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Draft RACGP standards for general practice residential aged care

AMA submission to Royal Australian College of General Practitioners – AMA submission to the Draft Standards

To: StandardsforRACF@racgp.org.au

AMA thanks the RACGP for the opportunity to provide feedback to the new draft RACGP standards for general practice residential aged care (the Standards).

The AMA welcomes the new Standards and commends the work of the RACGP team to produce this comprehensive document. AMA notes that the Standards entail:

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

It is the AMA's view that these are all crucial aspects of provision of appropriate health care for residents of aged care facilities. Before we go into details of individual standards, the AMA makes several broad comments about the document.

Firstly, AMA members noted that the draft Standards fail to explicitly mention the need for availability of registered nurses (RNs) on staff of residential aged care facilities (RACFs). It is the AMA's position that RNs must be available on-site at RACFs 24/7 to provide appropriate medical care for older patients. The draft Standards do make reference to nurses, but AMA members feel that there are specific criterions outlined in the Standards where the requirements for RNs should be explicit. More details are provided under individual criterions.

Secondly, the AMA welcomes the reference to the "shared electronic health record" but notes that My Health Record is not referenced in the document. At the moment My Health Record is the only national shared electronic health record that is expected to become interoperable with

My Aged Care in the near future. Recommending its use by the Standards should not be disputable.

The AMA welcomes the criterions regarding the training of RACF care teams and welcomes the requirement for training in CPR, cross-cultural training, dementia, palliative care etc and welcomes the recognition of in-house (on the job) training as part of the continuous professional development.

Below are the responses of AMA members in relation to specific criterions.

Criterion RAC1.1 – Access to GP care, including for urgent and after-hours care arrangements
The AMA members welcome the requirement of establishing collaborative agreements between GPs and RACFs. However, they emphasise that any such collaborative agreements should include clear lines of clinical responsibility. Those lines of responsibility should answer questions as to who is responsible for what and when, both on the part of the GPs and on the part of RACFs. For example, in these agreements RACFs should indicate the person responsible for assessing, escalating and notifying a clinical issue to the GP, and in what situations (when). Similarly, GPs should indicate when they are available to respond with a visit or by phone, etc, for what (e.g. level of urgency of situation). GPs should also indicate, if and when they are not available, who should be called and who should be clinically responsible (e.g. after-hours service). That way clear lines of responsibility and accountability would be established for all clinical situations, no matter the hour, thereby avoiding negative outcomes for patients but also for staff.

Criterion RAC1.4 – Supporting coordinated care
AMA members insist that RNs must be part of the care team that manages the handover of resident care with external care providers. Indicating the need for "a RACF staff member who is familiar with the condition and care needs of a resident" is not enough. RNs are the only aged care provider employees that can provide frontline, timely critical care within their scope of practice.

Criterion RAC1.4-D requires that a GP can access a member of staff familiar with a resident's condition, saying that the facility must "arrange for a nurse or member of RACF staff". AMA members insist that this should always be a RN and that any clinical handover should be done by an RN. 'Members of staff' can, and often in practice does, mean personal care attendants who have minimum or no qualifications to provide basic health care.

Criterion RAC3.1 – Health record systems
The AMA supports the recommended use of electronic health systems to store patient's information. While it is understood that at the moment the RACFs cannot be evaluated against interoperability, the AMA members suggest that the RACGP Standards should at least recommend interoperability between the clinical systems used by visiting GPs and those of RACFs. The current situation in aged care points to the need to work as quickly as possible to create an environment where the intersections between aged care and health care are complementing each other, rather than creating further gaps. This interoperability would improve communication and minimise any errors in treatment, particularly when a GP is required to respond to a clinical situation remotely (e.g. RN calls the GP at their practice about a change in

a resident's clinical status which requires a medication order or change). At the very least, the Standards could require or recommend RACFs to use My Health Record as a system of recording and sharing patient information, as opposed to the reference to "a national shared electronic health record system".

Criterion RAC4.1 – Management of medicines and treatment

Under RAC4.1, one of the indicators states that "RAC has at least one staff member who has primary responsibility for the management of medicines". It is AMA's position that medicines should only be managed and administered by RNs. While it is recognised that an RN is a staff member, AMA feels that this indicator should be more explicit.

Criterion RAC4.1. includes information on medicines review, but fails to indicate the new requirement for medication review every 3 months for those residents on antipsychotics and benzodiazepines.

Under RAC4.2 Vaccine potency and cold chain management, the Standards require that RAC nominate "a member of RAC care team to take responsibility for cold chain management" who "need to be trained so they have the knowledge and skills required to ensure that vaccines remain potent". It is the AMA's view that vaccines, vaccine preservation and cold chain management should only be done by qualified medical staff such as enrolled nurses and RNs.

Finally, regarding chemical restraints that are considered under this criterion, AMA members feel that it is important to emphasise the need to balance the standard requirements with real patients' wishes and goals. The decision on the use of chemical restraints should always be made on a case-by-case basis and needs to find a balance between the need to ensure the older person's safety, and those around them, while respecting their right to dignity and self-determination, including via previously expressed or known values or wishes (if they have lost decision-making capacity). Chemical restraints should always be considered a last resort.

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