RACGP

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Standards for general practices (6th edition)

Frequently asked questions

This document supports the *Standards for general practices* (6th edition) (second draft), which is available on the RACGP's website. The FAQ document will be updated alongside any future drafts and final publication of the Standards.

1. Changes from fifth to sixth edition Standards

1.1 How has the structure of the Standards changed?

1.1.1 Changes to terminology

The following changes have been made to the naming of components of the Standards:

- 'Indicators' are now called '**criteria'**
- The requirements previously referred to as 'musts' are now '**sub-criteria**' and describe specific actions. This change:
    - clarifies that responsibility rests with the practice, not any one individual
    - focuses on systems, processes, and structures rather than on personal compliance
    - refers to outcomes or results, regardless of the method chosen by the practice
    - is more neutral and collaborative than the previous terminology, thereby fostering a more constructive mindset aimed towards quality improvement
    - mirrors how surveyors evaluate evidence and outcomes.

1.1.2 Structure

The sixth edition of the Standards general practices is structured to include five **standards**, with thematically categorised criteria. The five standards are:

1. Foundations of general practice
2. Clinical governance
3. Patient participation
4. Continuous quality improvement
5. Point-of-care testing (PoCT) (optional standard)

Excluding the optional PoCT standard, the sixth edition Standards includes:

- 4 standards
- 35 criteria categories
- 86 mandatory criteria (31 fewer than equivalent indicators in the fifth edition)
- 3 aspirational criteria.

The explanatory notes for each criterion have the following sections:

- *Criteria*: These are activities the practice needs to complete, or evidence it needs to present.
- *Why this is important*: This section explains why criteria and sub-criteria are important from a quality and safety perspective.
- *Meeting these criteria*: This section sets out ways that the practice can choose to meet the relevant criteria and associated sub-criteria.

The five new standards allow a more effective classification of criteria into relevant themes for general practice's consideration:

- **The Foundations of general practice** standard captures core elements of setting up and running a practice.
- **Clinical governance** addresses systems and processes for the facilitation of quality and safety of clinical care.
- **Patient participation** is designed to encourage patients to be engaged with their health in meaningful ways that contribute to the quality and safety of their care.
- **Continuous quality improvement** addresses ongoing processes of assessing and improving the performance of general practices
- **Point-of-care testing** aims to improve the quality and safety of point-of-care testing performed by health services and help services identify and address gaps in their systems and processes.

The first four standards collectively cover the essential aspects of a safe and quality general practice, with the point-of-care testing standard being optional for general practices that provide point-of-care testing services.

Each standard has a code allocated to its criteria (F for Foundations of general practice, CG for Clinical governance, PP for patient participation, CQI for Continuous quality improvement and PoCT for Point-of-care testing).

1.1.3 Required and aspirational criteria

The flag symbol (►) has been removed from all criteria. The preamble explains that all criteria need to be met for accreditation unless they are identified as aspirational.

1.2 Inclusion of the Standard for Point-of-care testing

The fifth edition *Standards for point-of-care testing* has been updated and is included in the sixth edition Standards (second draft). The PoCT standard is an optional standard for those practices that provide PoCT. Practices must already be accredited to the first four standards (Foundations, Clinical governance, Patient participation and Continuous quality improvement) to be eligible for accreditation to the PoCT standard.

The PoCT Standard includes eight sets of criteria, inclusive of 17 required criteria and one aspirational criterion on the recording of results.

1.3 What are the consumer expectation statements at each criterion?

The RACGP has partnered with consumers in the development of the sixth edition Standards to develop consumer expectation statements that capture the meaning and importance of each criterion to consumers. These consumer statements help to align the standards with meeting the needs, preferences, and expectations of consumers. They empower patients by giving them a voice in the standards that govern their care.

1.4 What's new in the sixth edition Standards (second draft)?

Information below is generally grouped into criteria, excluding environmental sustainability. As environmental sustainability is embedded throughout the Standards, this document addresses it in one single section (See F3).

Explanatory materials	Explanatory materials have been updated extensively in line with changes to criteria and feedback from prior consultation and piloting. Some of these updates are outlined in this document; however, we recommend reviewing the relevant criteria to see all updates to explanatory materials.
F1 – Defining and planning for the practice **New criteria**	The sixth edition Standards introduces new criteria relating to defining and planning for the practice. These ask that the practice: • define and monitor its mission and values. • maintain a strategic plan and measure progress toward achieving its goals. • maintain an operational plan and measure progress toward delivering its objectives • incorporate and assess a strategic approach to the safe provision of healthcare • maintains currency, accuracy and accessibility of policies, procedures, and operational documents. Defining the practice's mission and values establishes the core principles and purpose for guiding the practice's operations. Having strategic and operational plans to set goals and objectives, respectively, aims to enhance professionalism, quality, ethics and progressive leadership within the practice.

F2 – Response planning **Updated criterion**	Response planning has expanded in the sixth edition. Emergency response planning is still included as well as planning for unexpected events more broadly, such as interruptions to business as usual. Response planning, including but not limited to responding to an emergency, helps practices to consistently identify, document and manage risks and will allow practices to be able to provide clinical care in an emergency.
F3 – Environmental sustainability and responsibility (embedded throughout the Standards) **New criteria**	The sixth edition Standards introduces environmentally sustainable measures. Measures such as reducing energy consumption, minimising waste, and promoting eco-friendly practices contribute to improved patient wellbeing and satisfaction and mitigate a practice's impact on the environment. The environmental sustainability criteria have been tested in general practice and have been critiqued by key stakeholders including the Australian Commission on Safety and Quality in Health Care (ACSQHC). Explanatory materials state the rationale for inclusion and ways a practice could meet the criteria. Rationale and intent Collectively, the intent of the environmental sustainability criteria is to achieve: • a strong organisational commitment to environmental responsibility • staff and patient empowerment through leadership, education, and shared resources • embedded sustainable practices into care and operations • tracked improvements in environmental performance through regular assessment and action • contribution to broader health sector efforts to reduce environmental and climate impacts. The explanatory materials provide many examples of ways that a practice could address environmental sustainability, neither prescribing specific actions, nor limiting the scope of actions a practice can take. For smaller practices, these actions do not need to be complex. Practices can start with small, achievable steps. Over time, the practice could build on this foundation with bigger or more formal initiatives as time and resources allow. Criteria to note The theme of environmental sustainability appears throughout the Standards: • At criteria F3.A and F3.B at F3 – Environmental sustainability and responsibility, the practice is asked to: – be aware of, and take steps to minimise, its environmental impact – have at least one member of the practice team who has primary responsibility for engaging in and promoting the environmental sustainability of the practice.. • At criterion CG4.C at CG4 – Clinical and medicines guidelines, the practice is asked to provide members of the practice team with access to information, resources and/or strategies for the implementation of environmentally sustainable clinical practices. • At criterion PP6.C at PP.6 – Health promotion and preventative care, the practice is asked to share information with patients about environmental issues relevant to the healthcare they receive. Engaging patients in discussions about environmental sustainability can also foster a sense of community and shared responsibility for addressing environmental challenges. • At criterion CQI1.B at CQI1 – Continuous quality improvement activities, the practice is asked to monitor and report on its environmental performance to track progress toward sustainability goals and compliance with its documented strategies to reduce direct and indirect carbon greenhouse gas emissions. Aspirational criterion CQI1.C asks the practice to measure environmental-impact metrics to assess and manage its overall environmental footprint.

F5 – Registration and qualifications of practitioners **Updated criterion**	The practice no longer needs to retain documentation regarding registration and CPD for each practitioner; however, the practice must still ensure each healthcare practitioner has current national registration and accreditation/certification.
F7 – Practice team culture, safety and involvement **New sub-criteria**	Criterion F7.A relates to the positive culture of a practice, incorporating elements from the fifth edition Standards. This criterion also introducing new sub-criteria, including that the practice: • has processes to manage occupational exposures • supports the practice team during emergencies or other traumatic events • supports staff involved in significant clinical incidents, including patient safety incidents • monitors and adjusts the workload of members of the practice team to support their wellbeing.
F10 – Digital health technologies **New criterion**	This criterion relates to the use of digital technologies and platforms to deliver healthcare services remotely or enhance in-person care, such as telehealth, mobile health apps, patient portals, remote monitoring devices, and secure messaging platforms. Criterion F10.A is new to the Standards and requires practices to use digital health technologies safely and securely, asking that the practice: • facilitates processes for members of the clinical team to obtain informed consent from patients when using digital health technologies • has a documented process for assessing, implementing and managing digital health technologies, including consideration of their potential impacts on the practice, members of the practice team and patients • provides members of the practice team with access to technical expertise for the digital health technologies it uses.
F11 – Artificial intelligence **New criteria**	The sixth edition Standards includes new criteria regarding artificial intelligence (AI). These criteria are applicable for practices using AI, whether in their clinical practice or administrative duties. The RACGP acknowledges the rapidly evolving nature of AI in healthcare. The criteria included in the sixth edition Standards may be updated as new national regulations, guidance, and resources become available. Practices need to continue to monitor developments in this space and adjust their implementation accordingly. The new AI criteria ask that the practice: • facilitates processes for members of the clinical team to obtain and document informed consent from patients when aspects of care will be delivered using AI • clearly defines that clinicians are accountable for care decisions supported by AI tools, and documents processes to support their clinical oversight • facilitates data deidentification/anonymisation when using AI tools that process patient data • discusses the implementation and use of AI with members of the practice team to identify practical implications and training needs • has a process to assess and evaluate the use of AI, including risk mitigation.
CG1 – Clinical information systems **Updated criteria**	Criterion CG1.A asks the practice to use a *digital* clinical information system to manage patient health information. Paper-based systems are no longer acceptable. CG1.A acknowledges that hybrid systems may still be needed, for instance if the practice has patients at residential aged care facilities, however all systems need to be digital.

CG3 – Facilitating complete patient health records **Updated criteria**	Criteria at CG3 – Facilitating complete patient health records broadly align with the fifth edition Standards regarding the content of health records; however, the Standards now call for: • active patient health records to contain each patient's current health summary using codable fields • all (100%) active patient health records to include known allergies or indicate that the patient has no known allergies • practices to support members of the clinical team to involve patients in shared decisions about their care • as an aspirational criterion: demographic and identification details for each active patient to include assigned sex at birth, variations of sex characteristics (intersex), gender and preferred pronouns. These criteria also ask that the practice's patient health record system *allows*: • clinicians to record all consultations and clinical related communications in the patient's health record • the practice team to record all communications with patients.
CG4 – Provision of clinical and medicines guidelines **New criterion**	Criterion CG4.D asks the practice to support members of the clinical team and patients to reduce inappropriate antibiotic prescribing. This criterion has been introduced in the sixth edition Standards to help address the growing issue of inappropriate antibiotic prescribing. The explanatory materials provide clarification on ways practices can help their clinical team and patients to reduce inappropriate antibiotic prescribing.
CG6 – Follow-up systems **New sub-criteria**	Criterion CG6.A introduces additional sub-criteria, asking that the practice: • has follow-up systems for recalling and documenting interactions with patients who have clinically significant results, which include documenting in the patient's health record each attempt to contact and recall patients with clinically significant results • has a process to follow-up results and investigations when they have not been provided to the GP.
CG7 – Managing clinical risk and incidents **New criteria**	Criterion CG7.A now also asks practices to: • report results of risk identification, management and mitigation to the practice's leadership (practice leadership is defined in the glossary) • have systems in place to receive and share public health notifications.
CG8 – Immunisations **Updated criteria**	Where previously the practice needed to *encourage* members of the practice team to obtain immunisations recommended by the current edition of the Australian Immunisation Handbook based on their duties and immunisation status, the sixth edition asks the practice to ensure all members of the practice team have recommended immunisations based on the risks of their role and as mandated by the relevant state or territory. The exact immunisation requirements and recommendations will depend on the risk of infection based on the practice's location, patient population and the duties of each member of the practice team. The practice could conduct a risk assessment regarding the types of immunisations each practice team member needs to have based on their role. In situations where a practice team member chooses not to have recommended or mandated immunisations, the practice needs to review relevant state / territory legislation, or obtain legal advice to ensure they continue to comply with workplace protections. This reflects a genuine commitment by the practice to the health, safety and wellbeing of the whole practice team and its patients. The RACGP is currently obtaining further legal advice regarding Criterion CG8.A.

CG9 – Infection prevention and control, including reprocessing **New criterion**	Criterion CG9.E has been introduced to the sixth edition Standards as is relevant to any practice that reprocesses reusable medica devices. It asks that the practice: • includes in the practice-specific infection control policy details of risk assessment for reprocessing reusable medical devices • reprocesses reusable medical devices in accordance with the RACGP *Infection prevention and control guidelines* or another model that meets the current Australian standard. The sixth edition Standards also requires the practice to have a process to record sterilisation load numbers for each patient when sterile items have been used (Criterion CG9.F).
CG10 – Practice environment **Updated criteria**	Criterion CG10.A now asks practices to have a cleaning policy aligned with the RACGP *Infection prevention and control guidelines* or another relevant Australian standard.
CG11 – Practice equipment **Updated criteria**	The following items of equipment have been added to criterion CG11.A: • infant weighing scales if appropriate to the patient population • razors for emergency management • scissors. The doctor's bag notes that practices need to have intravenous consumables, with the glossary clarifying that IV consumables include cannulas or butterflies, bungs, film dressing or tape, but does not necessarily include fluids. Duplicate information (such as bungs, cannulas and tape) has been removed from the doctor's bag.
CG12 – Maintaining vaccine potency **Updated criteria**	Criterion CG12.A specifically asks practices to base their cold chain management policy on the current edition of the *National vaccine storage guidelines: Strive for 5*, to communicate this policy to members of the practice team and patients, and for members of the practice team to implement this policy.
CG13 – Research **New criterion**	Criterion CG13.D has been added for practices that participate in research to help ensure patient privacy when sharing deidentified patient health information. Associated explanatory materials regarding sharing deidentified patient health information to third parties has been included.
PP4 – Informed consent **New criterion**	Informed consent criteria have been differentiated: • Criterion PP4.A asks the practice to have processes to obtain and document informed consent **for clinical procedures and treatments**. • Criterion PP4.B asks the practice to have processes to obtain and document informed consent **for when a third-party is present**.
PP8 – Engaging consumers **New criterion**	Criterion PP8.A asks the practice to engage with consumers to monitor, review and improve care. This strengthens the outcomes focus of CQI, asking the practice to work with patients and embed their contributions without prescribing a specific methodology. Both formal and informal feedback engagement mechanisms are needed.
PP10 – Care when the practice is not open **Updated criterion**	Criterion PP10.A asks practices to inform their patients how they can access care when the practice is not open. The explanatory materials provide advice on how practices could do this, as well as the types of services they could refer patients to when they are not open.
CQI1 – Continuous Quality improvement activities **New criteria**	Criterion CQI1.A asks the practice to undertake CQI activities but is not prescriptive as to what those activities are. To promote continuous quality improvement, this criterion asks practices to conduct at least one clinical improvement activity every 12 months, of which one must include the use of coded clinical data. Practices also need to have processes to report performance data and quality improvement activities to the practice's leadership.

PoCT6 – Data management **Updated criterion**	Data management has been strengthened with a new aspirational criterion that facilitates progress and alignment with criterion CG3.D (*The practice's clinical information system facilitates the recording of each patient's current health summary in codable fields*). Criterion PoCT6.B asks that the practice facilities the recording of PoCT results using a nationally recognised coding system.

2. Accreditation – eligibility and assessment

2.1 Can 'non-traditional' general practices be accredited against the sixth edition Standards?

The RACGP expanded its definition of a general practice for the purpose of accreditation in 2024 to include non-traditional practices, including mobile services (such as outreach disability services) or those servicing a specific patient cohort within facilities, such as residential aged care facilities (RACFs) or disability homes. The definition is retained in the sixth edition Standards and sets the eligibility criteria for practices to be access accreditation.

Services that provide limited and/or non-continuous care are not eligible for accreditation. This may include but is not limited to:

- telehealth-only services (including on-demand telehealth services), where continuous care may be provided but scope of care provided is limited (ie physical assessment is not possible)
- services that focus on a specific body system or disease process (such as skin cancer or mental health clinics), where scope of care provided is limited
- services that are not GP-led; that is, those that do not provide predominantly general practice services as per the description of predominantly within the definition (eg nurse-led services).
    - Note, a women's health service that offers the full scope of generalist services to women would be eligible for accreditation under the new definition; however if a women's health service only offers specific services to its patients (eg reproductive health), it is ineligible for accreditation.

Accreditation agencies can determine if a service meets the definition of a general practice for the purpose of accreditation. In determining eligibility, an agency may ask whether the service is able to provide any general practice care its patient population might reasonably expect to receive from a GP (eg are vaccines available?)

2.2 Will practices to able to choose to seek accreditation against the fifth or sixth edition of the Standards?

Practices can choose to be accredited against the fifth or sixth edition of the Standards for a period of time following the publication of the sixth edition (this period will be confirmed prior to the publication of the sixth edition Standards). All practices undergoing accreditation will need to meet the sixth edition Standards following the determined transition period.

3. Consultation and publication

3.1 What detail has informed the development of the draft sixth edition Standards?

The development of the sixth edition Standards has considered and incorporated:

- The Quintuple Aim for health care improvement
- Comprehensive literature review of current evidence
- Reviews by the Department of Health, Disability and Ageing, including the accreditation arrangements review and gap analysis for accreditation
- The National Safety and Quality Primary and Community Healthcare Standards
- The Principles of the International Society for Quality in Health Care International Society for Quality in Health Care (ISQua)
- Consumer engagement and development of consumer expectations of accredited practices.
- Stakeholder feedback (via consultation and piloting), including fifth edition scoping consultation with general practices (First round, Sep-Oct 2024). Stakeholders that provided feedback included:
    - general practitioners
    - practice managers
    - practice owners
    - other RACGP expert committees
    - accreditation agencies
    - medical and general practice peak bodies
    - governmental stakeholders (ie the Commission on Safety and Quality in Health Care and the Department of Health and Aged Care).

3.2 How will the RACGP incorporate further feedback from practices?

Following this consultation on the second draft (September 2025), the RACGP will consider all feedback received and develop the final draft of the sixth edition Standards, which will be submitted for RACGP Board endorsement and publication in early 2026.

The second draft of the sixth edition will be piloted in general practices, which will include practice self-assessments and discussions with surveyors as part of an accreditation visit. The pilot will seek feedback on:

- all criteria – whether they are feasible, acceptable, applicable and outcomes focussed
- clarity and usefulness of explanatory materials
- structure and presentation of the Standards
- any gaps and issues in implementation of the Standards.