

# Supporting the delivery of quality healthcare for aged care residents

Residential aged care services, general practitioners and health services



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health services

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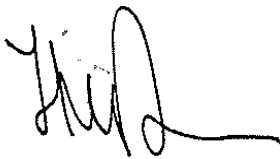
# Foreword

Health services are increasingly being delivered in the community in order to better meet the needs of clients. This includes services at the interface between acute and aged care such as the short term care coordination, outreach and specialist assessment and management of aged care residents provided by metropolitan, regional and some sub-regional health services in Victoria. The support provided by these health services has been well accepted by aged care residents and the aged care sector.

Health services, residential aged care services and general practitioners need to work collaboratively to ensure that the care that aged care residents receive is timely, effective and appropriate. It is through the provision of integrated care that clients achieve their best health outcomes.

Integrated care requires all parties to be aware of their roles and responsibilities. This document seeks to clarify the roles and responsibilities and accountabilities of health services, residential aged care services and general practitioners to support the delivery of quality healthcare to older people living in aged care facilities in Victoria.

We would like to acknowledge and thank members of the working group who supported the development of this document. In addition, we would like to acknowledge the contribution of the Commonwealth Department of Health.



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# Contents

- Purpose .....9**
- Introduction .....10**
- Residential aged care services .....11**
- General practitioners .....12**
- Health services .....13**
- General roles and responsibilities .....14**
- Advance care planning .....17**
- Access and initial needs identification on referral to a health service .....19**
- Consent of the resident or their representative .....21**
- Assessment of the resident .....22**
- Care planning and implementation .....23**
- Monitoring and reviewing the resident during an episode of care .....24**
- Concluding an episode of care .....25**
- Processes for providing feedback .....26**
- Glossary .....28**
- Appendix 1: Relevant MBS items and RACGP Accreditation Standards .....30**
- References .....31**





# Purpose

This guide was developed to:

- promote a common understanding of the roles, responsibilities and accountabilities of residential aged care services (RACS), general practitioners (GPs) and health services in relation to delivering quality healthcare for residents within aged care facilities in Victoria.
- support collaborative relationships between RACS, GPs and health services to ensure residents receive care that is continuous, safe, timely and effective and delivered in the most appropriate care setting.

The roles, responsibilities and accountabilities set out in this guide are reflective of the existing professional responsibilities, including the duty of care, of RACS, GPs and health services.

## Acknowledgements

This document was developed with the support of the Victorian Residential In Reach Aged Care Stakeholder Group and in consultation with a working group consisting of representation from Alfred Health, Ambulance Victoria, Networking Health Victoria, Leading Age Services Australia, Melbourne Health, Southern Cross, St Vincent's Health, the Commonwealth Department of Health and the Victorian Department of Health and Human Services.

# Introduction

People living in RACS have high rates of chronic disease and multiple comorbidities. Nationally, 25 per cent of people living in RACS are admitted to hospital annually (Department of Health and Ageing 2012). The risks associated with older people being hospitalised are well documented (for example, delirium, reduced mobility and falls) (Department of Health 2012).

The research literature indicates that between 13 and 67 per cent of hospital admissions of aged care residents are avoidable (Finn et al. 2006; Ouslander et al. 2010). A number of these admissions could potentially be avoided by:

- improving access to GPs and other primary care providers (Department of Health and Ageing 2012)
- ensuring that discussions with residents and their representatives regarding the resident's future health and personal care wishes occur (NHMRC 2006) and are documented in an advance care plan
- enhancing capacity within individual RACS to respond to changes in a resident's care needs (Intrator et.al. 2004, Wyman et al. 2010).

RACS, GPs and health services have a role in supporting people living in RACS to receive the right care, in the right place and at the right time.

# Residential aged care services

Residential aged care services (RACS) provide accommodation and support for people who can no longer live at home. Services are regulated in accordance with the *Aged Care Act 1997*, which includes clear expectations and accountabilities of approved providers.

Approved providers of residential aged care must:

- provide care and services specified in the *Quality of care principles*, Schedule 1 – Specified Care and Services for residential care – <<https://www.legislation.gov.au/Details/F2014L00830>>
- maintain an adequate number of appropriately skilled staff to ensure the care needs of residents are met
- provide care consistent with any rights and responsibilities of residents specified in the *User rights principles* – <<https://www.legislation.gov.au/Details/F2014L00808>>
- comply with the residential aged care Accreditation Standards.

# General practitioners

General practitioners (GPs) are the primary medical care providers for older people in the community, including people living in RACS.

*Medical care of older persons in residential aged care facilities* (the 'silver book') provides information for GPs and other health professionals working in the residential aged care service setting.

A number of Medicare items support general practitioner (GP) care of aged care residents, including GP consultations in RACS, comprehensive medical assessments of a resident, GPs organising or participating in multidisciplinary case conferences, GPs contributing to the resident's care plan and GPs participating in medication management reviews for residents.<sup>1</sup>

The RACGP *Accreditation standards for general practice*, 4th edition (used by more than 80 per cent of general practices for accreditation) require that practices inform patients of their services and their availability to provide care during and after normal opening hours.<sup>2</sup> Many general practices have arrangements with an accredited medical deputising (locum) service for providing care to patients outside normal opening hours.<sup>3</sup>

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<sup>1</sup> Refer to Appendix 1 for additional information.

<sup>2</sup> Refer to Appendix 1 for additional information.

<sup>3</sup> Locum services are available from 6 pm to 8 am Monday to Friday, from 12 pm Saturday until 8 am Monday and 24 hours for public holidays.

# Health services

Health services in metropolitan, regional and some sub-regional areas of Victoria provide short-term care coordination, outreach and specialist assessment and management of aged care residents. These health services aim to provide people living in RACS with an alternative to presenting to an emergency department, where appropriate and safe.

Specifically, these health services provide assessment and management (in appropriate circumstances) of acute medical conditions that would otherwise result in a resident unnecessarily going to hospital. Some health services may also be able to provide specialist geriatric medical assessment regarding a residents' other medical conditions.

The support provided by health services includes telephone consultation and liaison with RACS staff, GPs and other providers and assessment and management of the resident's acute medical condition at the aged care facility in collaboration with the resident and their representatives, RACS staff and the resident's GP. This support is provided by hospital based nurses and doctors and is commonly referred to as **residential in-reach**.

Health services aim to provide a rapid response to the change in the resident's health status with calls triaged by an experienced clinician who will consider the most appropriate care pathway for the resident. This may include recommending that the resident be transferred to the emergency department or referred to another service (internal or external to the health service), liaising with the resident's GP, providing telephone advice and/or attending the aged care facility to assess the resident and develop a plan of care.

The support provided by health services does not replace or substitute for the care that is the responsibility of the resident's GP or aged care facility.

Health services are usually contacted by RACS staff (in circumstances where the resident's GP or medical deputising service is unavailable and consideration is being given to transferring the resident to hospital) or the resident's GP. The resident's GP remains responsible for the resident's overall medical care.

The contact telephone number, hours of operation and catchment area for the support provided by each health service can be found via the Department of Health and Human Services' website.

# General roles and responsibilities

## Residential aged care services

- Ensure appropriately skilled nurses and other staff are available to meet the clinical and other care needs of the resident.
- Request that the resident's GP undertakes a comprehensive medical assessment of the resident on admission<sup>4</sup> (preferably within six weeks of admission) and on an annual basis thereafter.
- Request that the resident's GP contributes to the development of the resident's care plan, participates in case conferencing, undertakes medication management reviews and regularly attends the aged care facility to support optimal health outcomes for the resident (see Appendix 1 for a list of the relevant Medicare Benefit Schedule items).
- Discuss with the resident's GP their preferred arrangements for communicating a change in a resident's medical status, including by telephone, fax or a GP's communication book at the aged care facility.
- Ensure that the after-hours arrangements for the resident's GP are documented at the aged care facility.
- Have a process in place for confirming the identity of GPs providing care to residents. This may include checking the Australian Health Practitioner Regulation Agency website for evidence of the GP's registration and indemnity cover.
- Discuss with the resident and/or their representative and the resident's GP potential strategies for increasing access to general medical care for the resident, in circumstances where the resident's GP is regularly unable to attend the aged care facility to review the resident when they experience a change in their medical status.
- Include the *Resident and representative information sheet*, regarding the support provided by health services, in the package of information provided to new residents – search for 'residential in-reach' on the Department of Health and Human Services' website <<https://www2.health.vic.gov.au/>>
- Maintain the list of equipment as detailed in the *Residential aged care service equipment information sheet* – search for 'residential in-reach' on the Department of Health and Human Services' website <<https://www2.health.vic.gov.au/>>
- Include information about the support provided by health services in the orientation program for new staff, including the criteria for requesting support (that is, when the resident's GP or medical deputising (locum) service is unavailable and admission to hospital or presentation to an emergency department is being considered for the resident).
- Facilitate access to electronic record systems (where applicable) by GPs and health service clinicians to inform the assessment of residents and for the purpose of recording notes and developing the management plan for the resident.
- Ideally have available or be working towards having available information technology (IT) capability to support a remote consultation between clinicians external to the aged care facility and residents and staff at the aged care facility.

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<sup>4</sup> Provided that the resident has not already undergone a comprehensive medical assessment at another facility in the past 12 months.

## General practitioners

- The resident's GP ensures that all medical care (including after-hours care) provided by their practice is undertaken by credentialled medical practitioners or an accredited deputising service.
- GPs consult and work collaboratively with RACS to ensure residents receive appropriate care. Specifically, the resident's GP (RACGP 2006):
  - considers the staff skills and services at the aged care facility when providing medical care to residents
  - provides information to the aged care facility about services provided and after-hours arrangements including, for example, GP attendance times at the aged care facility, arrangements for medication reviews, comprehensive medical assessments, case conferencing and care planning
  - designates a practice staff member as a RACS key contact person
  - has a RACS patient register and recall/reminder system
  - reviews the resident when a change in their medical status is reported.
- The resident's GP undertakes a comprehensive medical assessment of the resident on admission<sup>5</sup> (preferably within six weeks of admission) and on an annual basis thereafter.
- GPs consider assisting RACS with staff immunisation to help minimise the risk to residents from seasonal infection (RACGP 2006; DSS 2015).
- In circumstances where the resident's GP is regularly unable to attend the aged care facility to review the resident when they experience a change in their medical status, the GP contacts the resident (and/or their representative) and the aged care facility to discuss the barriers to attending the aged care facility and the potential mitigating strategies to ensure the resident receives appropriate clinical care. This could include advising the resident and/or their representative of the need to seek the services of an alternative GP, if available, or using telehealth as an alternative to visiting the aged care facility to assess the resident.

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<sup>5</sup> Provided that the resident has not already undergone a comprehensive medical assessment at another facility in the past 12 months.

## Health services

- Provide details (such as their hours of operation, referral processes, out-of-hours arrangements and support provided) to the RACS to which they provide support and ensure this information is kept up to date.
- Provide the information (listed above) to the relevant Primary Health Network(s) and Ambulance Victoria.
- Give the RACS to which they provide support a copy of their referral form, where they exist.
- Maximise opportunities for shared learning with RACS staff during the delivery of care to a resident.
- Health service clinicians adhere to all relevant privacy laws in relation to record keeping and information sharing.
- Health service clinicians maintain good communication with RACS staff and the resident's GP throughout the resident's episode of care<sup>6</sup>.
- Consistent with health service policies and procedures, health service ensures all health service clinicians have a current registration and police check.

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<sup>6</sup> An episode of care refers to the period from the acceptance of a referral by a health service to the discontinuation of health service support for a resident.



# Advance care planning

Involving residents in decisions about their health and wellbeing to the maximum extent possible is a good practice approach to the care of older people.

A resident's capacity to be involved in decision making may fluctuate over time and may be decision specific. For example, a resident may be unable to manage their financial affairs but able to make healthcare decisions.

Advance care planning is a process of planning for future health and personal care whereby the person's values, goals, beliefs and preferences are made known so they can guide decision making at a future time when the person cannot make or communicate their decisions.

Residents and their representatives will ideally be given the opportunity to develop an advance care plan. This could include appointing a substitute decision maker and documenting the level of healthcare and quality of life the person would want if, for some reason, they become unable to participate in these discussions.<sup>7</sup>

To inform the development of an advance care plan, residents and their representatives need information about the resident's likely disease trajectory (NHMRC 2006). Discussions with residents and their representatives about advance care planning will ideally commence before or as soon as practical after the resident's admission to the aged care facility, and occur on a regular basis thereafter to ensure the wishes of the resident and their representative remain current (NHMRC 2006).

GPs have a central role in advance care planning. They are ideally involved in all related aspects such as:

- identifying and/or facilitating the formal appointment of a substitute decision maker, usually an enduring power of attorney (medical treatment)
- incorporating a resident's preferences regarding the level of healthcare and quality of life that they would want into a documented medical treatment plan.

This can assist the GP/medical deputising service or other service providers (for example, ambulance services or health services) to understand the treatment goals for the resident if their condition deteriorates.

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<sup>7</sup> The development of an advance care plan is supported by Victorian government policy: *Advance care planning: have the conversation. A strategy for Victoria's health services 2014–18*. Part 3 of this policy explains how the law in Victoria supports you to have this conversation, and refers to the refusal of medical treatment certificate under the *Medical Treatment Act 1988*; and the provisions under the *Guardianship and Administration Act 1986* where a patient does not have capacity to make a decision on their own behalf. Note: The new *Medical Treatment Planning and Decisions Act 2016* commences on 12 March 2018. The Act replaces most of the medical treatment provisions in the *Guardianship and Administration Act 1986* and repeals the *Medical Treatment Act 1988*.

## Residential aged care services

- To make available to residents and their representatives information regarding advance care planning.
- To have an advance care planning policy (and to have adapted other relevant policies to include advance care planning) that articulates the role of staff in advance care planning, and includes systems for storing and retrieving advance care plans and processes for regularly reviewing a resident's advance care plan.
- To ensure that if a resident has appointed a substitute decision maker that this is recorded in the resident's medical record. Information about substitute decision makers and enduring power of attorney (medical treatment) can be found on the Office of the Public Advocate website at [www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au)
- To support residents and their representatives to develop an advance care plan, in conjunction with the resident's GP, which outlines the level of treatment and health outcomes that the resident would want and can assist with future decision making about the resident's health and personal care.

## General practitioners

- GPs incorporate advance care planning into routine care to ensure the level of healthcare and quality of life that a resident wants is known. The role of GPs in advance care planning may include (RACGP 2006):
  - discussing the idea of advance care planning with residents and/or their representative
  - giving information to residents and/or their representatives about their current health status, prognosis and future treatment options
  - witnessing or completing a refusal of treatment certificate, where appropriate, and applying the resident's wishes to medical management
  - reviewing the plan regularly or when a resident's health status changes.

## Health services

- Health service clinicians should advocate for the development of an advance care plan for a resident if one does not exist.
- Health service clinicians may provide input into the development of an advance care plan for a resident and may support the aged care facility to implement a residents' advance care plan.
- Health service clinician(s) will review and consider a resident's advance care plan, where one exists, when assessing and preparing a management plan for a resident to ensure that the management plan is consistent with the resident's advance care plan.

# Access and initial needs identification on referral to a health service

## Residential aged care services

- Staff report any observed changes in a resident's status to the nurse or person in charge.
- Where an observed change in the resident's status has been identified, a suitably qualified person undertakes an assessment of the resident and determines an appropriate response, which is in accordance with the obligations of aged care providers as per the *Aged Care Act 1997* and is informed by the resident's advance care plan, where one exists, the scope and availability of staff and the resources that are expected to be available at the facility.<sup>8</sup>
- If advice about advance care planning or caring for a resident with palliative care needs is needed, consideration should be given to contacting Decision Assist – <[http:// www.decisionassist.org.au](http://www.decisionassist.org.au)><sup>9</sup>
- In circumstances where the resident's GP or medical deputising service is unavailable and consideration is being given to transferring the resident to hospital, the nurse or person in charge may contact the relevant health service and provide the following information:
  - the reason for contacting the health service
  - the resident's vital signs such as blood pressure, pulse, respirations, temperature, general observations of the resident, neurological observations in circumstances where a fall is suspected (and, where possible, the resident's usual baseline observations)
  - an overview of the resident's current situation
  - the resident's medical history including any pathology results
  - the actions taken by staff to date in response to the change in the resident's condition, including what other services have been contacted
  - a copy of the resident's medication chart, on request
  - details of the resident's advance care plan
  - the contact details for the resident's GP.

## General practitioners

- The resident's GP has regular attendance times at the aged care facility to provide general medical care to the resident and to facilitate the review of the resident when they experience a change in their medical status.
- When contacted by the aged care facility, the resident's GP supports a referral being made to the relevant health service, if they are unable to attend the aged care facility to assess the resident and consideration is being given to transferring the resident to hospital.
- The resident's GP remains responsible for the medical care of the resident and is central to decision making about the medical care and services provided to the resident.

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<sup>8</sup> The Royal Australian College of General Practitioners' *Best practice guide for collaborative care between general practitioners and residential aged care facilities* includes an aged care facility nurse triage information form, which is accessible via <<http://www.racgp.org.au/your-practice/business/tools/support/best-practice-guide>>.

<sup>9</sup> Decision Assist is funded by the Australian Government and provides support to GPs, aged care staff and other health professionals caring for older Australians regarding palliative care and advance care planning. This includes a telephone advisory service and workshops for GPs and aged care staff.

## Health services

- After an initial assessment of the resident's needs (based on the information provided), the health service clinician will advise the RACS staff member if the referral has been accepted. If the referral is not accepted, the health service clinician will provide a reason and advice regarding the most appropriate service for the resident.
- Where a referral is accepted, the health service clinician will advise the RACS staff member of the interim plan including the timeframe for attending the aged care facility to assess the resident, if this is indicated.
- The health service clinician will also provide advice about the action to be taken by RACS staff if the resident's condition deteriorates between the acceptance of the referral and the assessment of the resident.

# Consent of the resident or their representative

## Residential aged care services

- The aged care facility seeks to obtain consent from the resident or their representative, when the resident moves into the facility, to contact the local health service when it is clinically appropriate to do so.
- Where prior consent is obtained, to document this consent in the resident agreement.
- Where prior consent has not been obtained, the aged care facility facilitates obtaining consent from the resident or their representative each time a referral for health service support is made.

## General practitioners

- The resident's GP consents to involving the health service in the medical management of the resident if they are unable to attend the RACS to assess the resident and consideration is being given to transferring the resident to hospital.

## Health services

- The health service clinician ensures that consent is obtained from the resident or their representative before conducting an assessment of the resident.
- The health service clinician documents the consent of the resident or their representative in the resident's file.

# Assessment of the resident

## Residential aged care services

- The nurse or person in charge at the aged care facility introduces the health service clinician(s) to the resident.
- The nurse or person in charge actively participates in the assessment of the resident.
- Consistent with the *Aged Care Act 1997*, the aged care facility will assist with arranging transport for residents if the resident needs a diagnostic procedure that cannot be undertaken at the facility, or if the resident needs to be transferred to an emergency department.
- The aged care facility will support the use of appropriately credentialed onsite diagnostic services (such as mobile radiology services), where accessible, to reduce residents being unnecessarily transferred to hospital.

## General practitioners

- The resident's GP provides information to the health service clinician(s), upon request, to inform the assessment of the resident.
- The resident's GP reviews the resident as soon as possible after being advised of a change in the resident's medical status.
- In order to support the provision of coordinated care, the resident's GP will seek to inform the health service if they review the resident during the course of an episode of care.

## Health services

- The health service clinician(s) completes an assessment of the resident in consultation with the resident, their representative, their GP and RACS staff, and documents this in the resident's file.
- The health service clinician(s) will review and consider a resident's advance care plan, where one exists, when assessing and preparing a management plan for the resident to ensure that the management plan is consistent with the resident's advance care plan.
- The health service clinician organises diagnostic tests for the resident, as required.
- If the health service clinician determines that the resident needs to be transported to hospital, the health service clinician will liaise with the receiving emergency department or ambulance service.

# Care planning and implementation

## Residential aged care services

- The nurse or person in charge at the aged care facility actively participates and negotiates the development of a management plan<sup>10</sup> for the resident in response to the resident's acute medical condition.
- The aged care facility ensures the components of the management plan that the aged care facility has responsibility for implementing are implemented in accordance with that plan.
- The aged care facility ensures there is an adequate number of appropriately skilled staff and the necessary equipment to meet the care needs of the resident.

## General practitioners

- The resident's GP participates in the development and implementation of a management plan in response to the resident's acute medical condition.
- The resident's GP provides medication orders for the resident during the episode of care (where necessary) within required timeframes.

## Health services

- In response to the resident's acute medical condition, the health service clinician(s) will develop a recommended management plan for the resident in consultation with the resident and/or their representative, and in collaboration with the resident's GP and the RACS staff.
- The health service clinician will document the recommended management plan in the resident's medical history/record. The recommended management plan will detail the care to be provided by health service, the resident's GP and the aged care facility. The recommended management plan will be conveyed to the resident and/or their representative.
- The health service clinician ensures that the management plan includes an outline of the ongoing monitoring and observation required and recommended steps to follow if the resident's condition deteriorates.
- The health service clinician will advise the aged care facility of the timeframe for providing deliverables for the resident (such as medication orders) and will advise the aged care facility of any delays.

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<sup>10</sup> A management plan is the plan that is developed in response to an acute change in the resident's medical status by the health service in collaboration with the resident, their representative, the RACS and the resident's GP (as distinct from the resident's care plan, which is developed by the RACS in collaboration with the resident and their representative and outlines the care needs of the resident and how these care needs will be met).

# Monitoring and reviewing the resident during an episode of care

## Residential aged care services

- The nurse or person in charge at the aged care facility will ensure that the recommended monitoring and observation of the resident is undertaken and will advise the health service clinician if any changes to the resident's condition are observed outside of any agreed parameters.
- The aged care facility will maintain communication with the resident's GP and the resident's representative during the episode of care.

## General practitioners

- The resident's GP discusses the resident's medical care, as required, with the health service clinician during the episode of care.

## Health services

- If the resident needs to be reviewed, the health service clinician will advise the aged care facility when this will occur. They will also ensure any changes to a resident's management plan are communicated to all concerned (including the resident's GP) and recorded in the resident's file.



# Concluding an episode of care

## Residential aged care services

- The nurse or person-in-charge at the aged care facility will advise the resident and/or their representative when the provision of support by the health service has concluded, and the outcomes of care for the resident.
- The aged care facility will ensure it has the equipment to manage the resident's ongoing care.
- The aged care facility is responsible for ongoing staff education to provide care in accordance with resident needs.
- The aged care facility will review ongoing staffing and skill-mix arrangements and other system issues that may be impacting on an aged care facility using the support provided by health services to provide care that should be provided by the aged care facility.

## General practitioners

- In circumstances where the resident's GP has not reviewed the resident during an episode of care, the resident's GP reviews the resident (where medically appropriate) as soon as possible after the conclusion of an episode of care.

## Health services

- The health service clinician will discontinue providing support when clinically indicated and in consultation with the resident and/or their representative, the aged care facility and the resident's GP.
- The health service clinician prepares a summary of the support that was provided to the resident, which includes the interventions provided and the outcomes of care for the resident.
- The health service clinician develops a plan that includes indicators for re-referral and recommendations regarding ongoing medical management and care of the resident as they relate to the current episode of care.
- A copy of the summary of the support provided to the resident is filed in the resident's file.
- The health service clinician is responsible for sending a copy of the summary of the support that was provided by the health service to the resident's GP within 24 hours of this support being discontinued.

# Processes for providing feedback

## Residential aged care services

- If the aged care facility has a concern in relation to the health service clinician or the support being provided, the RACS member of staff should discuss this with the health service clinician.
- If the RACS member of staff is unsatisfied with the response from the health service clinician, the nurse/person in charge or the manager of the aged care facility should contact the relevant manager at the health service.
- If the nurse/person in charge or the manager of the aged care facility is unsatisfied with the response from the health service manager, they should contact the health service's patient liaison officer.
- If the nurse/person in charge or the manager of the aged care facility is unsatisfied with the response from the patient liaison officer, they should contact the executive officer at the health service.
- If the nurse/person in charge or the manager of the aged care facility is unsatisfied with the response from the executive officer, they should contact the Health Complaints Commissioner.

## General practitioners

- The GP's practice information sheet, which is provided to the resident and the aged care facility, should include information regarding how to provide feedback or make a complaint.
- If the GP has a concern in relation to the health service clinician or the support being provided, the GP should discuss this with the health service clinician.
- If the GP is unsatisfied with the response from the health service clinician, the GP should contact the relevant manager at the health service.
- If the GP is unsatisfied with the response from the health service manager, the GP should contact the relevant executive officer at the health service.
- If the GP is unsatisfied with the response from the executive officer, the GP should contact the Health Complaints Commissioner.
- If the GP has a concern in relation to the aged care facility, the GP should discuss this with the nurse/person in charge, in the first instance, or the aged care facility manager.
- If the GP is unsatisfied with the response, the GP should involve the manager of the aged care facility.
- If the GP is unsatisfied with the response from the manager of the aged care facility, the GP should involve the director or executive officer of the aged care facility.
- If the GP is unable to satisfactorily resolve the issue, consideration should be given to contacting the Commonwealth Government's complaints scheme.

## Health services

- Health services seek feedback from the aged care facility about the quality of the support provided.
- The health service clinician follows the health service's policy in relation to managing, documenting and responding to complaints.
- The health service clinician ensures the aged care facility is informed in writing of the processes for making a complaint about the support provided by the health service and ensures this information is available to residents and their representatives.
- If the health service clinician has a concern in relation to the aged care facility, the health service clinician should discuss this with the nurse or person in charge, in the first instance.
- If the health service clinician is unsatisfied with the response from the nurse or person in charge, the health service clinician should involve the manager of the aged care facility.
- If the health service clinician is unsatisfied with the response, the health service clinician or manager should involve the director or executive officer of the aged care facility.
- If the health service manager is unable to satisfactorily resolve the issue, consideration should be given to contacting the Commonwealth Government's complaints scheme.

# Glossary

## Advance care planning

Advance care planning is a process of planning for future health and personal care whereby the person's values, goals, beliefs and preferences are made known so they can guide decision making at a future time when the person cannot make or communicate their decisions due to a lack of capacity (referred to here as future wishes).

Advance care planning requires respect for the person and their autonomy. It is often about end-of-life care, but not always. It aims to improve quality of care and is based on human rights principles, including self-determination, dignity and the avoidance of suffering.

Advance care planning can be verbal or written. Ideally, advance care plans are written in order to strengthen their influence on clinical decision making.

Both verbal and written advance care plans can result in: expression of personal values, preferences for treatment and care; and appointment of a substitute decision maker.

An advance care plan comprises any of the following:

- a record of a discussion about future wishes
- a discussion with significant family members and/or friends that communicates a person's future wishes
- formal written wishes that are witnessed and signed
- informal written wishes that are neither witnessed nor signed
- a completed enduring power of attorney (medical treatment)
- the appointment in writing of a substitute decision maker
- a completed refusal of treatment certificate.

In whatever form the documentation takes it must have the potential to assist in some way with future decision making about health and personal care. This is by either appointing a substitute decision maker or recording the person's wishes.

Advance care planning can have several names including advance care directive, advance care plan, living will, advance directive and statement of choices. In Victoria, due consideration needs to be given to an advance care plan, whatever form this document takes.

*Advance care planning: have the conversation – A strategy for Victorian health services 2014–2018*, which is available online from <[www.health.vic.gov.au/acp](http://www.health.vic.gov.au/acp)>.

Information for residents and their representatives can be found at:

<<https://www.betterhealth.vic.gov.au/health/servicesandsupport/advance-care-plans>>.

## Episode of care

Episode of care refers to the period from the acceptance of a referral by a health service to the discontinuation of health service support for a resident.

## Health service

Health service refers to the acute and subacute campuses of a health service, as well as the additional programs that a health service provides in the community.

## **Health service clinicians**

Health service clinicians include, for example, clinical nurse consultants, nurse practitioners, medical registrars and geriatricians. The staffing complement varies across health services.

## **Nurse**

A nurse (a registered nurse) is someone who has undertaken a nursing and/or midwifery qualification and is registered with the Nursing and Midwifery Board of Australia.

## **Person in charge**

Person in charge refers to the person at the residential aged care service who is responsible for the clinical care of residents.

## **Residential aged care service**

A residential aged care service provides accommodation and support for people who can no longer live at home.

## **Residential in-reach**

Residential in-reach is the common name for the out-of-hospital support provided to aged care residents by health services, which involves the assessment and management (in appropriate circumstances) of acute medical conditions that would otherwise result in a resident of a RACS unnecessarily presenting to an emergency department or being admitted to hospital.

## **Resident's file**

A resident's file includes the resident's medical history at the RACS and at the health service.

## **Specified care and services**

Approved providers of residential aged care are required to provide a range of care and services to residents, as specified in the *Quality of care principles*, Schedule 1 – Specified Care and Services for Residential Care Services, at no additional cost to residents.

The care and services must be provided in a way that meets the needs of the individual resident and also meets the outcomes under the Accreditation Standards (Department of Health and Ageing 2009).

## **Substitute decision maker**

A substitute decision maker is a person who has legal authority to make decisions on behalf of someone else.

Usually the law treats the decisions of a substitute decision-maker as if they were made by the represented person with the capacity to do so.

Guardians, administrators and attorneys are substitute decision-makers (Victorian Law Reform Commission 2012).

# Appendix 1: Relevant MBS items and RACGP Accreditation Standards

The Medicare Benefits Schedule (MBS) includes a number of items to support the medical care of residents. They include:

- comprehensive medical assessment (items 701, 703, 705 and 707) once every 12 months
- Resident Medication Management Review (item 903)
- GP contribution to a multidisciplinary care plan (item 731) up to four times per year
- GP participates in a case conference (items 747, 750 and 758) up to five times per year
- GP organises and coordinates case conference (items 735, 739 and 743) up to five per year
- GP consultation at a RACS (items 20, 35, 43 and 51)
- GP consultation at a RACS after hours (items 5010, 5028, 5049 and 5067).

Information regarding these MBS items can be found at <[www.mbsonline.gov.au](http://www.mbsonline.gov.au)>.

RACGP Accreditation Standards for General Practice

Two items that relate specifically to access to care (RACGP 2015):

- **Home and other visits:** Regular patients of our practice are able to obtain visits in their home, residential aged care facility, residential care facility, both within and outside normal opening hours where such visits are deemed safe and reasonable (Standard 1.1; Criterion 1.1.3)
- **Care outside normal opening hours:** Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours (Standard 1.1; Criterion 1.1.4). Practices are aware of the arrangements in place for their patients to access after-hours care. Practices have processes in place to alert their patients to these arrangements.

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