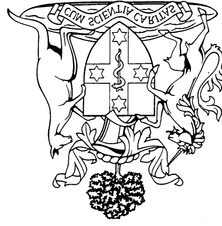
Appendix I

RACGP Entry Standards for General Practice - Draft for Field Test



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

STANDARDS DEVELOPMENT PROJECT

ENTRY STANDARDS
FOR
GENERAL PRACTICE

Draft for field testing and demonstration trials
9 December 1993

These standards have been prepared by a working party established by the Royal Australian College of General Practitioners and funded by a grant from the Department of Health, Housing, Local Government and Community Services. The working party comprised GP academics and general practitioners from rural and urban practices, all of whom have wide general practice experience.

The first and revised editions of the standards were circulated widely within the RACGP, the medical profession, to a variety of organisations and over 300 GPs Australia wide. Well over 100 submissions were received by the working party. The document was then thoroughly reworked, incorporating many of the ideas and concerns contained in the submissions.

The standards were then `piloted' in twenty five volunteer practices around Australia. The primary goal of piloting was to ensure that the standards were appropriate and could be assessed in practices. The standards are now ready for further discussion, and for testing in a much larger sample of practices during field testing and trialing.

Prepared by:
The Standards Working Party.
Established by the RACGP
and funded by the DHHLGCS.
December 1993

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Preamble

Introduction

As a profession, General Practice shares many of the important characteristics of professions including[1]:

(i) collective responsibility for maintaining the competence and integrity of the occupation as a whole; and

(ii) organisation in bodies which are concerned to provide methods for ensuring standards of competence and conduct.

Since its foundation in 1958, the Royal Australian College of General Practitioners has demonstrated its commitment to improving standards in general practice by development of the Fellowship exam, the RACGP Training Program and the Quality Assurance and Continuing Education Program. Recently it has had a major role in the introduction of vocational registration.

While these programs have been concerned with the quality of individual GPs, less attention has been paid to the practices in which they work.

Accreditation and standards

The prospect of the development of a system of accreditation for general practice was raised, among a number of other issues, by the Minister for Health, Housing and Community Services in Budget Related Paper No. 9 in August 1991.

Later that year the General Practice Consultative Committee, a group comprising representatives of the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP) and the Commonwealth Government began discussions on the future of general practice in Australia.

In July 1992 the General Practice Consultative Committee released a discussion paper *The Future of General Practice: A Strategy for the Nineties and Beyond*[2] which outlined a package of proposals for consideration by the profession and Government.

In that document the General Practice Consultative Committee proposed "that an independent and voluntary system of practice accreditation be developed to enhance the delivery of services and facilities by general practices through a process of continuing quality improvement."

The development of possible methods of accreditation then became the responsibility of the Interim Steering Group on Accreditation which, like the General Practice Consultative Committee, comprised representatives of the AMA, RACGP and Commonwealth Government.

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[1] Trade Practices Commission (1990) **Regulation of professional markets in Australia: issues for review**. A discussion paper, Commonwealth of Australia, Canberra. [Quoted in Harvey R. (1991) **Making it Better: strategies for improving the effectiveness and quality of health services in Australia**. National Health Strategy Background Paper No. 8.]

[2] Copies are available from the AMA and the RACGP.

The Interim Steering Group on Accreditation based its developmental work on principles adopted by the General Practice Consultative Committee. These principles, which will clearly shape how standards are applied in any accreditation process, state that accreditation should:

- (i) aim to attain the highest quality care of general practice in an achievable and gradual manner;
- (ii) provide a publicly recognisable measure of quality in general practice;
- (iii) be voluntary but should also have tangible benefits;
- (iv) be for a defined period;
- (v) be an educational and developmental process and not a punitive one;
- (vi) be self funding after initial establishment costs;
- (vii) be in the hands of the profession.

Discussion of general practice policy issues, including accreditation, is now the responsibility of the General Practice Policy Group which was established in August 1993. Like its predecessors, the General Practice Policy Group is a tripartite group with representatives from the RACGP, AMA and Commonwealth Government.

The Standards Working Party (SWP)

The Standards Working Party (see page 55) was established by the RACGP with a grant from the then Department of Health, Housing and Community Services to begin to develop standards for accreditation of general practice.

Drawing on their own experience, overseas material and published standards in related disciplines, the working party prepared this document for discussion by the profession.

Approaches to standards

Standards may serve two main purposes. They may be used to judge whether certain ***minimum*** levels have been attained.

Standards may also be used as an aid to continuous improvement in the quality of general practice. This approach identifies ***optimum***, or ideal, standards. In this case the emphasis is on the educational aspects of an accreditation process through practical feedback to participants.

A credible system of accreditation should employ both minimal and optimal standards. The General Practice Working Group decided to give priority to the development of minimum (or entry) standards. It is envisaged that fully developed minimum and optimum standards will eventually be combined in a single document.

The standards developed by the Standards Working Party are a mixture of standards that can easily be measured and others that are more difficult to assess. Nevertheless there is evidence that experienced general practitioners can and do make judgements about those aspects of general practice which cannot be quantified or measured numerically. These could be the important aspects of quality which need attention.

What sort of general practice ?

The Standards Working Party believes that the setting of standards need not, and should not, imply that all practices have to be the same. One of the great strengths of general practice is its diversity.

The key features of general practice must be guaranteed. These are the "provision of primary, comprehensive and continuing whole patient care to individuals, families and their community."[3]

A set of standards for general practices must address each of these key features of general practice.

In recognition of the wide variation within Australian general practice, any assessment process related to the standards should be based on common sense and should not seek to penalise or exclude practices on the basis of technicalities.

[3] Royal Australian College of General Practitioners, Policy Documents, Policy 30, Definition of General Practice / Family Medicine (Adopted 27/1 Council; September 1984).

Standards, criteria and indicators

This document contains 15 standards which describe the qualities required for particular practice activities.

Standard 1.1	All patients are able to obtain timely care and advice appropriate to their needs.
Standard 1.2	The practice provides the opportunity for patients to communicate their health problems and concerns and receive an appropriate response.
Standard 1.3	In order to promote high standards of care the practice reaches broad agreement on approaches to diagnosis, management and outcomes which are consistent with relevant RACGP, state and national guidelines.
Standard 1.4	Patient medical records contain sufficient information to identify the patient, and document assessment, management, progress and outcomes.
Standard 1.5	The practice makes all reasonable provisions for continuity of care.
Standard 1.6	The practice works with a range of other health and community services in its area to improve individual patient care.
Standard 1.7	The practice provides health promotion and disease prevention services. These are based on scientifically validated guidelines whenever possible.
Standard 2.1	The practice ensures that the doctor(s) and staff respect the rights and needs of patients.
Standard 3.1	The practice is committed to the principles of quality assurance and continuing education.
Standard 4.1	Practice staff deal with patients in a helpful and competent way and are able to identify emergencies and deal with complaints.
Standard 4.2	Medical records are easily accessible within the practice for individual patient care, health promotion, audit and research, paying due regard to confidentiality and patient rights.
Standard 4.3	The practice is under the clinical control of general practitioners.
Standard 5.1	The practice has facilities which are appropriate for general practice and which promote the health, safety and comfort of staff and people who use the practice.
Standard 5.2	Medical equipment and resources are appropriate and adequate to ensure comprehensive primary care and resuscitation. These are adequately maintained and checked.
Standard 5.3	The practice services are physically accessible.

As these are minimum standards, practices will be expected to meet every standard. Each standard is followed by more specific criteria which break it up into its key components.

There are two types of criteria. *Essential* criteria must be met in order to meet the standard. Essential criteria are clearly marked with a star (★) throughout the document.

Desirable criteria also describe important components of the standards. Practices that meet the desirable criteria will find it easier to demonstrate that they are meeting the standards. Desirable criteria may cover areas where resources are limited or there have been recent changes in what constitutes good practice.

Each criterion is followed by a number of indicators which will help to determine the degree to which practices have met the criteria. It is these indicators that are actually assessed or measured.

While all standards and their essential criteria should be met, **it is not necessary to meet every indicator**. In many cases it is not possible to meet every indicator for a given criterion. Surveyors will use the indicators to determine the extent of compliance with criteria.

Assessing the standards

Standards cannot be developed without consideration of how they may be measured or assessed.

Over the past few months the Standards Working Party has been overseeing a program of visits to a range of general practices around Australia.

These pilot visits have had a number of specific objectives:-

* to gain an understanding of how the standards might be applied and assessed in a practice setting;
* to test the standards against reality and suggest possible changes;
* to identify possible indicators, or ways of measuring the criteria;
* to develop a draft visit protocol for assessing the standards;
* to test the face validity of the standards and ensure that they are both comprehensive and appropriate.

The practice visit

The working party has used the piloting to begin to develop a protocol for practice visiting and standards assessment. This visit protocol is essentially a `users-guide' for those assessing the standards in practices.

Practices involved in the piloting were visited by two `surveyors', one member of the Standards Working Party and one local practicing GP.

The visits were conducted in three stages - an interview stage, an observation stage and an assessment stage. The first two stages involved data collection, while the third stage involved analysis of the data and assessment of the practice.

The first stage (interview) provided the two main sources of data about the practice:

(i) *Doctor interview(s)*: an interview with the principal GP in the practice. This interview, taking about an hour, covered all aspects of the standards document. Other doctors, if any, were then interviewed, usually for about 15 minutes each. These shorter interviews concentrated on specific aspects of the standards.

(ii) *Staff interview(s)*: all staff in the practice were interviewed. In practices with only one member of staff the interview lasted 20-25 minutes. In larger practices, where staff tend to specialise (eg receptionist, practice manager, nurse), the interviews were shorter ie 5-10 minutes.

The second stage of the visit, practice observation, involved four sources of data:

(i) *Medical records review*: an examination of 20-25 medical records, chosen at random.

(ii) *Appointments schedule review*: an examination of the practice's appointments schedule.

(iii) *Documents and other records*: an examination of any other practice-held records and documents that may assist in the assessment of indicators, eg copies of referral letters, staff manuals etc.

(iv) *Direct observation*: general observation of the practice, its facilities and equipment.

During the third stage of the visit (assessment) the surveyors used the indicators to determine the extent to which each criterion had been met. The level of achievement on each criterion was rated as either substantial, partial, nil or not applicable.

The surveyors' assessment was then discussed with the principal in a concluding 15 minute interview. Two weeks after the visit practices were sent a brief written report from the surveyors.

The length of the pilot visits ranged from 3-4 hours for solo practices to 5-6 hours for large practices.

Assessment visits may be shortened by the collection of more data prior to the visit. A pre-visit questionnaire is currently being developed for this purpose.

An additional source of information suggested by some of the practices visited during piloting was patient survey data. In future testing of the standards practices may be offered **the option** of having patients fill in a brief survey form. The survey, of perhaps 100 consecutive patients, would be completed prior to the practice visit and would provide a very useful additional perspective on the practice. A number of patient survey indicators have been included in the standards.

Future development of standards

This document represents a further stage in a continuing process of standards development. There will never be a final standards document, only a set of current standards. The standards will always be subject to re-evaluation, consultation and the on-going scrutiny of the profession.

Some standards and criteria are still controversial and may need further discussion and revision. Additional criteria and indicators may be identified.

It is proposed that urban and rural general practitioners will be involved at every stage of the process and that successive drafts will be available for comment. Consumer groups, allied health professionals and other bodies with an interest in general practice will also be involved to ensure the broadest possible consultation.

Comments and submissions on this set of standards should be forwarded to:

The Standards Working Party
C/- Standards Development Unit
Royal Australian College of General Practitioners
PO Box 906
Rozelle NSW 2039.

The Standards

These standards attempt to define minimum acceptable standards for accreditation of general practices[4].

Optimum standards with an emphasis on quality assessment and improvement are currently being developed to complement these minimum standards.

Structure

Each standard is preceded by a short introduction explaining the principle involved. There are 15 standards which describe the qualities required for particular practice activities.

These standards are followed by more specific criteria which break up each standard into its key components.

There are two types of criteria. *Essential* criteria must be met in order to meet the standard. Essential criteria are clearly marked with a star (★) throughout the document.

Desirable criteria also describe important components of the standards. Practices that meet the desirable criteria will find it easier to demonstrate that they are meeting the standards. Desirable criteria may cover areas where resources are limited or there have been recent changes in what constitutes good practice.

Each criterion is followed by a number of indicators which will help to determine the degree to which practices have met the criteria. It is these indicators that are actually assessed or measured.

While all standards and their essential criteria should be met, **it is not necessary to meet every indicator**. In many cases it is not possible to meet every indicator for a given criterion. Surveyors will use the indicators to determine the extent of compliance with criteria.

The surveyors will determine the degree of achievement on each criterion, rating it as either substantial, partial or nil (or, in some cases, not applicable). This rating is recorded in the box appearing after the indicators for each criterion:-

1.1.1: S P N NA

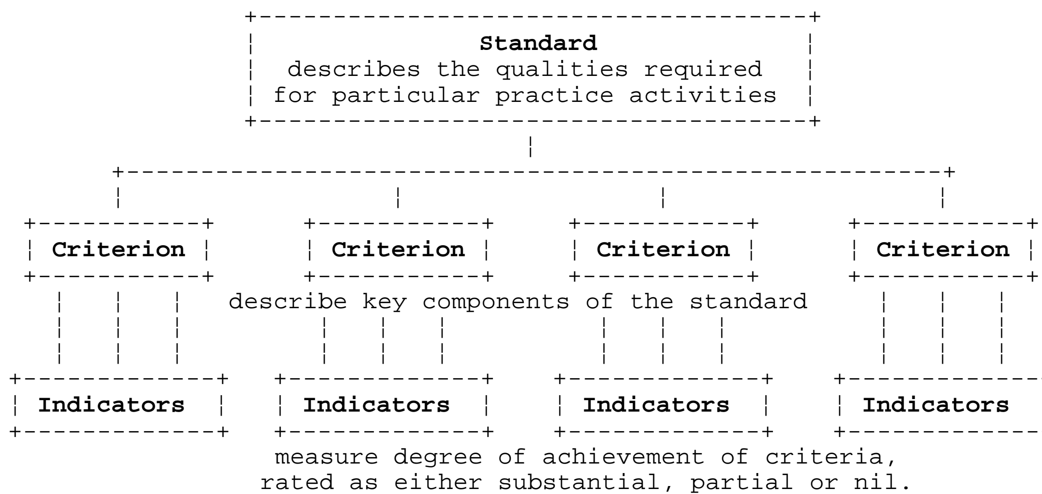
[4] It is assumed in these Standards that practices comply with all relevant Federal, State and Local Government laws and regulations.

The standards now contain over 100 indicators, identified during the pilot visits. Each indicator is followed by its source of information, italicised and bracketed, for example:

Indicators: ☐ B. The practice information sheet includes name(s) of doctor(s), their qualifications and, where appropriate, their special interests *(documents and other records)*.

The list of indicators is not necessarily exhaustive. An `other' category has been included for use when additional or alternative indicators are identified during practice visits.

The following flow chart shows the relationship between standards, criteria and indicators:-.



The degrees of achievement are as follows:

Substantial: The surveyors determine that sufficient indicators have been met and that the criterion has been met.

Partial: The surveyors determine that certain aspects of the criterion have not been met.

Nil: The criterion has not been met.

Section One:
PRACTICE SERVICES

Access and availability

Comprehensive, whole patient care is only possible when a range of general practice services are both available and accessible.

Standard 1.1

All patients are able to obtain timely care and advice appropriate to their needs.

Criteria:

★**1.1.1** Practice patients are normally able to obtain a consultation within two working days for non-urgent matters.

Indicators: ☐ A. Staff confirm that patients are usually able to obtain a consultation within two working days for non-urgent matters *(staff interview).*

☐ B. The appointments schedule can accommodate non-urgent patients within two working days *(appointments schedule review).*

☐ C. Patients indicate that it is usually possible to obtain an appointment within two working days *(patient survey)*[5].

☐ D. Other (specify) ....

1.1.1: S P N NA

Note: This criterion arises from research with patients (see, for example, Smith, C. and Armstrong, D. Comparison of criteria derived by government and patients for evaluating general practitioner services. British Medical Journal. 1989; 299: 494-6).

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[5] Practices participating in field testing and trialing may be offered the option of carrying out a patient survey before they are visited. This data could be used as indicators to help surveyors determine the degree of achievement of criteria.

★**1.1.2** Practice patients are able to obtain information or advice related to their clinical care by telephone in a situation where a consultation is unnecessary or impractical.

Indicators:

☐ A. The doctor(s) takes or returns phone calls from patients when appropriate *(doctor interview).*

☐ B. Staff responsible for answering telephones are aware of the doctor's policy on receiving and returning phone calls from patients and can describe how phone calls are triaged. *(staff interview).*

☐ C. There is evidence of doctor/patient phone contact in the medical or other records *(medical records review, documents and other records).*

☐ D. Patients indicate that they have been able to talk to a doctor on the telephone when appropriate *(patient survey).*

☐ E. Other (specify) ....

1.1.2: S P N NA

★1.1.3 Practice patients are normally able to obtain visits from a doctor (in their home, nursing home or hospital providing these are within a reasonable distance from the practice) for substantial medical reasons.

Indicators:

☐ A. The doctor(s) visits patients when appropriate *(doctor interview).*

☐ B. Staff are aware of the doctor's policy on home or other visits and can describe situations in which a visit is appropriate *(staff interview).*

☐ C. There is evidence of home or other visits in the medical records or appointment schedule *(medical records review, appointment schedule review).*

☐ D. The doctors indicate what the practice has decided is a reasonable distance in terms of the area and types of problems *(doctor interview).*

☐ E. The doctors can describe a few recent off-site visits and the reasons for the visits *(doctor interview).*

☐ F. Patients indicate that they feel it is possible to obtain a home or other visit when necessary *(patient survey).*

☐ G. The practice does not have any disincentives for home visits for substantial medical reasons *(doctor interview, documents and other records).*

☐ H. The practice's billing records show evidence of home or other visits *(documents and other records).*

☐ I. Other (specify) ....

1.1.3: S P N NA

Note: A `reasonable distance' in a rural community may be different to that in a suburban community. `Reasonable distance' might be defined by travelling time.

★**1.1.4** A doctor is available to see patients for urgent medical matters.

Indicators: ☐ A. Staff have been trained to recognise urgent medical matters *(doctor interview).*

☐ B. Staff can describe urgent medical matters and procedures for obtaining urgent medical attention *(staff interview).*

☐ C. Procedures for dealing with urgent medical matters are included in a staff manual, where one exists *(documents and other records).*

☐ D. Other (specify) ....

1.1.4: S P N NA

★**1.1.5** The practice ensures reasonable 24 hour medical cover for practice patients.

Indicators: ☐ A. There is evidence of one of the following:

(a) the practice doctor(s) provide(s) their own 24 hour cover either individually or through a roster of practice doctors; or
(b) an agreement with a nearby practice; or
(c) formal collaboration with a local hospital in rural areas; or
(d) an arrangement with a suitable deputising service *(doctor interview, staff interview, documents and other records).*

☐ B. Doctor(s) and staff can describe how patients are made aware of after hours arrangements *(doctor interview, staff interview).*

☐ C. There is an appropriate after-hours message on an answering machine, where one exists. Alternatively, the practice has call diversion, a paging system or a mobile phone *(direct observation).*

☐ D. The practice information sheet includes a section on after hours care arrangements *(documents and other records).*

☐ E. Patients are satisfied that there is adequate 24 hour cover *(patient survey).*

☐ F. Other (specify) ....

1.1.5: S P N NA

★**1.1.6** There is a flexible appointments system[6] to accommodate patients with urgent problems and patients who need a longer consultation.

Indicators:

☐ A. The doctor(s) can describe how patients with urgent problems and those needing longer consultations are accommodated *(doctor interview).*

☐ B. The staff can describe how patients with urgent problems and those needing longer consultations are accommodated within the practice's appointments system *(staff interview).*

☐ C. The appointments schedule allows urgent cases and longer consultations *(appointments schedule review).*

☐ D. Patients are satisfied with the practice's appointments system *(patient survey).*

☐ E. Other (specify) ....

1.1.6: S P N NA

[6] This may include a drop-in system with adequate feedback to patients on anticipated waiting time.

The consultation and communication

The consultation is the focus of the delivery of general practice care. Patient satisfaction with the consultation is a significant contributor to quality care. A key determinant of patient satisfaction is the quality of communication occurring during the consultation and the amount of information provided to patients.[7]

Standard 1.2

The practice provides the opportunity for patients to communicate their health problems and concerns and receive an appropriate response.

Criteria:

1.2.1 The practice provides patients with written information about the practice.

Indicators: ☐ A. There is a practice information sheet including name(s) of doctor(s), access arrangements, phone numbers, consulting hours, emergency and after hours arrangements *(documents and other records).* (A photocopied, typed A4 information sheet would be quite acceptable).

☐ B. The practice information sheet is freely available to patients *(direct observation).*

☐ C. Other (specify) ....

1.2.1: S P N NA

[7] See, for example, Williams, S. and Calnan, M. Key determinants of consumer satisfaction with general practice. Family Practice. 1991 Sep; 8(3): 237-42.

★**1.2.2** Consultation times are long enough to allow quality care. This means that ***average*** times are not less than 10 minutes. Actual time for individual appointments will vary according to clinical need.

Indicators: ☐ A. The average number of patients seen by each doctor in a four hour session does not exceed 24 *(appointments schedule review).*

☐ B. After each consultation the doctor routinely checks that the patient believes that their needs have been met and that the patient has understood the doctor's advice *(doctor interview, patient survey).*

☐ C. Patients feel that they have not been rushed when having a consultation *(patient survey).*

☐ D. Patients report that their condition is discussed enough with them and that words and explanations used by the doctor are easy to understand *(patient survey).*

☐ E. Other (specify) ....

1.2.2: S P N NA

Note: There will obviously be circumstances under which this will not be possible, for example during the winter cold epidemic or in areas where there is a low doctor/patient ratio (eg many rural areas). Any assessment of this criterion should be based on common sense, taking into account the specific circumstances of the practice.

Consultation times of this length have been shown to be associated with more communication between patient and doctor, more health promotion, higher patient satisfaction and reduced stress for GPs. For example, Ridsdale, L., Carruthers, M., Morris, R., and Ridsdale, J. Study of the effect of time availability on the consultation. Journal of the Royal College of General Practitioners. 1989 Dec; 39(329):488-91.

★**1.2.3** Patients attending the practice are informed of the risks associated with treatments or investigations proposed by their GP.

Indicators: ☐ A. The doctor(s) can describe the ways in which patients are given the opportunity to discuss the risks and benefits of proposed treatments or investigations *(doctor interview).*

☐ B. The doctor(s) can describe how they use leaflets, brochures or written information to support their explanation of conditions to patients when appropriate *(doctor interview).*

☐ C. Patients are not discouraged from asking questions and are satisfied that they have received enough information from the doctor *(patient survey).*

☐ D. Other (specify) ....

1.2.3: S P N NA

★**1.2.4** Patients attending the practice are given an indication of any substantial or unusual costs of treatments or investigations initiated by the doctor.

Indicators: ☐ A. The doctor(s) can describe the ways in which patients who have been referred to another practice are advised about billing procedures at that practice or, where billing procedures at such practices are unknown, the doctor(s) can confirm that patients are advised to check for themselves *(doctor interview).*

☐ B. The doctor(s) can describe the ways in which patients are advised of any substantial or unusual costs that may be involved in proposed treatments or investigations *(doctor interview).*

☐ C. The practice fees are clearly displayed within the practice *(direct observation).*

☐ D. Patients indicate that they have received adequate information about practice fees *(patient survey).*

☐ E. The practice information sheet includes information about practice fees *(documents and other records).*

☐ F. Other (specify) ....

1.2.4: S P N NA

Note: The intent of this criterion is to ensure that patients have some idea of what their out of pocket expenses may be. For example, a patient referred to a non bulk-billing specialist from a bulk-billing practice should be given some indication of what sort of fees are involved, or should at least be advised to check.

This is not to say that doctors should know what each test or treatment will cost, but they should indicate that there may be a cost.

It is, of course, the responsibility of other health care providers to give patients an indication of the costs of any treatments or investigations that they order.

★**1.2.5** The practice has appropriate strategies for dealing with patients whose first language is different from that of the practice medical staff.

Indicators: ☐ A. The doctor(s) and staff are aware of the availability and methods of access to interpreter services *(doctor interview, staff interview).*

☐ B. The doctor(s) and staff can describe how they manage patients who speak a different language e.g. allowing patients to choose between using an interpreter service or using family members and friends *(doctor interview, staff interview).*

☐ C. The doctor(s) can describe circumstances in which using family members and friends to interpret may be inappropriate *(doctor interview).*

☐ D. Other (specify) ....

1.2.5: S P N NA

★**1.2.6** The practice stocks an appropriate range of the many health pamphlets and brochures about common and serious conditions (such as asthma and diabetes) available from Departments of Health and other organisations. The practice also stocks information provided by local community organisations, support and self-help groups. These information brochures should be available in those languages most reasonably to be expected from the practice population, if readily available.

Indicators: ☐ A. There is a range of posters, leaflets and brochures freely available or on display in the waiting room, reception and/or consulting rooms. Where appropriate these are available in other languages *(direct observation).*

☐ B. There is a range of leaflets and brochures available in each consultation room *(direct observation).*

☐ C. The doctor(s) can describe how they use leaflets, brochures or written information to support their explanation of conditions to patients when appropriate *(doctor interview).*

☐ D. Other (specify) ....

1.2.6: S P N NA

Diagnosis and management of specific health problems

Practices have a responsibility to ensure that they are employing up to date methods for diagnosis and management that are broadly consistent with those of other Australian general practitioners.

Standard 1.3

In order to promote high standards of care the practice reaches broad agreement on approaches to diagnosis, management and outcomes which are consistent with relevant RACGP, state and national guidelines.

Criteria:

★1.3.1 The practice ensures that its approaches to common and serious conditions are broadly consistent with approaches adopted by the wider profession.

Indicators: ☐ A. The doctor(s) can describe how they ensure that their approaches to common and serious conditions are broadly consistent with approaches adopted by the wider profession *(doctor interview).*

☐ B. There is a selection of state and national guidelines available within the practice, e.g. the National Asthma Management Plan and the National Consensus Conference on Hypertension statement *(direct observation).*

☐ C. Other (specify) ....

1.3.1: S P N NA

1.3.2 Group practices ensure consistency within themselves of diagnosis and management of common and serious conditions.

Indicators: ☐ A. The doctors in a group practice can describe how they ensure consistency, within the practice, of diagnosis and management of common and serious conditions *(doctor interview).*

☐ B. There is a regular clinical meeting *(doctor interview).*

☐ C. Other (specify) ....

1.3.2: S P N NA

Content of medical records

Adequate medical records are essential for maintaining continuity of care, professional development and medico-legal protection.

The content of medical records is a clinical matter and so is included under Practice Services. The system of records used is an administrative concern and is therefore included under Practice Administration.

Standard 1.4

Patient medical records contain sufficient information to identify the patient, and document assessment, management, progress and outcomes.

Criteria:

★**1.4.1** The medical records contain sufficient information to allow another doctor to carry on the management of practice patients.

Indicators: ☐ A. Each medical record includes:-

- (i) a note of every doctor/patient encounter;
- (ii) reason for encounter;
- (iii) the diagnosis, where appropriate;
- (iv) the management plan (including, where necessary, expected date of review); and
- (v) prescribed medication (including strength, directions for use and number of repeats) *(medical records review).*

☐ B. Other (specify) ....

1.4.1: S P N NA

1.4.2 The patient's individual medical record includes a current health summary.

Indicators:

☐ A. The records of 50% of patients with ongoing medical problems contain a health summary *(medical records review).*

☐ B. Each health summary includes a social and family history, past problems, active problems, allergies and sensitivities, medication, immunisations and management *(medical records review).*

☐ C. Other (specify) ....

1.4.2: S P N NA

★**1.4.3** Non-active medical records are kept and stored by the practice.

Indicators: ☐ A. Individual medical records are kept for a minimum of seven years from the point of last contact with the patient *(medical records review).*

☐ B. `Non-active' medical records are stored in a safe place *(direct observation).*

☐ C. Records for patients who have not been seen for more than one year are marked with a throw-out date and stored safely, although some practices may choose (and it is preferable) to keep records indefinitely *(medical records review).*

☐ D. Records of minors are kept until the date of their 25th birthday *(medical records review).*

☐ E. When transferring records to another practice either the original record or a photocopy of the original is kept by the practice *(medical records review).*

☐ F. Other (specify) ....

1.4.3: S P N NA

Note: These indicators come from a state government act on limitations, which established that time frame for bringing an action for damages for personal injuries.

Continuity of care

Continuity of care allows patients to develop a relationship with their doctor over time. Doctors who know their patients are better able to provide high quality, comprehensive, whole patient care, including effective health promotion and early detection strategies.

Continuity is enhanced by GPs coordinating individual patient care within the health system and communicating with doctors and other health workers.

Patients have a significant role in facilitating continuity of care. The aim of this standard is to ensure that patients have the opportunity of receiving continuity of care.

Standard 1.5

The practice makes all reasonable provisions for continuity of care.

Criteria:

★1.5.1 The practice demonstrates its commitment to continuity of care through:-

	Relevant Standards
a. being available and accessible	1.1
b. developing agreed approaches on diagnosis and management	1.3
c. using adequate medical records	1.4; 4.2
d. acting as co-ordinator within the health system	1.6
e. employing health promotion and risk reduction strategies	1.7

Indicators: ☐ A. The practice meets the standards specified above.

☐ B. The practice has a number of long-term patients, where long-term is defined relative to the life of the practice *(medical records review, patient survey).*

☐ C. The practice has policies or strategies which encourage continuity of care *(doctor interview).*

☐ D. Other (specify) ....

1.5.1: S P N NA

★**1.5.2** Patients attending group practices are usually able to see the doctor of their choice, if available.

Indicators: ☐ A. Staff can describe how patients, when making an appointment or attending the practice, are able to request their preferred doctor, if they have one *(staff interview)*.

☐ B. Staff give patients a brief explanation if their preferred doctor is not available and tell them when he/she will be available *(staff interview)*.

☐ C. The appointments schedule clearly differentiates between appointments for each doctor *(appointments schedule review)*.

☐ D. Patients are free to see the doctor of their choice for follow-up visits *(staff interview, patient survey)*.

☐ E. Other (specify) ....

1.5.2: S P N NA

Integration of care

General practices can help patients make optimum use of the full range of health services available in the community. This requires well-developed channels of communication between general practices and other health workers, community health services and hospitals.

Standard 1.6

The practice works with a range of other health and community services in its area to improve individual patient care.

Criteria:

★**1.6.1** The practice demonstrates knowledge of and interaction with appropriate health and community services in its area to facilitate optimal patient care.

Indicators:

☐ A. The doctor(s) can describe a variety of local medical services such as diagnostic services, hospitals and consultant services *(doctor interview).*

☐ B. The doctor(s) can describe a variety of local allied health services (eg physiotherapists etc) *(doctor interview).*

☐ C. The doctor(s) can describe a variety of local community, social and other health services (eg self help groups etc) *(doctor interview).*

☐ D. The doctor(s) can describe their interaction with a variety of local services *(doctor interview).*

☐ E. The doctor(s) and staff can describe the practice procedures for referral to consultants, diagnostic and community health and other community services *(doctor interview, staff interview).*

☐ F. Directories for referrals are available for locums etc when necessary *(documents and other records).*

☐ G. There is evidence that the practice works with appropriate health services *(medical records review, documents and other records).*

☐ H. Other (specify) ....

1.6.1: S P N NA

★**1.6.2** All patients being referred have an appropriate referral letter. In the case of an emergency or other unusual circumstance a telephoned referral may be appropriate.

Indicators: ☐ A. Referral letters:

a. are legible (and preferably typed);
b. contain relevant background social information and history;
c. contain problem, key examination findings and current treatment;
d. include reason for referral and expectation of referral;
e. are on appropriate practice stationery - plain paper or practice letterhead is considered `appropriate stationery'. Routine use of drug company notepads is considered unacceptable *(documents and other records, doctor interview, staff interview).*

☐ B. Other (specify) ....

1.6.2: S P N NA

Note: There is a considerable body of evidence showing that problems exist with communication between GPs and other medical practitioners. See for example, Montalto, M.; Harris, P. and Rosengarten,P. Survey of Australian emergency physicians' expectations of general practitioner referrals. British Journal of General Practice. 1993,43:277-280.

Health promotion, risk reduction & prevention of disease

Over 80% of Australians see a general practitioner at least once a year.[8] This provides doctors with a unique opportunity for health promotion, risk reduction and preventive strategies.

Standard 1.7

The practice provides health promotion and disease prevention services. These are based on scientifically validated guidelines whenever possible.

Criteria:

★**1.7.1** The practice provides opportunistic preventive care and early case detection using scientifically validated guidelines where appropriate.

Indicators:

☐ A. Patient medical records include brief information about risk factors such as smoking, alcohol consumption, family history etc *(medical records review).*

☐ B. The doctor(s) can describe the opportunities for health promotion and disease prevention presented by a range of common patient problems *(doctor interview).*

☐ C. Other (specify) ....

1.7.1: S P N NA

[8] Deeble, J. Medical Services through Medicare. National Health Strategy, Background Paper No. 2, February 1991 (Page 30).

1.7.2 The practice provides systematic preventive care and early case detection using scientifically validated guidelines where appropriate and systematically encourages participation in preventive activities subject to patient consent.

Indicators: ☐ A. There should be one of the following:
(a) card based system showing due dates for preventive activities *(documents and other records, direct observation)*; or
(b) systematic flagging of medical records for opportunistic preventive activities *(medical records review)*; or
(c) a register of patients for reminder/recall for preventive activities *(documents and other records, direct observation)*; or
(d) a computerised recall system *(direct observation).*

☐ B. The practice utilises recall systems offered by other agencies, eg local pathology services or government Pap smear registers *(documents and other records).*

☐ C. Other (specify) ....

1.7.2: S P N NA

Note: See, for example, Guidelines for Preventive Activities in General Practice, (Red Book, 2nd edition 1993) designed by the RACGP Preventive and Community Medicine Committee.

Preventive activities should be scientifically validated. Examples of scientifically validated activities are blood pressure checks, immunisation, mammography in women over 50 and Pap smears.

★**1.7.3** The practice provides education and information to patients on how to they can prevent illness and improve their own health.

Indicators: ☐ A. The practice has a range of health promotion information materials and resources *(direct observation).*

☐ B. There is evidence in the patient medical records that education and counselling on illness prevention is provided to patients *(medical records review).*

☐ C. Patients report that they have discussed illness prevention with their doctor *(patient survey).*

☐ D. The doctor(s) can describe how they educate and counsel their patients on illness prevention *(doctor interview).*

☐ E. The practice uses posters and brochures in the waiting room to encourage health promotion *(direct observation).*

☐ F. Other (specify) ....

1.7.3: S P N NA

1.7.4 The practice identifies and co-operates with recognised local health promotion and public health programs.

Indicators: ☐ A. The doctor(s) can describe local health promotion programs, if any, and indicate how they have co-operated with programs they have determined to be appropriate *(doctor interview).*

☐ B. The doctor(s) can describe how they provide health education to community groups *(doctor interview).*

☐ C. Other (specify) ....

1.7.4: S P N NA

Section Two:
RIGHTS AND NEEDS OF PATIENTS

Respect for the rights and needs of patients

Confidentiality, privacy and ethical behaviour are crucial. Practices which respect these rights maintain confidence in the profession and increase patients' willingness to communicate fully with their doctor.

While it should also be recognised that patients have certain responsibilities[9] in relation to their health care, practices can only be assessed on their recognition of the rights of patients.

Standard 2.1

The practice ensures that the doctor(s) and staff respect the rights and needs of patients.

Criteria:

★**2.1.1** The practice provides respectful care at all times and under all circumstances, with recognition of patients' personal dignity regardless of sex, age, religion, ethnicity, sexual preference or medical condition.

Indicators: ☐ A. No new patient is ever refused access to a practice doctor on the basis of their sex, age, religion, ethnicity, sexual preference or medical condition. *(doctor interview, staff interview).*

☐ B. Other (specify) ....

2.1.1: S P N NA

[9] Those interested in the responsibilities of patients may consult, for example, Consumer Health Rights, A summary of your health rights and responsibilities (Consumers' Health Forum of Australia, Canberra, reprint 1992) or The ACHS Accreditation Guide. Standards for Australian Healthcare Facilities (Australian Council on Healthcare Standards. ACHS July 1991).

★**2.1.2** Patients are interviewed and examined in surroundings designed to ensure privacy. Discussion or consultation involving patients is conducted discreetly. Individuals not directly involved in patient care are not present without the consent of the patient concerned.

Indicators: ☐ A. The doctor(s) and staff can describe how they ensure patient confidentiality *(doctor interview, staff interview).*

☐ B. Visual and auditory privacy is ensured in the consultation room(s) *(direct observation).*

☐ C. There is a private area, eg a screen or curtain, for patients to undress *(direct observation).*

☐ D. The practice attempts to ensure auditory privacy in the waiting room, for example by using background music to mask conversations *(direct observation).*

☐ E. The waiting room is separate from the reception area *(direct observation).*

☐ F. Other (specify) ....

2.1.2: S P N NA

★**2.1.3** All communications and records pertaining to patients are treated as confidential.

Indicators: ☐ A. The doctor(s) and staff can describe how they ensure confidentiality of medical records and other documents pertaining to patients *(doctor interview, staff interview).*

☐ B. There is an appropriate method of disposal of material containing patient identifying information *(doctor interview, staff interview).*

☐ C. Staff are aware of confidentiality requirements for all patient encounters and recognise significant breaches of confidentiality as a `dismissible offence' *(staff interview).*

☐ D. Medical records, and other files containing patient information, are not stored or left in areas where members of the public have unrestricted access *(staff interview, direct observation).*

☐ E. Other (specify) ....

2.1.3: S P N NA

★**2.1.4** The practice acknowledges the right of patients to refuse any treatment, advice or procedure. Refusal may not absolve the treating doctor of the duty of ensuring the patients continuing care through appropriate referral to other providers.

Indicators: ☐ A. The doctor(s) can describe how they manage a patient who refuses specific treatments *(doctor interview).*

☐ B. Other (specify) ....

2.1.4: S P N NA

★**2.1.5** The practice acknowledges and, if requested, facilitates the right of patients to seek a further opinion.

Indicators: ☐ A. The doctor(s) can describe how they manage a patient who intends to seek a further opinion *(doctor interview).*

☐ B. Other (specify) ....

2.1.5: S P N NA

★**2.1.6** The practice acknowledges the right of patients to transfer their care to another doctor in the same practice or in another practice. Similarly, the treating doctor has the right to discontinue treatment of a patient. A doctor making such a decision assists the patient to find an alternative doctor.

Indicators: ☐ A. The doctor(s) can describe how they manage a patient who wants to leave the practice *(doctor interview).*

☐ B. The doctor(s) can describe how they manage a patient who they no longer wish to treat *(doctor interview).*

☐ C. Other (specify) ....

2.1.6: S P N NA

★**2.1.7** Participation by patients in clinical training programs involving observation of the consultation or involvement by a third party occurs only with the explicit consent of the patient after receiving information about the programs.

Indicators: ☐ A. The doctor(s) can describe how they obtain patient consent for involvement in clinical training programs *(doctor interview).*

☐ B. Where appropriate, there is evidence of patient consent for participation in clinical training programs noted in the medical records *(medical records review).*

☐ C. Other (specify) ....

2.1.7: S P N NA

★**2.1.8** Participation by patients in the gathering of data for research projects which involve the identification of patients, occurs only with the explicit and written consent of the patient after receiving a written and oral explanation about the proposed research. Patients have the right to withdraw their consent. Research projects in general practice should be approved by an appropriate ethics committee.

Indicators: ☐ A. The doctor(s) can describe how they obtain patient consent for involvement in research projects *(doctor interview).*

☐ B. Where appropriate, there is evidence of consent to participation in research projects noted in the medical records *(medical records review).*

☐ C. Other (specify) ....

2.1.8: S P N NA

★**2.1.9** The practice acknowledges and responds to patient complaints.

Indicators: ☐ A. The doctor(s) and staff can describe the practice procedures for dealing with complaints from patients and others *(doctor interview, staff interview).*

☐ B. Other (specify) ....

2.1.9: S P N NA

★**2.1.10** The practice maintains confidentiality and privacy of patients' accounts. Where patients' accounts are released to a third party, the information contained is not of a clinical nature.

Indicators: ☐ A. Staff can describe how they ensure confidentiality of patient accounts *(staff interview).*

☐ B. Patient accounts and related correspondence do not contain clinical information *(documents and other records).*

☐ C. Other (specify) ....

2.1.10: S P N NA

Section Three: QUALITY ASSURANCE AND EDUCATION

Quality assurance and continuing education

Quality assurance consists of educational and practice based activities which maintain a high professional standard. It also involves a commitment to acquiring new knowledge and skills by a process of continuing education and training.

Standard 3.1

The practice is committed to the principles of quality assurance and continuing education.

Criteria:

★**3.1.1** All medical staff participate in quality assurance and continuing medical education.

Indicators: ☐ A. The practice is able to demonstrate that all GPs are involved in quality assurance and continuing education *(doctor interview).*

☐ B. Other (specify) ....

3.1.1: S P N NA

3.1.2 All staff involved in patient care demonstrate a commitment to continuing education and to the maintenance of appropriate standards of care.

Indicators: ☐ A.[10] Staff have completed a St John's ambulance first aid course or equivalent *(doctor interview, staff interview, documents and other records).*

☐ B. Appropriate practice staff have participated in medical receptionist training, for example an RACGP course, an Australian Association of Practice Managers course or local TAFE course *(doctor interview, staff interview, documents and other records).*

☐ C. Appropriate practice staff have completed a medical terminology course *(doctor interview, staff interview, documents and other records).*

☐ D. Practice nursing staff have appropriate nursing training and experience and participate in appropriate continuing education *(doctor interview, staff interview, documents and other records).*

☐ E. The practice provides in-house training for staff *(doctor interview, staff interview, documents and other records).*

☐ F. Other (specify) ....

3.1.2: S P N NA

★**3.1.3** The doctor(s) and staff regularly review the administration of the practice.

Indicators: ☐ A. Staff are able to discuss administrative matters with the doctor(s) when necessary *(doctor interview, staff interview).*

☐ B. There is a regular staff meeting *(doctor interview, staff interview).*

☐ C. Other (specify) ....

3.1.3: S P N NA

[10] It is recognised that the indicators for 3.1.2 are desirable rather than essential.

Section Four:
PRACTICE ADMINISTRATION

Practice staff

Receptionists, practice nurses and practice managers should share the practice's commitment to providing quality care for patients.[11]

Standard 4.1

Practice staff deal with patients in a helpful and competent way and are able to identify emergencies and deal with complaints.

Criteria:

★**4.1.1** At least one person is present in the practice during normal practice hours who can provide practical help in an emergency.

Indicators: ☐ A. When the practice is open a person is available who can, for example, dial for an ambulance, assist in lifting an unconscious person etc *(doctor interview, staff interview).*

☐ B. At least one staff member is present when the practice is open *(doctor interview, staff interview).*

☐ C. Other (specify) ....

4.1.1: S P N NA

Note: This need not apply to the small branches of those rural practices that have offices in a number of locations.

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[11] See, for example, Arber, S. and Sawyer, L. The role of the receptionist in general practice: a 'dragon behind the desk'? Soc. Sci. Med. 1985:20(9); 911-921.

★**4.1.2** Staff have appropriate inter-personal skills for working in a medical practice.

Indicators: ☐ A. Staff demonstrate adequate communication skills in direct communication or on the telephone *(direct observation).*

☐ B. Patients are satisfied with the general attitude of staff *(patient survey).*

☐ C. Other (specify) ....

4.1.2: S P N NA

Medical records system

A well organised system of medical records[12] will contribute to the smooth running of the practice and quality care.

The system of records used is an administrative concern and so is included under Practice Administration. The content of medical records is a clinical concern and is therefore included under Practice Services.

Standard 4.2

Medical records are easily accessible within the practice for individual patient care, health promotion, audit and research, paying due regard to confidentiality and patient rights.

Criteria:

★**4.2.1** The records are comprehensive, well organised, legible and accurate.

Indicators:

☐ A. For each regular patient there is an individual file containing all clinical information relating to that patient. This file includes the patients' medical record, letters received from consultants and hospitals and all pathology and X-ray reports *(medical records review).*

☐ B. There is a separate medical record for each patient, which may or may not be contained in a family medical folder *(medical records review).*

☐ C. Individual patient records can be easily accessed within the practice *(direct observation).*

☐ D. Procedures exist for incorporation of responses to referrals to be included in the patient's individual file *(doctor interview, staff interview, medical records review).*

☐ E. Other (specify) ....

4.2.1: S P N NA

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[12] The RACGP Health Record is an example of a problem oriented, flexible structured record.

★**4.2.2** Confidentiality, privacy and security of records are maintained.

Indicators: ☐ A. Medical records are not stored or left in areas where members of the public have unrestricted access *(direct observation, staff interview).*

☐ B. The doctor(s) and staff can describe how they ensure confidentiality of medical records *(doctor interview, staff interview).*

☐ C. Other (specify) ....

4.2.2: S P N NA

★**4.2.3** On request by the patient, the practice transfers a copy of a patients' medical record, or a summary, to another medical practitioner.

Indicators: ☐ A. The doctor(s) and staff can describe the procedures for transferring records to another practice *(doctor interview, staff interview).*

☐ B. Other (specify) ....

4.2.3: S P N NA

★**4.2.4** There is a system for follow up and recall of patients with significantly abnormal test results.

Indicators: ☐ A. The doctor(s) can describe the procedure for follow up and recall of patients with significantly abnormal test results *(doctor interview).*

☐ B. There is a system for taking appropriate action on test results, eg the doctor initials each result and indicates appropriate action *(doctor interview, staff interview).*

☐ C. Other (specify) ....

4.2.4: S P N NA

Control of Practice

GPs principal responsibility is towards their patients and not their employers or the owners of their practice.

Standard 4.3

The practice is under the clinical control of general practitioners.

Criteria:

★**4.3.1** The practice ensures that all doctors in the practice may exercise full autonomy in decisions that effect clinical care.

Indicators: ☐ A. The doctors are free to determine their own appointments schedule, subject to criterion 1.2.2 *(doctor interview).*

☐ B. The doctors are free to determine the consultants to whom they refer *(doctor interview).*

☐ C. The doctors are free to determine what pathology they order, and where they order it *(doctor interview).*

☐ D. The doctors are free to determine what diagnostic services they order and where they order those services *(doctor interview).*

☐ E. The doctors are free to determine how and when to schedule follow-up appointments with individual patients *(doctor interview).*

☐ F. The doctors are free to determine whether to accept new patients, subject to criterion 2.1.1 *(doctor interview).*

☐ G. The doctor(s) decide(s) what equipment and supplies the practice orders *(doctor interview, staff interview).*

☐ H. The doctor(s) decide(s) whether particular bad-debts are to be pursued *(doctor interview, staff interview).*

☐ I. The practice is generally free from any financial integration of general practitioners with services to which the general practitioners may refer *(doctor interview).*

More indicators...

☐ J. The practice does not require patients to return for a consultation to receive negative results of routine tests, unless for substantial medical reasons *(doctor interview).*

☐ K. Other (specify) ....

4.3.1: S P N NA

Section Five:
PHYSICAL FACTORS

Quality patient care is facilitated by appropriate physical structures. The practice premises, including its facilities and equipment, should be adequate for the needs of the practice and should be maintained in a safe condition.

Practice facilities

Standard 5.1

The practice has facilities which are appropriate for general practice and which promote the health, safety and comfort of staff and people who use the practice.

Criteria:

★**5.1.1** The practice has one dedicated consulting/examination room for every doctor working in the practice at any one time. Each room has adequate and appropriate amenities for the comfort, privacy and safety of patients and others.

Indicators: ☐ A. *(direct observation).*

☐ B. Patients feel comfortable in the consultation rooms *(patient survey).*

☐ C. The practice meets criterion 2.1.2.

☐ D. Other (specify) ....

5.1.1: S P N NA

★**5.1.2** Each consultation room has adequate and appropriate facilities for patient assessment during the consultation process.

Indicators: ☐ A. The consultation room is free from excessive extraneous noise *(direct observation).*

☐ B. There is adequate lighting in the consultation room *(direct observation).*

☐ C. There is an examination couch in each consultation room *(direct observation).*

☐ D. Other (specify) ....

5.1.2: S P N NA

5.1.3 The practice has a patient waiting area sufficient to accommodate the usual number of patients and others who would be waiting at any one time.

Indicators: ☐ A. *(direct observation).*

☐ B. Patients feel comfortable in the waiting room *(patient survey).*

☐ C. Other (specify) ....

5.1.3: S P N NA

★**5.1.4** The practice has toilets and hand washing facilities readily available for use by patients and others.

Indicators: ☐ A. *(direct observation)*

☐ B. Other (specify) ....

5.1.4: S P N NA

★**5.1.5** The practice provides privacy for patients and others in distress.

Indicators: ☐ A. *(doctor interview, staff interview, direct observation)*

☐ B. Other (specify) ....

5.1.5: S P N NA

5.1.6 The practice has a telecommunications system adequate to its needs.

Indicators: ☐ A. The practice has a telephone system with sufficient inward and outward call capacity *(direct observation, staff interview, patient survey).*

☐ B. Other (specify) ....

5.1.6: S P N NA

5.1.7 The practice has adequate and appropriate secure storage for medical records, patient files and other records.

Indicators: ☐ A. *(direct observation)*

☐ B. Other (specify) ....

5.1.7: S P N NA

5.1.8 Practice security is maintained at all times.

Indicators: ☐ A. Drugs of dependency are safely secured (eg in a locked cupboard or safe) and adequately documented as required by state regulations *(direct observation).*

☐ B. Other drugs are securely stored *(direct observation).*

☐ C. Prescription pads, letterhead and other official documents are not accessible to unauthorised persons *(direct observation).*

☐ D. Other (specify) ....

5.1.8: S P N NA

★**5.1.9** The practice has appropriate facilities or arrangements for sterilisation, disinfection and decontamination.

Indicators: ☐ A. The practice has facilities for hand washing in each consulting room *(direct observation).*

☐ B. The doctor(s) and staff can describe procedures undertaken for sterilisation / disinfection / decontamination of surfaces *(doctor interview, staff interview).*

☐ C. The doctor(s) and staff can describe procedures undertaken for sterilisation / disinfection / decontamination of equipment *(doctor interview, staff interview).*

☐ D. The practice has appropriate equipment and materials for decontamination *(direct observation).*

☐ E. The practice has an arrangement for "off-site" sterilisation of equipment *(doctor interview, staff interview, documents and other records).*

☐ F. Other (specify) ....

5.1.9: S P N NA

Note: *Sterilisation/Disinfection Guidelines for General Practice* (RACGP Practice Management Committee of Council, RACGP, 1991) may be of interest.

★**5.1.10** The practice has provision for the safe disposal of contaminated waste.

Indicators: ☐ A. The doctor(s) and staff are aware of, and implement, appropriate methods of contaminated waste disposal *(doctor interview, staff interview).*

☐ B. There is a designated and appropriate container for contaminated waste *(direct observation).*

☐ C. Other (specify) ....

5.1.10: S P N NA

Note:	*National Guidelines for the Management of Clinical and Related Wastes* (National Health & Medical Research Council, Canberra, 1988) may be helpful here.

★**5.1.11** The practice has provision for the safe disposal of 'sharps' both within the practice, and from the practice to final destruction.

Indicators: ☐ A. The doctor(s) and staff are aware of, and implement, appropriate methods of `sharps' disposal *(doctor interview, staff interview).*

☐ B. There is a designated and appropriately labelled `sharps' container. The container is designed and constructed so as to minimise the possibility of injury to handlers *(direct observation).*

☐ C. Other (specify) ....

5.1.11: S P N NA

Note:	*National Guidelines for the Management of Clinical and Related Wastes* (National Health & Medical Research Council, Canberra, 1988) may be useful here.

5.1.12 The practice implements strategies to ensure the safety and comfort of doctors and staff.

Indicators:

☐ A. The practice has clear procedures for manual handling (ie lifting of heavy objects etc) *(doctor interview, staff interview, direct observation).*

☐ B. The practice provides counselling regarding risks of infection to female staff of child bearing age *(doctor interview, staff interview).*

☐ C. All staff are offered immunisation appropriate for their situation *(doctor interview, staff interview).*

☐ D. The practice has a sharps injury protocol *(doctor interview, staff interview, documents and other records).*

☐ E. Office equipment is properly designed for its purpose (eg chairs are adjustable) *(direct observation).*

☐ F. The practice implements universal precautions for the control of infection eg wearing gloves when taking blood samples *(doctor interview, staff interview, direct observation).*

☐ G. Other (specify) ....

5.1.12: S P N NA

★**5.1.13** The practice is well maintained and visibly clean.

Indicators:

☐ A. *(direct observation).*

☐ B. Other (specify) ....

5.1.13: S P N NA

Practice equipment

Standard 5.2

Medical equipment and resources are appropriate and adequate to ensure comprehensive primary care and resuscitation. These are adequately maintained and checked.

Criteria:

★**5.2.1** The practice has medical equipment necessary to ensure comprehensive primary care and resuscitation. (There is a large range of equipment that practices may, and perhaps should, have. The equipment a practice actually has will depend on the type of practice and the interests and styles of the doctors in it.)

Indicators: ☐ A. The practice has the following:

a. Stethoscope;
b. Auriscope;
c. Ophthalmoscope;
d. Sphygmomanometer;
e. Peak flow meter;
f. Vaginal speculum;
g. Thermometer;
h. Scales;
i. Urine testing strips;
j. Patella hammer;
k. Eye charts;
l. Equipment for maintaining an airway in both adults and children (eg Guedel airways);
m. Equipment to assist ventilation (eg AMBU bag or similar);
n. Disposable needles.

(direct observation)

☐ B. Other (specify) ....

5.2.1: S P N NA

★**5.2.2** The practice ensures that each doctor has access to a `doctors bag'. The doctors bag contains minimal equipment, drugs and stationery for diagnosis of common and urgent problems, treatment of emergencies and common problems necessitating home visits, referral to hospital and other services.

Indicators: ☐ A. The doctors bag contains a stethoscope, auriscope, ophthalmoscope, sphygmomanometer, equipment for maintaining an airway, drugs for medical emergencies, syringes and needles in a variety of sizes, a torch and stationery (including prescription pads and letterhead) *(direct observation).*

☐ B. Drugs carried are checked regularly to ensure that their "use by date" has not expired *(doctor interview, staff interview, direct observation).*

☐ C. Other (specify) ....

5.2.2: S P N NA

★**5.2.3** The practice has appropriate vaccine storage which maintains vaccines at temperatures between 2°C and 8°C.

Indicators: ☐ A. Vaccines are stored in a separate or an infrequently used refrigerator, i.e. a refrigerator not used for other purposes such as storing lunches etc *(direct observation, staff interview).*

☐ B. There is accurate monitoring of the temperature within the refrigerator - eg a cold chain monitor card or a maximum/minimum thermometer *(direct observation).*

☐ C. Other (specify) ....

5.2.3: S P N NA

★**5.2.4** The practice has equipment appropriate to the procedures performed in the practice.

Indicators: ☐ A. *(direct observation)*

☐ B. Other (specify) ....

5.2.4: S P N NA

Note: For those practices which regularly undertake procedures, *Standards for Office Procedures in General Practice* (RACGP Practice Management Committee of Council, RACGP 1992) would be useful.

5.2.5 The practice has access to a range of resources and reference materials for immediate reference.

Indicators: ☐ A. The practice has a range of recent medical and surgical texts *(direct observation).*

☐ B. The practice has an organised system of access to appropriate GP journals *(doctor interview, direct observation).*

☐ C. The practice has a computerised access system for medical information *(doctor interview, direct observation).*

☐ D. Other (specify) ....

5.2.5: S P N NA

Physical access

Standard 5.3

The practice services are physically accessible.

Criteria:

5.3.1 The practice provides appropriate physical access to the practice and its facilities including access for people with disabilities.

Indicators: ☐ A. There is adequate parking within a reasonable distance from the practice *(direct observation).*

☐ B. There is wheelchair access to the practice and its facilities, ie to consultation and examination rooms, toilets etc *(direct observation).*

☐ C. The practice has ramps, railings, accessible toilets etc to assist people with disabilities *(direct observation).*

☐ D. Other (specify) ....

5.3.1: S P N NA

★5.3.2 Where physical access is limited, the practice provides off-site visits to patients with disabilities.

Indicators: ☐ A. *(doctor interview, staff interview).*

☐ B. Other (specify) ....

5.3.2: S P N NA

The Standards Working Party

These standards have been prepared by the Standards Working Party (SWP) of the Royal Australian College of General Practitioners. The working party was established in November 1992 by the RACGP under a grant from the then Department of Health, Housing and Community Services to develop standards for voluntary accreditation of general practice.

Convened by Dr. Barbara Booth, RACGP Assistant Secretary General (Quality Assurance and Continuing Education), the SWP comprised six doctors with extensive experience in general practice:-

- *Jill Gordon, Chairman of NSW Faculty of the RACGP. Jill has been in general practice in Newcastle and Sydney and is currently partner in an RACGP Training Program accredited practice in Crows Nest. Formerly fellow in Community Medicine at Newcastle University and Director of FMP (now the Training Program) in New South Wales.*

- *Bruce Harris has over 27 years experience in general practice including 10 years in rural practice and 7 years overseas. He is currently in rural practice in Walgett, New South Wales.*

- *Liz Harris worked for 12 years in general practice, including 6 years in Narrabri and 5 years in Canberra, before joining Monash University's Department of Community Medicine as Senior Lecturer in 1990. After 3 years pursuing her research interest in general practice economics, she was appointed Director, General Practice of the Federal AMA in February, 1993. Dr Harris is currently finalising her doctoral thesis. On completion of her thesis she will be taking up an appointment with the RACGP.*

- *Mark Harris is currently Professor of General Practice, University of NSW; Director of General Practice, South West Sydney Area Health Service; Elected member of Board of NSW Faculty of RACGP and Chairman, Preventive and Community Medicine Committee of NSW Faculty of RACGP. He has been a general practitioner in private practice in Sydney and in Bourke (for seven years) in far western New South Wales.*

- *Richard Hays is currently Professor of General Practice and Rural Health at the North Queensland Clinical School, University of Queensland. He is also in general practice in Townsville, North Queensland. He has several years experience in rural and provincial city general practice in central western and northern Queensland.*

- *Graeme Miller is Clinical Senior Lecturer, Department of General Practice at Westmead Hospital. He has over 20 years experience in general practice and has research projects in Quality Assurance Measures and General Practice data collection.*

Submissions & Acknowledgments

The Standards Working Party would like to thank the following individuals and organisations for their comments and suggestions on earlier drafts of these standards.

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Other organisations:

Audiological Society of Australia
Australian College of Sports Physicians
Australian College of Health Service Executives
Australian Nursing Council Inc
Australian Nursing Federation
Royal College of Nursing
Australian Council of Community Nursing Services
Australian Council of Allied Health Professions
Australian College of Midwives Inc
Australian Orthotic Prosthetic Association
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Major references

Many of the standards contained in this document have been developed from published material:-

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* Royal College of General Practitioners. What sort of Doctor? Report from general practice 23. London: RCGP 1985.

The SWP would also like to acknowledge the valuable contribution made by the following:-

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