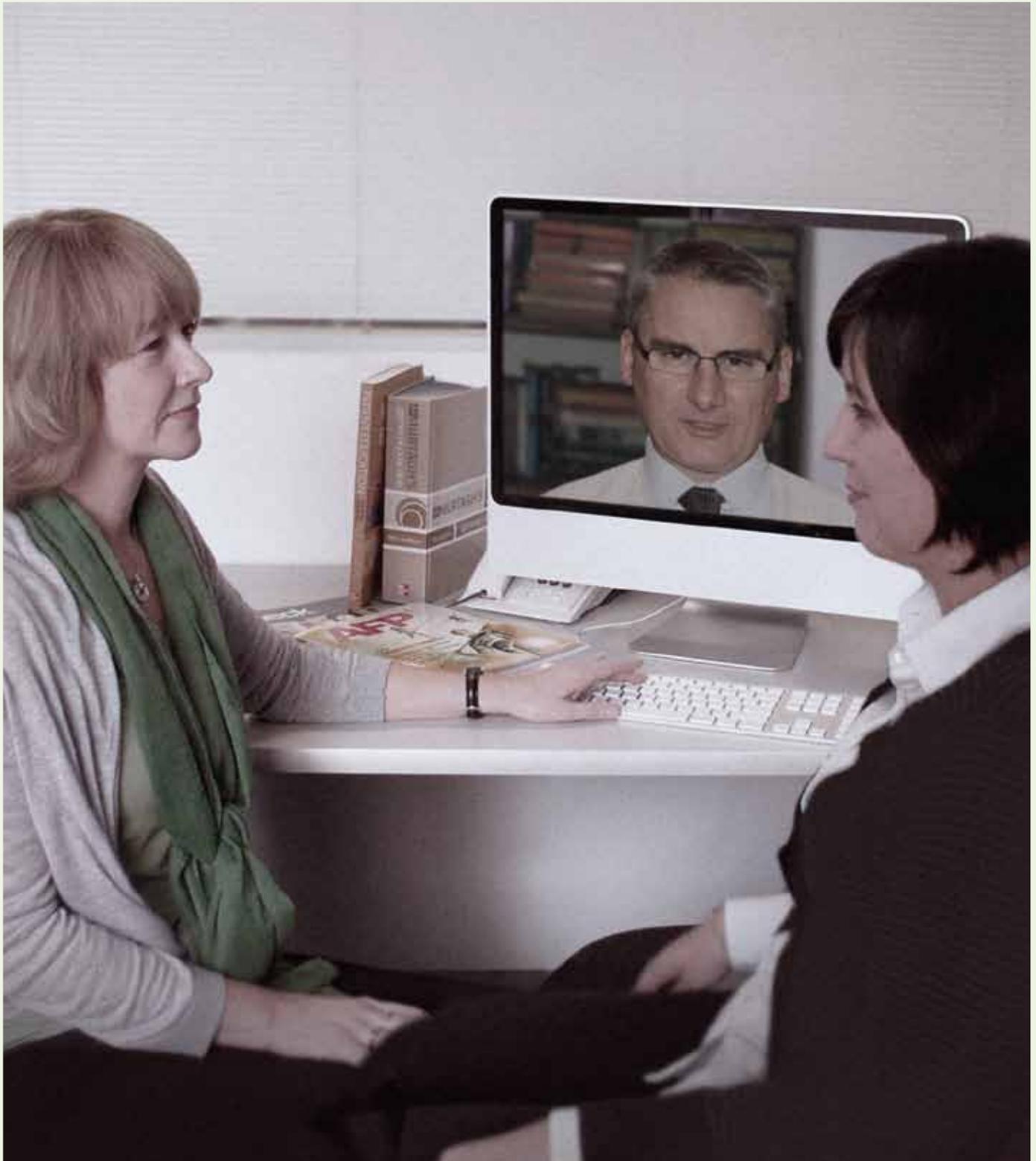The Royal Australian
College of General
Practitioners

# Standards for general practices offering video consultations

**An addendum to the RACGP *Standards for general practices* (4th edition)**



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## Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

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# *Acknowledgments*

**Australian Government**

**Department of Health and Ageing**

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# *Preamble*

## Telehealth care standards supporting high quality primary healthcare

The Royal Australian College of General Practitioners (RACGP) continues to play a leading role in the design and implementation of exciting e-health initiatives in the Australian primary healthcare setting. The RACGP welcomes the improved access to specialists and better health outcomes that video consultations are expected to deliver.

## Addendum to the RACGP Standards for general practices (4th edition)

This Addendum to the RACGP *Standards for general practices* (4th edition) (the Standards) highlights a range of safety and quality issues of particular significance to general practices offering video consultations. It should be emphasised that all criteria and related indicators in the *Standards* apply to general practices offering video consultation services – this addendum highlights areas of particular relevance.

The potential for new initiatives in the telehealth care arena is vast, as is the potential for enabling patients with special needs (such as the elderly or those with limited mobility) to gain better access to primary healthcare. This addendum, however, relates specifically to video consultations with a specialist in a distant location. In time, the *Standards* may be expanded to address different safety and quality issues for other types of consultations such as telehealth applications which will link to patients in their homes; multidisciplinary case conferences; e-consulting via media such as SMS, email or telephone; and tele-monitoring via the use of medical devices and software applications for collecting and reviewing medical data remotely.

Because video consultations are a new way of delivering healthcare for general practices, the RACGP intends to review this Addendum 1 year from its initial publication so as to learn from the experience of general practitioners and other stakeholders in the field.

The terminology used in this Addendum is designed to enhance the clarity of the text. While general practice is a recognised medical specialty in Australia, for the purpose of clarity in this Addendum, a general practice specialist is referred to as a 'GP' and other medical specialists are referred to as 'specialist' or 'distant specialist'.

## Medicare Benefits Schedule Item numbers

In July 2011, the Australian Government Department of Health and Ageing (DoHA) implemented MBS rebates for video consultations with medical specialists in a distant location. These MBS rebates are available across the full range of medical specialties and are for patient-end clinical support provided by GPs or by practice nurses and registered Aboriginal health workers on behalf of a GP, as well as specialist-end services provided by a specialist with a Medicare provider number. The rebates and related one-off incentive payments acknowledge the additional complexity in providing patients with online access to specialists. The consultations for which MBS rebates apply are available to patients from remote, regional and outer metropolitan areas as well as patients of residential aged care facilities or Aboriginal medical services anywhere in Australia.

# *Preamble*

To support the implementation of the MBS Items, DoHA engaged the RACGP to develop and disseminate standards that would help GPs interpret safety and quality issues in the context of a video consultation between a patient and a specialist in a distant location.

## Choosing to offer video consultation services

Decisions about whether or not the practice will offer video consultation services should be made by the GPs in the general practice team and careful consideration should be given to issues such as:

• patient safety

• clinical needs of patients

• clinical effectiveness

• patient preference

• location of the practice

• location of telehealth facilities

• availability of Australian registered participating specialists

• access to appropriate training

• professional indemnity insurance as provided by a medical defence organisation, employer or commercial insurer.

Video consultations are an alternative option to face-to-face consultations. While in many situations a face-to-face consultation will be the preferred option, there are scenarios where a video consultation that is clinically justifiable will enable more convenient and accessible healthcare delivery without compromising patient safety.

## Critical factors

Clinicians with experience in video consultations commonly refer to a set of critical factors that include:

• patient safety

• a justifiable clinical rationale

• managing the unique risks of a dual-care consultation where there is a clinician at the patient-end of a video consultation as well as a specialist in a distant location

• excellent service coordination

• reliable and secure equipment fit for clinical purposes

• secure management of patient health information

• positive patient experiences

• clinical champions (persons responsible for leading telehealth care initiatives)

• remuneration for services provided.

In general, video consultations should be seen as an alternative option for consulting, and not a quick 'fix add-on' to existing services or a lesser alternative to a face-to-face consultation. In circumstances where it would be

# *Preamble*

appropriate and there are no alternatives, a video consultation will certainly be better than no consultation at all and there can be benefits in a single three-way interaction versus two, two-way interactions. Experienced clinicians report that where a video consultation is deemed safe and clinically appropriate and where it also meets a patient's preference for avoiding personal inconvenience and the cost of travel away from home, a video consultation is routinely experienced by patients as a positive experience they are willing to repeat.

The efficient coordination of patient bookings, clinician availability and properly functioning equipment is considered a top priority for safe, high quality healthcare delivered by video consultation.

General practices need to use video conference systems that are fit for clinical purposes and protect the privacy of the consultation as well as the security, confidentiality and privacy of patient health information.

## Dual-care consultations

Video consultations between a patient with clinical support provided by a GP (or another support clinician) and a specialist at a distant location, essentially constitute a dual-care consultation in which the clinicians at both ends have an inherent and concurrent duty of care.

Acknowledging the importance of duty of care and being absolutely clear about who is responsible for what particular follow up action is a unique risk that needs to be well managed. Practices are encouraged to seek advance agreement with participating specialists on key risk management protocols such as the clear allocation of responsibility for follow up action, to support the continuity of safe, high quality healthcare.

In general, it will be the specialist who will confirm the clinical appropriateness of a consultation by video conference and whether clinical support is required at the patient-end, taking into account the referral information provided by the GP and the preferences of the patient.

## What the evidence says

To date, there is limited evidence on the clinical effectiveness and risks of video consultations in the Australian primary healthcare setting. Nevertheless, the majority of published clinical trials involving video consultations conclude it was a suitable method of healthcare delivery for their purposes (see *Appendix A*).

## Data collection is important

As video consultations are a new way of delivering healthcare in the Australian primary healthcare setting, it is suggested that general practices track their experience with video consultations to inform quality improvement initiatives at a practice level and help build the evidence on video consultations. In time, an evidence base will be generated from formal research on the implementation of video consultations in the primary healthcare sector.

# *Preamble*

To assist general practices with a patient evaluation process, the RACGP has developed a simple post-video consultation patient evaluation tool which is available at www.racgp.org.au/telehealth.

The RACGP supports the development of a practice evaluation tool for practices that want to generate practice-level data on the effectiveness and risks of video consultations. This type of tool would enable practices to evaluate and improve the process and outcomes of consultations via video conference.

## Further information

More information is available from the RACGP website at www.racgp.org.au/telehealth and from the MBS Online website at www.mbsonline.gov.au/telehealth, especially the section called 'information for practitioners'.

Queries may be addressed to the RACGP Telehealth service centre on 1800 257 053 (9 am to 5 pm Monday to Friday) or via an enquiry form which is available at www.racgp.org.au/telehealth.

The independent development of technical guidelines for video consultations will be iterative as technology advances and the uptake of video consultations increases. Practices are therefore encouraged to seek up-to-date information and advice on technical requirements and opportunities via the RACGP website (www.racgp.org.au/telehealth).

## Feedback welcome

The RACGP intends to review this Addendum 1 year from its initial publication to learn from the experience of GPs and other stakeholders in the field. In the meantime, the RACGP National Standing Committee – Standards for General Practices welcomes general comments on the RACGP *Standards for general practices offering video consultations*.

Comments may be forwarded to standards@racgp.org.au or
Chair, National Standing Committee – Standards for General Practices
The Royal Australian College of General Practitioners
1 Palmerston Crescent
South Melbourne Victoria 3205.

► This symbol means a particular indicator is 'flagged' or mandatory; indicators which are not 'flagged' are discretionary.

*Section 1*
*Practice services*

# Standard 1.1

## Access to care

Our practice provides timely care and advice.

# Standard 1.2

## Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

# Standard 1.4

## Diagnosis and management of health problems

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

# Standard 1.5

## Continuity of care

Our practice provides continuity of care for its patients.

# Standard 1.6

## Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

# Standard 1.7

## Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

## Standard 1.1

*Access to care*
Our practice provides timely care and advice.

# Criterion 1.1.1

## Scheduling care in opening hours

Our practice has a flexible system that enables us to accommodate patients' clinical needs.

### Indicators

▶ A. Our practice can demonstrate that we have a flexible system for determining the order in which patients are seen, to accommodate patients' needs for urgent care, non urgent care, complex care, planned chronic disease management, preventive healthcare and longer consultations.

▶ B. Our practice can demonstrate how we identify, prioritise and respond to life threatening and urgent medical matters (triage).

### Services providing care outside normal opening hours

▶ C. Our service obtains feedback from practices for which we deputise, about the quality and timeliness of our care for their patients.

### Explanation

Key points

• Practice staff need to be able to quickly and accurately identify patients' needs for urgent care as well as non urgent, complex, planned chronic care and preventive healthcare consultations

• Administrative staff members of the practice team require appropriate 'triage' training

• Practices need a responsive system for seeing patients

• Practices need procedures for administrative and clinical staff outlining:

– identifying patients with urgent medical matters

– seeking urgent medical assistance when required

– managing patients who have urgent medical needs when the practice is operating at full capacity

– a system for documenting triage responses by administrative staff.

Flexible systems to suit patients and setting

The needs of patients vary widely, as do the settings of general practice, so practices need to have flexible systems that can accommodate urgent, non urgent, complex and planned chronic care, as well as the preventive health needs of patients during normal opening hours. Such systems may focus on determining the order in which patients are seen, rather than an appointment system, in settings such as some Aboriginal medical services and other 'walk in' services.

Practices do not have to have a formal appointment system to meet this criterion if there is adequate communication to patients on anticipated waiting times and if the practice prioritises patients according to the urgency of need.

There are times when patients need urgent access to primary medical care and practices need to have systems that accommodate this. For example, some practices have an appointment system which includes unbooked appointment times for patients with urgent medical needs. Patients also value the opportunity to see a general practitioner within a reasonable time where possible for non urgent and preventive health matters.

### Triage

Both administrative staff and members of the clinical team need to be able to describe the practice's policy and procedures for identifying patients with urgent medical matters and the procedures for seeking urgent medical assistance from a clinical staff member. The practice team also needs to be able to describe how the practice deals with patients who have urgent medical needs when the practice is operating at full capacity (eg. when it is fully booked).

When patients contact general practices by telephone, often the reason for contact is to make an appointment. It is necessary for administrative staff receiving incoming calls to assess the urgency of the need for care (ie. 'triage' patients). Staff should ask the caller 'Is the matter urgent or may I put you on hold?', so that patients with urgent needs are able to convey this information. As administrative staff do not usually have access to patient health records, the practice needs to have a method for appropriately communicating triage responses by administrative staff.

The practice's policy on triage should make a distinction between triage undertaken by members of the clinical team and triage undertaken by staff with non-clinical roles. Appropriate training should be provided to assist administrative staff and members of the clinical team such as practice nurses to identify patients in need of urgent care. Such training may be undertaken within the practice or by an external training provider.

### Length of consultations

The length of individual consultations will vary according to clinical need. Data from Bettering the Evaluation and Care of Health (BEACH 2008–2009) show average consultation times in Australian general practice are 14.6 minutes. Patients should be encouraged to book longer consultations if they feel more time with the GP will be required. Members of the practice team should be sensitive to the need for longer consultations when the need for a longer appointment could be anticipated (eg. when the patient is attending for multiple or complex problems, chronic disease management or procedures). Practices generally recognise that some of their patients always need longer appointments.

Key indicators for whether consultation times are long enough include factors such as the adequacy of patient health records. Assessment of this criterion needs to take into account the specific circumstances of the practice.

### Patients with special needs

The practice system needs to include consultations of appropriate length for patients with special or more complex needs. Longer consultations may be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if the patient's carer or a translator is present. Patients need to be encouraged to ask for a longer consultation if they think it is necessary. Staff need to have the skills and knowledge to assist in determining the most appropriate length and timing of consultations at the time of booking. Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that practices have systems that predict and endeavour to meet this need.

### Practice closures

Where a practice is planning to close, the practice should develop a process which minimises any disruption to care. It is suggested the practice give patients at least four weeks notice of the practice closure and assist patients (especially those with high needs) in locating an alternative general practice or general practitioner. The practice should ensure that patient records are made available to the patient or transferred to an alternative general practice or care provider before the closure of the practice. Alternatively, patients should be given contact details for requests to access their health records.

## Standards for general practices offering video consultations

### Choosing to offer video consultations

Decisions about whether or not the practice will offer video consultation services as an alternative to face-to-face consultations should be made by the GPs in the general practice team and careful consideration should be given to issues such as:

- patient safety
- clinical needs of patients
- clinical effectiveness
- patient preference
- location of the practice
- location of telehealth facilities
- availability of Australian registered participating specialists
- access to appropriate training
- professional indemnity insurance as provided by a medical defence organisation, employer or commercial insurer.

## Face-to-face versus video consultation

Face-to-face consultations offer important opportunities for medical practitioners to establish rapport with patients, conduct a physical examination, gather three-dimensional information such as texture and smell, initiate opportunistic interventions, and build the cohesiveness of multidisciplinary teams. In many situations face-to-face consultations will be the preferred option. On the other hand, video consultations can provide an alternative option for patients to access timely healthcare.

Experienced clinicians report that where a video consultation is deemed safe and clinically appropriate, and where it also meets a patient's preference for avoiding personal inconvenience and the cost of travel away from home, a video consultation is a positive experience patients are willing to repeat.

Video consultations may facilitate continuity of care through the direct interaction which occurs between a patient, a GP, and a distant specialist with important opportunities for excellence in team work, continuity of care and professional upskilling.

In circumstances where there are no alternatives, a video consultation will be better than no consultation at all.

Provisional decisions about clinical imperatives and the clinical appropriateness of a video consultation should be made by the GP in full consultation with the patient and the rationale for proposing a video consultation with a distant specialist should be documented in the patient's health record.

Where a physical examination by a specialist is regarded as a critical component of the diagnostic process, then a face-to-face consultation between the patient and the distant specialist would generally be preferred over a video consultation. Where a video consultation may be clinically indicated but it is unclear whether a physical examination could be conducted by a GP (or another support clinician) at the patient-end on behalf of a distant specialist, it is envisaged that decisions about the clinical appropriateness of a video consultation will be confirmed by the distant specialist in consultation with the patient and the referring GP.

## Providing clinical support at the patient-end

The practice should adopt a consistent approach to considering the need for clinical support at the patient-end of a video consultation and recommending who should provide that clinical support. The inherent duty of care should be emphasised.

Where there is a clinician present at the patient-end of a video consultation, clinicians with experience in video consultations suggest it can be beneficial to organise appointments as scheduled 'clinics' to improve the efficiency of bookings for patients, GPs and specialists. A 'clinic' system is also seen to enable and enhance the upskilling of GPs. For example, the practice may have a regular video consultation 'clinic' for patients with diabetes to attend consultations with an endocrinologist in a distant location.

## Standard 1.2

### *Information about the practice*

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

## Criterion 1.2.1

### Practice information

Our practice provides patients with adequate information about our practice to facilitate access to care.

### Indicators

▶ A.  Our practice information sheet is available to patients and is accurate and contains at a minimum:

- our practice address and telephone numbers

- our consulting hours and arrangements for care outside our practice's normal opening hours, including a contact telephone number

- our practice's billing principles

- our practice's communication policy, including receiving and returning telephone calls and electronic communication

- our practice's policy for the management of patient health information (or its principles and how full details can be obtained from the practice)

- the process for the follow up of results

- how to provide feedback or make a complaint to the practice including contact details of the local state or territory health complaints conciliation body.

▶ B.  Our practice team can demonstrate how we communicate essential information to patients who are unable to understand our practice information sheet.

▶ C.  If our practice has a website, the information is accurate and contains at a minimum the information included in our practice information sheet and meets the advertising requirements of the MBA Code of Conduct.

### Explanation

#### Key points

Providing written information about the practice is important as it informs patients about the range and cost of services provided by the practice, such as:

- what clinical services are available at the practice

- how to obtain medical care within and outside normal opening hours

- billing principles, such as bulk billing, accounts settlement, representative or approximate costs for treatment

- communication policies, including the use of electronic means (eg. SMS and email)

- patient health information management policy (eg. how to obtain a copy of the health information kept by the practice)

- the process for follow up of results (eg. who will contact whom and by when)

- how to provide feedback and complaints to the practice (eg. a contact number for the person responsible for dealing with feedback and complaints).

### Format of the information sheet

A photocopied, typed or electronically generated information sheet is acceptable. The information on the practice information sheet is important to all patients and the practice needs to find alternative ways to provide or discuss this information with patients who are unable to read or understand it. Pictorial representations or a simple language version of the information may be helpful.

Where a practice serves defined ethnic communities, it is appropriate to make written information available in the most common languages used by the practice population.

Font style and size can be an issue for people with vision limitations. Vision Australia has produced legibility guidelines which practices may find useful. The guidelines are available at www.visionaustralia.org.au/info.aspx?page=785.

### Providing feedback or making a complaint

Practices are encouraged to be open about the way patients can provide feedback or make a complaint. It may be useful to state that the practice is receptive to feedback and will always endeavour to resolve any complaints directly, but where a matter can not be resolved, the relevant health complaints commissioner can be contacted by the practice or by the patient for advice and possible mediation.

### Practice websites

Where a practice has a website, it needs to ensure the information is regularly updated to reflect changes in the practice. Information on the website needs to be accurate and contain, at a minimum, the information included in the practice information sheet.

### Advertising within practice information

Information provided by the practice (eg. practice information sheet, health promotion information or 'tailor made' health information magazines) may contain local advertising. The practice should include a disclaimer that the inclusion of advertisements is not an endorsement by the practice of these services or products.

All advertising needs to comply with the MBA Code of Conduct on advertising including:

- Making sure that any information you publish about your medical services is factual and verifiable

- Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients

- Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations

- Not offering inducements or using testimonials

- Not making unfair or inaccurate comparisons between your services and those of colleagues.

The MBA Code of Conduct is available at http://goodmedicalpractice.org.au/.

## Standards for general practices offering video consultations

### Update your practice information sheet

For general practices offering video consultation services with specialists in distant locations, it is recommended the practice information sheet indicates:

- the practice offers video consultations with specialists provided the doctors involved consider it safe and appropriate
- when video consultation sessions are usually offered
- the location of the video consultation sessions and information about issues such as parking and wheelchair access.

### Patient feedback is important

It is recommended the practice information sheet also indicates how patients can provide feedback about video consultation services. It is suggested general practices generate patient-level data that can be used to improve video consultation systems quickly as issues emerge during the implementation phase.

### Resource

To assist general practices with a patient evaluation process, the RACGP has developed a simple post-video consultation patient evaluation tool which is available at www.racgp.org.au/telehealth. This simple evaluation tool is specific to video consultations.

## Standard 1.2

### Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

# Criterion 1.2.2

## Informed patient decisions

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

### Indicators

▶ A.   Our clinical team can demonstrate how we provide information to our patients about the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments.

▶ B.   Our clinical team can describe how we use leaflets, brochures or written or electronic information to support our explanation of the diagnosis and management of conditions when appropriate.

▶ C.   Our clinical team can describe how we provide information (printed or otherwise) about medicines and medicine safety to patients.

### Explanation

Key points

• Patients have the right to make informed decisions about their health

• Practices need to provide information in ways that are easy for individual patients to understand to support informed decision making

• This criterion cross references to Criterion 1.7.1 Patient health records, Criterion 1.2.4 Costs associated with care initiated by the practice and Criterion 4.2.1 Confidentiality and privacy of health information.

Appropriate and sufficient information

It is important that patients have sufficient information to make appropriate decisions about their own healthcare. Information about the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or treatments needs to be tailored to the individual patient's needs.

This information needs to be delivered in appropriate language and format – avoid the use of jargon or complicated terms – and where necessary include clear diagrams and written information. Consideration also needs to be given to the patient's physical, visual and/or cognitive capacities, which may impact on their ability to understand the information, make decisions or provide consent.

Consideration needs to be given to the way information is communicated in relation to potentially sensitive investigations or tests (eg. sexually transmissible infections, blood borne viruses, fetal abnormality screening and pregnancy tests).

If working with patients from a different cultural background, special care is needed to ensure there is a shared understanding between the GP and the patient about the information provided.

In situations where patients are dependent on a third party for their ongoing care it is important to ensure all appropriate information is also provided to carers.

Although it is not necessary for the practice to know the exact costs of referred services, patients need to be advised of the potential for out-of-pocket costs before a referral is made. Where patients require exact information about the costs of referred services they can be invited to make their own enquiries. If the patient indicates that such costs pose a barrier to the suggested referral, alternatives may need to be discussed (eg. referral to public services).

Informed consent also applies to any research being undertaken by a member of the practice team, in accordance with the NHMRC 'National statement on ethical conduct in human research' (www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf).

### Patient-doctor collaboration

The Australian Commission on Safety and Quality in Health Care encourages patients to actively discuss with their healthcare provider the purpose, importance, benefits and risks associated with their care. The publication '10 tips for safer healthcare' is available at www.health.gov.au/internet/safety/publishing.nsf/content/10-tips and provides further detail. Practices may find it useful to refer patients to this information to help create an understanding of shared responsibility between the patient and the practice.

If a GP is aware that a patient has decided not to follow the advice of the GP after receiving sufficient information to make an informed decision about their care, their refusal and their awareness of its implications, as discussed with the GP, should be documented in the patient health record (see Criterion 2.1.1 Respectful and culturally appropriate care).

### Medicines

The provision of information about medicines and medicine safety including consumer medicines information (CMI) may assist patients to make informed decisions about their medicines. Consumer medicines information provides an online version of leaflets produced by pharmaceutical companies and is available to the general public at www.nps.org.au/consumers.

GPs could offer to discuss any issues about medicines that could be confusing to patients and could also usefully suggest that patients obtain information about their medicines from their pharmacist.

## Standards for general practices offering video consultations

### Patient information about video consultations

Where a video consultation with a specialist in a distant location is initially being proposed by a GP, the practice is encouraged to give the patient information about the purpose, importance, benefits, risks and possible costs associated with the proposed video consultation to enable the patient to make properly informed decisions about their health. Such information would generally include:

- the rationale for a video consultation (ie. purpose and potential benefits)

- whether a support clinician is likely to be present at the patient-end of the video consultation and the clinical support role they may perform on behalf of the distant specialist

- confirmation that the patient may have their own support person present

- confirmation that other parties will only be present if the patient agrees to this in advance (ie. parties other than their own support person, the GP or another support clinician at the patient-end and distant specialist)

- advice that the patient will be asked to provide their name, address and date of birth at the commencement of a video consultation as a means of confirming their identity and ensuring that any patient-end clinician and the distant specialist are both consulting with the right patient for the right reason and are using the right patient health record

- confirmation that the patient can ask any support clinician to step out of the video consultation at any time if they wish to have a private discussion with the specialist, provided the support clinician deems it safe for this to occur

- confirmation that the practice makes every effort to protect patient privacy by using secure video conference systems and by not recording video consultations unless exceptional clinical circumstances apply, and the patient gives explicit prior consent and repeats this consent on camera

- an explanation that exceptional clinical circumstances for making a recording during a video consultation may include still images (eg. a wound or skin lesion) or moving images (eg. a tremor, gait abnormality, unusual movement or range of movement) where such images are deemed to have clinical value

- advice that patients are not authorised to make their own recording of a video consultation

- information about how video recordings (including discrete still images) would be managed, stored and accessed if they are made

- acknowledgment that in the unlikely event that the patient felt unable to continue with a video consultation they could end the consultation, and that consultation fees may still apply

- a patient information brochure containing standard information about video consultations.

### Resources

A template patient information brochure on video consultations and the RACGP *Implementation guidelines for video consultations in general practice* are available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 1.2

### Information about the practice

Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

# Criterion 1.2.4

## Costs associated with care initiated by the practice

Our practice informs patients about the potential for out-of-pocket expenses for health care provided within our practice and for referred services.

### Explanation

Key points
- Cost can be a barrier to care
- Patients need to know in advance about the potential for out-of-pocket expenses
- Patients need to know in advance about consultations that do not attract a government subsidy
- This criterion cross references to Criterion 1.2.2 Informed patient decisions.

### Costs and informed decision making

Patients and advocacy groups have indicated to the RACGP that the cost of treatment or investigations can pose a barrier to care.

Information provided in advance about the costs of healthcare is an important component of informed decision making by patients. It is important for patients to know in advance whether the healthcare services they may require from the practice will attract costs over and above consultation fees so they can make an informed decision about their own healthcare.

Clear communication about unexpected developments can assist the patient to understand the need for additional costs. While it is not practical to stop in the middle of a procedure and inform patients that it will cost more than originally thought, effort to inform patients of the possible cost of additional treatments or procedures is needed before proceeding.

Special care should be taken to advise patients of the costs of consultations that do not attract a government subsidy (eg. cost of telephone and electronic consultations and diving or commercial driving licence medical examinations).

### Components of health costs

Costs can include:

- brief, standard and longer consultations
- additional costs for late or missed appointments
- telephone and electronic communication
- nursing consultations
- home/other visits or care outside the practice's normal opening hours
- medicines (where the medicine is not subsidised or where the brand name prescribed is more expensive than a generic version).

### Costs of other services

The practice should advise patients of the potential for out-of-pocket costs related to services such as pathology, imaging, specialist or allied health. It is not necessary for the practice to provide more detailed information.

If the patient indicates that such costs pose a barrier to the suggested referral, alternatives may need to be discussed (eg. referral to public services).

## Standards for general practices offering video consultations

Where a video consultation with a specialist in a distant location is agreed, and where there will be a clinician present at the patient-end of the video consultation, the practice should inform patients that two professional fees will normally apply and that out-of-pocket expenses may apply for:

- a professional fee for the GP (or another support clinician) providing clinical support at the patient-end of the video consultation where the fee will be billed by the general practice

- a professional fee for the specialist where the fee will be billed by the specialist.

Where applicable, the practice should inform patients about any additional fee that applies (eg. an offsite facility fee).

Where a separate consultation on the same day as a video consultation with a specialist is clinically indicated, the practice should inform patients that the GP may charge a separate professional fee for that consultation. This scenario may be particularly relevant where patients have made a significant effort to attend the general practice on any given day (eg. patients who have travelled a significant distance or patients with a disability). For example, it could be clinically justifiable for a patient to have a separate consultation with the GP on the same day as a video consultation with a specialist to consider matters not pertinent to the video consultation. On the other hand, a separate consultation may not be justified where the patient receives, for example, wound care under the patient-end clinical support component of a video consultation with a specialist.

Practices should ensure they comply with the requirements of the Medicare Benefits Schedule for Medicare rebatable services.

## Standard 1.4

### *Diagnosis and management of health problems*

In consultation with the patient, our practice provides care that is relevant and in broad agreement with best available evidence.

## Criterion 1.4.1

### Consistent evidence based practice

Our practice has a consistent approach for the diagnosis and management of conditions affecting patients in accordance with best available evidence.

### Indicators

▶ A.  Our clinical team uses current clinical guidelines relevant to general practice to assist in the diagnosis and management of our patients.

▶ B.  Our clinical team can describe how we ensure consistency of diagnosis and management of our patients.

▶ C.  Our clinical team can demonstrate how we communicate about clinical issues and support systems within our practice.

▶ D.  Our clinical team can explain how we access and use specific clinical guidelines for patients who identify as Aboriginal or Torres Strait Islander.

### Explanation

Key points
- Consistency and quality of care can be assisted by the use of clinical guidelines
- Consistency and quality of care can be assisted by communication between team members.

Best available evidence
Contemporary practice is based on best available evidence in the context of current Australian general practice. This criterion recognises that, in the absence of well conducted clinical trials or other higher order evidence, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at that time.

Clinical practice guidelines provide important recommendations for clinical care and should be accessible at the point of care. Practices need to check that clinical practice guidelines are current.

Resources that support evidence based practice
General practitioners and clinical staff find it valuable, both for the treatment of patients and their own professional development, to have access to resources about a range of clinical issues. These may include paper based resources (eg. text books and peer reviewed journals) and electronic resources (eg. access via the internet or CD-ROM). This criterion does not necessarily require access to the most recent editions of texts, materials or publications, nor does it require those resources to be in electronic format. However, resources need to contain information that is consistent with current practice and not recommended management that is no longer applicable.

Recommendations on clinical care are available from sources such as:

- Australian Cancer Network clinical practice guidelines at www.cancer.org.au/healthprofessionals/clinicalguidelines.htm

- Australian Commission on Safety and Quality in Health Care *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol* at www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/former-pubs-archive-correct
- Australian Medicines Handbook at www.amh.net.au
- Australian Prescriber at www.australianprescriber.com
- Central Australian Rural Practitioners Association (CARPA) treatment and reference manuals at www.carpa.org.au
- Cochrane database at www.3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME
- Diabetes Australia at www.diabetesaustralia.com.au
- National Aboriginal Community Controlled Health Organisation (NACCHO) at www.naccho.org.au/resources/guidelines.html
- National Asthma Council at www.nationalasthma.org.au
- National Health and Medical Research Council at www.nhmrc.gov.au/guidelines/index.htm
- National Heart Foundation at www.heartfoundation.com.au
- National Prescribing Service at www.nps.org.au
- RACGP *Guidelines for preventive activities in general practice* (the 'red book') at www.racgp.org.au/guidelines/redbook
- RACGP *Medical care of older persons in residential aged care facilities* ('silver book') at www.racgp.org.au/guidelines/silverbook
- RACGP *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (the 'green book') at www.racgp.org.au/greenbook
- RACGP Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practice at www.racgp.org.au/guidelines/snap
- Rational Assessment of Drugs and Research (RADAR) at www.nps.org.au/health_professionals/publications/nps_radar
- Royal Children's Hospital Melbourne clinical guidelines at www.rch.org.au/clinicalguide
- Therapeutic Guidelines at www.tg.com.au/home/index.html.

### Patient identification

It is important to ensure the correct patient gets the correct procedure. A useful resource for GPs, especially those undertaking procedural work and minor surgery, is the *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol* from the Australian Commission on Safety and Quality in Health Care, or an equivalent protocol that incorporates these five steps. This is a nationally agreed protocol for public hospitals; compliance with the protocol reduces the risk of error for GPs who perform procedures in public or private hospitals, or in their own practices.

### Health inequalities

The Australian Institute of Health and Welfare (AIHW) report *Australia's Health 2010* (available at www.aihw.gov.au/publications/aus/ah10/ah10.pdf) outlines some significant differences in key indicators of general health and wellbeing. This information is important because it highlights the need for primary healthcare interventions tailored to specific groups within the Australian community.

The AIHW report explains that while the health of the Australian population improved markedly during the 20th century, health gains have not been equally shared across all sections of the population and today Australia is characterised by large morbidity and mortality inequalities between population subgroups. This includes homeless youth, children of single parent families, people with developmental disabilities, Aboriginal and Torres Strait Islander people, refugees and those from culturally and linguistically diverse populations.

For example, the AIHW identifies that Aboriginal and Torres Strait Islander people have a life expectancy that is significantly less than that of other Australian men and women.

The RACGP encourages and supports practices to accommodate the specific health needs of individuals who experience disadvantage. In particular, the RACGP has worked with the National Aboriginal Community Controlled Health Organisation to produce guidelines for the care of Aboriginal or Torres Strait Islander people (available at www.racgp.org.au/aboriginalhealth/nationalguide).

### A consistent approach is vital

Consistency in the approach to diagnosis and management of care across the various people who are involved in the clinical care of an individual patient (ie. the people involved do not work at 'cross purposes') is an important aspect of continuity of care. Patients value consistency in the quality of treatment they receive from a practice and expect that treatment and advice given by different GPs within the practice will not be in conflict. If the practice employs nurses or allied health professionals, patients expect that advice provided by these professionals will be consistent with the diagnosis and management approach of the treating GP. Providing consistency in diagnosis and management of health issues across a team of GPs, or a multidisciplinary general practice team, assists in ensuring that the practice provides continuity of care for patients (see Criterion 1.5.1 Continuity of comprehensive care and the therapeutic relationship).

This consistency is just as important in small or solo practices where the receptionist needs to have an approach (eg. to providing information) that is consistent with that of the GP, as it is in large practices with numerous clinical staff.

In addition to ensuring that clinical care is consistent with the best available evidence, it is important that there is continuity in the clinical care provided to the patient. Management continuity involves having a consistent and coherent approach to the management of a health condition that is responsive to the patient's changing needs and assists to ensure that the people providing services are not working at 'cross purposes'. An example is ensuring that general practice nurses and GPs treating a patient with diabetes provide consistent advice to the patient about their treatment and care. Management continuity is particularly important for people with chronic or complex diseases. For example, it may involve having a plan for the patient's care that is shared by the people providing the care.

### Communication within the clinical team

Good communication between members of the clinical team is important for ensuring a consistent approach to clinical care. Face-to-face meetings of the clinical team are preferable but communication books and electronic notice boards can be useful to consider clinical issues.

## Standards for general practices offering video consultations

### Building the evidence on video consultations

To date, there is limited evidence on the effectiveness and risks of video consultations in the Australian primary healthcare setting. General practices offering video consultations with specialists in distant locations are therefore encouraged to adopt a considered and consistent approach to their rationale and protocols for such consultations.

It is suggested that general practices track their experience with video consultations to inform quality improvement initiatives at a practice level and help build the evidence on video consultations. In time, an evidence base will be generated from formal research on the implementation of video consultations in the primary healthcare sector.

### Resources that support evidence based practice

The practice should continue its usual utilisation of clinical guidelines.

To assist general practices with a patient evaluation process, the RACGP has developed a simple post-video consultation patient evaluation tool which is available at www.racgp.org.au/telehealth. This evaluation tool is specific to video consultations and is designed to generate patient-level data that practices can use to improve their video consultation systems quickly as issues emerge during the implementation phase.

The RACGP supports the development of a practice evaluation tool for practices that want to generate practice-level data on the effectiveness and risks of video consultations. This kind of tool would enable practices to evaluate and improve the process and outcomes of consultations via video conference.

## Standard 1.5

### Continuity of care

Our practice provides continuity of care for its patients.

# Criterion 1.5.2

## Clinical handover

Our practice has an effective clinical handover system that ensures safe and continuing healthcare delivery for patients.

### Indicator

▶ A.   Our practice team can demonstrate how we ensure an accurate and timely handover of patient care.

### Explanation

Key points
- Clinical handover of patient care occurs frequently in general practice both within the practice to other members of the clinical team and to external care providers
- Clinical handover communications can be face-to-face, written, via telephone and also by electronic means
- Failure or inadequate transfer of care is a major risk to patient safety and a common cause of serious adverse patient outcomes. Inadequate handover can also lead to delayed treatment, delayed follow up of significant test results, unnecessary repeat of tests, medication errors and increased risk of medicolegal action
- Practices and services that provide care outside normal opening hours should have standard and documented processes for timely clinical handover
- Practices should encourage the reporting of near misses and breakdowns in clinical handover procedures and make improvements to minimise the risk of recurrence.

Defining clinical handover

Clinical handover has been defined by the Australian Medical Association as 'the transfer of professional responsibility and accountability for some or all aspects of a patient's or a group of patients' care to another person or professional group on a temporary or permanent basis'.

Clinical handover needs to occur whenever there is an interface of care by different providers. Examples of clinical handover include:

- a GP covering for a fellow GP who is on leave or is unexpectedly absent
- a GP covering for a part time colleague
- a GP handing over care to another health professional such as a practice nurse, physiotherapist, podiatrist or psychologist
- a GP referring a patient to a service outside the practice
- a shared care arrangement (eg. team care of a patient with mental health problems).

Whenever clinical handovers occur, whether external or internal, practices should ensure patients are aware of who will take over their care in the absence of their regular doctor. Patients need to be involved in the decision, particularly when they consult with more than one GP in the practice or a specialist or other care provider.

### System for clinical handover

Practices are encouraged to have a documented policy on clinical handover to ensure standard processes are followed. When appropriate, it is prudent to record the clinical handover in the consultation notes and document that the patient has shared in decision making and has been informed (see Criterion 1.6.2 Referral documents).

### Clinical handover within the practice

Clinical handover between GPs has become perhaps more common in recent years, with so many GPs now working on a sessional basis at a practice. Handover is important when a GP or other clinical staff member is away because of annual leave or illness. Practices should have a defined method to cover the handover of care of patients who have been under the care of the absent clinical team member. Many practices have a 'buddy' system whereby a 'buddy' follows up results and correspondence or continues the care of patients on behalf of an absent colleague. If a practitioner has a 'buddy' system to hand over care, this should be standardised and previously agreed, rather than ad hoc. Such arrangements do not necessarily have to be documented in the consultation notes, although the identity of the treating GP does need to be recorded.

Adequate clinical records, including a health summary, will enable another doctor to safely and effectively continue the routine care of patients. Practitioners should routinely read the patient's preceding clinical records for the past few consultations.

### Clinical handover outside the practice

Clinical handover of a patient's care outside the practice occurs in many ways. It includes but is not limited to: referral for an investigation, referral to an ancillary healthcare provider, referral to a specialist and referral to a hospital, as an outpatient or as an in patient. Criterion 1.6.2 Referral documents states that referral letters include sufficient information to facilitate optimal patient care including details of 'the purpose of the referral'. As an example, clarifying, rather than assuming, who will manage the responsibility for follow up of investigations when referring a woman with a breast lump to a breast physician or surgeon.

### When shared care ceases

Where a clinical handover involves complex or high risk patient care, such as suicidal patients, or patients on complex medication regimens, it is important for a GP to request that they be notified if the care of the patient ceases. Equally, if the GP stops seeing a patient they are treating on a handover basis, or the patient ceases to attend for treatment, it is important for the GP to notify others in the treating team in the interests of patient safety. This issue has been the subject of several coroners' recommendations.

### Medical deputising services

Many practices hand over care of all their patients to a medical deputising service or other provider outside the normal opening hours of the practice. It is prudent to notify the deputising care provider of patients that you anticipate may need care (eg. a patient with a terminal illness). Deputising services need to have a defined means of timely contact with a GP from the practice when they are deputising, should they need to access more detailed health information about a patient. Deputising services are responsible for handing the care of a patient back to the patient's regular medical practitioner in a timely and appropriate manner.

### Clinical handover to an emergency department

If a GP calls an ambulance from the practice to attend a patient's home, or if the GP is aware that an ambulance has been called to a patient's home to take the patient to an emergency department, the handover to the ambulance service should be face-to-face where practical or by telephone. When an ambulance service is not involved, the practice should ensure that sufficient information is provided to the emergency department about the clinical condition of the inbound patient, to facilitate prompt and appropriate care.

### Handover of tests and results

Pathology services sometimes need to contact a practice doctor after the practice is closed concerning a serious result (eg. an unexpected result suggesting a patient has acute leukaemia or a raised INR).

General practices need to have arrangements in place to allow abnormal and life threatening results identified by pathology outside normal opening hours to be conveyed to a medical practitioner in a timely way, so the medical practitioner can make an informed and appropriate medical decision that is acted on promptly (see Criterion 1.1.2 Telephone and electronic communications).

There are occasions when the need for a handover process is more critical, such as a patient having a test that is anticipated to be abnormal and may need to be followed up when the referring GP is not on duty; or the review of a child with undifferentiated abdominal pain later in the day to ensure he/she does not have a surgical condition such as acute appendicitis. While most practices do this well, these are occasions of greater risk of harm when failure of adequate handover occurs (see Criterion 1.5.3 System for follow up of tests and results).

### Transfer of patient health information

Where the practice produces a summary for transfer to another practice, the practice should keep a copy of the summary in the patient's health record. It is recommended that only a copy of the patient health information be transferred and that the practice retain the original health information.

### Errors in clinical handover

When errors in clinical handover occur, every member of the practice team is encouraged to report them using de-identified data, so the event can be analysed and processes introduced to reduce the risk of a recurrence and harm occurring to other patients (see Criterion 3.1.2 Clinical risk management systems). It is important that the practice nurture a culture of just and open communication to support the resolution of errors in clinical handover.

### Useful resources

- Australian Commission on Safety and Quality in Health Care OSSIE guide to clinical handover (electronic format only) is available at www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/con-clinical-ossie.

- Wong MC, Yee KC, Turner P. (2008). Clinical handover literature review, eHealth Services Research Group, University of Tasmania, is available at: *www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgramÅJ05.*

- Australian Medical Association (2006). Safe handover: Safe patients. Guidance on clinical handover for clinicians and managers is available at www.ama.com.au/web.nsf/doc/WEEN-6XFDKN.

## Standards for general practices offering video consultations

### Dual-care consultations

Video consultations between a patient with clinical support provided by a GP (or another support clinician) and a specialist in a distant location, provide a special example of a clinician-to-clinician interface that constitutes a dual-care consultation in which both clinicians present have an inherent and concurrent duty of care.

As with any clinician-to-clinician interface, risks associated with the effective transfer of care within a dual-care consultation need to be carefully identified and managed to ensure the continuity of safe, high quality healthcare.

### Managing risk

The practice's usual clinical handover system should be expanded to include protocols that address the unique risks of dual-care video consultations. General practices are encouraged to reach written prior agreement with participating specialists on relevant key risk management protocols.

Where a GP delegates another clinician to provide clinical support at the patient-end of a video consultation with a distant specialist, the GP should nominate a colleague with the requisite knowledge, skills and experience to act on their behalf. GPs need to be aware that the choice of support clinician may influence decisions about the clinical appropriateness of a video consultation.

The practice's risk management protocols to cover clinical handovers within a video consultation system may include:

- clinical handovers between the patient's usual GP and another support clinician, who has been asked to provide clinical support on behalf of the GP, where such handovers would usually occur both before and after the video consultation

- a professional obligation for the GP or another support clinician to decline to provide clinical support requested by a distant specialist if such support is deemed to lie outside the scope of practice of the GP or the other support clinician

- a professional obligation for a GP or other support clinician to evaluate information collected by a third party which is subsequently used in treatment

- protocols for appropriate documentation (see also Criterion 1.6.1 Engaging with other services and Criterion 1.7.3 Consultation notes)

- communication protocols for dual-care consultations (see also Criterion 1.6.1 Engaging with other services).

## Standard 1.6

*Coordination of care*

Our practice engages with a range of relevant health and community services to improve patient care.

# Criterion 1.6.1

## Engaging with other services

Our practice engages with a range of health, community and disability services to plan and facilitate optimal patient care.

### Indicators

▶ A.  Our practice team can demonstrate how we plan and coordinate comprehensive care by our interaction with other services such as:
- medical services including diagnostic services, hospitals and specialist consultant services
- primary healthcare nurses
- allied health services
- pharmacists
- disability and community services
- health promotion and public health services and programs.

### Services providing care outside normal opening hours

▶ B.  Our service seeks feedback about the quality and responsiveness of our service from the practices whose patients we see.

### Explanation

Key point
- Engaging with other services is an important feature of high quality healthcare.

#### Engaging with other services for optimal patient care

Engaging other medical services (eg. diagnostic services; hospitals and consultants; allied health; social, disability and community services) can assist the practice to provide optimal care to patients whose health needs require integration with other services.

Coordination of care for individuals, families and communities is part of the accepted definition of a GP. Where relevant, practices are encouraged to coordinate patient care across the general practice setting with other health services including allied health and pharmacy as well as social, disability, indigenous health and community services. The practice needs to have readily accessible written or electronic information about local health, disability, community and mental health services and how to engage with them to plan and facilitate patient care.

It is important for practices to identify relevant services within the local area that can enhance patient care, to develop registers of such services and to build good working relationships with these service providers to facilitate good collaborative care. These registers will be particularly useful for new members of the practice team.

Practices need to be aware of different referral arrangements for public and private providers.

### Services providing care outside normal opening hours

Services that provide care outside normal opening hours may, where clinically appropriate, coordinate referrals through the patient's usual GP/general practice.

# Standards for general practices offering video consultations

## Establishing a practice directory of participating specialists

To maintain the continuity of safe and high quality healthcare, general practices are encouraged to keep working with specialists who are already known to the practice or who are already involved in a patient's care.

Where a general practice decides to refer patients to specialists who have video conference facilities but are not already known to clinicians or patients of the practice, the practice should confirm that such specialists are listed on the relevant Australian register of medical practitioners.

## Reaching prior agreement on risk management protocols

As an important part of establishing a practice directory of participating specialists, it is recommended that key risk management protocols for video consultations be agreed in advance in writing.

For example, it would be prudent for general practices to obtain written prior agreement that:

- the interoperability of patient-end/specialist video conference equipment will be tested and confirmed in advance

- a designated member of the general practice team will coordinate bookings with a comparable member of the specialist's team

- GPs will be responsible for the practice's usual referral letters to specialists and specialists will be expected to provide timely follow up letters back to GPs to complete the clinical handover cycle

- for dual-care consultations, separate consultation notes will be written by the GP (or other support clinician) and the specialist

- for dual-care consultations, specialists will be expected to provide a verbal summary at the conclusion of a video consultation to confirm the diagnosis (where possible), including agreed diagnosis terminology and ongoing management which may include diagnostic investigations, procedures and/ or medications; specialists will be expected to take responsibility for making it explicitly clear which clinician will be responsible for specified follow up action; all clinicians will usually summarise the follow up action for which they are responsible as the final step in the video consultation

- specialists will be expected to provide patients with their standard information about clinical conditions, diagnostic investigations, procedures and medications or indicate how patients can access the information themselves

- the only parties present at the video consultation will be the patient, any support person nominated by the patient, the GP (or another support clinician) providing clinical support and the distant specialist, unless the patient has given explicit prior consent to the presence of other parties whether present on or off camera or at a separate location such as a teaching facility

- video consultations will commence with each party formally introducing themselves to confirm their identity; the support clinician at the patient-end will assume responsibility for asking the patient to provide their name, address and date of birth as a means of confirming the patient's identity; the support clinician at the patient-end will indicate the reason for the consultation

- in the unlikely event that the patient felt unable to continue with a video consultation they could end the consultation, and that consultation fees may still apply

- patients can ask any support clinician to step out of the video consultation at any time if they wish to have a private discussion with the specialist, provided the support clinician deems it safe for this to occur

- out of respect for the patient, the consultation with the patient should be continuous, but where the GP and distant specialist wish to discuss sensitive issues without the patient being present, this could be done at the beginning or end of the consultation

- the general practice will provide patients with general information about the video consultation process

- the video consultation will not be recorded at the patient-end unless exceptional clinical circumstances apply and the patient gives explicit prior consent which is verified on camera.

### Professional indemnity

The general practice should confirm that GPs, practice nurses and registered Aboriginal health workers have suitable professional indemnity for video consultations (whether provided by a medical defence organisation, employer or commercial insurer) and whether any exclusions such as initial consultations may apply.

### Good coordination is the key

The coordination of patient bookings, clinicians availability and properly functioning equipment is considered by experienced clinicians to be a critical factor for safe and clinically effective video consultations.

It is recommended that practices consider a range of practical factors including:

- appointing a designated member of the general practice team with primary responsibility for coordinating patient bookings and clinician schedules

- advance testing of the interoperability of patient-end/distant specialist video conference equipment

- a patient information brochure providing general information about video consultations (see also Criterion 1.2.2 Informed patient decisions)

- a practice booking checklist (designed to accompany a GP's letter of referral) confirming the arrangements for video consultations (see also Criterion 1.6.2 Referral documents)

- a video consultation etiquette agreed by participating specialists

- the prompt notification of cancelled consultations

- appropriate training for relevant members of the general practice team (see also Criterion 3.2.1 Qualifications of general practitioners, Criterion 3.2.2 Qualifications of clinical staff other than medical practitioners and Criterion 3.2.3 Training of administrative staff)

- advice outlined in the RACGP *Implementation guidelines for video consultations in general practice*

- patient eligibility criteria for Medicare rebates for video consultations.

## Resources

Practices will find useful resources on the RACGP website at www.racgp.org.au/telehealth, such as:

- a template for patient information brochures

- a template for practice video consultation booking checklists

- RACGP *Implementation guidelines for video consultations in general practice*

- a factsheet on video consultation etiquette.

Useful information is also available at MBS Online (www.mbsonline.gov.au/telehealth).

## Standard 1.6

### Coordination of care

Our practice engages with a range of relevant health and community services to improve patient care.

## Criterion 1.6.2

### Referral documents

Our referral documents to other healthcare providers contain sufficient information to facilitate optimal patient care.

### Indicator

▶ A.  Our practice can demonstrate that referral letters are legible, contain at least three approved patient identifiers, state the purpose of the referral and where appropriate:

- are on appropriate practice stationery
- include relevant history, examination findings and current management
- include a list of known allergies, adverse drug reactions and current medicines
- the doctor making the referral is appropriately identified
- the healthcare setting from which the referral has been made is identified
- the healthcare setting to which the referral is being made is identified
- if known, the healthcare provider to whom the referral is being made is identified
- if the referral is transmitted electronically then it is done in a secure manner
- a copy of referral documents is retained in the patient health record.

### Explanation

Key points
- Practices need to ensure enough information is provided on referrals to ensure that:
  - the correct patient is referred
  - the person to whom the patient is referred receives sufficient relevant information to manage the patient
  - patient confidentiality is preserved
  - 'known allergy' means a hypersensitivity reaction to a medicine or other substance that is made known to a GP
  - 'adverse drug reaction' means harm that results from a medicine
  - this criterion cross references to Criterion 3.1.4 Patient identification.

Patient identification
The correct identification of patients is crucial in referring patients to ensure the right patient receives the right treatment. This issue is covered in more detail in Criterion 3.1.4 Patient identification.

Approved patient identifiers include:

• name

• address

• date of birth

• gender

• patient record number where it exists.

### Sufficient information

Referral documents are a key tool in integrating the care of patients with external healthcare providers and therefore need to be legible (preferably typed) and contain sufficient information to allow the other healthcare provider to provide care to the patient, without disclosing sensitive patient health information that is not relevant to the referral (eg. inclusion of sensitive material such as a previous termination of pregnancy or STI would be unlikely to be of clinical relevance to a local physiotherapist, but would be important in an obstetric or gynaecological referral). Most of the information needed for a referral may be found in the patient's health summary; many practices routinely incorporate a copy of the patient health summary into a referral letter or attach the summary as a separate document.

### Disclosure of patient information

Patients need to be aware that their patient health information is being disclosed in these referral documents. Practices may consider whether patients should be given the opportunity to read the content of the referral letter before it is forwarded to another care provider.

### Referrals sent electronically

Unless the patient has provided informed consent to do otherwise, referrals forwarded by email should be encrypted and the practice must comply with standards for the secure transmission of health information to avoid a breach of patient confidentiality (see Criterion 4.2.2 Information security).

### Unique patient identifiers

The National E-Health Transition Authority is developing a system of unique patient identifiers for patients, as well as individual healthcare providers and organisations. Unique patient identifiers will support the electronic transfer of information and where available should be used to complement the three required patient identifiers. These identifiers will facilitate the accurate and secure transfer of patient health information between the different areas that provide care to an individual patient.

### Telephone referrals

In the case of an emergency or other unusual circumstance, a telephone referral may be appropriate. A telephone referral needs to be documented in the patient's health record.

## Keep copies of referrals

For both medicolegal and clinical reasons, practices need to keep copies of important (non routine) referral letters (ie. new referrals or those for serious conditions) in the patient's health record. While the significance of individual letters is at the discretion of the GP, practices where no referral letters have been retained would not meet this criterion.

## Practice software

The RACGP is aware that due to the limitations of some software which groups allergies and adverse drug reactions together, some practices may be unable to keep separate lists of known allergies and adverse drug reactions for a patient.

### Services providing care outside normal opening hours

Services that provide care outside normal opening hours need to forward a copy of referral letters to the patient's regular GP/general practice.

### Standards for general practices offering video consultations

#### Additional information for referral letters

General practices offering video consultation services should follow their standard protocols for referral letters to specialists and include additional key information such as:

- the rationale for a proposed video consultation

- any extra clinical information that may assist a distant specialist to confirm whether a video consultation would be safe and clinically appropriate (eg. still images of a wound or skin lesion)

- the proposed clinical support person if patient-end clinical support is indicated.

In addition to the referral letter, practices are encouraged to send specialists a separate video consultation booking checklist covering standard information about the practical aspects of the video consultation such as:

- patient information including special requirements and cultural considerations

- clinician details

- consultation details

- consent for third party presence

- contact details for the practice including the name and contact details of the practice's video consultation coordinator

- practice policy on video recording

- specialist requirements (including medical equipment).

#### Resources

A template video consultation booking checklist is available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 1.7

### Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

# Criterion 1.7.1

### Patient health records

For each patient we have an individual patient health record containing all the health information held by our practice about that patient

### Indicators

▶ A. There is evidence that each patient has a legible individual patient health record containing all health information held by our practice about that patient.

▶ B. Where our practice has an active hybrid medical record system, for each consultation/interaction, our practice can demonstrate that there is a record made in each system indicating where the clinical notes are recorded.

▶ C. Our active patient health records include patient identification, contact and demographic information (where appropriate) including:

  • the patient's full name

  • date of birth

  • gender

  • contact details.

▶ D. Our practice can demonstrate that we routinely record the person the patient wishes to be contacted in an emergency.

▶ E. Our practice can demonstrate that we routinely record Aboriginal and Torres Strait Islander status in our active patient health records.

  F. Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.

### Explanation

Key points
• Practices need to ensure that where a patient's information is held in different records it must be available when needed

• Practices need to routinely record the person the patient wishes to be contacted in an emergency (not necessarily the next of kin)

• This criterion cross references to Criterion 1.2.2 Informed patient decisions.

Dedicated patient health records

Practices need to have an effective system whereby a patient's health information is stored in a dedicated patient health record. Health records need to include: the patient's contact and other demographic information, medical history, consultation notes (including care outside normal opening hours and home visits), letters received from hospitals or consultants, other clinical correspondence, investigations or referrals, and results. Besides clinical information, the patient health record may

also contain other relevant information pertaining to the patient such as any WorkCover or insurance information or relevant legal reports.

It is critical that patient health records are legible so that another practitioner could take over the care of the patient if necessary. Not only does written information need to be legible (able to be read and understood), if the practice scans documents such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.

### Culling information from paper based record systems
Ease of storage may be assisted by culling outdated test results that no longer have clinical relevance (in line with relevant state and territory legislation regarding the retention of patient health information). In these circumstances, the practice needs to have a system for the timely identification of information that is no longer relevant. General practices may want to consult their GPs' medical defence organisations when determining the practice's policy regarding culling results.

### Risks of hybrid and paper record systems
There are potential risks associated with hybrid patient health record systems, where some information is recorded on a computer (eg. medicines list) and some information on paper notes (eg. past medical history). When the patient notes are stored in two areas it is possible for important issues to be overlooked, particularly if another doctor sees the patient. To make this less of a problem, a note in each system improves the continuity of these hybrid systems.

If health information about a patient is kept in two sites (as in the case of hybrid records or records held in a residential aged care facility), practices need to ensure all the information is available and accessible when needed.

In the interests of risk management, the RACGP recommends that practices with hybrid patient health record systems work toward the electronic recording of at least allergies and medications.

### Collecting information from patients
The information required from new patients might be collected by practice staff having new patients complete a generic form, or by interviewing patients in a private environment before consultation. Practices should also have a system whereby patient information is updated regularly so that it remains current and accurate. Practices should routinely record the person the patient would like contacted in an emergency.

### Recording cultural background
Practices in all clinical settings should work toward identifying and recording the cultural background of all patients since this background can be an important indication of clinical risk factors and can assist GPs in providing relevant care.

Recording Aboriginal and Torres Strait Islander status

The standard indigenous status question is: 'Are you of Aboriginal or Torres Strait Islander origin?' This question should be asked of all patients, irrespective of appearance, country of birth or whether the staff know of the client or their family background.

Sometimes practice teams feel concerned that obtaining Aboriginal or Torres Strait Islander status can be perceived as discriminatory. However, the information is very important because of the different health needs of Aboriginal and Torres Strait Islander people. The practice may wish to collect this information as part of a patient questionnaire and preface questions on cultural background by explaining that such information helps the practice provide appropriate healthcare.

The AIHW *National best practice guidelines for collecting Indigenous status in health data sets* provide useful background information and practical advice and are available at: www.aihw.gov.au/publications/index.cfm/title/11052.

An RACGP factsheet is available at www.racgp.org.au/standards/factsheets.

Indicators E and F apply prospectively. The practice may wish to seek information on cultural background from existing patients through a simple mechanism such as an update-your-information questionnaire.

## Standards for general practices offering video consultations

General practices offering video consultation services should meet their usual obligations to have an individual patient health record containing all a patient's health information held by the practice.

Where either still or video images are recorded during a video consultation the recording must be managed as securely as any other patient health information and stored as part of the patient's health record in accordance with usual requirements for retaining health records (see also Criterion 1.7.3 Consultation notes). Where a recording is stored by the practice in a separate location such as a separate hard drive, the location and storage medium should be documented in the patient's health record. Where a recording is stored securely by a third party service provider, the location of the recording should be documented in the patient's health record.

### Resources

The RACGP *Implementation guidelines for video consultations in general practice* are available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 1.7

### Content of patient health records

Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

# Criterion 1.7.3

## Consultation notes

Each of our patient health records contains sufficient information about each consultation to allow another member of our clinical team to safely and effectively carry on the management of the patient.

### Indicators

▶ A.  Our patient health records document consultations including consultations outside normal opening hours, home or other visits and telephone or electronic communications where clinically significant, comprising:

- date of consultation
- patient reason for consultation
- relevant clinical findings
- diagnosis
- recommended management plan and, where appropriate, expected process of review
- any medicines prescribed for the patient (including name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed)
- complementary medicines used by the patient
- any relevant preventive care undertaken
- any referral to other healthcare providers or health services
- any special advice or other instructions
- who conducted the consultation (eg. by initial in the notes, or audit trail in an electronic record).

▶ B.  Our patient health records show evidence that problems raised in previous consultations are followed up.

▶ C.  Our practice can demonstrate that we are working toward recording preventive care status (eg. currency of immunisation, smoking, nutrition, alcohol, physical activity, blood pressure, height and weight [body mass index]).

### Explanation

Key points
- Patient health records should be legible and understandable by another GP or clinical staff member to facilitate safe and effective care
- Complementary medicine consumption by patients should be documented to minimise drug interactions
- Patient health records should be updated as soon as practicable at or after consultations and visits. The records should identify the person in the clinical team making the entry.

Consultation notes are important for safe and high quality care
A consultation in general practice is the entry point to the healthcare system for most Australians. A consultation is an interaction between the practice and the patient related to the patient's health issues.

A consultation may be with a GP, nurse or other staff member who provides clinical care within the practice.

The quality of patient health information needs to be such that another GP or clinical staff member could read and understand the terminology and abbreviations used, and, from the information provided, be equipped to manage the care of the patient.

Ideally, information about the consultation needs to be entered into the patient health record as soon as is practical at the time of the consultation, or as soon as information (eg. results) becomes available.

Many people now take complementary and over-the-counter medicines which may react adversely with conventional medicines. Therefore, complementary medicines prescribed by a member of the clinical team or self reported by a patient need to be documented in the same manner as other medicines.

As part of risk assessment, practices are encouraged to routinely record patients' height, weight and blood pressure at intervals of their choosing. This is useful in children to assess normal growth or failure to thrive and also to document weight loss and gain over a period of time in all age groups as this may be an indicator of disease.

As part of the continuing care that GPs provide, information concerning patients is gathered over more than one consultation. It is important there is a connecting process so that information about clinically significant, separate events in a patient's life and in the care provided are not overlooked, but are recorded and managed in a way that makes this information readily accessible. Regularly updated health summaries are one method of managing this information. Clinically significant information may include the patient's health needs and goals, preventive health activities, medical condition(s), preferences and values. All this contributes to care that is responsive to patient needs.

### Consultation notes are a risk management tool

Medical defence organisations have identified lapses in following up on problems and issues raised previously by patients as a considerable risk. This can occur when patients are not seen by their usual GP, although it can also occur when a GP is busy or distracted. Thus, for high quality patient care, it is useful for general practices to have systems that reduce the risk of such lapses.

### Coding

Consistent coding of diagnoses, when available, should be used in the consultation notes to support continuous quality improvement of clinical care and patient outcomes.

### Services providing care outside normal opening hours

Consultation notes produced by services that provide care outside normal opening hours should contain, as a minimum, sufficient relevant information for the GP to provide safe and effective care. Copies of such notes should be provided to the patient's regular GP.

## Standards for general practices offering video consultations

General practices offering video consultation services should meet their usual obligations for documenting consultations.

### Additional documentation required

To manage the unique risks associated with video consultations, the GP (or other support clinician) should consider documenting in the consultation notes additional key information such as:

- the consultation was conducted by video conference
- patient-end location of the video consultation
- persons present (other than the GP and distant specialist) and the patient's explicit consent for such parties to be present
- rationale for a video consultation instead of a face-to-face consultation
- whether the video consultation was an initial or follow up consultation
- clinical findings, diagnosis where possible (including agreed diagnosis terminology), diagnostic investigations, procedures or medications as indicated by the distant specialist
- which clinician (whether distant specialist, GP or another support clinician) is responsible for specified follow up action
- the recording of any still or video images during the video consultation, the patient's written consent for such recording and the location of the recording as part of the patient's health record
- any period of time the support clinician was not present (eg. to allow the patient to have a private discussion with the specialist)
- any technical malfunctions in the video conference process (eg. poor sound or image) that may have compromised the safety or quality of the consultation.

The documentation of such information should occur in a timely manner irrespective of whether the specialist's follow up letter back to the practice has been received at that time, to allow, as necessary, another member of the clinical team to safely and effectively carry on the management of the patient.

Where a video consultation booking checklist is completed in hard copy, general practices may find it helpful to store standard information from the checklist in the patient's health record (eg. date, time, patient-end location of the video consultation, name of specialist, name of any clinical support person, other persons present, patient consent for persons present).

### Resources

A template for a practice video consultation booking checklist is available on the RACGP website at www.racgp.org.au/telehealth.

*Section 2*
*Rights and needs of patients*

# Standard 2.1

## Collaborating with patients

Our practice respects the rights and needs of patients.

## Standard 2.1

*Collaborating with patients*

Our practice respects the rights and needs of patients.

# Criterion 2.1.1

## Respectful and culturally appropriate care

Our practice provides respectful and culturally appropriate care for patients.

### Indicators

▶ A. Our practice does not discriminate against or disadvantage patients in any aspect of access, examination or treatment.

▶ B. Our clinical team can demonstrate how we provide care for patients who refuse a specific treatment, advice or procedure.

▶ C. Our clinical team can describe what they do when a patient informs them that they intend to seek a further clinical opinion.

▶ D. Our practice team can describe what they do to transfer care, in a timely manner, to another GP in our practice or to another practice when a patient wants to leave the GP's care.

▶ E. Our practice team can describe arrangements for informing a patient and transferring the care of a patient whom a GP within our practice no longer wishes to treat.

▶ F. Our practice team can describe how our practice provides privacy for patients and others in distress.

   G. Our practice team can identify important/significant cultural groups within our practice and outline the strategies we have in place to meet their needs.

### Explanation

Key points
- Patients have the right to respectful care, which promotes their dignity, privacy and safety

- The Federal Disability Discrimination Act (1992), as well as various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics

- Where patients indicate they wish to seek a second opinion, this should be documented in the patient's health record

- Where patients refuse advice, procedures or treatments, this should be recorded in the patient's health record

- Practices need a strategy which details the steps to be taken when GPs or the practice team no longer consider it appropriate to treat a particular patient, including how to assist the patient with ongoing care

- Practices need a plan to respectfully manage patients in distress

- Indicators C, D and E cross reference to Criterion 1.5.2 Clinical handover

- Indicator G cross references to Criterion 1.7.1 Patient health records.

### MBA Code of Conduct – a valuable resource

The Medical Board of Australia (MBA) has adopted a code of conduct that defines clear, nationally consistent standards of medical practice. The code is entitled *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

Section 3 of the Code of Conduct is on 'working with patients' and it contains helpful information and advice on the doctor-patient partnership, effective communication, culturally safe and sensitive practice, and informed consent. The MBA Code of Conduct is available at www.medicalboard.gov.au/codes-and-guidelines.aspx.

### Patients' rights

This criterion requires that both GPs and other members of the practice team deal with all patients in a respectful, polite and professional manner. Where a carer plays an ongoing role in the day-to-day care of a patient, it is generally advisable to include the carer in the doctor-patient relationship with the permission of the patient (if the patient is competent to give such consent).

Practices need to be aware that the Federal Disability Discrimination Act (1992), as well as the various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion).

Further information is provided by the Australian Human Rights Commission at www.hreoc.gov.au/. This website has guides to the relevant legislation and links to state and territory agencies with similar responsibilities.

The Australian Commission on Safety and Quality in Health Care has produced an Australian Charter of Healthcare Rights available in several languages at www.health.gov.au/internet/safety/publishing.nsf/content/priorityprogram-01.

### Mutual respect for successful collaboration

Patients have the right to respectful care that promotes their dignity, privacy and safety. Patients have a corresponding responsibility to give respect and consideration to their GPs and other practice staff. All members of the practice team need to have appropriate interpersonal skills to work with patients and others in the practice. Much of the success of a practice depends on the positive, friendly, attentive, empathetic and helpful behaviour of staff at the reception desk.

The ideal patient-doctor partnership is a collaboration based on mutual respect and a mutual responsibility for the health of the patient. The GP's duty of care is to explain the benefits and potential harm of specific medical treatments and to clearly and unambiguously explain the consequences of not adhering to a recommended management plan.

General practitioners have a responsibility to ensure that when taking a history from a patient and developing subsequent management plans, they themselves fully understand the discussion that takes place and that, in turn, the patient fully understands the proposed management and treatment. This may be facilitated by the use of translating services. It is of the utmost importance that

GPs ensure there is clear and effective communication between both parties in the doctor-patient relationship so that GPs can effectively manage their patients' healthcare.

### Second opinions

Patients have the right to seek further clinical opinion from other healthcare providers. Practices are encouraged to document in the patient's health record any indication that a patient intends to seek a further clinical opinion. Patients need to be encouraged to notify their GP when they are choosing to follow another healthcare provider's management advice. This allows the GP the opportunity to reinforce any potential risks of this decision.

Where patients do seek further clinical opinion, an appropriate risk management strategy for practices includes documenting this decision in the patient's health record. In addition, the GP is encouraged to document in the patient's health record an explanation of the actions taken when a patient seeks a further clinical opinion, including referral to other care providers if arranged.

### Refusal of treatment or advice

If a GP is aware that a patient has refused advice, procedures or treatments, an appropriate risk management strategy for practices needs to include recording of such refusals in the patient's health record, including referrals to other care providers and an explanation of the action taken.

### Patient requests for transfer of care

When a patient requests to be transferred to the care of another GP in another practice, a copy of patient health information needs to be transferred to the other practice in a timely manner to help facilitate care of the patient. Practice staff need to comply with the requirements of the state or territory legislation governing the transfer of patient health information.

### GP requests for transfer of care

There may be patients whom a GP no longer considers it appropriate to treat (eg. when a patient has behaved in a threatening or violent manner, or where there has been some other cause for a significant breakdown in the therapeutic relationship). General practitioners have the right to discontinue treatment of a patient, especially when the GP thinks they can no longer give the patient optimal care. In such circumstances it is advisable for the practice to document a process to be followed by practice staff if the patient makes any subsequent contact with the practice. In rural and remote areas it may be difficult for the practice to uphold a decision to discontinue the treatment of a patient. The College reminds GPs that irrespective of a decision to discontinue the treatment of a patient, there is still a professional and ethical obligation to provide emergency care. Section 2 of the MBA Code of Conduct provides helpful advice on these areas (available at www.medicalboard.gov.au/en/codes-and-guidelines.aspx).

### Dealing with patients who are distressed

A patient in distress may feel more comfortable in a private area than in a public waiting area. Practices, even those with limited facilities, need to attempt to

provide privacy for such patients (eg. by allowing them to sit in an unused room, staff room or other area). This does not mean that a practice needs to have a room permanently set aside for such patients, but that a practice needs to have a plan that can be implemented as the need arises to ensure the patient is treated respectfully.

### Managing health inequalities

The RACGP supports the choice of general practices to favour or specifically 'target' people and communities with high needs for comprehensive primary care, where choices need to be made about the allocation of limited resources. One way of addressing the health inequalities of some individuals, families and communities is by providing targeted, culturally appropriate care to these patients. In these cases, the RACGP believes the general practice is still providing initial, continuing, comprehensive and coordinated medical care to individuals, families and communities, despite targeting a specific patient group. For these practices it is important that the practice has clear systems to deal with requests for care by patients outside the target population. Examples of specific patient groups with high needs for comprehensive primary care include refugees, asylum seekers, prisoners, people of indigenous background or people from other cultural backgrounds associated with known health risk factors.

### Respectful patient health records

Demonstrating respect for patients extends beyond the face-to-face interaction between the practice staff and the patient to the recording of patient health information. Making or recording derogatory, prejudiced, prejudicial, or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other GPs and can result in differential treatment for such patients.

### Cultural awareness education

For information on the RACGP cultural awareness and cultural safety project see www.racgp.org.au/aboriginalhealth/culturalawareness.

Reconciliation Australia provides information about organisations that offer cultural awareness training available at www.reconciliation.org.au/home/reconciliation-action-plans/rap-community/cultural-awareness-training-register).

The Cultural Dictionary, a project of the Migrant Resource Centre Canberra & Queanbeyan Inc, aims to increase cultural understanding for service providers and is available at www.dhcs.act.gov.au/__data/assets/pdf_file/0017/5282/Cultural_Dictionary.pdf).

## Standards for general practices offering video consultations

### Educating patients about the video consultation process

General practices offering video consultation services are encouraged to provide patients with a patient information brochure containing standard information about the process of a video consultation (see also Criterion 1.2.2 Informed patient decisions). Where appropriate, the practice may choose to have the brochure translated into different languages.

### Respecting patient choice

Video consultations provide patients with an alternative option for a consultation without the personal inconvenience and cost of travel from home. Nevertheless, there will be patients who prefer to attend face-to-face consultations with specialists and this choice should be respected.

Where a patient or carer expresses a preference for a video consultation, this preference should be taken into account in the informed consent process and the clinical decision about whether a video consultation would be safe and clinically appropriate for the patient.

### Communication with patients

The video consultation setting allows clinicians at the patient-end and the distant specialist to engage in a direct clinical handover process. However, in line with face-to-face consultations, the main focus of communication needs to be on direct communication with the patient to establish their history, diagnosis and management, and any contraindications to treatment, or to review their progress.

Out of respect for the patient, the consultation with the patient should be continuous. Where the GP and distant specialist wish to discuss sensitive issues without the patient being present, this could be done at the beginning or end of the video consultation.

### Culturally appropriate care

General practices should be mindful of cultural sensitivities about personal images and the recording of personal images.

Where an interpreter is required, qualified medical interpreters are recommended and the practice should make technical provision for a separate audio lead where the interpreter is not present in person.

Information about an individual's cultural needs and preferences should be noted by the person responsible for coordinating the practice's video consultation services so that culturally appropriate care can continue to be provided.

### Resources

A template for a patient information brochure is available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 2.1

*Collaborating with patients*

Our practice respects the rights and needs of patients.

# Criterion 2.1.3

## Presence of a third party

The presence of a third party observing or being involved in clinical care during a consultation occurs only with the prior consent of the patient.

### Indicator

► A.  Our practice team can demonstrate how we obtain the prior consent of a patient for the presence of a third party during the consultation.

### Explanation

Key points
- Patients must be asked to provide consent for the presence of a third party before the consultation commences
- Third parties can be interpreters; carers; relatives; friends; medical, allied health or nursing students on placement; general practice registrars or chaperones
- When prior consent for the presence of a third party has been provided, it is prudent to check that the consent remains valid at the outset of the consultation.

Prior consent

Ideally, permission for the presence of a third party during the consultation needs to be sought when the patient makes an appointment, or, failing that, when they arrive at reception. It is not acceptable to ask permission in the consulting room, as some patients may feel 'ambushed' and unable to refuse. Once prior consent has been sought and given, the GP should confirm at the outset of the consultation that the patient has consented to the presence of any third party.

Chaperones

In some circumstances, the patient or GP may feel more comfortable if there is a chaperone present during an examination. Appropriate consent needs to be obtained from the patient where the doctor requests the presence of a third party for this purpose. The RACGP has a position statement on the use of chaperones available at www.racgp.org.au/policy/chaperones_in_GP.pdf.

Third parties such as family or carers

Where a patient is accompanied to the practice by a third person (such as a family member or carer) it is equally important to ensure that the patient consents to the presence of that person in their consultation and it is useful to record this consent in the consultation notes.

Practice staff need to be mindful of the particular needs of people with intellectual disabilities who may not be able to provide consent. In such cases a legal guardian or advocate may have been appointed to oversee the interests of the patient. More information on guardianship can be found at www.hreoc.gov.au/disability_rights/hr_disab/areas/appendices.htm#app1.

### Students on clinical placement

Exposure to general practice is important for the recruitment and training of our future GPs as well as other health professions.

Recent graduates and international medical graduates are more likely to enter general practice if they have exposure to general practice in their university education. The general practice term is the most important part of vocational training and most general practice registrars report that the experience is valuable. Hence, education and training are among the most important reasons for a third party to observe or to be involved during the consultation.

The permission of the patient must be obtained before the consultation if undergraduate students, general practice nurses or other doctors or health professionals are to be involved in the consultation, whether through direct observation, interview or examination.

## Standards for general practices offering video consultations

### Patient consent

For a video consultation with a specialist at a distant location, it remains the patient's prerogative to consent/not consent in advance to parties other than the patient, a support clinician (if indicated) and specialist being present during the consultation.

The presence of other parties and the patient's explicit prior consent for this presence should be documented in the consultation notes (see also Criterion 1.7.3 Consultation notes).

General practices offering video consultation services are encouraged to seek advance agreement that participating specialists will not bring other parties to a video consultation without the explicit prior consent of the patient, whether or not such parties would be present on or off-camera or at a separate location such as a teaching facility. Where a specialist does bring an unexpected party to a video consultation, a support clinician from the general practice may need to act as an advocate for the patient and invite the patient to step out of the video consultation to consider in private whether to consent or not consent to the unexpected party being present.

Patients should be empowered to ask any party, including a GP (or other support clinician) or a medical student to step out of the video consultation at any time if they wish to have a private discussion with the distant specialist provided the support clinician deems it safe for this to occur (see also Criterion 1.2.2 Informed patient decisions and Criterion 2.1.1 Respectful and culturally appropriate care).

As a courtesy to the patient and as a means of accurately identifying all parties present at a video consultation, it is recommended that video consultations commence with each party formally introducing themselves (see also Criterion 3.1.4 Patient identification).

*Section 3*
# Safety, quality improvement and education

# Standard 3.1

## Safety and quality
Our practice is committed to quality improvement.

# Standard 3.2

## Education and training
Our practice supports and encourages quality improvement
and risk management through education and training.

## Standard 3.1

*Safety and quality*

Our practice is committed to quality improvement.

# Criterion 3.1.2

## Clinical risk management systems

Our practice has clinical risk management systems to enhance the quality and safety of our patient care.

### Indicators

▶ A.  Our practice team can demonstrate how we:

- regularly monitor, identify and report near misses and mistakes in clinical care

- identify deviations from standard clinical practice that may result in patient harm.

▶ B.  Our practice has documented systems for dealing with near misses and mistakes.

▶ C.  Our practice team can describe improvements made to our systems to prevent near misses and mistakes in clinical care.

▶ D.  Our practice monitors system improvements to ensure successful implementation of changes made to our clinical risk management systems.

▶ E.  Our practice has a contingency plan for adverse and unexpected events such as natural disasters, pandemic diseases or the sudden, unexpected absence of clinical staff.

### Explanation

Key points

- There should be one member of the practice team with primary responsibility for clinical risk management systems (see Criterion 3.1.3 Clinical governance)

- Near misses and mistakes in clinical care occur in all general practices

- Practices need systems to recognise and analyse near misses and mistakes so solutions can be implemented to prevent their recurrence

- Solutions need testing to ensure they work effectively

- Deviations from standard clinical practice may be interpreted as deviations from practice which might reasonably be expected by the public or professional peers.

Allocation of responsibility

The practice should appoint one member of staff with primary responsibility for clinical risk management systems. Specific areas of responsibility can be delegated to other nominated members of the practice team and these particular responsibilities should be documented in the relevant position descriptions.

Defining mistakes and near misses

Mistakes are errors or adverse events that result in harm. (Adapted from the RACGP education module Thinking safety, being safer).

Near misses are incidents that did not cause harm but could have.

### The core elements of risk management
The following information has been adapted from the Avant website.

For simplicity's sake, medicolegal risks and strategies can be classified into three areas.

### 1. Clinical knowledge and skill
Fundamental strategies here include:

- keeping up-to-date
- taking a thorough history and examination and documenting thoroughly in the clinical record
- being aware of your own limitations and referring patients on appropriately
- investigating further if treatment is not working
- making use of protocols, checklists and diagnostic support aids
- looking after yourself
- preventing and dealing with fatigue
- reporting your concerns if you feel unsafe work practices are enforced on you.

### 2. Communication
Risks can be minimised by:

- building a doctor-patient relationship based on trust and honesty
- listening to patients and showing empathy
- minimising interruptions during consultations
- managing unrealistic patient expectations
- communicating with your practice staff
- encouraging an environment in the practice where patients feel welcome and staff are skilled in all aspects of managing patients
- fostering strong relationships with colleagues and other health professionals involved in the care of your patients
- Keeping open channels of communication with health facilities you interact with (eg. hospitals, radiology practices)
- Managing adverse events or complaints in a way that does not leave the patient feeling abandoned or that their concerns were ignored
- Ensuring your consent process allows the patient to understand the implications of a proposed treatment, medication or procedure so they can make up their own mind as to whether they want to have it or not.

### 3. Systems
Systems which can be 'fine tuned' to decrease medicolegal risk include:

- complaints handling process
- tracking tests ordered and referrals made
- recording of appointments, cancellation and any failure to attend
- infection control procedures

- recruitment, training and management of staff
- managing confidentiality and privacy.

### Mistakes happen

Near misses and mistakes in clinical care that might harm patients occur in all general practices. The evidence about the frequency of near misses and mistakes varies and the better constructed studies suggest even higher rates of occurrence.

Most GPs and practices already manage clinical risk on a daily basis. Many have informal and ad hoc methods of trying to prevent near misses and mistakes. Some GPs talk to other trusted peers or supervisors for advice. Other practices have a more formal process that includes practice discussions about what went wrong and how to reduce the likelihood of it happening again, or using structured techniques to analyse the causes of an error and reduce the likelihood of its recurrence.

### Just and open communication is vital

A systems approach to thinking about adverse events and errors highlights a need to shift away from the immediacy of blaming individual practitioners to cultivating a just, open and supportive culture where individual accountability and integrity is preserved, but mediated by thoughtful and supportive response to error (see the RACGP education module *Regaining trust after an adverse event*).

The practice needs to have a process in place where members of the practice team know who and how to notify when a near miss or mistake occurs, or when there is an unanticipated adverse outcome. All members of the practice team, no matter how junior, should feel empowered to recognise and report near misses and mistakes without fear of recrimination.

A study by Maxfield et al[3] highlights the critical importance of open communication. The study found that people see others make mistakes, violate rules or demonstrate dangerous levels of incompetence repeatedly and over long periods of time in ways that hurt patient safety and employee morale. However, they don't speak up and the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront. These findings give practices a powerful reason for focusing on open communication as a vital tool in clinical risk management.

### Consistent use of risk management systems reduces clinical risk

The same mistake can have different causes on different occasions. Part of the quality improvement process is to make sure there is consistent use of clinical risk management systems, so that the causes of near misses and mistakes are identified and processes improved to reduce the likelihood of them occurring again.

If the practice does not make improvements after identifying a near miss or mistake, patients may be exposed to an increased risk of adverse outcomes and the GPs and practice staff may be exposed to an increased risk of medicolegal action. An example of this situation is where a clinically significant test result is not communicated to the patient or adequately followed up; the

practice knows about this and makes no attempt to prevent a recurrence. Another example might be when an important detail in a previous consultation is not considered by the GP at that patient's next consultation, resulting in a problem being overlooked; the practice becomes aware of this and yet does not act to prevent it happening again. This second example is more likely with the use of certain electronic based record systems that do not show the previous consultation record when a patient's record is opened.

The vast majority of near misses and mistakes do not lead to patient harm as they are 'near misses' that are caught before any harm occurs. An example of this is when the GP prescribes a medicine for a patient, who then tells the GP that they are allergic to that medicine. Another is when a GP notices that the general practice nurse has prepared an incorrect vaccine before the vaccination takes place and replaces it with the correct vaccine. These 'near misses' can provide opportunities for quality improvement.

Practices will have different systems in place to identify and reduce clinical risk. It is important, however, for practices to be able to demonstrate how and why they have made changes to improve clinical care.

### Find it, fix it, confirm it approach
Poor performance and poor practice can too often thrive behind closed doors. Implementing a clinical governance framework should assist a practice in finding the balance of 'find it', 'fix it' and 'confirm it' functions in relation to improving the quality and safety of care.

• 'Find it': practices can use tools such as clinical audits and performance indicators to identify where quality improvement programs could impact on the quality of care delivered and improve patient health outcomes

• 'Fix it': once the gaps in quality care have been identified, practices can implement strategies to address the issue (eg. redesign of clinical services and the development of policies and procedures)

• 'Confirm it': confirmation of the improvement can be measured through an effective evaluation process (eg. systematic re-audit of targeted indicators).

### Event registers
Practices may find it beneficial to keep a record of de-identified near misses and mistakes to facilitate quality improvement initiatives. In April 2005 the RACGP obtained legal advice from Milstein and Associates which is pertinent to the use of event registers/records. The advice is still relevant and is available at www.racgp.org.au/content/navigationmenu/practicesupport/standardsforgeneralpractices/changes_to_college_standards_advice_re_medical_legal_repercussions.pdf

### Notifying your medical defence organisation is vital
The RACGP recommends that GPs notify their medical defence organisation of all events or circumstances that they perceive might give rise to a claim and certainly before any action is taken to resolve a complaint or apologise for a mistake involving clinical care.

## Contingency plans

Practices need to have contingency plans for unusual events that may disrupt patient care such as natural disasters or disease outbreaks that overstretch the practice's capacity, or the sudden, unexpected absence of key members of the clinical team.

## Emergency communication from RACGP

Subscribers to the RACGP *Fridayfacts* bulletin (www.racgp.org.au/fridayfacts) will receive notification via special emergency bulletins of any notices issued by the Commonwealth Chief Medical Officer in relation to national emergencies (eg. adverse reactions to vaccination of under fives or responses to pandemic).

## Resources

- RACGP guide *Using near misses to improve the quality of care for your patients* is available at www.racgp.org.au/publications/orders.

- RACGP *Regaining trust after an adverse event: an education module on managing adverse events in general practice* is available at www.racgp.org.au/content/navigationmenu/practicesupport/runningapractice/patientsafetyinitiatives/currentprojects/regainingtrustworkbook.pdf.

- RACGP education module *Being human, being safer* on human factors in general practice is a useful resource for all members of the practice team and is available at www.racgp.org.au/safety/beinghuman.

- RACGP education module *Thinking safety, being safer* is designed to help all members of the practice team understand and utilise 'near miss' analysis to improve the quality of patient care and is available at www.racgp.org.au/safety/thinkingsafety.

- RACGP *Pandemic flu kit* outlines disaster management and is available at www.racgp.org.au/pandemicresources. This section of the College website also provides links to the relevant departmental health units for up-to-the-minute information on areas such as human swine influenza.

- RACGP *Infection control standards for office based practices* (4th edition) provide information on infection control principles for general practices to prepare for an influenza pandemic. Topics include: how micro-organisms are acquired and grown; the use of standard and additional precautions; the correct use of personal protective equipment; the correct use of high filtration and surgical masks (eg. N95/P2 masks); cleaning the practice environment and equipment; triage and disease surveillance systems in the general practice. A copy can be ordered via the RACGP website at www.racgp.org.au/publications/standards.

- MBA Code of Conduct section 3.10 (available at www.medicalboard.gov.au/codes-and-guidelines.aspx) provides useful information on dealing with adverse events.

## Standards for general practices offering video consultations

General practices offering video consultation services need to be mindful of the unique risks involved in consultations where the specialist and the patient are at different locations. It is important for general practices to identify these risks and determine how they should be managed, if necessary in partnership with distant specialists (see also Criterion 1.6.1 Engaging with other services).

### Managing the risks in dual-care consultations

Video consultations with clinicians at both ends of the video conference constitute dual-care consultations where the clinicians at each end have inherent and concurrent duties of care.

Criterion 1.5.2 Clinical handover, emphasises the importance of clinicians being clear about individual and collective responsibilities for the patient's diagnosis (including agreed diagnosis terminology) and ongoing management which may include diagnostic investigations, procedures and/or medications. Where distant specialists do not make it explicitly clear which clinician will be responsible for specified follow up action, the clinician at the patient-end of the video consultation is expected to request clarification.

### Managing adverse events during a video consultation

The practice should have a documented contingency plan for managing patients who become distressed during a video consultation. This is particularly important if video consultation sessions are located away from the practice's usual systems and resources for handling contingencies and medical emergencies.

Practices should also have a documented plan for managing technical contingencies during a video consultation as these can potentially compromise the effectiveness of the consultation or the patient's safety (see also Criterion 5.2.1 Practice equipment). For example, a contingency plan could involve having easy-to-read troubleshooting guides for common technical difficulties, completing an interrupted consultation by telephone and ready access to technical support to fix core problems.

### Clinical audits for risk management and quality improvement

As video consultations are a new consultation option in the Australian primary healthcare setting, there is limited evidence on their risks and clinical effectiveness. In this context, general practices are strongly encouraged to collect, analyse and act on practice data about the process and outcomes of a video consultation system in order to prevent near misses and mistakes in clinical care and drive quality improvement initiatives (see also Criterion 1.4.1 Consistent evidence based practice).

### Reliable and secure technical systems fit for clinical purposes

The practice's technical systems for running video consultations should support the practice's clinical risk management systems. For the purpose of these *Standards*, the technical systems needed to support safe, secure and effective video consultations are deemed to be 'medical' as opposed to 'office' equipment and they should underpin safe and clinically effective medical practice (see also Criterion 4.2.2 Information security and Criterion 5.2.1 Practice equipment).

To avoid near misses and mistakes in clinical care, video conference equipment and connectivity should be capable of delivering sound and image quality suitable for clinical purposes.

### Offsite facilities

General practices using offsite facilities for video consultations should ascertain the availability of emergency resuscitation equipment in advance. As for any routine visit, GPs should take a suitably equipped doctor's bag to a video consultation at an offsite facility (see also Criterion 5.2.2 Doctor's bag).

### Resources

To assist general practices with a patient evaluation process, the RACGP has developed a simple post-video consultation patient evaluation tool which is available at www.racgp.org.au/telehealth. This simple evaluation tool is specific to video consultations and is designed to generate patient-level data that practices can use to improve their video consultation systems quickly as issues emerge during the implementation phase.

The RACGP supports the development of a practice evaluation tool designed to generate practice-level data on the effectiveness and risks of video consultations to enable practices to evaluate and improve the process and outcomes of consultations via video conference.

## Standard 3.1

*Safety and quality*

Our practice is committed to quality improvement.

# Criterion 3.1.3

## Clinical governance

Our practice has clear lines of accountability and responsibility for encouraging improvement in safety and quality of clinical care.

### Indicators

▶ A.  Our practice has leaders who have designated areas of responsibility for safety and quality improvement systems.

▶ B.  Our practice shares information about quality improvement and patient safety within the practice team.

### Explanation

#### Key points

• Good clinical governance ensures the accountability of individuals for the delivery of safe and effective quality care

• It takes leadership to build an empowered and participative team that delivers high quality and safe care to patients.

#### Clinical governance

Clinical governance is a 'system through which organisations are responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.[4]

The elements of clinical governance commonly include:

• education – basic and ongoing

• clinical audit

• clinical effectiveness – evidence based practice

• risk management – clinical and general

• research and development

• openness.

The Australian Commission on Safety and Quality in Health Care proposes a similar model[5] and argues that effective clinical governance includes:

• recognisably high standards of care

• transparent responsibility and accountability for maintaining those standards

• a constant dynamic of quality improvement.

In a recent study, Phillips et al[6] explored the link between quality and clinical governance in primary healthcare and found seven key areas to support clinical governance: ensuring clinical competence, clinical audit, patient involvement, education and training, risk management, use of information and staff management.

#### Clinical leaders

The appointment of a clinical leader is designed to ensure:

• the ongoing development of an organisational culture wherein participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded

- the ability to hold accountable all staff involved in monitoring and improving care and services
- a multidisciplinary team approach developed to endorse and promote a climate of safety and quality that does not blame, but rather seeks to solve problems.

In small practices one person may fulfil the role of clinical leader, while in larger practices several team members may become designated clinical leaders. Although a clinical leader will have primary responsibility for a particular area of activity (such as infection control), other members of the practice team may have delegated responsibility for specific activities (such as environmental cleaning or sterilisation within the area of infection control). Whatever the allocation of leadership responsibilities within a practice, it is vital that all members of the practice team take individual responsibility for a multidisciplinary culture of safety, quality and open communication.

### Role of clinical leaders

Through the clinical leader a general practice can develop a systematic approach to monitoring, managing and improving safety. This will include clear delineation of, and support for, corresponding staff accountability and responsibility. This approach should ensure practices have:

- a team based approach to care, in which each team member will be aware of their role and responsibilities for improving the patient's clinical outcomes
- an accurate record of each patient's health history
- supports to assist members of the clinical team in providing evidence based care
- mechanisms to identify and mitigate clinical risk for the practice, the staff and the patients
- systems and procedures to learn and share safety lessons and to implement solutions to prevent harm through changes to practice processes
- strategies to decrease variability in care delivery and outcomes for patients
- procedures to provide timely and equitable access to care
- accurate registers of patients with specified chronic conditions
- systems to manage patients with chronic conditions systematically and to proactively identify those at special risk or those who would benefit from special intervention
- the capacity to extract specified clinical data and to collate that data to guide improvement in the practice.

### Sharing information about quality improvement and patient safety

Good clinical leadership is required to engage the entire practice team in a commitment to excellence. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team as a whole. The clinical leader will need to nurture a culture of openness and mutual respect that allows just and open discussions about areas for improvement.

### Resources

A useful article on the role of clinical governance in improving quality has been published by Phillips et al and is available at www.anu.edu.au/aphcri/Spokes_Research_Program/Stream_Thirteen.php.

# Standards for general practices offering video consultations

## Clinical leader

As video consultations are a new consultation option within the Australian primary healthcare setting and there is limited evidence on their effectiveness and risks, it is important for general practices offering video consultation services to designate a clinical leader with overall accountability for the practice's video consultation system.

## New areas of responsibility

The clinical leader could be expected to assume or delegate responsibility for system components such as:

- professional indemnity for GPs or other clinicians such as practice nurses and registered Aboriginal health workers, providing clinical support at the patient-end of video consultations

- protocols for engaging with participating specialists

- coordination of video consultation arrangements

- a practice video consultation etiquette

- a practice policy on video recording (see also Criterion 4.2.1 Confidentiality and privacy of health information)

- technical specifications consistent with recognised technical guidelines

- troubleshooting common technical difficulties and contingency plans for dealing with technical problems

- risk management for dual-care style consultations

- patient and other stakeholder feedback and quality improvement initiatives based on this feedback

- clinical effectiveness of video consultations

- analysis of video consultation services offered by the practice

- staff training

- open discussion and documentation of the practice's progressive experience in video consultations.

## Resources

The RACGP *Implementation guidelines for video consultations in general practice* and the RACGP factsheet on video consultation etiquette are available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 3.1

### Safety and quality
Our practice is committed to quality improvement.

# Criterion 3.1.4

## Patient identification

Our patients are correctly identified at each encounter with our practice team.

### Indicator

▶ A.  Our practice has a patient identification process using three approved patient identifiers and the practice team can describe how it is applied.

### Explanation

Key points

- Correct patient identification is vital for patient safety and the maintenance of patient confidentiality

- Use at least three approved identifiers for each patient encounter or activity such as making appointments, writing prescriptions, writing referrals to other providers, giving results or entering results or correspondence into records

- Don't assume you have the correct patient record when treating familiar patients

- This criterion cross references to Criterion 1.7.1 Patient health records.

### Approved patient identifiers

All practice staff should be trained to check for approved patient identifiers as a matter of course.

Approved patient identifiers are those items of information accepted for use in patient identification and include:

- patient name (family and given names)

- date of birth

- gender (as identified by the patient themselves)

- address

- patient record number where it exists.

A Medicare number is not an approved identifier.

### Why three approved patient identifiers are required

Identifying patients consistently and correctly is a key element in reducing the risk of adverse events and enhancing patient safety.[7,8] Studies have confirmed that an adequate level of correct patient identification can be achieved by using at least three approved patient identifiers each time identification is made,[9] whether the practice has computer or paper based records. This minimises the risks of misidentification of patients and mismatches when they are undergoing procedures or clinical tests. Studies undertaken in the USA[10] using databases of medical records have demonstrated that the risk of false positive matching falls from a two in three chance using last name only to a one in 3500 chance when first and last names, postcode and date of birth are used.

### Asking for patient identifier information

When asking for patient identifier information, practice team members should ask the patient to state their name, date of birth and address rather than volunteering the information from the record the staff member has open. It is not appropriate for staff to volunteer patient identifier information and then ask the patient to confirm it – errors will occur if patients who are nervous, over obliging or hearing impaired verify incorrect information. In asking for patient identifier information, staff need to be mindful of privacy and confidentiality issues (see Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy).

When a patient is very familiar to the practice team, it may appear almost nonsensical to check their identity, but most practices have patients with identical names and the mismatching of patients and patient health records is not uncommon. Some practices overcome this by routinely asking patients to verify their address and other particulars each time they attend. This approach has the added benefit of ensuring patient contact details are kept up-to-date.

### Telephone and electronic identification

It is important to ensure correct patient identification when a patient telephones for a test result to maintain patient confidentiality and safety as identity checking is more difficult when the patient is not physically present. As before, patients should be asked to provide identifying information rather than asked to confirm information provided by the staff member.

Practices need to exercise caution in the use of text messages or emails to communicate clinical information to patients, since both methods can risk inaccurate patient identification and a breach of patient confidentiality.

It is equally important to ensure correct patient identification when patients ask for a repeat of their medications without attending the practice.

### Referral documents

Referral documents to another healthcare provider, such as a specialist, pathology or imaging service or hospital, should also document at least three of the approved patient identifiers of the patient being referred (see Criterion 1.6.2 Referral documents).

### Unique patient identifiers

The National E-Health Transition Authority is developing a system of unique patient identifiers for patients, as well as individual healthcare providers and organisations. Unique patient identifiers will support the electronic transfer of information and where available should be used to complement the three required patient identifiers. These identifiers will facilitate the accurate and secure transfer of patient health information between the different areas that provide care to an individual patient.

With the introduction of unique patient health identifiers, the practice's capacity to collect patient data and utilise this in quality improvement activities will be enhanced.

### Errors in patient identification

If errors in patient identification do occur, every member of the practice team is encouraged to report them, so that the event can be analysed and processes introduced to reduce the risk of a recurrence and harm occurring to other patients (see Criterion 3.1.2 Clinical risk management systems).

## Standards for general practices offering video consultations

General practices offering video consultation services should meet their usual obligations to identify patients using three approved patient identifiers.

### Verifying patient identify

For dual-care consultations, it is recommended the support clinician at the patient-end assume responsibility for asking the patient to provide their name, address and date of birth at the commencement of a video consultation as a means of confirming the patient's identity. The GP should also indicate the reason for the consultation to ensure the GP (or another support clinician) and the distant specialist are consulting with the right patient for the specified reason and are both using the right patient health record.

### Verifying the identity of other parties

All other parties in the video consultation whether present on or off camera or at a separate location such as a teaching facility, and including clinicians, students and family members, should also formally introduce themselves at the commencement of the video consultation. Clinicians should confirm their professional identity, specialty and location.

## Standard 3.2

### Education and training

Our practice supports and encourages quality improvement and risk management through education and training.

# Criterion 3.2.1

## Qualifications of general practitioners

All GPs in our practice are appropriately qualified and trained, have current Australian registration and participate in continuing professional development.

### Indicators

▶ A. All of our doctors can provide evidence of appropriate current national medical registration.

▶ B. Our practice demonstrates that all our doctors are recognised GPs, with the exception of:

- doctors enrolled in a recognised general practice training program

- other specialists practising within their specialty

- trainees undertaking a placement to gain experience in general practice as part of another specialist training program

- where recruitment of recognised GPs has been unsuccessful, our practice demonstrates that doctors have the qualifications and training necessary to meet the needs of our patients.

▶ C. Our practice can provide:

- evidence of satisfactory participation in the RACGP QI&CPD Program by all our GPs, or

- evidence that our doctors participate in quality improvement and continuing professional development to at least the same standard as the RACGP QI&CPD Program.

▶ D. Our GPs have undertaken training in cardiopulmonary resuscitation (CPR) in accordance with RACGP QI&CPD recommendations.

### Explanation

Key points

- General practitioners must be suitably qualified and trained and maintain the necessary knowledge and skills to provide good clinical care

- For practices unable to recruit vocationally recognised GPs, other doctors can be recruited provided they have the qualifications and training to meet the needs of patients

- General practitioners must undertake CPR training in accordance with RACGP QI & CPD recommendations.

General practice is a specialist discipline

General practice is a distinct discipline in medicine and requires specific training. Doctors in general practices need to be appropriately trained and qualified in the discipline of general practice and be either vocationally recognised, or have achieved Fellowship of the RACGP (FRACGP).

The RACGP defines a GP as a registered medical practitioner who is qualified and competent for general practice in Australia; has the skills and experience to provide patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities;

and who maintains professional competence for general practice through continuing professional development.

### Where vocationally recognised GPs are unavailable

In some areas it may be impossible to recruit vocationally recognised GPs. In such circumstances, practice doctors who are not recognised GPs need to be appropriately trained and qualified to meet the needs of the local community. Doctors who have not yet met the equivalent of the RACGP Fellowship need to be assessed for entry to general practice and be supervised, mentored and supported in their education to the national standards of the RACGP. Adequate professional and personal support for doctors entering general practice is critically important.

### Continuing professional development requirements

Doctors working in general practices who are not enrolled in the RACGP QCPD Program need to demonstrate recent and continuing participation in activities equivalent to Group 1 activities of the RACGP QI&CPD Program. The RACGP QI&CPD Program is based on adult learning principles (ie. knowledge is more likely to be gained when the adult undertaking the learning recognises a need to know, goes looking for the knowledge and reviews what has been learnt). The RACGP QI&CPD Program requires GPs to undertake two Group 1 activities in each triennium (eg. small group learning or clinical audits). Further information about the RACGP QI&CPD Program is available at www.racgp.org.au/QICPD.

The RACGP also has a factsheet that explains in detail the educational requirements for various subgroups such as GPs undertaking postgraduate studies, taking extended leave and starting in general practice. The factsheet is available at www.racgp.org.au/standards/factsheets.

### Cardiopulmonary resuscitation skills

The RACGP recognises that CPR skills are used infrequently and thus may diminish over time.

The College's QI&CPD Program states the requirements for CPR training:

- basic CPR courses must be consistent with current Australian Resuscitation Council (ARC) guidelines available at www.resus.org.au/policy/guidelines/section_9/9_1_1_feb07.pdf
- CPR courses must be a minimum of 1 hour in duration
- trainers must have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies available at www.resus.org.au/policy/guidelines/section_9/9_1_2_nov97.pdf.

Although Indicator D does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

### MBA Code of Conduct

The Medical Board of Australia has adopted a code of conduct for Australian doctors, which sets out expectations on good patient care such as recognising and working within the limits of an individual's competence and scope of practice and ensuring adequate knowledge and skills. The code also sets out expectations for maintaining professional performance and professional behaviour. The MBA Code of Conduct is available at www.medicalboard.gov.au/codes-and-guidelines.aspx.

## Standards for general practices offering video consultations

### Additional training for video consultations

Where a general practice offers video consultations, GPs should have appropriate training in key components of the practice's video consultation system including:

- dual-care duty of care

- professional indemnity obligations for video consultations

- patient safety and the clinical appropriateness of a video consultation

- informed patient decisions

- cultural awareness (eg. particular sensitivities about personal images and the recording of personal images)

- patient consent to the presence of third parties

- efficient coordination of patient appointments, clinician availability and properly functioning equipment

- core technical concepts such as interoperability and encryption

- proficient use of the practice's video conference equipment

- video consultation etiquette

- communication protocols including a clear allocation of follow up action to the specialist and general practice

- clinical handover within the general practice

- documentation by the GP (or another support clinician) in the patient's health record

- practice policy on video recording (see also Criterion 4.2.1 Confidentiality and privacy of health information)

- privacy and security of patient health information

- current evidence base for video consultations, with specific reference to patient safety; clinical effectiveness; privacy and security of patient health information

- evaluation of video consultation services.

Training should be regularly reviewed and updated as deemed necessary by the practice to reflect advances in technology, advances in the evidence base for telehealth care services, patient and other stakeholder feedback and advice from bodies such as the RACGP, the Medical Board of Australia and medical defence organisations.

### Resources

Practices will find useful resources including a factsheet on video consultation etiquette on the RACGP website (www.racgp.org.au/telehealth) and at MBS Online (www.mbsonline.gov.au/telehealth).

The MBA code of conduct 'Good Medical Practice: A Code of Conduct for Doctors in Australia' and the MBA guidelines: *Technology based patient consultations* are available at www.medicalboard.gov.au/codes-and-guidelines.aspx.

## Standard 3.2

### Education and training

Our practice supports and encourages quality improvement
and risk management through education and training.

## Criterion 3.2.2

### Qualifications of clinical staff other than medical practitioners

Other members of our clinical
team are appropriately qualified
and trained, have relevant
current Australian registration
and participate in continuing
professional development.

### Indicators

▶ A.  All our nurses and allied health professionals have:
- current national registration where applicable
- appropriate credentialing and competence
- work within their current scope of practice
- actively participate in continuing professional development relevant to their position in accordance with their professional organisation's requirements.

▶ B.  Our other team members involved in clinical care have appropriate qualifications, training and competence and participate in continuing professional development relevant to their role.

▶ C.  Our other team members involved in clinical care have undertaken training in CPR in accordance with the requirements of the relevant registration Act or professional organisation or at least every 3 years.

### Explanation

Key points
- Members of the clinical team must be suitably qualified and trained
- Members of the clinical team should work within their scope of practice and competencies
- Members of the clinical team should maintain the necessary knowledge and skills to provide good clinical care and to responsibly undertake delegated duties as required
- Cardiopulmonary resuscitation training needs to be undertaken at least every 3 years.

Other clinical staff

Practices are increasingly employing clinical staff in addition to GPs. This may include general practice nursing staff, medical students, allied health professionals, Aboriginal health workers or other clinical staff who provide clinical care. These health professionals are responsible for maintaining their own knowledge and skills and working within the limits of their competence and scope of practice.

Delegation

The RACGP Position statement on delegation of tasks is available at www.racgp.org.au/policy/GPs_and_their_teams.pdf.

The principles of task delegation include:
- respect and support for the patient-doctor relationship
- clearly defined roles that are aligned with licensing requirements, competency, education and training of the individual in that role

- practice systems that enable the provision of safeguards against error and harm
- mechanisms for ensuring provision of relevant patient information including the meeting of the ethical and legal requirements of the patient consent process
- availability of effective medical indemnity insurance
- availability of resources
- acceptability to the people – healthcare providers, patients and the broader community.

### Nurses in general practice
For information regarding employment and professional standards of practice nurses, refer to the following:

- Australian Nurses and Midwifery Council has produced a suite of competency standards for registered nurses, midwives, nurse practitioners and enrolled nurses and details are available at: www.anmc.org.au/
- Australian Practice Nurses Association has produced a number of resources specific to nursing in general practice, such as the 'A guide for the supervision of enrolled nurses in general practice'. For further information email admin@apna.asn.au or telephone 1300 303 184 (freecall).
- The Australian General Practice Network position statement on nursing in general practice is available at: www.aGPn.com.au/__data/assets/pdf_file/0010/4420/Nursing-in-General-Practice.pdf.

### Continuing professional development requirements
Other members of the clinical team are expected to comply with the professional development requirements of the relevant professional organisation, whether or not the individual is a member of the organisation.

### Codes of conduct
Other clinical team members are expected to comply with the code of conduct of the relevant professional organisation, whether or not the individual is a member of the organisation.

### Training
Training may be gained through participation in external courses or 'on the job' training at the practice. This criterion relates only to other clinical staff employed by the practice and not to co-located independent health practitioners who are not employed directly by the practice.

### CPR training
The RACGP recognises that CPR skills are used infrequently and will thus diminish over time. As other clinical staff may be present during a medical emergency, they need to be trained in CPR to assist the medical team. Cardiopulmonary resuscitation training for other clinical staff may be conducted by medical staff and the RACGP encourages practices to use medical staff who have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies. Alternatively, CPR training for other clinical staff may be conducted by an accredited training provider. Cardiopulmonary resuscitation training that is solely online does not meet ARC requirements for the physical demonstration of skills by trainees at the completion of the CPR course.

Although indicator C does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

## Standards for general practices offering video consultations

Where a general practice offers video consultations with specialists at distant locations, practice nurses and registered Aboriginal health workers who participate in video consultations on behalf of a GP should have appropriate training in key components of the practice's video consultation system including:

- dual-care duty of care
- professional indemnity obligations for video consultations
- patient safety and the clinical appropriateness of a video consultation
- informed patient decisions
- cultural awareness (eg. particular sensitivities about personal images and the recording of personal images)
- patient consent to the presence of third parties
- efficient coordination of patient appointments, clinician availability and properly functioning equipment
- proficient use of the practice's video conference equipment
- video consultation etiquette
- communication protocols including a clear allocation of follow up action to the specialist and general practice
- clinical handover within the general practice
- documentation by the GP (or another support clinician) in the patient's health record
- practice policy on video recording (see also Criterion 4.2.1 Confidentiality and privacy of health information)
- privacy and security of patient health information.

Training should be regularly reviewed and updated as deemed necessary by the practice to reflect advances in technology, advances in the evidence base for telehealth care services, patient and other stakeholder feedback and advice from bodies such as the RACGP, the relevant Registration boards and medical defence organisations.

### Resources

Practices will find useful resources including a factsheet on video consultation etiquette on the RACGP website (www.racgp.org.au/telehealth) and at MBS Online (www.mbsonline.gov.au/telehealth).

## *Standard 3.2*

### *Education and training*

Our practice supports and encourages quality improvement and risk management through education and training.

# Criterion 3.2.3

## Training of administrative staff

Our administrative staff participate in training relevant to their role in the practice.

### Indicators

▶ A.  Our administrative staff can provide evidence of training relevant to their role in the practice.

▶ B.  Our administrative staff have CPR training at least every 3 years.

### Explanation

Key points
• Administrative staff play a vital role in the provision of quality general practice care
• Administrative staff require training appropriate to their role in the practice
• Administrative staff are required to have CPR training at least every 3 years.

### Training relevant to the role

Administrative staff such as receptionists and practice managers who do not provide clinical care need training to be successful in their roles. This training may include formal courses in areas such as practice management, computers, software applications, first aid, medical terminology, medical practice reception and cross cultural engagement.

Additionally or alternatively, training may be 'on the job' training provided by GPs or other staff in the practice in areas such as learning how to use the patient health records system, making appointments, recognising medical emergencies when patients present in reception, confidentiality requirements and familiarisation with the practice policy and procedures manual.

### Triage training

From a risk management perspective, it is particularly important that the relevant nonclinical staff receive triage training in order to recognise medical emergencies and prioritise appointments for patients with urgent clinical needs. Triage training may be delivered by clinical staff within the practice or by appropriate external providers. If in doubt as to the urgency of a patient's need, administrative staff should be trained to consult with the practice nurse or GP to assess the degree of clinical urgency.

### CPR training

The RACGP recognises that CPR skills are used infrequently and will thus diminish over time. As administrative staff may be present during a medical emergency, they need to be trained in CPR to assist the medical team. Cardiopulmonary resuscitation training for administrative staff

may be conducted by medical staff or other clinical staff who feel competent to train colleagues and the RACGP encourages practices to use medical or other clinical staff who have a current CPR instructor's certificate that complies with ARC guidelines on instructor competencies. Alternatively, CPR training for administrative staff may be conducted by an accredited training provider. Cardiopulmonary resuscitation training that is solely online does not meet ARC requirements for the physical demonstration of skills by trainees at the completion of the CPR course.

Although Indicator B does not mandate CPR training more frequently than 3 yearly, many general practice professionals believe CPR training should be conducted on a more frequent basis, preferably annually.

### Resources
Information on courses run by the Australian Association of Practice Managers is available at www.aapm.org.au/html/s01_home/home.asp.

## Standards for general practices offering video consultations

### Additional training for video consultations
Where a general practice offers video consultations with specialists at distant locations, administrative staff who coordinate patient bookings, clinician schedules and video conference equipment should have appropriate training in key components of the practice's video consultation system.

### Good coordination is essential
Competence in the coordination of patient bookings and clinician availability as well as the efficient set up of rooms and properly functioning equipment, is considered by experienced clinicians to be a critical success factor for safe and clinically effective video consultations. Practices are therefore encouraged to invest in appropriate training for administrative staff in key components of the practice's video consultation system including:

- establishing a directory or accessing existing directories of participating specialists
- informed patient decisions
- cultural awareness (eg. particular sensitivities about personal images and the recording of personal images)
- patient consent to the presence of third parties
- efficient coordination of patient appointments including cancellations, clinician availability and properly functioning equipment
- proficient use of the practice's video conference equipment
- troubleshooting common technical difficulties
- video consultation etiquette

- communication protocols
- practice policy on video recording (see also Criterion 4.2.1 Confidentiality and privacy of health information)
- privacy and security of patient health information.

Training should be regularly reviewed and updated as deemed necessary by the practice to reflect advances in technology, advances in the evidence base for telehealth care services, patient and other stakeholder feedback and advice from bodies such as the RACGP, the Medical Board of Australia and medical defence organisations.

### Resources

Practices will find useful resources including a factsheet on video consultation etiquette on the RACGP website (www.racgp.org.au/telehealth) and at MBS Online (www.mbsonline.gov.au/telehealth).

*Section 4*
## *Practice management*

# Standard 4.1
## Practice systems
Our practice demonstrates effective human resource management.

# Standard 4.2
## Management of health information
Our practice has an effective system for managing patient information.

## Standard 4.2

*Management of health information*
Our practice has an effective system for managing patient information.

# Criterion 4.2.1

## Confidentiality and privacy of health information

Our practice collects personal health information and safeguards its confidentiality and privacy in accordance with National Privacy Principles.

### Indicators

▶ A.   Our practice team can describe how we ensure the confidentiality of patient health records.

▶ B.   Our practice team can demonstrate how patient health records can be accessed by an appropriate team member when required.

▶ C.   Our practice team can describe the processes we use to provide patients with access to their health information.

▶ D.   Our practice team can demonstrate how patients are informed about our practice's policy regarding management of their personal health information.

▶ E.   Our practice team can describe the procedures for transferring relevant patient health information to another service provider.

▶ F.   Our practice team can demonstrate how we facilitate the timely, authorised and secure transfer of patient health information in relation to valid requests.

▶ G.   When we collect patient health information for quality improvement or professional development activities, we only transfer de-identified patient health information to a third party once informed patient consent has been obtained.

▶ H.   Whenever any member of our practice team is conducting research involving our patients, we can demonstrate that the research has appropriate approval from an ethics committee.

### Explanation

Key points

• Privacy of health information is a legislative requirement

• The practice needs to have a documented privacy policy for the management of patient health information

• Patients need to be informed about the practice's privacy policy

• *Guidelines on Privacy in the Private Health Sector (2001)* will assist general practices to meet their legal obligations in relation to the collection, use and disclosure of health information.

National Privacy Principles
The Privacy Amendment (Private Sector) Act (2000) extends the operation of the Privacy Act (1988) to cover the private health sector throughout Australia. The ten National Privacy Principles form part of the legislation. The Principles promote greater openness between health service providers and consumers in relation to the handling of health information. The legislation complements the culture of confidentiality that exists in general practice.

Practices should make themselves familiar with the *Guidelines on Privacy in the Private Health Sector (2001)* published by the Office of the Federal Privacy Commissioner (OFPC). The *Guidelines* are not legally binding, but aim to help health service providers comply with the National Privacy Principles.

The OFPC *Guidelines* are available at www.privacy.gov.au/materials/types/guidelines/view/6517.

### RACGP Handbook

The RACGP *Handbook for the management of health information in private medical practice* describes minimum safeguards and procedures that need to be followed by general practices in order to meet appropriate legal and ethical standards concerning the privacy and security of patient records. This valuable resource is available at www.racgp.org.au/publications/tools.

### Privacy legislation

As well as being familiar with the Federal Privacy Act and National Privacy Principles, practices need to be familiar with the relevant state/territory privacy legislation as this will also impact on the way in which practices manage patient health information. For more information visit www.privacy.gov.au.

### Personal and health information

The Federal Privacy Act (1988) applies to personal information. Health information is a particular subset of personal information and can include any information collected to provide a health service, such as a person's name, address, account details, Medicare number and any health information such as a medical or personal opinion about a person's health, disability or health status.

Sometimes details about a person's medical history or other contextual information such as details of an appointment can identify them, even if no name is attached to that information. This is still considered health information and as such it must be protected under the Privacy Act.

### Practice privacy policy

National Privacy Principle 5 requires the practice to have a document that clearly sets out its policies on handling personal information, including health information. This document, commonly called a privacy policy, must be made available to anyone who asks for it.

The privacy policy should outline:

- the practice's contact details
- what information is collected
- why information is collected
- how the practice maintains the security of information held at the practice
- the range of people within the practice team (eg. GPs, general practice nurses, general practice registrars and students and allied health professionals), who may have access to patient health records and the scope of that access

- the procedures for patients to gain access to their own health information on request
- the way the practice gains patient consent before disclosing their personal health information to third parties
- the process of providing health information to another medical practice should patients request that
- the use of patient health information for quality assurance, research and professional development
- the procedures for informing new patients about privacy arrangements
- the way the practice addresses complaints about privacy related matters
- the practice's policy for retaining patient health records.

### Communicating with patients

The privacy policy can be made available to patients in a number of ways including a sign at reception, a separate brochure, a section of the patient information sheet or a notice/link on the practice website.

The Privacy Act sets out two compulsory mechanisms for informing patients about how their health information will be used.

1. A practice privacy policy. Organisations are required to provide this policy on request and commonly satisfy this requirement by making their privacy policy available on their website or on a sign at reception.

2. A 'collection statement' which sets out the following information:

- the identity of the practice and how to contact it
- the fact that patients can access their own heath information
- the purpose for which the information is collected
- other organisations to which the practice usually discloses patient health information
- any law that requires the particular information to be collected
- the main consequence for the individual if important health information is not provided.

### Patient consent

Patient consent should be provided at an early stage in the process of clinical care. It is important to distinguish between consent to treatment and consent to the handling of patient health information even if such consent processes happen to occur at the same time.

### Transfer of health information

The correct process for transferring patient health information to others, such as other health service providers or in response to third party requests, is outlined in section 2 'Use and Disclosure' in the OFPC *Guidelines on Privacy in the Private Health* Sector. Practices are advised to contact their insurers if they have any concerns about third party requests for the transfer of patient health information.

### Research

Research is an important component of general practice in Australia. Practices are encouraged to participate in research both within their own practice and through reputable external bodies.

Further information about research in general practice, including the requirements for ethics approval, can be found in the National Health and Medical Research Council (NHMRC) 'National statement on ethical conduct in human research' available at www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf.

### Quality improvement

For a quality improvement activity undertaken within a general practice, where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the practice, ethics approval is not required.

Clinical audits using a tool such as CAT (see Criterion 3.1.1 Quality improvement activities) or 'plan, do, study, act' cycles undertaken within a general practice as part of a quality improvement activity do not require ethics approval. For example, a practice wishing to determine how many of its pregnant patients are given advice on smoking cessation, or how many patients with heart failure are prescribed ACE inhibitors and beta blockers, may complete an audit on their practice data.

In general, a practice's quality improvement or clinical audit activities for the purpose of seeking to improve the delivery of a particular treatment or service would be considered a directly related secondary purpose for information use or disclosure. In other words, in general, the practice would not need to seek specific consent for this use of patients' health information.

To ensure patients understand and have reasonable expectations of quality improvement activities, practices are encouraged to include information about quality improvement activities and clinical audits in the practice policy on managing health information.

### Disclosure of health information to carers

In 2008 the Australian Law Reform Commission recognised that disclosure of information to 'a person responsible for an individual' can occur within current privacy law. If a situation arises where a carer is seeking access to a patient's health information, practices are encouraged to contact their medical defence organisation for advice before such access is granted.

### Practice closures

The correct process for handling patient health information on the closure of a practice is available in the OFPC *Guidelines* at www.privacy.gov.au/materials/types/guidelines/view/6517.

# Standards for general practices offering video consultations

Where general practices provide video consultation services they should be mindful of special issues related to the confidentiality and privacy of a clinical consultation and patient health information.

## Policy on video recording

The RACGP recommends that general practices adopt a default position of not recording video consultations and not authorising patients to make their own recordings of video consultations.

In accordance with the recognised principle of only collecting health information that is necessary, a decision to record images during a video consultation would generally be made by a clinician on the basis of collecting only that information which is clinically necessary for managing a patient. In the same way that a face-to-face consultation is not usually recorded, it is not anticipated that a video consultation would be recorded.

Where a video recording is made, the practice needs to meet community expectations and legal requirements to protect patient privacy. Clinicians need to be mindful of their own privacy in relation to the risk of video recordings being redistributed in the public domain without their consent. As these scenarios can be problematic for all parties and can have unintended consequences for all parties, it is suggested that recording be reserved for exceptional circumstances where it is absolutely clinically necessary.

Exceptional circumstances for making a recording during a video consultation may include still images (eg. a wound or skin lesion) or moving images (eg. a tremor, gait abnormality, unusual movement or range of movement) where such images are deemed to have clinical value.

In a situation where a clinician authorises a video recording, the following issues would need to be addressed:

- a practice protocol that describes the circumstances under which video recordings may be made (ie. when they are clinically indicated and the patient has consented)

- a practice protocol that requires informed patient consent to be obtained in advance, documented in the consultation notes and verified on camera

- secure storage (see also Criterion 4.2.2 Information security)

- a practice protocol for the retention and destruction of video recordings

- a practice protocol for defining who has access to video recordings and under what circumstances and who has overall responsibility for video recordings that have been made

- a protocol that stipulates whether recordings could be used for teaching purposes subject to all the appropriate consents being obtained in advance

- an understanding that clinicians present at the patient-end of a video consultation will not object to being present during a video recording which a distant specialist may authorise subject to a patient's prior consent
- an agreement that patients are not authorised to make their own separate recording of a video consultation
- an agreement by all parties that a video recording will not be redistributed in the public domain without the prior written consent of all parties.

### Resources

The RACGP *Implementation guidelines for video consultations in general practice* are available on the RACGP website at www.racgp.org.au/telehealth.

## Standard 4.2

### *Management of health information*

Our practice has an effective system for managing patient information.

## Criterion 4.2.2

### Information security

Our practice ensures the security of our patient health information.

### Indicators

▶ A.  Our practice team can demonstrate that the personal health information of patients of our practice is neither stored, nor left visible, in areas where members of the public have unrestricted access or where constant staff supervision is not easily provided.

▶ B.  Our practice ensures that our practice computers and servers comply with the RACGP computer security checklist and that:

- computers are only accessible via individual password access to those in the practice team who have appropriate levels of authorisation

- computers have screensavers or other automated privacy protection devices are enabled to prevent unauthorised access to computers

- servers are backed up and checked at frequent intervals, consistent with a documented business continuity plan

- back up information is stored in a secure offsite environment

- computers are protected by antivirus software that is installed and updated regularly

- computers connected to the internet are protected by appropriate hardware/software firewalls.

▶ C.  If our practice uses computers to store personal health information, we have a business continuity plan that has been developed, tested and documented.

▶ D.  Our practice has a designated person with primary responsibility for the practice's electronic systems and computer security.

▶ E.  Our communication devices are accessible only to authorised staff.

▶ F.  Electronic data transmission of patient health information from our practice is in a secure format.

▶ G.  Our practice has an appropriate method of destroying health record systems before disposal (eg. shredding of paper records, removal and reformatting of hard drives).

## Explanation

### Key points

- The privacy and security of health information held by a practice is a legal obligation
- Computer security is an important aspect of information security
- Information security must encompass availability of information, integrity of information and designated access to information
- Computerised practices need a contingency plan to cover computer crashes
- The practice needs a designated staff member with primary responsibility for computer security.

### RACGP resources

The RACGP *Computer security guidelines: A self assessment guide and checklist for general practice* (3rd edition) is available at www.racgp.org.au/ehealth/csg. The accompanying template for developing a policy and procedure manual should be completed by the designated staff member responsible for the practice's computer security and will form part of the practice's policy and procedure manual.

### Computer security

It is important to have a designated member of the practice team with responsibility for computer security.

This person needs to know who and when to call for expert advice, educate staff on data security and ensure security protocols are followed. The contact details of any external expert used by the practice need to be available to other relevant practice staff.

### Business continuity plan

When a practice uses computers to store patient health information, the practice needs to have a sound backup system and a contingency plan to protect practice information in the event of an adverse incident, such as a system crash or power failure. This plan needs to encompass all critical areas of the practice's operations such as making appointments, billing patients and collecting patient health information. Once a plan has been formulated, it needs to be tested on a regular basis to ensure backup protocols work properly.

Consideration needs to be given to the increasing portability of computer based systems. These need to be managed in an equally secure manner as the main practice network. Furthermore, being potentially more accessible to people outside the practice team, the physical security of portable equipment needs to be taken into account (eg. laptop computers, personal digital assistants [PDAs] and mobile telephones carried by GPs when travelling between different locations).

### Replacing equipment with hard drive memory

The practice is advised to review the RACGP *Computer security guidelines: A self assessment guide and checklist for general practice* (3rd edition) when

equipment is to be made redundant by the practice, to ensure key information is not lost or transferred inadvertently. Deleting records is insufficient to clear data from a computer system.

Practices need to be aware that other equipment such as photocopiers and fax machines may have hard drive memory and that confidential information needs to be properly removed before the practice disposes of such equipment.

### Preventing unauthorised access to patient health information

It is likely that practices will have different levels of access to patient health information for different staff members and this differentiated access needs to be documented in the practice's policy and procedure manual. To protect the security of health information, GPs and other practice staff should not give their computer passwords to others in the team.

Patient health records and computer screens should be positioned so confidential information is not readily visible to anybody but the appropriate members of the practice team. Screen savers or other automated privacy protection devices should be used to prevent unauthorised access to computers in a situation like a doctor momentarily leaving the consultation room. Although the focus of this criterion is information security, it is noted that many doctors now use the computer screen as a useful tool for sharing information with patients during a consultation.

### Active and inactive patient health records

The practice must ensure that both active and inactive patient health records are kept and stored securely. An inactive patient health record is generally considered to be the record of a patient who has not attended the practice/service three or more times in the past 2 years. It is recommended that inactive patient health records are retained by the practice indefinitely or as stipulated by the relevant national, state or territory legislation. General practices may want to consult their GPs' medical defence organisations when deciding on the practice's policy with respect to the retention of records.

Changes to computer hardware and software over time may prevent older versions of medical software from running correctly on newer systems and provision needs to be made for this eventuality, which may include retaining older systems for record storage purposes.

## Standards for general practices offering video consultations

Where general practices provide video consultation services, they should be mindful of special issues related to the privacy of a clinical consultation, and the privacy and security of patient health information.

### Secure technical systems are essential

The practice's technical systems for video consultations should provide a level of privacy appropriate for a clinical consultation and a level of privacy and security appropriate to the proper management of patient health information. This point cannot be overemphasised as any breach of security can be problematic for patients and clinicians alike.

Practices that use the internet to run video consultations will need additional products which support encryption to ensure patient health information is protected from inappropriate access. In the internet age, once a digital recording is in the public domain it remains there (see also Criterion 5.2.1 Practice equipment).

### Security of video recordings

Where a video recording is made, the practice needs to meet community expectations and legal requirements to protect patient privacy. Clinicians need to be mindful of their own privacy in relation to the risk of video recordings being redistributed in the public domain without their consent. As these scenarios can be problematic for all parties and can have unintended consequences for all parties, it is suggested that recording be reserved for exceptional circumstances where it is absolutely clinically necessary and that patients not be authorised to make their own recordings of video consultations (see also Criterion 4.2.1 Confidentiality and privacy of health information).

Where a video recording is made, patients would be entitled to access the recording under privacy legislation.

The practice of a clinician who authorises a video recording will generally be held responsible for its secure storage. Recordings must be managed as securely as any other patient health information and stored as part of the patient's health record in accordance with usual requirements for retaining health records (see also Criterion 1.7.1 Patient health records). Where a recording is stored by the practice in a separate location such as a separate hard drive, the location and storage medium should be documented in the patient's health record. Where a recording is stored securely by a third party service provider, the location of the recording should be documented in the patient's health record.

## Using third party service providers

Where a general practice delegates the secure storage of video consultation recordings to a third party, the practice should make it clear to the service provider that such recordings constitute patient health information and that the usual legislative requirements and RACGP standards should apply to the storage process. The practice should check the third party's security certificate to ensure they are a reputable and credentialled service provider.

## Resources

RACGP *Computer and information security standards* (4th edition) www.racgp.org.au/ehealth or the RACGP *Implementation guidelines for video consultations in general practice* at www.racgp.org.au/telehealth.

MBS Online – Connecting health services with the future: Guidance on security and privacy issues for clinicians at www.mbsonline.gov.au/telehealth.

The independent development of technical guidelines for video consultations will be iterative as technology advances and the uptake of video consultations increases. The RACGP will provide information about relevant technical guidelines developed by external organisations via the RACGP website (www.racgp.org.au/telehealth).

*Section 5*
*Physical factors*

# Standard 5.1

## Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

# Standard 5.2

## Equipment for comprehensive care

Our practice provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

## Standard 5.1

### Facilities and access

Our practice provides a safe and effective environment for our practice team and patients.

# Criterion 5.1.1

## Practice facilities

Our practice facilities are appropriate for a safe and effective environment for patients and the practice team.

### Indicators

► A.  Our practice has at least one dedicated consulting/examination room for every member of our clinical team working in our practice at any time.

► B.  Each of our consultation rooms (which may include an attached examination room/area):

- is free from excessive noise
- has adequate lighting
- has an examination couch
- is maintained at a comfortable ambient temperature
- ensures patient privacy when the patient needs to undress for a clinical examination (eg. by the use of adequate curtains or screens and gowns or sheets).

► C.  Our practice has a waiting area sufficient to accommodate the usual number of patients and other people who would be waiting at any given time.

► D.  Our practice has toilets and hand cleaning facilities readily accessible for use by both patients and staff.

► E.  Prescription pads, letterhead, administrative records and other official documents are accessible only to authorised persons.

► F.  Our practice and office equipment is appropriate to its purpose.

► G.  Our practice has one or more height adjustable beds.

  H.  Our practice waiting area caters for the specific needs of children.

### Explanation

Key points

- Practice facilities need to be safe for GPs, other practice staff and patients
- Patients should have auditory and visual privacy (eg. by the use of curtains, screens, drapes or gowns)
- Practices need to have one or more height adjustable beds
- This criterion cross references to Criterion 5.1.3 Physical access.

### Occupational health and safety

Health and safety requirements cover both consultation areas and all other areas of the practice. The practice facilities need to provide appropriate security for staff, patients and visitors.

### Design and layout

The RACGP publication *Rebirth of a clinic* assists practices with the design and layout of practice facilities which are fit for purpose and address security needs. It is available at www.racgp.org.au/publications.

Ideally, the practice layout should enable reception staff to see and monitor waiting patients to identify medical emergencies and reprioritise appointments as required.

While this criterion discusses consultation and examination 'rooms', it is acknowledged that some practices have consultation or examination 'areas' instead. Such consultation areas need to meet the same requirements for safety and appropriateness.

### Ambient temperature
Consultation room temperature needs to be such that a patient undressed for an examination remains comfortable.

### Privacy and patient dignity
The dignity of the patient should be protected by suitable visual and auditory privacy. Visual privacy can be afforded to patients during the clinical examination by the use of a gown or sheet and an adequate curtain or screen. This requirement includes situations in which there is a door opening to an area to which the public may have access and also when patients are required to undress/dress in the presence of the GP or practice nurse.

### Location of toilets and hand cleaning facilities
Ideally, toilets should be located within the practice. Toilets not within the practice itself need to be within close proximity. Toilets need to be easily accessible and well signposted. Separate staff and patient toilets are desirable. Washbasins need to be situated in close proximity to the toilets to minimise the possible spread of infection and need to be easily accessible to GPs, other staff and patients.

### Height adjustable beds
The RACGP has been involved in ongoing discussions with consumer bodies, the disability sector and the Australian Human Rights Commission (AHRC) with respect to improving access to high quality general practice for people with a disability.

Height adjustable beds are especially necessary for patients with limited mobility and the College has therefore determined that each accredited practice must have one or more height adjustable beds.

Height adjustable beds may assist general practice teams to:

• reduce the risks associated with patients getting on and off the examination couch, especially for people with impaired mobility

• reduce the risk of misdiagnosis or nondetection of serious medical conditions through difficulty in conducting an examination if a patient is not able to be examined on a standard examination couch

• reduce the risk of practice staff injuring themselves when examining patients or assisting patients on and off an examination couch

- reduce risks associated with the practice's legal responsibilities under the Disability Discrimination Act to ensure equal access for people with disability to the same range and quality of medical care as others.

Practices need to consider where a height adjustable bed may be best located. Many practices have told the RACGP that they have their height adjustable bed in a treatment room, rather than a consultation room.

The RACGP acknowledges that cost is a factor for some practices. The RACGP continues to advocate for infrastructure support for general practices in its representations to the Department of Health and Ageing.

Rebates for practice equipment that relates to occupational health and safety may be available through state and territory jurisdictions. Practices are advised to check jurisdictional WorkSafe websites for information on rebates that could apply.

In exceptional circumstances where the physical space of a practice is limited and a height adjustable bed cannot be accommodated, the practice needs to be able to demonstrate why it cannot accommodate a height adjustable bed, as well as how the practice safely manages examinations of patients with impaired mobility and protects the occupational health and safety of practice staff.

The disability sector has had experts review height adjustable beds available currently on the market to ensure they meet the needs of people with disabilities. Simple, functional specifications for appropriate beds are available at www.racgp.org.au/standards/factsheets.

### Services providing care outside normal opening hours

For services providing care outside normal opening hours that only provide visit based care, Indicators A, B, C, D, F, G and H are not applicable. However, all reasonable efforts should be made to protect the patient's privacy during a consultation and these services need to refer to, and meet, the infection control criterion in these Standards (see criterion 5.3.3 Healthcare associated infections).

While Indicator D is not applicable, services will need to ensure that effective hand cleaning (eg. with alcohol based hand rub) can occur when patients are seen outside the general practice.

## Standards for general practices offering video consultations

### Facilities for video consultations onsite

General practices offering video consultation services may need to adapt their practice facilities to provide an appropriate physical environment for telehealth care consultations.

Consideration should be given to elements such as:

- a quiet consulting room fit for purpose where the raised sound volume routinely associated with telehealth care consultations will not be overheard by others or disturb others

- arrangements to protect the privacy and dignity of patients who may be required to remove clothing for a physical examination (eg. a screen in the room or a separate private area where patients can remove clothing and be suitably covered with a gown or drape ahead of the video consultation)

- plain décor that will not distract from visual images on the screen

- good lighting where high intensity light behind the patient being filmed is avoided

- ready access to medical equipment that may be needed during a video consultation

- ready access to resources for managing adverse events during a video consultation

- protocols to minimise interruptions (eg. 'do not disturb' signage that indicates when a video consultation is in progress).

### Facilities for video consultations offsite

General practices offering video consultations from sites located away from the practice should satisfy themselves that the facilities provide a safe and effective environment for telehealth care consultations in line with the elements described above (see also Criterion 3.1.2 Clinical risk management systems).

For offsite facilities, it is useful to provide patients with information about how to get to the facility, access for people with a disability, parking, where to go and who to ask for on arrival.

### Resource

The RACGP factsheet on video consultation etiquette is available at www.racgp.org.au/telehealth.

## Standard 5.1

*Facilities and access*

Our practice provides a safe and effective environment for our practice team and patients.

# Criterion 5.1.2

## Physical conditions conducive to confidentiality and privacy

The physical conditions in our practice support patient privacy and confidentiality.

### Indicators

▶ A.  The physical facilities of our practice support patient privacy and confidentiality.

▶ B.  Visual and auditory privacy of consultations and treatments is supported.

### Explanation

Key points
• Visual privacy includes physical privacy for patients and the privacy of patient health information
• Auditory privacy means a patient's conversation with a member of the clinical team cannot be overhead by an inappropriate person, such as another patient or staff member
• This criterion cross references to Criterion 5.1.1 Practice facilities.

Visual privacy
Visual privacy can be afforded to patients during the clinical examination by the use of a gown or sheet and an adequate curtain or screen. Members of the clinical team need to be sensitive to patient dignity when patients are required to undress/dress in the presence of the GP or practice nurse.

Auditory privacy
Where possible, consultations should not be able to be overheard by others. Auditory privacy within the practice can be enhanced by the use of appropriate background music to mask conversations between staff members and between staff and patients. In areas of the practice such as nurses' treatment bays where auditory privacy is not possible, patients should be offered a private room for conversation as required.

The auditory privacy of consultation rooms can be significantly enhanced by having solid doors (rather than doors with paper cores), using 'draught proofing' tape around door frames and a draught excluder at the base of the door.

Protection of health information
It is important that patients have confidence their health information is being treated respectfully and with consideration to privacy and confidentiality. Privacy and confidentiality of patient information needs to be considered in all situations including discussions between staff members and telephone conversations between staff and patients.

Patient records and computer screens should be positioned such that confidential information is not readily visible to anybody but the appropriate members of the practice team and screen savers should

be used (see Criterion 4.2.2 Information security). Although the focus of this criterion is confidentiality and privacy, it is noted that many doctors now use the computer screen as a useful tool for sharing information with patients during a consultation.

### Physical layout of the practice

The RACGP has produced a design guide entitled *Rebirth of a clinic*: *A workbook for architecture in general practice and primary care* (2008). The design guide can assist practices with practical ideas on how to ensure auditory and visual privacy. The design guide is available through RACGP publications at www.racgp.org.au/publications.

### Services providing care outside normal opening hours

There is a range of circumstances in which patient confidentiality may be compromised when care outside normal opening hours is being provided. Patient privacy is as relevant in an environment outside a general practice (eg. patients' homes and residential aged care settings) as within.

### Standards for general practices offering video consultations

#### Adaptations to maintain privacy and confidentiality

General practices offering video consultation services may need to adapt their practice facilities to maintain appropriate support for patient privacy and confidentiality.

Consideration should be given to elements such as:

- a quiet consulting room fit for purpose where the raised sound volume routinely associated with telehealth care consultations will not be overheard by others or disturb others

- arrangements to protect the privacy and dignity of patients who may be required to remove clothing for a physical examination (eg. a screen in the room or a separate private area where patients can remove clothing and be suitably covered with a gown or drape ahead of the video consultation)

- protocols to minimise interruptions (eg. 'do not disturb' signage that indicates when a video consultation is in progress).

## Standard 5.2

### Equipment for comprehensive care

Our practice provides medical equipment and resources that are well maintained and appropriate for comprehensive patient care and resuscitation.

# Criterion 5.2.1

## Practice equipment

Our practice has access to the medical equipment necessary for comprehensive primary care including emergency resuscitation.

### Indicators

▶ A.  Our practice has equipment for comprehensive primary care and emergency resuscitation including:

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles
- equipment for resuscitation, equipment for maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask), IV access, and emergency medicines
- examination light
- eye examination equipment (eg. fluorescein staining)
- gloves (sterile and nonsterile)
- height measurement device
- measuring tape
- monofilament for sensation testing
- ophthalmoscope
- oxygen
- patella hammer
- peak flow meter
- scales
- spacer for inhaler
- specimen collection equipment
- sphygmomanometer with small, medium and large cuffs
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips
- vaginal specula
- visual acuity charts
- X-ray viewing facilities.

▶ B.  Our practice has timely access to a spirometer and electrocardiograph.

▶ C.  Our practice can demonstrate that the equipment we use is sufficient for the procedures we commonly perform.

▶ D.  Our practice can demonstrate how we maintain our key equipment, according to a documented schedule.

E.  Our practice has a pulse oximeter.

## Explanation

### Key points

- Practices need to have the necessary equipment for comprehensive primary care and emergency resuscitation

- Equipment that requires calibration or that is electrically or battery operated requires regular servicing in accordance with the manufacturer's instructions.

### Range of equipment

Practices need to have the necessary equipment for comprehensive primary care and emergency resuscitation. To meet this criterion, equipment must be in good working order. There is a wide range of equipment that practices may need in order to provide services which meet local needs, serve the nature of the practice and support any procedures the practice performs.

### All equipment must be in good working order

Equipment that requires calibration or that is electrically or battery powered (eg. electrocardiographs, spirometers, autoclaves, vaccine refrigerators, scales or defibrillators) needs to be serviced on a regular basis in accordance with the manufacturer's instructions to ensure it is maintained in good working order.

It is useful for practices to maintain a register of equipment in the practice, which includes the schedules for servicing or maintenance.

### Automated external defibrillator (AED)

There is evidence, both internationally and in Australia, to suggest that immediate defibrillation significantly improves the chance of survival after cardiac arrest. Although cardiac arrest in the general practice setting is a rare event[12], the difference in outcomes between early defibrillation (within 8 to 9 minutes) and later defibrillation is very significant (10% increase in mortality for each minute from the time of the arrest). Practices may choose to purchase an automated external defibrillator in view of the significant improvement in patient outcomes achieved by early defibrillation.

### Electrocardiograph and spirometer

Practices need timely access to an electrocardiograph and a spirometer. Some practices will choose to purchase this equipment and other practices will choose to make arrangements for timely access to the equipment (eg. arrangements with a pathology service or nearby local hospital).

For practices which have an electrocardiograph or spirometer onsite, it is important that staff are properly trained to use and maintain the equipment and analyse results.

The assessment of 'timely' access needs to be based on clinical need and what peers would consider to be an acceptable timeframe.

## Pulse oximeters

Pulse oximeters have been demonstrated to be useful in the general practice setting[13] for the assessment of hypoxia and, in some instances, to identify unsuspected hypoxia.

## Hazardous materials

All hazardous materials including liquid nitrogen and oxygen should be stored securely.

### Services providing care outside normal opening hours

Services providing care outside normal opening hours need to be able to demonstrate how the minimum equipment requirements outlined in this criterion would be accessed when needed.

## Standards for general practices offering video consultations

### Reliable and secure technical systems fit for clinical purposes

For the purpose of these *Standards*, the technical systems needed to support safe, secure and effective video consultations are deemed to be 'medical' as opposed to 'office' equipment (see also Criterion 4.2.2 Information security).

### Technical equipment

Consideration should be given to:

- a camera which can be zoomed in on the patient
- microphones which enable all participants in the video consultation to be clearly audible (eg. remote ceiling microphones or cabled/wireless extension microphones).

### Testing and maintaining technical equipment

Consideration should be given to:

- pre-testing the camera ahead of a video consultation session to ensure correct camera gaze angle so that eye-to-eye contact will be achieved
- pre-testing microphones ahead of a video consultation session to ensure all participants will be clearly audible
- documenting the checking and maintenance of video conference equipment in the practice's equipment maintenance schedule.

### Interoperability is imperative

Practices should pre-test the interoperability of general practice to distant specialist video conference systems because without it consultations cannot proceed. Practices are advised to keep a log showing the equipment used by participating specialists and confirmation of advance interoperability testing.

Where practices change their video conference systems, it is suggested that participating specialists be advised and that testing of interoperability be repeated.

### Technical support
Practices should have ready access to technical support to ensure video conference equipment and connectivity routinely deliver high quality sound and image for video consultations with specialists at distant locations.

### Technical contingencies
Practices should have documented plans for managing technical contingencies during a video consultation. It is useful to have easy-to-read troubleshooting protocols for common technical difficulties as well as one person in the practice who can help resolve such difficulties on the spot.

### Video consultations offsite
General practices offering video consultations from sites located away from the practice should satisfy themselves that the video conference equipment and connectivity are capable of delivering sound and image quality suitable for clinical purposes and of providing a level of security appropriate for the proper management of patient health information.

### Ready access to medical equipment
As part of the standard room set up, practices should ensure that any medical equipment likely to be needed during a video consultation is readily accessible. Ideally, as part of the booking process the distant specialist will have indicated in advance what equipment may be needed at the patient-end of the video consultation.

### Resources
RACGP *Implementation guidelines for video consultations in general practice* at www.racgp.org.au/telehealth.

RACGP *Computer and information security standards* (4th edition) at www.racgp.org.au/ehealth.

MBS Online: Guidance on technical issues for clinicians at www.mbsonline.gov. au/telehealth.

The independent development of technical guidelines for video consultations will be iterative as technology advances and the uptake of video consultations increases. The RACGP will provide information about relevant technical guidelines developed by external organisations via the RACGP website (www. racgp.org.au/telehealth).

# *Appendix A*

## Evidence relating to video consultations

To date, there is limited evidence on the clinical effectiveness and risks of video consultations in the Australian primary healthcare setting. Nevertheless, the majority of published clinical trials involving video consultations conclude it was a suitable method of healthcare delivery for their purposes. Some clear themes emerge from the current literature.

### Clarity of purpose

The key to successful telehealth care is a primary focus on the delivery of care not the technology.[1]

Video consulting standards should fit into current practice.[2]

The level of care afforded during a face-to-face consultation must equally be applied to a video consultation.[3]

### Safety and quality

If a specialist or GP is not satisfied that a video consultation is the correct medium to address a patient's issues, the specialist or GP should insist on a face-to-face consultation.[2]

The same rules of informed consent still apply[4] and the same processes for documentation, storage and retrieval of records apply.[5]

In Australia, there is no specific additional clinical information that needs to be kept for a telehealth care session.[6]

### Consumer centred care

The general practitioner and specialist should have cultural competencies relevant to the population they are treating.[7]

Each participant in a video consultation (including technical support, translators, medical students or administration staff) must be introduced.[8]

Patient groups that were initially apprehensive about a video consultation were normally satisfied with the delivery of care once the video consultation had been completed.[9]

Patients viewed a video consultation as a preferable alternative to face-to-face consultation when the specialist was more than 90 minutes travel time away.[10]

### Equipment, facilities and coordination

There is a range of media in which a video consultation may be conducted. There are many options for systems and for the use of medical peripheral devices.[11]

Environmental requirements are largely the same as those for a normal consulting room, ie. a room that is private and large enough for 2–4 people to sit comfortably.[3]

## *Appendix A*

Integrated technical and administrative support gives GPs and other medical providers, confidence in the telehealth care service, and is essential for seamless healthcare delivery.[12]

Video consultations should accommodate cultural needs around the display and recording of personal images.[13] This may be of particular significance for patients from an Aboriginal or Torres Strait Islander background.

### Education and training

General practitioners, specialists and practice staff must maintain their required professional registrations.[14]

It is desirable for all practice staff to be trained in the operation of the video consultation system.[15]

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# *Glossary of terms*

**Aboriginal and Torres Strait Islander status:** Patients able to be identified as being of Aboriginal or Torres Strait Islander origin in response to the practice asking the standard Indigenous Australian status question

**Aboriginal health worker:** A member of the indigenous health workforce who undertakes various roles including clinical functions (often as the first point of contact with the health workforce, particularly in remote parts of the country); liaison and cultural brokerage; health promotion; environmental health; community care; administration, management and control; and policy development and program planning

**Access:** The ability of patients to obtain services from the general practice

**Accreditation:** A formal process to ensure delivery of safe, high quality healthcare based on assessment against the RACGP *Standards for general practices*

**Active patient:** A patient who has attended the practice/service three or more times in the past 2 years

**Active patient health record:** The record of an active patient

**Administrative staff:** Staff employed by the practice who provide clerical or administrative services and who do not perform any clinical tasks with patients

**Adverse drug reaction:** See adverse medicines event

**Adverse medicines event:** An adverse event due to a medicine. This includes the harm that results from the medicine itself (an adverse drug reaction) and potential or actual patient harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident)

**Adverse event:** An incident that results in harm to a patient, where harm includes disease, injury, suffering, disability and death

**After hours services:** Services that provide care outside the normal opening hours of general practices, whether or not they deputise for other general practices, and whether or not they provide clinic or visit based care

**Allied health professional:** Health professionals who work alongside doctors and nurses to provide optimal healthcare for all Australians (eg. physiotherapists, dieticians, podiatrists)

**Another support clinician:** A member of the general practice team who provides clinical support on behalf of a patient's usual GP at the patient-end of a video consultation with a specialist at a distant location (eg. another GP, a practice nurse or a registered Aboriginal health worker)

**Antivirus software:** Software program that protects the computer or network from a virus program that can create copies of itself on the same computer and on others, and corrupt programs

# *Glossary of terms*

**Appointment system:** The system a practice uses to assign consultations between patients and GPs or other staff members who provide clinical care

**CALD:** People from culturally and linguistically diverse backgrounds

**Care outside normal opening hours:** Clinical care that is provided to patients of the general practice when the practice is normally closed. Each practice will have different opening and closing hours

**Carers:** People who provide care and support to family members and friends who have a disability, mental illness, chronic condition or terminal illness or who are frail

**Clinic based care:** Care that is provided when patients attend a general practice, in contrast to when they are visited at home

**Clinical governance:** A framework through which clinicians and health service managers are jointly accountable for patient safety and quality care

**Clinical indicator:** A measure, process or outcome used to judge a particular clinical situation and indicate whether the care delivered was appropriate

**Clinical management area:** Areas in the practice where clinical care is delivered

**Clinical risk management system:** A system or process the practice has put in place that is directed toward the effective management of potential opportunities for error and adverse events

**Clinically significant:** A judgment made by a health professional that something is clinically important for that particular patient in the context of that patient's healthcare. The judgment may be that something is abnormal and therefore clinically important for that particular patient, or it could be something that is normal but is clinically important for that particular patient

**Clinical team:** The members of the practice team who have qualifications related to health and perform clinical functions

**Cold chain management:** The system of transporting and storing vaccines within the temperature range of 2–8°C from the place of manufacture to the point of administration

**Complaint:** An expression of dissatisfaction or concern with an aspect of the general practice. Complaints may be expressed verbally or in writing and may be made through a formal complaints process, consumer surveys or focus groups

**Confidentiality:** The nondisclosure of information except to another authorised person, or the act of keeping information secure and/or private

# *Glossary of terms*

**Consumer Medicines Information:** Written information produced by pharmaceutical companies to inform consumers about prescription and pharmacist-only medicines

**Continuity of care:** The degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected and consistent with the patient's medical needs and personal context. Three aspects of continuity have been defined in the literature:

• informational continuity is the flow of information across healthcare events/ consultations, particularly through documentation, handover and review of notes from previous consultations

• management continuity is the consistency of care by the various people involved in a patient's care

• relational continuity is the sense of affiliation between the patient and their doctor

**Cooperative (as in after hours):** General practitioners from different practices working together to provide care to patients outside the normal opening hours of their practices

**Cultural background:** The particular ethnic or cultural heritage of a patient as collected and recorded by the practice

**Disability:** Any type of impairment of body structure or function, activity limitation and/or restriction of participation in society

**Disaster recovery plan:** A documented plan of the actions the practice needs to take to retain and restore patient health information in the event of a 'disaster' (normally a power failure or other such event)

**Discrimination:** Providing differential treatment or consideration based on characteristics of the patient. Discrimination can be positive (providing differential treatment to enhance care to the patient) or negative (providing differential treatment to the detriment of the patient's care)

**Distant specialist:** a specialist based in a separate location at a distance from the patient-end of a video consultation

**Dual-care:** The separate and concurrent duty of care which belongs to any support clinician providing patient-end clinical support and a specialist during a video consultation where the specialist is at a distant location

**Early detection and intervention:** The detection of early stages of disease and the prompt and effective intervention to prevent disease progression

# *Glossary of terms*

**Electronic communication:** The transfer of information (not necessarily patient health information) within or outside the practice through email, internet communications, SMS or facsimiles

**Encryption:** The process of converting plain text characters into cipher text (ie. meaningless data) as a means of protecting the contents of the data and guaranteeing its authenticity

**Enhanced Primary Care:** Relates to a government program to assist people with chronic illness and other people who need a range of services to support them in the community

**Enrolled nurse:** A nurse who works under the direction and supervision of a registered nurse as stipulated by the relevant nurse registering authority, where the enrolled nurse retains responsibility for his/her actions and remains accountable in providing delegated nursing care

**Error:** A generic term to encompass all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some chance agency

**Fellowship of the RACGP (FRACGP):** Fellowship of the RACGP is granted to GPs who have demonstrated that they have reached the standard required for unsupervised general practice in Australia

**Firewall:** A gateway or barrier between a private network and an outside or unsecured network (ie. the internet) to provide added security. A firewall can be used to filter the flow of data through the gateway according to specific rules

**Full backup:** A copy of all files residing on a computer or server hard drive. The files are marked as having been 'backed up'

**Gender:** Refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. By way of contrast, 'sex' refers to the biological and physiological characteristics that define men and women

**General practice:** General practice is the provision of patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities

**General practice registrar:** A registered medical practitioner who is enrolled in a general practice training program approved by the RACGP to achieve Fellowship of the RACGP

**General practitioner:** A registered medical practitioner who is qualified and competent to practise anywhere in Australia; has the skills and experience to provide patient centred, continuing, comprehensive, coordinated primary care to individuals, families and communities; and maintains professional competence for general practice

# *Glossary of terms*

**Hardware:** The physical components of a computer such as a monitor, hard drive or central processing unit

**Health outcome:** The health status of an individual, a group of people or a population which is wholly or partially attributable to an action, agent or circumstance in general practice

**Health promotion:** Preventive health activities that reduce the likelihood of disease occurring

**Home visits:** A general practice consultation conducted in the residence of a patient

**Human research ethics committee (HREC):** A committee that reviews applications from people or investigators/institutions undertaking research projects involving human subjects. The committee needs to be constituted according to National Health and Medical Research Council requirements

**Human resources:** Relating to the field of personnel recruitment, training and management

**Incident:** an event or circumstance that resulted, or could have resulted in, unintended and/or unnecessary harm to a person and/or complaint, loss, damage or claim for compensation

**Induction program:** A form of training provided to new staff members or GPs to introduce them to the practice systems, processes and structures

**Infection:** The invasion and reproduction of pathogenic (disease causing) organisms inside the body. This can cause tissue injury and progress to disease

**Infection control or infection control measures:** Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection (HAI) surveillance, infectious disease monitoring, hand hygiene and personal protective equipment

**Informed consent:** Consent by a patient (either written or verbal) to the proposed investigation, treatment or invitation to participate in research after achieving an understanding of the relevant purpose, importance, benefits and associated risks. For consent to be valid, a number of factors need to be satisfied including the patient receiving sufficient and appropriate information and being made aware of the material risks. The patient must have the mental and legal competence to give consent

**Interpreter service:** A service that provides trained language translation either face-to-face or by telephone

**Known allergy:** A hypersensitivity reaction to a medicine or other substance that is made known to a GP (see adverse drug reaction)

# *Glossary of terms*

**Medical deputising services:** Services that arrange for or facilitate the provision of medical services to patients of GPs (principals) by other medical practitioners (deputising doctors) during the absence of, and at the request of, the GPs

**Medication history:** an accurate recording of medications, comprising a list of all current medicines including all current prescription and non prescription medicines, complementary healthcare products and medicines used intermittently; recent changes to the medication list; past history of adverse drug reaction including allergies and recreational drug use.

**Mistake:** an error or adverse event that results in harm

**Near miss:** An incident that did not cause harm but could have

**Need:** Where these *Standards* use the phrase 'a practice needs...', the RACGP's position is that what 'needs' to be done in any situation is determined by what is reasonable in all the circumstances. In interpreting the *Standards*, care must be taken to be sensitive to the often highly variable circumstances of any particular situation

**Network:** A collection of connected computers and peripheral devices used for information sharing and electronic communication

**Normal opening hours:** The advertised opening hours of the general practice

**Nurse:** A registered nurse demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes and context of care. The registered nurse practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and other healthcare workers

**Nurse practitioner:** A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role where the scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice

**Other visit:** A general practice consultation conducted in a facility other than the general practice or the patient's home (eg. residential aged care facility)

**Outcomes indicators:** Indicators that relate to the effects of care on patients and communities

**Outside normal opening hours:** The hours not covered by normal opening hours

**Patient:** A person receiving healthcare. In relevant circumstances, the term is also intended to include a carer

**Patient-end:** The endpoint of a video consultation where the patient is present

# Glossary of terms

**Patient health information:** A patient's health information includes their name, address, account details, Medicare number and any health information (including opinion) about the person

**Patient health record:** Information held about a patient in hard or soft form, which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information and legal and occupational health and safety reports

**Physical facilities:** The building and equipment used to provide clinical care to patients

**Policy and procedures manual:** A resource document containing written practice information about the practice's policies and procedures

**Position description:** A document describing an employee's role, responsibilities and conditions of employment

**Practice information sheet:** A photocopied, typed or electronically generated information sheet which includes essential information for patients about services provided by the practice and methods of access to those services

**Practice team:** Teams of staff who provide care within the practice (eg. GPs, receptionists, practice managers, general practice nurses, allied health professionals)

**Primary care nurse:** a nurse who works in primary care where primary care nurses are not a formally identified profession

**Privacy of health information:** The protection of personal and health information to prevent unauthorised access, use and dissemination

**Process indicators:** Indicators that relate to what is done in giving and receiving care

**Public key infrastructure:** Public key infrastructure (PKI) is a secure method of transmitting information electronically to provide authentication and confidentiality. Public key infrastructure is used to transfer information between GPs and other healthcare providers

**QI&CPD:** Quality improvement and continuing professional development – educational activities that lead to quality improvement in clinical care as endorsed by the RACGP (formerly known as QA&CPD)

**Quality improvement:** An activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of healthcare delivered by the practice. Ethics approval is not required for quality improvement activities, including clinical audits using a tool such as CAT or 'plan, do, study, act' cycles, undertaken within a general practice

**Recognised GP:** See vocationally recognised GP

# *Glossary of terms*

**Referral:** To send on or direct a patient to another practitioner

**Relevant family history:** Information about the patient's family history that the GP considers to be important for the purposes of providing clinical care to the patient

**Relevant social history:** Information about the patient's social history (including employment, accommodation, family structure) that the GP considers important for the purposes of providing clinical care to the patient

**Risk:** an activity or factor that may increase the likelihood of disease or harm

**Risk management:** The culture, processes and structures that are directed toward the effective management of potential opportunities for adverse events

**Safe and reasonable:** A decision that each practice needs to make in light of factors affecting their practice (eg. location, patient population) in providing clinical care. What is safe and reasonable needs to be considered by the practice in light of what their peers (or practices in the same area) would agree was safe and reasonable

**Safety:** The degree to which potential risk and unintended results are avoided or minimised

**Screensavers:** A software program that displays constantly changing images or dims the brightness of a display screen to protect the screen from having an image etched onto its surface or being read

**Server:** Typically a computer in a network that provides services to users connected to a network (or 'clients'), such as printing, accessing files and running software applications. A server can be used as a central data repository for the users of the network

**SNAP:** An acronym used for major risk factors to a patient's health, viz. smoking history, nutrition, alcohol consumption and physical activity

**Software:** A program (or group of programs) which performs specific functions such as word processing or spreadsheets

**Specialist:** A medical practitioner who has undertaken post graduate qualifications and training in a recognised medical specialty and is registered to practise in an Australian State or Territory as a specialist in that specialty. (General practice is a recognised medical specialty but for the purpose of clarity in this Addendum, a general practice specialist is referred to as a 'GP' and other specialists are referred to as 'specialist' or 'distant specialist'.)

**Standard clinical practice:** Practice which might reasonably be expected by the public or professional peers

**Staff involved in clinical care:** Staff employed by the practice who perform any clinical tasks with patients

# *Glossary of terms*

**Structure indicators:** Indicators that relate to material resources, facilities, equipment and the range of services provided at the general practice

**Support clinician:** A patient's usual GP who provides clinical support at the patient-end of a video consultation with a specialist at a distant location

**System:** An organised and coordinated method or procedure

**Telehealth care:** 'Healthcare at a distance' which involves the electronic transmission of health information and/or images in the delivery of clinical services utilising a range of telecommunication technologies

**Timely:** A length of time which might reasonably be expected by professional peers for a defined situation

**Urgent:** A health need compelling immediate action or attention

**Video consultation:** A consultation conducted by video conference between a patient and a specialist at a distant location

**Video consultation coordinator:** The member of the general practice team with primary responsibility for coordinating patient bookings, clinician availability and properly functioning equipment

**Video consultation etiquette:** The professional behaviour that supports quality visual and audio performance and patient safety during a video consultation

**Video recording:** A recording of a video consultation which must be managed with the same level of security, privacy and confidentiality as any other patient health information

**Vocationally recognised general practitioner:** A GP on the RACGP Fellows list or the Vocational Register (grandparented) with Medicare, or a GP on the Australian College of Rural and Remote Medicine Fellows List with Medicare

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