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| Work Health & Safety I Policies & Procedures Template | |
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| Policy Statement:  [Your Organisation’s Name] is committed to providing a safe and healthy work environment for all employees, contractors, patients, and visitors. We recognize that the health and safety of our workforce is essential for delivering high-quality healthcare services. This policy outlines our commitment to complying with relevant legislation, promoting a positive safety culture, and continually improving our work health and safety practices. | |
| WHS Policy Objectives & Responsibilities | |
| 1. Objectives:   The objectives of the Work, Health & Safety policy for (Organisation’s Name) are:   * To ensure compliance with the Work Health and Safety Act [insert relevant state/territory legislation], Regulations, and Codes of Practice applicable to the healthcare industry.   + [ACT](https://www.legislation.gov.au/Details/C2011A00137)   + [NSW](https://www.safework.nsw.gov.au/)   + [NT](https://worksafe.nt.gov.au/)   + [Queensland](https://www.worksafe.qld.gov.au/)   + [Tasmania](https://www.worksafe.tas.gov.au/)   + [Victoria](https://www.worksafe.vic.gov.au/)   + [WA](https://www.commerce.wa.gov.au/worksafe/work-health-and-safety-legislation) * To prevent workplace injuries, illnesses, and incidents through hazard identification, risk assessment, and implementation of appropriate control measures. * To foster a culture of safety awareness, accountability, and continuous improvement throughout the Organisation. * To provide adequate resources, training, and supervision to enable employees to perform their work safely. * To consult and engage with employees, contractors, and relevant stakeholders on matters related to work health and safety. * To establish clear responsibilities and accountabilities for the management of work health and safety. * To monitor and review work health and safety performance regularly and implement corrective actions as required.  1. Responsibilities: 2. Management: 3. Provide leadership and commitment to work health and safety by allocating necessary resources and support. 4. Establish and maintain a safe work environment, including effective policies, procedures, and safety systems. 5. Ensure compliance with legislative requirements and relevant industry standards. 6. iv. Promote a positive safety culture through effective communication, consultation, and participation. 7. v. Conduct regular inspections, risk assessments, and audits to identify hazards and implement appropriate control measures. 8. vi. Investigate incidents and accidents promptly, and implement corrective actions to prevent recurrence. 9. vii. Provide adequate training, information, and supervision to employees and contractors. 10. viii. Review and revise the work health and safety policy and procedures as necessary.   2. Employees and Contractors:   1. Comply with all work health and safety policies, procedures, and instructions provided by the organisation. 2. Take reasonable care for their own health and safety and that of others who may be affected by their actions or omissions. 3. Report hazards, incidents, and near misses to their supervisor or the designated safety representative. 4. Participate in safety training programs and follow safe work practices. 5. Use personal protective equipment (PPE) and safety devices as required. 6. Cooperate with the Organisation in the investigation of incidents and implementation of control measures.   3. Consultation and Communication:   1. [Organisation's Name] recognizes the importance of consultation and communication in achieving and maintaining a safe work environment. 2. Consultation mechanisms will be established to allow employees and contractors to contribute to work health and safety decision-making processes. c. Communication channels, such as meetings, newsletters, notice boards, and electronic systems, will be used to disseminate information related to work health and safety. d. Employees and contractors will have access to relevant policies, procedures, and guidelines to enable them to understand their work health and safety obligations.   4. Risk Management:   1. [Organisation’s Name] is committed to identifying hazards, assessing risks, and implementing control measures to eliminate or minimize work-related risks. 2. A risk management process will be established to ensure hazards are identified, assessed, and control measures are implemented. 3. Risk assessments will be conducted regularly, and control measures will be reviewed to ensure effectiveness. 4. The hierarchy of controls will be applied, giving priority to elimination and substitution of hazards where possible. 5. Safe work procedures will be developed and communicated to employees and contractors. 6. Emergency preparedness and response plans will be developed and tested to ensure a timely and effective response to emergencies.   5. Training and Induction:   1. [Organisation’s Name] will provide appropriate work health and safety training to all employees and contractors. 2. Training needs will be assessed regularly, and training programs will be developed and implemented accordingly. 3. New employees and contractors will receive induction training to familiarize them with work health and safety policies, procedures, and emergency protocols. 4. Records of training will be maintained, including attendance, content, and outcomes.   6. Monitoring and Review:   1. [Organisation’s Name] will establish mechanisms to monitor and review work health and safety performance regularly. 2. Incident and hazard reporting systems will be implemented to identify trends and areas for improvement. 3. Internal audits and inspections will be conducted to assess compliance with policies, procedures, and legal requirements. 4. Work health and safety performance indicators will be established, monitored, and reported to relevant stakeholders. 5. The work health and safety policy and procedures will be reviewed periodically and updated to reflect legislative changes and Organisational requirements.   7. Document Control:   1. [Organisation’s Name] will maintain a central repository of work health and safety policies, procedures, forms, and guidelines. 2. Document control procedures will be established to ensure the availability, distribution, revision, and withdrawal of documents. 3. The document control process will include version control, review dates, and approvals. 4. [Organisation’s Name] is committed to the effective implementation of this work health and safety policy and procedures to protect the health, safety, and well-being of all individuals associated with the Organisation.   Note: This template serves as a starting point for developing a Work Health and Safety Policy and Procedure for Australian healthcare Organisations. It should be customized and tailored to meet the specific needs, legal requirements, and operational context of your Organisation. Additionally, ensure that you consult relevant legislation and seek legal advice to ensure compliance with current regulations. | |
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| WHS Policies & Procedures | |
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| **Workplace health and safety Policy**  This practice is committed to preventing workplace injury and illness and ensuring a safe and secure working environment for general practitioners, staff, contractors, patients and all other visitors.  We recognise that health and safety is an integral part of every activity we perform, and as such, we maintain current knowledge of our obligations under <select as appropriate> state/territory and federal workplace health and safety legislation, and we understand that non-compliance with these requirements can result in penalty.  All our workers have a duty of care to ensure that they work in a manner that is not harmful to their own health and safety or the health and safety of others.  Safe Work Australia ([www.safeworkaustralia.gov.au](http://www.safeworkaustralia.gov.au)) leads the development of national policy to improve work health and safety, and workers’ compensation arrangements across Australia. It does not regulate or enforce workplace health and safety legislation. Our practice is regulated under the <amend the following as appropriate> Work Health and Safety Act 2011 (ACT); Work Health and Safety Act 2011 (NSW); Work Health and Safety (National Uniform Legislation) Act 2011 (NT); Work Health and Safety Act 2011 (QLD); Work Health and Safety Act 2012 (SA); Work Health and Safety Act 2012 (TAS); Occupational Health and Safety Act 2004 (VIC); Occupational Safety and Health Act 1984 (WA).    Procedures  In our practice, we have appointed <insert the name and position of the person with designated responsibility> as our workplace health and safety officer.  The workplace health and safety officer has responsibility to ensure due diligence in relation to the practice’s workplace health and safety obligations.    ‘Due diligence’ in relation to workplace health and safety is defined as taking reasonable steps to:   * Acquire and keep up-to-date knowledge of workplace health and safety matters, * Understand the operations being carried out by the business they are employed by or contracted to, and the hazards and risks associated with the operations, * Ensure that the practice has, and uses, appropriate resources and processes to eliminate or minimise health and safety risks arising from work being done, * Ensure that the practice has appropriate processes in place to receive and respond promptly to information regarding incidents, hazards and risks, * Ensure that the practice has, and uses, processes for complying with duties or obligations under the Act, and * Verify the provision and use of these resources and processes.   If the workplace health and safety officer fails to exercise due diligence, they may be liable for penalties and/or imprisonment irrespective of whether there has been an injury or incident at the workplace.  To help support our practice and workplace health and safety officer in complying with workplace health and safety obligations, the workplace health and safety officer conducts a Practice Safety and Security Assessment on an annual basis.  All members of the practice team are aware of the person appointed as our workplace health and safety officer through <amend the following as appropriate> signage on the staff notice board and on the practice intranet. Information relating to workplace health and safety issues are posted on the <amend the following as appropriate> staff notice board and practice intranet and information is conveyed to all members of the practice team by the workplace health and safety officer during induction training, annually thereafter, or whenever there are changes or updates implemented.  We have current workers' compensation insurance, and keep a register of any work-related injuries, illnesses and incidents that are reviewed and monitored to prevent a recurrence.  To support the health, safety and wellbeing of our practice team we have policies and procedures in the following areas:   * Tasks involving manual handling are identified, and measures are taken to reduce or eliminate the risk of injury as far as reasonably practical. * Incidents and all injuries involving all workers, patients and others that occur in the workplace are documented and managed professionally and ethically, according to relevant medical standards and guidelines. * During induction, and periodically thereafter, all members of the practice team are instructed in safety and infection prevention and control protocols ensuring risks are known and precautions are taken, including immunisations. * We maintain a safe, physical work environment that includes ensuring regular breaks are taken, adequate staffing levels, and a smoke-free environment. * We have a duty of care to safeguard the health of our practice team members which covers psychological health as well as physical health. * We strive to encourage consultation between management and the practice team on all matters pertaining to workplace health and safety matters as obligated under legislation. * We endeavour to provide a working environment in which all general practitioners, staff, contractors, patients and visitors are not subject to unlawful discrimination, sexual harassment, violence or bullying. * Audits are undertaken to ascertain that all practice and office equipment is appropriate for its purpose, and records of maintenance, including electrical safety checks and calibration schedules, are maintained. * Records of updates and training provided to all members of the practice team in relevant equipment operation and maintenance, manual handling skills and compliance with workplace health and safety requirements are maintained. * We strive to ensure the practice environment and facilities are adequate, and provide for the comfort, safety and security of general practitioners, staff, contractors patients and visitors. * Non-medical emergency procedures and fire safety precautions are documented and designated members of the emergency team have a reference and a basis for their decisions and actions within that role. * We have appointed one member of the practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures which include environmental cleaning. * We have clear lines of accountability and responsibility for the delivery of safe and effective quality care. * We have a requirement for two members of the practice team to be present during normal opening hours of the practice. * New members of the practice team are to disclose any pre-existing injury that may be affected by certain working conditions required by the role before accepting the position. * The workplace is maintained in a safe condition, such as ensuring fire exits are not blocked, emergency equipment is serviceable, and the work areas are generally tidy, with adequate facilities provided to workers, such as clean toilets and hygienic eating areas. | |
| **Incidents and injury and adverse events (incidents and hazard form, incidents register) Policy**  This practice has designated <insert the name and position of the person with designated responsibility> with primary responsibility for clinical risk management, including following up on incidents, injuries and adverse patient events and near misses.  It is a legal requirement under the <amend the following as appropriate> Work Health and Safety Act 2011 (ACT); Work Health and Safety Act 2011 (NSW); Work Health and Safety (National Uniform Legislation) Act 2011 (NT); Work Health and Safety Act 2011 (QLD); Work Health and Safety Act 2012 (SA); Work Health and Safety Act 2012 (TAS); Occupational Health and Safety Act 2004 (VIC); Occupational Safety and Health Act 1984 (WA) and for insurance purposes, to report any injury sustained or thought to be sustained in the workplace. Consideration is taken to ensure that thorough reporting also leads to effective prevention.  Our practice encourages the identification, analysis and prevention of errors, failure or inadequate systems that can potentially be a risk to patient safety. To assist with risk management strategies, our practice does not apportion blame.  Incidents that should be reported (regardless of whether harm has occurred) to assist with making improvements to minimise the risk of recurrence, include:   * Needle stick injury or mucous membrane exposure to blood or body-substance, * Slip or fall, * Drug or vaccine incident (loss, misplacement or other), * Adverse patient outcome, * Failure or inadequate patient handover or identification of a patient at the point of transfer of care, * Delayed treatment or delayed follow up, or unnecessary repeat of tests, * Medication errors, and * Any deviations from standard clinical practice.   Accidents or incidents may involve the following:   * Staff (employed directly by this practice), * Non-staff (patients, visitors, contractors), and * Events (e.g. theft, non-patient assault, gas leak, bomb hoax, security breach, medication error or patient complication following medical intervention or breakdown in clinical handover).   Actual and potential risks are identified and actions are taken to increase the safety and improve the quality of care. The privacy of individuals involved is maintained.  Procedures  Reporting  In our practice, we use the Adverse Outcome Event/Incident Report form to report any slips, lapses or near misses in clinical care (including any breakdowns in the clinical handover system) or deviations in patient care that might result in harm. Where necessary, our medical defence organisation is contacted for events that might give rise to a claim.  In addition to the Adverse Outcome Event/Incident Report form, our practice team use the Blood/Body-Substance Exposure Incident Report form to report any needle stick injury or exposure to blood or body-substances as detailed under Section 3.3 – Sharps injury management and other body-substance exposure.  Completed Adverse Outcome Event/Incident Reports are:   * Completed as soon as possible after an incident occurs, preferably within 24 hours, * Provided to the person with designated responsibility for clinical risk management to facilitate a review of current systems and processes to prevent a recurrence, and * Filed in a designated ‘clinical incident’ file.   For injury occurring in the practice or during course of work, WorkCover reporting protocols must also be followed. It is a legal requirement to report all injuries sustained in the workplace.  Where there is a possible conflict of interest, for example a staff WorkCover claim being managed by the employing practitioner, the general practitioner should refer the patient to another practitioner.  Risk assessment  The person designated with primary responsibility for clinical risk management will conduct a thorough review of all hazards relevant to the cause(s) of any injury that has occurred, with a view to identify appropriate controls (also refer to Section 8.2 – Risk assessment and management).  Risk control  Risk control involves identifying and implementing all the practicable strategies to minimise subsequent and similar events or to eliminate/reduce the causes(s) of the injury or incident.    Practice team members are informed about any changes implemented, including why they have been implemented, to reduce the likelihood of recurrences. Depending on the circumstances, this will take place as soon as practicable following an incident, or during the next practice team meeting.  All documentation or evidence of the implementation of improvements is retained for periodic evaluation to ensure the successfulness of the improvement implemented.  Documentation  Documentation of the investigation process, agreed actions implemented, and the evaluation of the improvements implemented is retained using the Clinical Near Miss and Mistake Register. | |
| **Sharps injury management and other body-substance exposure Policy**  In our practice, we understand that the management of occupational exposure to blood or body-substances includes:   * Rapid assessment of the practice team member and the source patient * Documentation of the incident * Counselling for the practice team member involved * Timely administration of medications where appropriate, and * Investigation of the incident to enable modification of procedures if required.   Occupational exposure to needle stick injuries and body-substances can be prevented by using standard precautions, wearing personal protective equipment and implementing safe work processes.  Procedure  Preventing blood and body-substance exposure  All members of the practice team are instructed to:   * Use standard precautions where there is a risk of blood or body-substance exposure, * Implement safe work practices when handling sharps, specimens and waste, and when cleaning the practice environment <keep the following if reusable instruments are used> and reusable instruments, and * Assess and manage any blood or body-substance exposure immediately.   Following occupational exposure  In our practice, we follow this procedure after occupational exposure:  Decontaminate the exposed area  Wound -  Do not squeeze or rub the injury site.  Gently encourage bleeding from the skin wound.  Wash the area thoroughly with soap and water (or waterless cleanser or antiseptic if water is unavailable).  Apply waterproof dressing as necessary and apply pressure through the dressing if bleeding is still occurring.  Do not use strong solutions such as bleach or iodine on the wound site.  Skin -  Wash the area thoroughly with soap and water (or waterless cleanser or antiseptic if water is unavailable).  Do not use strong solutions such as bleach or iodine on the skin site.  Eyes -  Remove contact lenses.  Rinse the eyes gently (but thoroughly) while they are open for at least 30 seconds with water or saline.  Mouth -  Spit out any blood or body-substance that has entered.  Rinse with water and spit out (repeat several times).  Clothing -  If any clothing is contaminated, remove and shower if necessary.  Report and document  Report the exposure to an appropriate person (i.e. <insert position title of the person responsible for receiving reported incidents, e.g., WHS officer) to ensure prompt and appropriate commencement of treatment and investigation.  Document -  Document the incident using the Blood/Body-Substance Exposure Incident Report form.  Blood Borne Virus (BBV) testing  Source -  Take a history from the source to identify the risk of disease exposure, accounting for the following:   * Unprotected sexual intercourse * Sharing needles, tattoos or body piercing * Sharing razor blades or toothbrushes * Blood or body-substance exposure of mucous membranes or non-intact skin * Blood transfusion before February 1990 (For HCV) * Infected with HIV, HBV, or HCV   Where the source is positive, likely positive, or unknown for BBV, testing must be performed. Consent must be obtained prior to performing any baseline serology testing.  Perform baseline tests for:   * HIV * HBV * HCV   Request urgent testing and results from the laboratory.  Exposed Person -  Informed consent for BBV testing must be obtained prior to performing any baseline serology testing.  Perform baseline tests for:  HIV  HBV  HCV  Request urgent testing and results from the laboratory.  Risk assessment  High risk / Massive exposure -  Injection of large volume of blood/body-substance (>1mL).  Parenteral exposure to laboratory specimens containing high titre of virus.  Moderate risk / Definite exposure -  Injection of large volume of blood/body-substance (<1mL).  Skin penetrating injury with a needle contaminated with blood or body-substance.  Laceration or similar wound which causes bleeding, and is produced by an instrument that is visibly contaminated with blood or body-substance.  Low risk / Possible exposure -  Superficial injury with a needle contaminated with blood or body-substance.  A wound not associated with visible bleeding, caused by an instrument contaminated with blood or body-substance.  Prior wound or skin lesion contaminated with blood or body-substance.  Mucous membrane or conjunctival contact with blood or body-substance.  Scratched/broken skin caused by a fingernail injury when there is blood evident on the source hands.  Human bites that break the skin (clinical evaluation should include the possibility that both the person bitten and the person who inflicted the bite were exposed to BBVs).  Very low risk / Doubtful exposure -  Superficial injury with needle considered not to be contaminated with blood or body-substance.  Superficial wound not associated with visible bleeding, caused by an instrument considered not to be contaminated with blood or body-substance.  Prior wound or skin lesion contaminated with a body-substance other than blood (e.g., urine).  Mucous membrane or conjunctival contact with a body-substance other than blood.  No risk / No exposure -  Intact skin visibly contaminated with blood or body-substance.  Initiate treatment  Confidentiality must be maintained, especially if the exposed person is a practice team member.  Offer the exposed person counselling if the source is known to be HIV positive, ‘high risk’ or is unknown for BBV.  Where the source is unknown, post-exposure prophylaxis needs to be considered based on the outcome of the risk assessment.  If the source’s blood test results will not be available within 24 hours and the source is likely to be HIV positive, post-exposure prophylaxis needs to commence.  If post-exposure prophylaxis is required, it is important the exposed person commences this as soon as possible (best given within 1-2 hours of exposure, recommended within 48 hours of the incident or, up to 72 hours as decided by a medical practitioner).  If the source’s HBV result will not be available within 24-48 hours, and the exposed person’s HBV status is not known/documented, with consent give the exposed person:  Hepatitis B immunoglobulin  Hepatitis B vaccine (first dose)  Adult diphtheria and tetanus (ADT) if necessary.  Advise the exposed person to practice safe sex until the blood test results and source history has been reviewed.  Provide the exposed person with the contact details for the <select as appropriate> state/territory health department communicable disease office.  If there is a high risk of disease exposure, refer the exposed person to an infectious disease specialist.  Re-assess treatment initiated once the results of the blood tests become available.  Reporting and analysis of the incident  We have appointed a member of the practice team with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures (refer to - Principles of infection prevention and control). Using the Adverse Outcome Event/Incident Report form our team is to report any exposure to this person or delegated authority, in addition to normal incident reporting protocols, incorporating:   * What procedure was being undertaken, * How the injury happened and the name of anyone that witnessed it, * The nature and extent of the injury, * What caused the injury (e.g.,, specify the gauge of the needle), * The body-substance involved, * How much blood or body-substance was the health professional exposed to, * What personal protective equipment was being used, and * The full name and address of the source - if the source cannot be identified document “source patient not known”. | |
| **Practice team immunisation (immunisation consent & records)** **Policy**  In our practice, we have appointed <insert the name and position of the person with designated responsibility> with primary responsibility for the development and consistent implementation of our infection prevention and control systems and procedures which includes immunisations (refer to Section 4.1 - Principles of infection prevention and control).  All members of the practice team are advised of the risks of infection and are encouraged to be immunised against vaccine-preventable diseases to prevent transmission of disease to and from other members of the practice team and patients. Practice team members are also offered additional vaccinations where appropriate, depending upon the likelihood of their contact with patients and/or blood supply substances. These vaccinations may include protection against Hepatitis A, Meningococcal B, Meningococcal C, Poliomyelitis and Tuberculosis.  The practice keeps an extensive and up-to-date record of the immunisation history of each practice team member (including any refusals of immunisation, serology testing, or disclosure of vaccination history), and this assists in identifying non-immune team members to ensure they are excluded from contact with patients during disease outbreaks.    Procedures  A vaccination history, including serology testing where required and consented, is sought from all new employees during commencement of their employment. Based on the outcome of this, any immunisations then recommended are to be received within the first three (3) weeks of commencement (with the exception of influenza which is to be administered annually between March and May).  Contractors and volunteers working in the practice must provide evidence of vaccination, or proof that they are not susceptible to specified vaccine preventable diseases, prior to engagement/commencement.  Immunisation histories are recorded using the Practice Team Member Immunisation Consent/Refusal Record Form, which is held in each individual’s employment or contract file. Each team member’s immunisation history is reviewed regularly, and updated as required.  Guidelines for immunisation  All members of the practice team are encouraged to obtain immunisations recommended by the current edition of the Australian immunisation handbook based on their duties and immunisation status. The recommended immunisations for workers in healthcare include:   * Influenza, * Hepatitis B, * Measles Mumps and Rubella, * Pertussis (dTpa), and * Varicella.   To determine which vaccine preventable disease each member of the practice team should be protected against, we use to the following criteria to help form the basis of this determination. This list is not an exhaustive list, and other considerations may need to be made, which are determined by the infection prevention and control coordinator when discussing with the practice team member the risks and benefits of vaccination:  Influenza  Due to the highly transmissible nature of the influenza virus and possible serious consequences for the young and elderly, all practice team members are required to have the annual influenza vaccine.  Hepatitis B  Tasks that involve the possibility of exposure to blood or body-substances (direct patient contact or indirect contact with blood or body-substance):  hands-on clinical work,  collecting, transporting, handling or processing of pathology samples,  providing clinical care or treatment of any kind,  cleaning of spills that may contain blood or body-substances of any kind,  bed making and cleaning,  handling of soiled or contaminated linen,  handling of clinical or laboratory waste, or waste receptacles,  cleaning or maintaining equipment or surfaces or other items used in clinical areas,  assisting patients in using the bathroom, or mobilising, and  any manual handling of patients.  Measles, Mumps, Rubella, Pertussis, Varicella  Tasks or work settings that involve the possibility of contact that would allow acquisition and/or transmission of measles, mumps, rubella, pertussis or varicella (direct patient contact or indirect patient contact):  interacting face-to-face with patients,  the normal work location is an area where patients frequent, and  the work frequently or regularly requires attending a clinical area (such as consulting room or treatment room).  <According to the likelihood of exposure based on your practice location and patient population, amend or delete the following as required>  In addition to the above vaccinations, our practice team members are offered and encouraged to receive the following vaccinations:   * Hepatitis A, * Meningococcal B, * Meningococcal C, * Poliomyelitis, and * Tuberculosis.   Immunisation consent/refusal records  Immunisation consent/refusal records are initiated for all members of the practice team and include:   * Confirmation that the risks of infection relevant to the team member’s role have been outlined, and that the benefits of vaccination have been explained. * Consent (or refusal) to discuss or disclose immunisation history (including undertaking serology testing). * Consent (or refusal) to have the recommended vaccinations. * Any known allergies (where immunisation consent is given).   Blood and body–substance spills Policy  Our practice has management systems for dealing with blood and body-substance spills, and these include the following:   * Blood and body-substance spills include blood, vomit, urine, faeces, sputum and body tissue and are treated as potentially infectious substances that can transmit disease, should contact occur. * SEM practitioners, nurses, other health professionals, practice team members and external contractors (e.g., cleaners) use standard precautions to achieve a basic level of infection prevention and control regardless of the known or perceived infection status of the blood or body-substance. * Any spillage needs to be treated promptly to reduce the potential for contact with other patients, practice team members or visitors.   <Insert name and position title>, our team member with primary responsibility for coordinating and sustaining our infection prevention and control processes, is responsible for ensuring all team members are familiar with the practice’s policy and procedure for the management of blood and body-substance spills, that they receive adequate training on how to appropriately manage blood and body-substance spills, and that they are familiar with the actions to take in the event of exposure to blood or body-substance while cleaning a spill (refer to Section – Sharps injury management and other body-substance exposure).  Our practice has a spills kit readily available, consisting of a rigid walled container with a lid containing:   * A laminated guide containing a list of the spills kit contents and the spills management procedure * One (1) small bucket, with the water level marked, * A pre-measured amount of detergent\* in a labelled container ready to be made up when necessary, * Non-sterile utility gloves, * Goggles and a face shield, * Masks, * Disposable aprons, * Paper towels, * Scrapers (i.e. two pieces of firm cardboard), * Hazard sign to quarantine the area, * Plastic (clinical and general) bags, and * Polymerising beads (or other absorbent material such as kitty litter).   \*The detergent we use for our general cleaning is used for treating most spills. Where transmission-based precautions apply, a disinfectant that has label claims against the microorganism of concern is used.  Procedure  As part of our practice’s induction process, all members of the practice team are provided with information about our practice’s protocol for managing spills of blood and body-substances including what to do in the event of a needle-stick injury or exposure to blood or body-substance (refer to Section 3.3 – Sharps injury management and other body-substance exposure).  In our practice, the spills kit is located <insert the location of the spills kit>.  It is the responsibility of <insert the name/position title of the person with designated responsibility> to maintain the spills kit by ensuring all perishable items contained are within their expiry date and that stock is replenished/replaced as required.  Our management of spills is flexible enough to cope with different types of spills, taking into account the following factors:   * Nature of the spill: for example, sputum, vomit, faeces, urine or blood, * Pathogens most likely to be involved: for example, stool samples may contain viruses or bacteria, whereas sputum may contain Mycobacterium tuberculosis, * Size of the spill: for example, a spot, small or large spill, * Type of surface: for example, carpet or vinyl flooring, * Area involved: for example, in a contained area such as a consultation room or in a public area such as the waiting area, and * Possibility of some material remaining on a surface where cleaning is difficult (e.g., between tiles) and the possibility of bare skin contact with that surface.   The affected area must be left clean and dry. Disposable items in the spills kit must be replaced after each use and reusable items cleaned according to protocol.  Only those practice team members with their immunisation status and spills management training recorded are permitted to clean spills of blood or body-substances.  The method for cleaning spills in our practice is as follows:   * Apply standard precautions. * Don personal protective equipment. * Prepare detergent and water. * Tear off enough paper towel to manage the spill. * Prepare the rubbish bag. * Commence cleaning of the spill.   If the spill is on a hard surface:   * Wipe up any solid matter and excess material. * Clean with detergent and water using a clean piece of paper towel each time. * Dry the surface. * Dispose of contaminated material.   If the spill is on a soft fabric or carpet:   * Use polymerising beads or other absorbent material. * Scrape up residue. * Clean with detergent and water using a fresh piece of paper towel each time. * Quarantine the area until dry. * Consider arranging for the carpet to be ‘steam’ cleaned. * A disinfectant may be used after cleaning. * Dispose of contaminated material.   Hand washing and hand hygiene Policy  Effective hand hygiene has been proven to reduce the spread of infection. This minimises the risk of cross-contamination through physical contact with patients and co-workers, and touching inanimate objects such as door handles and telephones.  Gloves are not a substitute for hand cleaning. Fingernails are to be kept short and clean, and jewellery to be at a minimum as these may harbour bacteria; nailbrushes are not to be used. Cuts and abrasions are to be covered with water resistant dressings.  Our practice is responsible for ensuring all members of the practice team have been educated on effective hand hygiene and hand care.  Hand hygiene must be performed:   * Before and after eating, * After routine use of gloves, * After handling any used instruments or equipment, * After going to the toilet, * When visibly soiled or perceived to be soiled, * Before, after and between performing procedures (e.g., removal of moles, suturing lacerations, wedge resections, drainage of cysts), and * Before examining neonates and patients who are immunocompromised.   Easy access to hand hygiene facilities is promoted by having dedicated hand washing facilities with hot and cold water, liquid soap and single-use paper towel readily available in every clinical management and treatment area, including consulting rooms.  Hand disinfectants designed for use without water, such as alcohol-based hand gel, is available in:  The doctors’ bags to use when hand washing facilities are inadequate or not available (e.g., home or other visits),  All treatment and examination areas to encourage hand hygiene in addition to hand washing, and  Common areas used by patients and practice team members to encourage hand hygiene.  The most appropriate hand hygiene product to be used is selected with consideration of the following factors:  Type of hand hygiene required i.e. routine, aseptic (clinical), or surgical,  The location of the product,  Compatibility of agents if multiple agents are used e.g., hand creams, ointments, and  Care and protection of the person’s hands, and any sensitivities.  In our practice, we do not use soap bars under any circumstances. We have liquid hand wash dispensers with disposable cartridges, including a disposable dispensing nozzle available, and where these are not available, a pump pack is used. The liquid soap pump backs are discarded when empty; however, should they need to be re-filled, the container is washed and dried thoroughly prior to the re-fill (and not ‘topped up’).  Appropriate facilities for drying hands are provided. Single-use towels (paper or cloth) are available in all areas where hand washing facilities are provided; hot air dryers are not used in our clinical management and treatment areas. Disposable paper towels are used prior to aseptic procedures and hand moisturiser is made available for use.  Procedure  The methods of hand hygiene performed in our practice are as follows:   | **Type of hand hygiene** | **Technique** | **Duration** | **Drying** | **When** | | --- | --- | --- | --- | --- | | Routine hand cleaning for soiled hands | Washing:  Wet hands  Wash with neutral liquid soap  Rinse thoroughly  Use paper towel to turn off the taps if not ‘hands free’ | 10-15 seconds | Paper towel  OR  Clean, dry, single-use cloth towel  OR  Clean section of roller towel | Before eating  After going to the toilet  Before and after patient contact  After removing gloves | | Skin disinfectants:  Remove soil first, using hand wipes or soap and water  Apply alcohol-based hand rub  Rub over all surfaces in the same manner as washing hands | 10-15 seconds  OR  Until dry | Rub hands until dry, without wiping | Before eating  After going to the toilet  Before and after patient contact when hands are not visibly soiled  After removing gloves | | Hand washing for standard aseptic (clinical) procedures | Method:  Wet hands  Wash with neural liquid soap or antimicrobial cleaner  Rinse thoroughly  Use paper towel to turn off taps if not ‘hands free’  Alcohol based hand rub can be used in emergency situations outside the practice, provided hands are not visibly soiled | 1 minute | Paper towel  OR  Clean, single-use cloth towel | Before any procedures requiring a clean or ‘no touch’ technique | | Hand washing for surgical aseptic procedures | Method:  Remove jewellery  Wet hands and forearms  Wash with antimicrobial cleaner (4% chlorhexidine or 0.75% detergent-based povidone or 1% aqueous povidone)  Clean under nails only if needed (do not scrub hands with nail brush as they can break the skin and be a source of infection)  Rinse carefully, keeping hands above elbows  To turn off taps if not hands free:  Ask another member of the practice team to turn off the taps or use sterile towelling. | First wash of the day: 5 minutes  Subsequent washes: 3 minutes | Sterile towels | Before significant invasive surgical procedures |   Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)  The location of our hand washing facilities and available hand hygiene products are as follows:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Location** | **Hand washing facilities** | **Equipped for routine hand washing** | **Equipped for aseptic hand washing** | **Equipped for Surgical hand washing** | | Patient toilets | Liquid soap  Paper towel/air dryer | Yes | No | No | | Consulting rooms | Liquid Soap  Antimicrobial cleaner (2% Chlorhexidine)  Paper towel | Yes | Yes | No | | Treatment room | Liquid Soap  Antimicrobial cleaner (4% Chlorhexidine)  Paper towel  Sterile towel | Yes | Yes | Yes |     Standard and aseptic procedures Policy  Standard aseptic technique refers to work practices used by general practitioners and other healthcare professionals to minimise the risk of introducing and transmitting infection during clinical procedures. Standard aseptic technique is used during treatment of wounds such as lacerations and ulcers, as well as minor operative procedures such as removal of moles and biopsies and venepuncture.  Surgical aseptic technique refers to work practices that result in preventing or minimising microorganisms entering sterile body areas such as through surgical incisions during a procedure. Elements of this technique may be used in some settings for more invasive procedures.  We ensure all practice team members involved in procedures are adequately trained and educated to execute standard and surgical aseptic technique as required.    Procedures  Standard aseptic technique is achieved by:   * Using standard precautions, including hand hygiene and personal protective equipment where necessary, * Using barriers (e.g., clean single-use gloves), * Using water or saline to clean ulcers or lacerations, * Using skin disinfectants to prepare operative sites, * Using clean environmental surfaces, * Using a no-touch technique – that is, no direct contact between the health professional’s hand and the patient during the procedure, such as using forceps during dressings or clean single-use gloves if no-touch technique is not possible (e.g., probing a penetrating wound), * Using drapes to form a ‘clean field’ dependent on situation and risk, * Using sterile instruments and equipment, and * Reprocessing reusable instruments and other equipment between each patient.   Surgical aseptic technique involves:   * Using a sterile operating field where everything within a defined radius is clean and sterile, * Using sterile gloves, gowns, drapes and instruments, * Using skin disinfectant on the patient, and * Taking care to ensure that nothing unsterile comes within the sterile field.     Handling and use of chemicals Policy  Our practice does not use cleaning agents or other chemicals which are known to be toxic to the user such as glutaraldehyde and chlorine-based products. Chemicals and cleaning agents used in our practice are used in accordance to the manufacturer’s instructions and are disposed of in accordance with our waste management procedure (refer to Section 4.20 – Management of waste).  Cleaning solution (detergents) that is mixed with other liquids by our practice is made at the beginning of each working day and discarded at the end of each working day, with the container rinsed and left upside down to dry overnight. This is to avoid the spread of microorganisms, which may have contaminated the solution. To avoid wastage, only enough solution is made up for the day.  All containers of chemical agents are appropriately labelled. This is to ensure that the contents of the containers can be readily identified and used correctly. For this reason, labels must be kept fixed to the container at all times and clearly understood.  Specifically, it is our policy that a container with diluted cleaning agent states the following:  Name, type and purpose of chemical agent  Instructions on preparing and discarding the solution, and  Warnings and/or health and safety instructions.  Safety Data Sheets (SDS) are made available for all chemicals and hazardous materials found in our practice, and are visible on equipment and hazardous substances. The use and handling of chemicals, including cleaning agents, complies with the manufacturer’s instructions.  It is important that our practice stores chemicals in a safe area to prevent unauthorised access. Most of our containers of chemicals are stored in a designated cupboard that is out of the reach of children; however, we also use a cupboard that is below waist height and this cupboard is fitted with a child-proof lock.  We ensure all practice team members who are required to handle chemicals are trained in the correct and safe use of the chemical, and this includes correct use of personal protective equipment.  All chemicals and cleaning equipment used in our practice is used only for the purpose intended and in accordance with the manufacturer’s instructions including ensuring dilution ratios are strictly adhered to.  Procedure  Our practice stores the following listed chemical and cleaning products for the following uses <personalise the below table as appropriate>:   | **Product** | **Use** | **Storage location** | **SDS available** | | --- | --- | --- | --- | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   Safety data sheets (SDS) for each product are found <insert the location of the Safety Data Sheets (SDS)>.  Single-use items Policy  Single-use items and devices must not be reprocessed.    Procedures  Single-use items and devices include, but are not limited to: oxygen masks and tubing, nebuliser sets, spacers, razors, spatulas, auriscope tips, liquid nitrogen applicators, pins for sensory testing, medications such as eye drops and ointment, lancets for blood testing, spirometer and peak flow mouthpieces, and disposable instruments.  Single use is the only acceptable method in this practice for dressings, suture materials, suture needles, hypodermic needles, syringes and scalpels.  Single-use vials are used in preference to multi-dose vials of injectable substances due to the increased risk of an infection hazard of multi-dose vials if incorrectly used. If multi-dose vials are used, education and ongoing compliance with prescribed protocols are required to prevent the potential transmission of infectious diseases, minimise the potential risk of vial contamination, minimise the potential risk of medical errors, reduce potential wastage associated with the use of multi-dose vials and, in the case of vaccines, to ensure the delivery of a potent vaccine to the patient.  Where possible, saline solution and skin preparation agents are purchased in single-use sachets or containers; larger containers, if used, are dated when opened and changed regularly.  Some items may be reprocessed for use by the same patient where labelled by the manufacturer as “single-patient use” and, in this case, the manufacturer’s instructions for reuse is followed. This process may include specific cleaning requirements and/or limitations to the number of times the item can be reprocessed before needing to be disposed of.  Single-use items or equipment contaminated with blood or body-substance is disposed of in accordance with our waste management procedure (refer to Section – Management of waste).  Instrument and equipment processing area  <Keep this section if reusable instruments and equipment are used by the practice>  Policy  Our practice has a designated area for processing all instruments and equipment for reuse to prevent possible contamination of processed items.  A workflow pattern, systematically moving from dirty to clean, is established within the designated area to enable items to progress from the cleaning area to steriliser packaging and loading to unloading and storage of sterile stock without re-contamination. This area, including sinks and containers, is cleaned daily.  The equipment processing area includes:  Adequate bench space with surfaces made of a smooth, non-porous material without cracks or crevices to allow for cleaning,  Good lighting,  Dedicated and appropriate bins for waste, and  Adequate storage space for materials and equipment.  Our specified cleaning equipment includes:  Heavy duty utility gloves, plastic apron to protect clothing, protective eyewear and, if items are grossly soiled, a mask or visor,  A non-corrosive, non-abrasive, free-rinsing and mildly alkaline detergent in the original container,  Cleaning brushes of a suitable size to effectively reach all parts of the item being cleaned, and  Low-lint towelling for drying cleaned items.  Procedure  In our practice, our equipment processing area is located <insert location here> and our facilities include:  <Select from the following options to best describe your practice’s instrument cleaning facilities, and delete the options that are not applicable to your practice>  <Option 1>  A double sink with adequate bench space on either side for work to flow from dirty to clean.  A separate sink located away from the instrument processing area that is dedicated for hand washing.  According to the workflow pattern, the sink located on the ‘dirty’ side is allocated to washing instruments and is sign posted ‘Dirty’.  According to the workflow pattern, the sink located on the ‘clean’ side is allocated to rinsing instruments before and after cleaning and is sign posted ‘Clean’ – a plug must never be inserted in this sink.  <Option 2>  A double sink with adequate bench space on either side for work to flow from dirty to clean.  According to the workflow pattern, the sink located on the ‘dirty’ side is allocated to washing instruments and is sign posted ‘Dirty’.  According to the workflow pattern, the sink located on the ‘clean’ side is allocated to rinsing instruments before and after cleaning, and is also the sink used for hand washing. This sink is sign posted ‘Clean/Hand Washing’ – a plug must never be inserted in this sink.  Note: after the ‘clean’ sink is used during the instrument cleaning process, it is adequately cleaned to render it suitable for hand washing.  <Option 3>  A double sink with adequate bench space on either side for work to flow from dirty to clean.  A large plastic container to act as the ‘dirty’ sink.  According to the workflow pattern, the plastic container is positioned on the ‘dirty’ side and is allocated to washing instruments and is sign posted ‘Dirty’.  According to the workflow pattern, the sink located closest to the ‘dirty’ side is allocated to rinsing instruments before and after cleaning and is sign posted ‘Clean’ – a plug must never be inserted in this sink.  According to the workflow pattern, the sink located closest to the ‘clean’ side is allocated to hand washing and is signed posted ‘Hand Washing’.  <Option 4>  A single sink with adequate bench space on either side for work to flow from dirty to clean.  A separate sink located away from the instrument processing area that is dedicated for hand washing.  A large plastic container to act as the ‘dirty’ sink.  According to the workflow pattern, the plastic container is positioned on the ‘dirty’ side and is allocated to washing instruments and is sign posted ‘Dirty’.  Note: the sink is allocated to rinsing instruments before and after cleaning and is sign posted ‘Clean’ – a plug must never be inserted in this sink.  <Option 5>  A single sink with adequate bench space on either side for work to flow from dirty to clean.  A large plastic container to act as the ‘dirty’ sink.  According to the workflow pattern, the plastic container is positioned on the ‘dirty’ side and is allocated to washing instruments and is sign posted ‘Dirty’.  Note: the sink is allocated to rinsing instruments before and after cleaning, and is also the sink used for hand washing. This sink is sign posted ‘Clean/Hand Washing’ – a plug must never be inserted in this sink.  Note: after the sink is used during the instrument cleaning process, it is adequately cleaned to render it suitable for hand washing.  Environmental issues  The area and equipment associated with instrument and equipment processing:  Is only cleaned or managed by appropriately trained practice team members,  Must remain in a clean and tidy manner throughout the day, and  Is thoroughly cleaned at the end of each working day.    <Keep the following paragraph if a plastic container is used to act as the ‘dirty’ sink> In addition to the above, the container used to act as the ‘dirty sink’ is always treated with due care and is not touched with un-gloved hands. This container is not used for any purpose other than instrument cleaning.  Provision of sterile items  <Select the appropriate option below (and delete any that are not applicable) according to how your practice provides sterile items>  <Option 1 below - single-use disposable instruments>  Policy  Our practice is able to provide assurance that any items provided for procedures into normally sterile tissue, sterile cavities or the bloodstream are sterile.  Our practice understands that the process of sterility assurance includes all aspects of equipment procurement, storage, and use and practice team member education.  Procedure  Our practice purchases single-use sterile disposable instruments to use where appropriate.  The Class 1 Chemical Indicator and packaging integrity is checked prior to opening an instrument pack for use, and the batch number of all instruments used is recorded to enable tracking of the instruments if necessary.  It is the responsibility of all members of the practice team using the instruments to ensure that they are disposed of in the correct waste bins following use to prevent patient-to-patient or patient-to-team member cross contamination (refer to Section 4.20 – Management of waste).  After using an instrument, replacement stock is ordered to maintain an adequate stock of instruments for our practice’s requirements.  <Option 2 below - off-site sterilisation facility >  Policy  Our practice understands that sterilisation is more than simply putting loads through a steriliser, and that the process of sterility assurance includes all aspects of equipment procurement, storage, use, and reprocessing and practice team member education.  Our practice has a supply of reusable instruments and equipment that is maintained in good working order and free of rust and surface damage. Correct procedures are followed to ensure that these instruments are cleaned and sterilised after each use. As we do not have a steriliser on our premises, we have arranged for the instruments to be sterilised off-site through contracted arrangements with <insert the name of the off-site sterilisation provider>.  Our practice is able to provide assurance that any items provided for procedures into normally sterile tissue, sterile cavities or the bloodstream are sterile through the following:  A written agreement between our practice and the off-site sterilisation facility stating who is responsible for: washing packaging items, transport, turn-around time, quoted prices and names of contact people for both organisations.  Retaining a copy of the off-site facility’s current accreditation certificate.  Evidence that the off-site facility correctly performs sterilisation and validates it processes (e.g., validation documentation or certification that is provided to our practice annually).  Appropriate policies and procedures to ensure preliminary cleaning of items, packaging, safe transport of instruments and equipment to and from the off-site facility, and evidence of training and competency in these policies and procedures.  Procedure  It is the responsibility of <insert the name/role of the person with designated responsibility> to coordinate the following off-site sterilisation procedures:  All instruments that require sterilisation are cleaned in accordance with Section – Cleaning reusable instruments and equipment.  Items are packaged and labelled prior to despatch to the facility in accordance with Section 4.10 - Packaging of items for sterilisation.  All instruments are placed in a plastic container labelled ‘contaminated’ with a firmly fitting lid, and that standard precautions adhered to when handling this container and contents.  All instruments leaving the practice are documented in accordance with Section – Documentation of the cycle.  A telephone call is made to the off-site facility to inform them that a cycle of instrument sterilisation needs to be undertaken and to arrange a delivery and pick-up time.  A different plastic container labelled ‘sterilised items’ is used to collect sterile items from the off-site facility.  All instruments returning to the practice are documented in accordance with Section – Documentation of the cycle and are released for use only after checking the integrity of the packages thoroughly.  All sterile items are stored and handled in accordance with Section – Storage of sterile items.  Cleaning reusable instruments and equipment  <Keep this section if reusable instruments and equipment are used by the practice>  Policy  Our practice’s infection prevention and control coordinator ensures the level of processing for specific instruments and equipment is appropriate to the risk of infection posed by their reuse by using the Spaulding classification. The site of use (e.g., skin, mucous membranes and wounds) is a key determinant in this risk assessment as this determines the level of processing required to minimise the probability of infection to the patient.  Our practice team members, whose duties require them to process equipment for reuse, must have received adequate training and competency assessment in this area.  Thorough physical cleaning of items to remove blood and other debris is needed if effective disinfection or sterilisation is to be achieved. Preliminary cleaning must be done as soon as possible during or after use to prevent coagulation of blood and other proteins. Any delay will increase the bio-burden (through bacterial multiplication) and also increases the difficulty of removing adherent soil. The effectiveness of sterilisation is dependent on the bio-burden being as low as possible.  Procedure  All team members cleaning reusable items:   * Wear appropriate personal protective equipment, * Use equipment as specified, * Have received appropriate formal or in-house training, and * Are appropriately immunised.   When determining the level of processing for specific instruments and equipment appropriate to the risk of infection posed by their reuse, our practice’s infection prevention and control coordinator follows the Spaulding classification described as follows:   |  |  |  | | --- | --- | --- | | Level of risk | Application | Process | | Critical | Entry or penetration into sterile tissue, cavity or bloodstream | Sterility is required | | Semi-critical | Contact with intact non-sterile mucosa or non-intact skin | Sterilisation preferred where possible. If sterilisation is not possible then high-level chemical disinfection is required | | Non-critical | Contact with intact skin | Clean as necessary with detergent and water |   Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices, 5th edition  Our team members responsible for reprocessing reusable instruments and equipment follow these procedures during the pre-cleaning/cleaning process:  **Storage of sterile items** **Policy**  All sterile items, including those processed in the practice facility and those procured from commercial supplies, shall be stored and handled in a manner that maintains the sterility of the packs and prevents contamination from any source.  Factors that influence shelf life are event-related (not time-related) and are dependent on storage and handling conditions.    Procedures  Instruments in our practice are stored:  In a clean, dry and well-ventilated area,  In an area free from draughts,  In an area where there is reduced chance of contamination from dust and water,  with dust covers should items be stored for a long period of time,  In a manner which allows stock rotation, e.g., place recently used items at the back and take from the front, and  With the contents of the package clearly visible to reduce handling of instruments.  Instruments and items used for procedures in other locations such as aged care facilities and home visits are transported to the facility in a separate rigid walled container with a lid labelled sterile items. Care is taken to maintain the sterility of these while transporting to the facility.  Waste and sharps or disposable single-use instruments are disposed of into the appropriate waste stream in accordance with Section 4.20 – Management of waste.  Instruments and items requiring cleaning for reuse are wiped of gross soil at the time of use and placed in a separate rigid walled container with a lid labelled ‘dirty items’. These are cleaned as soon as possible in accordance with Section 4.9 – Cleaning reusable instruments and equipment. This dirty container and items within are managed using standard precautions.  Management of waste  Policy  Clinical and related waste must be handled, stored, packaged, labelled and transported appropriately to minimise the potential for contact with the waste and to reduce the risk to the environment from accidental release.  The RACGP’s Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition) outline policies and procedures that assist our practice to safely manage waste. We are also aware of our local, <select as appropriate> state/territory, and federal regulations that impact on our waste management and ensure that our processes align to the requirements of the Australian Standards AS 3816:2018.  All members of our practice team receive education regarding the management and handling of waste that is appropriate to their role, including the safe use and disposal of sharps (refer to Section – Sharps management), the management of spills (refer to Section – Blood and body-substance spills) and the management of blood and body-substance exposure (refer to Section – Sharps injury management and other body-substance exposure).  Our waste policies include:   * Use of standard precautions when handling waste * Segregation of waste into the correct category: ‘clinical and related’ and ‘general’ waste * Safe storage of waste, and * Safe disposal of waste.   Clinical and related waste is waste that has the potential to cause infection or disease, sharps injury or public offence and includes such things as: discarded sharps; human blood, fluids and tissue (excluding hair, teeth, nails, urine and faeces); waste from patients known to have (or suspected of having) an epidemiologically significant communicable disease or being colonised/infected with an antibiotic resistant organism; material that contains free flowing or expressible blood; and pharmaceutical, chemical or cytotoxic waste.  General waste is any waste that does not fall into the ‘clinical and related’ waste category and includes: office waste; kitchen waste; urine, faeces, teeth, hair and nails; disposable nappies; used tongue depressors; non-hazardous pharmaceutical waste (e.g., out of date saline); items contaminated with blood or body-substances (though not to such an extent that it would be considered clinical waste, i.e. not contaminated with ‘expressible blood’).  Procedure  All members of the practice team use appropriate personal protective equipment when handling waste including, at a minimum, wearing gloves. Clinical and related waste is only removed by trained practice team members, and waste, whether general or clinical and related, is not compressed by hand.  Our practice’s waste management procedures include sharps disposal. Our sharps containers and designated biohazard and cytotoxic bins are located in each area where the applicable waste is generated, and are emptied at the end of each day or when full.  <Insert name/position title of the person with designated responsibility> is delegated responsibility to ensure adequate stock levels of our waste containers are maintained and collection schedules are timely.  All clinical waste containers in our practice (with the exception of sharps containers - refer to Section – Sharps management):   * Are yellow in colour and lined with a yellow clinical waste bag * Are labelled ‘clinical waste’ and display the biohazard symbol * Have rigid walls * Are sealable with a secure lid * Are easy handled and have hands-free operation, and * Are positioned so as to be inaccessible to the public and particularly out of the reach of children.   While awaiting collection, our clinical waste is stored securely inside a locked yellow biohazard identified bin in an area that is separate from clean stores and with restricted access. Collection of our clinical waste is made only by a licensed transport and disposal company, and our practice contracts the services of <insert name of clinical waste disposal company> to achieve this. The clinical waste bins are collected every <insert frequency of clinical waste collection> and final disposal of our clinical waste is by special burial or high temperature incineration, depending on the category of the clinical waste as determined by the contents (which can vary from time to time).  All cytotoxic waste containers in our practice:   * Are purple in colour and lined with a purple cytotoxic waste bag * Are labelled ‘cytotoxic waste’ and display the cytotoxic symbol * Have rigid walls * Are sealable with a secure lid * Are easy handled and have hands-free operation, and * Are positioned so as to be inaccessible to the public and particularly out of the reach of children.   While awaiting collection, our cytotoxic waste is stored securely inside a locked purple cytotoxic identified bin in an area that is separate from clean stores and with restricted access. Collection of our cytotoxic waste is made only by a licensed transport and disposal company, and our practice contracts the services of <insert name of cytotoxic waste disposal company> to achieve this. The cytotoxic waste bins are collected every <insert frequency of cytotoxic waste collection> and final disposal of our cytotoxic waste is by high temperature incineration.  Hazardous and toxic waste, such as formaldehyde and glutaraldehyde, must be treated appropriately before being disposed of in landfill. Some chemicals are suitable for incineration, while others will need to be neutralised or fixed so that they cannot leach into the environment. <Insert name of hazardous and toxic waste disposal company>, an approved regulated waste treatment company, is engaged to perform these services and collection is arranged as required.  All general waste produced in our practice is segregated at the point of use into recyclable, non-recyclable and shred-only waste according to local council regulations, privacy and confidentiality requirements. Waste contaminated with blood or body-substance (that is not considered clinical waste) is placed into a bin, lined with a bag which is positioned so as to be inaccessible to the public and particularly out of the reach of children. The final disposal of this waste is made into the normal council waste collection bins. Waste containing sensitive information is shredded and disposed of in accordance with our privacy and confidentiality protocols.    Sharps management Policy  Our practice makes every attempt to minimise the risk of injury to the practice team and patients, and to prevent the possible transmission of disease by discarded sharps.  Sharps represent the major cause of accidents involving potential exposure to blood-borne diseases. All sharp items contaminated with blood and body-substance is regarded as a source of potential infection. Safe handling and disposal of sharps is essential to protect the operator and other team members from injury and possible transmission of disease. Sharps may be defined as any object or device that could cause a penetrative injury.  Consideration is given to the use of devices that significantly reduce the risk of sharps injury.  The member of the practice team who generates or uses a sharp is responsible for the safe use and disposal of that sharp; this responsibility cannot be delegated.  Our practice is responsible to ensure all members of the practice team are familiar with the practice’s policy and procedure for the safe handling and disposal of sharps and that they are also familiar with the actions to take in the event of a sharps injury (refer to Section 3.3 – Sharps injury management and other body-substance exposure).    **Procedures**  Sharps disposal containers are placed in all areas where sharps are generated. Where possible they are located between hip and shoulder height.  All sharps containers in our practice:   * Comply with Australian Standards AS 4031-1992, * Are positioned so as to be inaccessible to children, * Cannot be knocked over, * Are located so that the neck is clearly visible to health professionals when disposing of items, * Have scalpel blade removers securely mounted to the walls, and * Are closed and replaced when the full indicator is reached.   The following procedures are undertaken when disposing of sharps:  The person using the sharp is responsible for its safe disposal,  Sharps are preferably disposed of immediately, but must be disposed of at the end of the procedure being performed,  Used sharps must not be carried about unnecessarily,  Injection trays must be used to transport the needle and syringe to and from the patient,  Needles and syringes must be disposed of as one unit,  Needles must not be recapped,  Needles must not be bent or broken prior to disposal,  Containers must not be overfilled as injuries can occur whilst trying to force the sharp into an overfilled container – close container securely when at the fill line,  The lid must be securely closed once the contents reach the fill line,  Sharps containers must not be placed on the floor or in areas where unauthorised access or injury to children can occur,  Sharps containers must not be placed directly over other waste or linen receptacles, and  Assistance must be obtained when taking blood or giving injections to an uncooperative patient or to a child.  While awaiting collection, sharps containers are never reopened and are stored with and managed as clinical waste (refer to Section 4.20 – Management of waste), ready for collection by <insert name of clinical waste disposal company>.  Our practice assumes an active role in reducing the possibilities for sharps injury by purchasing safe equipment whenever such an option is available, without compromising the quality and safety of patient care. Examples include:   * Self-retracting single-use lancets for blood glucose testing, * Self-retracting cannula insertion devices and needleless IV administration systems, * Vacuum blood collection tubes, * Scalpel blade removal devices, and * Plastic ampoules.     Standard precautions Policy  Standard precautions must be taken by all practice team members involved in patient care or who may have contact with blood or body-substances (including secretions and excretions but excluding sweat) regardless of the known or perceived infection status of the patient. The blood and body-substances of all patients must be considered potentially infectious at all times.  Standard precautions are work practices that are used consistently to achieve a basic level of infection prevention and control in all healthcare settings and all situations.  Standard precautions are designed to protect both patients and the members of the practice team, and comprise the following measures:   * Hand hygiene, * Use of appropriate personal protective equipment, for example, heavy duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers, * Respiratory hygiene and cough etiquette, * Use of aseptic technique to reduce patient exposure to microorganisms, * Safe management of sharps and waste,   Appropriate immunisation of all general practitioners, clinical and healthcare professionals and administrative staff,  Effective reprocessing of reusable equipment and instruments,  Environmental controls such as design and maintenance, cleaning and spills management, and  Support services such as waste disposal, laundry and cleaning services.  The RACGP’s Infection prevention and control standards for general practice and other office-based and community-based practices (5th edition) recommends the use of heavy-duty protective gloves, gowns, plastic aprons, masks, eye protection or other protective barriers when cleaning, performing procedures, dealing with spills or handling waste.    Procedures  All staff involved in patient care or who may have contact with blood or body-substances are required to understand and use standard precautions when they are likely to be in contact with:   * Blood, * Body-substances including secretions and excretions (but excluding sweat), * Non-intact skin, and * Mucous membranes.     Transmission-based precautions Policy  Transmission-based precautions are measures used in addition to standard precautions when extra barriers are required to prevent transmission of specific infectious diseases. Transmission-based precautions are used for patients known or suspected to be infected with highly transmissible pathogens.  Our practice team members are educated in how to triage and apply transmission-based precautions for patients known or suspected with a potential communicable disease.  Transmission-based precautions require:   * Isolation of the infectious source to prevent transmission of the infectious agent to susceptible people in the healthcare setting, and * A means for alerting people entering an isolation area of the need to wear particular items to prevent disease transmission.   There are three (3) transmission-based precautions categories based on routes of infection transmission in a healthcare environment. These are:   1. Contact precautions, 2. Droplet precautions, and 3. Airborne precautions.     Procedures  Transmission-based precautions are used for patients known or suspected to be infected with highly transmissible pathogens (e.g., influenza or other novel viruses such as coronavirus).  In general, it our practice’s main goal to minimise exposure to others. This may be achieved through:  The use of personal protective equipment,  Distancing techniques (e.g., one and a half (1.5) metres between patients in the waiting room, isolating the patient in a separate room or in their car),  Effective triage and appointment scheduling, including advancing these patients ahead of others,  Hand hygiene,  Encouraging cough etiquette and respiratory hygiene,  Surface cleaning, and  By avoiding touch to one’s own nose and mouth.  To help prevent the transmission of communicable diseases, our patients are educated in respiratory etiquette, hand hygiene, our practice precautionary techniques (e.g., telephoning reception first if they suspect they may have influenza or coronavirus), and our distancing techniques by displaying posters and information leaflets in the waiting room and through our recorded ‘on hold’ message.  Where an emergency response is declared with a pandemic outbreak, whether globally, nationally or locally, our practice will follow the advice of the <select where appropriate> state/territory government or health department and/or federal government in relation to the appropriate personal protective equipment respective to that pandemic situation.  To determine the appropriate personal protective equipment to be used where transmission-based precautions are required in situations less significant to that of a novel virus such as influenza, our practice follows the guidelines as described in the RACGP’s Infection prevention and control standards for general practice and other office-based and community-based practices (5th edition).   |  |  |  |  | | --- | --- | --- | --- | | Requirement | Airborne transmission | Droplet transmission | Contact transmission | | Gloves | No | No | For all manual contact with patient, associated devices and environmental surfaces | | Impermeable gown, apron | No | No | Use when health professional’s clothes are in substantial contact with the patient (including items in contact with the patient and their immediate environment) | | Mask | Yes | Yes | Protect face if splash is likely | | Goggles/face shield | Protect face if splash is likely | Protect face if splash is likely | Protect face if splash is likely | | Special handling of equipment | Single use equipment or reprocess after patient use (includes all equipment in contact with patient) | No | Single use equipment or reprocess after patient use (includes all equipment in contact with patient) | | Other | Encourage patient to use respiratory etiquette  Segregate patient if possible  Give patient a mask to wear if segregation is not possible  Communicate the patient’s infectious status to other practitioners and health professionals involved in the case of the patient (e.g., ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained | Encourage patient to use respiratory etiquette  Segregate patient if possible  Give patient a mask to wear if segregation is not possible  Communicate the patient’s infectious status to other practitioners and health professionals involved in the case of the patient (e.g., ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained | Encourage patient to use respiratory etiquette  Wash hands after removing gloves and gowns  Communicate the patient’s infectious status to other practitioners and health professionals involved in the case of the patient (e.g., ambulance and emergency department staff if transferred to another healthcare facility) so that appropriate transmission-based precautions can be maintained |   Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)    Personal protective equipment Policy  Our practice has personal protective equipment available, including gloves, gowns, aprons, masks, goggles, and face shields.  All members of our practice team have easy access to this personal protective equipment, receive education about the proper use of personal protective equipment, and have a clear understanding of the purpose of personal protective equipment and how to apply, remove and dispose of it.  Procedure  All members of our practice team have easy access to appropriate personal protective equipment; and in the areas where personal protective equipment is used, there are posters providing education on the appropriate application, removal and disposal of the items.  Personal protective equipment is located <insert the location of personal protective equipment>, and the maintenance and re-ordering of the items is the responsibility of <insert name/role of the person with primary responsibility for stock control of the personal protective equipment>.  Personal protective equipment is used in all cases where there is potential for contact with blood or body-substances including:   * Any examinations requiring contact with mucous membranes, * Cleaning or dressing wounds, taking down bandages, * Cleaning up after procedures, * Preparing instruments and equipment for sterilisation, * Assisting with or performing procedures, * Cleaning of contaminated surfaces, * Cleaning spills of blood and body-substances, * Taking blood, * Handling all pathology specimens, and * Controlling bleeding.   Personal protective equipment is also used when handling chemicals such as liquid nitrogen.  Our practice ensures and documents that all members of the practice team receive education during their induction period and on an ongoing basis. This training focuses on the appropriate use of the various types of personal protective equipment and where to access this equipment.  Personal protective equipment includes:   * Gloves (sterile, non-sterile, general purpose utility, heavy duty puncture-resistant), * Face masks (surgical and P2/N95 respirators), * Goggles and face shields, * Gowns (long and short sleeved, cuffed, disposable, reusable), and * Plastic aprons.   All members of our practice team understand and are competent in:   * Determining the appropriate use and selecting the correct type of personal protective equipment for the presenting situation, * Explaining the purpose of the different types of personal protective equipment, and * Demonstrating the correct fitting and removal of personal protective equipment and the safe disposal of these items.   Disposable gloves should be used:   * When handling blood and body-substances or when contact with such is likely, * When handling equipment or surfaces contaminated with such substances, * During contact with non-intact skin, and * During venepuncture – although needle stick injury may still occur, the presence of the glove layer could reduce the volume of any inoculum.   Sterile gloves should be used:   * During any surgical procedure involving penetration of the skin or mucous membrane and/or other tissue, * When venepuncture is performed for the purpose of collecting blood for culture, and * During procedures that require a sterile field.   Heavy duty gloves should be used:   * During general cleaning and disinfection, * During instrument processing, and * During cleaning of blood or body-substance spills.   Surgical masks can be used:   * During procedures or activities that might result in splashing and the generation of droplets of blood, body-substances or bone fragments, * When there is a risk of droplet transmission of disease, * To protect unimmunised members of the practice team and patients, and * By the patient to prevent the spread of disease (suspected or known).   P2/N95 masks are to be worn by staff when there is a risk of airborne transmission of diseases (suspected or known) such as tuberculosis, pandemic influenza or coronavirus.  Protective eyewear should be used:   * To prevent splashing or spraying of blood and body-substances into the wearer’s eyes such as during surgical procedures, venepuncture, or the cleaning of spills, contaminated areas or instruments, and * When there is a risk of airborne/droplet transmission of disease (suspected or known).   Gowns and plastic aprons should be used when there is a risk of:   * Contamination of wearer’s clothing or skin with blood and body-substances such as during surgical procedures, venepuncture, or the cleaning of spills, contaminated areas or instrument processing, and * Airborne/droplet transmission of disease (suspected or known).     Laundry Policy  All members of our practice team have received education regarding the management of soiled linen including when to change linen, <keep the following if applicable> washing and drying of linen, storage of linen, and the use of appropriate precautions during the handling of linen.    Procedures  Linen needs to be changed if:   * A patient requires the use of contact precautions (e.g., known or suspected of having CA-MRSA, scabies or lice), * Blood or body-substance has been spilt on the linen, * It is visibly soiled, and * Before an operative procedure.   When changing linen:  Staff use personal protective equipment and standard precautions as required, and  Take care to ensure sharps are not caught up in the linen.  Clean linen is located <insert location> in a clean, dry and dust free location that is away from dirty linen and other items.  <Select from the following options to best describe your practice’s linen, and delete the options that are not applicable to your practice>  <Option 1 – disposable linen>  This practice uses only disposable linen on all examination beds and patient treatment areas. Linen is changed regularly and, provided it does not contain expressible blood or body-substance, is disposed of into the general waste bin. Any linen that is contaminated with expressible blood or body-substance is disposed of into the clinical waste bin.  <Option 1 – laundered and reused linen >  Used linen is stored in a covered, lined container which is located away from clean items in the <insert location of used linen> before laundering.  Any linen that is contaminated with blood or body-substance is collected in a plastic bag before being placed in the used linen receptacle and rinsed in cold water with oxygenated stain removal at the earliest opportunity.  All linen is transported in a leak proof container and a separate clean container or basket is used to return laundered linen to the practice.  <If laundered by the practice> Linen is washed in a washing machine on a hot or cold cycle using activated oxygen-based laundry detergent and dried in a clothes dryer.  <If laundered under contract arrangement> Our practice’s laundering is contracted out to a commercial laundry service and a copy of the service agreement is maintained.    Safe handling of pathology specimens Policy  Laboratory investigation of specimens is integral to clinical care. Specimen collection involves the sampling of various body sites for laboratory examination which will allow for the detection and identification of micro–organisms that cause disease and, if appropriate, to determine their antibiotic sensitivity.  The quality of the specimen received in the laboratory can have a major impact on the subsequent microbiological and clinical diagnosis. Valid results rely on the specimen being of the required quantity, collected correctly and transported appropriately to the laboratory.  False results may occur if specimens are kept for prolonged periods before examination in the laboratory, as some organisms may outgrow others, whilst other delicate organisms may not survive. False results may also occur if specimens are not stored at the correct temperature.  As all specimens may contain microorganisms capable of causing disease, care must be taken to ensure that they are handled and transported in a safe manner. Although the processes of obtaining patient specimens and transporting these to the laboratory are considered to be routine practice, they are not without risk. Transmission of infection to a healthcare worker may arise from suboptimal practice.    Procedures  Our practice’s procedures associated with the handling of pathology specimens is as follows:   * Containers are named and labelled before use to avoid the need for extensive handling after the specimen has been collected, * After collection of blood and body-substances, these are to be placed in the appropriate specimen container, as specified by the testing laboratory, * Wipe the container clean to remove any visible soiling and check the specimen is correctly identified, * Securely seal the container to prevent any leakage during transport, * Place the container upright in a waterproof bag or container, * Take care to avoid contamination of pathology slips by keeping them separate from the clinical specimens, * For transport between institutions and interstate, pack the primary specimen surrounded by sufficient material to absorb its contents in a sealable inner container and provide a sealable outer container of waterproof, robust material before labelling in accordance with postal and other transport regulations, and * Maintain any specimen to the temperature required to not compromise the laboratory investigation. | |
| **Response to pandemic outbreaks Policy**  A pandemic is an epidemic that occurs globally or over a widespread area, crossing international boundaries. A pandemic or public health emergency poses an imminent threat to human health as the present disease is contagious, meaning that it can be transmitted directly or indirectly by an infectious or toxic agent between sources. For a communicable disease to be considered as a pandemic, there must be little or no pre-existing immunity in humans; it must lead to illness, and it must have the capability to spread easily from source to source.  Pandemics are often, but not always, caused by influenza viruses. For the intent of the guidelines in the below procedures, the public health emergency shall be taken as contagious and posing a significant risk to human health, such as influenza or other novel viruses. These unexpected events require a quick, educated and efficient response from the practice team to minimise and eliminate risk where possible (also refer to Section 8.2 – Risk assessment and management)  During a pandemic, there is an increased demand for healthcare services and they are often working beyond capacity. It is critical that our practice can continue to operate during this time, where appropriate.  Our practice has appointed a member of the practice team with primary responsibility for managing and executing our pandemic response plan and sufficient training has been provided.  <insert organisation name>’s response to the emergency will prioritise to the greatest extent possible, the health and safety of the organisation’s practice team and the general public.    Procedures  Our practice has appointed <insert name and position title> with primary responsibility for managing and executing our pandemic response plan and sufficient training has been provided.  Our practice’s Emergency Response Business Continuity Plan is located <insert location of your practice’s documented emergency response plan> and details what measures the practice team should take to reduce risk and maintain the safety and wellbeing of team members and the public. It also details the best course of action for continuing practice’s operations, when appropriate, and the guidelines for the closure of the practice, if necessary. All practice team members are trained <insert time frame e.g., annually> in our practice’s pandemic response procedures.  In the event of a pandemic, our practice may experience illness of practice team members or immediate family, or the requirement of practice team members to isolate or self-quarantine. Personal issues may arise for team members, such as the need to care for children in the absence of childcare, or caring for ill family members. Other extenuating circumstances may arise, these can include but are not limited to practice team members suffering from mental anguish or autoimmune diseases, affecting their ability to be present in the practice.  All of the above may result in unplanned absences of clinical team members and as often there is an increased demand for healthcare during a pandemic, this may have an effect on the practices’ ability to provide quality patient care.  In order to combat the effects of a pandemic, whilst ensuring team and patient safety, we try to prevent and minimise the spread, prepare for the impact and respond to the effects.  Preventing the spread  Preventing the surfacing of a novel virus is almost impossible; however, it is possible to limit the spread of the disease by taking rigorous precautionary measures. The control measures taken at ACSEM to limit the spread of viruses and diseases in the event of a pandemic are as follows:  All practice staff members and patients/visitors, where appropriate, are provided with adequate personal protective equipment. This includes gowns, gloves, goggles and face masks/N95 respirators. All personal protective equipment is disposable, where possible, as viruses can remain infectious on surfaces for periods of time.  Hand hygiene is a key standard for limiting the spread of infection year-round, and adequate hand hygiene is practiced and encouraged at all times. Staff wash their hands with warm soapy water on a regular basis and employ the use of hand sanitiser where appropriate.  It is important to have communication with those experiencing symptoms of the occurring virus. <insert measures taken by your practice e.g., We implement a recorded telephone message with advice for patients experiencing symptoms and erect signs on our front entrance to advise patients who are experiencing symptoms to return to their car and call the surgery for further advice.>  We limit the number of patients in the practice at any one time to <insert the number of patients that can safely be present in the practice whilst maintaining social distancing>. This ensures that patients can appropriately maintain social distancing. We encourage this by rearranging furniture, mapping out adequate spacing for patients waiting in queues, having strict appointment slots and encouraging patients to come to appointments alone, where possible.  <insert if appropriate: We have installed clear Perspex screens at our reception area in order to create a protective barrier for reception staff who are in close proximity to multiple patients a day.>  We have an increased cleaning schedule, including the repeat cleaning of door handles, <lift buttons> and hard surfaces. We also perform a thorough clean and disinfection of the practice teamwork area between shift rotations and hand sanitiser is readily available for all practice team members and patients entering the practice. (also refer to Section – Hand washing and hand hygiene).  There is no hand-shaking or unnecessary touching between team members and patients and the sharing of personal items is limited, where possible e.g., telephones, stationery.  All children’s toys are removed from the waiting area and patients are encouraged to stand instead of sitting on chairs, where appropriate.  There are temperature checks of patients and staff entering the building.  Unwell practice team members  Due to the nature of healthcare, it is not uncommon for employees to become unwell at work. If this situation occurs, its management is imperative. Our procedures for this are as follows:  If an employee presents unwell or is showing signs of the symptoms of the virus, they are isolated from others and provided with personal protective equipment, including a disposable surgical type mask.  They are seen by a medical practitioner in the first instance, then arrangements made for their transportation either to a hospital or to their home - public transport will not be an option.  A record and contact details are kept of all personnel who become ill and leave the workplace and the people they have had contact with.  Once the suspected infected person has vacated the premises, their work area and communal areas are thoroughly cleaned and disinfected.  Unwell personnel cannot return to work until they have received approval by a medical professional or a negative test result.  Preparing for the impact  Planning and preparation in advance of a pandemic is likely to significantly reduce the number of people affected. Being prepared and having a plan to implement appropriate measures when a pandemic occurs not only improves the health outcomes of those affected but can help to protect essential services including the practice and critical infrastructure.  These are the measures that we implement to reduce the effects of a pandemic:   * The minimum staffing levels required to operate the practice is <insert the staffing levels required e.g., 2 GPs, 2 nurses and 1 receptionist>. We also analyse the composition of the workforce e.g., how many might be parents or have other caring responsibilities and have adequate procedures in place for unexpected absences including <insert practice procedures for unexpected absences, e.g., connections with casual staff that can be drawn on in an emergency>. * At all times the practice is appropriately stocked with clinical and non-clinical supplies and ordering of extra essential supplies. Personal protective equipment is purchased when required and stock levels are maintained. * Minor, non-urgent appointments are postponed in order to limit the number of people attending the practice. * Telephone and video conferencing appointments are offered in the first instance where appropriate, as this significantly reduces the number of people attending the practice and minimises the risk of spreading infections/viruses (also refer to Section 7.23 – Telehealth). * Communication is key in the midst of a pandemic, and we effectively keep in touch with our patients as well as other organisations, updating them with any relevant, critical information. We communicate with stakeholders by <insert means of communication taken by the practice, e.g., touching base with our patients via email communications, sending them updates about the practice, opening hours and services available>. * We have informative posters placed in the practice advising patients of relevant precautions and steps to take, including <insert examples of posters which can be displayed in the practice during a pandemic e.g., on our practice door we have displayed a poster which advises patients with any of the listed symptoms to remain outside the practice and call for further instructions. We also have posters to remind patients and staff in the practice to maintain social distancing requirements, and a sign advising of the nearest testing facility.> * The use of our air conditioning system is avoided. We keep the practice well ventilated by increasing outdoor air intake. * We hold daily practice team meetings, providing team members with regular updates and briefings on any procedural changes. * All team members are extensively vetted in regard to working from home arrangements, and a thorough work health and safety assessment will be conducted before commencing such, ensuring the respective team members have an appropriate and safe workspace that allows them to perform their duties comfortably. * We have a database in which all team members’ home telephone numbers and email addresses are stored. This information is treated with high sensitivity and is only to be used in complete emergencies if the team member is uncontactable using usual work methods e.g., work email address, work telephone number. All team members are able to opt out of having these details stored on the pandemic plan contacts list. * All employee vaccinations are up to date and appropriate seasonal vaccinations are offered to all staff in order to reduce the transmission of infectious diseases, limiting the risk of staff falling unwell. * All practice team members have been appropriately trained in our pandemic response plan.   Respond to effects/recovery  As the pandemic subsides, there is a planned recovery phase to assist in normalising services and getting work activities back on track. In order to fully recover from the pandemic, consideration is given to the restoration of social, economic, physical and emotional wellbeing. Actions required during this stage will be dependent on the impact that occurred on the usual operations of the practice. Any control measures implemented should be loosened in accordance with the threat of the virus and broader public health measures.  In order to recover from the pandemic strategically and effectively, a pandemic recovery team should be established. The pandemic recovery team will be responsible for the development and coordination of the practice’s recovery plan.  In our practice, the membership of the pandemic recovery team consists of the <insert roles here, e.g., practice owners, GP Principal, and the practice manager>. Team responsibilities consist of:   * Keeping up to date with the evolving situation and determining the impact this may have on the practice, as well as the implementation and the safe removal of control measures. * Reporting to senior staff members regularly on the effects on the practice and stages as well as the effectiveness of recovery. * Ensuring that any affected practice staff condition is assessed regularly, determining when it is safe for them to return to work, and when working from home/leave arrangements should be continued. * Tracking the status of practice staff who have become unwell and alerting those who they have been in contact with. * Touching base with the clinical and administration teams regularly to monitor any loss of staff, the impact this has had on the team and arranging for stand in team members where possible. * Determining the stages of the recovery plan, the continued duration of the plan, and when the plan is no longer required. * <insert any further responsibilities of your pandemic response team>   The pandemic recovery team will also take into consideration existing business continuity plans (also refer to Section – Non-medical emergency response and business continuity).  Pandemic Response Analysis  From the impact of a pandemic, it is important to assess and analyse the response measures that were taken and determine what worked well and how things can be improved if the situation were to occur again.  Evaluations of the weaknesses that occurred when handling the situation are crucial for determining improvements and minimising risk in the future. It is also critical to capture any strengths from the practice response and effective control measures as they may be permanently implemented into daily operations of the practice.  When reviewing the practice recovery systems and their ability to combat the impacts of the pandemic, the following is considered:   * Key lessons learned, * Key strengths of response to the pandemic, * Key weaknesses of response to the pandemic, * Changes needed to improve the practice pandemic response, * Updates required for business continuity plan in response to implemented changes, and * <insert any further considerations relevant to your practice>   Support for Practice Team Members  Working in healthcare may produce anxiety among staff during a pandemic. We have control measures in place including <insert control measures implemented in the practice e.g., promoting a supportive work environment, providing practice team members with up to date, relevant critical information in regards to developments on the virus and other protective measures that have been taken in the work place>.  During the midst of a pandemic, practice team members may experience unfamiliar work and increased workloads. In an effort to reduce stress in these circumstances, our practice sets clear performance expectations and promotes a supportive team environment, setting daily goals. We also closely monitor and supervise each practice team member with the employee assistance programs available, as required.  It is also common that some practice team members experience psychological strain due to fatigue and insomnia. At our practice, we support our practice team members by:  Advising all team members that their health and wellbeing is our priority.  Where possible, we allow practice team members to work from home in an effort to reduce the potential for their exposure to an infectious person.  Giving up to date, accurate information to all team members on decisions or changes in processes, including the control measures being implemented.  Offering counselling and support to all staff members that have been affected, physically, mentally or those who have experienced a loss due to the pandemic.  Encouraging all team members to create a self-care plan and supporting them in this development (also refer to Section 3.7 – Self-care).  When working from home, hosting daily catch-ups via video calls to keep visually connected.  Providing advice from credible sources.  <insert any further measures taken in the practice to support employees> | |
| **Non-medical emergency response and business continuity Policy**  Non-medical emergencies may occur that will require a quick, informed and effective response from our practice team.  Types of non-medical emergencies include: failure of electricity supply, telephone or water; fire or false fire alarm; property damage; break-in; abusive or threatening telephone calls or persons at the practice; leakage of toxic chemicals; or bomb threats and letter bombs.  It is important that our practice has contingency plans for unexpected events such as natural disasters, national or local infection outbreaks or the sudden, unexpected absence of clinical team members or computer system failures (also refer to Section 4.27 – Response to Pandemic Outbreaks, Section 8.2 – Risk assessment and management and Section 6.2 – Computer information security).  In an emergency, especially one such as a pandemic, the demand for healthcare services generally increases, so it is crucial that our practice can continue to provide services during this time, if appropriate.  As unplanned absence of clinical team members can affect our practice’s ability to provide quality patient care, we consider succession planning, and encourage the practice team to share their skills and knowledge among other members.  We have mechanisms in place to ensure the timely acquisition and dissemination of information (including regular updates) about alerts, emerging diseases, local disasters or emergencies.  The practice has appointed <insert person’s name and position title> with primary responsibility for managing and executing our practice’s non-medical emergency response and business continuity plan. Specific areas of responsibility can be delegated to other nominated members of the practice team and these responsibilities, where allocated, are documented in the relevant position descriptions.  Procedures  Our practice’s Emergency Response Business Continuity Plan is located <insert where to find your practice’s documented emergency response and business continuity plan> and details what the practice team could do to re-establish our practice’s operations, when appropriate, if our practice needs to close due to an emergency.  The purpose of the Emergency Response Business Continuity Plan is to formalise emergency procedures, including fire safety precautions within the practice, so that those who are required to take actions related to the protection of life and property have a reference and a basis for their decisions and actions.  All members of the emergency response team are familiar with the procedures in the manual and are able to carry them out in times of emergency.  In an emergency, our practice may experience the following:  Patients:  Increased demand for services.  Disruption to the normal health system functioning (e.g.,, inability to transfer patients to hospital).  Infrastructure and systems:  Minor or significant damage to the practice’s infrastructure.  Loss of access to vital information.  Loss of access to essential systems, networks, and communication.  Reduced capacity or loss of key members of the practice team.  Supplies and services:  Loss of critical equipment and supplies.  Loss of or disruption to power supply.  Loss of or contamination to water supply.  To help reduce the impact of an emergency, our practice undertakes appropriate emergency planning and preparation, and frequently identifies, reviews, and updates the actions that need to be completed before and during an emergency. These actions include:   * Having a documented emergency response plan, * Appointing an emergency management coordinator, * Undertaking research to identify, for example, local emergency services, the local geography, and previous events that have affected the community, * Providing the practice team with education and training that will help them effectively prepare for and respond to emergencies, * Testing components of the emergency response plan (e.g.,, evacuation drills) once a year, * Reviewing, monitoring and updating the emergency response plan every six (6) months, and * Keeping the emergency kit fully stocked.   Our practice’s emergency response plan contains:   * How to communicate with patients and other services, * Contact details of all members of the practice team, * Contact details for response agencies and other health services, * Details about the practice such as accounts, service providers (e.g.,, insurers, lawyers, and providers of telephone, internet, and utilities) and insurance policy numbers, * How the practice will triage and run clinical sessions during an emergency, * Details of equipment needed to continue to operate in an emergency, and * How to manage unplanned absenteeism of multiple practice team members. | |
| Home and other visits Policy  Where safe and reasonable, our practice makes visits to regular practice patients in their homes, aged or residential care facilities, or in hospitals within and outside of normal working hours. Our practice has decided upon a reasonable distance within which visits can be conducted.  Home and other visits are provided by appropriately qualified health professionals who have received information and advice about safety and security when conducting off-site visits.  Procedures  A patient can arrange for a home or other visit or a practitioner may request to see a patient in their place of residence if the following criteria are met:   * The patient is a regular patient of this practice, * The patient resides in a location that is within <insert pre-determined kilometre radius> of the practice, * Where it is safe and reasonable, * The practice has the correct contact details for the patient on file, and * The patient has the type of problem that necessitates a home visit such as: * Acutely ill * Immobile * Elderly * No means of transport * Unable to access the practice facilities due to disability * <insert any other criteria set by the practice>.   All practitioners and other healthcare professionals undertaking home or other visits are given information and advice about protecting their safety.  There may be occasions where it is unsafe or unreasonable to provide a patient requesting care at home with a home visit; this may apply after-hours or within opening hours. Our practice advises the following options <insert the alternate system of care that these patients can access in your area, e.g., name, telephone number and location of the nearest emergency department of the local hospital>. This advice is documented in the patient’s health record. | |
| Smoking, drugs & alcohol Policy  As a healthcare provider, our aim is to promote the health and wellbeing of all members of the practice team, patients and others whilst on our premises. Smoking is therefore not permitted in this practice and is discouraged on the premises or the surrounding area. The use of illegal drugs and alcohol is prohibited on and around the site.  No member of the practice team should present for work if under the adverse effects of alcohol or illegal drugs.    Procedures  Practice team members who are smokers should make an effort to remove any nicotine odour on or about clothing and self, prior to returning to duty.  No smoking signs are visible in the waiting and reception area and these signs are not to be removed, except to replace worn or frayed items.  Brochures and posters for ‘QUIT’ and related no smoking and drug free strategies are placed in the waiting room and visibly displayed to demonstrate our commitment to better health strategies. | |
| **Health and Wellbeing Policy**  This practice is committed to providing and maintaining a safe and healthy workplace for general practitioners, staff, patients and all other visitors. This includes psychological as well as physical health.  Health and wellbeing are an integral part of every activity we perform, and as such, the health and wellbeing of general practitioners and practice team members is a priority of this practice.  Our practice has implemented strategies to ensure current information on programs and support services available to the practice team are readily available to help them identify and manage any pressures and stressors.  We recognise that regular breaks for general practitioners during consulting times can reduce fatigue as well as enhance the quality of patient care.  Procedure  Regular breaks are scheduled for all practice team members, including general practitioners.  When a work break has been organised; where possible, a relieving member of the practice team will complete the workload of the absent team member, in addition to their own workload.  Strategies are implemented to manage workflow whenever a general practitioner or other team member is unexpectedly absent, or scheduled for leave. Unplanned leave will be covered by existing practice team members or by agency or locum staff as required (also refer to Section - Non-medical emergency response and business continuity).  To promote a healthy work environment, employed team members are encouraged to take leave when the balance of accrued leave is in excess of 20 days.  Current information on programs and support services is available to the practice team, including general practitioners.  Occasionally, our practice team may be confronted by stressful incidents or situations, including assisting with emergencies. The practice provides emotional debriefing and/or counselling in these situations as soon as practicable after the incident has occurred.  Ergonomics  Hands on treatments  Office equipment  **Self-Care**  Our practice promotes, and is committed to, the health and wellbeing of all practice team members and embeds self-care within our culture.  Due to the work undertaken in primary healthcare, it is essential for all practice team members to actively look after their mental health and physical wellbeing in order to meet personal, relationship and professional commitments.  Self-care refers to activities that preserve and maintain one’s physical, emotional and mental health. It is an ongoing commitment to look after oneself through helpful behaviours that protect one’s health during periods of stress. In order to achieve the best effects, self-care must be practiced throughout everyday life. Self-care correlates with what an individual does at work and outside of work to look after their wellbeing. It includes many activities, such as eating well, getting enough sleep, celebrating wins, learning a new skill or partaking in exercise.  How individuals respond to stress will be different. There may be instances in the practice that challenge our ability to cope. Practicing self-care is an important part of professional development, and by putting one’s health and wellbeing first, we can, more effectively, provide the best care and support to patients.  Procedure  Self-care is a personal matter, and everyone’s approach will be different. Listed below are different aspects of self-care and strategies that we engage in as a team and promote within our practice.  Workplace/professional self-care  Within our practice, we participate in/encourage our practice team to:  <insert workplace self-care methods used within your practice>  <E.g., engage in regular consulting with other staff members/managers>  <E.g., participate in a peer-support group>  <E.g., take regular breaks/lunch breaks away from the desk>  <E.g., eat a nourishing lunch and drink plenty water throughout the day>  <E.g., maintain a work-life balance, using annual leave spread out throughout the year>  <E.g., attend professional development programs>  <E.g., schedule work days and be realistic with what can be achieved>  <E.g., celebrate wins with other team members>  <E.g., create a work self-care plan and encourage other team members to do the same>  Physical self-care  We encourage our practice team to:  <insert physical activities that your practice encourages staff to partake in>  <E.g., develop a regular sleep routine and get between 6-8 hours of sleep each night>  <E.g., aim for a healthy, balanced diet and know what foods work best for your body and health>  <E.g., take regular exercise, for example, gym classes, bike rides, yoga>  <E.g., not be afraid to use sick leave when needed>  <E.g., aim for 10,000 steps per day>  <E.g., develop a personal hygiene routine>  Psychological self-care  We encourage our practice team to:  <insert psychological self-care methods used/encouraged within your practice>  <E.g., keep a reflective journal or reading books/journals/articles that interest them>  <E.g., Partake in extracurricular activities or hobbies>  <E.g., ensure they are taking time for relaxation and even consider a digital detox>  <E.g., have regular contact and spend time with positive friends and family>  <E.g., make time for self-reflection and celebrate wins with others>  <E.g., before they start the work day, write down three things which they want to accomplish that day>  <E.g., ensure to voice any work concerns or stresses to supervisors and managers>  Emotional self-care  We encourage our practice team to:  <insert emotional self-care methods used/encouraged within your practice>  <E.g., create professional boundaries that they are comfortable with>  <E.g., learn to say ‘no’ to things that they are not comfortable with>  <E.g., experience their emotions without judgment, guilt, or embarrassment>  <E.g., turn to other staff members when they are feeling overwhelmed>  <E.g., practice self-compassion>  <E.g., talk to trusted friends/family about how they are coping with work and life demands>  Relationship self-care  We encourage our practice team to:  <insert relationship self-care methods used/encouraged within your practice>  <E.g., arrive to work and leave on time every day>  <E.g., be aware of and respect other staff members’ boundaries and needs>  <E.g., attend the special events of family and friends>  <E.g., Ensure diversification of relationships e.g., friends that are not associated with work>  <E.g., surround themselves and build relationships with people who have a positive impact on them>  <E.g., engage in regular team work, developing listening and communication skills>  Self-care plans for practice team members  We encourage all team members to create an individual self-care plan, starting with assessing which self-care methods they already partake in, then planning improvements to their self-care routine. We supply new team members with a Self-Care Planning Tool upon induction to assist in this process.    Patient aggression and patient-initiated violence Policy  Our practice is responsible for providing a safe working environment; however, patient aggression and patient-initiated violence in healthcare settings can be an issue.  Procedure  To mitigate the risk of patient aggression and patient-initiated violence, our practice has the following strategies in place: <add and amend the following as appropriate>   * A zero tolerance towards violence policy, which is displayed prominently in the reception and waiting area. * A duress alarm system is installed that the practice team can use if a patient is threatening or violent.   Where a patient displays aggression or violence, our general practitioners have the right to discontinue the care of that patient. This includes the practitioner ending the professional relationship during a consultation or by letter or telephone, depending on safety considerations. A record is kept of this process when undertaken, and of any subsequent contact that the patient has with the practice. Our practitioners will, however, provide emergency care to patients whose care has been ceased in accordance with their professional and ethical obligation (refer to Section – Refusal to treat a patient). | |
| Practice facilities Policy  The practice premises comply with relevant building regulations and its facilities and equipment are safe and adequate to meet the needs of the practice team and patients.    Procedures  Every reasonable effort is made to make the environment safe and comfortable for all members of the practice team. The practice has heating and air conditioning to assist in providing comfort.  Our facilities make adequate provision for, and encourage, patient auditory and visual privacy. The physical conditions in our practice support patient privacy and confidentiality. Facilities are well maintained and visibly clean with surfaces accessible for cleaning.  Our practice displays a list of names of the practice’s team members on duty.  Consulting rooms Policy  Our practice has <insert number> dedicated consulting/examination rooms to accommodate every practitioner who would be working at any one time. All areas where consultations or treatments occur are appropriate for the health and safety of general practitioners, other members of the practice team and patients; <amend the following as appropriate> this includes having a height adjustable bed in each consulting/examination room in our practice.    Procedures  Our consulting rooms have sufficient space, are free from excessive extraneous noise and have adequate lighting for observation. The temperature in the consulting rooms is maintained at a comfortable level, particularly for situations that require patients to undress for an examination.  The practice ensures that both visual and auditory privacy is afforded to all patients in examination areas, treatment rooms and consulting rooms. Where patients are required to undress/dress, they are provided with a gown or sheet and the privacy curtain around the examination bed is drawn.  Privacy and confidentiality of patient information is considered at all times, including during telephone conversations between members of the practice team and patients.  Patient personal health information is treated with respect, and letters, forms or notes concerning patients are not readily visible to other patients. Computer screens are positioned to ensure the content on the screens are not visible to patients and visitors, and screensavers are activated.  We maintain adequate infection prevention and control procedures in the consulting and treatment areas, including:   * Cleaning examination beds regularly and as required, * Ensuring linen (including gowns and sheets), curtains and screens are laundered regularly and as required, * Ensuring the consulting and treatment rooms are maintained and visibly clean with surfaces accessible for cleaning, and * Storage areas for sterile/non-sterile items are dust proof and dry.   The security of the practice (and the practice team members) is an important issue and strategies are in place in the event of a breach of security.    Hand washing facilities Policy  Dedicated hand washing facilities with hot and cold water, liquid soap and single-use paper towels are readily available in every clinical management and treatment area, including the consulting rooms.    Procedures  Hand disinfectants designed for use without water, such as alcohol-based hand gels, are available in:   * The doctors’ bags to use when hand washing facilities are inadequate or not available (e.g., home or other visits), * All treatment and examination areas to encourage hand hygiene in addition to hand washing, and * Common areas used by patients and practice team members to encourage hand hygiene.   All new members of the practice team are informed about our hand washing and hand hygiene procedures (refer to Section – Hand washing and hand hygiene) and we provide regular updates and training in infection prevention and control.    Waiting area Policy  Our practice waiting area is fit-for-purpose. The design and layout enables privacy and is sufficient to accommodate the usual number of patients and others who would be waiting at any one time.    Procedures  The safety of patients and visitors is considered when selecting seating, furniture and toys, and the area is kept tidy and clean to maintain a safe environment.  The practice is able to provide appropriate and respectful care for patients and others in distress, i.e., vomiting, upset or in severe pain. Privacy for such patients is provided by allowing them to sit in an unused room, staff room or other designated area, rather than waiting in the general waiting area.  Auditory privacy within the waiting area is enhanced by the use of <amend as appropriate> background music/a television to mask conversations at reception; and privacy and confidentiality of patient personal health information is considered when team members are discussing patients and their health information within the reception area. Computer screens are not readily visible, and screensavers are used.  Our waiting area caters for the specific needs of children with play equipment or toys that are washed regularly. During an infectious outbreak, we remove the play equipment and toys to mitigate the risks of spreading infection.  The waiting room furniture is in good condition, without sharp edges, and the room is maintained in a clean and tidy state with surfaces easily accessible for cleaning.  A range of posters, leaflets or brochures about health issues is available in the waiting room for patients to self-select.    Toilets Policy  Toilet facilities for patients and others are easily accessible and well signposted. To reduce the possible spread of infection and to encourage good hand hygiene, washbasins are provided within each facility.  Procedure  Toilet facilities for patients are located within <amend the following options as appropriate> the practice / very close proximity to the practice, and are easily accessible and well signposted.  Hand washing facilities, including liquid soap and single-use paper towels are readily available for use by patients and visitors within the toilet facilities.  <Amend the following as appropriate> Our practice has separate toilets for staff and patients.  All toilet facilities are well maintained and visibly clean, with surfaces accessible for cleaning, <keep the following if baby change facilitates are available> including the baby change table.    Telecommunication system Policy  Our practice’s telecommunication system facilitates patient access to the practice services and aims to adequately meet the needs of patients and team members. The auditory privacy and confidentiality needs of patients have been considered when locating our telephones and facilities for electronic communication.  Procedure  Our telephone system provides sufficient inward and outward call capacity and has the functionality for electronic communication (either email or facsimile). The practice has <insert number> lines dedicated for telephone calls and <insert number> lines for electronic communication.  It is recognised that the telecommunication needs of the practice may change over time, in-line with staffing changes and growth of the practice. Strategies are in place to monitor, review and make the appropriate changes to the telecommunications system as required, and this includes monitoring through feedback from patients and practice team members.  A telephone line is available for the practice team to summon assistance in an emergency.    Unauthorised access areas Policy  SEM practitioners and other members of the practice team need to ensure the confidentiality and security of patient personal health information and other sensitive practice materials.  Procedure  Signage is displayed to prevent unauthorised public access to specified areas in the practice.  The presence of an additional person in the practice, in addition to the general practitioner(s) on duty, increases security and safety for patients, general practitioners and other team members, and also reduces the risk of unauthorised access to patient personal health information or sensitive practice materials.  The confidentiality and security of patient health records, prescription pads/paper, letterhead, administrative records and other official documents are maintained and stored in <insert storage arrangements>, which is in a restricted access area. Patient personal health information is also stored in manner that is not accessible to unauthorised persons, and all sensible security measures are taken to prevent unauthorised access to medications and to the doctors’ bags.  Facsimile machines, printers and other communication devices are not readily accessible to people other than the general practitioner(s) and authorised members of the practice team.    Security Policy  Our practice ensures, as much as possible, that our facilities provide appropriate security for patients, practice team members and visitors. All practice team members are aware of, and are able to, implement protocols to ensure the safety and security of all persons within the practice.    Procedures  <The following is provided as an example - amend this section as appropriate>  The premises are protected by a computerised alarm system that has motion detection sensors located at various points on-site; refer to the office floor plan available in the <insert location, e.g.,, practice manager’s office>.  A duress alarm, linked to the security system, is located under the reception desk. Our security firm also patrols the site after-hours.  During routine practice hours, at least one other practice team member in addition to the general practitioner(s) is present in the practice. By having another member of the practice team present, this allows for practical help to be provided during an emergency situation; reduces the risk of unauthorised access to patient personal health information and sensitive practice documents; and provides security and safety for patients, general practitioner(s) and other team members.  Rosters are checked daily, and staffing is then planned for the next workday. Where possible, this same strategy is strongly encouraged to be implemented outside of normal working hours, for example, at weekends and on public holidays or when non-routine ‘emergency surgeries’ are conducted for patients needing urgent care.  Equipment on-site is engraved with the practice name and item number, and the <insert position title of the person who is responsible for maintaining the practice’s asset register, e.g.,, practice manager> maintains the asset register that incorporates this information. Contracts and warranties for medical, office and other site equipment are securely locked, maintained and updated as required by the <insert position title of the person who is responsible for maintaining contracts and warranties, e.g., practice manager>. Confidential waste is placed in a locked storage box prior to shredding or secure destruction by a contracted document destruction company.  Security codes are routinely changed for computers and the security system, and patients, visitors and trades people are to report to the reception desk upon arrival. Where, appropriate visitors and trades people are to wear an identification name badge on-site.  <Keep the following if Schedule 8 medicines are kept by the practice> All Schedule 8 medications are stored securely and in accordance with <select as appropriate> state/territory legislative requirements (refer to Section – Medicine management (scheduled medicines)).  All practice team members are encouraged to be vigilant whilst on duty and to ensure the continuing safety of all general practitioners, patients, visitors and other team members.  Open and lock up protocol  At commencement of the working day:   * The premises are unlocked and the security alarm is deactivated using the practice team member’s allocated and confidential security code. * All exits are checked for unimpeded access, and windows are unlocked and opened as required for routine practice operation. * Lights are turned on, as well as the heating/cooling system, computers and photocopier. * The after-hours answering machine is turned off, and any messages are retrieved. * The facsimile machine is checked for any incoming messages. * Any unusual issues or missing items are reported to the <insert position title of the person with designated responsibility, e.g.,, practice manager>.   At the end of the day:   * All windows and doors are locked. * A check is conducted to ensure the computer backup is complete (or scheduled after-hours as required). * Designated computers, photocopier and heating/cooling system are turned off. * Checks are performed to ensure the medicines cupboard and medicines safe are locked. * Checks are performed to ensure all bins are empty. * All office areas are checked to ensure there are no unsecured confidential documents, including medical and finance records. * Prescription pads/paper, practice letterhead, health records, and other administrative records or official documents are stored away securely. * The cash box is secured, and the answering machine is turned on. * All lights are turned off, and the security lights turned on. * The security system is activated. | |
| Practice equipment Policy  The medical equipment, furniture and resources of this practice are appropriate and adequate to ensure:  Comprehensive primary care and resuscitation, and  Patient, practice team member and visitor safety.  Any legislative requirements are met and complied with.  We maintain a register of equipment which includes the scheduling requirements for service or maintenance. Any maintenance and calibration requirements are undertaken on a regular basis in accordance with the manufacturer’s instructions to ensure the equipment is maintained in good working order.  We ensure all members of our practice team are informed, educated and trained in all relevant standards or guidelines and requirements relating to the safe operation or use of specific practice equipment.  Procedure  All members of the practice team are instructed in the use of the practice equipment to ensure equipment is used and maintained in a competent manner.  Training requirements depend on the specific equipment, and the equipment’s relevance to the practice team member’s role. Practice team members are trained in how to use the practice’s equipment safely in order to avoid any adverse events. Our practice’s general practitioners assess whether specific training is required to use the practice’s equipment, such as the height-adjustable bed, point-of-care testing equipment <keep the following if applicable> and the defibrillator, and determine whether ongoing training is required. Appropriate training is undertaken by completing external courses where required; all other training is conducted through in-house programs, or ‘on the job’ training. Evidence of the training completed is retained in the practice team member’s employment or contract file.  Electrical safety checks and biomedical checks are performed on the required equipment annually or as required.  Maintenance, repairs, electrical and biomedical checks are documented in the equipment register. This register is retained as proof of the practice’s quality control and preventative maintenance program.  Furniture used by the practice team members and by patients is maintained in good condition, is ergonomically effective and can be easily cleaned and wiped down.    Medical equipment and resources Policy  The practice has all basic equipment and emergency drugs expected in a general practice. The practice ensures that these are maintained, safe and in a serviceable condition at all times.  The available equipment is sufficient for the procedures commonly performed within our practice and meets the needs of our patients.  Our practice maintains our key equipment according to a documented schedule.  Members of the medical and clinical team are consulted about the equipment and supplies the practice uses or purchases.    Procedures  Our practice has the necessary medical equipment to ensure comprehensive primary care and emergency resuscitation incorporating the following:  Auriscope,  Blood glucose monitoring equipment,  Defibrillator <keep if your practice has an AED on-site>  Disposable syringes and needles,  Equipment for resuscitation, maintaining an airway (for children and adults), equipment to assist ventilation (including bag and mask),  IV access,  Emergency medicines,  Examination light,  Eye examination equipment (e.g., fluorescein staining),  Gloves (sterile and non-sterile),  Height measurement device,  Height adjustable patient examination bed(s),  Measuring tape,  Monofilament for sensation testing,  Ophthalmoscope,  Oxygen,  Patella hammer,  Peak flow meter,  Personal protective equipment,  Pulse oximeter,  Scales,  Spacer for inhaler,  Specimen collection equipment,  Sphygmomanometer (with small, medium and large cuffs),  Stethoscope,  Surgical masks,  Thermometer,  Torch,  Tourniquet,  Urine testing strips (including pregnancy testing kits),  Vaginal specula,  Visual acuity charts, and  X-ray viewing facilities.  Our practice also has timely access to a spirometer and electrocardiograph <insert a description of your practice’s arrangements for timely access to a spirometer and electrocardiograph machine, whether it be on-site or available nearby>.  <Insert any additional equipment the practice may have depending on the type of practice and the interests and requirements of the practitioners and the maintenance of such equipment, e.g., dermatoscope>.  Relevant members of our practice team are trained in the care, use and maintenance of equipment and, where appropriate, to analyse and interpret any results. As liquid nitrogen and oxygen are hazardous materials, they are stored securely and the team are trained in their safe use.  Our key clinical equipment is maintained in working order and is appropriately maintained in accordance with our register of equipment below, which includes the scheduling requirements for service or maintenance and reflects the recommendations of the manufacturers of the equipment. Maintenance of the equipment is performed as required by suitably trained practice team members or qualified technicians where required.  <The following table represents examples of equipment that is battery or electrically operated and the types of servicing and calibration, and/or monitoring and checking typically encountered. Amend the information contained to ensure it aligns with the recommendations of the equipment manufacturer, and add/remove any equipment held/not held by the practice>   |  |  |  |  | | --- | --- | --- | --- | | Item | Servicing/Calibration | Monitoring/Checking | Parts/Supplies | | Audiometer | <In accordance with the manufacturer’s recommendations> | <In accordance with the manufacturer’s recommendations> |  | | Auriscope | Monthly clean of viewing glass or as required. | Replace or recharge batteries when light dims. | Spare batteries (standard or rechargeable), globe. | | Computer system including backups | According to the maintenance and servicing program. | Server temperature. | Backup media, spare computer. | | Dermatoscope | Monthly clean of viewing glass or more frequently as required. | Replace or recharge batteries when light dims. | Spare batteries (standard or rechargeable), globe. | | Defibrillator |  | Monthly check of function or in accordance with the manufacturer’s recommendations. | Battery. | | ECG | Annual servicing and calibration by qualified technician. | Each ECG push check button (1mv=large square). | ECG paper. | | Electrical cords and all computers, printers and appliances | Annual testing and tagging by a qualified person. |  |  | | Fire Extinguishers | Biannual check by qualified technician i.e.: MFB or private service. |  |  | | Generator | Annual full test of function. | Monthly check fuel level and starts. | Fuel. | | Glucometer | Annual comparison of an actual blood sugar level with a glucometer reading of same blood sample. | Monthly. | Test strips, batteries. | | Non-medical items e.g., door mats, floor surfaces | Yearly inspection and replacement as required. | Warning signs displayed when wet or fall risk is evident. |  | | Ophthalmoscope | Monthly clean of viewing glass or as required. | Replace or recharge batteries when light dims. | Spare batteries (standard or rechargeable), globe. | | Oxygen | Annual servicing and checking by qualified technician. | Weekly check that cylinder at least ¼ full. | Spare cylinder available. | | Panic Buttons |  | Monthly check. |  | | Printers |  |  | Spare cartridges. | | Scales |  | Compare with a known weight. |  | | Smoke Alarms | Replace batteries annually. | Monthly check. | Spare battery. | | Spirometer | Servicing and calibration according to manufacturer’s recommendations. | Regular calibration using 3L syringe. Monthly clean or more frequent as required. | Disposable mouth pieces, preferably one way and preferably filtered. | | Steriliser | Annual servicing, calibration and validation by a qualified technician. | Maintenance and regular cleaning according to manufacturer’s instructions. | Deionised or Distilled water, bags or pouches, printer paper and ink cartridge, chemical indicators, sealing tape, spares for heat sealer if used. | | Sphygmomanometer | Annual checking against a mercury device or recently checked aneroid device. Cleaning and checking of mercury by qualified technician if required. |  | Cuffs various sizes  Spare standard cuff and bladder, bulb and control valve. | | Telephone System |  | Quarterly check of battery backup function. |  | | Thermometer | Compare against mercury oral thermometer or other electronic thermometer. |  | Batteries, covers. | | UPS (Computer) |  | Quarterly and monthly check of battery backup function. |  | | Vaccine Storage | Annual logging of fridge temperature using a calibrated data logger. Replace batteries on min/max thermometer annually. | Twice daily min/max temperature recording. | Spare batteries. |     Doctor’s bag Policy  All of our general practitioners have access to a fully equipped doctor’s bag for emergency care and routine off-site visits. When not in use, the doctor’s bag is stored securely.  In some instances, our practitioners may share a doctor’s bag or items may be kept in two smaller bags. Required items may be added to the bag prior to use to avoid doubling up on equipment. Where this is the case, a note is attached to the outside of the bag to remind practitioners of the additional equipment required to be added prior to taking the bag off the premises.  The <insert name and position title of the person with designated responsibility for ensuring the doctor’s bag is adequately stocked, e.g., practice nurse>, in conjunction with the general practitioner, regularly reviews the contents of the doctor’s bag (refer to Section – Checking and rotating medical supplies). In addition to checking the condition, stock levels and expiry date of items and equipment, consideration is given during this process to incorporating additional items depending on the practice location, clinical conditions encountered, the shelf life and climatic vulnerability of various medications and the size of the bag.  In addition to containing the required equipment, the doctor’s bag also contains the recommended medications. Additional medications may also be added after consideration of the clinical conditions encountered or likely encountered.  Where a doctor’s bag is shared, the arrangements are reviewed on an ongoing basis to ensure the practitioners have access to the bag when required. Additional bags are purchased if required.  Sensible security measures are taken at all times and any relevant legislation or regulations relating to Schedule 4 <keep the following if Schedule 8 medicines are kept in the doctor’s bag> and Schedule 8 medicines are adhered to (refer to Section 7.18 – Medicine management (scheduled medicines)).  Procedure  When attending routine off-site consultations or emergency care, each of our practitioners has access to a fully equipped doctor’s bag containing:   * Auriscope, * Disposable gloves, * Equipment for maintaining an airway (in both adults and children), * In-date medicines for medical emergencies <NB: if Schedule 8 medicines are carried in the doctor’s bag, there must be a Schedule 8 record book included in the bag also. Add this item to the list if applicable> * Ophthalmoscope, * Practice stationery (including prescription pads and letterhead), * Sharps container, * Sphygmomanometer, * Stethoscope, * Syringes and needles in a range of sizes, * Thermometer, * Tongue depressors, and * Torch.   When selecting emergency drugs for the doctor’s bag, our practice considers the:  Types of clinical conditions and emergencies likely to be encountered,  Practice location,  Shelf-life and climatic vulnerability of medicines, and  Availability of emergency drugs at the practice if the doctor’s bag has been taken by another practitioner.  The following medicines have been considered as the most appropriate and necessary medicines and are, therefore, routinely included in the doctor’s bag: <the following is an example of the types of medicines likely to be included in the doctor’s bag. Amend as appropriate and necessary>   * Adrenaline, * Benztropine mesylate, * Benzylpenicillin, * Diazepam, * Furosemide, * Glucose 50% and/or Glucagon, * Ergotamine maleate, * Haloperidol or Chlorpromazine, * Hydrocortisone sodium succinate or dexamethasone, * Metoclopramide hydrochloride, * Morphine sulphate or appropriate analgesic agent, * Naloxone hydrochloride, * Prednisone, * Promethazine hydrochloride, * Aspirin soluble (oral), * Atropine sulphate, * Glyceryl trinitrate spray or tablets, and * Salbutamol inhaler.   To ensure patient safety, all general practitioners are familiar with the medicines that are included in their doctor’s bag, including the general usage, suggested dosage and possible side effects.  The doctor’s bag also contains the following items: <the following items are not mandatory for accreditation purposes; however, your practice might consider they are appropriate for inclusion. Amend as appropriate and necessary>  Cannulas, iv bungs, tourniquet, butterfly needles,  Alcohol swabs, specimen containers, urinalysis sticks,  IV fluids and giving set,  Peak flow meter,  Bandages, tape and other dressings,  MIMS,  Pathology and radiology request forms,  Medical certificates,  Useful telephone numbers – hospitals, health hotlines, and  Other medicines such as starter packs for antibiotics and analgesics.  Each SEM practitioner retains ultimate responsibility for maintaining the doctor’s bag by replacing used items, and for keeping the supplies of medicines at optimum levels.  Quarterly reviews of the doctor’s bag contents are undertaken by the <insert name/position title of the person with designated responsibility for ensuring the doctor’s bag is adequately stocked, e.g., practice nurse>, in conjunction with the general practitioner, to ensure any perishable items are within their expiry date. Any out-of-date items are discarded appropriately and the stock replenished. To facilitate this process, a Doctor’s Bag Checklist is used and records the identification of the person conducting the check and the date the check was conducted.  A list of the items that must be routinely included in the doctor’s bag when in use is included within the doctor’s bag contents and highlights those items of equipment that are not permanently stored with the doctor’s bag, but are to be added by the general practitioner before leaving the practice. Such items include an auriscope and ophthalmoscope as these items are expensive to duplicate.  Annually, the <insert name/position title of the person with designated responsibility for ensuring the doctor’s bag is adequately stocked, e.g., practice nurse> works with all general practitioners to conduct a comprehensive review of the items for the doctor’s bag to determine if current equipment is adequate based on accepted good clinical practice.  When not in use, the doctor’s bag is stored securely in the practice or remains in the locked boot of the doctor’s car. When kept in the boot of the car, the practitioner must ensure consideration is given to the possible temperatures within the boot and if the temperature could compromise the viability and integrity to any of the doctor’s bag contents, especially to any medicines.  Vaccine management  <A dedicated Vaccine Management Policy and Procedure Manual template is available and can be accessed and downloaded for your practice to personalise and implement.>  Our practice has a dedicated Vaccine Management Policy and Procedure Manual located <insert file and/or physical location>. Please refer to this document for our vaccine management policies and procedures.  Medicine management (scheduled medicines) Policy  <The following is an example of a policy and procedure for scheduled medicine management and is based on information obtained from the Standard for the Uniform Scheduling of Medicines and Poisons (Poisons Standard July 2020 <https://www.legislation.gov.au/Details/F2020L00899/Download>  Recognising that practices can invariably differ in the types of medicines maintained, and due to the significance of and differences between each state and territory’s legislative requirements, it is important your practice reviews and amends each aspect of the following to ensure it aligns to your practice and is also in accordance with your state/territory’s jurisdictional requirements.>  It is imperative that our practice ensures all scheduled medicines (including sample medicines) are acquired, stored, administered, supplied and disposed of in accordance with manufacturers’ directions and relevant jurisdictional requirements. Failure to comply may render individuals and practice entities liable to prosecution.  To ensure patients’ safe use of medicines, our practice stores scheduled medicines appropriately and securely and does not use or distribute them beyond their expiry dates.  According to the Standard for the Uniform Scheduling of Medicines and Poisons (Poisons Standard July 2020), poisons are classified according to the Schedules in which they are included. The following is a general description of the Schedules of medicines held in our practice.  Schedule 2 - Pharmacy Medicine: The safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.  Schedule 3 - Pharmacist Only Medicine: The safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.  Schedule 4 - Prescription Only Medicine: Substances, the use or supply of which should be by, or on the order of, persons permitted by State or Territory legislation to prescribe and should be available from a pharmacist on prescription.  Schedule 8 - Controlled Drug: Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.  Procedure  In our practice, we hold <amend as appropriate> Schedule 2, 3, 4 and 8 medications and we ensure these scheduled medicines are acquired, stored, administered, supplied and disposed of in accordance with manufacturers’ directions and the requirements of the <insert the name of the Act and Regulation relevant to your state/territory from the below>  ACT  [Medicines, Poisons and Therapeutic Goods Act 2008](https://www.bing.com/search?q=ACT+medicines+poisons+and+therapeutic+goods+act+2008&cvid=1da135451037461d9e025bc093feea7f&aqs=edge..69i57j69i11004.21479j0j4&FORM=ANAB01&PC=ACTS)  [Medicines, Poisons and Therapeutic Goods Regulation 2008](https://legislation.nsw.gov.au/view/pdf/asmade/sl-2008-392#:~:text=This%20Regulation%20makes%20provision%20with%20respect%20to%20the,have%20been%20seized%20under%20section%2043%20of%20the)  NSW  [Poisons and Therapeutic Goods Act 1966](https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1966-031)  [Poisons and Therapeutic Goods Regulation 2008](https://legislation.nsw.gov.au/view/pdf/asmade/sl-2008-392)  NT  [Medicines, Poisons and Therapeutic Goods Act 2012](https://legislation.nt.gov.au/en/Legislation/MEDICINES-POISONS-AND-THERAPEUTIC-GOODS-ACT-2012)  [Medicines, Poisons and Therapeutic Goods Regulations 2014](https://legislation.nt.gov.au/en/Legislation/MEDICINES-POISONS-AND-THERAPEUTIC-GOODS-REGULATIONS-2014)  QLD  [Health Act 1937](https://www.legislation.qld.gov.au/view/pdf/inforce/2002-08-01/act-1937-031)  [Health (Drugs and Poisons) Regulation 1996](https://www.legislation.qld.gov.au/view/pdf/repealed/current/sl-1996-0414)  SA  [Controlled Substances Act 1984](https://www.legislation.sa.gov.au/lz?path=%2FC%2FA%2FCONTROLLED%20SUBSTANCES%20ACT%201984)  [Controlled Substances (Poisons) Regulations 2011](https://www.legislation.sa.gov.au/lz?path=%2FC%2FR%2FControlled%20Substances%20(Poisons)%20Regulations%202011)  TAS  [Poisons Act 1971](https://www.legislation.tas.gov.au/view/html/inforce/current/act-1971-081)  [Poisons Regulations 2018](https://www.legislation.tas.gov.au/view/pdf/authorised/2021-12-17%202022-02-02/sr-2018-079)  VIC  [Drugs, Poisons and Controlled Substances Act 1981](https://www.legislation.vic.gov.au/in-force/acts/drugs-poisons-and-controlled-substances-act-1981/134)  [Drugs, Poisons and Controlled Substances Regulations 2017](https://www.legislation.vic.gov.au/in-force/statutory-rules/drugs-poisons-and-controlled-substances-regulations-2017/006)  WA  [The Medicines and Poisons Act 2014](https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13172_homepage.html)  [Medicines and Poisons Regulations 2016](https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13861_homepage.html)  Acquisition  All scheduled medicines (including doctor’s bag emergency medicines, samples obtained from pharmaceutical representatives and vaccines) are obtained by and only on the authorisation of a general practitioner.  Our scheduled medicines are acquired from <insert the methods (including name(s) of the suppliers) your practice acquires each of the scheduled medicines from, ensuring each acquisition complies with state/territory regulatory requirements>.  Storage  All scheduled medicines held in our practice are stored within the manufacturer’s recommended storage temperature range; and in any other environmental condition that is necessary to preserve the medicine’s stability and therapeutic quality.  Our practice ensures that all Schedule 2, 3 and 4 medicines are stored in a manner that ensures public access is restricted by <insert details of the storage methods used for each of the scheduled medicines that ensures they are inaccessible to the public, e.g., drawers/cupboards in the treatment/consulting rooms etc., and that the arrangements comply with state/territory regulatory requirements; incorporate the secure storage of vaccines into this section also.>  Schedule 8 medicines are stored separately from all other goods and in a receptacle that is securely attached to a part of the premises that is kept securely locked when not in immediate use and in a manner that ensures the contents are accessible only to authorised persons. <Insert details of the specific storage arrangements for Schedule 8 medicines in your practice that ensures compliance with state/territory regulatory requirements, including who the authorised person(s) in the practice are, and how Schedule 8 medicines are accessed, e.g., key that is kept in the person possession of the authorised person(s) etc.>  <NB: where your doctors’ bags contain scheduled medicines, ensure these arrangements are referenced in the above.>  Administration and supply other than vaccines  <The following points are an example of the types of information to include in this section. It is important your practice confirms this information as relevant to your practice and/or complies with the regulations of your practice’s state/territory before considering its inclusion.  Depending on professional scope and competencies, registered nurses or medication endorsed enrolled nurses can only administer Schedule 4 or Schedule 8 medications when:  There is a recent written instruction from a general practitioner identifying the patient, medication, dose, time, date and route of administration and date the order was written,  An oral instruction from a general practitioner if an emergency exists with written confirmation ‘ASAP’ by the practitioner and nurse,  On the written transcription of the oral instruction (given by a general practitioner in an emergency) by the nurse who received those instructions – this must be countersigned ‘ASAP’ by the practitioner, and,  To the designated patient in accordance with the directions on the label when the medications have been dispensed to the patient by a pharmacist or general practitioner.  Registered nurses must document any medications administered in the patient’s health records, and sign the entry or use their individual log in.    Enrolled nurses may have limitations on the routes of drug administration or types of drugs they can administer depending on the endorsements they have attained in their training (may not be able to administer via the IV route).  Nurse immunisers, employed or contracted, may have access to vaccines that are specifically approved by the relevant state/territory for use in vaccinations, and to Schedule 4 medicines necessary for the treatment of anaphylactic reactions to the vaccines.  Our nurse immunisers familiarise themselves with legislative issues that are applicable to their situation.>  Only a person who is authorised under legislation may supply a scheduled medicine. In our practice, <insert the person(s) (e.g., general practitioners, registered nurses) who are authorised under state/territory regulations to supply each of the scheduled medicines> are authorised to supply scheduled medicines.  When our practice supplies patients with scheduled medicines (including professional samples), we ensure the medicine is labelled in accordance with our <select as appropriate> state/territory regulatory requirements, and that a record of the supply is made. The general practitioner also ensures all reasonable steps are taken to ensure a therapeutic need exists before supplying or administering a scheduled medicine, and that the patient has no allergies or sensitivities to the contents of the medicine.  Schedule 2 and 3 medicines are to be labelled with the following particulars:  <Insert details of the particulars to be included on the label in accordance with state/territory regulations. NB: some of the particulars as required by the regulations may already be included on the standard packaging; however, it is the practice’s responsibility to ensure any particulars that do not conform to state/territory regulations or are omitted from the manufacturer’s packing must be included by other means, such as affixing a custom-made label. It is important that this section include the types of warnings necessary for display such as a ‘sedation’ or ‘external use only’.>  Schedule 4 medicines are to be labelled with the following particulars:  <Insert details of the particulars to be included on the label in accordance with state/territory regulations. NB: some of the particulars as required by the regulations may already be included on the standard packaging; however, it is the practice’s responsibility to ensure any particulars that do not conform to state/territory regulations or are omitted from the manufacturer’s packing must be included by other means, such as affixing a custom-made label. It is important that this section include the types of warnings necessary for display such as a ‘sedation’ or ‘external use only’.>  Schedule 8 medicines are to be labelled with the following particulars:  <Insert details of the particulars to be included on the label in accordance with state/territory regulations. NB: some of the particulars as required by the regulations may already be included on the standard packaging; however, it is the practice’s responsibility to ensure any particulars that do not conform to state/territory regulations or are omitted from the manufacturer’s packing must be included by other means, such as affixing a custom-made label. It is important that this section include the types of warnings necessary for display such as a ‘sedation’ or ‘external use only’.> | |

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| **Induction to include additional policies & procedures (induction checklist)** |
| Clinical Management  Clinical autonomy  Clinical content of patient health records  Informed consent  Referral protocols  Clinical handover  Patient identifiers  Follow up of tests, results and referrals  Reminder system for preventative care  Notifiable communicable diseases  Third party observing or clinically involved in consultation  Research projects  Management of a patient refusing treatment or advise  Refusal to treat a patient  Telehealth  Medical emergencies and urgent queries  After hours service  Ethical dilemmas  Continuous Improvement  Risk Assessment and management (risk register)  Registration  Insurance  Management of potential medical defence claims  Training, qualifications and continuing education  Privacy and security of personal health information (privacy form)  Computer information security  Practice privacy policy  Third party requests for access to personal health information  Request for access to personal health information  Transfer of patient health records  Communication with patients by electronic means  Using social media in our practice  Patient rights  Open Disclosure  Complaints  Non-English Speaking patients  Culturally appropriate care  Directory of local health and community services |

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| **Additional resources provided by (Organisation Name):** |
| Org chart and list of contacts including:  Practice Owner  Registrar Primary Supervisor  Registrar other Supervisors  Practice Manager  WHS Coordinator  Health & Wellbeing Coordinator  IPC Coordinator  HR  Privacy and Computer Security  Emergency Response  Pandemic Response |