The Royal New Zealand College of General Practitioners

20 September 2010

Aiming for Excellence

RNZCGP *Aiming for Excellence* 2011

The College would like to thank the many people who have provided comments for the review of *Aiming for Excellence*, The New Zealand Standard for General Practices, through written submissions, workshops, the CORNERSTONE general practice accreditation programme or completing the survey that was circulated through epulse.

The College has completed analysis of the results of feedback and the *Aiming for Excellence* Expert Advisory Committee[1] has met to discuss the results and provide advice on the new version. A small working group has met to consider all the advice and rebuilt the document to reflect all advice.

General practice in 2011 faces new challenges that have informed *Aiming for Excellence*, 2011. It sets the standard for general practice teams to deliver improvements in care for patients and communities and is demonstration of the commitment to high quality general practice care in a primary care setting.

The second round of consultation has commenced and submissions can be emailed to the College. For more information or to request a hard copy of the draft of *Aiming for Excellence*, please email mgillon@rnzcgp.org.nz or visit the College website www.rnzcgp.org.nz

The deadline for submissions is 10 October 2010.

The Royal New Zealand College of General Practitioners

Aiming for Excellence

The Foundation Standard for New Zealand General Practice

This document is under development and informed by:

- Feedback from practices and assessors in the CORNERSTONE programme during 2009 to 2010
- Feedback from PHOs that worked with their practices during 2009 to 2010
- Consultation feedback received from October 2009 to April 2010

As a result of feedback

- Legal, safety and risk indicators were updated and are in line with legislation or regulation
- Duplication has been stripped out
- A new structure based on a four quadrant model developed by the RNZCGP Board was introduced
- A draft was produced for the rebuild
- Identified gaps

The rebuild

Considerations: general practice in a primary care environment, gaps, opportunities, structure, patient journey, intent, clarification of wording:

1. 2 July 2010 – A Stakeholder workshop
2. 13 July 2010 – Working group
3. 21 July 2010 – Working group
4. 27 July 2010 – Working group
5. 31 August 2010 – Working group

2nd consultation period – October 2010

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Any changes to *Aiming for Excellence* since the first edition have been in response to feedback from general practice teams or other stakeholders. New evidence or information is used to continually refine the indicators in this document so they remain relevant and useful to New Zealand general practices. The Royal New Zealand College of General Practitioners (RNZCGP) will continue to monitor the use of *Aiming for Excellence* so that it can inform improvements in care provided to patients by general practice teams working in primary care.

Acknowledgements

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

Aiming for Excellence builds on the work of other international Colleges, particularly the Royal Australian College of General Practitioners, who have shared information and their experience of standards development and assessment. The RNZCGP has shared information with other international Colleges to help them develop their own standards, including, the Canadian Quality in Family Practice Programme, the Irish College of General Practitioners and the Royal College of General Practitioners.

The RNZCGP acknowledges Dr John Wellingham, Dr Tony Hanne and Stella McFarlane who have peer reviewed this version of *Aiming for Excellence*.
Academic Advisor, Dr Roshan Perera

2010 *Aiming for Excellence* Expert Advisory Group: Dr Chris Fawcett, Dr Jane Burrell, Dr Tane Taylor, Dr Jim Vause, Dr Jocelyn Tracey, Dr Malcolm Dyer, Dr Helen Bichan, Dr Keri Ratima, Dr Helen Rodenburg, Jane Ayling, Rosemary Gordon, Hayley Lord, Dr Luis Villa, Kevin Rowlatt, Maureen Gillon, Waveney Grennell, Jane O'Hallahan, Jeanette McKeogh, Mel Pande, Helen Glasgow.

Disclaimer

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

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Contents

Preface

We have pleasure in presenting you with the fourth edition of the RNZCGP Standard for General Practice, Aiming for Excellence. The standards signal an intent and commitment by general practice teams to constantly improve health outcomes through high quality general practice.

The College believes outcomes of care are influenced by the way a general practice is organised. The purpose of this document is to provide guidance and information to enable practice teams to reflect on their work and make changes based on the best evidence available.

The College encourages practices to take a questioning and systematic approach to when determining the effectiveness of care offered to patients. The underlying principle in the development of the standard is to promote quality improvement and encourage a critical thinking approach to generate positive change for patients.

The standards in the document build on the early work of a partnership between general practitioners, practice nurses, practice managers, Maori and consumers to develop indicators of best practice that are valid and relevant to New Zealand general practice.

The College notes the broad acceptance and uptake of the standards by general practice teams and primary care organisations who are working together to organise and deliver care. The standard has continued to influence positive outcomes as practices strive to improve their practice systems and processes. Practice teams are finding new ways to organise and deliver care, and are making incremental improvements.

One of the constant elements in primary care is change. General practice teams and the primary care landscape have changed considerably since the last published version of Aiming for Excellence. While it is clear the use of the standards has had a measurable and positive effect on General Practice, it is necessary to acknowledge the changes occurring in the primary care landscape. This version incorporates some of the RNZCGP responses to those changes.

New Zealand general practices are unique. They are characterised by:

- *A patient centred approach*
- *Involving patients and their whānau in their care*
- *A culture of safety, accountability and continuous quality improvement*
- *Multidisciplinary teams working together in networks of cooperation and support, providing both individual and population care for communities of patients*
- *Embracing new opportunities, including public health, screening, illness prevention, disease management and resource management*
- *Accepting greater accountability for health outcomes and best use of health resources*
- *Delivering clinical and management excellence in services, at all levels, to ensure optimum effectiveness and efficiency*

General practices are embedded in a variety of networks and in 2011 positive relationships continue to grow as practice teams develop working relationships with peers and colleagues. This extends their capacity to improve delivery to patients through better integration across primary care settings.

These standards are firmly rooted in an understanding of the quality landscape and reflect the blending of academic investigation with a pragmatic understanding of General Practice. The combination of core standards and a modular approach balances the need for quality assurance and continuous quality improvement. Clinical modules will provide aspirational targets, and allow for increasing diversity in primary care.

Furthermore the modules will clearly acknowledge the complexity of assessing any aspect of primary care, and the need to couple assessment with education to enable continuous quality improvement. Measuring and counting must be closely associated with a critical understanding of what the standards mean as well as education and a pathway towards improvement.

Aiming for Excellence provides general practice teams with a guide to high quality general practice services. It compliments other College programmes and is used as the standard for general practices by The RNZCGP CORNERSTONE General Practice Accreditation Programme to identify quality of care provided. It promotes teamwork and identifies managerial, organisational and clinical processes needed provide even better patient outcomes.

Aiming for Excellence Expert Advisory Group

Dr Chris Fawcett, Dr Jane Burrell, Dr Jim Vause, Dr Tane Taylor, Dr Malcom Dyer, Dr Helen Rodenburg, Dr Jocelyn Tracey, Dr Keri Ratima Jane Ayling, Kevin Rowlatt, Helen Bichan, Rosemary Gordon, Hayley Lord, Luis Villa, Maureen Gillon, Jane O'Hallahan, Waveney Grennell, Mel Pande

Introduction

General Practice

The mission of the RNZCGP is to "improve the health of all New Zealanders through high quality general practice care"[2]. It believes the provision of safe, high quality general practice services in a primary care environment is essential to achieve the best outcomes for patients. *Aiming for Excellence* describes the New Zealand standard for safe, high quality general practice care.

The Scope of General Practice Services[3]

General Practice[4] is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity. It is a clinical specialty orientated to primary health care. It is a first level service that requires improving, maintaining, restoring and coordinating people's health. It focuses on the needs of patients' and their whānau, enhancing the network among local communities, other health and non-health agencies.

1. Personal, family and community oriented comprehensive primary care that continues over time, is anticipatory as well as responsive, and is not limited by the age, gender, ethnicity, religion or social circumstances of patients, nor by their physical or mental states.

2. Normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, gender, culture or any other characteristic of the person concerned.

3. Makes efficient use of health care resources through the coordination of care, working with other professionals in the primary health care setting, managing the interface with other specialities, and taking an advocacy role for the patient when needed.

4. Develops a person-centred approach, orientated to the individual, as well as an approach that is responsive to the needs of their whānau and their community.

5. Has a unique consultation process that establishes a relationship over time, through effective communication between clinicians and patients.

6. Responsible for the provision of longitudinal continuity of care as determined by the needs of patients.

7. Specific decision-making processes determined by the prevalence and incidence of illness in a community.

8. Diagnose and manage simultaneously both acute and chronic health problems of individual patients.

9. Diagnose and manage illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.

10. Promotes health and well -being through appropriate and effective intervention.

11. Specific responsibility for health in the community.

12. Deals with health problems in their physical, psychological, spiritual, social and cultural dimensions.

Aiming for Excellence in 2011

Aiming for Excellence provides the RNZCGP standard for safe, high quality general practice in a primary care setting. It is used by general practice teams to establish internal quality assurance and transparent systems that can be subject to systematic and continuous improvement, and support clinical excellence[5].
It provides practice teams with:

- A standard to compare, maintain and improve standards of care that fit with the values and preferences of patients and their whānau, given the best information and resources available
- An overview of the scope of services needed for practices to be accountable, responsible and safe

Patient Centred Care and Whānau wellbeing – a commitment to improving health for all and Māori health

Patient centred care is a value that underpins collective responsibility and clinical effectiveness[6]. When combined with the core set of values, behaviours and relationships that underpin patient trust[7], it results in practice teams and patients using information to engage and navigate their way through the system together to achieve improvements in clinical outcomes[8] [9].

Potential within Whānau has never been greater [10]. As they support and involve each other in the process, there is a greater chance of successful recovery and management[11]. Improving Maori health will benefit and add greatly to the nation, and prospects of future generations. Whānau approaches expect practitioners to intervene by working with whānau, across primary care teams and other whānau centred services where possible.

Aiming for Excellence is based on the principle of Continuous Quality Improvement (CQI)

The measurements in *Aiming for Excellence* provide the foundation for general practice teams to develop their practice systems and clinical governance processes. Measurement alone is not useful and the synergy occurs when teams work together to improve their systems and processes.

CQI is a culture that seeks never-ending improvement of the whole system as part of normal daily activity, and continually striving to act according to the best available knowledge.[12] Undertaking a quality improvement process reflects the desire and commitment of the team to find out, "*Are we doing what we should be doing?*"

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

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

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

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

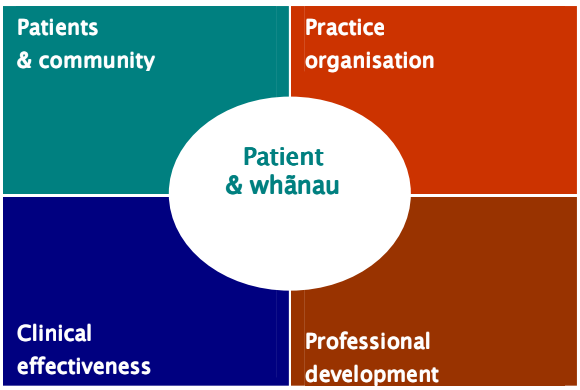
Raising the bar

It is not possible or useful to assess every function in a practice and the indicators and criteria in *Aiming for Excellence* reflect only a sample considered important by all stakeholders, including patients. The measurements provide a direction to practice teams who want to compare their practice systems and processes to identify where they are doing well or where there are gaps that require additional resources or clinical improvements.

Structure

The indicators are organised into four quadrants (fig 1). Each quadrant identifies indicators, criteria and standards considered important for patient centred general practice care. They guide practice teams with development of their clinical and practice systems in order to meet the needs of patients, their whanau[14] and other external stakeholders.

Figure 1



The measurements (Indicators, criteria and standards)

a) Indicators

Each indicator describes a measurable element of practice performance for which there is evidence or consensus that it can be used to assess quality, and be used to produce a positive change in the quality of care provided.[15]

b) Criteria

Criteria are discrete, definable, measurable and explicit.[16] These are the elements of care that are so clearly defined that they can be counted or measured to help understand whether the indicator was met or not.[17]

c) Standards

Each criterion guides improvement and provides a clear separation of external standards from developmental or aspirational standards [18]. The standard is viewed as a mark of success and specifies the acceptable level of care.[19].

★★ **RNZCGP Core standards**

These are the external, legal, safety or those that pose significant risk if not met and set out the minimum level of service patients can expect.

★ **RNZCGP Developmental standards**

Considered essential by the RNZCGP, these standards signal the direction of the patient journey and provide a framework for planning delivery of general practice clinical services to enable continual improvements in line with evidence and best practice.

Patients and community

Understanding patient experience is essential to informing services that are responsive to their needs. General practice teams that develop relationships with their local communities can identify their unique characteristics to understand the dynamics or complexity that can affect patient health outcomes. Knowing more about vulnerable patients and families through identification and early intervention is essential for coordinating care, and preventing problems.

Needs and rights of patients

Indicator 1

The practice team complies with the Code of Health and Disability Services Consumers' Rights 1996

Criteria

1.1 ★★	There is a documented policy that describes how The Code of Health and Disability Services Consumers' Rights 1996 (The Code) will be implemented
1.2 ★★	The practice team has received training within the last three years to implement 'The Code'
1.3 ★★	The practice team is able to describe their role in implementing 'The Code'
1.4 ★★	The Code of Health and Disability Services Consumers' Rights 1996 is displayed
1.5 ★★	Information about the local health advocacy service is available to take away

Further information

The Code of Health and Disability Services Consumers' Rights 1996, amended in 1999 and 2004, specifies the obligation of practice teams to show that they have taken "reasonable actions in the circumstances to give effect to the rights, and comply with the duties" in the Code.

RNZCGP Consumer Liaison Committee advice:

- The practice team should recognise individual values and beliefs, and culture. This includes ethnicity, spirituality, disability (physical, psychological, intellectual and sensory), gender, sexual orientation, social status and age
- Information: Hours, fees, services, after hours arrangements, doctors, practice personnel, place in practice, special information needs, translation, large print (font size should be no less than size 14 for legibility)
- Disability should not be a reason to curtail the process of informed consent. Extra time and resources should be made available if necessary to fulfil this right

- Services may be provided to a patient if they make an informed choice and give informed consent. Note: exemptions in legislated areas, e.g. emergency
- Any other relevant information should be noted, such as professional, ethical, legal and other relevant standards
- Patients have the right to decline or change their mind at any time
- Interpreters or advocates should be available to assist patients who need extra help with communication and making decisions about their care, e.g. people who are deaf, those for whom English is a second language or those with intellectual disabilities
- Receptionists have received training in dealing with the public, and difficult situations

Resources

The Code of Health and Disability Consumers' Rights 1996

Health and Disability Commissioner Website (this includes a copy of the Code of Health and Disability Services Consumers' Rights 1996). http://www.hdc.org.nz; email hdc@hdc.org.nz; phone: 0800 11 22 33

Health Navigator: www.healthnavigator.org.nz

Medical Council of New Zealand – Cole's Medical Practice in New Zealand (2008). http://www.mcnz.org.nz

Patient involvement

Indicator 2

There is patient and community input into service planning

Criteria

2.1 ★	The practice obtains formal feedback from patients to determine their satisfaction with the service is obtained at least three yearly
2.2 ★	Practice planning and development of services is responsive to their enrolled population
2.3 ★	Patient, whanau input and community feedback is used to improve the quality of service provision
2.4 ★	Information about the use of patient, whanau and community input is communicated to the practice team and patients

Further information

All teams should be aware of the importance of knowing the health needs of enrolled patients and using patient feedback to improve and plan services provided. Being responsive to the patient's and carers' needs may require a variety of approaches to include patient input and some methods require special skills which will not be readily available[20].

RNZCGP Consumer Liaison Committee advice:

- Use consumer participation and feedback
- Keep it simple and flexible, but generate a culture of consumer participation
- The cultural and demographic mix of the patient population should determine the preferred mix of patient feedback or participation
- Members of the practice team could approach people and their families on an individual basis

There are a range of methods that can be used to invite the views of patients and their Whanau about practice services. Methods used to capture information can include responses to community feedback, e.g. community liaison group, advisory groups, delegate on a practice committee, focus group, or hui. e.g. surveys, one-on-one feedback, documented, collection of informal complaints or comments. It is important that comments received are communicated to the practice team for improvement activity and patients to inform them about any changes to services.

Resources

Health and Disability Commissioner Website (this includes a copy of the Code of Health and Disability Services Consumers' Rights 1996. http://www.hdc.org.nz. hdc@hdc.org.nz; phone: 0800 11 22 33

The RNZCGP Better Practice Patient Questionnaire (BPPQ) is available from the College in Maori, Samoan, Chinese and Korean. rnzcgp@rnzcgp.org.nz

Integration of care

Indicator 3

The practice delivers health care that is integrated with other agencies and community services to improve individual care of patients

Criteria

3.1 ★★	The practice team can access a directory and/or resources about local, regional and national health, social and community agencies
3.2 ★★	The clinical team has established relationships with other agencies, secondary services, public health, disability, community services, or different providers
3.3 ★	The clinical team coordinates care with other agencies
3.4 ★ NEW	There are established links with Well Child services to integrate the care of children

Further information

Knowledge of other services informs care, referrals and can help plug information gaps[21]. Opportunities for working collaboratively and across the interfaces in primary care will depend on relationships and understanding of other services provided in the community. It may result in the need to change practice or identify new approaches to care management and these efforts will contribute to reducing variation, inequalities and improving health of populations, e.g. whanau ora approaches.

Examples of resources: handouts, directories, pamphlets, internet sites, local councils, Citizens Advice Bureau have access to databases with contact information about community and health services.
Examples of networks and opportunities to build in meetings between local practices and educational programmes: Child health initiatives, Arthritis field officer, Plunket, Care Coordination services, Whanau Ora providers.

Resources

Citizens Advice Bureau http://www.cab.org.nz/
The Ministry of Health http//www.moh.govt.nz and Ministry of Social Development http://www.msd.govt.nz have a list of local, regional and national agencies.
New Zealand Directory of the Health Sector. www.healthsector.co.nz

Access and availability

Indicator 4

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

Criteria

4.1 ★★	Patients are able to access information on 24-hour health advice or care
4.2 ★	Patients can access the after hours service via a maximum of two calls through call diversion or equivalent
4.3 ★	The practice follows up information received about patients seen after hours

Further information

Advice from the Health and Disability Commissioner's Office:

- If a practice does not provide after hours care, it must arrange for medical services cover 24 hours a day, 7 days a week e.g. Healthline or 0800 number
- If a doctor cannot respond to after hours care they must make provision to redirect a patient to the nearest after hours service, hospital, 111 or on call in the area

Patients should be able to access after hours care or be directed to the service when they need it by using methods that take into account local situations and enable flexibility if the practice does not provide its own 24-hour care.

- Phone diversion should be in place unless justifiable by circumstance
- Patients may have to dial a second number in some areas, as call diversion is not possible throughout New Zealand
- There are a number of possible combinations that include the practice providing its own service or referring to another service, such as switching the telephone to another service
- The 111 service is free on cell phone
- Call diversion, and voice messaging provide explicit information about which service is providing access to 24 hour care if after hours care is not provided at the practice

Practices should be able to provide an example that tracked information about patients seen after hours:

- How the information was received
- How information was followed up by the practice

Informed consent

Indicator 5

Patients are provided with information to enable them to make informed choices and give informed consent about their care

Criteria

5.1 ★★	Information is available for patients to help them understand and exercise their right to make informed choices
5.2 ★★	Informed consent is obtained from a patient or legally designated representative, when agreeing to a treatment or procedure
5.3 ★★	The clinical team documents informed consent in compliance with Rights 6 and 7 of 'The Code'
5.4 ★★	The clinical team documents discussing the harms and benefits of contentious screening tests with eligible patients in relation to harm versus benefit

Further information

RNZCGP Consumer Liaison Committee advice:

Practice teams should be trained to access information for patients in different languages, formats and to contact interpreters and translators as needed.

Patients and their Whanau must receive communication in a form, language, and manner that enables them to understand information provided.

Support offered must be made available, or obtained, to assist patients with understanding information provided and to enable them to make informed choices, so they can give consent about their care and treatment. There is a range of support available such as interpreters, family members/Whanau, patient advocate, clinical team members, counsellors.

Information provided can include:

- Explanation of the condition
- Explanation of options available
- Assessment of risks, side effects or potential harm
- Estimated time until service can be provided
- Results of tests
- Results of procedures
- Notification of any proposed participation in teaching or research

A record is important in contentious areas where there is disagreement between evidence and some medical practice (prostate specific antigen) or ethical issues (Down's Syndrome investigation in pregnancy).

The practice policy on informed consent should contain information required to gain consent, what information was provided (pamphlet/guideline) and what is used to gain consent. Evidence should exists of the benefits and risks discussed with patients prior to screening tests e.g. in patient notes where clinical members have recorded discussing screening and the result.

Consent must be in writing if:

- The patient is to participate in any research
- The procedure is experimental
- The patient will be under general anaesthetic

Practices should also document the:

- Date
- Name
- Procedure
- Whether a specimen was sent for histology
- Date result received
- Date patient was informed about result
- There is significant risk of adverse effects on the patient

The Code of Health and Disability Consumers' Rights 1996 – Rights 5, 6, 7 and 8:

5. The right to effective communication
6. The right to be fully informed
7. The right to make an informed choice and give informed consent
8. The right to support

Resources

Health and Disability Commissioner website (includes a copy of the Code of Health and Disability Services Consumers' Rights 1996): http://www.hdc.org.nz; email hdc@hdc.org.nz; phone: 0800 11 22 33.

Videos, audiotapes, posters, pocket cards and pamphlets can be purchased through the Health and Disability Commissioners Office, PO Box 1791, Auckland

Internal Affairs Translation Service –http:// www.dia.govt.nz

Medical Council of New Zealand – Cole's Medical Practice in New Zealand (2008): http://www.mcnz.org.nz

Medical Council of New Zealand – Information and Consent (April 2002): http://www.mcnz.org.nz

Medical Council of New Zealand – Legislative requirements about patient rights and consent (October 2005): http://www.mcnz.org.nz

Ministry of Health – Consent in Child and Youth Health (1998): http://www.moh.govt.nz

Ministry of Health – Refugee Health Care: A Handbook for Health Professionals (2001): http://www.moh.govt.nz

New Zealand Society of Translators and Interpreters (NZSTI), is a nationally representative body of translators and interpreters that provides a networking forum for its members, represents members' interests, and promotes continued professional development, quality standards and awareness of the profession within government agencies and the wider community. http://www.nzsti.org/

Complaints

Indicator 6

The practice upholds patients' right to complain

Criteria

6.1 ★★	The practice has a documented complaints policy
6.2 ★★	The practice team demonstrates the complaints process complies with Right 10 of 'The Code'
6.3 ★★	The Complaints Officer can demonstrate that the complaints process complies with Right 10 of 'The Code'
6.4 ★	Complaints and their resolution are used as opportunities for learning and quality improvement

Further information

Most complaints can be dealt with at practice level. Experiencing a complaint can be distressing for patients, families, individual practitioners or the practice team. Complaints can be an important indicator of problems with care provided, so the complaints system is an important element of clinical governance. The issue may not be an isolated complaint so the practice should establish whether there is a consistent pattern to the complaints received. An effective system will assist practices to respond positively and constructively to complaints.

A complaints procedure must show appropriate documentation and compliance with relevant timeframes and the legal requirements under Right 10 of 'The Code'.

To avoiding complaints:

- Establish quality systems in accordance with the legislative requirements
- Develop practice systems that encourage patient feedback and response

Managing complaints: The practice team should know how the complaints procedure is managed in the practice. They should know:

- That people have the right to complain
- Who complaints can be made to
- The method to implement a fair, simple, speedy and efficient resolution of complaints
- Managing complaints within the timeframes under 'The Code'
- What information should be provided to patients
- Provide examples of how complaints are used to inform clinical governance activity in the practice

Resources

Health and Disability Commissioner website, includes a copy of the Code of Health and Disability Services Consumers' Rights 1996, (The Code). http://www.hdc.org.nz; email hdc@hdc.org.nz; phone: 0800 11 22 33

Medical Council of New Zealand – Cole's Medical Practice in New Zealand (2008): http://www.mcnz.org.nz

Royal New Zealand College of General Practitioners: Managing Complaints – Process and Strategies (2009)

Maori

Indicator 7

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

Criteria

7.1 ★	The practice has a documented Maori Health Plan, that states how it implements measures to address the health needs of enrolled Maori patients
7.2 ★★	The practice team has had training in the Te Tiriti o Waitangi (the Treaty of Waitangi), including the principles of the treaty; Partnership, Participation and Protection
7.3 ★	The practice is meeting the health needs of its enrolled and Maori population to reduce inequalities
7.4 ★	The practice team has developed working relationships with local Maori organisations/providers and Maori groups

General practice commitment to the Treaty of Waitangi:

The RNZCGP is committed to improving the health status of Maori. It recommends taking an evolutionary approach to improvement, such as, attending Treaty of Waitangi training, collecting ethnicity data correctly, conducting clinical audits of Maori and non-Maori. All audit data requires analysis by ethnicity for identifying ethnic health inequalities. These activities will assist practices with a Maori population to identify needs and work towards improved health and parity of outcomes for Maori people.

The Crown is committed to the ongoing development and refinement of services that recognise both the partnership status and the current health disparities of Maori. As such, there is a commitment to seeing that Maori are involved at all levels of health services delivery.

This indicator looks for evidence of practice responsiveness to the Treaty of Waitangi. It assesses whether practices reach, know the health needs and have a plan to address these for Maori in their population such as:

- The patient management system identifies Maori
- The practice using the Health Equity Assessment Tool, Whānau Ora Tool or Whānau Ora Health Impact Assessment Tool in their planning process[22]
- The practice is aware of the special rights and health needs of Maori, and implements policies consistent with the Maori Health Strategy, to ensure access to a fair share of the practice resources
- The practice conducts regular clinical audits reviewing data by ethnicity, and makes changes to practice as indicated by the results of these audits
- Practice teams are expected to proactively identify the health needs of Maori with the purpose of providing equity to Maori

Te Akaranga a Maui 2010

Further information

The RNZCGP recognises that there is a diversity of understanding about Maori populations and Maori health issues throughout the country. Practices will provide their own solutions.

The RNZCGP has its own Cultural Competence resource which was developed by Mauri Ora Associates with the assistance of Te Akoranga a Maui. Cultural Competence – Advice for GPs to create and maintain culturally competent general practices in New Zealand 2007. rnzcgp@rnzcgp.org.nz

Heat[23]: For those practices who wish to implement HEAT, it may be simple to administer, but users should be mindful that to fully answer questions it requires information and research that may not always be to hand. It is recommended that people using this guide for the first time work with others who are experienced in its use, or work with people experienced in addressing health inequity, or undertake equity training.

Data capture must align with the MOH principles of patient self-identification. When collecting ethnicity, self-identification must be the process used to identify a patient's ethnic group. It is unacceptable for the collector to guess any patient's ethnicity or to complete the question on behalf of the patient based on what they perceive to be the patient's physical appearance. Ethnicity data must not be transferred from another form as it may have been incorrectly collected.

Practice members must be able to explain to patients the purpose for collecting ethnicity data. Providing quality ethnicity data will ensure that practice teams are able to track and share health by ethnicity and effectively monitor performance to improve health outcomes and reduce health inequalities. It will also provide Maori with quality information about their health status.

Resources

Ministry of Health: He Korowai Oranga – Maori Health Strategy (2002) http//www.moh.govt.nz/mhs.html

Health and Disability Commissioner Website (this includes a copy of the Code of Health and Disability Services Consumers' Rights 1996. http://www.hdc.org.nz; email: hdc@hdc.org.nz; phone: 0800 11 22 33

Mason Durie. Cultural Competence and Medical Practice in New Zealand, Discussion Paper, School of Maori Studies, Massey University, Palmerston North. 2001 http://www.massey.ac.nz

Medical Council of New Zealand: Best Health Outcomes for Maori: Practice Implications 2006; Statement on best practices when providing care to Maori patients and their whanau 2006

Ministry of Health. 2004. Ethnicity Data Protocols for the Health and Disability Sector. Wellington: Ministry of Health. http://www.moh.govt.nz/moh.nsf/pagesmh/3006

Ministry of Health. The HEAT Tool, the Whanau Ora Tool and the Whanau Ora Health Impact Assessment Tool are all available on the Ministry of Health website. www.moh.govt.nz

Cultural competence & responsiveness

Indicator 8

Patients and their families receive services that respect the values and beliefs of different cultural, religious, social and ethnic groups

Criteria

8.1 ★★	The practice provides services that are responsive to the cultural needs of diverse patient groups
8.2 ★★	The practice team has received training to maintain cultural competence within the last three years
8.3 ★	The practice team can identify interpreters and local resource people where language is a barrier to care
8.4 ★	The practice collects, records and audits patient ethnicity data consistent with the Health Information Privacy Code 1994 and the MOH Ethnicity Data Protocols for the Health and Disability Sector

Further information

Personal, family and community oriented comprehensive primary care continues over time, is anticipatory as well as responsive, and is not limited by age, gender, ethnicity, religion or social circumstances of patients, nor by their physical or mental states.

To be responsive to its local communities, practices should consider how to develop and maintain relationships with organisations or groups within the practice population and what processes are in place to respond to diverse needs. Practices who engage with other community or primary health organisations are able to obtain information about the health needs of diverse communities.

Patient surveys such as the RNZCGP BPPQ – Better Practice Patient Questionnaire can provide information about cultural impressions of care provided to meet specific requirements of its different populations, e.g. youth, older, ethnic, religion.

Some patients will need translation services where interpretation is beyond family members' capability. The New Zealand Society of Translators and Interpreters (NZSTI), is a nationally representative body of translators and interpreters. It provides a networking forum for its members, represents members' interests, and promotes continued professional development, quality standards and awareness of the profession within government agencies and the wider community.

Under Section 118 of the Health Practitioners Competence Assurance Act 2003, registration authorities have a responsibility to set standards for cultural competence, review and maintain the competence of health practitioners, and set programmes to ensure ongoing competence.

The Code of Health and Disability Consumers' Rights 1996 – Rights 1, 2 and 3
5. The right to be treated with respect

6. The right to freedom from discrimination, coercion, harassment, and exploitation
7. The right to dignity and independence

Collection of demographic data from patients must be in line with the, Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health 2004.

Resources

Braille translation – Royal New Zealand Foundation for the Blind. http://www.rnfb.co.nz

Consumers' Rights 1996. http://www.hdc.org.nz; email hdc@hdc.org.nz. phone: 0800 11 22 33

Deaf Association. http:// www.deaf.co.nz

Health Navigator. http://www.healthnavigator.org.nz/centre-for-clinical-excellence/health-literacy

Internal Affairs Translation Service. http:// www.dia.govt.nz

Health and Disability Commissioner Website (this includes a copy of the Code of Health and Disability Services

Medical Council of New Zealand. Best Health Outcomes for Pacific peoples: Practice implications 2010 http://www.mcnz.org.nz

Mason Durie. Cultural Competence and Medical Practice in New Zealand, Discussion Paper, School of Maori Studies, Massey University, Palmerston North; 2001

Medical Council of New Zealand: Statement on cultural competence 2006. http://www.mcnz.org.nz

Medical Council of New Zealand: Best Health Outcomes for Maori: Practice implications 2006. Statement on best practices when providing care to Maori patients and their whanau 2006. Best Health Outcomes for Pacific peoples: Practice implications 2010

Ministry of Health. 2004. Ethnicity Data Protocols for the Health and Disability Sector. Wellington: Ministry of Health. http://www.moh.govt.nz/moh.nsf/pagesmh/3006

Ministry of Health. Korero Marama: Health Literacy and Maori 2010 http://www.moh.govt.nz/moh.nsf/indexmh/korero-marama-health-literacy-maori-feb2010Ministry of Health – Refugee Health Care: A Handbook for Health Professionals 2001. http://www.moh.govt.nz

Ministry of Health: He Korowai Oranga – Māori Health Strategy 2002. http//www.moh.govt.nz/mhs.html

New Zealand Society of Translators and Interpreters NZSTI. http://www.nzsti.org/

The Centre for Clinical Excellence. http://www.healthnavigator.org.nz/centre-for-clinical-excellence

The Royal New Zealand College of General Practitioners. Cultural Competence – Advice to GPs to create and maintain culturally competent general practices in NZ 2007. rnzcgp@rnzcgp.org.nz

Strategic Plan

Indicator 9

The practice has a documented Strategic Plan

Criteria

9.1 ★	The practice has a documented Strategic Plan with quality objectives and an identified date for review
9.2 ★	The annual business plan achieves the quality objectives
9.3 ★	Practice team members have input into the Strategic Plan
9.4 ★	Patient input is used for strategic and annual planning purposes

Further information

Practice plans provide clear business direction to what the practice is doing across all areas of the practice, such as finance, professional development or information technology; why it is doing these things; what it wants to achieve; how it is going to do this; and how it will know that the changes it makes signify improvements.

Strategic plans should include:

- A mission statement and purpose
- Long-term and short-term strategic objectives
- Functions and range of services
- A SWOT analysis (environmental and financial)
- Quality goals and objectives
- Evidence that the practice has reviewed its annual business plan every six-months against its strategic objectives
- Risk management to cover clinical and non clinical risk, financial, reputation, personnel and environmental risk

Development of a Strategic Plan can make use of tools to address the health needs of population groups within the practice. For those with a Maori patient population this could include the Health Equity Assessment Tool (HEAT) [24], the Whanau Ora Tool or the Whanau Ora Health Impact Assessment Tool.

The Health Equity Assessment Tool (HEAT) encourages consideration of health inequalities, how to intervene to address them, and to evaluate whether the intervention has been successful in reducing health inequalities. Team members report having opportunities to have input into the Strategic Plan for service planning and improvement purposes; e.g. meetings and other ways of feeding back such as information from appraisals or questionnaires.

Resources

Standards New Zealand: Business Continuity Plan NZS HB 221:2004

Practice Organisation

Practice facilities must be of a high standard to meet the needs of those who work in, and use practice services. There must be good access for patients, their whanau and the facilities must also protect the safety of patients, their whanau and the practice team, so they are not at risk. This section identifies how systems and processes need to consider safety and quality in the practice environment.

External facilities

Indicator 10

The practice premises are physically safe, clearly signposted and accessible

Criteria

10.1 ★★	External practice signage is legible, visible and well placed to read from a distance
10.2 ★★	Lighting outside the practice facilitates safe entry and exit to and from the practice
10.3 ★★	People with disabilities can access the practice premises
10.4 ★★	There is parking close to the practice with dedicated parking for patients with mobility difficulties

Further information

Practices must be safe, enable all people to access the premises and find their way without difficulty.

RNZCGP Consumer Liaison Committee advice:

- Consider those who have mobility problems and potential difficulties: wheelchair walking frames, parking and heavy entrance doors into the practice.
- The weight of the door at the entrance into the building is important. The door must be able to be opened easily by people who are frail, older or unwell.
- Dedicated disabled parking or alternative arrangements are able to be made

To make the practice safe for patients the practice must consider their internal and external environment to assist all people and those with disabilities to access practice facilities such as railings, ramps, lighting, slippery surfaces, lifts or other relevant equipment available.

Regional council regulations may restrict the placement of disabled parks. If the regulations do not permit the practice to establish a disabled park, then a written explanation may be obtained from the local council.

Resources

Department of Building and Housing Website: Building Code Compliance Documents; Accessible car parking spaces and Accessible reception and service counters. http://dbh.govt.nz

Standards New Zealand – NZS 4121:2001 – Code of practice for design of access, use of buildings and facilities by disabled persons and others (This applies to new buildings and in some cases alterations to existing buildings)

Practice facilities

Indicator 11

The practice facilities ensure patient comfort and safety

Criteria

11.1 ★★	The waiting area has adequate space, seating, heating, lighting and ventilation
11.2 ★★	The waiting area has appropriate seating for disabled patients
11.3 ★★	There is a toilet with hand washing facilities on site with access for disabled people
11.4 ★★	There are facilities to ensure hand hygiene in all patient contact areas
11.5 ★★	Each consultation room is maintained at a comfortable temperature and has adequate lighting, including task lighting
11.6 ★★	Examination couches are accessible, safe and visually private
11.7 ★★	Patients are assured of auditory privacy during consultations or when any personal information is conveyed

Further information

Practices must be safe, enable all people to access the premises and make their way through the practice without difficulty, and consultation areas should be responsive to the needs of patients and their families comfort and safety.

RNZCGP Consumer Liaison Committee advice:

- The waiting room should accommodate guide dogs comfortably (Guide dogs are trained to lie at the handler's feet)
- Practice waiting rooms are comfortable and large enough to accommodate patients and families
- There should be space for them away from foot traffic areas and doorways
- There should be enough seats (Recommendation – 4 seats per full time doctor) with a range of chair heights and armchairs
- There should be elevated seating with arms to assist patients with disabilities such as arthritis or hip problems
- It is important that the practice waiting area does not put patients at risk, e.g. electric sockets without safety plugs
- Be aware of patient hazards in the practice, such as footstools in the consultation room e.g. that they are not too high or in the way of patients
- It is recognised that when treating/observing patients who are acutely unwell, the provision of optimum medical care could compromise aspects of patient privacy

Practices must meet the needs of disabled patients and seating spaces are adequate to cope with the demand, e.g.

- Wheelchair, push chair, walking frame
- Report on a consultation exercise carried out with the relevant disabled patient/s or group

Practices need to make all reasonable efforts to facilitate access to patient toilets. They should have disabled access and hand washing facilities with running water and liquid dispensed soap.

- Water must be available in designated hand washing areas with hand drying facilities
- Liquid dispensed soap available for routine hand washing
- Disposable hand towels
- Alcohol based hand rubs for hand washing before clinical procedures (70% alcohol based hand rub)

Consultation rooms should be maintained at a comfortable temperature for patients who need to undress and they should be private so conversations cannot be heard. The light in the room should be enough to observe the patient and task lighting available for examinations.

- Treatment rooms used for surgery need a good overhead lighting
- Task lighting may be located in specific areas and not in every consulting room
- Examination couches must be accessible and safe for disabled or frail patients, e.g. they are a safe height, hydraulic or portable steps are available

Resources

Code of Health and Disability Services Consumers' Rights 1996. http://www.hdc.org.nz

Department of Building and Housing website: Building Code Compliance Documents; Accessible car parking spaces and accessible reception and service counters

Standards New Zealand – NZS 4121:2001 – Code of practice for design of access, use of buildings and facilities by disabled persons and others (Applies to new buildings and in some cases alterations to existing buildings)

Standards New Zealand – AS/NZS 4815:2006 – Office Based Health Care Facilities – Reprocessing of reusable medical and surgical instruments and equipment and maintenance of the associated environment.

World Health Organisation Patient Safety – WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft): A Summary. http://www.who.int/patientsafety/events05/HH_en.pdf

Information management technology

Indicator 12

The practice team uses a secure information system that integrates electronic clinical decision support tools and management systems

Criteria

12.1 ★	The clinical team has access to electronic decision support tools
12.2 ★	The practice maintains a secure internet connection which is available for use by the clinical team
12.3 ★	The practice implements a clearly defined policy for computer security
12.4 ★	The practice implements a clearly defined policy for computer back up

Further information

Good patient management requires that the practice has, and uses, the information it needs to identify and respond to patient needs and population health priorities. There is acknowledgement that the practice may not have control over the capacity of the information management system and that this would be a limiting factor for some activities.

Computer availability, security and management support the needs of all team members to enable them to carry out their specific roles in the practice. Data should be available when they need it, the integrity of the data should be intact, and access should be to designated users, e.g. financial, clinical, information.

Access to electronic decision support tools

In order to seek reference tools for supporting clinical decision making, the clinical team require access to electronic support tools. Typically, these tools are provided by an external provider via a web page or externally hosted application. Attention needs to be paid to the security of the connection used to access these tools.

Pre-requisites, for Electronic Decision Support such as those for CVD, are patient demographic data, electronic notes and disease coding systems. e.g. READ, SNOMED

Internet access

The clinical team should be able to access to the internet from within the practice. Computers with access to the local network or Internet must have antivirus/antimalware software installed. The network should be protected by Perimeter Security (typically a managed firewall).

All computers must have current anti-virus and anti-malware software installed. The software should be set to automatically update virus definitions in accordance with the recommendations of the software vendor.

Computer Security

The policy should include:

- Password management
- Screen locking
- Hard-drive destruction
- Physical access

PMS and other sensitive files should be password protected. Passwords should be of a moderate security. (6 digits alpha-numeric). External access to practice computers (e.g. remote desktop connections) must be via a secure connection. Password management ensures that previous staff members do not have access to the network or files.

Screensavers can and should be set up to lock the computer after a set time (recommended 10 minutes). Screens should not be visible from the patient waiting area.

Disused hard drives should be physically destroyed, and/or the data obfuscated. Note: Formatting the drive does not destroy the data and therefore is insufficient on its own.

Computers, and devices containing confidential data (eg; backup drives) are protected from physical access by members of the public.

Backup protection

The policy should include

- Automation, validation & monitoring
- Encryption & Security
- Transportation / Transmission
- Offsite storage
- Retention & archiving

The practice should have a documented policy covering computer data backup, verification, transportation and storage. The policy is to be implemented in accordance with the Privacy Code 1994, and staff need to understand their role in implementing the policy.

Computer backup systems should backup PMS and other important data at least once daily. Data should be encrypted and verified for integrity following each backup. The system should be either automated or be operated by trained personnel.

A copy of each backup should be stored in an offsite location. Data taken offsite, either physically or electronically, should only be carried and stored by a qualified service provider (e.g. a security company with Ministry of Justice COA certification). Data transmitted electronically should be done so via a secure connection which complies with the NZ Government ICT standards document (NZSIT 402).

The backup system should include a system for data retention. Historical copies of backups should be retained for 31 days (minimum 7 days). This allows for a previous backup to be restored, should the current backup be found to include corruption or other data integrity problems.

Resources

Health Information Privacy Code 1994 including Commentary. http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-incl.-amendments-revised-commentary.pdf

NZ Security of Information Technology (NZSIT 402). http://www.gcsb.govt.nz/newsroom/nzsits/nzsit-402-feb08.pdf

Standards New Zealand: Code of Practice for Information Security Management: AS/NZS ISO/IEC 17799:2006

Standards New Zealand: Health Network Code of Practice: SNZ HB 8169:2002Standards New Zealand: Primary Healthcare Patient Management Systems: Publicly Available Specifications: SNZ PAS 8170:2005

Privacy of Patient Information

Indicator 13

The practice maintains privacy of individual patient information in accordance with the Health Information Privacy Code 1994

Criteria

13.1 ★★	The practice has a documented policy that describes how the requirements of the Health Information Privacy Code 1994 will be implemented
13.2 ★★	The practice team has received training to implement the principles of the Health Information Privacy Code 1994
13.3 ★	The practice team is able to describe their role in implementing the policy
13.4 ★★	The collection, use, storage, disposal and disclosure of individual patient information complies with the Health Information Privacy Code 1994
13.5 ★★	There are safeguards in the reception area to ensure confidentiality of patient information (includes verbal, documented and electronic)
13.6 ★★	The content of medical records and documents is not identifiable in public areas
13.7 ★	Non lockable files are in non public working areas only
13.8 ★	Files are secure or password protected unless in active use by the practice team

Further information

The Health Information Privacy Code 1994 applies to identifiable health information about individuals. Development of the Code has taken account of the characteristics of health information to protect individuals, such as its confidentiality, sensitivity and use by different health care providers. Practices must identify the measures they take to protect individual privacy in order to meet the legislative requirements set out in the Health Information Privacy Code 1994, including layout of the practice.

A Privacy Policy should contain:

- Purpose of collection of health information
- Source of health information
- Collection of health information from individuals
- Manner of collection of health information

- Storage and security of health information
- Access to personal health information
- Correction of health information
- Retention of health information – archiving
- Limits on use of health information
- Limits of disclosure of health information
- Unique identifiers

Implementation of the privacy policy should cover:
- Collection
- Use
- Storage and security
- Disposal and disclosure of individual patient records including electronic
- Correction and alteration of medical records

Section 23 of the Act places a responsibility on each practice to ensure a dedicated person has responsibilities that include:
- Encouraging the agency to comply with the Code
- Dealing with requests under the Act and Code
- Working with the Privacy Commissioner

Mitigating privacy risks:
- Written, verbal or electronic information about patients cannot be seen or heard in the waiting area
- Permission sought from patients
- Methods used to capture patient information in a confidential manner; e.g. background music, elevated front desk, training in telephone etiquette
- The content of medical records and documents (paper or electronic) is not identifiable in public areas
- Non-lockable files (or non-secure computers) are in non-public working areas
- Any access to information by third parties can be interpreters, carers, relatives, medical or nursing students on placement, general practice registrars
- Computer Security: The Patient Management System should be secure and passwords should be of a moderate security (4 digits, alpha numeric)

Resources

Health Act, Section 22F – Communication of information for diagnostic and other purposes. http://www.legislation.govt.nz

Health (Retention of Health Information) Regulations 1996. http://www.legislation.govt.nz

Health Information Privacy Code 1994 including Commentary. http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-incl.-amendments-revised-commentary.pdf

Medical Council of New Zealand – The maintenance and retention of patient records 2005. Statement on use of the internet and electronic communication 2006. Information and Consent (2002); Confidentiality and Public Safety 2002. http//www.mcnz.org.nz

Privacy Commissioner Website (includes training and education); A practical Health Guide – On the record. http://www.privacy.org.nz; email: enquiries@privacy.org.nz: 0800 803 909

Standards New Zealand: Health Records. NZS 8153: 2002

Management of medical records

Indicator 14

The practice has effective systems for enrolment of new patients and transfer of medical records

Criteria

14.1 ★★	A patient registration process to collect personal and health information
14.2 ★★	Requests for the transfer of medical records are acted on within 10 working days
14.3 ★★	Details of the transfer of medical records to and from the practice are recorded

Further information

Patients are identified in the practice through the registration process. The enrolment process facilitates continuity of care and is the first point of entry, linking them to health care services. Their information is linked to their patient record and remains an identifiable information source about them and records care provided.

Collection of personal and health information improves patient ethnicity recording for contractual requirements and informs clinical care, e.g. new patient questionnaire, or registration form, initial health and wellness consultation.

- Data capture must align with the MOH principles of patient self-identification
- It is unacceptable for the recorder to guess any patient's ethnicity or to complete the question on behalf of the patient based on what they perceive to be by the patient's physical appearance
- Ethnicity data may not be transferred from another form as it may have been incorrectly collected

Transfer of notes: See Rule 11 Permitted Disclosure:
When a patient has requested their notes be sent to another practice the agency disclosing the information would have reasonable grounds to believe that disclosure has been authorized. In this case authorization need not be in writing. http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-2008-revised-edition.pdf

Transfer of medical records must be recorded in a register or on the Patient Management System. It should include:

- Name of person who requested transfer
- Date requested
- Where records are transferred to or from
- How records were transferred (courier, post)
- Date of delivery

Resources

Code of Health and Disability Services Consumers' Rights 1996. http://www.hdc.org.nz

Health Information Privacy Code 1994; and A Practical Health Guide – On the Record. http://www.privacy.org.nz

Medical Council: The maintenance and retention of patient records 2005. http://www.mcnz.org.nz

Medical Council of New Zealand Cole's Medical Practice in New Zealand 2008. http://www.mcnz.org.nz

Medical Council of New Zealand Good Medical Practice – a guide for doctors 2004. http://www.mcnz.org.nz

Privacy Act 1993. http://www.privacy.org.nz; or http://www.legislation.govt.nz

Standards New Zealand: Health Records: NZS 8153: 2002

Standards New Zealand: Code of Practice for Information Security Management: AS/NZS ISO/IEC 17799:2002

Standards New Zealand: Primary Healthcare Patient Management Systems: Publicly Available Specification: SNZ PAS 8170:2005

Patient Test Results and Medical Reports

Indicator 15

There is a safe and effective system to manage patient test results, medical reports and investigations

Criteria

15.1 ★★	There is a policy describing how patient test results, medical reports and investigations are tracked and managed
15.2 ★★	All incoming medical reports are seen and actioned by the team member who requested them or by a designated deputy
15.3 ★★	Patients are provided with information about the practice procedure for notification of test results
15.4 ★★	The clinical team can demonstrate how they identify missing results of potentially significant investigations and urgent referrals
15.5 ★	A record is kept of communication with patients informing them about test results

Further information

Practices must operate a defined process for managing patient tests, reports and referrals. It should have a clear indication of what action was initiated, when and by whom – incoming, tracking and management. For every report or test there must be a person in the practice responsible for management and tracking. It is good practice to keep a record of telephone conversations with patients about test results, noting the date and who advised the patient.

A policy should outline the process to track and manage patient test results.

Principle: That the reports are processed to ensure the right people get the right information within the timeframes identified by the practice:

- There is a person responsible for monitoring, review and action on all incoming test results and medical reports
- There is a designated deputy to process the reports if the designated person is not available
- Members of the practice can describe the system used to transfer duty of care with respect to test results, e.g. locums, holiday period
- Tracking specialist referral letters – practices should keep records to note that the results have been sighted

Any medical investigations requested should have a clear pathway to an outcome:

- Request
- Results
- Communicate results
- Record results
- Patient informed
- Action taken
- Dated & time limit identified

Members of the practice team should be able to describe the system used by the practice to ensure all incoming test results and medical reports are acted on:

- Recorded in medical records
- How they are monitored
- How they are reviewed
- How they are acted on

The Health and Disability Commissioner accepts that no system is infallible, but there is an expectation that important test results and referrals are tracked to ensure appropriate follow up.

- The practice should identify how it notifies patients about test results
- Obtain, where possible, the patient's consent to notify only abnormal results
- Encourage patients to call the practice if they want confirmation of normal results or have questions

Information about the procedure for notification of reports must be provided to patients or displayed, i.e. patient information handouts, test request forms. Some practices provide patients with written information about how to contact the practice and who to contact to obtain results.

Tracking process

The practice must be able to demonstrate its use of a system to ensure that tests ordered by the practice, e.g. histology, have been received in the practice and any missing tests can be identified.

A tracking or audit process should:

- Identify missing results i.e. not received from the laboratory, or ordered but information is not complete
- Provide information about what has happened to medical investigations that have been returned to the practice from primary or secondary care

Communication about tests should be recorded in the electronic health record with:

- The date
- The person who ordered the test
- The person who provided the result to the patient
- Any other information provided

Resources

RNZCGP Managing Patients Test Results – Minimising Error: 2003: Discussion Paper

RNZCGP Managing Patients Test Results – Minimising Error 2005: Second Edition

Medicine Management

Indicator 16

Prescribing is accurate, appropriate and timely

Criteria

16.1 ★	The practice has a documented policy for repeat prescribing
16.2 ★	The practice team is able to describe how the policy for repeat prescribing is implemented
16.3 ★	There is evidence of changes made as a result of evaluating the medication review
16.4 ★	Prescriptions for non controlled drugs are computer generated
16.5 ★★	The clinical team uses an alert system to highlight potential risk of an adverse event

Further information

The appropriateness or otherwise of long-term repeat prescribing and repeat prescribing without consultation will always be a matter of professional judgement. This judgement will be assessed against accepted standards of best practice in the profession and must be capable of withstanding scrutiny.

Clause 40A of the Medicines Regulations 1984

(1) Where an authorised prescriber finds it necessary to do so, he or she may communicate orally to a pharmacist to whom he or she is known personally (whether in the pharmacist's presence or by speaking to the pharmacist on the telephone) a prescription relating to a prescription medicine that the authorised prescriber requires urgently.

(2) Within 7 days after a communication made by an authorised prescriber to a pharmacist under sub clause (1), the authorised prescriber must forward to the pharmacist a written prescription confirming the oral communication.

A Practice Prescribing policy should outline how repeat prescribing is tracked and monitored in the practice.

Clause 41 of the Medicines Regulations 1984

Every prescription given under these regulations shall:

(a) Be legibly and indelibly printed

(b) Be signed personally by the prescriber with his usual signature (not being a facsimile or other stamp), and dated

(c) Set out the address of the prescriber

(d) Set out:

  (i) The title, surname, initial of each given name, and address of the person for whose use the prescription is given; and

  (ii) In the case of a child under the age of 13 years, the date of birth of the child

(e) Indicate by name the medicine and, where appropriate, the strength that is required to be dispensed

(f) Indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription
(g) If the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose
(h) If the medicine is for application externally, indicate the method and frequency of use
(i) If it is the intention of the prescriber that the medicine should be supplied on more than one occasion, bear an indication of:
    (i) The number of occasions on which it may be supplied
    (ii) The interval to elapse between each date of supply
    (iii) The period of treatment during which the medicine is intended to be used

Clinical team members can only be aware of potential risk if it is recorded in the patient record e.g. Allergies to medication, pharmaceutical products or vaccines.
Risk mitigation:

- Team members can describe their role in prescribing
- Identify practices used in the absence of a face to face consultation for repeat prescriptions
- Repeat medications can be identified in the patient records
- The practice should meets with a pharmacist advisor at least annually to identify actions for improvement
- Undertake regular audits to review protocols for prescribing, accuracy and efficacy
- Review issues raised in audits and identify changes needed as a result
- Evaluating a medication review to identify:
    - Accuracy
    - Adherence to the formulary
    - Generic prescribing rates
    - Costs

Right 4, Code of Health and Disability Service Consumers' Rights 1996. Prescribing in the absence of a consultation:

- Reasonable care and skill
- Complies with legal, professional, ethical and other relevant standards
- Provided in a manner consistent with needs
- Minimises potential harm and optimises the quality of life
- Cooperation among providers to ensure quality and continuity of services

Resources

RNZCGP Medicine management module –

Health and Disability Commissioner Website (this includes a copy of the Code of Health and Disability Services Consumers' Rights 1996. http://www.hdc.org.nz. hdc@hdc.org.nz; phone: 0800 11 22 33

Medical Council: Good Prescribing Practice 2010. http://www.mcnz.org.nz

Access to Medicines and Pharmaceutical Products

Indicator 17

Security is maintained to ensure there is only authorised access to medications and pharmaceutical products

Criteria

17.1 ★★	Medicines, pharmaceutical products and clinical bags or portable emergency kits are stored securely so that they are only accessible to authorised people
17.2 ★★	Controlled drugs are stored in line with current legislation
17.3 ★★	A register is maintained for controlled drugs

Further information

Access to medications and pharmaceutical products must be restricted to authorised practice team members. Medications and pharmaceutical products must be secure and stored 'out of sight', not in open containers on bench/trolley tops or in high-traffic areas where they could be accessed by unauthorised people, including children.

The Misuse of Drugs Regulations 1977, Storage – Regulation 28

(a) Keep in a locked cupboard, or a locked compartment that is constructed of metal or concrete or both, and that, in the case of a cupboard or compartment installed in a building after the commencement of these regulations, is of an approved type.

(b) Ensure that the cupboard or compartment is securely fixed to, or is part of, the building or vehicle within which the controlled drug is kept for the time being.

(c) Ensure that the key of the cupboard or compartment is kept in a safe place when not in use. Where the building or vehicle within which the controlled drug is kept for the time being is left unattended, that safe place shall not be within the building or vehicle.

Risk mitigation:

- A register is maintained for any controlled drugs kept on site
- Practice security and precautions ensure security for medications and pharmaceuticals
- Low open shelving does not contain pharmaceuticals
- GPs must not store medications or pharmaceutical products on their desks
- Low-level cupboards, which contain medications, should be fitted with child locks or are lockable

Controlled drugs are recorded appropriately:

- Bound volume
- Each page is numbered consecutively
- Each page identifies one form of controlled drug
- Entries must be made no later than the ordinary business day next following the day on the transaction
- Twice yearly balances shall be undertaken (at the end of the business day of June 30 / Dec 31)
- Entries should be legible and indelible and in the format specified in the Regulations

Resources

Medical Council: Good Prescribing Practice 2010

Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977. http://www.legislation.govt.nz

Controlled drug registers are available from David Lewis Products ph/fax (03) 332 3001

Medical Council: Good Prescribing Practice 2010. http://www.mcnz.org.nz

Sharps, Contaminated Materials and Hazardous Waste

Indicator 18

There is safe storage and disposal of sharps, contaminated materials and hazardous waste

Criteria

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

Further information

Practices must provide safe storage and disposal of sharps, contaminated materials and hazardous waste that pose a risk to people if not disposed of properly.

The Hazards Substance and New Organisms Act 1966, was enacted to:

- Protect the environment
- Protect the health and safety of people and communities
- Prevent or manage the adverse effects of hazardous substances and new organisms

There may be differences in Council Bylaws throughout New Zealand. Refer to the local Council on the web to find relevant regulations for storage, collection and disposal of contaminated waste.

- Hazardous waste, other than that classified by legislation, is the responsibility of the healthcare facility generating the waste
- Healthcare waste is categorised by its properties and characteristics rather than the source of the waste, e.g. laboratory, home healthcare
- Sharps – cytotoxic, radioactive, infectious
- Non sharps – cytotoxic, radioactive, infectious, other hazardous waste, body parts
- Puncture resistant sharps containers display a biohazard symbol and are located in clinical areas where sharps are used. They are wall mounted, high enough to be away from children and are not located in high traffic areas
- Practices in rural areas may not have the same access to urban methods of disposal and should contact their local authority to find out local regulations

Resources

Standards New Zealand, Management of Healthcare waste – NZS 4304:2002

Infection Control

Indicator 19

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

Criteria

19.1 ★★	The practice has documented policies and procedures that describe infection control practices
19.2 ★★	There is evidence that the infection control policies and procedures are implemented
19.3 ★★	Appropriate team members have received infection control training within the last 3 years
19.4 ★★	Records are kept to monitor the effective physical parameters for each sterilising cycle
19.5 ★★	A current calibration and validation record is available for the steriliser

Further information

Infection control practices prevent the spread of infectious organisms to patients and within the practice. Monitoring, validation, maintenance, calibration, cleaning and training are essential to ensure equipment and procedures meet requirements.

An Infection Control Policy should include but is not limited to:

- The purpose of infection control
- Staff immunity – staff with infections
- Hand hygiene
- Respiratory hygiene & cough etiquette
- Standard precautions
- Single use items
- Management of occupational exposure to blood / body fluids
- Bloods and body spills
- Cleaning, decontamination, disinfection and/or sterilisation of instruments and equipment
- Commercial cleaning
- Wound management
- Waste management
- Linen services
- Venepuncture
- Cryotherapy
- Cleaning and servicing of steriliser
- Laboratory specimens
- Hard toys

The practice can provide evidence of correct implementation of infection control policies by undertaking an audit that records efficacy of the steriliser for sterilisation of non-disposable instruments and materials AS/NZS 4815: 2006.

High level disinfection:

- Autoclave – 121°C for 15 mins, 126°C for 10mins, 132°C for 4mins, 134°C for 3mins
- Dry heat – 160°C for 60mins, 170°C for 40mins, 180°C for 20mins

Sterilising cycle monitoring:

- Processing print outs from steriliser
- Chemical Criteria / integrators
- Validation / calibration records
- Servicing of sterilizer records

Print out of cycle parameters or direct observation and recording of cycle parameters or Class 4, 5 or 6 chemical criteria (where no print-out is available).

- Class 1 chemical indicator in each load of unwrapped items
- Class 1 external chemical indicator on the outside of every package item in the load

If items are processed off site proof of the current validation and calibration of the steriliser used by the third party must be provided.

Packaging and storage of equipment should be checked against the policy:

- Storage of instruments – Sterile or surgically clean. Instruments are protected from dust, vermin and in a dry space, e.g. closed cupboard, sealed containers
- There is a rotation system
- Items are loosely packed to avoid damage
- The length of safe storage is event related and frequent handling is detrimental
- Instruments are not to be stored in disinfectant or under ultraviolet lights before or after any form of reprocessing AS/NZS 4815:2006
- Items shall be handled carefully, protected from sharp objects or any other factors that may damage the packaging
- List type B sterilisers (e.g. Autoclave benchtop machines delivering at least Type B cycles) that meet existing standards described in AS/NZS 4815: 2006

Production of a record for the validation and calibration of the steriliser AS/NZS 4815 2006

- The steriliser manual is available in the practice
- Only sterilisers with a drying cycle are suitable for sterilising wrapped items
- Passive drying with a closed or 'cracked-door' is not suitable for processing wrapped items
- If sterilising is outsourced, then evidence of an audit trail is required along with written proof that outsourced contractors have followed correct procedures

Resources

Department of Labour. An introduction to Employers' Rights and Responsibilities under the Health and Safety in Employment Act 2002. http:// www.workinfo.govt.nz

Hazardous Substances and New Organisms Act 1996. http://www.legislation.govt.nz

Health and Safety in Employment Act 1992. http://www.legislation.govt.nz

Standards New Zealand – AS/NZS 4815:2006 – Office Based Health Care Facilities – Reprocessing of reusable medical and surgical instruments and equipment and maintenance of the associated environment

Standards New Zealand – NZS 4304:2002 – Management of Healthcare Waste

World Health Organisation Patient Safety – WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft): A Summary. http://www.who.int/patientsafety/events05/HH_en.pdf

NQIP Infection Prevention and Control. www.infectioncontrol.org.nz

Cold Chain Management

Indicator 20

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

Criteria

20.1 ★★	The practice has current national Cold Chain Accreditation as per the Ministry of Health (NZ) protocol
20.2 ★★ NEW	The practice can demonstrate monitoring of the Cold Chain in accordance with the protocol
20.3 ★★ NEW	If offsite immunisation is undertaken the practice can demonstrate Cold Chain procedures

Further information

Effective immunisation programmes minimise the risk of infection among at risk populations. To ensure efficacy practices must store and manage vaccines, in line with the National Cold Chain guideline. Practices immunisation programmes should support high immunisation coverage and control disease at a population level through identification and recording results. The National Immunisation Handbook contains the current national standard for vaccination practices.

Certificate of Cold Chain Accreditation against the current MOH Protocol.

- The Authorised Vaccinator can be identified
- The practice can identify how they manage the review of immunisation procedures in the practice
- Clinical team members can show how they identify and recall all eligible patients

The Vaccinator:

1. Is competent in the immunisation technique and has appropriate knowledge and skills for the task
2. Obtains informed consent to immunise
3. Provides safe immunisation
4. Documents information on the vaccine(s) administered and maintains patient confidentiality
5. Administers all vaccine doses for which the vaccinee is due at each visit and only follows true contraindications
6. Reports adverse events following immunisation promptly, accurately and completely
7. The organisation, which employs vaccinators to offer vaccination services, has links to comprehensive primary health care and the Well Child programme
8. The organisation achieves high immunisation coverage of its population
9. The organisation supports the vaccinator
10. The service is readily available with no barriers to access

Preserving the Cold Chain during storage, offsite immunisation and transporting vaccines:

- Chilly bin lid must be tight fitting
- 'Slickers' to preserve the temperature during transportation
- Bubble plastic, shredded paper or polystyrene pellets to separate the vaccine from the cold source (IMAC Standards)

Resources

Immunisation Advisory Centre website: for cold chain resources, education and training. http://www.immune.org.nz

Medicines Act 198. http://www.legislation.govt.nz

New Zealand National Immunisation Handbook. http://www.moh.govt.nz/moh.nsf/indexmh/immunisation-handbook-2010

National Immunisation Register. http://www.immune.org.nz

The Centre for Adverse Reaction Monitoring: Record and report all significant adverse reactions to CARM. http://carm.otago.ac.nz/ Vaccinator Training Programmes. http://www.immune.org.nz

Medical Equipment

Indicator 21

Medical equipment and resources are available and maintained to meet patient needs

Criteria

21.1 ★★	**There is an audit trail to monitor the servicing of all medical equipment according to relevant regulations, maintenance and operating instructions**
21.2 ★	**The practice has Residual Current Devices (RSD's) in any area where mains powered medical equipment is used for patient procedures**
21.3 ★	**All essential basic equipment is available** • Auriscope • Blood glucose test strips/glucometer –*expiry dates must be current /Check calibration of glucometer to number on strip* • Cervical smear equipment • Dressings adequate to the services provided – *check expiry dates* • Ear syringe or suction • ECG & Defibrillator are readily accessible or within 10 minutes of clinicians request (*if on site, and the clinical team are trained*) • Eye – *local anaesthetic* • Fluorescein dye for eyes • Gloves • Height measure • Measuring tape • Monofilament • Nebuliser – *via air or oxygen, or large spacer device* • Ophthalmoscope • Peak flow meter • Pregnancy testing kit • Proctoscope • Sphygmomanometer – *Extra wide and paediatric cuffs* • Spatulae • Stethoscope • Surgical instruments appropriate for any procedures carried out • Suture equipment • Syringes and needles • Reflex hammer • Tuning fork • Thermometer • Urine dipstick – protein, glucose, ketones –*expiry dates must be current* • Visual acuity chart – *at the correct distance* • Weight scale
21.4 ★	**All emergency equipment is easily accessible and in a single location**

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21.5 ★

All essential emergency equipment is available

Emergency and resuscitation equipment:

- Airways and/or laryngeal masks – *varied sizes 00 to adult*
- Ambubag and masks – *paediatric to adult*
- Emergency bag/trolley
- IV equipment – *set up and infusion*
- Oxygen
- Saline/plasma expander – *any one of e.g. penpaspan/crystalloid, expiry dates are current*
- Tourniquet

Rural practices:

Rural practices require a greater level of off site equipment

- Assortment of inflatable splints
- Blood taking equipment
- Defibrillator, pads available, paper in machine, battery changed/charged –*In accordance with manufacturers instructions*
- Full stretcher kit
- Intubation equipment
- Manual defibrillator and/or automatic electronic defibrillator (AED) with annual function (*AED alone without three lead ECG monitor is inadequate*) – back up battery
- Mobile phone/RT system
- Oropharyngeal airways
- Portable oxygen supply with regulator, tubing, masks and replacement cylinder
- Portable suction
- Regional maps
- Strobe lighting for aerial rescue
- Urinary catheter or other means for urgent catheterisation

21.6 ★

All essential emergency medications are available

In stock or in the doctor's bag/clinical bag or portable emergency kit

- 50% Glucose/glucagons injection
- Adrenalin 1/1000
- Analgesia – paracetamol
- Antiemetic
- Antihistamine
- Aspirin tablets
- Atropine
- Corticosteroid
- Diazepam injection/rectal
- Local anaesthetic
- Sodium Chloride for injection
- Naloxone
- Penicillin injection – (*Some need refrigeration and in addition powdered version for offsite emergencies*)
- An alternative for those allergic to penicillin
- Sterile water for injection

21.7 ★

There is a documented process for medication maintenance to ensure medicines expiry dates, including patient medicines held in the practice, are current

21.8 ★	**There is a documented process to check and maintain the contents of all clinical bags/portable emergency kits and emergency equipment – at least monthly**
21.9 ★	**The practice team conducts annual drills to enable them to respond to medical emergencies**

Further information

All medical equipment and resources should be suitable for supporting comprehensive primary care, safe resuscitation and safe performance of any additional procedures offered. All essential medical equipment and resources must be available when needed, and members of the practice team must know how to use the equipment. Equipment must be calibrated, in working order and have current expiry dates for servicing. The adequacy and appropriateness of basic equipment is determined by the circumstances of the practice and any omissions should be justified by the practice.

Calibration and validation:

- Audit trail and tracking systems must show that all medical equipment has been regularly tested and serviced according to relevant regulations and that maintenance and operating instructions are performed (date and by whom)
- Manuals are available to train new staff to use equipment

Residual Current Devices (RSD's):

- Equipment for medical locations should comply with the AS/NZS 3200 series and be maintained in accordance with the recommendations of AS/NZS 3551
- Electrical installations – Patient area of hospitals and, medical and dental practices – testing requirements NZS 3003: 1: 2003

An ECG should be accessible within 10mins. If an ECG is held in the practice clinical team members know how to use it.

Rural practices and type of general practice definition:
Note: Practices <35 are not considered rural

1. Rural (35 – 59)
2. Isolated (> 60)

The Rural Ranking Scale is calculated in consideration to:

- Travelling time from surgery to major hospital
- On call duty
- On call for major trauma
- Travelling time to nearest GP colleague at place of work
- Travel time to most distant practice boundary
- Regular peripheral clinics
- Possible extra points where recruitment and retention of doctors is difficult

Verification and maintenance of clinical bags includes a checklist, date and signature of the person holding the responsibility for the procedure.

Resources

RNZCGP Assessment Visit Module: Contents of the Doctor's Bag: 2000

Standards New Zealand: Technical Management Programs for Medical Devices AS/NZS 3551: 2004 and Amendment 1: 2005

Guide to the safe use of electricity in patient care AS/NZS 2500: 2004

Disaster response

Indicator 22

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

Criteria

31.1 ★★	The practice implements an Evacuation Scheme or Evacuation Procedure as required by the Fire Safety and Evacuation of Buildings Regulations 2006
31.2 ★	There is an Emergency Management Plan in the event of a disaster or event that would severely impair the practices ability to maintain normal services

Further information

Practices must have the capability to protect patients and staff during an emergency in the community, such as a fire in the practice, flood, extended power outage, earthquake or pandemic.

The Ministry of Health has funded regional primary care emergency planning coordinators. Their role is to support practices through the emergency planning process and they have developed a free resource for primary care.

- Southern : John Coleman, SISSAL: john.coleman@sissal.govt.nz
- Central: Barry Simpson barry.simpson@midcentraldhb.govt.nz
  Simon Barton simon.barton@midcentraldhb.govt.nz
- Northern: Andy Wisheart, NDSA, 021450219, andy.wisheart@ndsa.co.nz

The practice follows a scheme or procedure approved by the New Zealand Fire Service.
Note: Schemes and procedures:

a) Important – An evacuation scheme that is approved by the Fire Service is a legal requirement for practices that have more than 10 people employed.

The Emergency Management Plan should,

- Identify risk and contingencies for an event
- Maximise patient safety and continuity of care
- Plan to keep the practice team safety in the event of a disaster
- Establish response networks in the event of a district or region wide disaster
- Manage service delivery
- Set up a safe, alternative practice location, if necessary
- Establish an efficient and effective Incident Management Team within the practice

The three components to a robust emergency plan are,

1. Business continuity planning
2. Response planning
3. Major incident planning

Business continuity planning

The purpose of a Business Continuity Plan is to help understand and organise the core functions of the practice:

- Prioritises the core functions for recovery, to identify critical and non critical functions, processes and activities
- Understand and describe the consequences of adverse events on the critical functions of the practice
- Work required before the event to minimise the impact of an adverse event
- Outlines a response plan in case an event occurs

The plan should documents areas such as:

- Comprehensive insurance assessment of: policies, adequacy of value of cover
- Alternative solutions for: Reduction, Response, Readiness and Recovery, from:
    - Electricity disruptions
    - IT failures
    - Telephone failures
    - Staffing shortages
    - Supplies, clinical and other
- Identify alternative operating locations if premises damaged

Response Planning

This plan provides information and guidance about what to do immediately after an event has occurred:

- Identifying the practice emergency management team is and their contacts details
- PHO/DHB emergency management and other support agency contact details
- Who should be contacted in a given scenario
- What immediate actions must be undertaken by the staff on scene
- All staff contact details
- Communication tree
- Service provider contact information

Major incident planning

This plan outlines how a practice fits into the overall local health response to an emergency situation and what is expected of them. It also sets out what they can expect in terms of information, coordination and support and all communication channels.

The above examples are an illustration of the different aspects of emergency planning and are by no means complete.

Resources

The Ministry of Health's website has various areas holding information, such as:

National Health Emergency Plan http://www.moh.govt.nz/moh.nsf/indexmh/emergencymanagement-nhep 27 August 2010

Ministry for the Environment: Impact of climate change on New Zealand. Climate change resources.

http://www.mfe.govt.nz/issues/climate/about/impacts.html

New Zealand Fire Service: Evacuation Scheme. http://evaconline.fire.org.nz

New Zealand Influenza Pandemic Action Plan

http://www.moh.govt.nz/moh.nsf/indexmh/nzipap-framework-for-action 27 August 2010

Infection control and prevention

http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/4013c98b3e5b384dcc2571490017ec3d?OpenDocument 27 August 2010

The Lancet: Managing the Health Effects of Climate Change

Clinical Effectiveness

General practices deliver services that must be organised and managed effectively to meet the needs of patients and members of the practice team who manage the range of resources, people and systems, to provide comprehensive care. This section outlines systems needed to support and maintain continuity of care and integration with other organisations and groups in support of safe, accessible and effective patient care.

Patient records

Indicator 23

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

Criteria

23.1 ★	**All practice generated patient information is recorded electronically**
23.2 ★	**Patient records are coded or classified according to a recognised disease coding system or classification**
23.3 ★	**The content of patient records meets or exceeds the minimum expected standard and ensures continuity of patient care** *Demographic data:* • Name of patient • NHI number • Gender • Address • Date of birth • Contact phone number • Ethnicity • Registration status • ICE – Contact person in case of emergency
	Other demographic data: • Occupation history • Significant relationships • Hapu-iwi • Alternate names
	Medical records show: • Clinically important drug reactions and other allergies (*or the absence thereof*) • Directives by patients *where applicable* • Problem lists are easily identifiable (Each problem has a code against each disease recorded) • Past medical history • Disabilities of the patient *where applicable* • Current and long term medication are identifiable • Clinical management decisions made outside consultations, e.g. telephone calls

	Consultation records: • Each entry is dated • Person making the entry is identifiable • The entry can be understood by someone not regularly working at the practice, *e.g. a locum*
	Consultation records should also include: • Reason for encounter • Examination findings • Investigations ordered • Diagnosis and assessment • Management plans • Information given to patients, including notification of recalls, test results, referrals and other contacts • Medications are identifiable: drug n*ame/ dose/ frequency/ amount/time / volume* • Current and long-term medications have been reviewed • Intermediate clinical outcomes e.g. HbA1c • Brief interventions are recorded • Screening and preventive care initiatives recommended • A follow up plan • End of life needs *where applicable*
	Risk factors are identified: • Awareness alert e.g. deaf, blind • Family history • Current smoking status • Smoking history of patients over age 15 • Where appropriate, offer of smoking cessation • Alcohol/drug use • Blood pressure • Weight/height/BMI • Immunisations
	Referral letters contain: • Reason for referral • Background information and history • Current treatment • Key examination findings • Problem • Current medical warnings • Long-term medications
	Incoming information is filed or are available electronically in patient's medical records: • Laboratory results • Radiology results • Other tests or health information e.g. psychological testing • Other health information

Screening is up to date, e.g.

- Cervical Smears
- Mammograms
- Cardiovascular risk assessment
- Diabetes screening

Further information

Keeping good clinical records is a safeguard for practices. Patient records must be sufficient to meet legal requirements to describe and support the management of health care. Medical records must contain information to identify the patient and facilitate continuity of care. Assessment, management, progress and outcomes must be sufficiently documented for another team member to carry on with coordination, management of care, and referral to other services requires clear and effective communication.

Managing patient records

Practice Management Systems (PMS) and electronic notes are essential for management and auditing patient and population information – it is the only way to provide accurate readily accessible data and an audit trail of activity for practice teams to meet primary care objectives, Health and Disability or legal requirements.

- The practice team keeps the practice database up to date, e.g. checking demographic data at each patient encounter
- There are new applications integrated with practice management systems that assist to identify needs of enrolled patient populations

Disease Coding Systems, e.g. READ, SNOMED

- READ codes are a hierarchical coding system – each level provides a more specific diagnosis
- SNOMED CT® Systematized Nomenclature of Medicine — Clinical Terms) is the most comprehensive multilingual clinical healthcare terminology. It was developed as an international clinical terminology by the National Health Service in England and the College of American Pathologists in 1999

Identifying issues for populations

Identification and tracking depends on coding conditions at source and become most successful when they are routinely undertaken, for example to assess disease prevalence in the enrolled population being looked after. It also provides information to clinical team members of potential risk if it is recorded in patient records e.g. allergies to medication, pharmaceutical products and/or vaccines.

Identifying high risk groups provides clinical information to target care, e.g.

- Delivery of influenza vaccines to a target population; patients over 65 years
- Smoking status is recorded on the Patient Management System

A legally defensive record:

- A record that is not altered, disguised or added to
- A record of all house calls, phone calls
- Kept for a minimum of 10 years
- Abbreviations and ticks with a glossary
- Written in ink, not pencil
- Legible handwriting (includes not using abbreviations that do not have a key)
- To be signed and dated (include times) after being checked for accuracy

Resources

There are a variety of Health and wellness plans that can be accessed on the web, e.g.
http://www.healthwellnessplans.org/category/exercise

Health promotion

Indicator 24
The practice offers services for disease prevention and promotion of healthy lifestyles

Criteria

24.1 ★	The clinical team implements or refers patients to programmes to improve, maintain or restore patient health
24.2 ★	Practice teams deliver preventive care and promote healthy lifestyles
24.3 ★	A wide range of current health promotion material is accessible to patients
24.4 ★	The practice uses disease registers to identify high risk priority groups from the enrolled population and develop interventions
24.5 ★	The practice database is used to identify the health needs of the enrolled population and develop interventions

Further information

Practices are working in different ways to support patients to improve their quality of life. This may need a range of responses such as meeting with internal or external teams to identify different approaches, using new evidence or resources, to influence changes in practice[25] . Some practices work with other primary health organisations to develop health promotion and social marketing approaches that encourage and enable people to make healthier lifestyle choices. This work is directly geared to achieving specific and measurable health goals over the short, medium and long-term.[26] General practices could consider Green Prescriptions[27] as one of many approaches.

RNZCGP Consumer Liaison Committee advice:
Practice teams should be trained to access information for patients in different languages, formats and to contact interpreters and translators as needed.

Whanau ora approach
A key concept in the development of a whanau ora approach is supporting families to work across services and being proactive. Guidelines and case studies will prove useful as a guide to inform best practice, patient, whanau or population needs, or reduce inequalities.

Health promotion includes developing patient skills, involving community in the planning and delivery of care, advocating for healthy local public policy and creating a supportive practice environment for the practice team and patients.

Preventive care approaches are based on shared responsibility and working collaboratively with health professionals, social agencies and community representatives. It is essential to work within an interdisciplinary approach on priority health issues.

Identifying high risk patient groups

The electronic Patient Management System and patient demographic data enable query building to identify specific health issues, and provides data to support screening, tracking, and recording management provided.

Audit data is used for:

- Audit activity and disease coding to build queries
- Analysis of demographic data such as ethnicity, to identify, address and monitor patients with high risk factors

Brief interventions

Brief interventions are well-judged brief comments or discussion with a patient to encourage them to consider changes beneficial for their health e.g. reduction in alcohol intake, smoking cessation, weight loss management, drug using behaviour.

The practice may offer a range of options to educate patients, e.g. appointment system with practice nurses. Practices could consider social marketing or whanau initiatives to support people with managing change.

Practices can use a range of methods to facilitate services that improve, maintain or restore patient care e.g. Arthritis care, Green prescriptions, Chronic Care Management. It could be a practice initiative, or provided by referral to an external provider. If the practice is working to develop interventions, then it could meet with local networks to share ways of identifying solutions.

Resources

Health Sponsorship Council. New Zealand. http://www.hsc.org.nz/socialmarketing.html 2010.8.25.

Ministry of Health. Green Prescriptions. http://www.moh.govt.nz/greenprescription 2010.8.26

Screening and recall

Indicator 25

The practice maintains an effective screening and recall system

Criteria

25.1 ★	The practice team has received training to implement screening and recall programmes
25.2 ★	Clinical team members can describe their role in providing screening and recall
25.3 ★★	Audit data is used to identify enrolled patients in practice for all national screening programmes
25.4 ★★	The practice uses the audit data to implement clinical interventions
25.5 NEW	Audit data of clinical interventions demonstrates improved clinical outcomes

Further information

Together the practice register and disease coding system e.g. READ, SNOMED, are essential for identifying patients in national screening and recall programmes. They are used to identify and systematically offer programmes to defined populations. Specific characteristics identified by the register such as age, gender or ethnicity may be a precursor to diagnosis or treatment.[28]

Opportunistic Screening highlights the importance offering evidence based screening to specific individuals with a higher risk, e.g. familial polyposis risk for colon cancer. Opportunistic screening is not part of an organised programme of targeted population based screening such as breast or cervical cancer.

Planned and National Screening Programmes are those which practices engage and collaborate with other organisations, and local networks (e.g. national, regional, local) to plan and deliver screening programmes that improve health outcomes and reduce health inequalities for individuals and populations.

The Ministry of Health, National Screening Unit (NSU) provides health screening programmes in New Zealand and is responsible for the safety, effectiveness and quality of health and disability screening programmes. www.moh.govt.nz/nationalscreeningunit

The NSU is responsible for five screening programmes:

- Antenatal HIV Screening Programme www.nsu.govt.nz – screens pregnant women for HIV to reduce the chances of HIV being passed to the baby
- BreastScreen Aotearoa www.nsu.govt.nz – screens women for breast cancer
- National Cervical Screening Programme www.nsu.govt.nz – screens women for abnormal changes to cells on the cervix

- Newborn Metabolic Screening Programme www.nsu.govt.nz – screens newborn babies for certain metabolic disorders
- Universal Newborn Hearing Screening Programme (www.nsu.govt.nz) – screens newborn babies for hearing loss

The electronic Patient Management System (PMS) and patient demographic data enables practices to undertake query building (SQL – Structured Query Language). It provides data to identify specific health issues support screening, tracking, and a record of management provided.

A case review is a useful way of providing an example of how screening is tracked and managed by the practice e.g. Chlamydia, mental health, cervical screening. Use of decision support tools can determine potential benefit from the screening and whether it outweighs the potential physical and psychological harm (caused by the test, diagnostic procedure and treatment).

Use of audit data
- Data is used in building queries to audit enrolled patients and disease prevalence
- Audit data can be analysed by ethnicity to identify, address and monitor ethnic health inequalities

Team members can describe their role in managing the implementation of opportunistic screening policies such as taking blood pressure or measuring weight.
An audit of screening activity shows the results of clinical team activity on patient outcomes, e.g. records show results showing positive for Chlamydia have received treatment and follow up testing.

Resources

Breast Screen Aoteoroa. http://www.nsu.govt.nz/Current-NSU-Programmes/854.asp

Chlamydia Screening in New Zealand December 2006. http://www.moh.govt.nz

Diabetes New Zealand. http://www.diabetes.org.nz/resources/patient_charter

Health Information Privacy Code 1994; and A Practical Health Guide – On the Record. http://www.privacy.org.nz

Health (Retention of Health Information) Regulations 1996. http://www.legislation.govt.nz

HIV Screening in Pregnancy Oct 2004. http://www.nhc.health.govt.nz

Ministry of Health: Improving Quality – A framework for Screening Programmes in New Zealand October 2005. http://www.moh.govt.nz

National Cervical Screening Programme. http://www.nsu.govt.nz/Current-NSU-Programmes/564.asp

RNZCGP Cervical Screening – Information and practice review activities to aid in the provision of quality cervical screening in general practice 1996

RNZCGP Preventive Care and Screening – A systems approach to improving preventative care and screening in general practice 2006

RNZCGP Developing Practice Review Activities form a quality perspective 2000

The Assessment and Management of Cardiovascular Risk 2003. http://www.nzgg.org.nz

The New Zealand Health Strategy December 2000. http://www.moh.govt.nz

Unsolicited Electronic Messages Act 2007. http://www.legislation.govt.nz

National Immunisation Programme

Indicator 26

The practice maintains an effective immunisation programme

Criteria

26.1 ★★	The practice uses audit data to identify and recall all patients requiring immunisations from the national schedule
26.2 ★	The practice has a process to improve immunisation rates for all patients

Further information

Immunisations help minimise the risk of infection among at risk populations. Immunisation programmes support high coverage to control disease at population level. The success of these programmes relies heavily on correct identification and recording to enable services to monitor effectiveness and reduce risk of outbreaks.

Clinical team members must be able to show how they identify and recall all eligible patients requiring immunisation and measures taken to improve immunisation rates for their patients. Children that are enrolled with WellChild providers are more likely to receive immunisation and other Well Child services.

The Vaccinator:

1. Is competent in the immunisation technique and has the appropriate knowledge and skills for the task
2. Obtains informed consent to immunise
3. Provides safe immunisation
4. Documents information on the vaccine(s) administered and maintains patient confidentiality
5. Administers all vaccine doses for which the vaccinee is due at each visit and only follows true contraindications
6. Reports adverse events following immunisation promptly, accurately and completely
7. The organisation, which employs vaccinators to offer vaccination services, has links to comprehensive primary health care and the Well Child programme
8. The organisation achieves high immunisation coverage of its population
9. The organisation supports the vaccinator
10. The service is readily available with no barriers to access

Resources

The National Immunisation Handbook contains the current national standard.
New Zealand National Immunisation Handbook: http://www.immune.org.nz

Disease prevention – smoking

Indicator 27

The practice routinely identifies smokers and offers appropriate interventions

Criteria

27.1 ★	The smoking status of newly enrolled patients is recorded
27.2 ★	The practice uses a Patient Management System to identify and record the smoking status and smoking history of patients over the age of 15
27.3 ★	Practice team members actively promote smoking cessation strategies and provide educational intervention programme information to patients
27.4 ★	The practice team has access to specific programmes that assist patients with smoking cessation
27.5 ★	There is a process to update the smoking status of patients

Further information

Routine approaches to problem identification and providing interventions are proven to make a difference to patients by reducing avoidable hospitalisations (ASH). The New Zealand Smoking Cessation Guideline[29] recommends use of evidence-based interventions in priority population groups, in particular Māori, Pacific people, pregnant women, and people who use mental health and addiction services.

The NZ Smoking Cessation Guidelines (2010) promote the use of a memory aid – ABC. It is a simple tool that all health care workers can use. It provides prompts to:

- **Ask** about smoking status
- Give **Brief advice** to stop smoking to all smokers
- Provide evidence-based **Cessation support** for those who wish to stop smoking

- Health care workers should give brief advice to stop smoking to all people who smoke, regardless of whether they say they are ready to stop smoking or not
- Provide evidence-based cessation support for those who express a desire to stop smoking
- Health care workers should only recommend smoking cessation treatments of proven effectiveness, as identified in these guidelines, to people interested in stopping smoking

Prerequisites in a practice:

- A practice registration form that captures smoking status
- Smoking status is recorded on the Patient Management System
- Smoking status is coded so data can be audited
- READ codes are used to enable linking through a query builder
- Clinical team members know about national programmes e.g. Pamphlets, Quitline or other local providers
- Clinical team members can describe their system for updating smoking status of patients

Resources

Ministry of Health. NZ Tobacco Use Survey. MOH, Wellington. NZ. 2005

NZ Smoking Cessation Guidelines 2010. http://www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines, http://www.moh.govt.nz, http://www.moh.govt.nz/moh.nsf/indexmh/literature 23 July 2010

The Royal New Zealand College of General Practitioners. Preventative Care and Screening, RNZCGP. Wellington, NZ. 2006

Clinical and Practice Risk Management Systems

Indicator 28

There is an effective Incident Management System

Criteria

28.1 ★★	The practice has an Incident Management Policy
28.2 ★★	The Incident Reporting Register records incidents and potential events
28.3 ★★	The practice uses a risk management process to analyse incidents and prevent potential events
28.4 ★	The practice team can demonstrate how incidents are used as a learning opportunity to minimise risk
28.5 ★★	Adverse reactions to medicines and vaccines are recorded and reported to the Centre for Adverse Reactions Monitoring (CARM)

Further information

Having a risk management plan as an early warning system in place can help prevent adverse outcomes and promote excellence in practice. Using it as a guide to developing systems to manage risk or minimise events, will improve safety in the practice and help teams to take a positive approach to risk management.

Incidents:

- The formal definition is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65673
- Incident reporting and management systems can be used for positive situations, near misses or adverse outcomes. The process outlines a 'no blame' approach to help practices consider 'what is wrong', rather than 'who is wrong'. Alternatively, if something went well, the process encourages teams to identify the reason for success
- Documenting events can be useful for preventive activity and education, e.g. used sharps on benches that could lead to the injury of a staff member
- The incident management process should be used to follow up and analyse incidents, e.g. recorded in a register, minutes, reporting incidents to the National Incident Management System or CARM

The process for managing & monitoring Risk

- Report near misses and mistakes in clinical care that might harm patients
- Identify the source of the problem, how it was identified and how solutions were found
- Solutions need testing and review to ensure they work effectively
- Practices need a business continuity plan for unusual but potentially disruptive events, e.g. power outage

There should be a consistent method of recording adverse reactions to medication or immunisations in the medical record and all significant adverse reactions reported to the NZIMS or CARM.

The National Immunisation Handbook defines reportable adverse events as those that significantly affect a patients management, including reactions suspected of causing:

- Death
- Danger to life
- Hospitalisation
- Prolongation of hospitalisation
- Interruption of productive activity in an adult recipient
- Increased investigational or treatment costs
- Birth defects

Resources

The Royal New Zealand College of General Practitioners. Significant Event Management – A general practice guide. Wellington, NZ. 2010

Continuity

Indicator 29

The practice has processes to ensure continuity of care

Criteria

29.1 ★	There is a process to manage continuity of patient care within the practice
29.2 ★	There is a process to follow up unresolved health problems identified in previous consultations
29.3 ★	Patients needing palliative care can access their choice of provider (or an informed deputy), at all times

Further information

The most radical feature of working across primary care is the notion that there is shared responsibility for providing high quality. Providing comprehensive care means that practices must be able to recognise and act on the full range of health related needs in its patient population, provide patients with a broad range of health care and be able to refer to services that are not provided by the practice. The ability of practices to provide all services will vary over time and from place to place.

The Health and Disability Commissioners cases note that lapses in following up problems have occurred when patients are not seen by their usual GP, although it can also occur if a practice is busy with high patient loads. It is important for general practices to develop systems and processes that reduce the risk of unresolved conditions being missed. There should be a system in place to reduce the risk of unresolved conditions being missed.

Good communication is essential for working across interfaces to prevent patient information getting lost in the system. This has become more important as multidisciplinary health networks work more closely and information is shared.

Mitigating risk to patients:

- Identify ways to inform coordination and integration of care
- Plan and manage for the complexity of problems that present so that patient information is not lost or care compromised
- Undertake regular case management analysis to identify how continuity is provided by the practice and identify gaps or areas for improvement
- People with palliative care/terminal illness needs, or their caregiver, can access direct help from their doctor (or an informed deputy), during normal hours and after hours

Note: Vicarious liability: Based on the principle that (the owner) is responsible for the actions of those engaged to do your work.

Resources

MOH Standing Orders

Triage

Indicator 30

The practice identifies and responds appropriately to all patients with clinically urgent medical conditions

Criteria

30.1 ★★	The practice team monitors the clinical condition of waiting patients
30.2 ★★	A triage system is in place to assess and prioritise patients with urgent medical needs
30.3 ★★	Receptionists/telephonists have been trained to identify, prioritise and respond appropriately to patients presenting with life threatening conditions
30.4 ★★	Practice team members who may be required to administer cardiopulmonary resuscitation (CPR) have current certificates to an appropriate level from certified trainers

Further information

Training to recognise and respond to an emergency is essential for practice teams. Triage services operated by a range of health professionals are being utilised more often and this means that CPR skills are essential for all members of the practice team who interact with patients. They must understand their specific role and response during any medical emergency in the practice.

CPR training is a requirement for:

- General practitioners participating in the RNZCGP Maintenance of Professional Standards and Advanced Vocational Education Programme (minimum level 5) must be current
- Practice nurse Continuing Professional Development (CPD) requirements – a minimum of level 4

Mitigating risk:

- Practice CPR training (level 1 – 7) records confirm that all team members required to administer CPR are trained to the correct level and record the certified trainer e.g. ACLS, St Johns, New Zealand Heart Foundation
- Practice teams must have systems in place to observe the clinical condition of patients
- Observing body language or signs of distress is important
- Practice teams must be able to demonstrate effective assessment of urgent conditions
- Practice teams must know how to manage an emergency drill

Resources

Medical Council of New Zealand, Coles Medical Practice in New Zealand 2008

Medical Council of New Zealand, Good Medical Practice – a guide for doctors 2004. http//www.mcnz.org.nz

Professional Development

Continuing Professional Development

Indicator 31

The practice team complies with the Health Practitioners Competency Act 2003

Criteria

31.1 ★★	All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003
31.2 ★	Medical staff in the practice are vocationally registered in general practice or working towards this
31.3 ★★	All team members participate in Continuing Professional Development

Further information

To meet the requirements of the Health Practitioners Competence Assurance Act 2003, all practice team members must demonstrate their competence and fitness to perform their duties. The intent of this criterion is to ensure that all health professionals are engaged in the Maintenance of Professional Standards programme.

The New Zealand Medical Council requires maintenance of Continuing Professional Development (CPD). Practices must hold a record of:

- Medical Council certificates stating whether GPs are vocationally registered or are general registrants with the name of the supervisor and NPI number
- Vocational Registration: (RNZCGP decision: 24 July 2009)
- Practices must provide evidence that each clinical team member has a current Practising Certificate and the Annual Practising Record is checked annually.

Practices should use opportunities to review the learning needs of its team members annually to inform and plan for professional development needs:

- Practice meetings
- Results from performance reviews
- Any other feedback or issues identified as important for the practice population

To assist team members to complete their professional requirements, practices should hold a training record that records the dates, type of continuing professional development, training (in-house or other) and any certificates.

Cultural competency is a requirement of the HPCA. It is recommended that all practice team members learn about Whanau ora and how it would be applied in practice.

Resources

Health Practitioners Competence Assurance Act 2003. http://www.legislation.govt.nz

New Zealand College of Primary Care Nurses NZNO – Accreditation

http://www.emergencynurse.co.nz/Site/Sections/Colleges/Practice_Nurses/acreditation.aspx

Medical Council of New Zealand. http:// www.mcnz.og.nz

Nursing Council of New Zealand. http://www.nursingcouncil.org.nz/certs.html

New Zealand Medical Association. http:// www.nzma.org.nz

RNZCGP Pathway to Fellowship. http://www.rnzcgp.org.nz/education/gpep2/docs/FellRegs_180707.pdf

RNZCGP Maintenance of Professional Standards Programme 2010 – 2012

Teamwork

Indicator 32

There are clear lines of communication, accountability and responsibility for creating an environment of excellence in teamwork

Criteria

32.1 ★	Practice team members understand how their individual roles and responsibilities link with other team members
32.2 ★	There are clear documented lines of accountability and reporting structures
32.3 ★	There is evidence of regular meetings involving the practice team
32.4 ★	Practice team members report their input is valued during practice meetings
32.5 ★	There is a process for dissemination of information to all team members

Further information

It's worth considering how team interaction and culture might influence patient outcomes. It can influence plans for introducing clinical governance, improvement activity and engagement in practice initiatives.

Successful clinical governance requires a team culture where members:

- Are willing and able to acknowledge their problems
- Work together to improve performance
- Value personal development and education
- Feel valued in their work
- Recognise the importance of the patient's experience of care
- Seek ways of improving care as a matter of routine[30]

The first step is to identify team culture. It cannot be created to order and will take time to develop. Practices may include development of team culture as part of its long-term plans for developing clinical governance. The process should begin with the team identifying how well they perform on; communication, accountability, and responsibility for creating an environment of excellence in teamwork.

Improving team work

- Communication channels in the practice must be sufficient to provide guidance to all team members on performance, roles and duties in the practice
- Team members report that they understand their roles and responsibilities within the practice team and when working in external domains, or in multidisciplinary teams
- There is an organisational diagram that outlines the structure of the organisation and outlines designated roles

- The practice holds regular meetings with the whole team which records decisions made and actions taken
- Minutes are available to team members
- Extra-ordinary meetings are held to address urgent matters
- Team members must be able to provide examples of where their input was valued.
- Examples of methods of communication can be provided, e.g. email, notice board, meetings, peer groups

Resources

The Team Climate Assessment Measure (TCAM) programme measures teamwork, particularly behaviours essential to the maintenance of patient safety and effective patient safety incident management in clinical settings. It also gives staff the opportunity to improve on their team working.
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59884

Human resources

Indicator 33

All practice team members have employment agreements and current position descriptions

Criteria

33.1 ★★	Practice team members have employment agreements with position descriptions
33.2 ★★	Practice team members and others who have access to patient information have signed a confidentiality agreement
33.3 ★★	Each member of the clinical team is insured to cover liability
33.4 ★	There is an orientation process for new team members
33.5 ★	There is a resource with information about the practice available to new team members and locums
33.6 ★	Performance reviews are conducted annually and used to guide professional development for all practice team members

Further information

Employment matters must be given due consideration to enable team members to operate effectively. Each team member must have a structure that provides role clarity and their place in the team.

Mitigating risk

- There is evidence that the practice and professional team are covered by organisational and professional insurance, e.g. New Zealand Nurses Organisation, College of Nurses Aotearoa (NZ) Inc, Medical Assurance Society, Professional Indemnity Insurance
- All employees of the practice have a current position description that includes key tasks, functional relationships and annual review dates
- Employment agreements have been signed with terms and conditions
- Confidentiality agreements may be part of employment agreements
- There is evidence of an orientation process for new members
- A Practice Induction Resource or Orientation Manual exists for all new team members, locums or casual staff
- Although practice owners cannot contract with themselves, the College recommends that GPs who own their practice have partnership agreements in group practices, and position descriptions to clarify roles and responsibilities
- All members of the practice team including practice partners should participate annually in performance reviews which should be recorded and contain review dates, date of review, outcomes and proposed forward plans

Resources

Employment Relations Act 2000. http://www.ers.dol.govt.nz; or http://www.legislation.govt.nz

Health and Safety

Indicator 34

The practice team complies with the Health and Safety in Employment Act 2002

Criteria

34.1 ★★	The practice has documented policies that describe how the Health and Safety in Employment Act 1992 and 2002 Amendment will be implemented
34.2 ★★	The practice team complies with health and safety policies and procedures to identify and manage hazards
34.3 ★★	The Health and Safety Officer/s has received training
34.4 ★★	The practice team conducts a health and safety review annually and makes changes as necessary
34.5 ★★	Health and safety accidents and incidents are reported, recorded, investigated and followed up

Further information

Protection of the practice team and patients health and safety in the practice environment is essential. The practice has a responsibility to ensure the service has Health and Safety policies and procedures that describe how the practice aligns with the Health and Safety in Employment Act. The policies address patients, their whanau, employees, employers, contractors and visitors. All team members must be aware of the health and safety policies and use a hazard plan and register to identify and manage risk.

To comply with the regulations there must be a trained Occupational Health and Safety Officer in the practice. (see s19E and s19F of the Health and Safety in Employment Act 1992).

A policy should cover:

- Manmade emergencies such as injury, armed robbery, power failure
- Workplace stress
- Accident recording
- Training of employees
- Annual review and updating as necessary
- Significant hazards
- Workplace stress
- A smoke-free environment
- Workplace processes e.g. how an employee uses machinery or equipment
- Physical environment e.g. working off site

- Equipment used e.g. proper use of electrical equipment
- External factors e.g. robbery
- Input to the work process e.g. toxic chemicals
- Work organisation e.g. shifts and breaks designed to minimise fatigue and disruptions to sleep
- Access to critical information e.g. Instructions available at an appropriate literacy or language level for employees in the workplace
- Construction of the building e.g. floor is safe when wet
- Impairment of individual employees e.g. when a diabetic employee misses meals due to work pressures

There must be a Health and Safety Accident and Incident Register that records accidents/incidents, how these were investigated and any changes that resulted.

- A sample form is available on the OSH website. www.osh.dol.govt.nz/report/accident/index.shtml
- Regulation 4 of the Health and Safety in Employment (Prescribed Matters) Regulations 2003 sets out the information that must be recorded or reported in the register.
- An annual review must be undertaken

Resources

Health and Safety in Employment Act 1992. http://www.legislation.govt.nz

Civil Defence Emergency Management Act 2002. http://www.legislation.govt.nz

Civil Defence Emergency Management Regulations 2003. http://www.legislation.govt.nz

Fire Safety and Evacuation of Buildings Regulations 2006. http://www.legislation.govt.nz

Department of Labour Website. http://www.osh.govt.nz/order/catalogue/index.shtml

Department of Labour: An Introduction to Employers' Rights and Responsibilities under

the Health and Safety in Employment Act 1992 and Amendment 2002. www.workinfo.govt.nz

Hazardous Substances and New Organisms Act 1996. http://www.legislation.govt.nz

Health Act 1956. http://www.legislation.govt.nz

Influenza Pandemic Planning: Business Continuity Planning Guide 2005.
http://www.med.govt.nz/upload/27552/planning-guide.pdf

National Health Emergency Plan: Infections Diseases. http://www.moh.govt.nz

New Zealand Fire Service: Evacuation Scheme. http://evaconline.fire.org.nz

Resource Management Act 1991. http://www.legislation.govt.nz

Standards New Zealand: Business Continuity Plan AS/NZS HB221: 2004

Environmental Responsibility

Indicator 35

The practice is committed to environmentally responsible actions

Criteria

35.1 ★ **The practice has an active recycling programme**

Further information

There is growing international awareness that healthcare is contributing to issues such as the unsustainable use of the earth's resources and degradation of the environment. To assist primary care to address these concerns, a NZ-specific toolkit has been developed which focuses on easy changes that individual medical centres can make to reduce their environmental impact. In addition, these ideas on waste minimisation and energy efficiency carry with them other benefits such as improved patient health, time efficiencies and significant financial savings. The toolkit is specific and user-friendly, and was developed by RNZCGP Fellows Rebecca Randerson and Rochelle Phipps. To obtain a copy, greeningyourpractice@gmail.com

Examples of environmentally responsible actions include:

Lighting

- Energy efficient bulbs: A policy to replace spent incandescent bulbs with CFLs or IRC-Halogen (new generation. For further information see www.rightlight.govt.nz
- Arrangements to ensure lights in unused rooms are switched off, or have occupancy detectors fitted in infrequently used areas

Appliances

- Adopt a procurement policy to prefer energy efficient appliances. Using Energy-star or energy-rating logo. www.eeca.govt.nz/node/8086 Factsheet "Choosing and using your appliances"

Computers

- Encourage all team members to switch off each PC monitor unit at the end of each day, and build the checking of this action into one team member's routine
- Arrange for 'Power Management' settings to automatically 'sleep' computer components after a set time period. These need to be set independently for PC and monitors; for further information, Toolkit p. 11/12, or www.eeca.govt.nz/node/8543
- Action sheet – "Saving energy in business: equipment and appliances"

Paper

- Recycle (including confidential shredded paper)
- Buy office paper with recycled content where possible
- Buy hygiene paper with recycled content where possible

Waste Minimisation

- Source separation of waste to minimise the amount of waste going into landfills is becoming generally accepted practice
- Local and regional councils may have programmes to support practices to achieve environmental sustainability
- Adopt a policy to discontinue unnecessary incoming mail or receive one copy for the entire practice and post it on a central noticeboard

Specialty waste

- Ensure only hazardous human waste goes into the yellow hazard collection bins (hazardous waste is energy intensive to dispose of). Toolkit p. 30

- Safe disposal of sharps, e.g. diabetic needles, reusable sharps containers are used where appropriate
- Ensure correct disposal and recycling of long fluorescent tubes and CFLs – see p. 31/32 of toolkit or www.mfe.govt.nz/publications/waste/disposal-household-lamps-mar07/index.html
- Ensure correct disposal and recycling of batteries, especially hazardous batteries – see p.32 of toolkit or www.mfe.govt.nz/publications/waste/use-disposal-batteries-jul06/

Recycling

- An active recycling programme
- Printer toner cartridges are recycled – Toolkit p. 19 or www.mfe.govt.nz/publications/waste/safe-use-and-disposal-computer-equipment/use-disposal-computer-equipment.html
- Reuse old computer equipment. It can be gifted, see p. 28 & 33, 34 of toolkit, or contact the product's manufacturer to access their 'take-back' scheme
- Recycle by accessing a list of e-recycling providers on www.mfe.govt.nz/publications/waste/safe-use-and-disposal-computer-equipment/use-disposal-computer-equipment.html

Pharmaceutical wastage

- Drop off point for patients who have not used medicines
- When new permanent medications are initiated, the practice has a mechanism of limiting initial supply until tolerance is established e.g. by using a keyword to split the prescription into a 2 week initial supply with a 10 week repeat. Toolkit p.39
- Collaboration with local pharmacists where able to enhance patient compliance and reduce medications wastage e.g. Medication Use Reviews (MURs) and Comprehensive Medicine Management programmes (p. 40/41 of toolkit)

Future options may be:

- Practice premises are fully insulated. Toolkit p. 13/14
- Use email referral systems where able (Immigration medicals, Referral to specialist, Insurance medicals)
- High-need patients are actively encouraged to improve their homes by way of readily available insulation subsidies, home heating initiatives and curtain banks

Resources

World Health Organisation information on the health impacts of climate change.

http://www.who.int/topics/climate/en/

Energy Efficiency and Conservation Authority. http://www.eeca.govt.nz/

Ministry for the Environment: Impact of climate change on New Zealand.

http://www.mfe.govt.nz/issues/climate/about/impacts.html

Ministry for the Environment: Climate change resources.

http://www.mfe.govt.nz/issues/climate/resources/index.html

World Business Council for Sustainable Development. Triple Bottom Line. www.wbcsd.org

Section 2

PDSA Cycles (PLAN, DO, STUDY/CHECK, ACT)

– Continuous Cycles of reflection, change and improvement

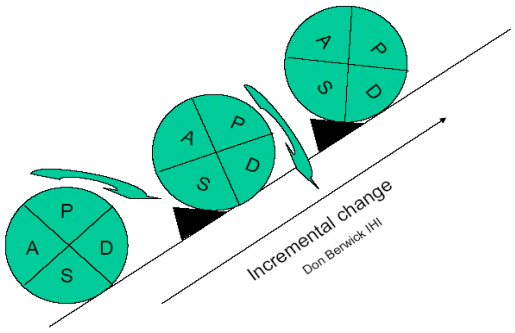
Continuous improvement leading to change is not likely to sustain unless there is a culture and framework that supports it. The design of improvement processes can be simple or complex and use problem solving techniques such as brainstorming or making tangible practice improvements[31]. The RNZCGP model builds on the work of other international organisations, in particular, JCAHO[32], which emphasises team processes as an essential element of quality improvement. Even where there are relevant tools and processes, it is essential that team engagement and activity make CQI happen.[33]

The approach

Systems and pprocesses should be analyzed and measured to identify sources of variation that cause safety or risk issues for patients or the practice. When placed in a continuous feedback process team members can identify and change the parts of the process that need improvements. PDSA cycles provide a simple illustration of the continuous improvement process[34].

PDSA Cycles:

- A simple tool to guide practice improvement activity through gap identification, reflection and action
- Apply to any aspect of care or service and should always involve the whole team[35] [36]
- Encourage consideration of patients and whānau/families, populations
- Guide incremental and continuous change[37]



Plan	**To design or revise processes to improve results** Establish the objectives and processes necessary to deliver results in accordance with the expected output. By making the expected output the focus, it differs from other techniques in that the completeness and accuracy of the specification (or standard) is also part of the improvement.
Do	**Implement the plan and measure its performance** Implement the new processes. On a small or manageable scale if possible.
Check/ Study	**Assess the measurements and report the results (find out who needs to know)** Measure the new processes and compare the results against the expected results to ascertain any differences.
Act	**Decide on changes needed to improve the process** Analyze the differences to determine their cause. Each will be part of either one or more of the PDSA steps. Determine where to apply changes that will include improvement. When a pass through these four steps does not result in the need to improve, refine the scope to

which PDCA is applied until there is a plan that involves improvement.

Improving Practice Outcomes

Compare your practice against *Aiming for Excellence* and make improvement using the PDSA Cycle as a guide

Start	Compare the practice against the criteria in *Aiming for Excellence* • Are we doing what we should be doing? • Where are the gaps? • What could we do better?
1. Plan	*Aiming for Excellence* – Identifies the expected standard of care by general practices • Where are we going? • Set markers for improvement (Indicators) The practice ensures infection control to protect the safety of patients and team members • What are the questions? (Criteria) Records are kept to monitor the effective physical parameters for each sterilising cycle • What are the expectations? (Standards) ★ Considered essential by the RNZCGP
2. Do	What information needs to be collected? • Undertake a self-assessment against criteria • Collect data from the practice • Score against criteria in *Aiming for Excellence*
4. Check/ Study	Undertake a gap analysis • Were objectives met? • What is the gap between the information obtained and the expectations in *Aiming for Excellence?*
5. Act	What changes can be made to improve patient care as a result of the information obtained? • Develop a quality action/management plan to address outstanding issues • Identify who takes responsibility for the actions • Meet regularly to ensure actions being implemented are successful • Discuss problems or benefits • Report on activity
Monitor	Undertake a regular review of progress against changes agreed • What were the outcomes?

Recording sheet
– identify how your practice compares against the standard

Patients and community

Indicator 1 **The practice team complies with the Code of Health and Disability Services Consumers' Rights 1996**			
1.1 ★★	There is a documented policy that describes how The Code of Health and Disability Services Consumers' Rights 1996 (The Code) will be implemented	The policy covers all areas of 'The Code': The right to: • Be treated with respect • Freedom from discrimination, coercion, harassment and exploitation • Dignity and independence • Services of an appropriate standard • Effective communication • Fully informed • Make an informed choice and give informed consent • Support • Teaching or research • Complain	
1.2 ★★	The practice team has received training within the last three years to implement 'The Code'	All practice team members can verify the scope of training received. The training record documents the provider of training, participants and the date.	
1.3 ★★	The practice team is able to describe their role in implementing 'The Code'	Practice team members can describe actions taken to implement 'The Code'. The actions may be applicable to all members, e.g. respect, but could be role related, such as informed choice.	
1.4 ★★	The Code of Health and Disability Services Consumers' Rights 1996 is displayed	'The Code' must be displayed in the practice, so that patients can view the content.	
1.5 ★★	Information about the local health advocacy service is available to take away	Leaflets are available	
Indicator 2 **There is patient and community input into service planning**			
2.1 ★	The practice obtains formal feedback from patients to determine their satisfaction with the service is obtained at least three yearly	Identify methods used to invite the views of patients and their Whanau about the practice, e.g. surveys, one-on-one feedback, documented, collection of informal complaints or comments. Surveys must reflect the view of the whole practice population, e.g. Results of the RNZCGP Better Practice Patient Questionnaire (BPPQ) questionnaire show each response by ethnicity, age, gender.	
2.2 ★	Practice planning and development of services is responsive to their enrolled population	The methods used to capture comments received from patients, their Whanau and/or carers about practice services or care, e.g. Responses to community feedback, community liaison group, advisory groups, delegate on a practice committee, focus groups or hui.	
2.3 ★	Patient, whanau input and community feedback is used to improve the quality of service provision	Patient feedback, comments and suggestions noted, discussed and developed at team meetings and used to plan service developments and improvements.	
2.4 ★	Information about the use of patient, whanau and community input is communicated to the practice team and patients	Information about how practice services were improved as a result of feedback. How feedback is provided to the practice team and patients e.g. Team meetings, newsletters, brochures, supermarket notice board, community centres, youth health clinics.	
Indicator 3 **The practice delivers health care that is integrated with other agencies and community services to improve individual care of patients**			
3.1 ★★	The practice team can access a directory and/or resources about local, regional and national health, social and community agencies	Examples: Handouts, directories, pamphlets, internet sites such as local councils or Citizens Advice Bureau have access to databases with contact information about community and health services.	
3.2 ★★	The clinical team has established relationships with other agencies, secondary services, public health, disability, community services, or	Examples: Child health initiatives, Arthritis field officer, Plunket, Care Coordination services. Opportunities to build in meetings between local practices and educational programmes.	

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	different providers		
3.3 ★	**The clinical team coordinates care with other agencies**	Members of the clinical team can provide examples of care coordination.	
3.4 ★	**There are established links with WellChild services to integrate the care of children**	Practices have identified local WellChild or other providers such as Whanau Ora that they could refer to if needed.	
Indicator 4 **The practice makes provision to ensure all patients can access 24 hour care**			
4.1 ★★	**Patients are able to access information on 24-hour health advice or care**	The practice provides up to date information about its services, how to access to after hours services such as Healthline or an 0800 number, and offers information in appropriate languages, if required, to meet the needs of patients.	
4.2 ★	**Patients can access the after hours service via a maximum of two calls through call diversion or equivalent**	Patients should be able to access after hours care or be directed to the service when they need it by using methods that take into account local situations and enable flexibility if the practice does not provide its own 24-hour care. • Phone diversion should be in place unless justifiable by circumstance • Patients may have to dial a second number in some areas, as call diversion is not possible throughout New Zealand • There are a number of possible combinations that include the practice providing its own service or referring to another service, such as switching the telephone to another service • The 111 service is free on cell phone • Call diversion, and voice messaging provide explicit information about which service is providing access to 24 hour care if after hours care is not provided at the practice If the practice is unable to provide access, there must be a process that ensures patients are able to access 24 hour care with maximum ease.	
4.3 ★	**The practice follows up information received about patients seen after hours**	Practices should be able to provide an example that tracked patient information when seen after hours: • How the information was received • How information was followed up by the practice	
Indicator 5 **Patients are provided with information to enable them to make informed choices and give informed consent about their care**			
5.1 ★★	**Information is available for patients to help them understand and exercise their right to make informed choices**	Practices ensure support is available, or obtained, to assist patients to understand information provided so they can make informed choices, and give consent about their care and treatment e.g: • Explanation of the condition • Explanation of options available • Assessment of risks, side effects or potential harm • Estimated time until service can be provided • Results of tests • Results of procedures • Notification of any proposed participation in teaching or research	
5.2 ★★	**Informed consent is obtained from a patient or legally designated representative, when agreeing to a treatment or procedure**	RNZCGP Consumer Liaison Committee advice: Practice teams must be trained to access information for patients in different languages, formats and to contact interpreters and translators if needed. Support could include interpreters (where necessary and reasonably practical) and others, such as family member/Whanau, patient advocate, clinical team members, counsellor.	
5.3 ★★	**The clinical team documents informed consent in compliance with Rights 6 and 7 of 'The Code'**	A record is important in contentious areas where there may be disagreement between evidence and medical practice (prostate specific antigen) or ethical issues (Down's Syndrome investigation in pregnancy). The practice policy should outline: • What information needs to be obtained • What information should be provided (pamphlet/guideline) • Methods used to obtain consent • Procedures on the process and documentation of informed consent Documentation should include: • Date • Name • Procedure • Whether a specimen was sent for histology • Date result received • Date patient was informed about result	
5.4	**The clinical team documents**	Evidence exists that benefits and risk were discussed with patients prior to	

★★	**discussing the harms and benefits of contentious screening tests with eligible patients in relation to harm versus benefit**	screening tests e.g. in patient notes where clinical members have recorded discussing screening and the result. Consent must be in writing if: • The patient is to participate in any research • The procedure is experimental • The patient will be under general anaesthetic • There is significant risk of adverse effects on the patient	
Indicator 6 **The practice upholds patients' right to complain**			
6.1 ★★	**The practice has a documented complaints policy**	The complaints procedure must show: • Appropriate documentation • Compliance with relevant timeframes • Legal requirements under Right 10 of 'The Code' Avoiding complaints: • Establish quality systems in accordance with the legislative requirements • Develop practice systems that encourage patient feedback and response	
6.2 ★★	**The practice team demonstrates the complaints process complies with Right 10 of 'The Code'**	All members of the practice team know how the complaints procedure works in the practice. The policy should include: • The acknowledgement of the right to complain • Who the complaints can be made to • The method to implement a fair, simple, speedy and efficient resolution of complaints • Managing complaints within the timeframes under 'The Code' • Information provided to the patient	
6.3 ★★	**The Complaints Officer can demonstrate that the complaints process complies with Right 10 of 'The Code'**	There is a Complaints Officer and they can demonstrate how they respond to manage the complaints process.	
6.4 ★	**Complaints and their resolution are used as opportunities for learning and quality improvement**	The practice can provide examples of where complaints were used to inform and improve clinical governance or practice systems.	
Indicator 7 **The practice acknowledges and is responsive to the special status, health needs and rights of Maori whānau**			
7.1 ★	**The practice has a documented Maori Health Plan, that states how it implements measures to address the health needs of enrolled Maori patients**	• The Maori Health Plan states how to implement measures to address priority areas as stated in He Korowai Oranga Maori Health Strategy 2002 • The practice plan for the practice population can be underpinned by their local District Health Board, or primary health organisation Maori Health Plan • The plan states how it intends to address Maori Health Priority areas as stated in the Maori Health Strategy • Practices can demonstrate measures they have implemented to address each of the priority areas • The plan has specific targets and timelines • To implement the measures in the plan, there is a patient management system that collects ethnicity data The RNZCGP recognises that there is a diversity of understanding about Maori populations and Maori health issues throughout the country. It is understood that practices will provide their own solutions.	
7.2 ★★	**The practice team has had training in the Te Tiriti o Waitangi (the Treaty of Waitangi), including the principles of the treaty; Partnership, Participation and Protection**	Training should preferably be provided by external organisation/resources; however an individual team member may attend dedicated training and run in-house programmes. Evidence of training for all practice team members, must include the rights and of Maori under the Te Tiriti o Waitangi – The Treaty of Waitangi.	
7.3 ★ **New**	**The practice is meeting the health needs of its enrolled and Maori population to reduce inequalities**	Data capture must align with the MOH principles of patient self-identification. When collecting ethnicity, self-identification must be the process used to identify a patient's ethnic group. It is unacceptable for the collector to guess any patient's ethnicity or to complete the question on behalf of the patient, based on what they perceive to be from the patient's physical appearance. Ethnicity data must not be transferred from another form as it may have been incorrectly collected. To maintain consistency of responses and quality of data, the following requirements must be met: • The practice registration form records patient ethnicity • The reception team can demonstrate how it records audit data for contractual	

		requirements • The team can explain the process for collecting data in keeping with the MOH Ethnicity Data Protocols for the Health and Disability Sector, and how it improves its ethnicity recording • The format should align with the actual graphics recommended by the MOH Protocol • For consistency, categories must be in the order shown in the protocol • The font size, format and dimensions are to remain the same as in the Protocol where practicable • Practice members are able to explain to patients the purpose for collecting ethnicity data Providing quality ethnicity data will help practice teams to track and share health by ethnicity and effectively monitor performance to improve health outcomes and reduce health inequalities. It will provide Maori with quality information about their health status.	
7.4 ★	**The practice team has developed working relationships with local Maori organisations/providers and Maori groups**	• Practice services relevant to Maori • The practice has identified any barriers for Maori to access the practice services, and is addressing these where possible • Identify enrolment of Maori patients on specific programs such as Care Plus, Diabetes Get Checked, DHB programmes in Chronic Care Management • Internal/external audits on Maori health outcomes • All audits must be analysed by ethnicity • The practice team can describe how it seeks appropriate Maori participation in governance, service planning and review of service delivery, in a manner designed to improve health outcomes • The percentage of Maori enrolled with a practice versus the percentage residing in the practice catchment area • The practice enrolled population reflects the local ethnicity mix in respect to Maori • Evidence of improvements in health outcomes for the enrolled Maori population • Identification of any barriers for Maori to access practice services • Identification of enrolment of Maori patients on specific programs such as Care Plus, Diabetes Get Checked, DHB programmes in Chronic Care Management, Mental Health Programmes, Primary Options The practice has developed networks with tangata whenua[1], local Maori providers and other Maori community groups. This includes having a list of local Maori providers they can refer to, and meeting with key groups at least once every three years. Evidence of effectiveness: • Records of meetings, Memorandum of Understanding, committee membership By Maori, for all: • The practice has developed networks with tangata whenua, local Maori providers, community and iwi	
Indicator 8 **Patients and their families receive services that respect the values and beliefs of different cultural, religious, social and ethnic groups**			
8.1 ★★	**The practice provides services that are responsive to the cultural needs of diverse patient groups**	To be responsive to local communities, practices should: • Develop and maintain relationships with organisations or groups within the practice population • Identify what processes are in place to respond to diverse needs in the practice population • Engagement with other community or primary health organisations to obtain information about the health needs of its diverse communities	
8.2 ★★	**The practice team has received training to maintain cultural competence within the last three years**	Under Section 118 of the Health Practitioners Competence Assurance Act 2003, registration authorities have a responsibility to set standards for cultural competence, review and maintain the competence of health practitioners, and set programmes to ensure ongoing competence. All practice team members can: • Verify the scope of training received	

[1] Tangata whenua is a Maori term referring to the Maori being the indigenous peoples of Aotearoa (New Zealand) and means "people of the land", from tangata, 'people' and whenua 'land'. In a particular tribal geographical area Tangata whenua refers to the local Maori tribe.

		• The training record documents the provider of training, participants, and date	
8.3 ★	**The practice team can identify interpreters and local resource people where language is a barrier to care**	Practice members clarify how they identify whether a patient needs translation services and where interpretation is beyond a family members' capability.	
8.4 ★	**The practice collects, records and audits patient ethnicity data consistent with the Health Information Privacy Code 1994 and the MOH Ethnicity Data Protocols for the Health and Disability Sector**	Members of the practice team can describe how they collect data in line with the, Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health 2004.	
Indicator 9 **The practice has a documented Strategic Plan**			
9.1 ★	**The practice has a documented strategic plan with objectives and an identified date for review**	The practice has a 3 – 5 year strategic plan that includes a mission statement and purpose, long-term and short-term strategic objectives/functions and range of services. It includes: • A SWOT analysis (environmental and financial), plus goals and objectives • Evidence that the practice has reviewed its annual business plan every six-months against its strategic objectives • Risk management to cover clinical and non clinical risk, financial, reputation, personnel and environmental risk. Team members report having opportunities to have input into the strategic plan for service planning and improvement purposes; e.g. meetings and other ways of feeding back such as information from appraisals or questionnaires.	
9.2 ★	**The practice has a documented annual business plan**	Standards New Zealand: Business Continuity Plan NZS HB 221:2004	
9.3 ★	**Practice team members have input into the strategic plan**	Review audit data by ethnicity and any patient suggestions/input and identify how it can contribute to planning, e.g. research or innovation activity, results of questionnaire.	
9.4 ★	**Patient input is used for strategic and annual planning purposes**	Development of the strategic plan can make use of tools to address the health needs of population groups within the practice. For those with a Maori population in their practice this might include the Health Equity Assessment Tool (HEAT)[38], the Whanau Ora Tool or the Whanau Ora Health Impact Assessment Tool.	

Practice Organisation

Indicator 10 **The practice premises are physically safe, clearly signposted and accessible**			
10.1 ★★	**External practice signage is legible, visible and well placed to read from a distance**	Confirm	
10.2 ★★	**Lighting outside the practice facilitates safe entry and exit to and from the practice**	The internal and external environment such as railings, ramps, lighting, slippery surfaces, lifts or other relevant equipment is available to assist people and those with disabilities to access all areas of the practice.	
10.3 ★★	**People with disabilities can access the practice premises**	The weight of the door at the entrance into the building is important. The door must be able to be opened easily by people who are frail, older or unwell.	
10.4 ★★	**There is parking close to the practice with dedicated parking for patients with mobility difficulties**	Dedicated disabled parking or alternative arrangements are able to be made. If local regulations do not permit the practice to establish a disabled park, then an explanation may be obtained from the local council.	
Indicator 11 **The practice facilities ensure patient comfort and safety**			
11.1 ★★	**The waiting area has adequate space, seating, heating, lighting and ventilation**	Practice waiting rooms are comfortable and large enough to accommodate patients and families.	
11.2 ★★	**The waiting area has appropriate seating for disabled patients**	The practice meets the specific needs of disabled patients and seating spaces are adequate to cope with the demand, e.g. • Wheelchair, push chair, walking frame • Report on a consultation exercise carried out with the relevant disabled patient/s or group	
11.3 ★★	**There is a toilet with hand washing facilities on site with access for disabled people**	There is a toilet with disabled access and hand washing facilities that include running water and liquid dispensed soap. Practices need to make all reasonable efforts to facilitate access to patient toilets.	
11.4 ★★	**There are facilities to ensure hand hygiene in all patient contact areas**	• Water is available in designated hand washing areas with hand drying facilities • Liquid dispensed soap is available for routine hand washing • An alcohol based hand rub is used before clinical procedures • Where hand-washing facilities are not available, alcohol formulations can be used (70% alcohol based hand rub) • Disposable hand towels are available	
11.5 ★★	**Each consultation room is maintained at a comfortable temperature and has adequate lighting, including task lighting**	• The consultation room is maintained at a comfortable temperature for patients who need to undress • The room is light enough to observe the patient and task lighting is available for examinations • Treatment rooms used for surgery need a good overhead lighting • Task lighting may be located in specific areas and not in every consulting room	
11.6 ★★	**Examination couches are accessible, safe and visually private**	Examination couches are: • Accessible and safe for disabled or frail patients • A safe height and use a hydraulic system or portable steps are available The examination area should be private so that others cannot observe the examination	
11.7 ★★	**Patients are assured of auditory privacy during consultations or when any personal information is conveyed**	Consulting rooms are sound proof and the team can describe strategies used to make sure confidential information is conveyed in private and cannot be heard by others.	
Indicator 12 **The practice team uses a secure information system that integrates electronic clinical decision support tools and management systems**			
12.1 ★	**The clinical team has access to electronic decision support tools**	The clinical team have access to electronic support tools that support clinical decision making. These are normally provided by an external provider via a web page or externally hosted application. Pre-requisites, for Electronic Decision Support such as PreDict for CVD, are patient demographic data, electronic notes and disease coding systems. e.g. READ, SNOMED	
12.2 ★	**The practice maintains a secure internet connection which is available for use by the clinical team**	*Internet access* • The clinical team should be able to access to the internet from within the practice • Computers with access to the local network or Internet must have antivirus/antimalware software installed • The network should be protected by perimeter security (typically a managed firewall)	

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		• All computers must have current anti-virus and anti-malware software installed • Software should be set to automatically update virus definitions in accordance with the recommendations of the software vendor	
12.3 ★	**The practice implements a clearly defined policy for computer security**	The policy should include: • Password management • Screen locking • Hard-drive destruction • Physical access *Computer Security* • PMS and other sensitive files should be password protected • Passwords should be of a moderate security (6 digits alpha-numeric) • External access to practice computers (e.g. remote desktop connections) must be via a secure connection • Password management ensures that previous staff members do not have access to the network or files • Screensavers can and should be set up to lock the computer after a set time (recommended 10 minutes) • Screens should not be visible from the patient waiting area • Disused hard drives should be physically destroyed, and/or the data obfuscated. Note: Formatting the drive does not destroy the data and therefore is insufficient on its own • Computers and devices containing confidential data (e.g. backup drives) are protected from physical access by members of the public	
12.4 ★	**The practice implements a clearly defined policy for computer back up**	The practice should have a documented policy covering computer data backup, verification, transportation and storage. The policy is to be implemented in accordance with the Privacy Code 1994, and the practice team need to understand their role in implementing the policy. The policy should include • Automation, validation & monitoring • Encryption & Security • Transportation / Transmission • Offsite storage • Retention & archiving *Backup protection* • Computer backup systems should backup PMS and other important data at least once daily • Data should be encrypted and verified for integrity following each backup • The system should be either automated or be operated by trained personnel • A copy of each backup should be stored in an offsite location • Data taken offsite, either physically or electronically, should only be carried and stored by a qualified service provider (eg: a security company with Ministry of Justice COA certification) • Data transmitted electronically should be done so via a secure connection which complies with the NZ Government ICT standards document (NZSIT 402) • The backup system should include a system for data retention Historical copies of backups should be retained for 31 days (minimum 7 days). This allows for a previous backup to be restored, should the current backup be found to include corruption or other data integrity problems.	
Indicator 13 **The practice maintains privacy of individual patient information in accordance with the Health Information Privacy Code 1994**			
13.1 ★★	**The practice has a documented policy that describes how the requirements of the Health Information Privacy Code 1994 will be implemented**	The policy describes: • Purpose of collection of health information • Source of health information • Collection of health information from individuals • Manner of collection of health information • Storage and security of health information • Access to personal health information • Correction of health information • Retention of health information – archiving • Limits on use of health information • Limits of disclosure of health information • Unique identifiers	

13.2 ★★	**The practice team has received training to implement the principles of the Health Information Privacy Code 1994**	• Training records document the provider of training, participants and the date • All members of the practice team can verify the scope of training received	
13.3 ★	**The practice team is able to describe their role in implementing the policy**	Section 23 of the Act places a responsibility on each practice to ensure a dedicated person has responsibilities that include: • Encouraging the agency to comply with the Code • Dealing with requests under the Act and Code • Working with the Privacy Commissioner	
13.4 ★★	**The collection, use, storage, disposal and disclosure of individual patient information complies with the Health Information Privacy Code 1994**	Team members can describe how they implement the privacy policy for: • Collection • Use • Storage and security • Disposal and disclosure of individual patient records including electronic • Correction and alteration of medical records	
13.5 ★★	**There are safeguards in the reception area to ensure confidentiality of patient information (includes verbal, documented and electronic)**	Written, verbal or electronic information about patients cannot be seen or heard in the waiting area, e.g. • Methods used to capture patient information in a confidential manner such as; background music, elevated front desk, training in telephone etiquette, permission sought from patients	
13.6 ★★	**The content of medical records and documents is not identifiable in public areas**	The content of medical records and documents (paper or electronic) is not identifiable in public areas.	
13.7 ★	**Non lockable files are in non public working areas only**	Non-lockable files (or non-secure computers) are in non-public working areas.	
13.8 ★	**Files are secure or password protected unless in active use by the practice team**	*Computer Security:* • The Patient Management System should be secure and passwords should be of a moderate security (4 digits, alpha numeric) • Access to information by third parties such as; interpreters, carers, relatives, medical or nursing students on placement, general practice registrars	
Indicator 14 **The practice has effective systems for enrolment of new patients and transfer of medical records**			
14.1 ★★	**A patient registration process to collect personal and health information**	Collection of personal and health information improves patient ethnicity recording for contractual requirements and clinical care: • Questionnaire for new patients, or registration form, initial health and wellness consultation. • Data capture must align with the MOH principles of patient self-identification • It is unacceptable for the recorder to guess any patient's ethnicity or to complete the question on behalf of the patient based on what they perceive to be by the patient's physical appearance • Ethnicity data may not be transferred from another form as it may have been incorrectly collected	
14.2 ★★	**Requests for the transfer of medical records are acted on within 10 working days**	The practice can produce evidence of a process that meets the timeframe. Transfer of notes: See Rule 11 Permitted Disclosure: When a patient has requested their notes be sent to another practice the agency disclosing the information would have reasonable grounds to believe that disclosure has been authorized. In this case authorization need not be in writing. http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-2008-revised-edition.pdf	
14.3 ★★	**Details of the transfer of medical records to and from the practice are recorded**	Transfer of medical records is recorded in a register or on the Patient Management System. It should include: • Name of person who requested transfer • Date requested • Where records are transferred to or from • How records were transferred (courier, post) • Date of delivery	
Indicator 15 **There is a safe and effective system to manage patient test results, medical reports and investigations**			
15.1 ★★	**There is a policy describing how patient test results, medical reports and investigations are tracked and managed**	The policy outlines the process to track and manage patient test results. Principle: Reports are processed to ensure the right people get the right information within the timeframes identified by the practice: • There is a person responsible for monitoring, review and action on all incoming test results and medical reports • There is a designated deputy to process the reports if the designated person is not available	

		• Members of the practice can describe the system used to transfer duty of care with respect to test results, e.g. locums, holiday period • Tracking specialist referral letters – practices should keep records to note that the results have been sighted	
15.2 ★★	**All incoming medical reports are seen and actioned by the team member who requested them or by a designated deputy**	Requested medical investigations should have a clear pathway to an outcome (Request, results, communicate results, record results, patient informed, action taken, dated & time limit identified). Members of the practice team can describe the system used by the practice to ensure all incoming test results and medical reports are acted on: • Recorded in medical records • How they are monitored • How they are reviewed • How they are acted on	
15.3 ★★	**Patients are provided with information about the practice procedure for notification of test results**	The Health and Disability Commissioner accepts that no system is infallible, but there is an expectation that important test results and referrals are tracked to ensure appropriate follow up: • Information is given to patients or displayed, i.e. patient information handouts, test request forms • Identify how the practice notifies patients about test results • Some practices provide patients with written information about how to contact the practice and who to contact to obtain results • Obtain, where possible, the patient's consent to notify only abnormal results • Encourage patients to call the practice if they want confirmation of normal results or have any questions	
15.4 ★★	**The clinical team can demonstrate how they identify missing results of potentially significant investigations and urgent referrals**	The practice can demonstrate its use of a system to ensure that tests ordered by the practice have been received in the practice and any missing tests can be identified. e.g. histology. A tracking or audit process should: • Identify missing results such as those not received from the laboratory, or ordered but information is not complete • Provide information about what has happened to medical investigations that have been returned to the practice from primary or secondary care	
15.5 ★	**A record is kept of communication with patients informing them about test results**	Communication about tests should be recorded in the electronic health record: • Date • Person who ordered the test • Person who provided the result to the patient • Any other information provided	
Indicator 16 **Prescribing is accurate, appropriate and timely**			
16.1 ★	**The practice has a documented policy for repeat prescribing**	Repeat medications can be identified in the patient records. The practice prescribing policy outlines how repeat prescribing is tracked and monitored in the practice.	
16.2 ★	**The practice team is able to describe how the policy for repeat prescribing is implemented**	Team members can describe their role in prescribing and practices used in the absence of a face to face consultation when implementing the repeat prescribing policy. Prescribing in the absence of a consultation: • Reasonable care and skill • Complies with legal, professional, ethical and other relevant standards • Provided in a manner consistent with needs • Minimises potential harm and optimises the quality of life • Cooperation among providers to ensure quality and continuity of services (Right 4, Code of Health and Disability Service Consumers' Rights 1996)	
16.3 ★	**There is evidence of changes made as a result of evaluating the medication review**	The practice meets with a pharmacist advisor at least annually to identify: • Actions for improvement • Any audits undertaken must review protocols for prescribing, accuracy and efficacy	
16.4 ★	**Prescriptions for non controlled drugs are computer generated**	There is evidence of a review and changes made as a result of evaluating an audit of a medication review to identify: • Accuracy • Adherence to the formulary • Generic prescribing rates • Costs	
16.5	**The clinical team uses an alert**	There is a risk to patients if this criterion is not met.	

★★	**system to highlight potential risk of an adverse event**	Clinical team members can only be aware of potential risk if it is recorded in the patient record, e.g. Allergies to medication, pharmaceutical products and/or vaccines.	
Indicator 17 **Security is maintained to ensure there is only authorised access to medications and pharmaceutical products**			
17.1 ★★	**Medicines, pharmaceutical products and clinical bags or portable emergency kits are stored securely so that they are only accessible to authorised people**	Medications and pharmaceutical products are secure and stored 'out of sight', not in open containers on bench/trolley tops or in high-traffic areas where they could be readily accessed by unauthorised people, including children. • A register is maintained for any controlled drugs kept on site • Practice security and precautions ensure security for medications and pharmaceuticals • Low open shelving does not contain pharmaceuticals and GPs do not store medications or pharmaceutical products on their desks • Low-level cupboards, which contain medications, should be fitted with child locks or are lockable	
17.2 ★★	**Controlled drugs are stored in line with current legislation**	The Misuse of Drugs Regulations 1977 – 28(a) notes that storage should be in a metal or concrete container that is affixed to the building. *Storage - Regulation 28 - Controlled drugs not for immediate use:* (a) Keep in a locked cupboard, or a locked compartment, that is constructed of metal or concrete or both, and that, in the case of a cupboard or compartment installed in a building after the commencement of these regulations, is of an approved type (b) Ensure that the cupboard or compartment is securely fixed to, or is part of, the building or vehicle within which the controlled drug is kept for the time being (c) Ensure that the key of the cupboard or compartment is kept in a safe place when not in use. Where the building or vehicle within which the controlled drug is kept for the time being is left unattended, that safe place shall not be within the building or vehicle *If there are no controlled drugs stored on site this criterion should be scored as met*	
17.3 ★★	**A register is maintained for controlled drugs**	Controlled drugs are recorded appropriately: • Bound volume • Each page is numbered consecutively • Each page identifies one form of controlled drug • Entries must be made no later than the ordinary business day next following the day on the transaction • Twice yearly balances shall be undertaken (at the end of the business day of June 30 / Dec 31) • Entries should be legible and indelible and in the format specified in the Regulations	
Indicator 18 **There is safe storage and disposal of sharps, contaminated materials and hazardous waste**			
18.1 ★★	**Biohazardous waste is safely stored, collected and disposed of in accordance with the industry standard (NZS 4304:2002) for the management of health care waste**	There may be differences in Council Bylaws throughout New Zealand. Refer to the local Council on the web to find relevant regulations for storage, collection and disposal of contaminated waste. • Hazardous waste, other than that classified by legislation, is the responsibility of the healthcare facility generating the waste • Healthcare waste is categorised by its properties and characteristics rather than the source of the waste, e.g. laboratory, home healthcare • Sharps – cytotoxic, radioactive, infectious • Non sharps - cytotoxic, radioactive, infectious, other hazardous waste, body parts	
18.2 ★★	**The practice has appropriate puncture-resistant sharps containers, displaying a biohazard symbol NZS 4304:2002, in all areas where sharps are used**	Puncture resistant sharps containers display a biohazard symbol and are located in clinical areas where sharps are used. They are wall mounted, high enough to be away from children and are not located in high traffic areas.	
18.3 ★	**Sharps containers are kept out of reach of children**	Sharps containers are stored high enough to be away from children, and not wall mounted in high traffic areas.	
Indicator 19 **The practice ensures infection control to protect the safety of patients and team members**			
19.1 ★★	**The practice has documented policies and procedures that describe infection control practices**	A policy should include but is not limited to: • The purpose of infection control • Staff immunity – staff with infections • Hand hygiene	

		• Respiratory hygiene & cough etiquette • Standard precautions • Single use items • Management of occupational exposure to blood / body fluids • Bloods and Body spills • Cleaning, decontamination, disinfection and/or sterilisation of instruments and equipment • Commercial cleaning • Wound management • Waste management • Linen services • Venepuncture • Cryotherapy • Cleaning and servicing of steriliser • Laboratory specimens • Hard toys	
19.2 ★★	**There is evidence that the infection control policies and procedures are implemented**	An audit that records efficacy of the steriliser for sterilisation of non-disposable instruments and materials AS/NZS 4815: 2006.	
19.3 ★★	**Appropriate team members have received infection control training within the last 3 years**	Team members can verify the scope of training received. • Training should preferably be provided by external organisation/resources; however individual team members may attend dedicated training and run in-house programmes • The training record documents the provider of training, participants, and the date	
19.4 ★★	**Records are kept to monitor the effective physical parameters for each sterilising cycle**	Print out of cycle parameters or direct observation and recording of cycle parameters or Class 4, 5 or 6 chemical criteria (where no print-out is available). • Class 1 chemical indicator in each load of unwrapped items • Class 1 external chemical indictor on the outside of every package item in the load Sterilising cycle monitoring may include: • Processing print outs from steriliser • Chemical Criteria / integrators • Validation / calibration records • Servicing of sterilizer records • Items shall be handled carefully, protected from sharp objects or any other factors that may damage the packaging • List type B sterilisers (e.g. Autoclave benchtop machines delivering at least Type B cycles) that meet existing standards described in AS/NZS 4815: 2006 • If items are processed off site, proof of the current validation and calibration of the steriliser used by the third party must be provided. Packaging and storage of equipment should be checked against the policy: • Storage of instruments – Sterile or surgically clean. Instruments are protected from dust, vermin and in a dry space, e.g. closed cupboard, sealed containers • There is a rotation system • Items are loosely packed to avoid damage • The length of safe storage is event related and frequent handling is detrimental • Instruments are not to be stored in disinfectant or under ultraviolet lights before or after any form of reprocessing AS/NZS 4815:2006	
19.5 ★★	**A current calibration and validation record is available for the steriliser**	Production of a record for the validation and calibration of the steriliser AS/NZS 4815 2006 The steriliser manual is available in the practice. • Only sterilisers with a drying cycle are suitable for sterilising wrapped items • Passive drying with a closed or 'cracked-door' is not suitable for processing wrapped items • If sterilising is outsourced, then evidence of an audit trail is required along with written proof that outsourced contractors have followed correct procedures	
Indicator 20 **The practice has appropriate vaccine storage and maintains the Cold Chain in line with national guidelines**			
20.1 ★★	**The practice has current national Cold Chain Accreditation as per the**	Certificate of Cold Chain Accreditation against the current MOH Protocol.	

	Ministry of Health (NZ) protocol		
20.2 ★★	**The practice can demonstrate monitoring of the Cold Chain in accordance with the protocol**	• The Authorised Vaccinator can be identified • The practice can identify how they manage the review of immunisation procedures in the practice • Clinical team members can show how they identify and recall all eligible patients	
20.3 ★★	**If offsite immunisation is undertaken the practice can demonstrate Cold Chain procedures**	Preserving the Cold Chain during storage, offsite immunisation and transporting vaccines: • Chilly bin lid must be tight fitting • 'Slickers' to preserve the temperature during transportation • Bubble plastic, shredded paper or polystyrene pellets to separate the vaccine from the cold source (IMAC Standards)	
Indicator 21 **Medical equipment and resources are available and maintained to meet patient needs**			
21.1 ★★	**There is an audit trail to monitor the servicing of all medical equipment according to relevant regulations, maintenance and operating instructions**	Calibration and validation: • An audit trail and tracking system shows that all medical equipment has been regularly tested and serviced according to relevant regulations and that maintenance and operating instructions are performed (date and by whom) • Manuals are available to train new staff to use equipment	
21.2 ★	**The practice has Residual Current Devices (RSD's) in any area where mains powered medical equipment is used for patient procedures**	Residual Current Devices (RSD's): • Equipment for medical locations should comply with the AS/NZS 3200 series and be maintained in accordance with the recommendations of AS/NZS 3551 • Electrical installations – Patient area of hospitals and, medical and dental practices – testing requirements NZS 3003: 1: 2003	
21.3 ★	**All essential basic equipment is available** • Auriscope • Blood glucose test strips/glucometer –*expiry dates must be current /Check calibration of glucometer to number on strip* • Cervical smear equipment • Dressings adequate to the services provided – *check expiry dates* • Ear syringe or suction • ECG & Defibrillator are readily accessible or within 10 minutes of clinicians request (*if on site, and the clinical team are trained*) • Eye - *local anaesthetic* • Fluorescein dye for eyes • Gloves • Height measure • Measuring tape • Monofilament • Nebuliser – *via air or oxygen, or large spacer device* • Ophthalmoscope • Peak flow meter • Pregnancy testing kit • Proctoscope • Sphygmomanometer – *Extra wide and paediatric cuffs* • Spatulae • Stethoscope • Surgical instruments appropriate for any procedures carried out • Suture equipment • Syringes and needles • Reflex hammer • Tuning fork	The adequacy and appropriateness of basic equipment are determined by the circumstances of the practice. Any omissions should be justified by the practice.	

	• Thermometer • Urine dipstick – protein, glucose, ketones –*expiry dates must be current* • Visual acuity chart – *at the correct distance* • Weight scale		
21.4 ★	**All emergency equipment is easily accessible and in a single location**	An ECG should be accessible within 10mins. If an ECG is held in the practice clinical team members know how to use it.	
21.5 ★	**All essential emergency equipment is available** **Emergency and resuscitation equipment:** • Airways and/or laryngeal masks - *varied sizes 00 to adult* • Ambubag and masks - *paediatric to adult* • Emergency bag/trolley • IV equipment - *set up and infusion* • Oxygen • Saline/plasma expander - *any one of e.g. penpaspan/crystalloid, expiry dates are current* • Tourniquet **Rural practices:** ***Rural practices require a greater level of off site equipment*** • Assortment of inflatable splints • Blood taking equipment • Defibrillator, pads available, paper in machine, battery changed/charged -*In accordance with manufacturers instructions* • Full stretcher kit • Intubation equipment • Manual defibrillator and/or automatic electronic defibrillator (AED) with annual function (*AED alone without three lead ECG monitor is inadequate*) – back up battery • Mobile phone/RT system • Oropharyngeal airways • Portable oxygen supply with regulator, tubing, masks and replacement cylinder • Portable suction • Regional maps • Strobe lighting for aerial rescue • Urinary catheter or other means for urgent catheterisation	Rural practices and type of general practice definition: Note: Practices <35 are not considered rural 3. Rural (35 – 59) 4. Isolated (> 60) The Rural Ranking Scale is calculated in consideration to: • Travelling time from surgery to major hospital • On call duty • On call for major trauma • Travelling time to nearest GP colleague at place of work • Travel time to most distant practice boundary • Regular peripheral clinics • Possible extra points where recruitment and retention of doctors is difficult	

21.6 ★	**All essential emergency medications are available** ***In stock or in the doctor's bag/clinical bag or portable emergency kit*** • 50% Glucose/glucagons injection • Adrenalin 1/1000 • Analgesia – paracetamol • Antiemetic • Antihistamine • Aspirin tablets • Atropine • Corticosteroid • Diazepam injection/rectal • Local anaesthetic • Sodium Chloride for injection • Naloxone • Penicillin injection – (*Some need refrigeration and in addition powdered version for offsite emergencies*) • An alternative for those allergic to penicillin • Sterile water for injection	The adequacy and appropriateness of essential emergency medication is determined by the circumstances of the practice. Any omissions should be justified by the practice. *If Ergometrine is used it should be stored in the refrigerator.*	
21.7 ★	**There is a documented process for medication maintenance to ensure medicines expiry dates, including patient medicines held in the practice, are current**	Verification and maintenance of clinical bags includes a checklist, date and signature of the person holding the responsibility for the procedure.	
21.8 ★	**There is a documented process to check and maintain the contents of all clinical bags/portable emergency kits and emergency equipment – at least monthly**		
21.9 ★	**The practice team conducts annual drills to enable them to respond to medical emergencies**	There should be evidence of an annual emergency drill.	
Indicator 22 **The practice has planned response and recovery procedures for fire, disaster or emergency**			
22.1 ★★	**The practice implements an Evacuation Scheme or Evacuation Procedure as required by the Fire Safety and Evacuation of Buildings Regulations 2006**	The practice follows a scheme or procedure approved by the New Zealand Fire Service. Important: Schemes and procedures • An evacuation scheme that is approved by the Fire Service is a legal requirement for practices that have more than 10 people employed	
22.2 ★	**There is an Emergency Management Plan in the event of a disaster or event that would impair the practices ability to maintain normal services**	The Emergency Management Plan should identify risk and contingencies for an event: • Maximising patient safety and continuity of care • Practice team safety is planned for in the event of a disaster • Response networks have been established • Managing service delivery • Setting up a safe and appropriate environment • Establishing an efficient and effective governance	

Clinical Effectiveness

Indicator 23 **Patient records meet requirements to describe and support the management of health care provided**			
23.1 ★	**All practice generated patient information is recorded electronically**	Practice Management Systems (PMS) and electronic notes are essential for management and auditing patient & population information. It is the only mechanism that provides accurate readily accessible data and an audit trail of activity for practice teams to meet primary care objectives, Health and Disability or legal requirements. • The practice team keeps the practice database up to date, e.g. checking demographic data at each patient encounter • There are new applications integrated with practice management systems that assist to identify needs of enrolled patient populations	
23.2 ★	**Patient records are coded or classified according to a recognised disease coding system or classification**	Disease Coding System, e.g. READ, SNOMED • READ codes are a hierarchical coding system – each level provides a more specific diagnosis • SNOMED CT® Systematized Nomenclature of Medicine — Clinical Terms) is the most comprehensive multilingual clinical healthcare terminology. It was developed as an international clinical terminology by the National Health Service in England and the College of American Pathologists in 1999	
23.3 ★	**The content of patient records meets or exceeds the minimum expected standard and ensures continuity of patient care** *Demographic data:* • Name of patient • NHI number • Gender • Address • Date of birth • Contact phone number • Ethnicity • Registration status • ICE - Contact person in case of emergency	A legally defensive record: • A record that is not altered, disguised or added to • A record of all house calls, phone calls • Kept for a minimum of 10 years • Abbreviations and ticks with a glossary • Written in ink, not pencil • Legible handwriting (includes not using abbreviations that do not have a key) • To be signed and dated (include times) after being checked for accuracy Identification and tracking depends on coding conditions at source and become most successful when they are routinely undertaken, for example to assess disease prevalence in the enrolled population being looked after. Identifying high risk groups provides clinical information to target care, e.g. • Delivery of influenza vaccines to a target population; patients over 65 years • Smoking status is recorded on the Patient Management System	
	Other demographic data: • Occupation history • Significant relationships • Hapu-iwi Alternate names		
	Medical records show: • Clinically important drug reactions and other allergies (*or the absence thereof*) • Directives by patients *where applicable* • Problem lists are easily identifiable (Each problem has a code against each disease recorded) • Past medical history • Disabilities of the patient *where applicable* • Current and long term medication are identifiable • Clinical management decisions made outside consultations, e.g. telephone calls		
	Consultation records: • Each entry is dated • Person making the entry is		

	identifiable • The entry can be understood by someone not regularly working at the practice, *e.g. a locum*		
	Consultation records should also include: • Reason for encounter • Examination findings • Investigations ordered • Diagnosis and assessment • Management plans • Information given to patients, including notification of recalls, test results, referrals and other contacts • Medications are identifiable: drug n*ame/ dose/ frequency/ amount/time / volume* • Current and long-term medications have been reviewed • Intermediate clinical outcomes e.g. HbA1c • Brief interventions are recorded • Screening and preventive care initiatives recommended • A follow up plan • End of life needs *where applicable*		
	Risk factors are identified: • Awareness alert e.g. deaf, blind • Family history • Current smoking status • Smoking history of patients over age 15 • Where appropriate, offer of smoking cessation • Alcohol/drug use • Blood pressure • Weight/height/BMI • Immunisations		
	Referral letters contain: • Reason for referral • Background information and history • Current treatment • Key examination findings • Problem • Current medical warnings • Long-term medications		
	Incoming information is filed or are available electronically in patient's medical records: • Laboratory results • Radiology results • Other tests or health information e.g. psychological testing • Other health information		
	Screening is up to date, e.g. • Cervical Smears • Mammograms • Cardiovascular risk assessment • Diabetes screening		

Indicator 24 **The practice offers services for disease prevention and promotion of healthy lifestyles**			
24.1 ★	**The clinical team implements or refers patients to programmes to improve, maintain or restore patient health**	Health promotion includes: • Developing patient skills • Involving community in the planning and delivery of care • Advocating for healthy local public policy • Creating a supportive practice environment for the practice team and patients	
24.2 ★	**Practice teams deliver preventive care and promote healthy lifestyles**	The practice can provide examples of: • Shared responsibility • Working collaboratively with health professionals, social agencies and community representatives • Working within an interdisciplinary approach on priority health issues. • The methods used to facilitate services that improve, maintain or restore patient care e.g. Arthritis care, Green prescriptions, Chronic Care Management. It could be a practice initiative, or provided by referral to an external provider	
24.3 ★	**A wide range of current health promotion material is accessible to patients**	• Members of the practice team are able to show how they use practice electronic systems and processes in the practice to identify high risk groups. • The practice may offer a range of options, e.g. appointment system with practice nurses. • Practices could consider social marketing or whanau initiatives, as it may be difficult for an individual to make or sustain changes	
24.4 ★	**The practice uses disease registers to identify high risk priority groups from the enrolled population and develop interventions**	The electronic Patient Management System and patient demographic data enable query building to identify specific health issues. It provides data to support screening, tracking, and a record of management provided. It is used for audit activity and disease coding to build queries. Audit data can be analysed by ethnicity to identify, address and monitor patients with high risk factors.	
24.5 ★	**The practice database is used to identify the health needs of the enrolled population and develop interventions**	Brief interventions are a well-judged brief comment or discussion with a patient to encourage them to consider changes beneficial for their health e.g. reduction in alcohol intake, smoking cessation, weight loss management, drug using behaviour.	
Indicator 25 **The practice maintains an effective screening and recall system**			
25.1 ★	**The practice team has received training to implement screening and recall programmes**	Together the electronic Patient Management System (PMS) and patient demographic data enable practices to undertake query building (SQL – Structured Query Language). • The system provides data to identify specific health issues support screening, tracking, and a record of management provided	
25.2 ★	**Clinical team members can describe their role in providing screening and recall**	A case review is a useful way of providing an example of how screening is tracked and managed by the practice e.g. Chlamydia, mental health, cervical screening. • Use of decision support tools can determine potential benefit from the screening and whether it outweighs the potential physical and psychological harm (caused by the test, diagnostic procedure and treatment)	
25.3 ★★	**Audit data is used to identify enrolled patients in practice for all national screening programmes**	Use of audit data • Data is used in building queries to audit enrolled patients and disease prevalence • Audit data can be analysed by ethnicity to identify, address and monitor ethnic health inequalities	
25.4 ★★	**The practice uses the audit data to implement clinical interventions**	Team members can describe their role in managing the implementation of opportunistic screening policies such as taking blood pressure or measuring weight.	
25.5	**Audit data of clinical interventions demonstrates improved clinical outcomes**	An audit of screening activity shows the results of clinical team activity on patient outcomes, e.g. Results showing positive for Chlamydia have received treatment and follow up testing.	
Indicator 26 **The practice maintains an effective immunisation programme**			
26.1 ★★	**The practice uses audit data to identify and recall all patients requiring**	Clinical team members can show how they identify and recall all eligible patients requiring immunisation.	

	immunisations from the national schedule		
26.2 ★	**The practice has a process to improve immunisation rates for all patients**	Certified Vaccinators can identify measures taken to improve immunisation rates for their patients. Practice team members can explain how the practice works with children and families to ensure children enrolled with the practice are linked and receiving WellChild services.	
Indicator 27 **The practice routinely identifies tobacco smokers and offers appropriate interventions**			
27.1 ★	**The smoking status of newly enrolled patients is recorded**	The practice registration form captures smoking status.	
27.2 ★	**The practice uses a Patient Management System to identify and record the smoking status and smoking history of patients over the age of 15**	Members of the clinical team are able to describe how they promote smoking cessation to patients. • Smoking status is recorded on the Patient Management System • Smoking status should be in a field where data can be audited • READ codes are used to enable linking to the query builder	
27.3 ★	**Practice team members actively promote smoking cessation strategies and provide educational intervention programme information to patients**	The NZ Smoking Cessation Guidelines (2010) Guidelines promote the use of a memory aid – ABC. It is a simple tool that all health care workers can use. It provides prompts to: • **Ask** about smoking status • Give **Brief advice** to stop smoking to all smokers • Provide evidence-based **Cessation support** for those who wish to stop smoking	
27.4 ★	**The practice team has access to specific programmes that assist patients with smoking cessation**	Team members have an understanding of local or national programmes e.g. Pamphlets, Quitline or other local providers.	
27.5 ★	**There is a process to update the smoking status of patients**	The clinical team can describe their system for updating smoking status of patients.	
Indicator 28 **There is an effective Incident Management system**			
28.1 ★★	**The practice has an Incident Management Policy**	The practice has a documented incident management policy.	
28.2 ★★	**The Incident Reporting Register records incidents and potential events**	There is documented evidence that the incident management process has been used, for positive events, preventive activity and education, as well as incidents, e.g. used sharps on benches that could lead to the injury of a staff member.	
28.3 ★★	**The practice uses a risk management process to analyse incidents and prevent potential events**	There is evidence that the incident management process has been used to follow up and analyse incidents, e.g. in a Register, minutes, reporting incidents to the National Incident Management System or CARM.	
28.4 ★	**The practice team can demonstrate how incidents are used as a learning opportunity to minimise risk**	Managing & monitoring Risk • Report near misses and mistakes in clinical care that might harm patients • How the source of the problem was identified and how solutions were found • Solutions need testing and review to ensure they work effectively • Practices need to have a plan for business continuity for unusual but potentially disruptive events	
28.5 ★★	**Adverse reactions to medicines and vaccines are recorded and reported to the Centre for Adverse Reactions Monitoring (CARM)**	There is a consistent method of recording adverse reactions to medication or immunisations in the medical record and all significant adverse reactions have been reported to the NZIMS or CARM. The National Immunisation Handbook defines reportable adverse events as those that significantly affect a patients management, including reactions suspected of causing: • Death • Danger to life • Hospitalisation • Prolongation of hospitalisation • Interruption of productive activity in an adult recipient • Increased investigational or treatment costs • Birth defects	
Indicator 29 **The practice has processes to ensure continuity of care**			

29.1 ★	**There is a process to manage continuity of patient care within the practice**	The practice can provide examples of how it plans and manages for the complexity of problems that present so that patient information is not lost or care compromised.	
29.2 ★	**There is a process to follow up unresolved health problems identified in previous consultations**	Provide a case management example of how continuity is provided by the practice. HDC cases note that lapses in following up problems have occurred when patients are not seen by their usual GP, although it can also occur if a practice is busy with high patient loads. • It is important for general practices to develop systems and processes that reduce the risk of unresolved conditions being missed • Provide an example of the system in place to reduce the risk of unresolved conditions being missed	
29.3 ★	**Patients needing palliative care can access their choice of provider (or an informed deputy), at all times**	There is evidence that patients with palliative care/terminal illness needs, or their caregiver, can access direct help from their doctor (or an informed deputy), including for after hours.	
Indicator 30 **The practice identifies and responds appropriately to all patients with clinically urgent medical conditions**			
30.1 ★★	**The practice team monitors the clinical condition of waiting patients**	Observation of clinical condition includes body language or signs of distress, e.g. mirrors, observation windows.	
30.2 ★★	**A triage system is in place to assess and prioritise patients with urgent medical needs**	The practice team can demonstrate effective assessment of urgent conditions and how to manage an emergency drill.	
30.3 ★★	**Receptionists/telephonists have been trained to identify, prioritise and respond appropriately to patients presenting with life threatening conditions**	Training to recognise and respond to an emergency to a level identified by the practice, including CPR.	
30.4 ★★	**Practice team members who may be required to administer cardiopulmonary resuscitation (CPR) have current certificates to an appropriate level from certified trainers**	Practice CPR training (level 1 – 7) records confirm that all team members required to administer CPR are trained to the correct level and record the certified trainer e.g. ACLS, St Johns, New Zealand Heart Foundation.	

Professional Development

Indicator 31 **The practice team complies with the Health Practitioners Competency Act 2003**			
31.1 ★★	**All clinical team members have current annual practising certificates as required under the Health Practitioners Competence Assurance Act 2003**	There is evidence that each clinical team member has a current Practising Certificate and the Annual Practising Record is checked annually. To meet the requirements of the Health Practitioners Competence Assurance Act 2003, the practice training record notes: • Dates • Type of continuing professional development • Training (in-house or other) • Certificates	
31.2 ★	**Medical staff in the practice are vocationally registered in general practice or working towards this**	The intent of this criterion is to ensure that all health professionals are engaged in the Maintenance of Professional Standards programme. There is a record of: • Medical Council certificates stating whether GPs are vocationally registered or are general registrants with the name of the supervisor and NPI number • Vocational Registration: (RNZCGP decision: 24 July 2009)	
31.3 ★★	**All team members participate in Continuing Professional Development**	The New Zealand Medical Council requires maintenance of Continuing Professional Development (CPD). The learning needs of team members are reviewed annually and are used to plan professional development and determine current issues or trends identified in: • Practice meetings • Resulting from performance reviews • Identified as important for the practice population	
Indicator 32 **There are clear lines of communication, accountability and responsibility for creating an environment of excellence in teamwork**			
32.1 ★	**Practice team members understand how their individual roles and responsibilities link with other team members**	Communication channels in the practice are sufficient to provide guidance to all team members on performance, roles and duties in the practice and team members report that they understand their place in the team and roles and responsibilities are clear.	
32.2 ★	**There are clear documented lines of accountability and reporting structures**	Practice team members are able to provide their understanding about roles and responsibility when working in external domains, or in multidisciplinary teams.	
32.3 ★	**There is evidence of regular meetings involving the practice team**	An organisational structure diagram outlines designated roles.	
32.4 ★	**Practice team members report their input is valued during practice meetings**	Team meetings involve the whole practice team: • There is a records of decisions made and actions taken • Minutes are available to team members • Extra-ordinary meetings are held to address urgent matters	
32.5 ★	**There is a process for dissemination of information to all team members**	Team members are able to provide examples of where their input was valued. The team can provide examples of communication dissemination e.g. email, notice board, meetings, peer groups.	
Indicator 33 **All practice team members have employment agreements and current position descriptions**			
33.1 ★★	**Practice team members have employment agreements with position descriptions**	• All employees of the practice have a position description that includes key tasks, functional relationships and annual review dates • Employment agreements have been signed with terms and conditions • Although practice owners cannot contract with themselves, the College recommends that GPs who own their practice have partnership agreements in group practices, and position descriptions to clarify roles and responsibilities	
33.2 ★★	**Practice team members and others who have access to patient information have signed a confidentiality agreement**	Confidentiality agreements may be part of employment agreements.	
33.3 ★★	**Each member of the clinical team is insured to cover liability**	There is evidence that the practice and professional team are covered by organisational and professional insurance, e.g. New Zealand Nurses Organisation, College of Nurses Aotearoa (NZ) Inc, Medical Assurance Society, Professional Indemnity Insurance.	
33.4 ★	**There is an orientation process for new team members**	There is evidence of an orientation process for new members.	
33.5	**There is a resource with information**	Practice Induction Resource or Orientation Manual exists for all new team	

★	**about the practice available to new team members and locums**	members, including locums or casual staff.	
33.6 ★	**Performance reviews are conducted annually and used to guide professional development for all practice team members**	All members of the practice team including practice partners should participate annually in performance reviews: • The review process is documented • The record should contain review dates, date of review, outcomes and proposed forward plans	
Indicator 34 **The practice team complies with the Health and Safety in Employment Act 2002**			
34.1 ★★	**The practice has documented policies that describe how the Health and Safety in Employment Act 1992 and 2002 Amendment will be implemented**	The policy includes but is not limited to: • Man made emergencies such as injury, armed robbery, power failure • Workplace stress • Accident recording • Training of employees • Annual review and updating as necessary	
34.2 ★★	**The practice team complies with health and safety policies and procedures to identify and manage hazards**	All team members are aware of the health and safety policies and use a hazard plan and register to identify and manage risk, e.g. • Significant hazards • Workplace stress • A Smoke-free environment • Workplace processes e.g. how an employee uses machinery or equipment • Physical environment e.g. working off site • Equipment used e.g. proper use of electrical equipment • External factors e.g. robbery • Input to the work process e.g. toxic chemicals • Work organisation e.g. shifts and breaks designed to minimise fatigue and disruptions to sleep • Access to critical information e.g. Instructions available at an appropriate literacy or language level for employees in the workplace • Construction of the building e.g. floor is safe when wet • Impairment of individual employees e.g. when a diabetic employee misses meals due to work pressures	
34.3 ★★	**The Health and Safety Officer/s has received training**	There is a trained Occupational Health and Safety Officer. (see s19E and s19F of the Health and Safety in Employment Act 1992).	
34.4 ★★	**The practice team conducts a health and safety review annually and makes changes as necessary**	There is evidence of an annual review.	
34.5 ★★	**Health and safety accidents and incidents are reported, recorded, investigated and followed up**	The Health and Safety Accident and Incident Register records accidents/incidents, how these were investigated and any changes resulting. Regulation 4 of the Health and Safety in Employment (Prescribed Matters) Regulations 2003 sets out the information that must be recorded or reported in the register.	
Indicator 35 **The practice is committed to environmentally responsible actions**			
35.1 ★	**The practice has an active recycling programme**	Examples include but are not limited to: • Paper and plastics recycling, turning off lights in unused areas, paper shredding • Safe disposal of sharps e.g. diabetic needles • Drop off point for patients who have not used medicines	

Aiming for Excellence – History of development

Year	Development of *Aiming for Excellence*, the NZ standard for general practice	CORNERSTONE General Practice Accreditation development
1996	• The Goodfellow Unit, University of Auckland, reviewed the literature to identify indicators of good quality general practice. • A range of provider groups and consumer organisations reviewed the indicators for relevance. • A paper on Key Performance Indicators in Primary Health Care was produced with advice on their use in New Zealand[39].	
1998	• There was an international and New Zealand leadership response to the need for increased accountability in general practice. • The Waikato Faculty proposal and expression of interest by members of the RNZCGP and Independent Practitioner Associations at an IPA Conference prompted urgent response by the RNZCGP to consider development of a standard for general practices. • The RNZCGP Practice Standards Committee was established to review the applicability of existing international standards for use in New Zealand practices. • The RACGP provided the most relevant example however, differences between the Australian and New Zealand general practice structures, health systems and populations made the Australian standards difficult to adopt in the New Zealand setting. • The Committee agreed to adopt the structure provided by the Australian Standard but use the KPIs developed by the Goodfellow Unit.	
1999	• The RNZCGP agreed to develop a standard specifically for New Zealand General Practice and established the RNZCGP Practice Standards Working Party to continue the development work. • The Working Party developed the set of indicators to produce the final set of standards and produced the first draft of *Aiming for Excellence* in 1999 for wider consultation and testing.	
2000	Early adopters • The first edition of *Aiming for Excellence* (2000) was pretested and six assessors were trained to undertake a pilot study of 20 practices to determine its usefulness for NZ general practice and develop an assessment process.	
2001 - 2002	• The RNZCGP Practice Standards Validation Field Trial. Was undertaken to validate *Aiming for Excellence* (2000), assessor training and the process of assessment. They were subjected to a rigorous evaluation in a field trial of 81 practices during 2000-2001 and found to be reliable, valid and feasible for use in measuring the quality of care provided by a general practice. • *Aiming for Excellence* – An assessment tool for General Practice (2002, 2nd edition) was published.	General practice accreditation development • With the validation field trail complete, the RNZCGP began identifying the principles and key issues for practice accreditation. • The RNZCGP Professional Development Practice Sub-Committee agreed to provide oversight of the design and development of an accreditation process that required an assessment against Aiming for Excellence and used a continuous quality improvement model to inform learning and improvement by general practice teams. • 61 general practitioners, practice nurses and practice manager assessors were trained undertake assessments. • A business model was developed to establish operations.
2003		• Early programme establishment. QIPNZ a subsidiary of RACGP/AGPAL was contracted to establish an accreditation programme for NZ general practice.

2004		• Review of QIPNZ contract. • RNZCGP established the CORNERSTONE General Practice Accreditation Programme. • HDANZ was contracted to provide external validation of CORNERSTONE process. • Development of fully automated IT system, connectivity and support for the CORNERSTONE programme and practices - GDSL/MedAudit. • Ministry of Health funded implementation of practice accreditation – 85 practices.
2005	• *Aiming for Excellence* (2002) was reviewed by the RNZCGP Professional Development Practice Sub-Committee for continued relevance. • Feedback from the review highlighted the need to produce better guidance for practices and assessors to reduce variation in interpretation.	• Te Puea Marae Clinic in Auckland was the first general practice in New Zealand to become CORNERSTONE accredited. • The CORNERSTONE General Practice Accreditation Programme was established as a formal RNZCGP quality programme for practice teams. • ACC funded 100 practices to enable further rollout and refinement of the process. • Pinnacle funded 100 practices to test the process and a practice support process through a network of quality facilitators.
2006	• Consultation phase *Aiming for Excellence* (2002) from July 2006 to January 2007.	• The implementation phase of CORNERSTONE was completed.
2007	• *Aiming for Excellence* (2002), was reviewed by the RNZCGP Board of Quality and informed by the rollout of CORNERSTONE, analysis of consultation data, research evidence, and consensus building among local experts.	• By the end of December 2007, 520 practices had enrolled in the CORNERSTONE programme and 274 achieved CORNERSTONE General Practice Accreditation.
2008	• *Aiming for Excellence* – (2008) third edition	• December 2008 – 335 practices achieved CORNERSTONE General Practice Accreditation.
2009	• *Aiming for Excellence* (2009) revised third edition • The RNZCGP Board of Quality undertook a further review following feedback from general practices, CORNERSTONE Assessors and other organisations who considered the bar had been raised to high for the majority of practices. This required removal of some new indicators and reverting back to previously validated indicators.	• December 2009 – 382 cycle 1 & 134 cycle 2 practices achieved CORNERSTONE General Practice Accreditation
2010	• *Aiming for Excellence* (2009) Consultation phase from October 2009 to April 2010. • The RNZCGP Aiming for Excellence Expert Advisory Group undertook a review and rebuild to reflect the place of general practice in a primary care setting and the role of multidisciplinary and interdisciplinary teams.	• December 2010 – 474 cycle 1 and 156 cycle 2 practices achieved CORNERSTONE General Practice Accreditation
2011	• *Aiming for Excellence* (2011) fourth edition	

References

[1] Dr Jane Burrell, Dr Chris Fawcett, Dr Jim Vause, Dr Tane Taylor, Dr Helen Rodenburg, Dr Jocelyn Tracey, Dr Malcom Dyer, Dr Luis Villa, Dr Jane O'Hallahan, Dr Helen Bichan, Jane Ayling, Kevin Rowlatt, Rosemary Gordon, Hayley Lord, Maureen Gillon, Waveney Grennell, Mel Pande, Jeanette McDonald

[2] The Royal New Zealand College of General Practitioners. Mission Statement. RNZCGP Wellington, NZ. RNZCGP.

[3] New Zealand Gazette. Medical Council of New Zealand Scope of practice and prescribed qualifications for the practice of medicine in New Zealand. Supplement 29 January 2010. Wellington: Issue no. 8.

[4] WONCA Europe. The European definition of the key features of the Discipline of General Practice, the role of the General Practitioner and a description of the core competencies of the general practitioner/family physician. 2002

[5] Scally, Donaldson 1998 (adapted)

[6] Sullivan WH. Repairing medicine's social contract: whose responsibility? Unpublished paper given at a joint meeting of the Royal Society of Medicine and New York Academy of Medicine, New York, 2002

[7] Royal College of Physicians. Doctors in Society: medical professionalism in the new millennium: a physicians' charter. Med J Aust 2002;177:263-265

[8] Irvine D. Time for hard decisions on patient-centred professionalism. MJA.Volume 181:No.5:6 September 2004

[9] Sullivan WH. Repairing medicine's social contract: whose responsibility? Unpublished paper given at a joint meeting of the Royal Society of Medicine and New York Academy of Medicine, New York, 2002

[10] Whānau Ora. The Report of the Taskforce on Whānau Ora Initiatives to Hon Tariana Turia, Minister for the Community and Voluntary Sector. New Zealand

[11] Whānau Ora. The Report of the Taskforce on Whānau Ora Initiatives to Hon Tariana Turia, Minister for the Community and Voluntary Sector. New Zealand

[12] WONCA Working Party on Quality in Family Medicine. Family Doctors Journey to Quality. National Research and Development Centre for Welfare and Health. Gummerus Printing, Finland. 2001

[13] Dr Tony Hanne, Goodfellow QA Unit. University of Auckland. 2002

[14] Ministerial Task Group on Clinical Governance (2009): Dr Jeff Brown – Chair, Dr Andrew Connolly, Ron Dunham, Mrs Anne Kolbe, Dr Harry Pert, Helen Pocknall

[15] Marshall M, Roland M, Campbell S, Kirk S, Reeves D, Brook R, et al. Measuring general practice. A demonstration project to develop and test a set of primary care clinical quality indicators. Manchester: NPCRDC, 2003

[16] Marshall M, Roland M, Campbell S, Kirk S, Reeves D, Brook R, et al. Measuring general practice. A demonstration project to develop and test a set of primary care clinical quality indicators. Manchester: NPCRDC, 2003

[17] Marshall M, Roland M, Campbell S, Kirk S, Reeves D, Brook R, et al. Measuring general practice. A demonstration project to develop and test a set of primary care clinical quality indicators. Manchester: NPCRDC, 2003

[18] Department of Health. Standards for better health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf 20.10.7.12

[19] Department of Health. Standards for better health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf 20.10.7.12

[20] Roland M. Baker R. Clinical Governance. A practical guide for primary care teams. National Primary Care Resarch & Development Centre, University of Manchester. Clinical Governance Research & Development Unit, University of Leicester. 1999. www.doh.nhs.uk/nhs/clinggov.htm

[21] Roland M. Baker R. Clinical Governance. A practical guide for primary care teams. National Primary Care Resarch & Development Centre, University of Manchester. Clinical Governance Research & Development Unit, University of Leicester. 1999. www.doh.nhs.uk/nhs/clinggov.htm

[22] Ministry of Health. The HEAT Tool. The Whanau Ora Tool, Whanau Ora Health Impact Assessment Tool. www.moh.govt.nz

[23] Ministry of Health. The HEAT Tool, the Whanau Ora Tool and the Whanau Ora Health Impact Assessment Tool are all available on the Ministry of Health website www.moh.govt.nz

[24] Ministry of Health. The HEAT Tool. The Whanau Ora Tool, Whanau Ora Health Impact Assessment Tool. www.moh.govt.nz

[25] Roland M. Baker R. Clinical Governance. A practical guide for primary care teams. National Primary Care Resarch & Development Centre, University of Manchester. Clinical Governance Research & Development Unit, University of Leicester. 1999. www.doh.nhs.uk/nhs/clinggov.htm

[26] Health Sponsorship Council. New Zealand. http://www.hsc.org.nz/socialmarketing.html 2010.8.25.

[27] Ministry of Health. Green Prescriptions, Wellington. New Zealand. http://www.moh.govt.nz/greenprescription 2010.8.26

[29] Ministry of Health. New Zealand Smoking Cessation Guidelines. Wellington: Ministry of Health.2010. http://www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines 2010.7.20

[30] Roland M. Holden J. Campbell S. Quality Assessment for General Practice: Supporting Clinical Governance in Primary Care Groups. National Primary Care Research & Development Centre. University of Manchester. 1998. www.npcrdc.man.ac.uk

[31] Continuous Improvement. http://www.c2econsulting.co.uk/services_continuous.asp

[32] The Joint Commission on Accreditation of Health Care Organisations (JCAHO). www.jacho.org/mainmenu.html

[33] WONCA Working Party on Quality in Family Medicine. Family Doctors Journey to Quality. National Research and Development Centre for Welfare and Health. Gummerus Printing, Finland, 2001.

[34] Deeming E.The PDCA cycle, in The Man Who Discovered Quality. A. Gabor, Penguin Books, 1990

[35] Wellingham J, Gillon M. Outcomes of the implementation of the Cornerstone General Practice Accreditation Programme. NZFP 2007;Vol.34,No.4:263-265

[36] Buetow S, Roland M. Clinical governance: Bridging the gap between managerial and clinical approaches to quality of care. Quality in Healthcare 1999;8:184-190

[37] Berwick D, Institute of Healthcare Improvement (IHI), Boston, USA

[38] Ministry of Health. The HEAT Tool. The Whanau Ora Tool, Whanau Ora Health Impact Assessment Tool. www.moh.govt.nz

[39] Wellingham J, Hanne T, McFarlane S, Buetow S, Coster G. Identification of an appropriate quality measurement tool for use in New Zealand General Practice. Report to the Northern Regional Health Authority. Auckland: Goodfellow Unit, University of Auckland, 1998.