phn BRISBANE SOUTH
An Australian Government Initiative

Quality Improvement Toolkit for General Practice

Patient Population Groups

Visiting Residential Aged Care Facilities
MODULE

Version 1

January 2022

VISITING RESIDENTIAL AGED CARE FACILITIES (RACF)

Introduction

This Quality Improvement (QI) toolkit is made up of modules that are designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients. The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply.
- Reduced risk by starting small.
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change implementation into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted. There is an example using the MFI to increase the number of case conferences completed at the end of this module.

This icon indicates the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Toolkit aim - encourage General Practitioners (GPs) who currently visit RACF to review their systems to ensure maximum benefit for the resident, facility and GP. It also is a step-by-step guide for GPs to identify opportunities to commence providing care to RACFs.

Together, we are working to ensure older people have access to quality health and aged care that is tailored to their individual needs and preferences, promotes dignity and respect, and enables choice and decision-making.[1] This toolkit is designed to assist you to manage people living in an RACF and their health needs. If you would like to review your whole older patient population, please refer to the QI toolkit – Older people.

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

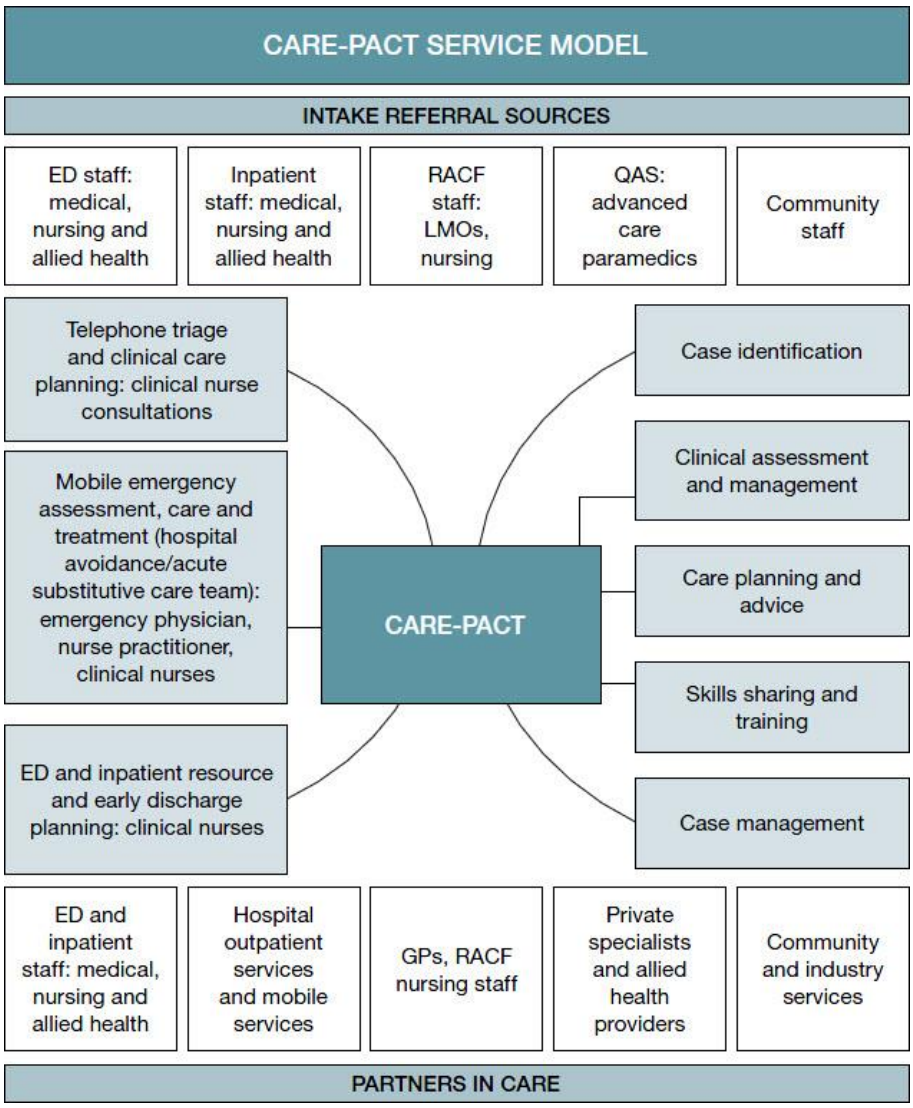
support@bsphn.org.au

1300 467 265

[1] https://www.advancecareplanning.org.au/docs/default-source/acpa-resource-library/acpa-publications/advance-care-planning-in-aged-care-implementation-guide.pdf

CAREPACT

CAREPACT is a collaboration between the Metro South Hospital and Health Service, PHN, GP's and RACF's designed to provide increased choice for residents in their location of specialist medical care. The CAREPACT Telephone Triage service provides RACF nurses a direct line to a Clinical Nurse Consultant and request advice on the management of an acutely deteriorating patient that may be requiring hospital level care. CAREPACT can then send a Mobile Emergency Team instead of transferring the resident to an Emergency Department – and can provide the equivalent level of care. CAREPACT has direct referral pathways to Hospital in the Home, Aged Care Imaging (plain film and ultrasound imaging in the RACF), pathology, and direct specialist review.



The CAREPACT service also provides a direct GP and paramedic referral line (0437252746) for a GP servicing RACF patients to discuss cases and request specialist advice from an Emergency Physician or Geriatrician. This has been helpful in gaining additional information from the inpatient treating teams, or the hospital clinical record to fine tune the advice received on discharge summaries. This advice line has also allowed GP's a direct feedback mechanism for hospital-based care.

Endorsement from Dr Peter Adkins (GP Clinical Advisor – Brisbane South PHN)

Providing care to patients in residential aged care has been a traditional part of general practice in caring for people of all ages and stages. Currently residential aged care facilities face an increasing demand on services and although residents will not stay as long as previously will be frailer and more medically complex. Financial and workforce issues are current challenges to be addressed in aged care.

To provide optimal care for residents in aged care, GP practices need to work together with facilities to establish efficient and effective systems of care with the focus being on maximising and maintaining resident health and wellbeing.

This resource has been designed to examine a number of areas related to residential aged care provision, such as medication management and communication with the aim of assessing current practice and looking at improvement. GP practices and RACFs are encouraged to use this resource in working through the current challenges facing residential aged care. Dr Peter Adkins.

Contents

ACTIVITY 1 – VISITING RESIDENTS

First visit and/or admission appointment

In this consult, the priority is to get a brief medical history from the resident, their family or the paperwork that comes with them. You can access information on My Health Record including medications, health summary, MBS, and PBS information, and hospital health provider portals where available to identify advance health directive/Statement of Life Choices documents. The RACF will need a completed drug chart. The drug chart is an opportunity to review the resident's medications and consider ongoing care. It is suggested that a case conference is booked including the family. Arrange to visit the resident in a week's time to commence the comprehensive medical assessment (CMA) – this can be virtual or face-to-face. It is useful to determine if the resident has decision-making capacity and who is/are the Enduring Powers of Attorney. This is critical to know when making decisions about care.

Second visit

The focus of this appointment is around proactive care and planning. Complete the CMA, review the RACF care plan and prepare your contribution. Proactive care is based on maintaining or improving wellbeing and function/ability/independence. At this appointment it is useful to conduct a Residential Medication Management Review (RMMR) with respect to deprescribing.

Routine GP consultations

An example of a routine GP consultation would be a health assessment for a resident, a review of resident's medical or medication management. Routine consultations are recommended at least every 3 months.

Acute care requests

When a resident is unwell, but it is not an after-hours callout or an emergency, it is important to have a system that the facility is able to contact the GP to discuss the care needs of the resident in a timely manner. It is important to determine the degree of clinical risk/clinical acuity, and an effective notification system, which also allows enough clinical information to be exchanged to make an appropriate decision on care (phone/video consultation, face to face visit, referral for further assessment e.g. CARE-PACT).

After hours care

In order to provide timely, effective and safe care to residents in RACFs, GPs may have a formal, collaborative agreement with the facility regarding their provision of urgent and after-hours care. Such an agreement might entail what medical deputising service and after-hours medication (pharmacy) arrangements are in place, and acute notification and callout protocols.

Residents in RACFs face barriers in accessing their preferred primary care, and this is even more prominent after hours. Residents may not be able to simply contact and/or access their usual GP (or the RACF's regular visiting GP) after hours. A medical deputising or after-hours service may be required to provide this care. [2]

Case conferencing and multi-disciplinary care

Case conferences are an incredibly useful tool. In RACFs there are always teams of health care professionals looking after the residents. Getting them all in one room prevents miscommunication, wasted time repeating yourself and leads to more effective care.

[2] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/silver-book-part-b/provision-of-after-hours-aged-care-services

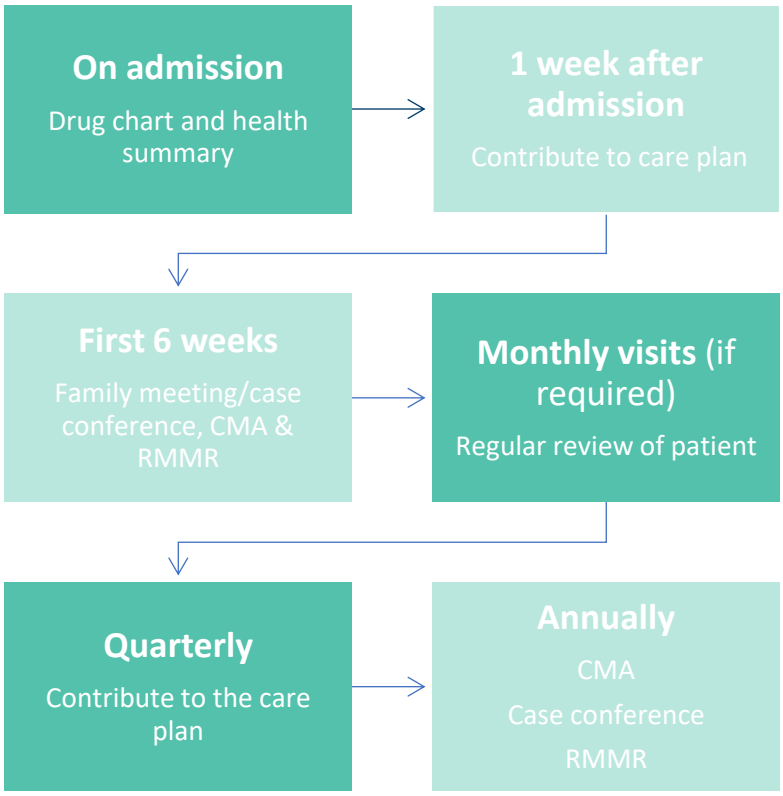
Family meetings

The registered nurse (RN) can coordinate a meeting time with the family GP and at least 3 other health care professionals. The participants can be the RACF nurse, a carer or co-ordinator, physio and GP. Basically, anyone from the facility that cares for the resident. Family members do not count towards the 3 participants.

Standard case conference

A case conference can be used anytime such as when the resident's condition changes or becomes complex. When organising a case conference, involve the physio, podiatrist, pharmacist, RN or clinical nurse as your other providers. A case conference needs some planning as there are consent and documentation criteria to fill.

Summary of annual proactive care pathway



Virtual health care including telehealth and videoconferencing

Telehealth has been transformational to health care and has played a critical role in ensuring the continuity of care for residents during the COVID-19 pandemic. It has offered greater flexibility to health care, while supporting Medicare access. Telehealth allows for information sharing and communication via technology to provide health care remotely. Examples include: wound management, medication and prescription management, alerts/change of clinical condition, remote consultations, remote health record access, clinical advice request and provisions.

Healthdirect video call services

The Department of Health is funding healthdirect Video Call as a free platform for healthcare providers to use for virtual care. The video platform allows a single consistent entry point to a secure webpage where residents, RACF staff, carers or family members enter an online waiting area to await their appointment. This requires a smart phone, tablet/iPad at the RACF, or a family member can bring their own personal device for use.

Brisbane South PHN will create a healthdirect account for your healthcare organisation once you fill in this form. Then you can configure your organisation's details as you require (e.g. add logo, customise messages for residents while they are in your virtual waiting room and add clinical and administration staff to the account).

Further information and resources:

- healthdirect 5-minute video
- healthdirect guides and fact sheets
- How to attend a consultation (for residents).

Activity 1.1 – Understanding options for visiting RACF

The aim of this activity is to increase your understanding of the options available for visiting RACF.

Description	Status	Action to be taken
Do all GPs ensure residents are provided with a visit on a regular basis?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Discuss with the RN at the facility, how they can ensure each resident has a consultation with a GP at least monthly.
Is there a system in place to ensure residents have access to GP clinical care after hours?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Review options for after-hours care, either from the practice, or via a deputising service. Consider the same arrangement that the practice has for practice patients.
Do all GPs ensure a case conference with the resident's family is organised on admission to the facility?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Ask the RN can coordinate a time with the family, GP and at least 2 other health care professionals who provide a different kind of care or service to the resident.
Do GPs have a checklist/pathway to ensure residents in a RACF receive optimal care, whilst maximising funding streams?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to summary of annual proactive care pathway.
Do GPs have access to computer, laptop, iPad or similar with a camera to be able to provide video health consultations?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Identify and access hardware to allow for video consultations. Confirm RACF videoconferencing facilities.
Have you completed the privacy checklist for telehealth services?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to privacy checklist for telehealth service factsheet.
Do all providers have adequate internet? (You can check this on speedtest). Providers could include GP, practice, RACF, other health professionals involved in case conferencing.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Ask all provider to check internet speed on home and work computer and report back to the practice.

Description	Status	Action to be taken
Have all practice team members participated in training on conducting appointments via telehealth?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to: • healthdirect – video calls • MBS telehealth - fact sheet • ADHA - Telehealth Australian Digital Health Agency.
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
 After reviewing the options for visiting RACF, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, **see action to be taken** to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 2 – ESTABLISHING SYSTEMS FOR COMMUNICATION

GPs caring for residents in RACFs ideally need to be able to provide routine visits at mutually convenient times for general practice and RACF nursing staff. It is important that residents are informed if their regular GP routinely visits the facility and that access to care is arranged accordingly. It is an advantage if the GP can remotely access the patient record at the facility to access vital signs and observations.

In the event that the resident's regular GP is unavailable, and/or urgent and emergency care is required, it is important that appropriate care for the resident is determined and agreed upon. Effective follow-up of abnormal and life-threatening results relies on robust and reliable systems for contact and escalation of care.[3]

Activity 2.1 – Communication strategies between RACF and medical practices

The aim of this activity is to review systems of communication between RACFs, GPs and medical practices.

Description	Status	Action to be taken
Is there a formalised agreement in place between GP and RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider completing agreement. Refer to LASA template. Ensure this agreement is reviewed on an annual basis.
Do GPs have regular times to visit the RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Develop a system including: • Identify a regular time when the GP is available to visit the facility. It is useful to coordinate with other GPs and avoid times when staff are at lunch or handover. • Mark time in the appointment book as RACF visiting. • Communicate visit times with RACF.
Is there the option to establish regular clinic times at the RACF you visit?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	• Mark time in the appointment book as RACF visiting. • Communicate visit times with RACF.
Do you have set times during the day that a facility can contact the GP to discuss a resident? (*E.g. between 12pm and 2pm each day, or between 8am and 9am each day?*)	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Establish times during the day, when GPs can accept phone calls from the RACF. Communicate these times to the practice receptionist and the facility.

[3] https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Draft-RACGP-Standards-for-GPRAC-1st-edition.pdf

Description	Status	Action to be taken
Do you have a system to action any messages coming from the facility in relation to a resident?	☐ Yes: **see action to be taken**. ☐ No: **see action to be taken.**	Outline what is your system, including what sort of things need to be communicated: Is the system: ☐ working well ☐ needs some minor changes ☐ needs major improvements.
		Develop a system for actioning all messages. You may consider asking the receptionist to notify the RACF when a message is received. Encourage RACF staff to follow up with a phone call to the practice to ensure messages are received.
Has the RACF communicated any outbreak management plans/processes for GPs? Is there a system for RACF to alert GPs of illness outbreaks?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss this with the facility and identify a plan and ensure this is documented and communicated.
Do you have a system to ensure residents have access to a GP 24 hours a day?	☐ Yes: **see action to be taken**.	Outline your system:
	☐ No: **see action to be taken.**	Develop a system and document your coverage for residents 24 hours a day. How will you communicate this system to your team and the facility?

Description	Status	Action to be taken
Do you have a buddy system, or another GP who can provide health services to residents in a facility if regular GP is on leave or unavailable?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider coverage for the facility if the GP is on leave or unavailable. How will you communicate this service to your team and the facility?
Is there a system in place if a regular GP is no longer able to provide care to patients at a RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider succession planning. Contact the Older People's team at Brisbane South PHN. How will this be communicated to the RACF?
Do you have a system for clinical handover for the residents? (*e.g. GP to GP, facility to hospital etc.*).	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information on yellow envelope. Update practice policy and procedures to reflect clinical handover.
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
 After reviewing your strategies on communication between RACF, GP and practice, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, see **action to be taken to help set you goals**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 3 – IDENTIFYING RESIDENTS IN AN AGED CARE FACILITY

GPs are the primary medical care providers for residents in RACF settings who oversee residents' medical care. It is beneficial for GPs to have a comprehensive list of residents in facilities, with next of kin, emergency contacts and enduring power of attorney details. GPs may rely on the RACF to keep all of the residents' contact details, however, GPs should understand the facility's process.

Activity 3.1 – Identifying residents in an aged care facility

The aim of this activity is to develop a system to easily identifying residents at the practice who are in an aged care facility

Description	Status	Action to be taken
Do you ensure resident address details are updated when they move into a facility?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Develop a system to ensure address and contact details are updated when they move facility. This may be driven by the GP, or when the pharmacy contacts for prescriptions.
Do you know how to search for residents by address in your clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions from Best Practice and MedicalDirector.
Do you ensure contact details for the resident are up to date including: next of kin, emergency contact, enduring power of attorney?	☐ Yes: **see action to be taken**.	Outline how you ensure details are kept up to date?
	☐ No: **see action to be taken.**	Refer to instructions from Best Practice and MedicalDirector on how to record next of kin and emergency contacts.
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
After reviewing your systems for identifying residents in an RACF, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, **see action to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 4 – MEDICARE AND OTHER FUNDING STREAMS AND RACFs

Medicare provides funding for eligible GPs and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim these items. The following item numbers *may be* used for residents in an RACF. Always refer to the guidelines in the Medicare Benefits Schedule (MBS). This can be accessed at MBS online, education guides or eLearning guide. These items include:

MBS items

- Call out fee – first patient only
- Attendance fee – fact sheet
- Bulk billing incentive
- After hours
- MBS telehealth fact sheet
- MBS Attendance Items for RACFs
- Presentation on the use of MBS items in RACFs
- Health assessments
- Residential medication management reviews
- Case conferences.

TIP: GPs are required to make sure each resident meets the MBS criteria prior to claiming each item number.

Until 30 June 2022, MBS items are available for care recipients in RACFs. There is a range of items available for mental health, chronic disease management and physical therapy.

- Management plans – until 30th June 2022
- Mental health support – until 30th June 2022
- CDM GP or OMP in RACFs (Fact Sheet)
- Mental Health Treatment Plans in RACFs(Fact Sheet)

The PIP General Practitioner (GP) Aged Care Access Incentive (ACAI)

The PIP GP ACAI aims to encourage GPs to provide increased and continuing services in RACFs.

To be eligible for the PIP GP ACAI payments, GPs must:

- be registered in the PIP at an approved PIP practice
- use a Medicare provider number linked to a PIP practice when claiming MBS services in RACFs
- provide eligible MBS services to residents in RACFs
- reach the Qualifying Service Level (QSL) by providing the required number of MBS services in RACFs in a financial year.

PIP GP ACAI payments and requirements

Tier	Qualifying Service Level (QSL)	Service Incentive Payment (SIP)
Tier 1a	60 to 99 services	$2,000
Tier 1b	100 to 139 services	+ $2,500
Tier 2a	140 to 179 services	+ $2,500
Tier 2b	180 or more services	+ $3,000

Eligible GPs can get 4 payments totalling $10,000 for the financial year, in addition to the consultation fee.

Activity 4.1 – Understanding MBS and funding streams for visiting residents in RACFs.

The aim of this activity is to increase your understanding of the practice's use of MBS claiming and other funding available for visiting residents in RACFs.

Description	Status	Action to be Taken
Are all GPs aware of the MBS items available for visiting residents at a RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to the MBS Attendance Items for RACFs. How will this information be communicated to the practice team?
Does the practice claim a call out fee for one resident each time they visit the facility?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to criteria for Call out fee. How will this information be communicated to the practice team?
Does the practice/GP have a system to ensure all residents have a comprehensive health assessment completed every year?	☐ Yes: **see action to be taken.**	What is your practice system? Is the system working well? ☐ Yes ☐ Needs improving.

Description	Status	Action to be Taken
	☐ No: **see action to be taken.**	Identify all residents in an RACF and review their status of CMA. Discuss with the facility a system to complete these on the residents.
Does the practice/GP have a system to ensure all residents have an RMMR completed every year?	☐ Yes: **see action to be taken.**	What is your practice system? Is the system working well? ☐ Yes ☐ Needs improving.
	☐ No: **see action to be taken.**	Identify all residents in an RACF and review their status of RMMR. Discuss with the facility a system to complete these on the residents.
Are all GPs in the practice aware of the PIP GP ACAI payment?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to PIP GP ACAI guidelines. How will this information be communicated to the practice team?
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
After reviewing your practice's MBS claiming and other funding streams for RACFs, are there any changes with the management of your resident's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 5 – QUALITY PATIENT RECORDS

Quality patient records refers to the management, storage and disposal of records (paper and electronic), and the technology used in the process. The GP and the RACF is required to comply with the relevant state and federal laws relating to the collection, storage, use, disclosure and disposal of residents' health and personal details. During this activity topics will include:

- recording RACF visits consistently (either all electronic or all paper-based)
- creating shortcuts to record as a RACF visit
- uploading health summaries and episodes of care to My Health Record (MHR).

It is vital to ensure that the GP is maintaining their own patient notes as it is not adequate for a GP to solely use the RACF's systems as their medical notes. Notes in the RACF's systems are not under the control of the GP and the practice, and do not allow for clinical governance and proactive medical care.[4] GPs need to have consistency in recording clinical records, practice management/billing software. These all need to be consistent.

Activity 5.1 – Review systems for recording patient records

The aim of this activity is to review systems to identify ways of recording patient records.

Description	Status	Action to be Taken
Do you ensure clinical notes are recorded consistently for every resident?	☐ Yes: **see action to be taken.**	How is this done? ☐ handwritten notes at the facility, that are copied and sent to the practice to scan into practice software. ☐ notes entered into clinical records at the facility. ☐ notes are recorded in the practice software when the GP returns to the practice. ☐ GP takes laptop to the facility and completes notes as they are visiting resident. Any relevant information is shared with the facility. Is the system working well? ☐ Yes ☐ No
	☐ No: **see action to be taken**.	Refer to RACGP aged care clinical guide (silver book) for options on recording clinical notes. GP discuss with the facility and identify preferred option.

[4] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/silver-book-part-b/medical-records-at-residential-aged-care-facilitie

Description	Status	Action to be Taken
Do GPs ensure that records include: • reason for GP or RACF care team visit • health summary • medication chart • observation notes • a copy of care plan and ACP/ACD, where appropriate.	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	This is requirement outlined in RACGP accreditation standards for GPs and RACFs.
Can the GP access the RACF's clinical records remotely?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the facility options for establishing a VPN. Are there times when this option is unavailable?
Do GPs know how to create shortcuts in practice software to make it easier to record clinical notes.	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector. How will this information be communicated to the practice team?
Do GPs have a consistent system for recording and submitting visits for payments from Medicare/DVA?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Identify if vouchers are submitted via paper based or electronically. Ensure the GP has the responsibility to check any billings submitted by the practice.
Do GPs ensure health summaries and any other relevant information is uploaded to MHR?	☐ Yes: **see action to be taken.**	Outline how this is completed: (*e.g. clinical records is updated after each visit. Uploads to MHR are completed when there are changes to conditions, medications or any plans/assessments are updated).*

Description	Status	Action to be Taken
	☐ No: **see action to be taken**.	Refer to: • information from My Health Record • information from Brisbane South PHN. • Recipe from CAT4 on uploading shared health summaries.
 After reviewing your practice's systems for maintaining quality patient records, are there any changes with the management of your patient's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 6 – MEDICATION MANAGEMENT

As the population ages, more people are living with multiple chronic diseases with an associated increase in polypharmacy (multiple medicines use). Medication use in older people is a complex balance between managing disease and avoiding medication related problems. Supervised withdrawal of unnecessary medicines (deprescribing) is safe and may improve quality of life in older people. Optimal medication management in older people requires a multidisciplinary approach to ensure the best quality of life.

Medication charts

A medication chart in a residential aged-care facility serves as a communication tool between doctors, nurses, pharmacists, other health professionals and hospitals regarding a resident's medicines. It is used to direct how and when drugs are to be administered and as a record of their administration. Medication charts can be either hard copy or electronic, however, as part of the 2021-22 Budget, the Australian Government announced support for RACFs to implement an Electronic National Residential Medication Chart. An eNRMC system can benefit residents, providers, workers, prescribers and pharmacists, through:

- decreasing medication safety risks, such as inconsistencies between prescriber records and paper medication charts, also lessening time spent by suppliers reconciling these differences
- increasing visibility of residents' medication record for prescribers, pharmacists and aged care staff.
- timely provision of medications
- alerts to advise allergies or medication interactions, and reminders of new prescriptions or follow up consultations
- reducing administration burden for aged care providers, prescribers and pharmacists
- reducing the amount of daily medications taken by an individual (polypharmacy).

Deprescribing medications

- Deprescribing is the process of discontinuing drugs that are either potentially harmful or no longer required.
- It can be achieved in older people and may be associated with improved health outcomes without long-term adverse effects.
- The risk of drug withdrawal effects can often be mitigated by carefully monitoring and gradually tapering the dose.
- Deprescribing should ideally be a shared decision-making process between the resident and the prescriber.

Medicines should be reviewed regularly to ensure that each drug is effective for that individual and therapy remains consistent with their care goals. Treatment should also be underpinned by a current and valid diagnosis. A significant event like a fall, or an admission to hospital or a residential care facility, should prompt a thorough medicine review. A review should also be triggered by increasing frailty or a decline in either their cognitive function or ability to manage activities of daily living.[5] This review could be conducted as part of an RMMR.

Electronic prescribing and Qscript

Electronic prescriptions are part of the broader digital health and medicines safety framework. They enable the prescribing, dispensing and claiming of medicines, without the need for a paper prescription.

QScript is a read-only computer system that provides doctors, other prescribers and pharmacists monitored medicine prescription information at the point of care.

Health practitioners can visit QScript to log into the QScript system, register for access and access the learning portal.

[5] https://www.nps.org.au/australian-prescriber/articles/deprescribing-in-older-people

Activity 6.1 – Reviewing medication management

The aim of this activity is to review the current practices of medication management within an RACF and your practice.

Description	Status	Action to be Taken
Do all relevant practice team members understand the current format and process of managing medication charts at the RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Discuss with the nurse manager of the facility to understand the current process of managing medication charts. Are they electronic? ☐ Yes ☐ No How often are they updated?
Are all medication lists for the residents similar including records kept at the practice, the RACF and MHR?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Review each resident's medication lists across the multiple portals to ensure consistency. Address any medication issues.
Does each GP have a system for deprescribing medications on residents in a RACF?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to deprescribing guides.
Does the practice have a system to ensure all residents of an aged care facility have an annual RMMR?	☐ Yes: **see action to be taken.** ☐ No: **see action to be taken.**	Outline what is your system: Is the system working? ☐ Yes ☐ No Identify all residents in a RACF and those eligible for a RMMR. Arrange referrals, and discuss with the community pharmacist.
Are all providers registered to prescribe scheduled medications with QScript?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information about registering for QScript. How do you ensure GPs are using this system?

Description	Status	Action to be Taken
 After reviewing the medication management in RACFs, are there any changes with the management of your residents you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 7 – PREVENTION AND RISK FACTORS

Older people are at increased risk of multiple chronic conditions that may impair their function and quality of life. Their health problems may be exacerbated by poor nutrition, poor oral health, lack of physical activity, taking multiple medications and lack of sun exposure. All of which can be addressed in preventive activities.

The Royal Australian College of General Practice (RACGP), have a prevention activities over the lifecycle chart for adults available that can be used as a guide for reviewing activities in an aged care facility. Some primary or secondary preventive activities may not be appropriate based on age and physical or mental ability (e.g. 30 minutes of walking each day).

Activities include:

- Prevention of chronic disease, including smoking, alcohol, nutrition, weight and physical activity.
- Prevention of vascular disease, including absolute cardiovascular disease (CVD) risk assessment, blood pressure (BP), cholesterol and lipids, type 2 diabetes, stroke and kidney disease.
- Cancer, including skin cancer.
- Psychosocial, including depression screening, loss of family and cognitive assessment.
- Vaccination management, including influenza, COVID, shingles (70-year-old), pneumococcal & diphtheria, pertussis and tetanus (dTpa).
- Falls prevention.
- Vision, glaucoma, hearing and oral health.
- Osteoporosis risk.[6]

These risk factors need to be considered on an individual basis, dependent on the residents' mobility, and stage in life.

Activity 7.1 – Understanding the status of prevention activities in all residents

The aim of this activity is to increase your understanding of systems available to monitor and record prevention activities for residents.

Description	Status	Action to be Taken
Is there a system to monitor and measure smoking status, alcohol status, nutrition, weight and physical activity on all residents in the facility?	☐ Yes: **see action to be taken.**	Please explain: (*e.g. the RACF check and record this information on a regular basis. The GP conducts annual comprehensive medical assessments on all residents*).
	☐ No: **see action to be taken**.	Discuss with the residential care manager how this information is collected from residents. Develop a system to ensure this is completed.

[6] https://www.racgp.org.au/getattachment/c9b0be76-8320-4f64-b0f8-371ae429a41b/Lifecycle-chart.pdf.aspx

Description	Status	Action to be Taken
Is there a system to monitor and measure absolute CVD risk, BP, cholesterol/lipids, type 2 diabetes, stroke and kidney disease on all residents in the facility?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the residential care manager how this information is collected from residents. Develop a system to ensure this is completed.
Do you conduct skin cancer checks on all residents?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	The RACGP recommends in their lifecycle chart, that this is conducted opportunistically. Develop a system to monitor these.
Is there a system to monitor residents for depression and their cognitive state?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to cognitive and screening assessments and geriatric depression scale.
Do you monitor the vaccination status of all residents for influenza, COVID, shingles, pneumococcal & dTpa?	☐ Yes: **see action to be taken.**	Outline how this is done: Do you ensure the vaccinations are uploaded to Australian Immunisation Register? ☐ Yes ☐ No
	☐ No: **see action to be taken.**	Develop a system to monitor the vaccination status of the residents in accordance with the Australian Immunisation Handbook. Consider using the practice's reminder system to notify when next vaccination due.
Are residents assessed for a falls risk at least every 12 months?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to falls risk screening assessment tools. Discuss with the facility who will complete these tools and how the information will be shared amongst relevant care providers.
Are residents' vision, hearing and oral health checked every 12 months?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the facility if a dentist, audiologist and ophthalmologist currently visit or determine best pathway for screening.

Description	Status	Action to be Taken
Is an osteoporosis risk assessment completed every 12 months?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Garvan risk calculator or fracture risk assessment tool. Discuss with the facility who will complete these tools and how the information will be shared amongst relevant care providers.
Are CMAs completed on all residents every 12 months?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the CMA template and MBS criteria. Consider creating a reminder in the practice software to ensure the assessment is completed every 12 months.
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
 After reviewing the prevention activities on residents, are there any changes with the management of your residents you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 8 – ADVANCE CARE PLANNING AND LAST DAYS OF LIFE

Advance care planning

Advance care planning is the voluntary process of planning for future health and personal care needs. Advance care planning is not a single event but an ongoing process and conversation that should be undertaken early and revisited regularly. Revisiting these conversations is especially important when a person's health or social situation changes.

Key components of advance care planning in aged care are:

- the person thinking about what's important to them in terms of specific care, medical treatment preferences and where they wish to receive care
- the person talking about their values and preferences for future health care with others
- the person selecting and appointing a trusted substitute decision-maker
- the person documenting their preferences in a legally-binding Advance Care Directive (ACD)
- if the person has insufficient capacity, having the substitute decision-maker document the person's preferences in an advance care plan to inform care.[7]

Testing for medical capacity

It may be difficult to assess whether an individual person can make valid decisions on very serious issues when they have borderline or fluctuating capacity. For example, a person may be capable of making decisions about minor health care, such as the application of a dressing or simple analgesia for a headache, but may not be able to understand the implications of more complex or significant health care which involves greater risks or complexity.

Most issues surrounding capacity can be resolved by the medical practitioner responsible for the resident's care. However, there may be times when doubt persists or consensus cannot be reached within the health care team. In these circumstances the medical practitioner should consider obtaining a second opinion or psychiatric evaluation from a suitably qualified and experienced medical practitioner such as a geriatrician, psychiatrist or neurologist.[8]

Three conditions need to be met to assess testamentary capacity:

1. The ability to understand the decision to be made.
2. The ability to express that decision (verbal of non-verbal).
3. Not influenced by other parties.

Last days of life care

Hospitalisation during the last weeks of life when there is no medical need or desire to be there is distressing and expensive. It is important for the resident's wishes to be documented and followed. A management plan would be useful, especially if the facility is required to contact an after-hours GP.

As patients approach the last days of life, the GP's role is to apply the principles and approach to care of older people presented throughout the RACGP aged care clinical guide (Silver Book). There is a sharper focus on:

- person-centred care to support wellbeing and quality of remaining life, respecting the person's values, goals and treatment choices
- proactive clinical care planning to anticipate and provide care as the person's clinical condition deteriorates, and as goals of care shift from treating the illness towards comfort and managing death.

[7] https://www.advancecareplanning.org.au/docs/default-source/acpa-resource-library/acpa-publications/advance-care-planning-in-aged-care-implementation-guide.pdf
[8] https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf

All GPs who care for older people are engaging with issues their patients face towards the last days of life. Emphasis towards anticipating and planning to minimise the effect of predictable problems can improve the care offered, and the quality of life experienced by patients and carers.

CAREPACT is available to streamline and educate the care pathway for the people in an RACF.

Medical APPS

There are a number of apps that health professionals can access for a palliative care approach including:

- *caring@home app* - this app assists health professionals, supporting families, carers and patients, to assist with caring for people at home. There are resources, in English and nine other languages, for both carers (including training videos) and health professionals.
- palliAGEDgp app - this app provides nurses and GPs with easy and convenient access to information to help them care for people approaching the end of their life.
- palliMEDS app - developed by NPS MedicineWise, this app familiarises primary care prescribers with eight palliative care medicines that have been endorsed by the Australian & New Zealand Society of Palliative Medicine (ANZSPM) for management of terminal symptoms.

Issuing medical certificate of cause of death certificates (MCCD)

The MCCD is an important legal document required to notify deaths to the registrar of births, deaths and marriages. To complete a death certificate, you must be 'comfortably satisfied' about the cause of death and that the circumstances of the death do not constitute a 'reportable death' to the coroner.[9] The MCCD can be completed using the traditional carbonless form or online.

SpotOnHealth HealthPathways provides an overview to completing certificates, however, a summary of requirements includes:

- acting on a request for a death certificate within 2 working days of the person's death
- providing the certificate free of charge
- determining whether the death is reportable
- there is no requirement to have:
  - seen the person within a certain time frame
  - seen or examined the person's body
  - treated the person in the past.

Activity 8.1 – Understanding advance care planning, testamentary capacity and certificates of death.

The aim of this activity is to increase your understanding of advance care planning, testamentary capacity and certificates of death.

Description	Status	Action to be Taken
Do all relevant practice team members know where to locate advance care planning documentation? Do they know how to upload documents to patient records?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to advance care planning forms. Refer to GP Information from the Queensland Government.

[9] https://avant.org.au/Resources/Public/20160411-death-certificates/

Description	Status	Action to be Taken
		How will this information be communicated to the relevant practice team members?
Do you know how many residents at the facility have an AHD or a Statement of Choices	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Identify list of residents and discuss with facility to determine the number with an AHD or a statement of choices.
Do any of the practice team require training/assistance on having end of life conversations?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Refer to training modules. How will this information be communicated to the practice team?
Are all relevant team members aware of the capacity assessment guidelines?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to guidelines. How will this information be communicated to the practice team?
Are all team members aware of the information on SpotOnHealth HealthPathways in relation to issuing medical certificates of cause of death?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to SpotOnHealth HealthPathways.
Do all practice team members understand the importance of marking the patient's file as deceased and how to update this information on the patient's file?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.

Description	Status	Action to be Taken
Are you aware of the end of life directions for aged care model?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the module from ELDAC.
Are all GPs aware of the services provided by CAREPACT?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information on CAREPACT.
Have relevant team members completed the older person training module on DiscoverPHN?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to training module.
 After reviewing your understanding of advance care planning and end of life, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, **see action to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 9 – ROLES AND RESPONSIBILITIES OF THE PRACTICE TEAM

Roles and responsibilities of the practice team

Successful teams

Engaged and effective practice teams are the foundation for achieving sustainable improvements.

Consider how your team currently operates. Is your team working together effectively and efficiently? To achieve sustainable improvement, you will likely need to do some work on achieving a whole of team approach. There are a range of responsibilities for the effective management of residents in an aged care facility. Documented role clarity is important to ensure efficiency and accountability. Below is an example of how responsibilities could be shared across the team. As there is a great deal of diversity between practices, consider what will work best for your team.

General Practitioners (GP)

- Provide clinical support to residents in the facility, via face-to-face or virtual health.
- Communicate with the RACF team to establish systems for maintaining ongoing documentation requirements (e.g. repeat prescriptions, medication charts, ongoing referrals etc).
- Understand the roles and responsibilities of the various facility team including manager, RN, EN, AIN, personal carer.
- Perform appropriate screening and management including: vaccinations, medication reviews, comprehensive medical assessments.
- Identify and utilise appropriate referral pathways.
- Maintain RACGP Standards for General Practice and Aged Care Quality and Safety Standards.
- Send MBS billing recommendations to reception.
- Ensure coverage for residents after hours and when on leave.

Practice nurse

- Triage any urgent calls from the facility in relation to residents.
- Organises GPs' schedules and work.
- Liaises with RACF staff, families and other service providers.
- Takes notes, makes referrals, drafts management plans, collects data for health assessments, collects records for admissions, drafts advance care plans, etc.
- Follows up on any results/investigations as requested by the GP.

Practice manager

- Monitors MBS item numbers claimed.
- Establishes and oversees recall/reminder systems.
- Supports GPs with the flow of information to and from the RACF.
- Identifies and implements infrastructure to allow telehealth and videoconferencing.
- Communicates after hours arrangements with the facility.
- Facilitates a GP buddy system within the practice.
- Supports and manages reception staff responsibilities.
- Manages succession planning.
- Documents policy and procedures.

Reception staff

- Ensures residents' demographic and personal details are up to date include next of kin (NOK).
- Ensure adequate time is blocked in the GPs appointment diary to accommodate resident visits.
- Process MBS claiming.
- Ensure any messages are communicated to the GP and/or practice nurse in a timely manner.

Activity 9.1 – Practice team roles in RACF

Based on the example above, identify the person responsible for each part of the process required to care for residents in an aged care facility. Document each person's responsibilities in the table below.

Tasks for (insert QI Activity Name)		
	Name	**Responsibilities**
GP 		
Practice nurse 		
Practice manager 		
Receptionist 		

Activity 9.2 – Review task allocation

The aim of this activity is to review task allocation for team members in your practice.

Description	Status	Action to be taken
Do all team members understand their roles and responsibilities?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to individuals or groups within your practice.
Has the GP or another representative from the practice agreed on communication channels with the RACF?	☐ Yes: **see action to be taken**.	How will this be done? Does someone in the practice have the responsibility to acknowledge receipt of communication? ☐ Yes ☐ No Who is responsible?
	☐ No: **see action to be taken.**	Arrange a meeting with key members of the practice and the facility to discuss communication channels, frequency and delegated responsibilities.
Has the practice identified suitable telehealth and/or video conferencing facilities?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Contact the Digital Health team (ehealth@bsphn.org.au) at Brisbane South PHN to discuss options. Contact Healthdirect.
Are there arrangements for providing care to residents at the RACF after hours?	☐ Yes: **see action to be taken**.	Outline the arrangements:
	☐ No: **see action to be taken.**	Decide as a practice, the arrangements for after hours care. Will this be done by the practice or via a Medical Deputising Service?

Description	Status	Action to be taken
		How will this information be communicated to the practice and facility team?
Does the practice have a buddy system to ensure services to the facility are still maintained when the GP is on leave?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider a system that works for your practice to allow for adequate coverage. Communicate this system to the practice team.
 After reviewing your practice roles and responsibilities for managing residents at a RACF, are there any changes you would like to implement over the next 12 months?	☐ Yes, **see action to be taken to help set you goals**. ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 10 – ONGOING CARE CO-ORDINATION

Care coordination between RACF, primary care and acute health services influences quality care in RACF. Communication and information sharing between services is seen as vital to providing quality care to residents.

Clinical handover is a core component that supports care coordination. Access to current health information and qualified RACF staff involved in the day-to-day care of residents is critical to a quality clinical handover.[10]

Activity 10.1 – Ongoing care co-ordination

Complete the checklist below which reviews the processes that are available to facilitate ongoing care co-ordination for residents in a facility

Description	Status	Action to be taken
Do you know the system the facility uses to ensure clinical handover of residents occurs between change of shifts?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Contact the nurse manager at the facility to identify the system.
Do GPs understand the services that are available onsite to residents? (*E.g. do physiotherapists, podiatrists, occupational therapists etc. visit?*)	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the nurse manager at the facility, the services that are available onsite.
Do GPs understand the role and responsibilities of the facility staff including: manager, RN, EN, AIN and personal carer.	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the facility to understand roles and responsibilities of the various team members.
Are details of visits provided by allied health professionals and specialists recorded in the resident's record?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss with the facility how communication about health appointments can be readily available in the resident's records.
Are GPs able to access the resident's clinical notes? Are these electronic? Do they require a password?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss how the GP and facility can collaborate and provide up-to-date clinical information related to each resident.

[10] https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Draft-RACGP-Standards-for-GPRAC-1st-edition.pdf

Description	Status	Action to be taken
Is there a system to communicate when a resident has been transferred to hospital?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information about yellow envelopes or training module.
Do all residents have a care plan created by the facility? Do GPs have the opportunity to contribute to the plan?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Discuss care plan arrangements with the facilities. Refer to MBS online to understand funding available for GPs.
 After reviewing the systems for ongoing care coordination, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 11 – EDUCATION, TRAINING AND RESOURCES

GP resources

- RACGP – Aged care clinical guide (Silver Book Part A & Part B)
- SpotOnHealth HealthPathways
- Health Translations Victoria
- First Nations Health Focus
- GP Psychiatry Support Line.

Metro South health teams

- CAREPACT - The **CAREPACT Specialist Consult Line** collaborates with residential aged care facilities and GPs to provide clinical support, resources, education and a central referral contact for acutely unwell residents to allow specialist review or consultation.
- Palliative Care
- Older Adult Mental Health Services
- Geriatric Medicine.

Brisbane South PHN resources

- Older people's health and wellness strategy 2019-2024
- Yellow envelopes
- Older person training module
- End of life care in residential aged care facilities
- First Nations Health Focus
- GP Psychiatry support line.

Activity 11.1 – Identifying health professionals with a special interest in visiting RACF

Complete this checklist to identify relevant team members who have a special interest in older people and supporting them at a RACF.

Description	Status	Action to be taken
Do you have any GPs in your practice who have a special interest or have done extra training in managing residents in a RACF?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	List GPs who have a special interest in older people: _____ _____ _____ _____ If there are GPs with a special interest in older people, could you contact the Older Persons Team at Brisbane South PHN to ensure they are fully supported.

Description	Status	Action to be taken
Do you have any GPs in your practice who are interested in pursuing further training or professional development in this area?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Contact the PHN to discuss available training options.
 After reviewing your practice's interest in managing residents in a RACF, are there any changes you would like to implement in the practice to help manage residents over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Links to other QI toolkits

Brisbane South PHN have a suite of QI toolkits available for general practice. After completing this toolkit, you may benefit from choosing one of the following:

- MBS
- Influenza
- Pneumococcal
- Shingles vaccination
- Osteoporosis
- Cancer screening
- Advance care planning.

The full suite of toolkits are available on Brisbane South PHN's website. PDF fillable workbooks are available on DiscoverPHN.

ACTIVITY 12 –POLICY AND PROCEDURES

It is important that the practice reviews its policy and procedure manual, to ensure relevant documentation is in place and up to date. It is recommended that the following policy and procedures are in place:

Activity 12.1 – Policies and Procedures

*Complete the below table to gather information on your **current** policies and procedures relating to visiting RACFs.*

Activity 12.1 – Review Policy & Procedures				
Does the practice have a policy and procedure for the following?	**Policy up to date**	**Policy needs reviewing**	**Who will review or update?**	**Date completed**
Advocacy support in aged care	☐	☐		
GP self-care (Doctor's Health in Queensland)	☐	☐		
Transfer of resident care (including buddy systems within the practice, transferring to another GP and transfer care to hospitals). This also includes the yellow envelope.	☐	☐		
Residents' rights and responsibilities	☐	☐		
Resident confidentiality	☐	☐		
Resident feedback (including complaints from relatives)	☐	☐		
Whistle blowers and elder abuse	☐	☐		
After hours care	☐	☐		
Continuing professional development and ongoing training	☐	☐		
Mentoring and supervision	☐	☐		

Activity 12.2 – Policies and procedures review

The aim of this activity is to complete a PDSA if any policy and procedures need updating in your practice.

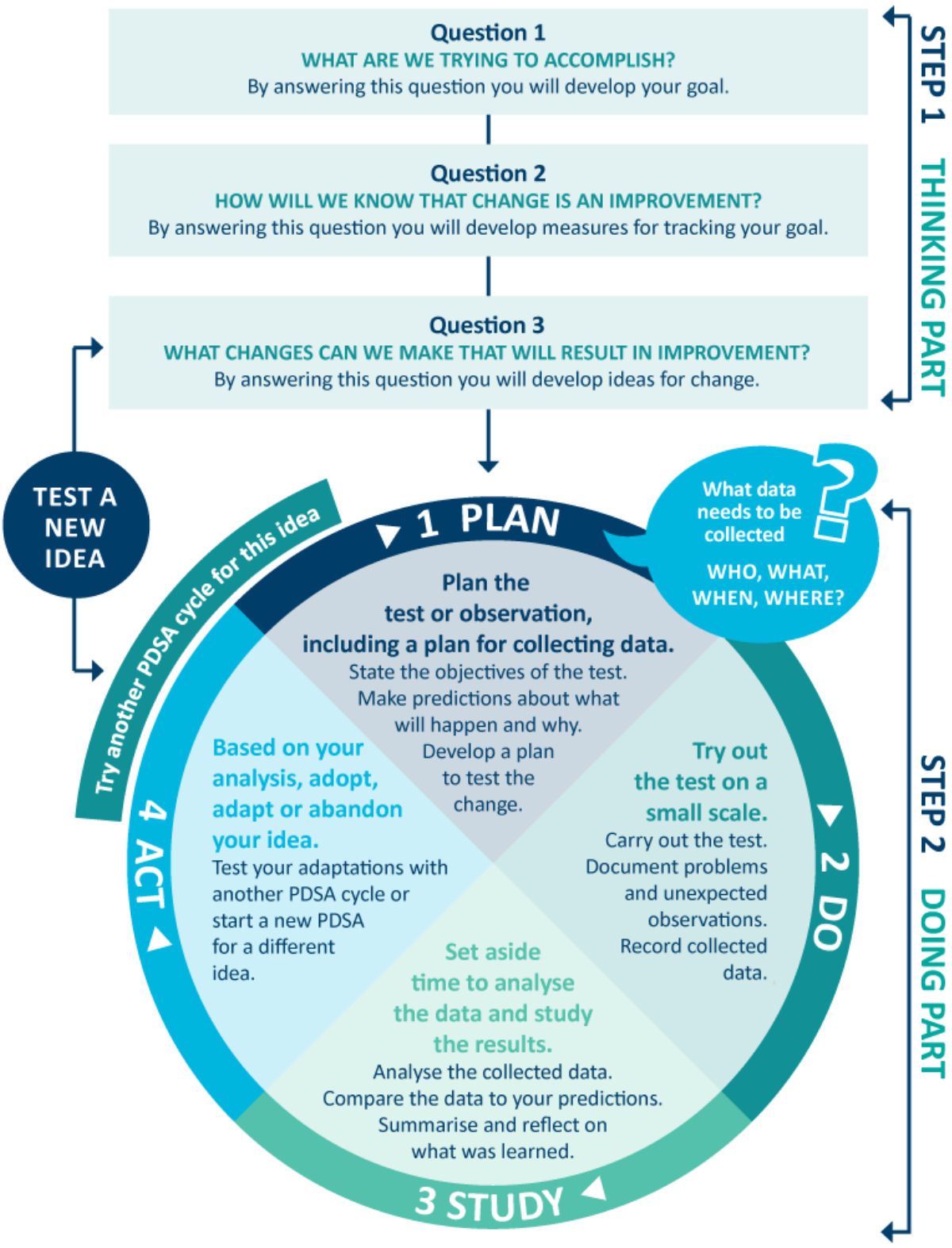
Description	Status	Action to be taken
After reviewing your relevant policy and procedures, are there any changes you would like to implement in the practice, to help manage residents, over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Example PDSA for residents in a RACF

See below for suggested goals related to older patient's you may wish to achieve within your practice: (please ensure you input the relevant age group prior to conducting each search).

Goal	How you may achieve the goal
Ensure 75% of active residents in a RACF, aged 75 years and older have a RMMR completed.	Refer to CAT4 recipe: Identify residents eligible for a RMMR.
Ensure 90% of active residents in a RACF have a CMA completed.	Refer to CAT4 recipe: identify residents eligible for health assessment. (Sort the table by address, to identify any residents in a RACF).
Increase the number of flu injections given to active residents in a RACF over the past 15 months by 10%.	Refer to CAT4 recipe: QIM4 – Influenza immunisation for patients aged 65 years and over. (Sort the table by address, to identify any residents in a RACF).
Increase the number of shared health summaries uploaded by 15%.	Refer to CAT4 recipe: Shared health summaries.
Ensure all staff have completed the older person training module.	Refer to: training module.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.

Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to:

Increase the number of case conferences completed on residents in a RACF.

This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to increase the number of case conferences completed for residents in a RACF by 15% by 31st December.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, resident surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the number of case conferences claimed on residents in a RACF. To do this we will:

A) Identify the number of active residents currently living in a RACF.

B) Identify the number of active residents currently living in a RACF with a case conference claimed in the past 12 months.

B divided by A x 100 produces the percentage of residents in a RACF with a case conference completed.

BASELINE MEASUREMENT: 37% of active residents have a case conference completed. DATE:

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active residents eligible for a case conference.

IDEA: Ensure all relevant team members have received training on completing case conferences.

IDEA: Ensure case conference templates are available and up to date in the practice clinical software.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active residents eligible for a case conference.	

PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.

WHAT:

Mary will conduct a search on CAT4 to identify active residents in a RACF eligible for a case conference. She will then generate individual lists for each GP and highlight the residents who do not have any record of case conferences from their medical record. Each GP will identify suitable residents, outline times when they will be available to conduct the case conferences and identify other health professionals. Mary will contact the relevant facility to provide the list of residents to the RN, to discuss times to co-ordinate these. Case conferences will be set up and ensure a family member participates. At the conclusion of the case conference the GP will document agreed outcomes.

WHO/WHEN/WHERE:

Who: Practice manager When: Begin 30th October. Where: Practice manager office.

DATA TO BE COLLECTED: Number of active residents currently living in a RACF with a case conference claimed in the past 12 months.

PREDICTION: 52% of active residents in a RACF will have a case conference completed.

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).

Done – completed 20th December – individual GP reports were generated from CAT4 outlining residents living in a facility who were eligible for a case conference. Each GP identified residents who would be suitable, available times and suggested team members. Mary then provided that list to the RN at the facility. After the RN had reviewed the list and the suggested team members, some suggestions for inclusion were made. The RN, then coordinated one appointment only. As the family member was interstate, the case conference was going to be held with the GP and other health professionals being at the facility and then video link to the family member, the RN wanted to test the process, before booking in multiple appointments. The initial appointment worked well and received positive feedback from the health professionals and having the opportunity to be all in the same room to plan health management for each individual resident.

The RN, then coordinated more appointments for other residents.

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
A total of 47% of residents had a case conference completed. This was lower than predicted, as the facility needed to go into a lockdown, and then the GP had planned leave over the school holidays. Results have been shared with the whole practice team and the facility. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	
ACT	**Record what you will do next**
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*
ADOPT: The practice has decided that they will adopt this. Mary will do a quarterly focus on generating reports from CAT4 to identify any active residents who do not have a case conference completed in the past 12 months. ADAPT: ABANDON:	

Repeat step 2 to re-test your adapted plan or to test a new change idea

Acknowledgements

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