Tū Ora
COMPASS HEALTH

Clinical Assistant Delegation Policy and Framework

Clinical Assistant Guide

Better Health Outcomes
through Great Primary Care

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Document Name: Clinical Assistant Delegation Policy and Framework

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About this Resource:

The purpose of this resource is to guide the Clinical Assistant within Primary Care working under the delegation of a General Practitioner or Nurse Practitioner.

Please note – all practices utilising this resource need to ensure that the recommended actions have been reviewed and agreed upon within the practice context or updated to a practice specific version under the guidance of practice clinical governance/leadership.

This has been written with Wellington based laboratory limits and 3D HealthPathways recommendations and was last fully reviewed in November 2023.

Delegation Policy

This outlines the responsibilities of the clinical assistant, the clinician and the employer in relation to using the below delegation protocol.

Delegation

The transfer of responsibility for the performance of an activity from one person to another, with the original person retaining accountability for the outcome (adapted from Guideline: delegation of care by a registered nurse to a health care assistant May 2011)

Requesting Clinicians

The clinician who ordered the test, or the clinician who is responsible for the patient as their enrolled provider, and therefore receiving results such as recall blood tests, hospital letters etc.

Supervision

The clinical assistant must have a supervisor within the practice. This supervisor should be a vocationally registered general practitioner or nurse practitioner. The supervisor is responsible for providing ongoing support and supervision to the clinical assistant. This could take the form of a regular meeting, participation in peer review group, written communication such as tasks with questions from the clinical assistant to the supervisor and audit of random selection of patient records for which the clinical assistant has processed inbox records under the delegation framework.

The supervisor of the clinical assistant must be clearly outlined during the orientation process and the process by which supervision will occur must be defined and understood by both the supervisor and the clinical assistant.

The supervisor must ensure that the clinical assistant who has been delegated the activity:

1. Understands the delegated activity
2. Has received training in the delegated activity and that this has been recorded
3. Knows when to escalate a result to a duty clinician and the process for how to do this
4. Knows that if a result is not able to be managed in the delegation framework, then it is to be left in the inbox for review by the requesting clinician
5. That the clinical assistant understands they should not file any inbox result unless this is both allowed within the delegation framework, and the clinical notes associated with the result include documentation that makes it clear there is no follow up required of normal results.

Escalation Protocol

The process for escalation for results that are deemed to need same day review under the delegation framework must be clearly documented and should be understood by both the full clinical team at the practice employing the clinical assistant as well as the clinical assistant.

Monitoring and Evaluation

Once per week, a minimum of five patient records for which the clinical assistant has processed results, are recommended to be audited by the supervisor to ensure the clinical assistant has applied the delegation framework correctly. Any instances in which it has been applied incorrectly need to be addressed with further training and additional supervision and this should be documented by the supervisor so that the actions taken are clearly understood.

Responsibility of the clinical assistant

1. The clinical assistant performing the delegated activity is accountable for their own actions

2. The clinical assistant must inform their supervisor if they have not been trained to action information in the delegation framework

3. If the clinical assistant does not understand how to apply the delegation framework to a result, or consider that it sits outside the delegation framework, they must leave that result in the inbox to be reviewed by a requesting clinician.

4. The clinical assistant should not file any inbox result unless this is both allowed within the delegation framework, and the clinical notes associated with the result include documentation that there is no follow up required of normal results.

5. The clinical assistant must follow the escalation protocol when this has been deemed the next step within the protocol, and if for some reason the duty clinician is unavailable, they must seek same day guidance from a senior member of the practice such as the nurse team leader or practice manager

The employer of the clinical assistant must:

- Ensure that the practice has a documented escalation protocol that enables the clinical assistant to hand over results within the same working day when deemed appropriate by the delegation framework

- Ensure the clinical team at the practice is aware of the escalation framework and their responsibilities within this

- Ensure there is a named supervisor within the practice for the clinical assistant who is available on a regular basis to provide support, training, and advice

- Ensure the supervisor has time available to audit a minimum of 5 records per week where the clinical assistant has processed results under the delegation framework
- Ensure the clinical assistant has completed training in use of the delegation framework before being expected to begin undertaking their role.
- Ensure the clinical assistant has a position description and understands their delegated activities.

Delegation Framework

Improving the ability of the clinical assistant to help with test results is reliant on clinical documentation at the point of ordering tests.

The clinical assistant can only file normal results if there is a clear comment in the notes 'no follow up of normal results required'.

If results are normal but this comment has not been made, the result will be annotated normal and left in the inbox for review by clinician.

If the clinical assistant is being delegated to file normal results as above, any required safety netting and instructions around review or follow up must be done at the time of the consultation and should be documented in the clinical record.

Patient notification of results: Practices will need to provide the clinical assistant with their results notification policy/protocol and ensure the clinical assistant is aware of how and when the practice wants them to notify patients of results.

If at any point the clinical assistant is unsure of whether to file a result, or next step to take, the result should be left in the inbox for the clinician to review.

Where the delegation framework states that a result needs to be escalated to the duty clinician, the expectation is that the duty clinician is notified as soon as practicable eg between patients, and that this handover of the result is documented by the clinical assistant. Once the clinician has been notified, they assume responsibility for actioning the abnormal result from that point onward.

All results actioned, annotated or filed by clinical assistant should have Cl Assist at end of comment field to ensure it is clear who has done this. Can be set as keyword. Not to use initials or CA as difficult to track later.

Framework

This delegation framework applies to people aged 18 years or older. It cannot be used for children and young adolescents.

Changes made during 2023 Updates

- *HPV section updated to reflect new HPV primary screening guidance*
- *Creatinine and eGFR section simplified slightly and guidance set from the Kidney Health CKD Summary Guide, with reference to 3D Chronic Kidney Disease pathway.*
- *Covid-19 Section updated*
- *Bowel screening results added.*
- *Patient Portal Guidance added*

Cervical/HPV Screening	
HPV Primary Screening 'HPV: not detected'	**Action:** • Annotate in comments **normal, rpt in 5 years or 3 years if immune deficient** • Immune deficiency should be noted at time of test by ticking immune deficient box on order form and therefore result note will state 3 years. Considering immune deficiency sits with person doing the test. **Clinical Assistant needs to confirm within practice that this is their process.** • Update recall • Notify patient as per practice policy • If clinical notes document no follow up of normal result required, can file • Process for uploading results varies between PMS software, ensure workflow is clarified locally
HPV Primary Screening 'HPV: HPV 16 or 18 detected'	**Action:** • Annotate in comments **HPV 16/18** • Next step is colposcopy referral – either leave in clinician inbox to refer, or if the practice has a nominated person to complete these referrals, forward the result to them. • Responsible clinician to inform patient of result and plan
HPV Primary Screening 'HPV: HPV Other detected'	**Action:** • Annotate **HPV Other,** and leave in inbox for clinician review. • Next step depends on whether this is first or second HPV Other result and whether cytology has been done
HPV Primary Screening 'HPV test invalid or test unsuitable for analysis'	**Action:** • Annotate: **invalid/unsuitable for analysis** • Follow practice process to contact patient and arrange repeat test
Cervical Cytology	**Action:**

'Negative for intraepithelial lesion or malignancy'	• Leave in inbox for clinician to review • Next step depends on age and how many HPV Other results they have had previously
Cervical Cytology 'ASC-US or LSIL'	**Action:** • Leave in inbox for Clinician to review • Next step depends on age and how many HPV Other results they have had previously
Cervical Cytology Any other abnormal result or result not fitting into any above category	**Action:** • Leave in inbox for Clinician to review
Blood Test/Screening/Swab Results	
Chlamydia/gonorrhoea swab Both negative	**Action:** • Notify patient as per practice protocol • If clinical notes state no follow up of normal results required, can file • Do not state that the test was an STI check if texting the patient
Chlamydia/gonorrhoea swab Gonorrhoea positive	**Action:** • Discuss with duty/acute nurse – if they are able to treat with standing order, make note in daily record 'positive gonorrhoea test, discussed with [name] who will arrange treatment and follow up • If duty/acute nurse not able to treat, annotate 'positive gonorrhoea', leave in inbox for clinician • Send task to requesting clinician that notification to medical officer of health required.
Chlamydia/gonorrhoea swab Chlamydia positive	**Action:** • Discuss with duty/acute nurse – if they are able to treat with standing order, make note in daily record 'positive chalmydia test, discussed with [name] who will arrange treatment and follow up • If duty/acute nurse not able to treat, annotate 'positive chlamydia', leave in inbox for clinician.
Coeliac Screen Anti TTG IgA <20 CU = negative **AND** IgA within normal range (0.8-4.0)	**Action:** • Annotate comment with 'normal coeliac screen' • If clinical notes state no follow up of normal results required, can file • Notify patient as per practice policy
Coeliac screen Anti TTG IgA <20 CU **AND** IgA outside normal range <0.8 or >4.0	**Action:** • Annotate IgA low/elevated • Requesting clinician to review result
Coeliac screen	**Action:**

Anti TTG IgA 20-100 CU = weak positive	• Annotate 'weak positive' • Requesting clinician to review result
Coeliac screen Anti TTG IgA > 100 = positive	Action: • Annotate 'positive' • Requesting clinician to review result
Covid-19 PCR Swab Negative	**Action:** • Notify patient via text message as per practice policy or following wording *'Your Covid-19 test result was negative. This means it did NOT show Covid-19. Please remain at home until your symptoms have been gone for 2 days. If you feel worse, please contact the medical centre or healthline 0800 358 5453'* • Negative results for Covid-19 can be filed by clinical assistant after patient notification sent.
Covid-19 Swab Positive	**Action:** Annotate **positive covid-19** and leave in inbox. See Te Whatu Ora website for up to date management recommendations.

Creatinine and eGFR

Any egfr drop of >10ml/min since most recent prior result, do not file, needs clinician review

New drop to egfr <60 where is was previously >90, follow escalation protocol and notify clinician of acute renal impairment.

Creatinine normal range varies depending on age. eGFR is calculated from the creatinine, age of patient and sex of patient.

Acute renal impairment – rapid (eg hours to days) drop in renal function causing elevated creatinine and reduced eGFR. Out of scope for this protocol

Chronic renal impairment - can be stable or progressive.

Stable – egfr change <5ml/min over past 12 months

Progressive egfr decreased by >5ml/min over past 12 months

The below guidelines are based on kidney-health-ckd-summary-guide.pdf and informed by 3D Health Pathways.

Creatinine and eGFR egfr >90ml/min	**Action:** • Annotate with Cr [xx], egfr [xx], normal
Creatinine and eGFR eGFR 60 – 89 **AND** Prior result egfr >90	• Annotate 'Cr [xx], egfr [xx], new renal impairment' • Requesting clinician to review result, not for clinical assistant filing
Creatinine and eGFR eGFR 60 – 89	• Annotate with Cr [xx], egfr [xx] stable

AND Prior eGFR within 5ml/min of current result	• Check if has a classification of chronic kidney disease (CKD) stage 2 – if not, add • Request CVRA bloods, urine ACR and BP check if not done in past 12 months • Set task to clinical assistant to ensure above happens, inform requesting clinician when results available and ask if review of patient needed • Requesting clinician to review result –chronic renal impairment is often associated with other medical conditions
Creatinine and eGFR eGFR 60 – 89 **AND** current result >5ml/min reduction compared to previous egfr result	**Action:** • Annotate with Cr [xx] and egfr [xx], progressive impairment • Requesting clinician to review result, not for clinical assistant filing • Requesting clinician to decide if further testing needed
Creatinine and eGFR eGFR 45 – 59	**Action:** • Annotate 'cr [xx] gfr [xx] ckd – now stage 3a,' • Request urine ACR if not done in past 12 months • Clinical assistant to task self to follow up that urine ACR is completed • Ensure has CKD classification • Add annual recall for: urine ACR, creatinine, electrolytes, urea and MSU for haematuria if not already present • Requesting clinician to review result, not for clinical assistant filing.
Creatinine and eGFR **eGFR** 30 – 44	**Action:** • Annotate 'cr [xx] gfr [xx] • Ensure has classification of CKD • Clinical assessment recommended 6 monthly – if patient not seen for >6months, task clinician asking if they would like appointment arranged. • Update recalls to: 6montly urine ACR, 6monthly Creatinine, Na/K (electrolytes), urea, CBC, calcium, phosphate and annual MSU for haematuria. Hba1c recall annually if no diabetes. If has diabetes, then HBA1c as per diabetes monitoring plan. • If any of the above recalls overdue, request those tests and notify patient of need for extra tests as per practice protocol • Requesting clinician to review result, not for clinical assistant filing.
Creatinine and eGFR eGFR 15-29 **AND** within 5ml/min of previous eGFR	Action: • If not seen in past 4 months by primary care or renal clinic (check inbox for renal clinic outpatient letter), task clinician to see if needs review appointment booked • Ensure classification of CKD stage 4 present

	• Requesting clinician to review result, not for clinical assistant filing Note: this group should have regular monitoring of bloods/ urine and in place, however the parameters of this are variable depending on clinical scenario and therefore out of scope of this protocol. Needs decision by requesting clinician.
CVRA Hba1c, Lipids and Creatinine will come through together in results	Action: • Annotate lipid result with "ratio [value], LDL [value] CVRA [value]%" • Follow instructions in Creatinine and eGFR for the creatinine result • Follow instructions in the Glycated Haemoglobin section for Hba1c • Check notes for a BP in past 3 months – if not present organise BP check – could be in practice (RN, PCPA) or offsite eg pharmacy and result communicated to clinical assistant and entered into notes • Check practice protocol for who actions CVRA results – follow protocol regarding who is notified • If no clear protocol then remains in inbox for requesting clinician Calculating CVRA results depends on a number of clinical factors and requires assessment and interpretation which should be undertaken by someone with clinical training. Therefore it is not included in the clinical assistant role.
Faecal Helicobacter Ag Negative	Action: • Annotate 'negative' • If clinical notes document no follow up of normal result required, can file • Notify patient as per practice policy.
Faecal Helicobacter Ag Positive	Action: • Annotate 'positive' • Requesting clinician to review result, not for clinical assistant filing.
Faecal PCR Will include result for campylobacter, salmonella, shigella, yersinia, giardia, cryptosporidium and shiga toxin producing e. coli. Categories for urgent/non urgent notification *From the Regional Public Health website, covering the greater Wellington region* Notifiable diseases | RPH listofdiseases-urgent-nonurgentnotification.pdf (rph.org.nz) health-practitioner-notice-of-notifiable-disease.pdf (rph.org.nz)	
Faecal PCR: Negative result for all categories	Action: • If clinical notes document no follow up of normal result required, can file

<table>
<tr><td>Faecal PCR:
positive for Shiga toxin producing e.coli or shigella</td><td>Action:
Escalate to duty clinician for clinical decision about treatment/review and as needs urgent notification to regional public health or on-call medical officer of health
Make note in clinical record ‘positive [……] test, discussed with [name] who will arrange notification, treatment and follow up</td></tr>
<tr><td>Faecal PCR:
positive for campylobacter, cryptosporidium, giardia, salmonella, yersinia</td><td>Action:
Clinical Assistant to download notification form from regional public health and complete and fax.
Requesting clinician to review result to decide regarding treatment, follow up and whether requires urgent notification as per Acute gastroenteritis criteria
Acute gastroenteritis is urgently notifiable if linked to common source, or if patient is food worker, caregiver or chemical/bacterial or toxic food poisoning. Clinician to make this decision when views inbox record.</td></tr>
<tr><td>FIT Bowel Screening:
Negative result</td><td>Action:
Annotate ‘negative’
Add READ Code 4792, FOB-ve or add to screening term (clarify local process)
Confirm with practice if normal bowel screening results can be filed by clinical assistant</td></tr>
<tr><td>FIT Bowel Screening:
Positive result</td><td>Action:
Annotate ‘positive’
Add READ Code 4794, FOB+ve or add to screening term (clarify local process)
Leave in inbox for clinician to notify patient and refer</td></tr>
<tr><td colspan="2">Full blood count
Critical Limits – escalate to duty clinician and document who it was discussed with.

<table><tr><td></td><td><</td><td>></td></tr><tr><td>Hb g/L</td><td>80</td><td>200</td></tr><tr><td>HCT (female)</td><td></td><td>0.56</td></tr><tr><td>HCT (male)</td><td></td><td>0.6</td></tr><tr><td>Platelets x10^9 (pregnant)</td><td>80</td><td>1000</td></tr><tr><td>Platelets x10^9 (not pregnant)</td><td>20</td><td>1000</td></tr><tr><td>Neutrophils x10^9</td><td>0.5</td><td>15</td></tr></table>
NB: Note no abnormal FBC will be filed by clinical assistant. Abnormal FBC will still be seen by requesting clinician, but a trigger for escalation is a safety net in scenario of busy clinic/part time staff where clinical assistant may have seen result before requesting clinician.</td></tr>
<tr><td>Full blood count
Parameters all normal</td><td>Action:</td></tr>
</table>

	• If clinical notes document no follow up of normal result required, can file • If no instructions in clinical notes, annotate as 'normal' but do not file.
Full blood count Parameters out of normal range but **NOT** critical (see above table)	Action: • Annotate comment field with name and value of the abnormal parameter • e.g. hb 102 or platelets 135 • Requesting clinician to review result
Full blood count Parameter breaches a critical limit	Action: • Escalate to duty clinician for urgent review • Make note in clinical record 'full blood count with abnormal result outside critical limit, discussed with [name] at [time]'
Glycated haemoglobin **HbA1c** <40	Action: • Annotate comment field [value of hba1c] • Check daily record for filing/follow up instructions. If no clear plan, leave in inbox • If part of CVRA (came in batch with lipids and renal function, leave in inbox as per CVRA section) Check classifications for **gestational diabetes mellitus**: if present requires recall for annual hba1c. Action: • If has classification gestational diabetes mellitus but no recall: add annual hba1c recall • Has recall for annual hba1c -> reset recall for 12months from date of current hba1c result.
Glycated haemoglobin **HbA1c** 40-49	Action: • Annotate comment field [value of hba1c] • Add classification 'pre-diabetes' if not present • Add recall for annual HbA1c. If already present, reset this for 12 months from date of current hba1c result • If part of CVRA (came in batch with lipids and renal function, leave in inbox as per CVRA section) • Clinician review pre filing
Glycated haemoglobin Hba1c >50 (in patient with no diagnosis diabetes)	Action: • Annotate [value of hba1c] • Check if CVRA and urine ACR have been done in the past 12 months. If not, arrange. • Clinician to review result and make follow up plan
Glycated Haemoglobin	Action: • Annotate [value of hba1c]

Hba1c >50 and classification **Type I Diabetes Mellitus**	• Check that CVRA and urine ACR have been done in the past 12 months. If not, arrange. • Clinician to review result prior to filing
Glycated Haemoglobin Hba1c >50 and classification **Type II Diabetes Mellitus**	**Action:** • Annotate [value] • Check that CVRA and urine ACR have been done in the past 12 months. If not, arrange. • Requesting clinician to review result prior to filing OR forward to nominated practice clinician if practice policy in place.
Critical limits for Liver function tests – these must be escalated to the duty clinician Bilirubin > 400umol/L, ALT >1000, AST >1000	
Liver function tests All parameters normal	**Action:** • If clinical notes document no follow up of normal result required, can file • If no instructions in clinical notes, annotate as 'normal' but do not file.
Liver function tests Abnormal value below critical limit	Action: • Annotate comment field with name and value of the abnormal parameter, eg ALT 135 or GGT 74 • Requesting clinician to review result
Mammogram Normal **AND** No classification or recall for high risk family history or annual mammogram	**Action:** • Reset recall for two years • Annotate in comments normal, next due [mth/yr], recall set for [….] • Practice to localise policy around whether normal results can be filed by clinical assistant – the recalls are managed by BreastScreen Aotearoa, and so filing a normal result appears reasonable.
Mammogram Normal **AND** Has classification or recall for high risk family history or annual mammogram	• If present then annotate result 'normal, high risk history/annual mammogram recall' **Action:** • Requesting clinician to review result and process for ordering next mammogram
Mammogram Abnormality detected or further investigation required	**Action:** • Requesting clinician to review
Sodium (Na) and Potassium (K) Na 135-145 **AND** K 3.6-5.2	**Action:** • Annotate 'normal' • If clinical notes state no follow up of normal results required, can file
Sodium (Na) and Potassium (K)	**Action:** • Annotate Sodium [high/low] or Potassium high

Na 126-135 or 135-154 **OR** K 5.2-5.5	• Requesting clinician to review – leave in inbox
Sodium and Potassium Critical limits Na ≤125 or ≥ 155 K ≤3.5 or ≥5.6	**Action:** • Escalate to duty clinician for review • Record 'electrolytes outside critical limit, discussed with [name] at [time]'
Renal function - See Sodium and Potassium AND Creatinine/eGFR sections	
Trichomonas PCR Negative	**Action:** • Notify patient as per practice protocol • If clinical notes state no follow up of normal results required, can file • If no instructions in notes, annotate 'trichomomas negative' and requesting clinician to review • Do not include that the test was an STI check if texting the patient
Trichomonas PCR Positive	**Action:** • Discuss with duty/acute nurse – if they are able to treat with standing order, make note in daily record 'positive trichomonas test, discussed with [name] who will arrange treatment and follow up • If duty/acute nurse not able to treat, annotate 'positive trichomonas', leave in inbox for clinician
Thyroid function tests TSH 0.4-3.8 Non pregnant	**Action:** • If clinical notes state no follow up of normal results required, can file • If no instructions in clinical notes, annotate 'normal TSH' and requesting clinician to review • If patient is pregnant (check if mentioned in recent clinical record, or if result is batched with first antenatal bloods), requesting clinician to review result before filing
Thyroid function tests TSH <0.4 or >3.8	**Action:** • Annotate 'TSH [value] • Requesting clinician to review result
Uric Acid Female: 0.15-0.36 Male: 0.20-0.36	**Action:** • Annotate [value], normal • If clinical notes state no follow up of normal results required, can file NB: top of lab normal for men is 0.42, however as gout target is 0.36 have set this as the trigger for this protocol
Uric acid > 0.36	**Action:** • Annotate [value], elevated • Requesting clinician to review before filing.

Clinical Documents	
Referral or Waitlist letter received	Letter from department acknowledging the referral, sometimes with an accompanying comment regarding expected time to appointment **Action:** • Annotate either 'referral received [department] OR '[department] accepted, waitlist [xx], task set • (This point to be discussed with practice, decision around this point will be practice/clinician dependent) Set task to requesting clinician to follow up referral 4 weeks after expected waitlist time ie. 'follow up ortho referral, expected to be seen in [x] timeframe' and date task is due is 4 weeks after this time • Requesting clinician to review before filing in case referral was urgent or needs escalating etc
Clinical or specialist letter	Letters from a health care professional outside the practice **Action:** • Read letter • Identify any diagnoses made and add to classifications • Add ACC number to the relevant field in practice management system • Identify if any medication changes (compare medication list in letter to medication list in practice management system). Add comment to daily record • Identify any tests the practice has been asked to follow up – send a task to the requesting clinician with the name of the tests, and the timeframe they have been requested in. ○ Leave this task as due immediately so it is seen by clinician, however they can then alter the timing to suit when they wish to action. • Identify if the practice has been asked to see the patient and in what time frame, book this appointment with the appropriate clinician • Annotate '[speciality] letter – actioned as per clinical record' or '[speciality] letter – meds update needed, otherwise actioned as per clinical record'– document any actions made from the above list in clinical record – eg classification updated, test recall added, follow up booked • A clinical assistant (unregistered healthcare workforce) can not update medications in the medication list. • Requesting clinician to review before filing, responsibility lies with the requesting clinician to ensure that all necessary tasks and actions have been generated.

Discharge letter	Summary of care or admission done at the time the patient is discharged – could be from after hours, emergency department or hospital speciality Action: • Read letter • Identify any diagnoses made and add to classifications • Add ACC number if present to relevant field in practice management system • Identify if any medication changes (compare discharge medication list to medication list in practice management system). Add comment to daily record • A clinical assistant (unregistered healthcare workforce) can not update medications in the medication list. • Identify if any procedure done eg incision and drainage, sutures, or wound dressing – these are likely to need follow up • Identify if a surgery was done and add operation name to classifications • Identify if vaccination eg tetanus booster was given – if so, enter into vaccination record • Identify any tests the practice has been asked to follow up – send a task to the requesting clinician with the name of the tests, and the timeframe they have been requested in. o Leave this task as due immediately so it is seen by clinician, however they can then alter the timing to suit when they wish to action. • Identify if the practice has been asked to see the patient and in what time frame, annotate in comment field and filing clinician to notify clinical assistant via task if they would like this booked. • Annotate 'discharge [speciality/ED/afterhours] – actioned as per clinical record' or 'discharge [speciality/ED/afterhours] – meds update needed, otherwise actioned as per clinical record'– document any actions made from the above list in clinical record – eg classification updated, test recall added, vaccination entered, follow up booked • Requesting clinician to review before filing, responsibility lies with the requesting clinician to ensure that all necessary tasks and actions have been generated and to update any medication changes

Patient Portal Management	
Prescription Request via message	**Action:** • Confirm pharmacy with patient if not stated • Leave message for GP to action • Give patient instructions on script request portal function *"Thank you for your repeat prescription request. We have actioned today's request received by message, but for future script requests please use the 'request repeat script' function instead of the message function. This helps make sure the medication and pharmacy information is up to date and accurate.*
Simple responses 'Thanks' or 'OK"	**Action:** • Discuss within practice for policy – could be filed if clinicians agree.
Appointment Request via message	**Action:** • Call patient to schedule – check if routine or urgent • If routine – book routine appointment • If patient requests urgent – refer to nurse or GP to triage • Advise process when wanting to book appointment in future – particularly urgent requests should be made by …. (check practice process)
Blood Test Request	**Action:** • If expected/routine bloods refer to nurse – eg if you can see there is a recall on the system for the same tests the person is emailing about • Otherwise leave for clinician to review
Clinical Query New query or reply to clinician - ongoing conversation	**Action:** • Leave for clinician review
Long or complex clinical Query	**Action:** • Advise patient they need to book appointment and the process • This is likely to be variable by practice, so have a conversation with the GPs/NPs you are working with around preferences on how this is managed. *"Please make an appointment so we can discuss this in person – you can make an appointment by….. (practice process including portal bookings if this is turned on).*

	Optional: Please see attached document highlighting our terms and the best way to use the portal (if this is something the practice has implemented.
Referral Query	Action: • Information on how to contact appropriate service for update *"We have received your request for an update on your referral. Please call Wellington Hospital on xxxx and ask to speak to xxxx outpatients and they will be able to provide you with a referral update. "*
Administrative Query "When was my last flu jab?" "Can I have a copy of my vaccination records?" "Can I have a copy of my referral letter?"	Action: • If no clinical input required and information is able to be provided – send information and file. • If grey area – unsure if able to provide or not sure what to advise, then refer to nurse or leave for clinician • This section will need some discussion with practice to decide what is in and out of the clinical assistant role. The current admin team may be able to provide guidance on what they would action if a person phoned for information.

References *Initial access 2021, reviewed 2023* *Policy document is adapted from the Delegation of care by a registered nurse to a health care assistant, Nursing Council of New Zealand. May 2011.*	Health Professional Guides and Calculators (kidney.health.nz) Type 2 Diabetes Management Guidance - New Zealand Society for the Study of Diabetes (nzssd.org.nz) Prediabetes - New Zealand Society for the Study of Diabetes (nzssd.org.nz) Guidance on Infectious Disease Management under the Health Act 1956 Kidney_Health_CKD_Summary_Guide_.pdf Chronic Kidney Disease (CKD) in Adults - Community HealthPathways 3D (Lower North Island) Nov 2023 WSCL-Critical-Action-Limits-Feb-2017_1.pdf (awanuilabs.co.nz) clinical_practice_guidelines_final_version_1.1.pdf (tewhatuora.govt.nz)