



# **South Australian Rural Medical Engagement Responsibilities (SARMER)**

DRAFT

**Version 1.0  
July 2009**

*'Without Prejudice' working document*

This document is to be read in conjunction with the “South Australian Rural Medical Finance Agreement” (SARMFA), the “Country Health SA General Practitioner Fee for Service Agreement”, and the “Credentialing & Defining Scope of Clinical Practice for Country Health SA Health Service for Medical and Dental Practitioners 2009”

## 1. Introduction

The South Australian Rural Medical Engagement Responsibilities (SARMER) describes the expectations that medical practitioners and country health units should have of each other in the support of a positive professional relationship.

Medical practitioners covered by this document are independent contractors and are recognised as having advanced medical skills relevant to the rural environment and as such are responsible for the manner in which outcomes are achieved. However, they work in an environment which is strongly controlled by the Country Health SA (CHSA) to ensure a safe working environment with the best outcomes for patients.

It is in the best interest of all concerned that there are agreed responsibilities of the parties involved in the outcome for the patient. The purpose of this document is to assist in the achievement of that goal.

### CHSA Mission

The mission of CHSA is to:

- deliver accessible, equitable and high quality health services to country South Australians; and
- promote health and well-being amongst country South Australians.

### CHSA Values

CHSA operates from a position which values patients and consumers, staff and partners in health, and places a premium on accountability, access and equity, safety, empowerment, personal and professional integrity, respect, strength and courage.

Mainstream hospital and health services will be supported to enable them to deliver culturally safe and competent services to Aboriginal people, and a key enabler in this process is the implementation of the SA Health Cultural Respect Framework and the whole-of-government Cultural Inclusion Framework.

## 2. Mutual Obligations

Parties to the application of this document are considered to be committed to:

- recognising that each health unit is part of a total health care system
- ensuring sustainability of country health service provision
- making the best use of resources
- providing a focus and contributing to safety and quality systems
- ensuring effective open communication within and across communities and service providers
- engaging in discussion about service planning and clinical change that is designed to achieve ongoing and sustainable health service improvements
- respectful behaviour in all dealings
- speedy dispute resolution based on the principles of natural justice, and
- the clear delineation of the rights, responsibilities, duties and obligations of each party.

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### 3. Policy and Practice Development

The Australian Council on Healthcare Standards (ACHS) state that Clinical Governance is “the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient safety, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care.” The Clinical Governance Structures of CHSA work to set consistency of policies and clinical care standards across the region.

#### 3.1 Country Clinical Governance Committee

**Role:**

The role of the CHSA Clinical Governance Committee is to support the provision of safe and high quality health care for country South Australians by providing leadership and advice to the CHSA Executive and Chief Executive Officer (CEO) on all issues related to clinical care, minimising risks to consumers and quality improvement. The Country Clinical Governance Committee also acts as the Information Technology Clinical Reference Group for Country Health SA.

**Functions:**

The CHSA Clinical Governance Committee is responsible for:

- leading the Country Health SA clinical governance agenda in accordance with the directions established by SA Health and national policy
- providing strategic leadership for the country region in the area of clinical safety and quality
- ensuring mechanisms are in place to review and monitor the effectiveness and quality of clinical care across the region and to bring about continuous quality improvement
- provide leadership and oversight of clinical risk management in country SA
- making effective use of data, knowledge and expertise in decision making, to ensure clinical policies and procedures are based on the best possible evidence base
- sponsoring a patient focus and ensuring that the views of health service users are systematically and effectively engaged in clinical governance activities
- providing a forum for clinician participation in the decision making process in relation to country clinical service planning, and
- receiving reports and issues from sub committees and oversee their functions.

The following sub committees report to the Country Clinical Governance Committee:

- Safety and Quality Committee
- Country Drug and Therapeutics Committee
- Central Clinical Privileging Committee
- Blood Transfusion Committee
- Infection Control Forum

#### 3.2 Role of the Chief Portfolio Advisors

The Chief Portfolio Advisors are appointed by the CEO, CHSA. They are responsible for:

- providing clinical system advice and broad support to rural resident medical practitioners throughout country SA by way of their identified area of expertise
- acting as a point of specialty contact for clinicians in country regarding system issues, as related to their specialty area, and participation in problem resolution
- participating in the development of policy and procedures that guide clinical practice in country SA. In addition, the Chief Portfolio Advisors, CHSA, will work with the Chief Medical Adviser, CHSA and other country health staff in relation to decision making and policy setting as related to their speciality area, and
- providing leadership and coordination for the implementation of CHSA priorities and action plans within the context of the medical workforce.

Where appropriate, the Advisors will engage with the established networks and committees of relevant rural organisations throughout South Australia including, the RDASA, Rural Divisions of General Practice, RACGP, ACCRM, and Rural GP Training Providers.

### 3.3 Role of Principal Medical Officers

The Principal Medical Officers are appointed by Cluster Directors in those clusters for which there is no appointed Director of Medical Services. Principal Medical Officers act as a principal medical advisor, and are responsible for:

- providing a clinical perspective on issues and systems within the relevant health service(s)
- acting as a conduit between other medical practitioners and the Health Service Executive
- providing advice on local clinical policy development and clinical protocols, and
- involvement with the development of service delivery within the relevant health service(s) and along with other medical practitioners supports students and junior doctors in training.

Principal Medical Officers [contracted under the Country Health SA Rural General Practitioner Fee for Service](#) Agreement are remunerated in accordance with the South Australian Rural Medical Finance Agreement.

### 3.4 Role of Directors of Medical Services

Directors of Medical Services are appointed to the majority of larger CHSA health clusters and are responsible for the development, provision, evaluation and management of medical services locally.

Each Director of Medical Services is appointed by and is responsible to the local cluster Director, but will also work collaboratively with the Chief Medical Advisor, CHSA and the Chief Portfolio Advisors on issues related to clinical practice.

Directors of Medical Services currently exist in the following clusters:

- [Barossa, Gawler, Eudunda and Kapunda Health Services](#)
- [Lower South East Health Services](#)

- Whyalla, [Eastern Eyre and Far North Health Services](#)
- Adelaide Hills, [Southern Fleurieu and Kangaroo Island Health Services](#)
- Port Augusta, [Roxby Downs, Woomera, Hawker, Leigh Creek and Quorn Health Services](#)
- [Port Pirie, Port Broughton, Southern Flinders and Mid North Health Services](#)
- Riverland Regional Health Service

### 3.5 Role of the Clinical Directors

Clinical Directors are appointed by the CEO, CHSA and are responsible for:

- providing leadership in the nominated area of services across CHSA
- providing leadership in the analysis, implementation and review of best practice clinical process, as well as implementation of evidence based medicine and systems on a country wide basis
- ensuring the provision of high standard, cost effective clinical services to patients through consultation with the local Directors of Health Services
- providing advice, as required, to local Directors of Health Services, on the budget and provision of human resource management and or contractors in the nominated area of services
- ensuring that relevant service staff contribute effectively to teaching/training and research, and
- contributing to the provision of high standard clinical services to patients of CHSA and to teaching/training of undergraduates and post graduates.

Clinical Directors report to the Chief Medical Advisor, CHSA and are appointed in accordance with the then current Enterprise Agreement.

### 3.7 Role of Chief Executive Officer, CHSA,

The Chief executive Officer, CHSA, is responsible for

### 3.7 Role of Executive Directors, Service Operations

Executive Directors, Service Operations, are members of the Country Health Executive team who in the main receive direct reports from Directors of defined clusters and have upward reporting responsibility to the CEO, CHSA. The role includes management responsibilities for amongst other things, service delineation, program and system design, service standards, performance reporting and clinical leadership to effectively deploy CHSA resources. In particular, the incumbent is responsible for building relationships within CHSA and across the health system to optimise health outcomes across the State.

## 4. Quality, Safety and Risk Management

### 4.1 Credentialing

Credentialing (previously known as clinical privileges) refers to the formal process used to verify the qualifications, experience, professional standing and other

relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional standing.

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## 4.2 Scope of Clinical Practice

Scope of Clinical Practice (previously known as admitting rights) follows on from Credentialing and is the formal process used to determine the scope in which medical practitioners are approved to practice within a health service. This is based on Credentials and the approved services level of the health service.

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### 4.2.1 Policy Reference

“Credentialing & Defining Scope of Clinical Practice for Country Health SA Health Service for Medical and Dental Practitioner-July 2009<sup>(4)</sup>”

### 4.2.2 Responsibility of Country Health SA

Country Health SA will:

- review all actively practicing medical practitioners in SA Country Public Health Service to ensure they hold and maintain relevant Credentials and Scope of Clinical Practice
- provide advice and a liaison point for all health services, medical practitioners and the Central Clinical Credentials Advisory Committee
- appoint an Executive Officer to provide comprehensive administrative support to the Central Clinical Credentials Advisory Committee
- maintain all records centrally and maintain an active and accurate Credentialing and Scope of Clinical Practice database
- review and update the medical practitioner’s relevant board registration and professional indemnity insurance on an annual basis

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### 4.2.3 Responsibility of the Health Unit:

The health unit that provides services must:

- ensure the practicing medical practitioner has adequate Credentials and Scope of Clinical Practice for the services being provided
- provide accurate recommendations on Scope of Clinical Practice applications
- report any concerns or issues in relation to a medical practitioner to the Central Clinical Credentials Advisory Committee for review, where necessary.
- collect data to forward to the Central committee to assist medical practitioners in providing appropriate log book information in regards to the numbers of procedures undertaken (eg anaesthetics, surgical and obstetrics caseload).
- provide guidelines on the expectations of medical practitioners to satisfy ongoing credentialing requirements.

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### 4.2.4 Responsibility of the Medical Practitioner:

The medical practitioner that provides services must:

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- maintain adequate Credentials and Scope of Clinical Practice for the services that they are providing within SA Country Public Health Services
- maintain registration with the Medical Board of South Australia,
- maintain Professional Medical Indemnity Insurance that is equivalent or greater than the Credentials held
- be committed to participating in ongoing Continual Medical Education, applicable to their approved Credentials and
- provide written evidence of CME activities eg ACRRM, RACGP, MOPS statements including appropriate emergency updates (if on emergency on call rosters) and current references upon request.
- practice within his/her scope of clinical practice.
- ensure any changed situations that would affect credentials and/or scope of practice are immediately communicated to CHSA.
- notify CHSA if he/she is suspended or has any restrictions on their capacity to practice medicine made by the Medical Board of SA or by any other medical regulatory authorities

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#### 4.3 Quality Improvement and Accreditation

##### 4.3.1 Policy Reference

Country Health SA Quality & Safety Strategic Priorities 2009/10  
*South Australian Safety and Quality Framework & Strategy 2007 – 2011'*

Local health unit Quality Improvement/Accreditation policies and guidelines. These policies are developed as per Quality Improvement Programs (e.g. ACHS, EQUIP).

##### 4.3.2 Responsibility of Country Health SA and the Health Unit:

- demonstrate that the health unit has successfully informed medical practitioners engaged by the unit of all appropriate policies, standards and guidelines that affect medical practice
- ensure that all policies, standards and guidelines are readily accessible at each health unit in both written and electronic forms with the latter being a specific section of the CHSA website.
- provide, wherever practical, all medical practitioners with intranet access to legislative and policy directives, on-line access to relevant applications and professional journals
- ensure that all services provided by and through the health unit are delivered in line with best practice and the relevant policies, standards and guidelines including IT/ IM Resources
- ensure the provision of appropriate infrastructure at agreed levels for each health unit as mandated by CHSA Strategy December 2008
- administration and coordination of quality improvement programs and the accreditation process within the health unit, toward the achievement of accreditation.
- consult fully with all relevant medical practitioners regarding the provision and timing of Q&S and QIP events involved with the health unit's accreditation process.

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#### 4.3.3 Responsibility of the Medical Practitioner

Assist the Health Unit Executive to ensure that medical services are delivered effectively by:

- active participation in quality and safety and quality improvement programs of the health unit and
- co-operating and participating in the health unit's accreditation process after full consultation as to suitable times, and
- where required to attend Quality and Safety meetings, excluding meetings for individual patient care (eg Case Conferences), these will be reimbursed at the agreed meeting payment schedule contained within SARMFA

#### 4.4 Patient Safety, Incidents and Reporting

##### 4.4.1 Policy Reference

*South Australian Safety and Quality Framework & Strategy 2007 – 2011'*

Patient Safety Framework Policy 04-1 (PSFP-04-1) Ensuring Correct Patient, Correct Site, Correct Procedure' 2011'

##### 4.4.2 Responsibility of Country Health SA and the Health Unit

- implement all policies and procedures related to patient safety, incident and reporting
- conduct and oversee safety activities (including AIMS and assist in Root Cause Analysis)
- investigate and manage all reports of serious incidents, accidents and near-misses
- report to CHSA Quality Assurance Committee all Sentinel Events
- wherever possible, based on the nature of an event and the subsequent follow up process that is implemented, directly involve medical practitioner(s) that are involved in an event in reviewing that event
- wherever possible, based on the nature of an event and the subsequent follow up process that is implemented, inform the medical practitioner(s) involved in an event of the outcomes of any investigation

##### 4.4.3 Responsibility of the Medical Practitioner

- participate in all patient safety activities as agreed between the parties (eg team steps clinical handover, and hand hygiene activities )
- report all serious incidents and accidents immediately (or as soon as reasonably practicable) – to enable ease of reporting, incident forms have been replaced by the ability to contact the SA Incident Management System contact centre on 1800 668 439, for incidents such as medication errors, etc
- to report 'sentinel events' within 24 hours on the appropriate form available from the health unit to the Department of Health when they have an active role in them. The eight national sentinel events are:

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1. Procedures involving the wrong patient or body part
  2. Suicide
  3. Retained instruments or other material requiring further surgical procedure
  4. Intravascular gas embolism resulting in death or neurological damage
  5. Haemolytic blood transfusion
  6. Medication error leading to death
  7. Maternal death or serious morbidity associated with labour or delivery
  8. Infant abduction or discharge to the wrong family
- will participate in the review of an event and be informed of the outcome within an appropriate time.

#### 4.5 Elective Surgery

##### 4.5.1 Policy Reference

*Elective surgery and systems at South Australian country public hospitals will be managed in accordance with the 'SA Health – Country Health SA – Elective Surgery Policy'.*

*Department of Health 'Policy Framework and Associated Procedural Guidelines for Elective Surgery', Department of Health 'Booking List Information Systems (BLIS) Guidelines' and the policy and standards outlined in the 'Department of Health Risk Management Policy and Framework'.*

##### 4.5.2 Responsibility of Country Health SA and the Health Unit

- identify procedural work which can be undertaken for the next 12 months and associated Fee For Service (FFS) expected expenditure
- provide an elective theatre roster for a period of 12 months (financial year) that is updated no later than the 20th of April each year for the following financial year so that there is a minimum of three months notice of provision of funded lists for resident/visiting providers
- provide resident/visiting providers with appropriate and timely information to enable them to plan their clinical workload and lifestyles appropriately and provide transparency to workload if additional Elective Surgery Strategy funding is secured. Theatre session rosters will be negotiated in a timely manner with affected surgeons and anaesthetists.
- ensure that all general practitioners participating in on-call rosters will be advised no less than three months in advance of their commitment to the health unit to ensure the respective clinics can then roster GP anaesthetists to the theatre roster
- advise all visiting specialists by the 20th of April each year of their commitments to the health unit for the following financial year thereby providing a reasonable degree of flexibility to both parties and
- provide resident/visiting providers with Health Unit collected Elective Surgery Waiting List information as requested from Chiron and maintain

all Elective Surgery information provided from surgeons within Department of Health's confidentiality guidelines.

#### 4.5.3 Responsibility of the Medical Practitioner:

- advise the health unit no less than one month in advance of the cancellation of a monthly list or in the case of weekly lists, no less than a fortnight
- provide the health unit with operating lists 10 days in advance to ensure an appropriate mix and supply of consumables and instrumentation is available and
- ensure that where possible patients will have their surgery in the local health unit instead of being added to a public metropolitan waiting list unless there are medical reasons that contraindicate this strategy
- work within Department of Health and Country Health SA Elective Surgery Strategy by providing health unit with Waiting List forms within 10 working days from date decision was made that a patient requires an Elective Surgery procedure and advise health unit of any changes to status of patients currently on a Elective Surgery waiting list
- assist health unit and CHSA in ensuring patients are not waiting for their Elective Surgery procedure for longer than the required Department of Health performance measurement targets

#### 4.6 Immunisation of Health Professionals

##### 4.6.1 Policy Reference

'Immunisation Guidelines for Health Care Workers in South Australia' (January 2008).

*Note – These Guidelines are voluntary.*

##### 4.6.2 Responsibility of Country Health SA and the Health Unit

- to implement the 'Immunisation Guidelines for Health Care Workers in South Australia'
- Medical Practitioners who are attached to and provide services for country health units will be provided free vaccinations similar to those offered to health unit employees.

##### 4.6.3 Responsibility of the Medical Practitioner

Medical practitioners should strongly consider:

- taking reasonable steps to be aware of their own infectious disease and vaccination status to minimise the risk of transmitting infectious diseases to patients or other staff
- being vaccinated against vaccine preventable diseases such as Polio, Diphtheria / Tetanus, Hepatitis B, Influenza and Pertussis (see Immunisation Guidelines 'Vaccination recommendations' for further information), and especially those persons working in high-risk areas e.g. emergency, obstetrics and surgery

- complying with the health unit's screening, education and vaccination program, including the 'Immunisation Guidelines for Health Care Workers in South Australia'

#### 4.7 Medical Records and Documentation

##### 4.7.1 Policy Reference

SA Health standards, which are applicable across the public health system.

'South Australian Medical Record Documentation and Data Capture Standards'

*South Australian Public Hospital Retention Disposal Schedule (Operational Records Disposal Schedule No. 2000/0012)*

##### 4.7.2 Responsibility of Country Health SA and the Health Unit

- ensure the creation, storage and maintenance of patient medical records in accordance with best practice standards, guidelines and policies.
- Health units should help facilitate sharing of outpatient and inpatient medical records with the patient treating and usual medical practitioner in appropriate circumstances.

##### 4.7.3 Responsibility of the Medical Practitioner

- maintain accurate contemporaneous and legible patient medical records in accordance with best practice standards, the requirements of the health unit and the 'South Australian Medical Record Documentation and Data Capture Standards' and other relevant guidelines and standards and
- ensure that medical records are not removed from the health unit, except upon prior authorisation from the hospital executive or delegate

#### 4.8 Clinical Audits

##### 4.8.1 CHSA Audits

CHSA is not only committed to quality and safety, but as a provider of services in a rural environment it is also keen to better understand the relationship between the care setting, the training, experience and competency of health care professionals, and different models of care that are conducive to best practice outcomes. To this end, Directors of Medical Services, Clinical Directors and Principal Medical Officers will engage Medical Practitioners from time to time in a range of CHSA initiated clinical audits.

Medical Practitioners will be remunerated for these activities in accordance with the rate detailed within SARMFA (Clause 4.2) and administrative support will be provided as required.

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#### 4.8.2 State wide Audits

CHSA is required to collect a range of data for which input from medical practitioners and associated health professionals is required. These include but are not limited to:

- South Australian Audit of Peri-operative Mortality (SAAPM)
- Pregnancy Outcome
- Cancer Registry
- Peri-natal Mortality

#### 4.8.3 Responsibility of Country Health SA and the Health Unit

- oversee, encourage and coordinate input to clinical audits as necessary in a 'no blame' environment
- participate in clinical audits as required
- provide feedback to all the participants within 28 days of the audit being completed, and
- reimburse medical practitioners for attendance at Clinical audit meetings in accordance with SARMFA

#### 4.8.4 Responsibility of the Medical Practitioner

- participate in up to two clinical audits per year as conducted by CHSA via health units, plus any that may be required to address specific issues or problems. Audits may include peer review of de-identified medical records and the provision of information as required under legislation.

### 4.9 Priority of Treatment

#### 4.9.1 Responsibility of Country Health SA and the Health Unit

- to ensure that medical practitioners are provided with accurate and up to date information relevant to the priority of treating patients.
- to ensure, where the opportunity presents, that patients are clearly informed prior to attending the local Emergency Department of local arrangements that may involve them being charged for services provided by the local Medical Practitioner
- to ensure that information provided by the Medical Practitioner in regard to their fee structure for after hours services provided to patients is displayed appropriately Emergency departments, and
- that Health Information Lines (eg *healthdirect*) will be advised that for some health units fees may be charged for outpatient attendances and to bring relevant identification with them (eg Medicare card).

#### 4.9.2 Responsibility of the Medical Practitioner

- to ensure that clinical need is the primary factor to be considered for priority of treatment. Where patients' clinical needs are not significantly

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different, the patient who had been waiting longest for medical services shall be given priority.

#### 4.10 Treatment of Relative or Dependant

Normally, it is not expected that a medical practitioner would treat one of their relatives or dependants as an admitted patient. For the rare occasion for an urgent acute illness requiring admission, where the medical practitioner is on-call and no other medical practitioner is available, then an initial payment may be made. However, it is expected that the medical practitioner will be transferring the care of the patient to another medical practitioner as soon as practicable, in line with ethical practice.

#### 4.11 Out of Hospital Strategy

##### 4.11.1 Responsibility of Country Health SA and the Health Unit

- CHSA and Health Services will support people in the community by providing integrated service responses for individuals living with chronic disease with priority areas of cardiology, respiratory and endocrinology.
- the program response will involve and engage medical practitioners in local strategies including increased coordination and support for those patients with frequent admissions and a flexible service response to encourage early discharge to home for those with suitable clinical requirements.
- health units will consult with their medical practitioners to determine an agreed method of achieving the goals of the Out of Hospital Strategy.

##### 4.11.2 Responsibility of the Medical Practitioner

- the medical practitioner will negotiate in good faith with the health unit to assist the provision of this service.

### 5. Relationships and Partnerships

#### 5.1 Orientation / Induction

##### 5.1.1 Policy References

*'Corporate Induction Policy'. This is a SA Health policy, which is applicable across the public health system and will be of assistance to contractors delivering outcomes to health units*

*Local health unit 'Orientation / Induction Policy' – adapted from the Department of Health's Corporate Induction Policy.*

*'Rural Doctors Workforce Agency Orientation Manual'*

*'Code of Professional Conduct'- Medical Board of SA*

*'Code of Conduct for South Australian Public Sector Employees' – Commissioner of Public Employment, March 2009.*

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### 5.1.2 Responsibility of Country Health SA and the Health Unit

- provide a formal Orientation / induction to all new medical practitioners, as independent contractors to a health unit, on commencement. This will include ensuring all doctors have appropriate orientation on health unit IT resources-including access to clinical protocols on line etc and that these are easily accessible at all times by the medical practitioner
- familiarise all new medical practitioners with the existence and location of all relevant documents including values, goals, strategic directions, plans, policies, guidelines, procedures, by-laws and protocols relevant to their practice in the health unit/ service and
- familiarise all new medical practitioners with the work environment including organisational cultures, work relationships, structures, systems and resources.

### 5.1.3 Responsibility of the Medical Practitioner

- actively engage in the health unit orientation / induction process to enable an informed use of all the resources and facilities available
- seek clarification or advice if required and
- familiarise themselves with the health unit, its operations, services, staff, relevant policies, guidelines, procedures, by-laws and protocols.

## 5.2 Consultation and Liaison meetings

### 5.2.1 Responsibility of Country Health SA and the Health Unit

- health service representatives should meet with medical practitioner(s) on a regular basis, documenting these meetings and with agreed forward actions and timeframes to be documented and promptly circulated
- where a health service proposes to implement changes in program, organisation, structure or technology that are likely to affect medical practitioners, the health service shall consult with the medical practitioners during the planning process as far as possible,
- in circumstances where a health service may need to cease an existing service they shall negotiate with all affected medical practitioners and provide a period of notice of not less than three months and wherever possible 12 calendar months notice, and
- reimburse medical practitioners in accordance with SARMFA (Clause 4.5) for attendance at meetings with CHSA or a health unit at the request of either CHSA or the health service.

### 5.2.2 Responsibility of the Medical Practitioner

- medical practitioners shall meet with health service representatives on a regular basis to assist with communication and planning at a time appropriate to the medical practitioner.
- in circumstances where a medical practitioner plans to cease an existing service they shall negotiate with CHSA and provide a period of

notice of not less than three months and wherever possible 12 calendar months notice will be given.

- medical practitioners may cease providing an existing service without notice if through personal ill health or their immediate family members they are unable to continue to provide the service.

### 5.3 Criminal History / Police Checks

#### 5.3.1 Policy Reference

'Interim Whole of Health Criminal History Screening Minimum Standard' (SA Health – October 2006). *This policy is based on* The Children's Protection (Miscellaneous) Amendment Act, 2005.

Consistent with the '*Interim Whole of Health Criminal History Screening Minimum Standard*', and or the health unit's criminal history / police check policy, the medical practitioner, as service provider, will be required **at their own expense** to undergo a criminal history check prior to the provision of services.

'Offender History Checking' Country Health SA – Workforce Services  
December 2007

### 5.4 Confidentiality

#### 5.4.1 Policy References

Code of Ethics, AMA (2004) editorially revised 2006  
South Australian Medical Record Documentation and Data Capture Standards, SA Health (2000)  
Freedom of Information Act, 1991  
Code of Fair Information Practice 2006  
Privacy Act, 1988  
Code of Professional Conduct, Medical Board of South Australia

#### 5.4.2 Responsibility of Country Health SA and the Health Unit

- oversee and administer and maintain the overall safety, storage and quality of health unit patient medical records and
- maintain the confidentiality of patient's personal health information in accordance with privacy requirements, relevant legislation, organisational guidelines and as otherwise lawfully permitted and required

#### 5.4.3 Responsibility of the Medical Practitioner

- maintain the confidentiality of patient's personal health information in accordance with privacy requirements, relevant legislation, organisational guidelines and as otherwise lawfully permitted and required
- ensure security of storage, access and utilisation of patient information and

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- ensure that the medical record is not removed from the health unit unless prior authorisation is given from the hospital executive or delegate

## 5.5 Occupational Health, Safety & Welfare

### 5.5.1 Policy References

'SA Health – Workforce Safety and Wellbeing Unit'.

Occupational Health Safety & Welfare Act, 1986

Occupational Health, Safety and Welfare (Penalties) Amendment Act 2007

### 5.5.2 Responsibility of Country Health SA and the Health Unit

To meet its duty of care responsibilities, the health unit will ensure a safe and healthy environment to eliminate risks to the health, safety and welfare of persons in the workplace by:

- securing and promoting the health, safety and welfare of people at work
- promoting the adoption of safe work practices
- protecting people against workplace health and safety risks
- identifying risks and developing measures to eliminate those risks and
- ensuring that all persons entering the health unit comply with Occupational Health, Safety and Welfare legislation and associated health unit policies, guidelines, procedures, by-laws and protocols.
- ensuring that all medical practitioners that use the premises and facilities are informed of the location and availability of all relevant policies.
- being aware of unsafe working hours and the need of medical practitioners to provide primary health care to the community through their own general practices.

### 5.5.3 Responsibility of the Medical Practitioner

- to make themselves aware of and adhere to all relevant policies, guidelines, procedures, by-laws and protocols used by the health unit including those related to Occupational Health, Safety & Welfare
- support the promotion of safe work practices and
- identify and report risks in conjunction with health unit representatives.
- be cognisant of the effect of unsafe hours on their performance.

## 5.6 Conduct

### 5.6.1 Policy References

Code of Ethics, AMA (2004) editorially revised 2006

Code of Professional Conduct, Medical Board of South Australia

### 5.6.2 Responsibility of Country Health SA and the Health Unit

- act professionally at all times and treat the medical practitioner and their staff with respect and courtesy

- approach health care as a collaboration between multiple players and
- act honestly in all dealings with the medical practitioner and practice staff

### 5.6.3 Responsibility of the Medical Practitioner

- act professionally and treat all health unit staff, members of the public and colleagues with respect and courtesy
- approach health care as a collaboration between multiple service providers
- act honestly when performing their duties and
- to adhere to all health unit policies, procedures and protocols where they are not in conflict with legislation and the requirements of the Medical Board and the code of ethics of the AMA.

## 5.7 Bullying / Discrimination / Harassment

### 5.7.1 Policy References

'Bullying, Discrimination and Harassment Policy'  
Equal Opportunity Act, 1984. The Occupational Health, Safety & Welfare Act 1986, Section 55A of the Amended Act includes a definition of *Workplace Bullying and details the methodology involved for the investigation, mediation and conciliation of involved parties.*

### 5.7.2 Responsibility of Country Health SA and the Health Unit

- ensure a safe and healthy work environment and to eliminate risks to the health, safety and welfare of persons in the workplace
- ensure that the health unit is free of discrimination as far as reasonably possible, for the benefit of health unit staff, independent contractors, volunteers, visitors, patients, members of the public and colleagues as per policy, equal opportunity or other anti-discrimination legislation
- conduct and investigate all claims of bullying, discrimination and/or harassment in the workplace and
- ensure that there is natural justice and fully inform all those involved in a claim of the findings and provide the opportunity to appeal the findings.

### 5.7.3 Responsibility of the Medical Practitioner

- will not engage in bullying or other forms of harassment, including sexual harassment
- will abide by the relevant legislation and related health unit policies/procedures regarding bullying, discrimination and harassment and
- will not discriminate directly or indirectly in the treatment of health unit staff, patients, members of the public, visitors and colleagues on any grounds covered by health unit policy, equal opportunity or other anti-discrimination legislation

## 6. Facilities and Equipment

### 6.1 Responsibility of Country Health SA and the Health Unit

As well as providing a safe environment, CHSA and health services agree to provide resources as is reasonably required for the treatment of public patients.

In addition, each unit should have available as appropriate the following:

- Video-conferencing, tele-radiological, fax and email facilities
- Medical monitoring equipment including appropriate Imaging , CTG and ECG facilities, and Point of Care testing
- Means for medical practitioners to immediately access their practice notes in the emergency department through a dedicated computer terminal and broadband connection.
- Drug formulary will be as specified by the CHSA Drugs and Therapeutics Committee for the services provided by the unit.
- Accessible computers to enable discharge planning to be completed in a timely and efficient manner.
- IT links that are easily accessible 24 hrs a day in clinical areas to access clinical protocols and guidelines

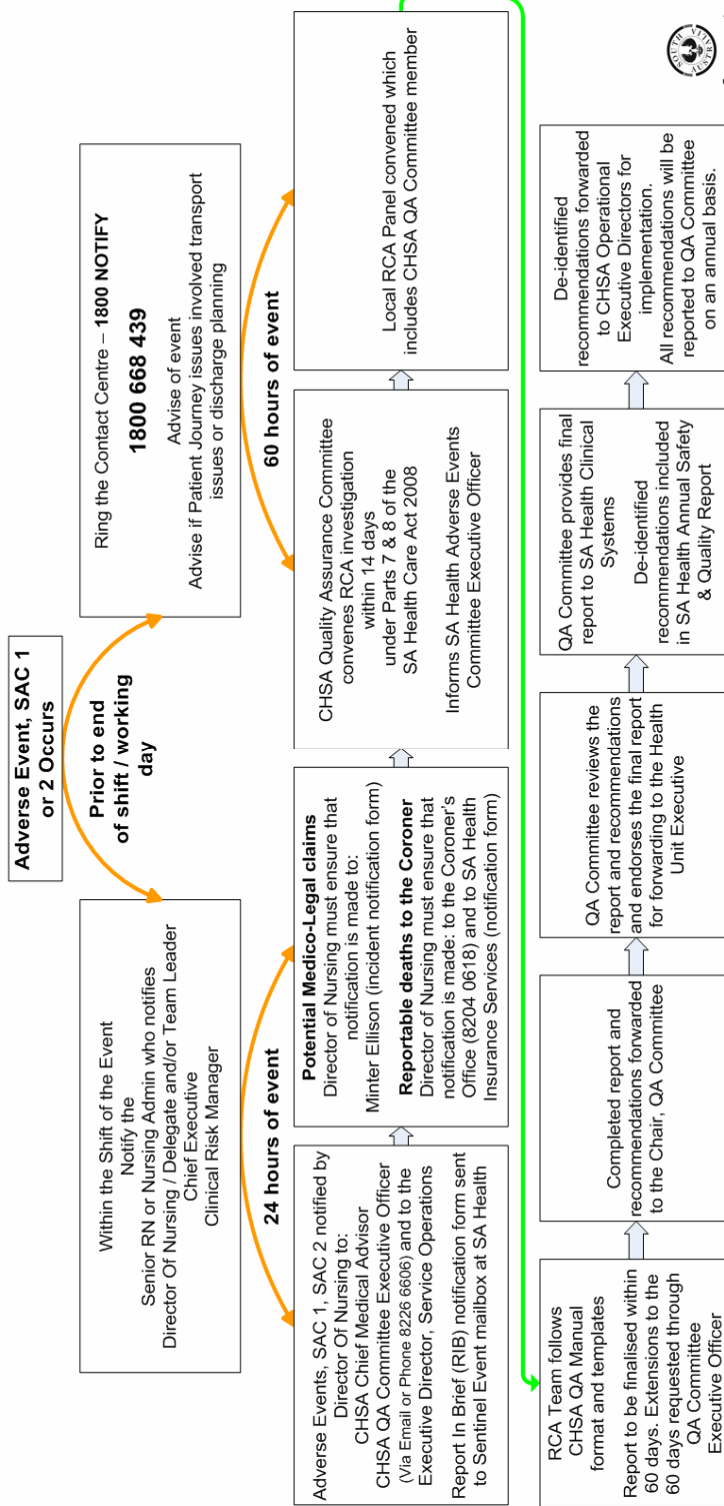
### 6.2 Responsibility of the Medical Practitioner

- To be fully trained in the equipment provided by the health unit relevant to their practice.
- Enable their practice notes to be accessible [by the medical practitioner](#) at the health unit under protocols that protect the privacy of the patients.

COUNTRY HEALTH SA – GOVERNANCE COMMITTEE FRAMEWORK  
- JULY 2008 –

**Country Health SA Quality Assurance Committee Sentinel Event Notification Flowchart**  
**These steps must be followed immediately after the event once the patient is stabilised and safe**

**SAC 1 = Extreme risk: immediate action required - Ring 1800 Notify, contact Senior RN and DON RCA investigation must be commenced by CHSA QA Committee.**  
**SAC 2 = High risk: Chain of Command must be notified, 1800 Notify and CHSA QA Committee.**  
**SAC 3 = Moderate risk - management responsibility must be specified - e.g. aggregate data then undertake practice improvement project.**  
**SAC 4 = Low risk - manage by routine procedures - aggregate data then undertake practice improvement project.**  
**Only report a SAC of 3 or 4 if likely to attract external attention or requires notification under existing legislative reporting requirements.**



**RCA'S ARE A NO BLAME CULTURE**

Version 2 - October 2008

