RACGP *Standards for general practice residential aged care (1st edition)*

Contents

Introduction to the Standards for general practice residential aged care (1st edition)

The Royal Australian College of General Practitioners (RACGP) has developed the *Standards for general practice residential aged care* (1st edition) to support and enhance the delivery of quality and safe general practitioner (GP) care in residential aged care facilities.

Why do we need the Standards for general practice residential aged care?

The RACGP *Standards for general practice residential aged care* (hereafter the Standards for GPRAC) focus on the clinical interface between the GP (and GP team, including other practitioners from the same practice) and Residential Aged Care (RAC) facilities. The Standards for GPRAC set out essential minimum requirements for GPs in order to provide quality and safe care in this setting.

Development process

The Standards for GPRAC were developed by the RACGP to align with the requirements of the Aged Care Quality Standards (from 1 July 2019) and in consultation with GPs, residential aged care facilities, practice managers, nurses, consumers, subject matter and technical experts, and many other stakeholders.

Definition of general practice services in residential aged care for the purposes of accreditation

Residential aged care facilities must meet the following criteria to be accredited against the RACGP Standards for GPRAC. The residential aged care facility must:

- provide personal care and other support services such as pharmacy, allied health, social services, specialist services or respite care to older people who are unable to live at home
- coordinate multidisciplinary care for all residents 24 hours a day / 7 days per week
- be accredited against the Australian Department of Health's Aged Care Quality Standards
- meet all of the mandatory Indicators in the Standards for GPRAC.

The Standards for GPRAC do not replace existing requirements for accreditation against the Aged Care Quality Standards, as set by the Department of Health.

Numbering of Criteria and Indicators

The numbering system works as follows:

- the Standards in each module are numbered separately (Standards 1 – 5 in the Standards for GPRAC module)
- the Criteria for each Standard have a code indicating the setting (RAC), followed by sequential numbering that indicates the Standard and Criterion. For example, RAC1.1 is the first Criterion for the first Standard in the Standards for GPRAC
- each module starts with **Standard 1**: therefore, there is Criterion **RAC1.1**
- each Criterion has one or more Indicators, labelled alphabetically (A, B, C, etc).

Indicators that focus on outcomes and residents

The Indicators in these Standards have, where appropriate, been written with a focus on outcomes and residents, instead of prescribed processes or what your RAC does.

By focusing on outcomes, your RAC facility can develop systems and processes that reflect your preferred ways of working, and choose how to demonstrate that you meet the intent of each Indicator. It is important that you can provide evidence of meeting the Indicator, either through inspection or interview. Focusing on outcomes will give your RAC facility greater ownership of your processes and systems, making your team members more likely to follow them not only during the accreditation process but also as business as usual.

Explanatory notes

The explanatory notes for each Criterion have three sections.

- *Why this is important*
  This section explains why the Indicators are important from a quality and safety perspective.
- *Meeting this Criterion*
  This section outlines ways that your RAC facility can choose to demonstrate that you meet the Criterion and / or its Indicators.
- *Meeting each Indicator*

  This section contains a list of any **mandatory** activities your RAC facility must do to meet the Indicator, and/or **optional** ways your RAC can choose to meet the Indicator.

Use of ‘could’ and ‘must’

In the explanatory notes, the words ‘could’ and ‘must’ are used as follows:

- ‘Could’ is used to indicate that something is optional.
- ‘Must’ is used to indicate that something is mandatory.

Plain English

Plain English has been used to write these standards to create less ambiguity and reduce the amount of technical language.

Language used in these Standards

These Standards are written with terminology that reflects the varied arrangements with general practices and practitioners who engage in resident care. The term 'broader RAC care team' reflects the complexity of practitioners that provide this care in RAC.

The term RAC indicates the residential aged care facility and is used interchangeably with RAC facility depending on the context within the document.

Use of 'Our RAC'

The term 'Our RAC' indicates a sense of ownership/inclusiveness for the RAC staff working in a facility. It does not reflect the ownership of the actual RAC facility.

Use of resident and patient

The term 'resident' refers to a person who lives within a RAC facility.

The term 'patient' is used occasionally when referring to a direct consultation with a resident's GP.

Citation of federal, state or territory legislation

Legislation has been cited only where it is especially important to a particular aspect of service provision (eg in RAC1.1 B - state and territory laws vary on advanced care planning and advance health directives. GPs must familiarise themselves with the forms used in their state or territory). Therefore, most of the relevant federal, state or territory legislation has not been cited in this document.

As federal, state or territory, and local legislation overrides any non-legislative standards, including those in this document, your RAC is responsible for ensuring that you comply with relevant legislation.

If your RAC is accredited against the Standards for GPRAC, you will have met some of your legislative requirements, but this does not mean that you have automatically met all of them, as the Standards for GPRAC do not address all of the relevant state and territory legislation.

Evidence-based standards

The Standards for GPRAC are based on the best available evidence of how RAC facilities can provide safe and quality healthcare to their residents.

This evidence is based on two sources:

- relevant studies

- level IV evidence (where studies are not available). Level IV evidence is also known as evidence from a panel of experts.

To ensure that this Level IV evidence is as robust as possible, the Standards for GPRAC, have been tested by Australian residential aged care facilities and consumers, overseen by an expert committee consisting of GPs, academic GPs, nurses, practice managers, and consumer representatives.

The Resource guide

The RACGP has developed a Resource guide that contains useful supplementary information that will help your RAC meet the Indicators. The Resource guide is available at [insert weblink].

RACGP Standards for GPRAC

RAC Standard 1

Resident care coordination

RAC Standard 2

Infrastructure, equipment, consultation spaces and treatment room

RAC Standard 3

Information management

RAC Standard 4

Medication management

RAC Standard 5

Qualifications of the RAC care team

RAC Standard 1: Resident care coordination

Our RAC supports and facilitates the coordination of care for residents

Care coordination is essential in RAC facilities. General practitioners (GPs) are the primary medical care providers for residents in RAC settings who oversee residents' medical care. [1] RAC residents' multidisciplinary care is provided by a range of health professionals including nurses, nurse practitioners, allied health practitioners, pharmacists and other medical practitioners. RAC staff, including personal care assistants, are part of the internal RAC care team. It is essential that systems of care and collaborative arrangements are clearly defined so that residents have access to safe and timely comprehensive and quality care.

Criterion RAC1.1 – Access to care

Indicators

RAC1.1►A Our RAC facilitates access to GP care, including urgent and after-hours care arrangements.

RAC1.1►B Our RAC coordinates residents' treatment according to advanced care directives, where available.

RAC1.1►C Our RAC participates in planning and updating resident care with the resident's GP.

RAC1.1►D Our RAC facilitates and communicates with a resident's GP about care services provided within the facility.

RAC1.1►E Our RAC communicates with a resident's GP when an external care transition has occurred.

RAC1.1►F Our residents are informed of when their regular GP routinely visits the facility.

Why this is important

Coordinating arrangements

Providing medical care for residents requires effective and robust systems with transparent arrangements that support GPs and other members of the RAC care team who may work in multiple RACs. Due to the complexity of multidisciplinary care needs and multiple care providers, systems of care and collaborative arrangements need to be clearly defined and documented to ensure access to safe and timely comprehensive and quality care for residents.

Resident choice is important in regards to the GPs who provide their care as well as their choice of pharmacy services.

Collaborative arrangements between the RAC facility and GP:

- strengthen the relationship between RAC facilities and GPs [2-5]
- ensure that residents can access appropriate care 24 hours a day
- help maintain continuity of care for residents[6, 7]
- potentially prevent avoidable hospital presentations and admissions. [8, 9]

GPs caring for residents in RAC ideally need to be able to provide routine visits at mutually convenient times for general practice and 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.

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.

Advanced care plans and directives

Advanced Care Plans (ACP) are the embodiment of person-centred healthcare and a response to the challenges that an ageing population and modern healthcare present. An ACP allows for an individual's wishes regarding their care and treatment options to be documented. When a person loses the ability to make decisions about their care, the ACP enables their wishes to be expressed. There is evidence that ACPs improve end-of-life care, reduce the rate of hospitalisations and ambulance calls, and increase referrals to specialist palliative care services. [7, 10, 11]

ACPs will often lead to the completion of an Advance Care Directive (ACD). An ACD is a document, for use when a resident may no longer be able to make decisions about their care, and legally allows for a Substitute Decision Maker to record preferences for future health and personal care.[12] ACDs are not clinical care or treatment plans, however clinical care or treatment plans can and need to be informed by ACDs. It is important to note that verbally communicated and documented instructions also hold weight. RACs must have a process to determine whether a resident has an ACD and document this within the resident's electronic health notes. ACP's and ACD's are ideally offered as soon as practical and completed upon admission to the RAC.

Consumer dignity and choice is of particular importance in the Aged Care Quality Standards.

GPs develop ongoing and trusted relationships with their patients and are well positioned to initiate and promote the use of ACPs. The role of GPs is pivotal in supporting their patients through the planning process, involving the discussion of any problematic issues, and providing information regarding the patients' current health status, prognosis and future treatment options. [11]

Care transitions

There are sometimes cases where a resident may transition to another RAC facility or request to transfer their care to another practitioner. It is important that when this transition occurs that all relevant information is communicated to a resident's regular GP so they may follow-up with the new RAC or prepare documentation to transfer to the new RAC facility/GP.

Meeting this Criterion

Collaborative arrangements between RAC and GPs

Collaborative arrangements between your RAC and GPs will generally include:

- methods of communication
- mutually agreed access times
- protocols for referral arrangements
- information management e.g. medical records, pathology and imaging results
- after-hours and emergency care.

Advanced care plans

Advance care planning will often involve the following components:

- discussions about prognosis and possible future scenarios and a persons' concerns
- appointment of a Substitute Decision Maker(s) and details of the extent of their involvement in initial and subsequent ongoing documented discussions
- reaching consensus on current and possible future goals of care. These goals may be supported by a statement describing the reasoning underpinning the choices a resident has made
- discussions of choices around preferred place of care during their illness and in the terminal phase
- documentation of these discussions in an easily retrievable format, held by the RAC facility, resident, their Substitute Decision Maker(s), their family and GP. [13]

State and territory government laws vary on ACP and ACDs. Advance Care Directives in some form are legally binding documents in every state / territory of Australia. GPs must familiarise themselves with the guidelines and forms used in their state or territory.

Information required from each party that will be providing resident care

Formal arrangements, such as ACPs and ACDs, need to consider the Australian Privacy Principles and the *Privacy Act 1988* and any state-specific legislation.

Meeting each Indicator

RAC1.1►A Our RAC facilitates access to GP care, including for urgent and after-hours care arrangements.

You must:

- have a collaborative arrangement with all GPs providing services in your RAC including arrangements for urgent and after-hours care
- implement arrangements to ensure RAC residents can access appropriate medical care 24 hours a day, seven days per week.

You could:

- establish pre-arranged routine visits with GPs during reasonable hours (usually between the hours of 8am and 8pm)
- create and complete an agreed care and communication template for use by GPs and RACs with regard to your residents' care
- provide a floor map of your RAC facility to GPs
- provide access codes to building, nursing stations and dementia wings, where appropriate
- ensure car parking is available for visiting GPs.

RAC1.1►B Our RAC coordinates resident's treatment according to advanced care directives, where available.

You must:

- determine whether each resident has an ACD

- record whether an ACD is in place and communicate this with the GP
- if relevant, involve the Substitute Decision Maker in advanced care planning/directive discussions.

You could:

- upload the ACP and/or ACD to a resident's national shared electronic health record
- nominate the custodian/substitute decision maker(s) of the resident's ACP and/or ACD in the resident's health record
- clearly document whether a resident and/or guardian(s)/ carer(s) has refused to have an ACP within the resident's national shared electronic health record.

RAC1.1►C Our RAC participates in planning and updating resident care with the resident's GP.

You must:

- keep an up-to-date multi-disciplinary care plan for each resident
- document different clinical circumstances in collaborative arrangements with the RAC and GP for use when the resident's health changes

You could:

- seek to establish a collaborative arrangement between the GP and RAC
- where relevant, document receipt of discharge summaries and specialist reports, in the resident's health record
- document resident's appointments in the resident's health record e.g. specialist or outpatient clinic appointments.
- have a shared electronic health record system for all residents that GPs and all members of the RAC care team can access.

RAC1.1►D Our RAC facilitates and communicates with a resident's regular GP about care services provided within the facility.

You must:

- provide evidence of structured care arrangements between your RAC and other care services.

You could:

- seek to establish a collaborative arrangement between the RAC and other services, including the GP
- have a structured triage process
- have signed agreements with local hospitals, if relevant.

RAC1.1►E Our RAC communicates with a resident's GP when an external care transition has occurred.

You must:

- communicate with a resident's regular GP if an external care transition is requested or takes place.

You could:

- document requests from residents to change GP
- communicate with the regular GP regarding the resident request to change GPs
- develop a process regarding a resident's requests to transfer their care to another GP
- have a process for a residents transfer to external care providers
- request the regular GP provide a comprehensive health summary of the resident's care to date upon, or leading up to transfer.

RAC1.1►F Our residents are informed of when their regular GP routinely visits the facility.

You must:

- inform residents and their guardian(s)/or carer(s) when their regular GP is visiting the facility.

You could:

- document the time frame in which each resident's GP will be visiting the facility (eg day of the week, AM or PM)
- make sure the resident will be available when the regular GP is attending the facility.

Criterion RAC1.2 – Responsive system for resident care

Indicators

RAC1.2►A Our RAC has a system in place to support GPs when communicating with residents' carer(s) and/or guardian(s).

RAC1.2►B Our RAC has a triage system with our residents' regular GPs.

RAC1.2 C Our RAC includes a resident's regular GP in critical incident reviews.

Why this is important

Coordinating care for residents is a necessary function in RAC, due to each resident's individual requirements (ie physical, psychological, financial). Some residents may need more assistance than others. Having an arrangement like a care plan for each resident addresses their immediate and long-term needs, goals for their care and identifies coordination requirements. Access to up-to-date care plans enables GPs and / or the GP team to make appropriate clinical decisions based on the resident and/or guardian(s) / carer(s) wishes. Timely RAC staff communication to a residents' RAC care team and guardian(s) / carer(s) regarding health changes is highly important. [14]

Primary care for residents in RAC includes management of chronic diseases, geriatric syndromes, acute episodic care, rehabilitation, preventive care, and palliative (including end-of-life) care. [15, 16] Your RAC facility needs to be able to identify each resident's needs and provide care accordingly. To identify residents' needs, triage needs to be performed by suitably qualified staff, such as registered nurses or other staff in the care team using appropriate triage protocols.

Critical incident review discussions identify ways to prevent future harm to a resident after an incident has occurred. Including a resident's regular GP in critical incident review discussions enables GPs to determine if these changes will have an impact on a residents' clinical care ie changes to medicines.

Meeting this Criterion

RAC care plans

All RAC facilities are required to assess and plan residents' needs, goals and preferences in a care plan that is readily available to the resident, resident's guardian(s) / carer(s), facility staff and their regular GP. When new referrals occur it is important that individual care plans include a contribution from a resident's regular GP. GPs review care plans intermittently however it is important that they are advised of any changes to a resident's care plan.

Holding a case conference between a resident, the resident's guardian(s)/ carer(s), RAC staff and the regular GP to develop a care plan upon a resident's admission to a RAC is an effective way to ensure care plans are implemented.

Triage

Your RAC needs to have a triage protocol to follow when a resident's health changes so RAC staff responsible for triage can determine the resident's needs and communicate with their regular GP appropriately. Communication with a resident's regular GP needs to be clearly arranged according to the urgency of the situation and in line with a resident's ACD (refer to Criterion C1.1 – Access to care).

Triage is undertaken by clinical staff who:

- understand how emergency conditions are defined
- follow a process to identify residents who need urgent medical attention.

Your RAC facility's triage process could include:

- a triage flowchart so that staff can quickly and appropriately manage emergencies
- questions that trained staff know to ask residents about their condition, including their symptoms, duration of condition, severity, pain level and self-management
- appropriate triage of residents based on:
    - urgent attention
    - non-urgent or routine general practice matters only requiring a GP visit with their regular doctor during normal business hours.

Preventing cross-infection through triage

Effective telephone triage can identify the risk of infection before a GP visits your RAC facility. The following transmission-based precautions need to be followed to minimise other residents and staff exposure to highly transmissible infection (eg influenza):

- implement effective triage and appointment scheduling
- use personal protective equipment (PPE) such as masks
- implement distancing techniques
- place appropriate material (eg posters or digital displays) at the facility requesting that residents and/or guardian(s)/carer(s) notify the RAC staff if they have certain symptoms or conditions
- isolate the infected resident
- strictly adhere to hand hygiene measures
- adhere to cough etiquette.

Meeting each Indicator

RAC1.2►A Our RAC has a system in place to support GPs when communicating with residents' carer(s) and / or guardian(s).

You must:

- keep individual care plans for each resident that includes a contribution from a resident's regular GP, where relevant
- have the care plan available for the GP, resident, resident's guardian(s) / carer(s) and other members of the RAC care team.

You could:

- provide evidence that the individual care plan has been reviewed and updated at required intervals
- provide evidence in the resident health record and/or individual care plan of discussions between the GP and the resident or guardian(s) / carer(s) relating to the development of goals and progress towards goals.

RAC1.2►B Our RAC has a triage system with our residents' regular GP.

You must:

- demonstrate there is a triage system with your residents' regular GP

You could:

- provide evidence that triage guidelines are available
- provide the RAC staff with a triage flowchart
- establish a protocol with a resident's regular GP for their triage
- establish a system to advise residents and their guardian(s)/carer(s) of the approximate wait time for medical treatment.

RAC1.2 C Our RAC includes a resident's regular GP in critical incident reviews.

You could:

- demonstrate that a resident's regular GP has been included in any critical incident reviews, where relevant
- hold a case conference with a resident's regular GP to discuss the critical incident review
- note a resident's regular GP involvement in the critical incident review.

Criterion RAC1.3 – Continuity of care

Indicators

RAC1.3►A Our RAC staff and care team are aware of each residents' regular GP.

RAC1.3►B Our residents can see their regular GP.

Why this is important

Continuity of care is the process by which a resident and regular healthcare provider (ie a regular GP) have an ongoing healthcare relationship. Continuity of care is important for providing high quality and effective care, and having a preferred or regular GP helps promote a consistent relationship in line with resident's needs.(17)

Having a regular GP ensures residents are provided continuous, comprehensive care and helps build a trusting doctor-patient relationship. Continuity of care can also help build the therapeutic relationship between GP and their patient, which in turn increases resident satisfaction, adherence to treatment, and improves participation in preventive care.(17)

Having a regular GP has been linked with decreased hospital presentations and admissions and a lower risk of mortality, particularly among vulnerable populations or people with a higher burden of chronic disease (eg older people). (18)

RAC facilities must take steps to make sure residents can access their regular GP (refer to Criterion C1.1 – Access to care). The RAC staff need to be aware who the residents' regular GP is and that this information is recorded and easily accessible.

Meeting this Criterion

Preferred general practitioners

All residents need to nominate their regular GP, and could also nominate a secondary GP who they would choose to see if their preferred practitioner is not available.

The name of the regular GP and the secondary GP must be recorded in the resident health record and be available to all staff members of the RAC and broader care team. All RAC staff and members of the RAC care team need to be aware of each resident's regular GP.

All tests and investigation results must be sent to the residents' regular GP and copies retained in the residents' health record. All documentation sent from external members of the RAC care team to the RAC must also be forwarded to the residents' regular GP.

It is important that RACs enable residents to see their regular GP.

If the resident sees a GP other than their regular GP, the reason for this must be recorded in the resident's health record. An event summary describing significant events from the consultation must also be provided to the residents regular GP.

Meeting each Indicator

RAC1.3►A Our RAC care team is aware of each residents' regular GP.

You must:

- document the name of each resident's regular GP in the resident health record.

You could:

- document the name of each resident's secondary GP, in the resident health record, if relevant
- demonstrate that residents consistently see their regular GP.

RAC1.3►B Our residents can see their regular GP.

You must:

- demonstrate a process for residents to see their regular GP
- provide evidence that residents consistently see the same GP.

You could:

- record why a resident has seen a GP other than their regular GP
- notify residents/guardian(s)/carer(s) when their regular GP is on leave.

Criterion RAC1.4 – Supporting coordinated care

Indicators

RAC1.4►A Our RAC provides GPs and members of the RAC care team with current resident health information during clinical handover.

At a minimum, for each resident this information contains:

- reason for GP or RAC care team visit
- health summary
- medication chart
- observation notes
- a copy of care plan and ACP/ACD, where appropriate.

RAC1.4►B Our RAC staff manage the coordination of resident care within the RAC.

RAC1.4►C Our RAC staff manage the handover of resident care with external care providers.

RAC1.4►D Our RAC ensures that resident's regular GP can access a member of staff, familiar with a resident's condition.

RAC1.4 ►E Our RAC informs a resident's GP of the multidisciplinary provider/services that are contracted to the facility.

RAC1.4 F Our RAC staff ask residents, and their guardian(s) / carer(s) about self-referrals and requests reports from the RAC care team.

RAC1.4 G Our RAC tracks referrals for residents until the consultant or specialist's report is available.

Why this is important

Care coordination between RAC, primary care and acute health services influences quality care in RAC. Communication and information sharing between services is seen as vital to providing quality care to residents (refer to Criterion 3.1 - Health record systems). [14]

Clinical handover is a core component of supporting care coordination. Access to current health information and qualified RAC staff involved in the day-to-day care of residents is critical to a quality clinical handover. Clinical handover of resident care to other staff members of the RAC facility, the broader RAC care team and to external care providers occurs frequently. Lack of, or inadequate, transfer of care is a major risk to resident safety. It can result in serious adverse patient outcomes, including:

- unnecessary hospitalisations
- delayed treatment
- delayed follow-up of significant test results
- unnecessary repeats of tests
- medication errors.

It can also result in potential legal action. All members of the clinical team must (within the boundaries of their knowledge, skills and competence) comply with the professional and ethical obligations required by law, their relevant professional organisation, and the RAC. Information about relevant codes of conduct is available at the Australian Health Practitioner Regulation Agency (AHPRA) (www.ahpra.gov.au).

Meeting this Criterion

Clinical handover needs to occur whenever there is a transfer of a residents care from one provider to another.

For example, when:

- RAC staff are handing over care to another health professional, such as a GP, nurse, physiotherapist or psychologist
- the resident has a referral to a service outside the RAC
- there is a shared-care arrangement (eg a team is caring for a resident with mental health, cancer, palliative care needs)
- there is an emergency, such as transfer to hospital or attendance by an ambulance
- the resident makes a request (eg to upload their health summary to a national shared electronic health record).

It is important during clinical handover that:

- a RAC staff member who is familiar with the condition and care needs of a resident is available when that resident receives care from their regular GP or GP team member visiting that resident
- a RAC staff member discusses with the broader RAC care team the diagnosis and management order proposed by a residents' regular GP during their visit.

Whenever clinical handovers occur due to the absence of a resident's regular GP, it is good practice to:

- inform the resident's guardian(s) / carer(s) who will take over their care
- pass on information about the resident's goals and preferences to the visiting practitioner
- support residents, guardian(s) / carer(s) and other relevant parties about who will be involved in the clinical handover, according to the wishes of the resident.

Clinical handovers can be completed face to face, over the phone or by passing on written information (eg in hard copy or via secure message delivery).

You could consider having a policy to ensure that standard processes are followed during a handover.

The policy could include how to:

- use the progress notes in the residents' health record during a clinical handover
- have a secure clinical handover when sharing electronic health records (eg using healthcare identifiers that uniquely identify the individual resident)

- give and receive information relating to after-hours services, hospital discharges and care provided by other healthcare professionals such as specialists
- record the clinical handover in the consultation notes
- report near misses and failures in a clinical handover
- use a buddy system that enables a buddy to follow up results and correspondence and continue the care of the resident when a colleague is absent.

Coordinating care with other services

Relevant staff in your RAC must demonstrate awareness of the local healthcare providers and services that support residents. These may be providers within or outside of your RAC facility. Similarly, it is important that all residents' regular GPs are aware if a resident has seen these services when they visit them in the RAC.

Tracking referrals

The RAC staff and care team need to track referrals from the time that they are requested until a report is available. If a report has not been received within the expected timeframe, your RAC facility needs to flag that the report has not been received. The flag may be an icon that automatically appears in the electronic system or a manual tracking system. Your RAC could have a process to ensure that follow-up occurs to obtain the report.

Your RAC facility could use a log to track referrals. A tracking log could include the date on which a referral was initiated, the date when you expect to receive the report, and the date on which you receive the report. If your RAC does not receive a report, you must contact the relevant practitioner's office, and document your efforts to obtain the report.

Self-referrals

Residents may see allied health professionals, specialists or other health professionals (ie ongoing referral from a previous GP) without a referral from their regular GP. These other health providers may not be aware of the resident's regular GP in your RAC.

Upon admission to your RAC facility staff, could ask residents if they have seen a specialist, allied health provider or other health professional outside of their RAC care team. If the resident is seeing another health professional, the RAC could request a report from that health professional. This request and report must be included in the resident health record and a copy forwarded to the GP.

Aged Care Funding Instrument (ACFI)

Clinical evaluations performed as part of the ACFI conducted at admission to a RAC facility provide important information for a resident's regular GP. Including a copy of these clinical evaluations within resident health record is therefore important to ongoing resident care.

Meeting each Indicator

RAC1.4►A Our RAC provides GPs and members of the RAC care team with current resident health information during clinical handover.

At a minimum, this information contains for each resident:

- reason for GP or RAC care team visit
- health summary
- medication chart
- observation notes
- a copy of care plan and ACP/ACD, where appropriate.

You must:

- notify the resident's regular GP of any urgent changes or transfers (eg death, hospital admission or transfer to palliative care)
- develop a care plan for the resident within four weeks of admission, including contribution from the resident's GP, where relevant
- ensure the resident's regular GP can access a copy of the resident's care plan.

You could:

- ensure that the ACFI assessments conducted at admission are included in residents' health records
- work towards installing and maintaining an IT system at the RAC that enables regular RAC care team providers to access relevant medical information externally
- use secure messaging to communicate with RAC care team members
- use software, such as resident information and management systems, that enable you to upload a resident's shared health summary/record or event summary to the resident's national shared electronic health record when the resident requests it.

RAC1.4►B Our RAC staff manage the coordination of resident care within the RAC.

You must:

- demonstrate an internal handover policy ensuring coordination of resident care.

You could:

- document referrals for attending allied health services, other practitioners, specialists and ambulance staff in the resident's health record
- conduct face-to-face handovers
- provide a list detailing appropriate contacts at the RAC for clinical handover
- keep records of any breakdowns in the clinical handover system that were identified and addressed
- have a policy explaining how to conduct handovers with locum practitioners
- create document and use a buddy system.

RAC1.4►C Our RAC staff manage the handover of resident care with external care providers.

You must:

- document referrals to allied health services, other practitioners, specialists and ambulance staff in the resident's health record.

You could:

- keep a copy of referrals to allied health services, other practitioners, specialists and ambulance staff in the resident's health record
- conduct handovers (eg face-to-face, telehealth, phone, secure message delivery or written)
- provide a list detailing appropriate contacts at the RAC for clinical handover
- keep records of any breakdowns in the clinical handover system that were identified and addressed
- have a policy explaining how to conduct external handovers, including to locum practitioners
- have a standard form to be used for ambulance transfers
- create, document and use a buddy system.

RAC1.4►D Our RAC ensures that resident's regular GP can access a member of staff, familiar with a resident's condition.

You must:

- arrange for a nurse or member of the RAC staff who is familiar with a resident's condition and care needs to be available when the resident's regular GP visits
- ensure a RAC nurse is available to discuss diagnosis and management with the residents regular GP.

You could:

- arrange for two nurses to be available for off-site communication of medication changes, as required
- provide a list detailing appropriate contacts at the RAC for clinical handover for in-hours and after-hours
- have in place a procedure for the RAC nurse or other appropriate RAC staff to identify their qualifications when they first contact the GP.

1.4► E Our RAC informs a resident's GP of the multidisciplinary provider/services that are contracted to the facility.

You must:

- demonstrate awareness of the local healthcare providers and services that support residents
- inform a resident's GP if a resident has seen a multidisciplinary provider/service.

You could:

- have a register of multidisciplinary services (ie allied health, pharmacy), pharmacist providing supply and pharmacist contracted to provide medication reviews that visit the RAC
- coordinate multidisciplinary care team meetings between a resident's regular GP and other health provider/services.

RAC1.4 F Our RAC staff ask residents, and their guardian(s)/carer(s) about self-referrals and requests reports from the RAC care team.

You could:

- document conversations about any resident self-referrals, in the resident's health record
- include relevant reports from health professionals that the resident has self-referred to, in their health record.

RAC1.4 G Our RAC tracks referrals for residents until the consultant or specialist's report is available.

You could:

- document a procedure for tracking referrals
- document conversations about referral reports in the resident's health record
- include received specialist reports in the resident health record
- develop a tracking log showing data collected in the tracking system.

Criterion RAC1.5 – Follow-up systems

Indicators

RAC1.5►A Our RAC staff documents and communicates residents' care in a timely manner to their regular GP.

RAC1.5►B Our RAC staff communicate with a resident's regular GP about any changes related to the care of our residents.

RAC1.5►C Our RAC staff provide timely information to a residents' regular GP when they have been hospitalised.

RAC1.5►D Our RAC staff provide timely information to a residents' regular GP when a death of a resident occurs.

RAC1.5►E Our RAC staff ensures that any discharge summary received by a RAC is provided to the residents' regular GP.

Why this is important

Timely communication of changes in a resident's health to the GP and RAC care team is important to reduce the likelihood of adverse events.[19] These may include physical or psychological changes. Arrangements around two-way communication and the handover of clinical details between the RAC care team and a resident's regular GP is critical to help ensure high-quality patient outcomes and decrease disputes.

When a resident has been admitted to hospital or visited the emergency department, obtaining relevant discharge information is necessary to ensure ongoing resident safety and to help prevent additional hospital admissions. [20] When a RAC receives a discharge summary, it is necessary to check that the resident's regular GP has also received one.

In the event that the RAC receives urgent pathology and imaging results or reports it is important that a resident's GP or member of the RAC care team is notified. Clinically significant results need to be followed-up quickly and appropriately by a resident's GP or member of the RAC care team. This assists in suitable action being taken and reduces the likelihood of an adverse patient outcome.

Meeting this Criterion

It is critical for the RAC staff to monitor changes in each residents' health, and for these changes to be reported to the resident's regular GP in a timely manner.

Once a GP has discussed a treatment plan, follow up option(s) and/or other action required, and the resident and/or guardian(s) / carer(s) have understood this advice, it is up to the resident and / or guardian(s) / carer(s) to decide and communicate their intentions.

Follow-up post hospital admission

The RAC could include in the resident agreement [21] (completed by residents' upon acceptance into a RAC) that the RAC staff will notify the resident's regular GP of any hospital visits or admissions as soon as practical.

The RAC could consider contacting a resident's guardian(s) / carer(s) to inform them of appropriate follow-up care after a hospital admission or emergency department visit.

Meeting each Indicator

RAC1.5►A Our RAC staff documents and communicates residents' care in a timely manner to their regular GP.

You must:

- notify the resident's regular GP about urgent pathology or imaging results/ reports received by the RAC
- notify the resident's regular GP about any investigations initiated by the RAC and document this communication within the resident's health record.

You could:

- develop a protocol for the identification and management of urgent pathology and imaging results with the RAC care team
- document a staff member's role in the recall process in their position description.

RAC1.5►B Our RAC staff communicate with a resident's regular GP about any changes related to the care of our residents.

You must:

- notify the resident's regular GP of any acute changes in a residents condition
- notify the GP of impending transfer to another level of care (taking into account any specific requests from a resident's regular GP).

You could:

- establish preferred methods of communication between the resident's regular GP and other specialists.

RAC1.5►C Our RAC staff provide timely information to a residents' regular GP when they have been hospitalised.

You must:

- notify the GP of any emergency transfers to hospital facilities, as soon as possible.

You could:

- establish a formal process for notification of emergency transfers to hospital .

RAC1.5►D Our RAC staff provide timely information to a residents' regular GP when a death of a resident occurs.

You must:

- notify the GP of a resident death, as soon as possible.

You could:

- establish a formal process for notification of a resident death in a RAC facility.

RAC1.5►E Our RAC staff ensures that any discharge summary received by a RAC is provided to the residents' regular GP.

You must:

- notify the residents' regular GP that a discharge summary has been received by your RAC
- have a follow-up process for residents who have had a hospital encounter.

You could:

- demonstrate that follow-up appointments with a resident's regular GP are documented in the resident health record post hospital discharge
- establish a formal process for receiving information from local or identified hospitals
- demonstrate that changes to care plans in response to unplanned hospitalisations are documented in resident health records.

RAC Standard 2: Infrastructure, equipment, consultation spaces and treatment room

Our RAC has appropriate infrastructure, consultation space/s, treatment room/s and equipment to support the provision of quality and comprehensive general practice services to residents.

Residential aged care facilities must:

- provide a safe and appropriate environment for the delivery of general practice services
- ensure that GPs have access to the medical equipment they need to provide comprehensive primary care to residents.

Criterion RAC2.1 – Appropriate consultation space and treatment room

Indicators

For RAC's that meet Indicator **2.1►A**, all flagged indicators apply.

For RAC's that meet both Indicator **2.1►A** and **2.1 B**, all flagged indicators apply.

RAC2.1►A Our RAC ensures appropriate consultation space is available for GP or broader RAC care team/resident consultations.

RAC2.1 B Our RAC ensures a treatment room is available for GP or broader RAC care team.

RAC2.1►C Our RAC ensures resident privacy and confidentiality during consultations.

RAC2.1►D Our RAC facility has accessible toilets.

RAC2.1►E Our RAC facility has accessible hand cleaning facilities.

RAC2.1►F Our RAC facility is visibly clean.

Why this is important

You must consider how GPs practice when meeting the Indicators in this Criterion. For example, RACs that have a physical consultation space and treatment room for GPs or members of the broader RAC care team will have different infrastructure and equipment to those RACs that only receive visit-based care. However, RACs must ensure that a dedicated consultation space is available for GPs or members of the broader RAC care team.

Resident care may be compromised if the RAC does not have appropriate consultation space. You need to provide GPs and members of the broader RAC care team with a dedicated, safe and private environment in order to protect residents and support the delivery of quality care.

Having a dedicated treatment room available in your RAC could improve resident access to care. Treatment rooms offer a large variety of services that are able to be conducted including bloods tests, dressings, minor procedural operations, management of injuries, immunisations etc. Many residents in RAC could therefore avoid multiple care transitions outside the RAC for simple procedures.

Meeting this Criterion

Design and layout of physical facilities

Your RAC's consultation space and treatment room must:

- be fit-for-purpose
- satisfy requirements relating to privacy, security, design and layout
- have sufficient lighting
- have access to facilities such as toilets, including for residents with disability
- be kept at a comfortable temperature.

Protecting residents privacy and dignity

Your RAC facility must take reasonable efforts to protect a resident's privacy during a consultation, and consider particular circumstances in which resident confidentiality may be compromised when providing care in a RAC environment.

Patient privacy is as relevant in RAC settings as it is within other primary health care / general practice settings.

Always use appropriate visual and auditory privacy to protect the resident's dignity.

Visual privacy means the resident can undress in private, be covered as much as possible during a consultation/examination, and that other people cannot see them during the consultation.

This can be achieved by providing an adequate curtain or screen.

Auditory privacy means that other people cannot overhear a consultation. This can be achieved by:

- having solid doors (instead of doors with paper cores)
- using draught-proofing tape around door frames and a draught-excluder at the base of doors
- playing appropriate background music to mask conversations.

Location of toilets and hand-cleaning facilities

Toilets need to be easily accessible from the consultation space and treatment room, be well lit and sign posted.

Washbasins need to be in or close to the toilets to minimise the possible spread of infection. Staff and residents need to be able to access them easily.

Your RAC must ensure effective hand cleaning can occur during any consultation. The RACGP *Infection prevention and control standards* (5th edition) Section 1.3 Hand Hygiene, documents various ways to perform hand hygiene. These methods included soap and water, antiseptic hand wash, alcohol based hand rubs or wipes.

Environmental cleaning

Your RAC facility must appoint one member of staff who has the primary responsibility for ensuring that your consultation space and treatment room has appropriate cleaning processes.

If your RAC facility engages commercial cleaners for environmental cleaning, create a written contract that outlines a cleaning schedule, suitable cleaning products to be used and areas to be cleaned, and have the cleaners sign this contract. You could also consider having the cleaners record their work in a cleaning log that is specific to the consultation space.

Meeting each Indicator

RAC2.1►A Our RAC ensures appropriate consultation space and treatment room is available for GP or broader RAC team /resident consultations.

You must:

- demonstrate that all resident consultations take place in an appropriate consultation space.

You could:

- facilitate timely GP access to a secure RAC consultation space when required.

RAC2.1 B Our RAC ensures a treatment room is available for GP or broader RAC team.

You must:

- demonstrate that minor operational procedures take place in an appropriate treatment room.

You could:

- facilitate timely GP access to a secure RAC treatment room when required.

RAC2.1►C Our RAC ensures resident privacy and confidentiality during consultations.

You must:

- demonstrate that residents' have privacy and confidentiality during a consultation.

You could:

- make resident privacy screens available
- maintain a policy on resident privacy in the consultation and treatment room space
- create consultation and treatment room spaces that have auditory and visual privacy
- demonstrate a process for maintaining confidentiality and privacy during consultations.

RAC2.1►D Our RAC facility has accessible toilets.

You must:

- demonstrate how residents' can access toilet facilities when required during a consultation.

You could:

- have appropriate signs to indicate the location of toilets.

RAC2.1►E Our RAC facility has accessible hand cleaning facilities.

You must:

- provide access to effective hand cleaning facilities in your RAC consultation spaces and treatment room (where relevant) and during other visit-based care.

You could:

- provide alternatives for effective hand cleaning that ensures hand hygiene during a consultation

RAC2.1►F Our RAC facility is visibly clean.

You must:

- demonstrate that the RAC consultation spaces and treatment room (where relevant) are regularly cleaned
- ensure the consultation spaces and treatment room (where relevant)in the RAC are visibly clean, particularly where medical equipment is stored.

You could:

- have a written and signed agreement with commercial cleaners
- use a cleaning log.

Criterion RAC2.2 – Facility equipment

Indicators

For RAC's that meet Indicator **2.2►B**, all flagged indicators apply.

For RAC's that meet both Indicator **2.2►B** and **2.2 C**, all flagged indicators apply.

RAC2.2►A Our RAC has equipment that supports the provision of comprehensive care and emergency resuscitation.

RAC2.2►B Our RAC ensures GPs have access to a well-equipped consultation space.

RAC2.2 C Our RAC ensures GPs have access to a well-equipped treatment room.

RAC2.2►D Our RAC maintains clinical equipment in accordance with manufacturers' recommendations.

RAC2.2►E Our RAC provides height-adjustable beds for resident consultations.

RAC2.2►F Our RAC has an electrocardiograph.

RAC2.2►G Our RAC has an automated external defibrillator.

RAC2.2 H Our RAC has timely access to a spirometer.

Why this is important

GPs need to have access to equipment that enables them to treat acute, episodic illnesses and injuries during RAC visits or where emergency resuscitation is required. You need to consider what equipment GPs or the broader RAC care team require to provide comprehensive services. GPs and/or RAC care team member's providing visit-based care only will carry some of the equipment required during consultation.

Complex and chronic health conditions are common in RAC. [22] The availability of diagnostic equipment such as spirometers and electrocardiograms (ECGs):

- aid GPs to provide comprehensive onsite care
- reduces the need to transfer resident's to hospital for tests. [23]

Equipment needs to be maintained to ensure it is in good working order so that GPs can provide quality healthcare.

Research shows that, despite the efforts of medical practitioners, policy makers and consumer advocates and people with disabilities continue to experience poorer health outcomes in a range of areas compared to the broader population [24]. One reason has been the lack of height-adjustable examination beds in healthcare services, resulting in fewer opportunities for residents with a disability to have thorough and dignified clinical examinations. Using height-adjustable beds may also reduce workplace injuries because it will reduce the need for practitioners to help residents' onto an examination bed that is too high.

Residential aged care facilities are the most common locations for out-of-hospital cardiac arrests to occur. [25] Having an automated external defibrillator (AED) can reduce the risk of fatality from cardiac arrest. [26] However, evidence has suggested that RAC residents who are resuscitated by paramedics have half the rate of survival in comparison to the elderly in the community [27] and that the quality of life in these survivors is extremely poor. [28] Therefore, it is important that residents and their guardian(s)/carer(s) discuss preferences for cardiopulmonary resuscitation (CPR) in advanced care planning meetings on admission to an RAC. [29]

Most cases of sudden cardiac arrest are due to ventricular fibrillation that can be returned to a normal sinus rhythm with the use of an AED. Using an AED is easy as AEDs analyse the cardiac rhythm and will only deliver a shock if it is necessary.

Survival rates after sudden cardiac arrest drop 7–10% for every minute without defibrillation. [30, 31] CPR alone has a 5% survival rate in the elderly. [32] It is important that residents and their guardian(s) / carer(s) are aware of the risk of performing CPR on ageing residents.

Meeting this Criterion

Your RAC consultation space and treatment room (where relevant) must have the following equipment:

RAC consultation space equipment

- auriscope
- blood glucose monitoring equipment
- disposable syringes and needles in a range of sizes
- equipment for resuscitation, (ie equipment for maintaining an airway for adults, and equipment to assist ventilation, including bag and mask)
- intravenous access
- ear irrigation device
- emergency medicines
- examination light
- eye examination equipment (eg fluorescein staining)
- disposable gloves (sterile and non-sterile)
- measuring tape
- equipment for sensation-testing
- ophthalmoscope
- oxygen
- patella hammer
- personal protective equipment (PPE)
- pulse oximeter
- scales
- spacer for metered dose inhalation
- specimen-collection equipment

- sphygmomanometer (with small, medium and large cuffs)
- stethoscope
- surgical masks
- thermometer
- torch
- tourniquet
- urine testing strips
- vaginal specula
- visual acuity charts
- the ability to view X-rays.

RAC treatment room equipment

- surgical trolley
- medical consumables including:
    - biopsy packs
    - casting materials and splints
    - disposal gloves
    - dressing packs
    - eye pads
    - gauze swabs
    - excision packs
    - lignocaine
    - range of bandages, tapes and dressings
    - saline
    - scalpels
    - single use equipment
    - slings
    - specimen jars
    - surgical glue
    - suture packs
    - swabs syringes and needles
    - tongue depressors
    - tubular bandages.

Your RAC consultation space and treatment room must have all of the equipment necessary to:

- provide care that meets resident needs
- support the procedures that GPs perform, including equipment that is relevant to your location and patient population.

Personal protective equipment can include:

- P2/N95 masks

- plastic aprons
- gowns
- goggles/glasses
- face shields
- gloves
- swabs.

Point-of-care testing in RAC

Point of care testing can help GPs and the broader RAC care team to make immediate and informed decisions about a patient's care and management. The RACGP has *Standards for point-of-care testing* (5th edition) that describes the requirements for implementing point-of-care testing which can be applied to RAC. Examples of point-of-care testing include electrolyte testing, blood glucose monitoring, influenza testing and urine sampling testing strips.

Maintaining clinical equipment

Your RAC care team must ensure all clinical equipment in the RAC consultation spaces and treatment room is maintained and in working order at all times. You could establish a register that lists all clinical equipment in your service and schedules for servicing and maintenance.

Equipment that requires calibration or is powered by electricity or batteries (eg electrocardiographs, vaccine refrigerators, scales, defibrillators) must be serviced regularly in accordance with the manufacturer's instructions to ensure it remains in good working order. Your RAC facility could keep receipts from any external equipment testing and calibration companies to which you could refer in order to schedule regular maintenance checks. You could also keep a checklist of equipment where you could record dates of servicing, and regularly check that maintenance is up to date.

You must store all hazardous materials securely, including liquid nitrogen and oxygen.

Height-adjustable beds

The following guidelines have been provided by disability advocacy groups for services to follow when purchasing height-adjustable beds:

- Preferred minimum range of height adjustment: 45–95 cm
- Preferred minimum weight capacity: 175 kg
- Preferred minimum width of table: 71 cm
- Preferred minimum length: 193 cm
- Number of sections: two sections (so the head section can be raised).

You may also consider providing other features and equipment for your height-adjustable beds (where applicable) (eg options that meet gynaecological examination requirements).

Electrocardiograph, automated external defibrillator and spirometer training

You must have an ECG and AED onsite. Timely access to a spirometer is also important. You can purchase a spirometer or make arrangements with a service that has this equipment (eg a GP practice) so you have timely access to the equipment.

You must determine what 'timely access' means for your RAC, based on clinical need and what peers would consider an acceptable timeframe. Training requirements to use the equipment available at the RAC will depend on the specific equipment your facility has.

The RAC staff and broader RAC care team must be trained in how to use and maintain your facility's equipment safely in order to avoid any adverse events.

There must be an assessment to determine whether your RAC staff require specific training in the use of particular equipment, such as height-adjustable beds, point-of-care testing equipment or AED, and whether ongoing training is required.

Automated external defibrillator

Your RAC facility needs to install an AED (either fixed or mobile), based on the risks of harm from cardiac arrest, by considering:

- the number and composition of RAC and care team staff, residents and other persons who use your RAC [31]
- records of injuries, illnesses and near misses.

Your AED:

- must be maintained and stored according to the manufacturer's specifications
- staff must be appropriately trained to use and maintain the equipment
- must be placed where it is clearly visible and accessible
- must have clear signs indicating its location.

Consulting with RAC care team members

In accordance with Safe Work Australia recommendations, [33] consider consulting with GPs before making decisions on health and safety matters and deciding what new equipment your RAC consultation space needs.

Meeting each Indicator

RAC2.2►A Our RAC has equipment that supports the provision of comprehensive care and emergency resuscitation.

You must:

- have all required equipment

You could:

- maintain an equipment register.
- maintain a checklist for consultation space equipment
- perform a regular audit of your RAC's equipment.

RAC2.2►B Our RAC ensures GPs have access to a well-equipped consultation space.

You must:

- provide a consultation space for GPs and the broader RAC care team to conduct patient appointments
- have all required equipment.

You could:

- maintain an equipment register
- provide access to a computer and printer to print scripts and referrals.

RAC2.2 C Our RAC ensures GPs have access to a well-equipped treatment room.

You could

- provide a treatment room for simple procedures to take place
- have all required equipment
- maintain an equipment register

RAC2.2►D Our RAC maintains clinical equipment in accordance with manufacturers' recommendations.

You must:

- maintain all required equipment in good working order
- maintain a maintenance log.

You could:

- keep receipts from any external companies that test and calibrate equipment.

RAC2.2►E Our RAC has height-adjustable bed/s for resident consultations.

You must:

- have at least one height-adjustable bed.

You could:

- have a height-adjustable bed in each consultation space and treatment room.

RAC2.2►F Our RAC has an electrocardiograph.

You must:

- demonstrate that the RAC care team has access to an electrocardiograph
- provide your RAC care team with appropriate training in the safe use of ECGs.

You could:

- keep training logs that record training the RAC care team have completed, particularly in specialist or emergency equipment
- maintain documents that identify training needs and completed training of each member of your RAC care team
- keep a register of issues, near misses, or adverse events related to the use of ECGs .

RAC2.2►G Our RAC has an automated external defibrillator.

You must:

- have an automated external defibrillator
- provide your RAC staff with appropriate training in the safe use of the defibrillator.

You could:

- keep training logs that record training the RAC staff have completed.

RAC2.2 H Our RAC has timely access to a spirometer.

You could:

- demonstrate that you have timely access to a spirometer
- provide your RAC care team with appropriate training in the safe use of spirometers.

RAC Standard 3: Information management

Our RAC has an effective system for managing resident health information.

Information management refers to the management, storage and disposal of records (paper and electronic), and the technology used in the process. Your RAC facility is required to comply with the relevant state / territory and federal laws relating to the collection, storage, use, disclosure and disposal of residents' health and personal details.

Criterion RAC3.1 – Health record systems

Indicators

RAC3.1►A Our RAC has a system to manage residents' health information.

RAC3.1►B Our RAC provides GPs and other members of the RAC care team with access to residents' health records.

RAC3.1►C On resident admission to our RAC we request the residents' medical information from their regular GP.

Why this is important

A fully electronic health record system is preferable to a paper-based or hybrid system because the clinical notes in an electronic clinical system:

- are more legible
- are more accessible
- reduce time spent undertaking manual activities such as filing or file locating
- reduce duplication
- provide immediate availability of electronic medical records and both onsite and offsite
- improve management of patients with complex chronic disease by providing timely offsite access to a resident's regular GP when required
- improve communication between your RAC, GP and other providers/services, such as pathology, radiology
- provide more robust patient confidentiality and privacy through use of secure message delivery (SMD)
- are more easily protected and backed up, which means your facility is less likely to lose or misplace information as a result of incorrect filing, natural disaster, fire or theft.

Your RAC needs to ensure that each resident's clinical files are organised, centralised, appropriately filed and easily accessible during GP visits.

In addition, electronic clinical systems can support clinical decision-making (eg alerts can be set for any known allergies) and the resident's detailed health summaries can be accessed more easily.

Using a hybrid system to record resident health information is discouraged, as it can result in some information being recorded on one system (eg a medicines list on a computer) and other information being recorded on another system (eg past medical history on handwritten notes), or some information not being recorded at all. Your RAC could work towards installing and maintaining an IT system at the RAC to enable the GP to access relevant RAC medical information externally.

Meeting this Criterion

Your RAC facility must provide GPs and other members of the RAC care team with access to residents' health records and other important information to support clinical decision making (refer to

Criterion 1.4►A). A national shared electronic health record system is preferred to enable the sharing of resident health information among GPs and the broader RAC care team.

Using a hybrid health record system

If your RAC uses a hybrid health record system:

- all members of the RAC care team must know that your health record system is a hybrid
- all members of the RAC care team who see residents must know to look at both systems in order to access all relevant information
- information in both systems must be readily available at all times
- information does not need to be duplicated in both systems, but there must be a clearly visible note in both systems stating that your RAC uses a hybrid patient health record system and where information is recorded
- work towards updating to a dedicated electronic clinical record system that is easily accessible and fit for GP use
- upload resident health information from the clinical record system to national shared electronic health record system.

Meeting each Indicator

RAC3.1►A Our RAC has a system to manage residents' health information.

You must:

- have a system to manage your residents' health information
- have all residents' health information available and accessible by GPs when needed.

You could:

- use clinical software to manage health information
- conduct audits to identify gaps in resident information
- provide relevant training to your RAC staff, GP and broader RAC care team including when the clinical software is updated
- ensure that relevant RAC staff:
    - record medical observations for RAC residents (such as weight, pulse, blood pressure), reviewing at least quarterly
    - record blood glucose levels at periods as requested by the GP or broader RAC care team
    - provide access to resident's charts for the GP or broader RAC care team.

RAC3.1►B Our RAC provides GPs and other members of the RAC care team with access to residents' health records.

You must:

- keep a record of consultations in the residents health record
- have all resident health information available and accessible when needed.

You could:

- transition to a electronic patient health information system that is easily accessible and fit for GP use
- provide remote/external access to the resident health record
- regularly upload a residents health summary to a national shared electronic health record system.

RAC3.1►C On resident admission to our RAC we request residents' medical information from their regular GP.

You must:

- request a comprehensive health summary (including relevant hospital discharge summaries and information from a previous GP, if applicable) from a resident's GP

You could:

- encourage and coordinate a Comprehensive Medical Assessment with the residents GP
- record medical observations for RAC residents (such as weight, pulse, blood pressure) on admission
- request access to your residents' national shared electronic health record.

RAC Standard 4: Medication management

Our RAC has an accurate record of a resident's medication list.

Polypharmacy and adverse medication events are of particular concern in older people and are associated with avoidable hospitalisations and negative health outcomes. [34, 35] Having accurate and up-to-date medication information helps RACs, GPs and the broader RAC care team to provide safe, high-quality care, and ensures that other healthcare providers who see a resident are able to have the current and correct medication information.

Ideally, effective communication about medication changes that may occur needs to take place between community pharmacies that are contracted to a RAC facility.

Criterion RAC4.1 – Management of medicines and treatment

Indicators

RAC4.1►A Our RAC ensures all medicine of a resident are reviewed at least annually, or where a significant change in health status has occurred.

RAC4.1►B Our RAC staff assess residents' responses to treatments.

RAC4.1►C Our RAC staff acquire, store, administer, supply and dispose of medicines, samples and medical consumables in accordance with manufacturers' directions and relevant laws.

RAC4.1►D Our RAC has a least one staff member who has primary responsibility for the management of medicines.

RAC4.1►E Our RAC staff assess residents' barriers to treatment adherence.

RAC4.1 F Our RAC communicates medicine management processes with GPs and the broader RAC care team.

Why this is important

When residents understand the reason for taking medicines and the benefits and risks associated with particular medicines, they can make informed decisions about their treatment and will be more likely to follow the recommended treatment plan. Research has shown that good communication between the GP, broader RAC care team, and resident and guardian(s) / carer(s) during the initial prescribing of medications can improve adherence by residents. (36)

Practitioners who have access to current information about medicines can implement best practice prescribing. Reviewing medicines and having an up to date medicine list for residents reduces the risk of errors being made when prescribing or referring. It also provides opportunity to assess the resident's adherence to the medicine and provide adherence support where necessary, and to assess whether the resident is experiencing side effects. (37)

Antimicrobial stewardship

Antimicrobial resistance is a significant and growing global health issue that must be addressed in a unified and strategic manner. It is important to have effective RAC-wide systems for preventing, managing and controlling infections and antimicrobial resistance. Communicating these processes and policies with GPs and the broader RAC care team is important in preventing antimicrobial resistance. (38) The integration of point-of-care testing (PoCT) in RAC could help inform the GP or GP team regarding clinical decisions to use antibiotics in RAC. (39)

Evidence based guidelines need to be used in the selection of the appropriate antimicrobial agent dose and duration of treatment eg latest edition of the eTG Therapeutic Guidelines Antimicrobial (2019). Ideally this could be available electronically in every RAC.

Residents' must not be given or use medicines, samples or medical consumables that have been prescribed for other residents or have passed their expiry dates.

Chemical restraint

Medication safety is an important issue in RAC. Overuse of antipsychotics and benzodiazepines in RAC is of major concern in RAC, particularly when used as a form of chemical restraint. (40)

GP access to shared electronic health records and regular review of medicines is important to reducing the risks associated with these medicines. A three monthly medical review of residents taking regular antipsychotics or benzodiazepines is required and ongoing use documented within a resident's health record. (41, 42) Documentation of other nursing non-drug interventions must also be made.

Medicines review

The quality use of medicines program requires the close cooperation of all prescribers before the addition of any new medication for an individual/resident. Regular medicines reviews prompted by RAC staff and undertaken by the contracted consultant pharmacist can aid GPs and the broader RAC team in managing resident medicines. Medication misadventure is a common cause of adverse patient events, potentially avoidable hospitalisations and indemnity risk. (40)

Polypharmacy, the concurrent use of five or more prescription medicines and over-the counter or complementary medicines, constitutes a particular risk. Wherever possible, the resident's regular GP or member of the broader RAC care team must be involved in avoiding drug–drug or disease–drug interactions. Deprescribing should be considered at regular intervals, not just at end of life. The RACGP resource *Medical care of older person in residential aged care facilities* (the Silverbook) provide guidance on deprescribing in RAC.

Residential medicines management reviews provide an important support for the treating GP in the quality use of medicines. (43) Accredited pharmacists and GPs are able to work collaboratively to decide on contraindications that may occur between certain medicines. (44-46)

Medicine reviews can also be conducted by a geriatrician and GP case conference. (47)

Meeting this Criterion

Medication purpose, options, benefits, risks

Consumer Medicines Information (CMI) can help residents and their guardian(s) / carer(s) to understand the purpose, options, benefits and risks of their medicines. It is particularly important that residents and/or their guardian(s) / carer(s) understand the difference between generic drugs and trade-named drugs in order to avoid dosage problems. If a resident and/or carer has a low level of literacy (including health literacy), impaired cognitive function or the information is not available in the resident's preferred language, it may be appropriate to use pictures and diagrams, or translators.

It is important that RAC staff support resident medicine adherence by communicating information about their regular or other common medicines should a resident ask why they are taking them.

The resident's role in their own treatment

Consumer dignity and choice is of particular importance in the Aged Care Quality Standards and is crucial to medication management. Providing residents and/or their guardian(s) / carer(s) with education improves their knowledge and makes them more likely to follow treatment plans.

The GP and broader RAC care team could share decision-making with residents during consultations by discussing the likely benefits, harms and risks of all medications, including antibiotics. Resident-centred discussions could include:

- why antibiotics may not be appropriate/ antibiotic resistance
- why certain medicines are required for health concerns
- advice on self-management of conditions.

Your RAC could provide leaflets or website details with information on antimicrobial resistance and the appropriate prescribing of antibiotics.

Nominating a person with primary responsibility

Your RAC must nominate a staff member to take responsibility for the management of medicines including acquisition, storage and disposal in accordance with the relevant state / territory legislation.

The staff member with primary responsibility for the management of medicines could also monitor residents' need for a medication review and prompt with a resident's regular GP or GP team.

The RAC staff member responsible for the management of medicines must be appropriately trained so they have the knowledge and skills required to meet their legislative requirements.

All RAC staff must know which staff member has primary responsibility for medicine management so they can seek advice and support from this person.

Your RAC needs to have a process for the nominated person to hand over to another designated and trained staff member in your RAC when they are unavailable.

Using and reviewing best practice treatment

Your RAC could use other resources to ensure quality use of medicines, including latest editions of:

- the Australian Medicines Handbook (jointly owned by the RACGP, the Pharmaceutical Society of Australia, and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists [ASCEPT]) (https://shop.amh.net.au)
- Therapeutic Guidelines (www.tg.org.au)
- Therapeutic Guidelines: Antibiotic (https://tgldcdp.tg.org.au/guideLine) to promote and support informed prescribing of antibiotics
- Therapeutic Guidelines: Palliative Care (https://tgldcdp.tg.org.au/guideLine=Palliative+Care)
- National Prescribing Service/ NPS MedicineWise (https://www.nps.org.au/)

- Department of Veterans' Affairs (DVA) Medicines Advice and Therapeutics Education Services (Veterans' MATES) (www.veteransmates.net.au).

Your RAC facility could also make other resources available to help members of the RAC care team reinforce to patients the important messages about appropriate antibiotic use and actions that can be taken to reduce antimicrobial resistance.

Quality improvement activities/audits

Your RAC may wish to involve its GPs or broader RAC care team in quality improvement activities that will improve clinical practice. Individual practitioners could also conduct a clinical audit to identify their patterns of antibiotic prescribing and monitor compliance with policies on antibiotic prescribing.

Storage of medicines

To ensure residents' safe use of medicines, vaccines and other healthcare products, your RAC staff must store these products appropriately and securely, and do not use or distribute them after their expiry dates. You could appoint a designated person to have primary responsibility for the proper storage and security of medicines, vaccines and other healthcare products.

Requirements relating to the acquisition, use, storage and disposal of Schedule 4 and Schedule 8 medicines are contained in legislation, and RACs need to comply with these laws.

Meeting each Indicator

RAC4.1►A Our RAC ensures all medicines of a resident are reviewed at least annually, or where a significant change in health status has occurred.

You must:

- provide an up-to-date list in the resident's health record of all prescribed medicines, including complementary medicines (supplements) where relevant
- keep documentation relating to residential medication management reviews (RMMR) in the resident's health record, including information given to the resident about the purpose, importance, benefits and risks of their medicine
- ensure residents' medication charts are reviewed by a resident's regular GP, at least annually, or where a significant change in health status has occurred
- ensure residents' medication charts are updated by the RAC care team, as required.

You could:

- use an electronic clinical software program
- use current best-evidence medicine guidelines
- conduct a multidisciplinary team medicine review involving pharmacist and GP or geriatrician and GP teams.

RAC4.1►B Our RAC staff assess residents' responses to treatments.

You must:

- demonstrate that the RAC care team has documented residents' responses to treatments prescribed by the GP in their health record
- document residents' responses to medication changes following a RMMR.

You could:

- provide residents with consumer medicine information
- provide residents with a written action plan.

RAC4.1►C Our RAC staff acquire, store, administer, supply and dispose of medicines, samples and medical consumables in accordance with manufacturers' directions and relevant laws.

You must:

- acquire, store, administer, supply and dispose of medicines, samples and medical consumables according to manufacturers' directions and relevant laws
- maintain a Schedule 8 medicines register in accordance with relevant state/territory legislation, if relevant.

RAC4.1►D Our RAC has a least one staff member who has primary responsibility for the management of medicines.

You must:

- identify the member of your RAC staff who has primary responsibility for medicine management
- educate the RAC staff member with primary responsibility for management of medicines
- inform the RAC staff of who is responsible for the management of medicines
- have a process to transfer responsibility of medicine management when the designated RAC staff member is unavailable.

You could:

- have the person with primary responsibility for medicine management monitor residents' need for a medication review and initiate one with a resident's regular GP or GP team
- have a policy that outlines the management of medicines in your RAC
- include education about the management of medicine at induction and in ongoing training for the RAC staff.

RAC4.1►E Our RAC staff assess residents' barriers to treatment adherence.

You must:

- document patients' barriers to treatment adherence in their health record
- develop an agreed protocol for the management of medicine changes with the GP and broader RAC care team.

You could:

- review resident population healthcare needs
- maintain a disease register
- establish a reminder system.

RAC4.1 F Our RAC communicate medicine management processes with GPs and the broader RAC care team.

You must:

- communicate medicine management processes (ie antimicrobial stewardship policy) with GPs and the broader RAC care team.

You could:

- implement point-of-care testing to inform medicine prescribing
- develop and implement policies or protocols in areas such as antibiotics and/or drugs of dependence.

Criterion RAC4.2 – Vaccine potency and cold chain management

Indicators

RAC4.2►A Our RAC has at least one staff member who has primary responsibility for cold chain management in the facility.

RAC4.2►B The RAC staff member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the National vaccine storage guidelines: Strive for 5.

RAC4.2►C The RAC staff member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:

- ordering and stock rotation protocols
- maintenance of equipment
- annual audit of vaccine storage procedures
- continuity of the cold chain, including the handover process between designated members of the RAC care team or GP
- accuracy of our digital vaccine refrigerator thermometer.

RAC4.2►D Our RAC has a written, RAC-specific policy that outlines our cold chain processes.

Why this is important

The success of any vaccination program depends on the potency of vaccines when they are administered to patients. To maintain their potency, vaccines need to be transported and stored within the temperature range of 2–8°C. As vaccines are delicate biological products, they become ineffective if they are not transported and stored within this temperature range.

Meeting this Criterion

Nominating a person with primary responsibility

Your RAC must nominate a member of the RAC care team to take responsibility for cold chain management and compliance with cold chain management guidelines.

The team member responsible for cold chain management must be trained so they have the knowledge and skills required to ensure that vaccines remain potent.

All members of the RAC staff must know which team member has primary responsibility for cold chain management so they can seek advice and support from this person in order to ensure vaccine potency.

Your RAC facility needs to have a process for this person to hand over to another designated and trained member of the RAC care team when they are unavailable.

Your RAC facility's quality assurance and risk management processes can include self-auditing of your cold chain management protocols and/ or procedures.

Choosing a refrigerator

Your RAC facility must store vaccines in a reliable refrigerator that is capable of maintaining a stable temperature and large enough to store a sufficient number of vaccines to meet your needs (with consideration of frequency and size of orders).

Do not use cyclic defrost or bar refrigerators because their internal temperatures fluctuate considerably.

Domestic refrigerators (including bar fridges) are not built or designed to store vaccines and must not be used for vaccine storage. Refer to your state or territory health department for further advice.

Monitoring the refrigerator's temperature

Your RAC must:

- monitor and record the minimum and maximum temperatures of refrigerators in which any vaccine is stored at least twice a day on each day the facility is open (ideally at the beginning and end of the day)
- take appropriate action if the temperature is not stable or within the required range.

Data loggers or digital thermometers in refrigerators

Your RAC can use data loggers and digital thermometers to verify the efficacy of your cold chain and to conduct quality control checks of the temperature of the refrigerator(s) storing vaccines. Data loggers are small electronic devices that continuously measure temperatures, with the data uploaded to computer software so you can view and monitor the results. Some vaccine refrigerators come with inbuilt data loggers, but you can also purchase an external data logger if necessary.

Data loggers will help you identify and record:

- the accuracy of the thermometer
- temperature fluctuations inside the refrigerator, including the duration of the fluctuations
- areas in the refrigerator that are potentially too cool or too warm to store vaccines.

Cold chain management

To be confident of the potency of vaccines stored at your RAC, you must:

- document and follow routine processes to maintain the cold chain, identify risks to the potency of vaccines (such as a loss of power), and implement appropriate strategies to manage this risk
- provide all RAC staff who handle vaccines with ongoing education which is appropriate to their level of responsibility and forms part of their professional development
- be aware of what action is required if the temperature of the refrigerator has not been maintained within the required range.

Self-auditing

Your RAC could conduct a self-audit of your cold chain management every 12 months as part of your routine quality assurance and risk management process in order to ensure you only administer potent vaccines. An example of a self-audit is contained in the *National vaccine storage guidelines: Strive for 5*.

Meeting each Indicator

RAC4.2►A Our RAC has at least one staff member who has primary responsibility for cold chain management in the facility.

You must:

- have a RAC staff member who has primary responsibility for cold chain management
- educate the RAC staff member with primary responsibility for cold chain management about their role
- inform all RAC staff members of who is responsible for cold chain management
- have a process to transfer cold chain management when the team member with primary responsibility is unavailable.

You could:

- include education about cold chain management in induction and ongoing training for the RAC staff.

RAC4.2►B The RAC staff member who has primary responsibility for cold chain management ensures that the process used complies with the current edition of the National vaccine storage guidelines: Strive for 5.

You must:

- maintain a cold chain management policy and procedure
- have a team member who has primary responsibility for the facility complying with the current edition of the National vaccine storage guidelines: Strive for 5.

You could:

- conduct an audit of vaccine storage to determine whether it complies with the National vaccine guidelines: Strive for 5.

RAC4.2►C The RAC staff member who has primary responsibility for cold chain management reviews the following processes to ensure potency of our vaccine stock:

- ordering and stock rotation protocols
- maintenance of equipment
- annual audit of vaccine storage procedures
- continuity of the cold chain, including the handover process between designated members of the RAC care team or GP

- accuracy of our digital vaccine refrigerator thermometer

You must:

- maintain a cold chain management policy and procedure
- have procedures that require a written record of all monitoring of refrigerators in which vaccines are stored, including the temperature.

You could:

- create a template to make monitoring and recording of refrigerator temperatures easier
- create a roster for monitoring cold chain compliance.

RAC4.2►D Our RAC has a written, RAC-specific policy that outlines our cold chain processes.

You must:

- maintain a cold chain management policy and procedure.

You could:

- review the cold chain management policy once a year
- discuss the cold chain management policy in team meetings.

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RAC Standard 5: Qualifications of the RAC care team

Our RAC care team is appropriately qualified and trained to perform their role.

This Standard focuses on ensuring that all RAC care team are suitably qualified to provide residents with safe, high-quality care.

Criterion RAC5.1 – Qualifications of the RAC care team

Indicators

RAC5.1►A Our RAC care team:

- have current national registration where applicable
- have accreditation or certification with their relevant professional organisation
- actively participate in Continuing Professional Development (CPD) relevant to their position and in accordance with their legal and/or professional organisation's requirements
- have undertaken training in CPR in accordance with the recommendations of their professional organisation, or at least every three years.

Why this is important

Ensuring that all RAC care team members are suitably qualified can reduce the risk of medical errors and ensures that your RAC provides residents with safe, high-quality care.

All members of RAC care team must:

- be suitably qualified and trained
- maintain the necessary knowledge and skills that enable them to provide good clinical care
- comply with the professional development requirements of the relevant professional organisation, regardless of whether the individual is a member of the organisation
- comply with the code of conduct of the relevant professional organisation, regardless of whether the individual is a member of the organisation
- work within their scope of practice and competencies
- meet supervision requirements.

Meeting this Criterion

Registration, credentialing and Continuing Professional Development (CPD)

Health practitioners have the responsibility to maintain their relevant national registrations, provide proof of their credentialing, and comply with their ongoing CPD requirements.

CPD and other relevant training

The RAC care team members must consider what CPD and other training is relevant to their position and the specific needs of the resident population. This may include training related to:

- caring for and treating older people
- caring for and treating people with dementia
- supporting residents and guardian(s)/ carer(s) s through end of life and palliative care
- Aboriginal and Torres Strait Islander health
- Aboriginal and Torres Strait Islander cultural awareness
- cross-cultural safety
- communicating with residents with special needs

- managing ethical dilemmas.

CPD and other training can be undertaken by completing external courses, in-house programs, or 'on the job' training at your RAC facility.

Providing care to RAC resident populations

The resident cohort in RAC have substantial health needs requiring special knowledge and expanded skills required for appropriate care. This can include managing difficult behaviours in dementia, supporting and managing palliative or end-of-life care. It can also include working in a setting where access to diagnostic tests, specialists or equipment are delayed. (1)

Care provided to residents in RAC facilities must be provided or supported by RAC care team members with formal competence in geriatric health, including training in dementia and palliative care. Dementia education can be shown to improve care quality in managing residents with dementia. (48)

CPR training

All healthcare practitioners must be trained in CPR so they can provide care in emergencies.

CPR training must be conducted by an accredited training provider.

The Australian Resuscitation Council requires that CPR trainees physically demonstrate their skills at the completion of the CPR course. CPR training that is completed solely online does not meet this requirement. For members of the RAC care team, CPR must be undertaken in accordance with CPR recommendations set by their professional organisation, or at least every three years.

Meeting each Indicator

RAC5.1►A Our RAC care team:

- have current national registration where applicable
- have accreditation or certification with their relevant professional organisation
- actively participate in Continuing Professional Development (CPD) relevant to their position and in accordance with their legal and/or professional organisation's requirements
- have undertaken training in CPR in accordance with the recommendations of their professional organisation, or at least every three years.

You must:

- provide evidence that all members of the RAC care team are appropriately qualified, registered and meeting their professional obligations according to their professional requirements.

You could:

- keep training logs that record training members of the RAC care team have completed
- store documents that identify training needs and completed training of each member of the RAC care team.

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Glossary

This glossary contains the definitions of terms used in this document.

Term	Definition
Aboriginal and Torres Strait Islander status	A way of recording and identifying a resident's response when the practice asks them, 'Are you of Aboriginal and/or Torres Strait Islander origin?' The standard response options should be provided either verbally or in written form: • No • Yes, Aboriginal • Yes, Torres Strait Islander For people of both Aboriginal and Torres Strait Islander origin, both 'Yes'.
Aboriginal health worker/practitioner	A member of the indigenous health workforce. Roles include, but are not limited to: • providing clinical functions • liaison and cultural brokerage • health promotion • environmental health • community care • administration • management and control • policy development • program planning. An Aboriginal and Torres Strait Islander health worker/practitioner is often an Aboriginal and Torres Strait Islander person's first point of contact with the health workforce, particularly in remote parts of the country.
Access	The ability of residents to obtain services from the service.
Accreditation	A formal process to assess a service's delivery of healthcare against the RACGP's Standards for GPRAC.
Administrative staff	Staff employed by the RAC facility who provide clerical or administrative services and who do not perform any clinical tasks with residents.
Advanced Care Directive	Advanced Care Directive, also known as Advanced Health Directive in Queensland and Western Australia, is a written record of a patient's preferences for future care. The Directive can record a patient's values,

	life goals and preferred outcomes, or directions about care and treatments. Advance Care Directives differ between states and territories.
Advanced Care Plans	Advance Care Planning is a process of reflection, discussion and communication that enables a person to plan for their future medical treatment and other care, at a time when they are unable to make, or communicate, decisions for themselves.
Adverse drug reaction	Refer to *Adverse medicines event*.
Adverse event	An incident in which harm resulted to a person receiving healthcare (eg a resident falls and fractures a hip).
Adverse medicines event	An adverse event caused by a medicine (eg the resident was given a drug to which they have an allergy and they had an allergic reaction). This includes harm that results from the medicine itself (an adverse drug reaction) and potential or actual resident harm that comes from errors or system failures associated with the preparation, prescribing, dispensing, distribution or administration of medicines (medication incident).
After-hours service	A service that provides care outside the normal opening hours of a general practice, whether or not that service deputises for other general practices, and whether or not the care is provided physically inside or outside of the RAC.
Allied health	A health professional who collaborates with doctors and nurses to provide optimal healthcare for residents (eg dietitians, exercise physiologists, physiotherapists, podiatrists).
Appointment system	The system that a RAC and general practice use to assign consultations to residents and practitioners.
Buddy system	A system whereby a ‘buddy’ follows up results and correspondence, or continues the care of patients on behalf of an absent colleague. If a practitioner has a ‘buddy’ system to hand over care, this must be standardised and previously agreed upon, rather than ad hoc. Likewise when other practitioners hand over patient care ie registered nurse, nurse practitioners. Such arrangements do not necessarily have to be documented in the RAC health record, although the identity of the treating practitioner does need to be recorded.

Care outside normal general practice opening hours	Clinical care that is provided to the practice's residents when the practice is normally closed. Different practices can have different opening and closing hours.
Carer	Someone who provides care and support to a family member or friend who is frail, or has a disability, mental illness, chronic condition, or terminal illness. As per the *Carer Recognition Act 2010*, an individual is not a carer in respect of care, support and assistance if he or she provides care under a contract of service or contract for the provision of services.
Care coordination	Care coordination needs are based on a resident's healthcare needs and treatment recommendations, which reflect physical, psychological, and lifestyle factors. Care coordination needs are also determined by the residents' current health and health history, self-management knowledge and behaviours, and needs for support services.
Care team	A multidisciplinary team of practitioners who are responsible for the care of residents living in residential aged care. The care team are physically located both within and external to the residential aged care facility.
Care plan	A document that addresses residents immediate and, long-term needs, goals for their care and identifies coordination requirements. It is compiled and updated by the RAC in consultation with appropriate multidisciplinary health providers.
Chemical restraint	A form of medical restraint where a drug is used to restrict the freedom or movement of a patient or in some cases to sedate a patient.
Clinical decision-making tools	Electronic or paper-based supports to assist clinicians and their residents make decisions. They commonly assist the resident (and clinician) to go through several necessary steps: listing the options available; quantifying the benefits and harms of each; and then ensuring that the resident's preferences are articulated, and then incorporated, into the final decision.
Clinical handover	The transfer from one clinical professional or group to another of clinical professional responsibility and accountability for some or all aspects of a resident's care.
Clinical information system	A computer-based system designed for the collection, storage, retrieval, and reporting of clinical and resident information to assist in healthcare delivery processes.

Clinical risk management system	A system to manage the risk of errors and adverse events in the provision of healthcare.
Clinical significance	A way of referring to an assessment of the probability that a resident will be harmed if they do not receive further medical advice, treatment or other diagnostics, and the likely seriousness of the harm.
Clinical team	Staff employed by the practice and residential aged care facility who have health qualifications and provide clinical care for residents.
Code of conduct	A set of principles that characterise good practice and explicitly state the standards of ethical and professional conduct that professional peers and the community expect of members of the service team.
Cold chain management	The system of transporting and storing vaccines from the place of manufacture to the point of administration in order to keep the vaccines within the temperature range of 2–8°C.
Collaborative arrangement	A collaborative arrangement is an arrangement between a GP and the RAC. These generally include information about methods of communication; times of operation; protocols for referral arrangements; information management and after-hours and emergency care.
Communicable disease	An infectious disease that is transmissible from one person to another, or from an animal to a person, by: • direct contact with an affected person (or animal) • direct contact with an affected person's (or animal's) discharges indirect means.
Confidentiality	The act of keeping information secure and/or private, so it is only ever disclosed to an authorised person.
Consultation space	Consultation space is a term to describe the physical environment in which the provision of primary health care and other services are provided to the residents in RAC.
Continuity of care	The degree to which a resident experiences a series of discrete healthcare events and/or services as coherent, connected and consistent with their medical needs and personal circumstances.
Contraindication	Is a specific situation in which a drug, procedure, or surgery should not be used because it may be harmful to the person.

Coordinate	The work of organising, planning, and assessing the priorities and needs of residents in RAC.
Cultural background	Details of a resident's ethnic or cultural heritage that the facility/general practice has collected and recorded.
Cultural safety	The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs. Health service organisations have a responsibility to 'develop and sustain healthcare services that are free from discrimination and delivered in a manner that shows respect for residents and consumers' (quoted from *Roles in Realising the Australian Charter of Healthcare Rights* released by the Australian Health Ministers in 2008).
Disability	An umbrella term for any one, or combination, of the following: • impairments resulting in problems in body function or structure • activity limitations resulting in difficulties in executing activities • participation restrictions resulting in problems an individual may experience in involvement in life situations.
Discrimination	Different treatment or consideration of a resident based on particular characteristics (such as gender, age, ethnicity, religion). Positive discrimination enhances the care given to the resident, and negative discrimination potentially reduces, or does reduce, the quality of the resident's care.
Disease–drug interaction	An event in which a drug that is intended for therapeutic use causes some harmful effects in a patient because of a disease or condition that the patient has.
Drug-to-drug interaction	A change in a drug's effect on the body when the drug is taken together with a second drug. A drug-drug interaction can delay, decrease, or enhance absorption of either drug.
Electronic communication	The transfer of information (including but not limited to resident health information) within or outside the facility, internet communications, SMS, or facsimiles.
Encounter	An interaction between a resident and healthcare provider(s) in a hospital for the purpose of providing healthcare service(s) or assessing the health status of a resident.

Encryption	The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity.
Enrolled nurse	A nurse who works under the direct supervision of a registered nurse as stipulated by the relevant nurse registering authority, but who remains responsible for their actions and accountable for the delegated nursing care they provide.
Equipment	The set of articles or physical resources serving to equip a health practitioner in RAC.
Ethical dilemma	The need to choose between two courses of action, both of which will result in an ethical principle being compromised.
Ethics (or code of behaviour)	The principles adopted by an organisation to ensure that all its decisions and actions conform to normal and professional principles of conduct.
Event summary	A document detailing a resident's significant health information, their presenting concern, and any diagnosis and advice given or action taken by the practitioner when a service provides healthcare to a resident. The event summary is sent to the resident's regular GP/practice. An event summary may also be uploaded to a national electronic health record system.
Follow-up	Activities that are the logical and responsible steps to take after taking earlier related actions. For example: • making a phone call to find out the status of tests and results that are expected but not yet been received • contacting a resident to discuss a report, test, or results.
Gender	A classification based on socially constructed differences between men and women that result in roles and expectations being assigned according to whether someone identifies (or is identified) as male or female. (The word 'sex' refers to the biological and physiological characteristics that define men and women.)
General practice	The provision of resident-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities.
General practitioner	A registered medical practitioner who: • is qualified and competent to provide general practice anywhere in Australia • has the skills and experience to provide resident-centred,

	continuing, comprehensive, coordinated primary care to individuals, families and communities • maintains professional competence in general practice.
General practice registrar	A general practice (GP) registrar is on a pathway to general practice Fellowship.
GP team	A member of a general practice team such as another GP, GP registrar or registered nurse in the same practice that may attend an RAC when the regular GP is unavailable.
Health information	A subset of a resident's personal information that is collected in connection with the provision of a health service. It includes information or opinions about the health or disability of an individual, and a resident's wishes about future healthcare and health services.
Health outcome	The health status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals, such as nurses and specialists.
Health promotion	The process of enabling people to increase their control over, and improve their health. More than just influencing an individual's behaviour, it includes a wide range of social and environmental interventions.
Health summary	Documentation usually included in a resident's health record that provides an overview of all components of the resident's healthcare. For example, current medications, relevant past health history, relevant family history, allergies, and adverse drug reactions.
High-risk results	Clinical test results that that are seriously abnormal and life-threatening and need to be communicated in an appropriately timely manner.
Home visit	A general practice consultation conducted in the resident's (or someone else's) home.
Hospitalisation	The act or process of being hospitalised.
Infrastructure	The underlying foundation or basic framework (ie systems) required in RAC.
Information security	The protection of the confidentiality, integrity, and availability of information.

Informed consent	The written or verbal consent that a resident gives to the proposed investigation, proposed treatment, or invitation to participate in research, when they understand the relevant purpose, importance, benefits, and risks. For consent to be valid, a number of criteria need to be satisfied, including: • the resident has received and understood sufficient and appropriate information and is aware of the material risks • the resident has the mental and legal competence to give consent.
Informed refusal	A resident's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment.
Interpreter service	A service that provides trained language interpretation or translation, either face-to-face or by telephone.
Locum practitioners	A clinical practitioner, such as a GP or nurse, who works in the place of the regular practitioner when they are absent, or when a RAC is short staffed.
Manage	To handle or direct a situation in a RAC.
Medical deputising service	A service that arranges for, or facilitates, the provision of medical services to a resident by a medical practitioner (deputising doctor) during the absence of, and at the request of, the resident's GP (principal doctor).
Medical student	A person who is studying medicine at a university. Medical students must be supervised during any RAC placements.
Medication	Substances used to treat an illness or medical condition. They can be a prescription medicine, or over-the-counter medication, and can include complementary medicines.
Medicine	A drug or other preparation for the treatment or prevention of disease.
Metered dose inhaler	Is a device that delivers a specific amount of medication to the lungs, that is usually self-administered by the patient via inhalation.
Nurse	Refer to 'registered nurse' and 'nurse practitioner'.
Nurse practitioner	A registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical

	role where their scope of practice is determined by the context in which they are authorised to practice.
Other visit	A general practice consultation conducted somewhere that is not the general practice or the resident's home (eg a residential aged care facility, a workplace).
Outside normal opening hours	The hours other than the RAC's normal opening hours.
Over-the-counter medicine	Medicines that people can purchase from retailers (such as pharmacies, supermarkets, and health food stores) for self-treatment and which do not require prescription.
Practitioner	A member of the care team who has appropriate qualifications to perform clinical functions.
Privacy of health information	The protection of personal and health information to prevent unauthorised access, use and dissemination.
Qualified	Holding the educational or other qualifications required to perform a specific activity (eg administer first aid) or hold a specific role (eg GP, registered nurse).
Quality improvement	One or more activities that a facility undertakes to monitor, evaluate, or improve the quality of healthcare delivered.
RAC care team	RAC residents' multidisciplinary care that is provided by a range of health professionals including nurses, nurse practitioners, allied health practitioners, pharmacists and other medical practitioners ie a practitioner from the same GP practice, a geriatrician, psychiatrist etc.
RAC staff	Staff in residential aged care facilities involved in the direct care of residents including enrolled and registered nurses, personal care assistants and other practitioners employed by the RAC.
Recall	The process of requesting a resident to attend a consultation to receive further medical advice on matters of clinical significance.
Referral	The process of sending or directing a resident to another practitioner.
Registered nurse	A registered nurse practises independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. A

	registered nurse demonstrates competence in the provision of nursing care as specified by registration requirements, Nursing and Midwifery Board of Australia [NMBA] standards and codes, educational preparation, relevant legislation and context of care.
Regular GP	A regular GP has an ongoing healthcare relationship with a resident. The regular GP provides a continuous, comprehensive care and helps build a trusting doctor-patient relationship.
Relevant family history	Information about a resident's family history that the practitioner considers important in order to provide appropriate clinical care to the resident.
Resident	A person who resides in a RAC facility and is receiving healthcare from the general practice.
Resident agreement	Is a legal agreement a resident has with their RAC that sets out the care and services the aged care home will provide and how much you will be asked to help pay for them.
Resident health information	A resident's name, address, account details, Medicare number and any information (including opinions) about the resident's health.
Resident health record	Information, in paper or electronic form, held about a resident, which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information, legal information and reports, and work health and safety reports.
Residential Aged Care	Facilities that provide personal care and other support services such as pharmacy, allied health, social services, specialist services or respite care to older people who are unable to live at home, coordinate multidisciplinary care for all residents 24 hours a day
Safe and reasonable	A desired description of the outcome of a clinical care decision made by a practice that was based on relevant factors (eg the practice's location and resident population) and an understanding of what their peers (or practices in the same area) would agree was safe and reasonable.
Shared electronic health record	Shared electronic health records contain information that can be managed, added to and accessed across multiple healthcare organisations.

Substitute decision maker	A substitute decision maker is a person permitted under the law to make decisions on behalf of someone who does not have capacity. The formal appointment of guardians and administrators in Australia occurs under state and territory laws.
Supplements	A product taken orally that contains one or more ingredients (such as vitamins or amino acids) that are intended to supplement one's diet and are not considered food.
Telephone triage	A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care.
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers.
Transfer in level of care	Residents may need to be transferred within a RAC to an area that provides specialist services, palliative services and higher levels of care.
Treatment adherence	The resident following a recommended course of treatment—eg taking all prescribed medications, adhering to a recommended diet and exercise plan and reducing or eliminating alcohol or tobacco intake.
Triage	Resident prioritisation based on where resources can be best used or are most needed.
Urgent	Requiring immediate action or attention.
Visit based care	Different general practitioners have different RAC visiting behaviours. Visit based care may involve less frequent visits to the RAC because their patients are not as sick as other cohorts of patients in the facility.