organisation, structure and culture
* A list of key staff within the organisation
* If you have a large number of staff, consider having a buddy system to show a new person around and answer any questions
* Who to contact in case of absence or emergency (give them a copy of the contact details to keep at home)
* Paperwork to complete (e.g. staff details form, tax code declaration)
* Staff welfare facilities (e.g. toilets, changing rooms, first aid facilities, meal rooms)
* The practice policies and where to find them
* Role specific position description.
* Start times, finish times and the duration of breaks
* All aspects of the employment relationship, levels of quality, performance, expected behaviour and conduct in the workplace, contractual obligations, benefits schemes (if you have them), and so forth
* Legislative and professional requirements (e.g. APC, safety checks for the Vulnerable Children Act 2014)
* Health and safety issues including:
* Their responsibilities for health and safety
* Information about hazards, risks and control measures
* Any safety or other equipment, e.g. personal protective equipment (PPE), and how to use it
* Certification and training for specific pieces of equipment (e.g. steriliser)
* Fire and emergency procedures and equipment. Include evacuation requirements, responsibilities and assembly points
* How to report incidents and accidents
* How they can participate in health and safety matters on an ongoing basis
* Workstation set up
* Financial allocations and arrangements if applicable
* Environment/location information

*Disseminating practice information to all team members*

Your practice will need to provide evidence that information is disseminated to members of the practice to keep them all informed about practice activities and decisions. Sharing ideas and information is inclusive and keeps everyone informed about practice activities or decisions. This enhances team culture and provides a shared and consistent approach to business and the delivery of health care.

Ways you can communicate with your practice team:

* Practice intranet
* Staffroom notices
* Staff notebooks or communication books
* Staff newsletter
* Staff meetings
* PMS features

Staff meetings are important. Staff meetings help support transparency, give staff the ability to contribute to discussion and enable two-way communication. These things can help improve practice team involvement and functionality.

You should retain minutes that demonstrate regular meetings of the practice team(s). The minutes may be in the form of electronic files or in hardcopy.

*Performance and development reviews*

You’ll need to think about how you will set objectives for your employees and conduct their performance and development reviews. You should, in consultation with the employee/staff contractor, set objectives at least on an annual basis. You can take these objectives into account when assessing the employee’s performance.

Formal review at agreed times during the year ensures your employees have clear targets to aim for and can perform to agreed standards, both in terms of what is expected and how the results are achieved. The degree of formality of the review will vary depending on your practice. Position Descriptions should also be reviewed on a regular (annual) basis.

You should conduct a performance and development reviews of your staff on at least an annual basis. This is in addition to regular coaching and performance discussions.

All members of the practice team including practice partners should participate in performance and development reviews.

You can use information from the performance and development reviews to help guide continued education or professional development for all your practice team members. This may be in a response to changing performance requirements, poor performance, new performance objectives or personal ambition.

To meet the requirements of the Health Practitioners Competence Assurance Act 2003 (HPCA Act), all clinical team members must demonstrate their competence and fitness to perform their duties. The main purpose of the HPCA Act is to protect the health and safety of the public.

It is an offence for a clinical health professional to practice without a current practising certificate. Each health professional is responsible for maintaining competence to practice in accordance with the Health Practitioners Competence Assurance Act 2003.

For risk management it is recommended your practice maintains a record of certification, including expiry dates.

**Resources**

*Employment resources:*

[Employment Relations Act 2000](http://www.legislation.govt.nz/act/public/2000/0024/latest/DLM58317.html)

[Employment New Zealand](https://www.employment.govt.nz/)

[HRINZ: Induction and HRINZ: Induction guide checklist](http://www.hrinz.org.nz/Site/Resources/Knowledge_Base/I-P/Induction.aspx)

[Quality Practice Accreditation, Induction/orientation program checklist template](https://www.gpa.net.au/general-practices/templates/)

[The BMJ, Induction for GP locums—how to get it right](https://www.bmj.com/content/330/7499/gp190/related)

[Business.govt.nz: Performance appraisals](http://www.business.govt.nz/staff-and-hr/employee-and-team-performance/performance-appraisals)

[Healthy Practice (MAS)](https://mas.co.nz/)

# Section 9: Taputapu | Medical equipment and resources

Indicator 22. Medical equipment and medicines

**Our practice keeps and maintains routine and emergency medical equipment and medicines.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 22.1 | Ensure the practice has available equipment and medicines specified Appendix 1. | Required equipment and medicines are available. |
| 22.2 | Ensure all medical equipment is serviced, calibrated and verified annually. | Documented annual servicing, calibration and remedial work as required. |
| 22.3 | Ensure stock levels are routinely checked and expiry dates of all medicines are documented and monitored. | Documented checking of all stock levels and expiry dates at a practice agreed frequency. |
| 22.4 | Ensure medicines are secured and out of reach by unauthorised people. | Demonstrate medicines are secured and out of reach from unauthorised persons. |
| 22.5 | Ensure portable emergency equipment including emergency medicines, specified in Appendix 1, are stored in a single secure, but readily accessible to all clinicians. | Demonstrate emergency equipment / medicines are stored in a single, and accessible location. |
| 22.6 | Have Residual Current Devices (RCDs) where electrical medical devices are used. | Demonstrate the use RCD’s in Body protected areas. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

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

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

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

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

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

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

1. **Environment:**

* Is the place you will be using the equipment configured for the purpose?

1. Equipment safety:

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

1. Training and competence:

* Does the operator know how to use the equipment?
* Is the operator using the equipment safely?
* Instructions and rules around its use are provided.

*Calibration and validation*

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

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

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

*Testing RCDS*

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

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

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

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

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

Your electrical testing records should include:

1. Who did the testing

2. What equipment was tested (list what was tested)

3. What they are claiming (e.g. it is safe, it has been verified it is performing properly, etc.)

4. What the basis/evidence for the claim is (e.g. test results, etc.)

*Body Protected Areas*

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

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

The features of a Body Protected Area are:

1. They use isolating RCDs (10mAmp Type 1).

2. They use socket indicators (lights on/off).

3. RCDs need to be accessible in the Body Protected Area/room or be labelled with lights on the switchboard in accordance with AS/NZS 3003.

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

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

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

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

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

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

*Required documentation*

The practice should hold:

* A register of the medical equipment with a schedule and reminder process to ensure everything is current.
* A copy of the annual medical equipment servicing report (this should be certified and dated).
* A record confirming the date when RCDs have been tested.

*Safe storage of medical equipment, medicines and pharmaceutical products*

The Medicines Act 1981 – Section 47 states:

Storage and delivery of medicines

1. No person who is in possession or in charge of any prescription medicine or restricted medicine shall put it—

a. In any cupboard, box, shelf, or other place of storage in which articles of food or drink are stored or kept for ready use; or

b. In any place to which young children or unauthorised persons have ready access.

2. No person shall pack any medicine, or prepare it for use, in any room, or on any table or bench, that is used for the purpose of packing, preparing, or consuming any food or drink.

3. Except as otherwise provided in any regulations made under this Act, no person who is in possession, for the purposes of any business, of a prescription medicine or a restricted medicine that is kept for the time being within any building or vehicle shall leave that building or vehicle unattended, unless they have taken all reasonable steps to secure that building or vehicle, or the part of it in which the medicine is kept, against unlawful entry.

**Resources**

[Automated External Defibrillators (AEDs) locations in your community](https://aedlocations.co.nz/)

[Electrical (Safety) Regulations 2010](http://www.legislation.govt.nz/regulation/public/2010/0036/73.0/DLM2763501.html) (referenced clauses cover electrical medical devices)

* [Clause 25: Specific installations, fittings, and appliances deemed to be electrically safe](http://www.legislation.govt.nz/regulation/public/2010/0036/73.0/DLM2763649.html)
* [Clause 60: Certain installations must comply with Part 2 of AS/NZS 3000](http://www.legislation.govt.nz/regulation/public/2010/0036/73.0/DLM2763691.html)
* [Clause 75: Periodic assessments of certain installations](http://www.legislation.govt.nz/regulation/public/2010/0036/73.0/DLM2763710.html)
* Clause 91: Periodic assessment of electrical medical devices

[Worksafe NZ, RCD Safety](https://worksafe.govt.nz/about-us/campaigns/energy-safety-summer/rcd-safety/)

[Energy Safety – Using RCDs (2006)](http://www.energysafety.govt.nz/about/news-and-updates/archive-media-releases/2006-archived-media-releases/lifesavers-2013-rcds-and-electrical-safety-15-january-2008)

Indicator 23. Cold chain

**Our practice maintains cold chain accreditation in accordance with the Ministry of Heath National Standards for National Immunisation Programme cold chain management.**

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| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 23.1 | Ensure they hold a current cold chain accreditation. | A current cold chain certificate.  Documented records displaying temperature monitoring. |

**Required training**

Practices storing and/or administering vaccines must be familiar and compliant with the following documents:

* [National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017](https://www.health.govt.nz/publication/national-standards-vaccine-storage-and-transportation-immunisation-providers-2017)
* [Annual Cold Chain Management Record](https://www.health.govt.nz/publication/annual-cold-chain-management-record)
* [Cold chain management policy template (Word, 227 KB)](https://www.health.govt.nz/system/files/documents/pages/sample_template_cold_chain_management_policy_2017.docx).

**Guidance notes**

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

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

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

Compliance with cold chain standards will be demonstrated through a practice/provider self-assessment followed by a review by a local Immunisation Facilitator/Coordinator. Cold Chain Accreditation will be valid for up to three years, based on the CAA reviewer’s findings.

**Resources**

[Ministry of Health: National Immunisation Programme Cold Chain management](http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/national-immunisation-programme-cold-chain-management)

[Immunisation Advisory Centre](http://www.immune.org.nz/)

[Ministry of Health: Immunisation Handbook 2017](https://www.health.govt.nz/publication/immunisation-handbook-2017)

[The Centre for Adverse Reactions Monitoring (CARM)](https://nzphvc.otago.ac.nz/carm/)

# Section 10: Whakahau rongoā | Medicines management

Indicator 24. Prescribing and medicine reconciliation

**Our practice’s** **prescribing is accurate and appropriate, and medicines are reconciled.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 24.1 | Ensure all medicines prescribed, administered or supplied are recorded in the Patient Management System (PMS). | Clinical notes review of 10 patient records in the 12 months prior to an onsite assessment is completed by all clinicians. |
| 24.2 | Comply with a documented policy for repeat prescribing. | A documented Repeat Prescribing Policy.  A documented audit of repeat prescribing. |
| 24.3 | Ensure Standing orders, where used, comply with the Ministry of Health standing order guidelines 2016. | Documented Standing Orders Policy and procedures.  A list of standing orders used in the practice.  Evidence of countersigning or auditing of Standing Orders.  A sample audit tool if auditing.  Evidence of annual review of the Standing Order(s) by the issuer.  Evidence of training and auditing of each registered nurse working with the Standing Order(s). |
| 24.4 | Undertake medicines reconciliation in a timely manner. | A documented Medicine Reconciliation Policy and Procedure including discharge/clinic letters.  A clinical notes review that demonstrates:   * The collection, comparison and communication between medicines lists. * Any medicine discrepancies and actions taken for reconciliation. * Reasons for alteration or discontinuation where available. * Evidence of timely reconciliation. |
| 24.5 | Reconcile medical warnings and update in the PMS. | Demonstrate the reconciliation of medical warnings and update in the PMS. Reconciliations include; allergies, adverse effects and significant interactions. |

**Required training**

Training for registered nurses is required for standing orders with an annual review / update.

**Guidance notes**

*Patient records*

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

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

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

* Current medical conditions
* Any previous adverse reactions
* Concurrent or recent use of medicines (including non-prescription, complementary and alternative medicines

*Repeat prescriptions*

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

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

Before signing a repeat prescription, you must have secure procedures in place to ensure that:

* The patient is issued with the correct prescription.
* Each prescription is regularly reviewed so that it is not issued for a medicine that is no longer required.
* The correct dose is prescribed for medicines where the dose varies during the course of the treatment.
* Any subsidy conditions that have changed since the last prescription are amended.
* All relevant information has been reviewed before completing the prescription.

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

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

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

**Resources**

[Ministry of Health: Standing order guidelines August 2016](https://www.health.govt.nz/publication/standing-order-guidelines)

[MCNZ: Good prescribing practice](https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf)

[New Zealand Nurses Organisation: Medicines – Guidelines and Information](https://www.nzno.org.nz/resources/medicines_-_guidelines_and_information)

[NZ ePrescription Service (NZePS)](http://healthitboard.health.govt.nz/our-programmes/emedicines/nz-eprescription-service-nzeps)

[The New Zealand Formulary](http://nzformulary.org/)

[Ministry of Health. Implementing Medicines New Zealand 2015 to 2030](https://www.health.govt.nz/system/files/documents/publications/implementing-medicines-new-zealand-2015-to-2020-jun15-v2.pdf).

Indicator 25. Controlled drugs

**Our practice stores, prescribes and dispenses and reconciles controlled**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 25.1 | Store controlled drugs according to the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977. | Policy and procedure for the storage of controlled drugs. |
| 25.2 | Have a process for recording transactions of controlled drugs. | Demonstrate the use of a controlled drug register.  Where controlled drugs are dispensed, demonstrate how they are recorded in the register and reconciled in the PMS. |
| 25.3 | Securely store and monitor the use of controlled drugs’ prescription pads. | Demonstrate storage of controlled drug prescription pads.  Documented record for the monitoring the controlled drug prescription pads. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

The handling and [prescribing of controlled drugs](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicines-control/controlled-drugs) reflects the need to restrict access to, and minimise the misuse of, this type of medicine.

*Storage and custody of controlled drugs*

Any controlled drug that is not required for immediate use:

* Keep it in a locked cupboard, or a locked compartment, that is constructed of metal or concrete or both, and that, in the case of a cupboard or compartment installed in a building after the commencement of these regulations, is of an approved type.
* Ensure that the cupboard or compartment is securely fixed to, or is part of, the building.
* Ensure that the key of the cupboard or compartment is kept in a safe place when not in use.
* Controlled drug prescription pads and forms must also be kept secure (usually in the controlled drugs cabinet or a locked cupboard) and recorded for monitoring. Your practice will need to be able to demonstrate how you store and monitor the use of controlled drugs prescription pads. There should be a process for notifying relevant authorities if controlled drug prescriptions are found to be missing.

*Controlled drug register*

If you hold or administer controlled drugs (CD) then you are required to keep a [controlled drug register](http://www.legislation.govt.nz/regulation/public/1977/0037/latest/DLM55960.html?p=1) which documents the details of all transactions and includes a running balance of stock.

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

If you maintain a controlled drug register, you must:

* Use an [approved bound volume](http://www.hiltonpress.co.nz/Controlled_Drugs__Registers.php)
* Keep that register or book in a neat and orderly manner in a secure place
* Keep the register or book for a period of four years following the date of the last entry made in it

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

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

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

Your practice should have a process for the identification and destruction/disposal of expired controlled drugs and the relevant actions must be documented in the controlled drug register.

The [following details are required](http://www.legislation.govt.nz/regulation/public/1977/0037/latest/DLM56104.html?p=1#DLM56105) for each transaction in a controlled drug register:

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

*Monitoring controlled drugs in an emergency bag*

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

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

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

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

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

* Another staff member should witness the stocking the bag from the controlled drug stock and record an entry in the controlled drug register.
* The controlled drugs should be stored in a lockable receptacle, which can only be opened by the person to whom the regulation applies. A digital combination lock is a convenient solution.
* Each clinician must keep a record in the register for the controlled drugs carried in their bags. The clinician is responsible for those drugs.
* Administration of a controlled drug to a patient should be recorded in the controlled drug register and in the PMS.
* If a controlled drug has expired, the clinician should return it to the practice stock awaiting destruction. This should be recorded in the register. If there is no practice stock, then the expired controlled drug needs to be destroyed directly from the bag and witnessed by an authorised person. A record should be made.

*Stocktaking*

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

**Resources**

[Ministry of Health: Controlled drugs](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicines-control/controlled-drugs)

[Ministry of Health: Frequently asked questions: Controlled drugs prescribing](https://www.health.govt.nz/system/files/documents/pages/controlled-drugs-prescribing-v1.pdf)

[MCNZ: Good prescribing practice](https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf)

[NZNO: Medicines - Guidelines and Information](https://www.nzno.org.nz/resources/medicines_-_guidelines_and_information)

[Medical Protection: Risk alert: controlled drugs](http://www.medicalprotection.org/uk/practice-matters-issue-7/risk-alert-controlled-drugs)

# Section 11: Tikanga pokenga | Infection prevention and control

Indicator 26. Infection and health care waste

**Our practice prevents and controls infection and manages health care waste.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 26.1 | Ensure they have and follow active infection control procedures aligned to AS/NZS 4815:2006. | Documented policies and procedures, aligned with standards, for infection control and management of health care waste.  Demonstrate how these polices, and procedures are followed. |
| 26.2 | Ensure they have and follow active health care waste management procedures aligned to NZS 4304:2002. |
| 26.3 | Have puncture-resistant sharps containers that are out of reach of children and display a biohazard symbol in accordance with NZS 4304:2002, in all areas where sharps are used. | Demonstrate the use of and disposure of puncture resistance containers. |
| 26.4 | For practices that use sterilisers:   * Monitor the effectiveness of each sterilisation cycle. * Ensure current calibration and validation of the steriliser(s). | Documented current calibration and validation records are available).  Documented evidence of sterilisation calibration and effectiveness monitoring. |

**Required training**

General practice team members responsible for sterilisation and disinfection have received training in the last three years.

**Guidance notes**

*Health Care Waste*

New Zealand Standard NZS 4304:2002 details how health care waste is managed. Management of some hazardous waste will require reference to other sources (e.g. National Radiation Laboratory Code or controls under the HSNO Act).

Health care waste refers to all waste generated by a health care facility and includes ‘non-hazardous’, ‘controlled’ and ‘hazardous’ waste. Non-hazardous waste constitutes the bulk of waste generated and is managed in the same way as household waste. Hazardous waste requires proper handling, storage, transport and disposal to minimise risk to personnel, the public and the environment, and to prevent causing cultural or aesthetic offence.

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

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

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

*Infection control policy*

You are required to document how you are going to manage infection control in your practice. Your infection control policies and procedures must align with the AS/NZS 4815:2006 Standard.

*Sterilisation processes*

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

Calibration on site should be done (and documented):

* When steriliser is first installed
* Annually
* When serviced or repaired

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

* Servicing
* Calibration
* Validation

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

**Resources**

[National Institute for Health and Care Excellence, Healthcare-associated infections: prevention and control in primary and community care](https://www.nice.org.uk/guidance/CG139/chapter/introduction)

[Standards New Zealand: AS/NZS 4815:2006 Office-based health care facilities— Reprocessing of reusable medical and surgical instruments and equipment and maintenance of the associated environment](https://shop.standards.govt.nz/catalog/4815%3A2006%28AS%7CNZS%29/view)

[Standards New Zealand: NZS 4304:2002 Management of Healthcare Waste](https://shop.standards.govt.nz/catalog/4304%3A2002(NZS)/view)

[bpacnz: Exposure to body fluids: keeping the primary healthcare   
team safe](https://bpac.org.nz/BT/2014/November/exposure.aspx)

[HQSC: Hand Hygiene](https://www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/projects/hand-hygiene/)

[bpacnz: Antimicrobial resistance in New Zealand: What is my role in primary care?](http://www.bpac.org.nz/BPJ/2013/August/upfront.aspx)

# Section 12: Tikanga ohotata | Risk management

Indicator 27. Adverse events

**Our practice has an active procedure that records and responds to adverse events, incidents and near-misses.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 27.1 | Ensure they record, review, analyse and mitigate all adverse events, incidents and near misses. | Document practice Incident/Adverse Event Risk Management Policy and processes.  Maintain an up-to-date register. |
| 27.2 | Ensure they identify and reference in the clinical record adverse events and near-misses as they relate to individual patients. | Documented adverse events are recorded in patient records and in the incident register. |
| 27.3 | Ensure they use adverse and related events for learning and quality improvement opportunities. | Documented practice meetings reviewing adverse events and actions taken. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Adverse Event Management*

The purpose of adverse event reporting and management is to identify, analyse and correct or minimize the risk relating to hazards, patient harm or incidents, including near misses, to reduce the likelihood of recurrence and to improve patient safety.

The term ‘Adverse Event management’ covers a range of other terminology that may be used in general practice, including serious adverse events, significant events, adverse events, incidents, events or reportable events.

A clearly defined system for reporting and managing all levels of adverse events is important.

The system for managing adverse events should include continuous quality improvement (CQI) mechanisms to ensure:

* All reports are acted upon appropriately and within set timeframes
* Feedback to team members happens
* The appropriate levels within the practice/organisation/sector are involved to support quality and safety of service provision

**What is an adverse event?**

Often in our health system an adverse event is defined as any event that could have or did cause harm to a consumer; however, other incidents occur in general practice, such as staff accidents and injuries, fire or other damage to the facilities, loss or disruption to service delivery.

An incident is deemed to be any event that:

* Could have or did cause harm to a health consumer, employee or visitor
* Could have or did cause damage to property
* Could have or did cause loss of process

Near-miss events are often an early warning system that helps identify potential gaps in systems and processes before an event occurs.

*Recording of adverse event*

You can use your practice’s incident management process for all forms of incidents/adverse events/accidents/near misses, including health and safety accidents/near misses.

*Reporting*

Reporting and follow-up is an essential quality improvement activity that enables the use of actual or near-miss event learning to support the implementation of safe practice, to reduce risk and improve systems and processes within your practice.

Incident Reporting, follow-up and management are all part of the process to reduce risk and promote best practice processes.

*Management process*

There are several components that help support and guide the process:

* Using a system to categorise events enables you to identify trends and patterns which then support CQI activities for system and process improvement.
* Using a risk level measurement (also referred to as the Severity Assessment Code (SAC)) will assist your practice in determining the level of risk of an incident and to assist in determining the level of investigation required. See [HQSC Severity Assessment Code tables](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/636/).
* Using a register or log (preferably electronic) enables you to monitor trends and processes in your practice that may need adjustment or change to reduce potential risk.

*Benefits of a good system include:*

* Greater support for individual general practices or business units to meet legislative, industry or best practice requirements for recording, investigating and reporting incidents as necessary.
* Increased levels of understanding about key areas of risk that can be addressed to minimise harm/loss.
* Shared lessons leading to greater patient safety (and safety of staff too).
* Enhanced reputation and transparency of continuous improvement across the health sector.
* Increased accountability to governance mechanisms through more comprehensive standardised reporting.
* Mitigating risk of liability.

*Reporting of adverse drug reactions (ADR)*

Reporting adverse drug reactions (ADR) is a clinical responsibility that enables centralised national monitoring of medication reactions by the [New Zealand](https://nzphvc.otago.ac.nz/) Pharmacovigilance Centre. This includes several monitoring agencies such as [CARM (Centre for Adverse Reactions Monitoring)](https://nzphvc.otago.ac.nz/carm/), [Psychoactive Substances, Recreational Substances and Legal Highs](https://nzphvc.otago.ac.nz/psychoactive-substances/).

Reporting to these agencies can be done via several methods – online and hardcopy. See [How to Report](https://nzphvc.otago.ac.nz/reporting/).

*Reporting of Serious Adverse Events (SAC 1 or 2 rated serious harm to patients)*

In New Zealand, reporting of adverse events and near misses is guided by the National Adverse Events Reporting Policy 2017 (‘the Policy’).3 The Policy supports a nationally consistent approach to reporting, review and learning from adverse events and near misses. Under the Policy, health and disability service providers with obligations under the Health and Disability Services (Safety) Act 2001, and those who voluntarily comply, are expected to (a) notify the Health Quality & Safety Commission (‘the Commission’) of serious adverse events and (b) provide the Commission with findings and recommendations from review of these events to enable national learning.

Primary care is not explicitly required to report serious adverse events. However, the HQSC National Policy supports nationally consistent reporting, review and learning across the whole health and disability sector, including a single policy and reporting process for events that occur in different parts of the sector and therefore reporting is encouraged.

It can be a good idea to work with your PHO/Network when significant incidents occur. This can enable support with the investigation and management of incidents while providing learning into and out of the practice in order to improve patient safety across the health sector.

**Resources**

[The Centre for Adverse Reactions Monitoring (CARM) – accessed through the NZ Pharmacovigilance Centre’s website](https://nzphvc.otago.ac.nz/carm/)

[HQSC: Adverse Events](https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933/)

Indicator 28. Emergency and service disruption

**Our practice has a planned response to an emergency or significant service disruption.**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Your practice is required to:** | **Required evidence** |
| 28.1 | Ensure they can prioritise, support and recover critical and non-critical functions following an emergency or service disruption. | A documented Business Continuity Plan.  A documented Emergency Response Plan. |
| 28.2 | Ensure your business continuity plan is understood and accessible by team members at any time. | The practice team can access and demonstrate an understanding of the business continuity plan. |

**Required training**

The practice can determine the training required to achieve the Indicator and Criteria.

**Guidance notes**

*Business continuity planning*

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

Business continuity planning is not just about how the practice will operate during the disaster or significant event but should also consider requirements (including viable alternatives) to enable the practice to continue operating in the short to medium term after the significant event.

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

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

Examples of essential services may include:

* Power (equipment, lighting, heating)
* Water (service provision, cleaning, drinking, hygiene)
* Toilet facilities
* IT solutions (PMS/patient information)
* Phones (communications)
* Medical supplies

A copy of the practice’s business continuity plan should be maintained off-site in either an electronic or hard copy format that can be readily accessed and used when required. Key staff members must be familiar with how to access the plan at the time.

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

Ongoing access to fuel may be required if the practice has access to a generator.

The practice should maintain a ‘power down’ kit containing paper forms, prescription pads, pens, marker pens and other resources to support the manual processing of patients should the practice experience a prolonged power outage (power down) situation.

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

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

*Emergency assistance*

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

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

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

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

Business continuity plans and emergency response documentation should be reviewed and updated annually. Plans should be dated and include a next review date.

**Resources**

* Ministry of Health:
* [Emergency management, disaster planning and business continuity in primary care](https://www.health.govt.nz/our-work/emergency-management/emergency-management-disaster-planning-and-business-continuity-primary-care)
* [Emergency management](http://www.health.govt.nz/your-health/healthy-living/emergency-management)
* [National Health Emergency Plan](http://www.health.govt.nz/our-work/emergency-management/national-health-emergency-plan)
* [Health sector pandemic influenza guidance](https://www.health.govt.nz/your-health/healthy-living/emergency-management/pandemic-planning-and-response/health-sector-pandemic-influenza-guidance-0)
* [Ministry of Civil Defence and Emergency Management](https://www.civildefence.govt.nz/)

1. Glossary

| Term | Definition |
| --- | --- |
| Autoclave | Colloquial term for a steam-under-pressure steriliser (AS/NZS 4815:2006) |
| Calibration | The comparison of a measurement system or device of unknown accuracy to a measurement system or device of a known accuracy to detect, correlate, report, or eliminate by adjustment, any variation from the required performance limits of the unverified measurement system or device  (AS/NZS 4815:2006). |
| CARM | [The Centre for Adverse Reactions Monitoring](https://nzphvc.otago.ac.nz/carm/): The CARM database provides New Zealand–specific information on adverse reactions to medicines and vaccines. |
| CD | Controlled drug |
| Chemical indicator | Dye, which can be impregnated into materials or contained within a device, and which changes colour when subjected to the sterilising process  (AS/NZS 4815:2006). |
| Cleaning | The removal of soil and reduction in the number of microorganisms from a surface, by a process such as washing with water and detergent without prior processing (AS/NZS 4815:2006). |
| Clinical correspondence | Includes test results, investigations, medical reports (received and sent), procedures and referrals for tests and procedures. It also includes secondary/specialist referrals |
| Clinical team | Refers to clinical staff only |
| CME | Continuing medical education |
| Cold Chain | The ‘Cold Chain’ is the system of transporting and storing vaccine at +2°C to +8°C from the place of manufacture to the point of vaccine administration. |
| Control measure | A way of eliminating or minimising the risk of harm |
| CQI | Continuous quality improvement |
| DHB | District health board |
| Disinfection | The inactivation of non-sporing organisms using either heat and water (thermal) or by chemical means. |
| Equity | In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.[[1]](#footnote-1) |
| Ethnicity Data Protocols for the Health and Disability Sector | Procedures for the standardised collection, recording and output of ethnicity data for the New Zealand health and disability sector (Ministry of Health). |
| Evacuation scheme | An [evacuation scheme](https://onlineservices.fire.org.nz/Home/EvacuationSchemes) describes the measures that have been put in place to enable safe and timely evacuation if there is a fire (or suspected fire) or other reason to immediately vacate the practice premises. |
| GP2GP | [GP2GP](http://www.patientsfirst.org.nz/services-products/gp2gp/) enables medical records to be electronically transferred from one GP to another. |
| Hazard | Anything that can cause harm |
| Health monitoring | Monitoring workers’ health to see if their work is harming their health and to assess ongoing effects. |
| HISO | [Health Information Standards Organisation](http://healthitboard.health.govt.nz/health-it-groups/health-information-standards-organisation-hiso) |
| HPCA | [Health Practitioners Competence Assurance Act 2003](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act) |
| HQSC | [Health Quality & Safety Commission](http://www.hqsc.govt.nz/) |
| HSWA | Health and Safety at Work Act 2015 |
| MCNZ | [Medical Council of New Zealand](https://www.mcnz.org.nz/):  The Medical Council registers doctors in New Zealand and carries responsibilities in the areas of standards, conduct and competence. |
| MECA | Multi-employer collective agreement |
| Notifiable event | When someone dies or when a notifiable incident, illness or injury occurs as a result of work (See sections 23 and 24 of HSWA). |
| NSU | [National Screening Unit](https://www.nsu.govt.nz/):  Responsible for the development, management and monitoring of nationally organised population-based screening in New Zealand. |
| NZePS | [NZ ePrescription Service](http://healthitboard.health.govt.nz/our-programmes/emedicines/nz-eprescription-service-nzeps):  The New Zealand Electronic Prescription Service (NZePS) provides a secure messaging channel for prescribing and dispensing systems to electronically exchange prescription information. |
| PES | [Primary care Patient Experience Survey](http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/patient-experience/primary-care-patient-experience/) |
| PHO | [Primary Health Organisation](http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations?mega=NZ%20health%20system&title=Primary%20health%20organisations) |
| PMS | Patient management system |
| PPE | Personal protective equipment – anything used or worn by a person (including clothing) to minimise risks to the person’s health and safety  (e.g. mask, gloves). |
| PRIME programme | PRIME – Primary Response in Medical Emergency  The [PRIME programme](http://prime.stjohn.org.nz/about/) utilises the skills of specially trained rural GPs and/or rural nurses in areas to support the ambulance service where the response time for assistance would otherwise be significant or where additional medical skills would assist with the patient’s condition. |
| RCD | Residual current devices |
| Reusable device | A device designated or intended by the manufacturer as suitable for reprocessing and reuse. It is not a device that is designated or intended by the manufacturer for single use only (AS/NZS 4815:2006). |
| Risk | Risk can be described as the likelihood certain consequences (death, injury, illness, loss or other negative result) occur when a person, process or activity is exposed to a hazard.  Risks often involve people being exposed to a hazard (a source of harm) but can be non-human related. |
| RNZCGP | The Royal New Zealand College of General Practitioners |
| SAC | [Severity assessment code](http://www.hqsc.govt.nz/assets/Reportable-Events/Resources/guide-to-using-sac-2008.pdf):  The method used by any person who has identified an incident or adverse event to determine the appropriate action to take on that incident.  The score is ascertained by rating the consequence of the event and its likelihood of occurrence. The SAC allocates a numerical rating to every incident to identify the most appropriate response and management of the event. |
| Safety netting | Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved. |
| SLM | The System Level Measures (SLMs) Framework aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. It provides a foundation for continuous quality improvement and system integration. |
| Tangata Whenua | The indigenous Māori people of a particular area, of New Zealand or of the country as a whole. |
| Team members | Refers to both clinical and administrative staff and includes full- and part-time employees, contractors and locums. |
| The Code / Code of Rights | [The HDC Code of Health and Disability Services Consumers’ Rights 1996](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)) |
| Trial evacuation | An evacuation drill that is carried out when there are no signs of fire (or emergency situation), for the purpose of evaluating the effectiveness of an evacuation procedure. |
| Validation | Documented procedure for obtaining, recording and interpreting the results required to establish that a process will consistently yield a product complying with pre-determined specifications (AS/NZS 4815:2006) |
| Warden | A person who has specific responsibilities during an evacuation of a building during an emergency or trial evacuation. |

Appendix 1. Medical equipment and emergency medicines register

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

All essential medical equipment, resources and medicines must be available when needed, and members of your practice team must know how to use the equipment.

Equipment must be calibrated, in working order and servicing expiry dates must be current.

The adequacy and appropriateness of basic equipment is determined by the circumstances of the practice and any omissions must be able to be justified by the practice.

*Equipment to be present in each clinic room used by a GP, Nurse Practitioner or Nurse*

* Auroscope
* Ophthalmoscope
* Monofilament
* Gloves for examination
* Reflex hammer
* Spatula
* Sphygmomanometer (manual or electronic) – extra wide and paediatric cuffs
* Stethoscope
* Thermometer
* Tuning fork
* Tape measure

*Equipment to be easily available to all clinicians in the practice*

* Blood glucose test strips and glucometer
* Urine dipstick – protein, glucose, ketones, blood
* Blood taking equipment
* Pregnancy testing kit
* Cervical smear equipment
* Proctoscope
* Dressings adequate to the services provided
* Eye local anaesthetic
* Fluorescein dye for eyes
* Height measure
* Weight scales – adult, baby
* Peak flow meter
* Spirometer, hand held or otherwise
* Spacer device
* Surgical instruments appropriate for any procedures carried out in the practice
* Sterile gloves for procedures
* Suture equipment
* Syringes and needles
* Visual acuity chart – at the specified distance with viewing distance marked.
* Colour visual chart (Ishihara) hard copy or if on line, it is presented in a position for a patient to easily view.
* Digital camera with capability to upload photos into the PMS and attach to referrals to other services e.g. dermatology.
* Dermoscope
* AED

*To be available either in the practice or close by:*

* 12 lead Electrocardiogram. If ECG is outside the practice, then it must be within 10 minutes patient access by vehicle at a facility capable of handling the clinical findings of an abnormal ECG.
* Urinary catheters and local anaesthetic gel or other means for urgent catheterisation (e.g. urgent referral in urban area within 30 minutes’ drive).

*Emergency medicines to be available in stock, or in the bag/clinical bag or portable emergency kit.*

* Adrenalin 1/1000 injection
* Analgesia
* An alternative for those allergic to penicillin
* Antiemetic oral /injection
* Antihistamine injection
* Aspirin tablets
* Atropine injection
* Corticosteroid injection
* Diazepam injection/rectal
* Frusemide oral / injection
* 50% glucose/glucagon injection
* Local anaesthetic injection
* Naloxone injection
* Nitrolingual spray
* Penicillin injection
* Sodium chloride (NaCl) for injection
* Sterile water for injection

1. This definition of Equity is the Ministry of Health’s formal definition, approved in March 2019. [↑](#footnote-ref-1)