1.0 Clinical Autonomy

Policy

Doctors at WHN are free to make decisions that affect the management of their patients in accordance with accepted clinical judgement, best available evidence and adherence to valid clinical care guidelines.

Doctors exercise full autonomy in determining:

- The appropriate clinical care of their patients;
- The health professionals including specialists, other General Practitioners and Para-Medical Practitioners to whom they refer;
- The pathology, diagnostic imaging or other investigations they order and the provider they use;
- How and when to schedule follow up appointments with individual Patients;
- Whether to accept new Patients provided that this action is non-discriminatory and does not apply to emergencies.

Doctors and clinical staff are consulted about appointment schedules and the purchase of new clinical equipment and supplies.

Feedback is sought from Doctors and other staff concerning the use of practice equipment, appointment scheduling and other matters relating to professional autonomy.

All members of the clinical team comply with their professional and ethical obligations and practice within the boundaries of their knowledge, skills and competence and their role within the practice team.

2.0 Clinical Governance

Policy

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

WHN recognises that good clinical leadership is required to engage the entire practice team in a commitment to excellence by nurturing a culture of openness and mutual respect that allows just and open discussions about areas for improvement.

WHN aims to develop an organisational culture where participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded and all staff feel accountable and involved in monitoring and improving care and services.

To promote clear lines of accountability and responsibility, for encouraging improvement in the safety and quality of clinical care, the sharing of information about quality improvement and patient safety within the practice team, we have appointed leaders who have designated areas of responsibility for safety and quality improvement systems within the practice.

Our leaders promote a multidisciplinary team approach to endorse a climate of safety and quality that does not blame, but rather seeks to solve problems.

Our practice leaders oversee the delegation of tasks to others but retain accountability for quality and safety.

Roles and responsibilities are specified in our position descriptions and all members of the practice team are aware of the designated leadership responsibilities of key staff.

Our leaders promote compliance with the RACGP Standards for general practice and relevant jurisdictional legislation, or accepted industry requirements.

Procedure

We have nominated key staff with primary responsibility for the clinical governance of specific areas. Our leaders are resourced and supported to make improvements in their specified areas of responsibility through the coordination of practice activities such as:

- Education and information sharing;
- Clinical audits, research or data analysis;
- Promoting evidence based practices;
- Risk management analysis-clinical and general;
- Openness to suggestions and feedback;
- Policy and Procedure development and review

Our leaders can delegate specific areas of responsibility to other nominated members of the practice team and these particular responsibilities should be documented in position descriptions.

3.0 Clinical Handover

Policy

Clinical handover is ‘the transfer of professional responsibility and accountability for some or all aspects of a patient or a group of patients’ care to another person or professional group on a temporary or permanent basis’.

Failure or inadequate handover of care is a major risk to patient safety and a common cause of serious adverse patient outcomes. It can lead to delayed treatment, delayed follow up of significant test results, unnecessary repeat of tests, medication errors and increased risk of medical legal action.

Clinical handover communications can be face-to-face, written, via telephone and also by electronic means.

Clinical handover of patient care occurs frequently in general practice both within the practice to other members of the clinical team, and to external care providers.

Procedure

Clinical handover needs to occur whenever there is a change of care providers. Examples of clinical handover include:

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

When appropriate, the clinical handover is documented in the consultation notes including that the patient has shared in decision making and has been informed.

Written or verbal clinical handover between Doctors occurs on a formal arranged basis when Doctor's cover for those working on a sessional basis or when a Doctor or other clinical staff member is away because of annual leave or illness. In addition to a formal handover, adequate clinical records, including a health summary, enable the routine care of patients to continue. Doctors relieving for another should read the patient's preceding clinical records.

WHN recognises that an accurate and current medication list helps to minimize errors and promote safety when clinical handover occurs. Patients with multiple medications may be provided with a copy of their medication list and encouraged to show the list to other providers of health care.

Clinical handover of a patient's care outside the practice occurs in many ways. It includes but is not limited to: referral for an investigation, referral to an ancillary healthcare provider, referral to a specialist and referral to a hospital, as an outpatient or as an in-patient. Referral letters include sufficient information to facilitate optimal patient care, including details of the purpose of the referral and clarification of who will manage the follow up of investigations.

WHN should ensure that sufficient information is provided to the emergency department about the clinical condition of an inbound patient, to facilitate prompt and appropriate care. This may be directly to the ambulance service or to the hospital.

We have arrangements in place with our pathology service to ensure abnormal and life threatening results identified by pathology outside normal opening hours can be conveyed to a Doctor in a timely way.

Where complex or high risk patients, such as suicidal patients, or patients on complex medication regimens are handed over to another provider for all or part of their care, it is important for the handing over provider to request notification if the new provider ceases to care for the patient. Equally, a provider treating a patient on a handover basis has an obligation to notify others in the treating team if they stop seeing the patient.

When errors in clinical handover occur, every member of the practice team is encouraged to report the incident, so the event can be analysed and processes introduced to reduce the risk of a recurrence and harm occurring to other patients (Refer to Incidents and Injuries and Adverse Patient events).

4.0 Clinical References and Resources

Policy

Consistency and quality of care can be assisted by the use of current resources, access to clinical guidelines and communication between team members. This process is encouraged and facilitated by the practice clinical leader.

WHN provides medical, nursing and allied Health workers access to a range of resources and materials for reference on clinical matters and items of interest for professional development. General practitioners can access current information on medicines to enable best practice prescribing.

We are selective about the resources clinical staff to use to support information provided during a consultation. We aim to ensure they contain culturally appropriate, current and evidence based information and are obtained from reputable source. Where possible these resources should be dated, contain the name of the source and referenced to supportive evidence.

The references available contain information that is consistent with current practice guidelines or based on best available evidence. In the absence of well conducted trials or other higher order evidence the opinion of consensus panels of peers is acceptable. References and resources including practice guidelines should be accessible at the point of care.

There is an organised system of access for all practice staff to journals, clinical guidelines and other reference material.

The clinical references available and any new additions, deletions or updated versions is communicated to all staff and clinical team members to assist with consistency in the approach to diagnosis and management of patient care.

Procedure

At least annually we conduct an audit of our clinical resources and references to ascertain if they comply with current practices and are providing consistent management and information to patients across the practice team.

It is a standing item at our clinical meetings to discuss any new clinical issues, resources or clinical practice guidelines.

5.0 Referral Protocols

Policy

Patients are referred for diagnostic testing or to another medical specialist, general practitioner or allied health professional which may be better placed to deliver a service that may benefit the patient.

WHN has an up to date computerised directory of local allied health providers, community and social services and also local specialists to assist when choosing practitioners to facilitate optimal patient care. This information includes different referral arrangements and how to engage with these providers to plan and facilitate care.

Referral documents (i.e. letters and pre-printed forms) to other health care providers are legible and contain relevant and sufficient information to facilitate optimal patient care. This should include at least 3 approved patient identifiers. (Refer Patient identification) and an accurate and current medication list (Refer Clinical content of the Medical records).

Clinical handover needs to occur when all or some aspects of the patients care is transferred to another provider such as when a patient is referred. Patients are made aware that patient health information is being disclosed in the referral documents.

The medical records contain evidence of patient referrals to other health care providers such as diagnostic services, hospital and specialist consultation, allied health services, disability and community services and health promotion and public health services and programs.

Patients are made aware that their health information is being disclosed in referral letters and documents.

Procedure

Suggesting a referral to a particular practitioner or allied health professional carries with it an implicit endorsement that the receiving practitioner or service provider is appropriately skilled and qualified to administer the treatment or service. Generally this is not an issue, but if it is, the referral is qualified.

Our directory of local allied health providers, community and social services and also local specialists is available in Best Practice.

The patient is given information about the purpose, importance, benefits and risks associated with investigations, referrals or treatments proposed by their doctor to enable the patient to make informed decisions. The doctor may use leaflets, brochures or written information to support their explanation where appropriate. Clear communications about unexpected developments can assist the patient to understand the need for additional costs.

Patients are advised of possible costs involved, including additional out of pocket costs, for procedures, investigations and treatments conducted on site prior to them being conducted. For referred services where costs are not known the patients are advised of the potential for out of pocket expenses and encouraged or assisted to make their own enquiries. If the patient indicates that the costs pose a barrier to the suggested treatment or investigation alternatives may need to be discussed (e.g. referral to public services).

Special care is taken to advise patients of the costs of consultations or procedures that do not attract a government subsidy.

Letters of referral may be paper or computer based. Referrals sent electronically should be encrypted. Plain paper or practice letterhead is considered appropriate stationery. Routine use of drug company notepads or prescription pads is unacceptable. For medico legal and clinical reasons practices need to keep copies of important (non-routine) referral letters in the patient health record.

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

Referral letters should:

- be legible (preferably typed) on appropriate practice stationary.
- contain relevant background social information and history.
- contain the present problem and reason for the referral and additional relevant or sufficient information for continuing health management and to avoid duplication.
- include relevant health problems, key examination findings and current management.
- include any allergies, adverse drug reactions and a current accurate medications list.
- include the reason/purpose for the referral and expectation of the referral.
- identify the Doctor or clinical staff member making the referral.
- identify the setting from which the referral is being made and also the setting to which the referral is being sent.
- if known, identify the healthcare provider to whom the referral is being made
- be dated.
- contain at least 3 of the approved patient identifiers e.g. name, date of birth and address.
- be electronically transmitted in a secure manner if appropriate.

Requests for pathology, diagnostic or other investigations should:

- be legible.
- contain relevant clinical information.
- contains at least 3 of the approved patient identifiers e.g. name, date of birth and address.

For medico-legal and clinical reasons copies of any clinically significant referral letters, pathology, diagnostic or other investigation requests and especially those which contain significant clinical details, are retained by the practice and documented in the patients medical record.

- a copy of all significant or non-routine referrals is kept in the medical record through the use of NCR pads, photocopying or electronically on the computer.
- results of referrals and continuation notes or letters received from consultants and hospitals are also retained in the patient health records.

Clinically significant referrals are followed up.

Patients seeking a further clinical opinion from another healthcare provider are encouraged to notify their General practitioner to allow an opportunity to reinforce any potential risks of the decision. Any advice or actions taken when a patient seeks a further clinical opinion, or refuses recommended clinical management are documented in the patients' health record.