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AMA Submission in response to the Draft RACGP Standards for General Practices (5th edition)

Thank you for inviting the AMA to comment on the Draft RACGP Standards for General Practices (5th edition). The AMA notes that the College has in a number of areas taken account of comments made in our earlier submission during the development phase of the revised standards. Nevertheless, the AMA would like to re-emphasise the following points:

- The importance of appropriate guidance and resources being provided to the accreditation bodies for assessing practices' compliance with the Standards, particularly as there will now be greater flexibility afforded in demonstrating how the standard criteria are met. This will help ensure greater transparency in, and consistency of, assessments.
- The importance of the Standards retaining comprehensive notes in the "meeting this criterion" sections, where required, to assist practices determine how they will meet the standards.
- The cost for practices of complying with the Standards must always be a consideration and there should be no financial or other impediment to the ability of small practices, rural practices, remote practices and/or indigenous practices to participate in the accreditation process.

General comments

There are instances within the draft Standards where the actions to meet one criterion may also be appropriate for meeting another criterion or aspect of a criterion – e.g.: a) establishing a recalls and reminder system; and b) our practice initiates recalls and reminders - which covers aspects of criteria covering preventative activities, comprehensive care, and follow up systems. It is suggested that annotations are made within the explanatory notes to cross reference these criteria.

The presentation of the Standards is inconsistent, with some criteria failing to list examples of how a practice may meet the criterion. This creates uncertainty for practices in knowing what

is required to meet the criterion. We understand there is also some concern from accrediting agencies that this will create potential problems with inter-assessor and inter-agency reliability in the assessment of practices.

The AMA would encourage the RACGP to work with accrediting agencies to ensure inter-assessor and inter-agency reliability and that fair consideration is given to the diversities of general practice in the application of standards. For example the assessment of how a one-doctor practice in a rural or remote location meets a criterion (such as Standard 1: Criterion 1.5) may reasonably vary from that of a large metropolitan general practice, with multiple GPs and administrative staff.

Module 1: Standard 1: Criterion 1.1 – Business risk management systems

In response to the "Stakeholder question: does this terminology, 'a strategy for planning' make sense to general practices?" – this is a tautology and as such should read:

> Our practice has a strategy for improving our services.

In the notes under *Induction program* it is suggested that the following dot point be included so that new staff understand the principles underpinning practice culture and behaviour:

- The principles under which the practice operates.

Module 1: Standard 1: Criterion 1.2 – Accountability and responsibility

No explanation is provided as to why it is important to have a team member who has primary responsibility for leading risk management systems and processes, nor does "meeting this criterion" contain any details specific to this responsibility. This could make it difficult for practices to understand the importance and expectations of the leadership role and more information is needed to spell this out.

To ensure position descriptions accurately reflect the roles and responsibilities of staff members, not only should employees have to sign their position description as an indication that they accept and understand their roles and responsibilities, the position description should be regularly reviewed as the roles and responsibilities may change over time.

Under "meeting this criterion" it is suggested that a sentence to this effect be included: For example:

> Regularly review employees position statements (e.g., once a year) to ensure the currency of the position statement and employees' understanding of their roles and responsibilities.

Module 1: Standard 1: Criterion 1.3 – Clinical communication

Under "meeting this criterion" it is suggested that the following additional example be included:

- A clinic intranet where members of the team can access a range of clinical guidelines and pose clinical questions/issues for internal discussion.

Module 1: Standard 1: Criterion 1.4 – Open disclosure

This is a new (non-mandatory) indicator and may cause some GPs concern given their mindfulness of litigation risks. While 'open disclosure' does not create legal liability clinicians must be aware of the risk of admitting liability. Therefore it is suggested that in meeting this criterion that practitioners should understand the difference between open disclosure and admitting liability.

Under "meeting this criterion" it is recommended the following sentence be included:

> Practitioners within the practice are familiar with the open disclosure process and understand the difference between open disclosure and admitting liability.

It would also help to emphasise the importance for practices and practitioners to mitigate their risks around open disclosure by bolding the following sentence (which appears on p22):

> Contact your medical defence organisation for further guidance and advice about incidents when you may need to participate in open disclosure.

Module 1: Standard 1: Criterion 1.5 – Work health and safety

Under "meeting this criterion" the first paragraph suggests having at least two staff members present during business hours. The focus is seemingly more on practice efficiency than the safety of the practice team. It is suggested the paragraph be amended to reflect the safety aspect. For example:

> To help ensure the safety and well-being of practice staff consider having at least two staff members present during normal working hours to manage the practice workload and to provide assistance should an emergency situation arise.

References to OH&S under "why this is important" and "meeting this criterion" should be replaced with Work Health and Safety (WHS), as it is now known.

Indicators B and C refer to staff immunisations. However, there are no examples provided under "examples of how a practice might choose to meet this criterion". It is recommended that an example be included, and the following is suggested:

- Maintain staff immunisation records, including documenting any refusals to vaccinations offered.

Module 1: Standard 2: Criterion 2.2 – Telephone and electronic communications

Based on Indicator A, it would appear that this criterion is about managing messages not calls. Assuming this is the intention, then under "meeting this criterion" the section on *Communicating by telephone* is superfluous. However, it would seem, based on the content of the notes for meeting the criterion, the actual intention of the criterion might be to manage telephone calls and telephone or electronic messages from patients. If this is the case then the indicator should be corrected accordingly. In addition, the current wording of the criterion implies that practices are required to manage both telephone and electronic communications from patients, despite the notes identifying that practices can choose whether or not to communicate with patients electronically.

It is recommended Indicator A read as follows:

> Our practice manages telephone calls and either telephone or electronic messages from patients.

This wording would make it clear that practices have a choice in whether or not they communicate electronically with patients.

In general the following principles should frame this criterion:

- no patient should be placed on hold if it is an emergency;
- calls unanswered within a specified time should be directed to a recorded message advising them that, if the nature of their call is a medical emergency, to hang up immediately and ring 000 and if not to leave a message; and
- where a call is answered and the caller is put on hold the "on-hold" message should be different to the "unanswered call" message.

Module 2: Standard 2: Criterion 2.4 – Interpreter and other communication services

Under the notes on meeting this criterion a more modern method than a sticker on the patient's file for identifying a patient who requires an interpreter is required, particularly as most practices are now computerised.

Module 1: Standard 3: Criterion 3.1 – Respectful and culturally appropriate care

It seems superfluous to say that our practice considers the healthcare of our patients as per Indicator A. The AMA would expect that this is a given for any general practice. It would be more appropriate if Indicator A was amended to read:

> Our practice, in providing patient health care, considers patients' rights and cultural beliefs.

Module 1: Standard 3: Criterion 3.2 – Presence of a third party during a consultation

> Stakeholder question: the requirement to document the presence of a third party is a change from the 4th edition. What are stakeholders' views?

This requirement would be potentially onerous and unreasonable if a practitioner had to note the names of all family members or visitors who may be present during a home visit (e.g. for a sick child or palliative patient) or all the nurses or relatives present during a RACF visit. To ensure a practical approach to this criterion it is suggested that the last paragraph under *Prior consent to the presence of a third party arranged by the practice* be amended along the following lines:

> Practitioners should, where practicable, record the patient's consent and the name of the third party in the consultation notes or where multiple parties are present record the patient's consent for the presence of multiple parties. It may be sufficient to record the initials of a medical student in the notes, if the practice can later provide the student's full name.

Module 1: Standard 3: Criterion 3.3 – Access to services

Access to services does not only have to be about physical access. As this criterion seems to be primarily focussed on access for patients with disabilities, the provision of services via telehealth gives greater access for patients with mobility issues. It would therefore better

reflect the use of existing and emerging technologies in modern general practice if telehealth services were included and additional examples were provided to demonstrate to practices how they might meet the criterion. For example:

- The practice provides access to telehealth consultations for regular patients when and where appropriate.
- Our practitioners provide home visits where appropriate.

Module 1: Standard 6: Criterion 6.4 – Contingency plan

It would be useful in the notes on "meeting this criterion" to have a statement directing readers to the Resources Guide for information and tools for developing an emergency or disaster plan.

With this in mind, it may also be useful to include in the Introduction to the Standards a paragraph advising of the availability of the Resources document to assist practices in meeting the criteria within the Standards.

Module 1: Standard 7: Criterion 7.2 – Medical record systems

The explanation under this criterion, while explaining what a hybrid system is, does not adequately highlight the potential risks to patient care if patient notes are stored in two areas. It is recommended that the following statement be included:

> When patient notes are stored in two areas it is possible for important issues to be overlooked, particularly if another doctor sees the patient. To reduce this risk, a note in each system improves the continuity of the hybrid system.

Module 1: Standard 7: Criterion 7.4 – Information security

The requirement for a policy on the use of social media is new and, therefore, it is recommended that the "why is this important" section include information describing why it was considered relevant. The following sentence from the "description and explanation" box in the new indicator on p69 of the draft would be sufficient:

> Practices are increasingly using electronic forms of communication to convey information about their services to the public and their patients, and therefore need an email and social media policy.

To better reflect the range of portable devices currently used by practices, it is suggested that in the examples provided on p79 "tablets" be included.

Under "how to meet this criterion" and under *Protect mobile devices and the information stored on them* suggest an additional dot point as follows:

- Ensure all devices have current anti-virus software or are password protected.

Module 1: Standard 8: Criterion 8.1 – Patient health records

It is recommended that "legible" continue to be included as part of the requirement for Indicator A.

Under *Content of the patient health record* it would be useful for preventative health care to include waist measurement in the routine patient information recorded. Waist measurement is a good clinical indicator of whether a patient is carrying excess body fat around their middle. Waist measurements in adults of more than 80cm for women and 94cm for men indicate visceral fat deposits and is indicative of an increased risk of weight related diseases including diabetes type 2, heart disease and stroke.

Module 2: Standard 2: Criterion 2.2 – Safe and quality use of medicines

The notes highlight that practitioners need to be aware of any complementary medicines the patient is taking, and the potential for side effects and drug interactions with conventional medicines. It should be noted that not all practice software enables the recording of complementary medicines in the Medications List. To facilitate this in practice, it is suggested that the College consider working with the medical software industry to enable the recording of complementary medicines in either the general medications list or a dedicated list.

Module 2: Standard 3: Criterion 3.1 – Clinical risk management systems

In the notes for this criterion practices should be advised that they may want to have their Medical Defence Organisation (MDO) check and approve their process for recording and acting on near misses and mistakes.

Module 3: Standard 1: Criterion 1.1 – Responsive system for patient care

If it is the intention of the RACGP that in some circumstances it may be appropriate for administrative staff to have access to patient health records, then this should be explicitly stated. The statement that appears under *Triage* in "meeting this criterion" on p 128 does not clearly make this point. Where this situation does exist, it would be appropriate for the practice to document and describe the nature of each staff member's access, how it is allocated and oversighted and how this is outlined in their staff position statements.

Module 3: Standard 1: Criterion 1.3 – Comprehensive care

The AMA is concerned that the notes under this criterion focus more on the provision of after-hours by others outside the practice and do little to encourage practices to provide their own after-hours care.

To better encourage practices to provide their own after-hours care it may be appropriate to include prior to the existing first paragraph a statement such as:

> Provide evidence that your practice provides after-hours services to its patients and/or has in place arrangements for patients to access care in those periods not covered by the practice.

The fourth dot point on p 133 under *After-hours care* appears superfluous. Given these dot points are about how the practice's patients can access care after-hours from another provider, this dot point should be removed.

In addition, it would appear there are a number of typographic and grammatical errors in this section that cloud clarity.

Under the heading "Examples of how a practice might choose to meet this criterion" it is suggested that the fifth dot point should be amended to:

- Ensure our pathology providers know how to contact relevant practice staff with seriously abnormal or life-threatening results in the after-hours.

Dot points six and seven seem to be written for an MDS rather than for the practice. It is recommended that they be rewritten with a focus on the following priorities:

- The practice receives timely reports on the care provided to their patient on their behalf.
- The practice can contact the AHs doctor if they have any follow-up queries.
- The AHs service can contact a practice practitioner if it needs advice on a patient.
- The practice provides AHs services with a list of patients likely to need their care in the AHs period with relevant factors for provision of care, e.g. for palliative patients.

Module 3: Standard 1: Criterion 1.6 – Engaging with other services

Under *Patient information in referrals* the statement about only passing on "irrelevant" patient information when the patient has consented seems incongruous. Passing irrelevant information does no service to the patient or the practitioner treating the patient. It is suggested this should be amended to 'relevant'.

Module 3: Standard 3: Criterion 3.1 – Practice equipment

For general practices the purchase and maintenance of a defibrillator is costly considering the purchase price, the cost of the battery (which is a single use item), and other maintenance costs. This should be a key consideration in any future contemplation by the RACGP of lifting Indicator F from desirable to mandatory.

Module 3: Standard 5: Criterion 5.2.2 – Doctors bag

The requirement for an ophthalmoscope has been removed from the list of equipment for a fully equipped doctor's bag. However, it is mentioned in the notes on p161 under 'meeting this criterion'. It is suggested that this reference be removed.

Resources Guide

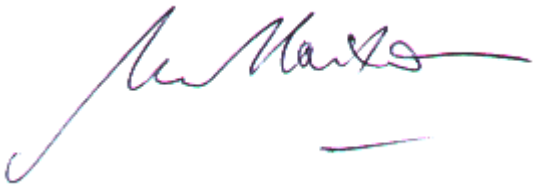
There are a number of criterion where references to AMA position statements could be useful for practices in meeting the criterion.

These are as follows:

Criterion	AMA Position Statement
Module 1, Standard 1, Criterion 1.5 – Work health and safety	Sexual harassment in the medical workplace - 2015 Safe work environments - 2015 Workplace Bullying and Harassment - 2009. Revised 2015

Module 1, Standard 2, Criterion 2.5 – Costs associated with care initiated by the practice	AMA List of Medical Services and Fees AMA Fees Indexation Calculator
Module 1, Standard 3, Rights and Responsibilities of Patients	AMA Code of Ethics
Module 1, Standard 5, Criterion 5.2 – Clinical autonomy for practitioners	AMA Code of Ethics
Module 1, Standard 6, Criterion 6.2 – Clinical handover	General practice/hospitals transfer of care arrangements - 2013
Module 1, Standard 7, Criterion 7.3 – Confidentiality and privacy health information	Social Media and the Medical Profession: A guide for online professionalism for medical practitioners and medical students

Yours sincerely



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