RACGP

RACGP Submission to the Department of Health and Aged Care

Aged Care Quality Standards Review

About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. We are Australia's largest professional general practice organisation representing more than 40,000 urban and rural general practitioner members. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

The RACGP is currently developing the *Standards for general practice residential aged care* (1st edition) (Standards for GPRAC) to address member feedback and the many challenges GPs face when delivering care to their patients living in Residential Aged Care Facilities (RACF). The Standards for GPRAC focus on the clinical and systemic interface between the GP (and GP team, including other practitioners from the same practice) and RACFs. The Standards for GPRAC set out essential minimum requirements that GPs require in order for them to provide quality and safe care in this setting.

By engaging with the Standards for GPRAC for accreditation purposes, a RACF can enhance the delivery of services and the quality of care provided by GPs within their facilities. The Standards for GPRAC supports and facilitates RACFs and GPs to work collaboratively to provide care that is respectful, responsive and coordinated while addressing some of the challenges facing GPs in delivering care to patients in RACFs. The RACGP intends to support the implementation of the Standards for GPRAC with a Collaborative Arrangement Toolkit and a Memorandum of Understanding, developed in consultation with key stakeholders in the aged care sector.

The RACGP recommends the adoption of the Standards for GPRAC by the Department of Health and Aged Care and the Australian Commission for Safety and Quality in Health Care (ACSQHC). Doing so will address all of the concerns that the RACGP has highlighted in this response and fill the void at the interface of RACFs and the general practitioners providing care to the older people/ residents.

After a period of hiatus due to the COVID-19 pandemic, the Standards for GPRAC is now in its final stages of development, following two rounds of stakeholder consultation and a successful pilot. The RACGP anticipates their publication to occur in the first half of 2023.

General feedback

The RACGP commends the Department of Health and Aged Care and the Australian Commission for Quality and Safety in Health Care for revising Aged Care Quality Standards (Quality Standards) in line with some recommendations and findings of the Royal Commission into Aged Care Quality and Safety (ACRC). The RACGP notes the various improvements to the Quality Standards, including more detailed requirements around food and nutrition, improving clinical care requirements, recognising diversity in the aged care population, and improving cultural safety for Aboriginal and Torres Strait Islander people.

However, the RACGP has identified numerous gaps within the revised Quality Standards, which is presented in this consultation response.

Proposed 'actions' not mandatory

The RACGP understands that the inclusion of actions against each outcome is a direct response to feedback received from providers – that more detailed and prescriptive requirements are needed to clarify expectations and improve measurability. However, the RACGP is concerned that actions within the Quality Standards are not mandatory and only provides a description of how the provider **might** demonstrate meeting an outcome. With no mandatory actions, it is unclear how each outcome would be met, and this has the potential to impact how the sector interprets and subsequently implements the Quality Standards.

The RACGP strongly recommends that, at a minimum, a set of mandatory actions are identified for each outcome with additional aspirational actions that providers could choose to meet or work towards achieving.

Reference to aged care staff as workers

The RACGP notes that the revised Quality Standards refers to all RACF/aged care staff as 'workers'. The RACGP understands that in the new regulatory model, the revised Quality Standards will be applied differentially based on the types of service being delivered.

However, for the purposes of accrediting residential aged care facilities, it is important that the RACF/aged care staff role is acknowledged, differentiated and defined based on their level of responsibility (eg RACF clinical staff, RACF care team). This will help differentiate responsibilities particularly between clinical care and service delivery, clarifying expectations for the aged care providers as well as other health professionals.

Minimum requirements upon admission in a RACF or commencement in the Commonwealth Home Support Programme

There must be minimum requirements for all RACFs/aged care providers on what actions need to be taken when an older person/resident is first admitted into the RACF or has commenced in the Commonwealth Home Support Programme (CHSP). These include:

- confirming with the older person who their regular GP is
- notifying the older person's regular GP when the older person has commenced in CHSP
- notifying the older person's regular GP of the services that will be provided (if in CHSP)
- obtaining the older person's current medical information from their regular GP
- determining if the older person is receiving ongoing treatment from allied health providers, specialists, or other health professionals
- confirming whether the older person has any advance care planning documentation
- holding a case conference to develop a care plan with the older person, the older person's carer/guardian, the older person's regular GP, and RACF staff.

The RACGP strongly recommends that an outcome specific to the actions above is included in the revised Quality Standards.

Access to after-hours care

The RACGP notes that the revised Quality Standards does not contain any requirements for the provision of after-hours care to older people living in RACFs. Older people in RACFs face barriers in accessing their preferred primary care practitioner, and this is even more prominent after hours. Older people may not be able to simply contact and/or access their usual GP (or the RACF's regular visiting GP) after hours. A medical deputising or after-hours service may be required to provide this care.

It is important that appropriate systems and procedures which enhance care for older people living in RACF be determined and agreed upon (eg arrangements around two-way communication and the handover of clinical details and

consultation notes), as there may be cases where an older person's regular GP is unavailable and/or urgent and emergency care is required. This could include a collaborative arrangement between the RACF, GPs providing services in the RACF, and after-hours providers.

The RACGP strongly recommends that an outcome specific to ensuring older people in RACF have access to after-hours care is included in the revised Quality Standards.

The provision of after-hours care is a requirement in the draft *Standards for GPRAC* and in the *Standards for general practices* (5th edition).

Inconsistency in language

The RACGP welcomes the stronger focus on the rights of the older person in the revised Quality Standards and commends the Australian Commission for Safety and Quality in Health Care (ACSQHC) on the use of person-centred language in the Quality Standards.

The RACGP notes however that the use of person-centred language has not been applied consistently throughout the document. The RACGP strongly recommends a review of the Quality Standards with the view to aligning the 'voice' of the various components to ensure that a patient-centred outcome is captured within each Standard.

Use of generic terms

The RACGP notes that the use of generic terminology within the revised Quality Standards (ie provider, governing body, workers). The RACGP understands that in the new regulatory model, the revised Quality Standards will be applied differentially based on the types of service being delivered.

However, for the purposes of accrediting RACF, it is important that the use of generic terminology is clarified and where possible kept to a minimum. This is particularly important where assigning of responsibility is concerned. For example, it is important that the RACF staff role is acknowledged, differentiated and defined based on their level of responsibility (eg RACF clinical staff, RACF care team). This will help differentiate responsibilities particularly between clinical care and service delivery, clarifying expectations for the RACF as well as other health professionals.

Generic terminology can leave room for interpretation. Further, the use of terminology such as provider and governing body has the potential to confuse and complicate as RACF functions are no longer clearly defined. To ensure consistency in the application of the Quality Standards for accreditation, the RACGP strongly recommends that the use of generic terms such as provider, governing body and worker is limited or are defined within a glossary.

Infrastructure for the delivery of clinical care

The RACGP notes the broadening of requirements on the physical environment of RACFs in the revised Quality Standards. However, the requirements must also extend to the provision of appropriate infrastructure for the delivery of clinical care which is a gap within the revised Quality Standards.

As mentioned in RACGP's submission to the ACRC, the significant lack of infrastructure is a key barrier for GPs attending and appropriately consulting older people living in residential aged care. The lack of dedicated consultation rooms and variable access to appropriate equipment impacts the ability for GPs to provide safe and high-quality care to their patients.

The RACGP has provided subject matter expert representatives to the consultation on the Development of a new Residential Aged Care Accommodation Framework (Accommodation Framework), currently underway and due for implementation from 1 July 2024. These representatives reported that the framework under consideration failed to include any discussion on appropriate infrastructure for the safe and effective delivery of primary care.

The RACGP strongly recommends that RACF infrastructure on new and existing sites supports GPs attending and providing care to older people and is required within the revised Quality Standards.

Mapping of Aged Care Quality Standards to the National Safety and Quality Health Service Standards (NSQHS)

At the launch of the Aged Care Quality Standards consultation on 17 October 2022, participants were advised that a mapping of the revised Quality Standards against the National Safety and Quality in Healthcare Standards (NSQHS) had been undertaken and that this will be provided as part of the consultation documentation.

The RACGP has not been able to locate this document and would like the ACQHSC to note that the responses provided in this submission may be incomplete.

External accreditation of the Quality Standards

The RACGP strongly recommends that the finalised Quality Standards are submitted for an independent, third-party assessment and evaluation against international best practice benchmarks. For example, by a body such as the Joint Accreditation System of Australia and New Zealand (JAS-ANZ), International Society for Quality in Health Care (ISQua) or a similar third-party organisation responsible for accrediting standards. External accreditation of the Quality Standards would demonstrate credibility, drive continuous improvement, encourage sector acceptance and demonstrate to older communities and their families that the Department of Health and Aged Care and the Australian Commission on Quality and Safety are doing everything possible to respond to the ACRC recommendations, and restore faith in the sector.

Standards specific feedback

Standard 1: The Person

Outcome 1.1: Person-centred care

Outcome statement: The provider understands and values the older person, including their identity, culture, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person. Care and services are provided in a way that upholds the rights of older people and fosters their relationships and social connections.

Actions:

1.1.1 The way the provider and workers engage with older people supports them to feel safe, welcome, included and understood.

1.1.2 The provider implements strategies to:

- **a)** identify the older person's individual background, culture, diversity, beliefs and life experiences as part of assessment and planning and use this to direct the way their care and services are delivered
- **b)** deliver care that is trauma aware, healing informed and culturally safe
- **c)** deliver care that is right for older people with specific needs and diverse backgrounds, including Aboriginal and Torres Strait Islander peoples and people living with dementia
- **d)** continuously improve its approach to inclusion and diversity.

1.1.3 The provider recognises the rights, and respects the autonomy, of older people, including their right to intimacy and sexual expression.

1.1.4 Workers have professional and trusting relationships with older people and work in partnership with them to deliver care and services.

RACGP response

The delivery of person-centred care must include the ability for all older people to choose their preferred / regular GP. RACFs must provide older people with the option to choose to see their regular GP upon admission and to nominate a secondary GP if their regular GP is unavailable.

Being able to see their regular GP is critical to providing continuity of care for older people as an older person's regular GP will typically know the medical, clinical and social history of the older person, often including the older person's whole

life experience beyond medical encounters. This knowledge and experience are crucial in ensuring continued high-quality medical care. Providing continuity of care to older people as they age and making clinical judgements on the most appropriate care for the individual, is a fundamental part of quality general practice. Where an older person's regular GP is not available to provide care, the RACF must consider alternative ways to engage with primary care providers.

An older person's autonomy in their own healthcare is a requirement in the *Standards for GPRAC)* in *Criterion RACF1.3 – Continuity of care*.

The RACGP recommends further strengthening Outcome 1.1 to include the following actions:

- On admission, the provider asks the older person if they have a regular GP they would like to see.
- Older people can nominate a preferred GP if their regular GP is unavailable.

Outcome 1.2: Dignity, respect and privacy

Outcome statement:

Older people are treated with dignity and respect, they receive care and services free from discrimination, and their personal privacy is respected.

Actions:

1.2.1 Older people are treated with kindness, dignity and respect.
1.2.2 The relationship between older people and their carers is recognised and respected.
1.2.3 The provider implements a system to prevent and respond to violence, abuse, racism, neglect, exploitation and discrimination.
1.2.4 The personal privacy of older people is respected, older people have choice about how and when they receive intimate physical care or treatment, and this is carried out sensitively and in private.

RACGP response

The RACGP supports the inclusion of Outcome 1.2 to strengthen the Quality Standards and agrees that the personal privacy of older people must be respected in the RACF. The privacy of older people when receiving health services and treatment in an aged care setting is as relevant as it is within any other primary health care or general practice settings.

To do this, there must be provision of appropriate clinical spaces in RACFs such as dedicated consultation and treatment rooms. This will provide assurance to older people that they are provided with a safe, appropriate and private environment when receiving any form of treatment, whether with their regular GP or any other health professional.

The provision of dedicated clinical spaces improves access to care for older people and reduces the number of care transitions outside the RACF for simple procedures such as blood tests, dressings, and injury management. This will improve patient outcomes and prevent unnecessary hospitalisations and iatrogenic complications (such as falls and infections). The availability of such spaces is also part of delivering care that is respectful and culturally appropriate.

The RACGP strongly recommends the addition of an action in Outcome 1.2 to include the provision of dedicated clinical spaces within RACFs. This is currently a requirement in the draft Standards for GPRAC in Standard 2 – Infrastructure, equipment, consultation spaces and treatment room.

Outcome 1.3: Choice, independence and quality of life

Outcome statement:

Older people have independence and make decisions about their care and services, with support when they want it. Older people are provided accurate and sufficient information in a way they understand. Care and services are provided in a way that supports independence, dignity of risk and personal goals.

Actions:

1.3.1 The provider implements a system to ensure information provided to older people:
- **a)** is current, accurate and timely
- **b)** is plainly expressed and presented in a way the older person understands
- **c)** enables the older person to make informed decisions.

1.3.2 The provider implements a system to ensure the informed consent of older people where this is required for a treatment, procedure or other intervention.

1.3.3 The provider implements a system to ensure older people who require support with decision-making are identified and have access to the support necessary to make, communicate and participate in decisions that affect their lives.

1.3.4 The provider supports older people to access advocates of their choosing.

1.3.5 The provider supports older people to live the best life they can, including by exercising dignity of risk.

RACGP response

The RACGP supports the inclusion of Outcome 1.3 into the strengthened Quality Standards.

To provide older people with choice and independence about their care and services is to enter into a partnership with them. RACFs can further support and facilitate this by sharing decision making with older people about their care and treatment. For example, discussing the likely benefits, harms and risks of all medications and treatments, as well as advice on self-management of conditions. This is mentioned in the *Standards for GPRAC* in *Criterion RACF4.1 – Management of medicines and treatment*.

Outcome 1.4: Transparency and agreements

Outcome statement:

Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices.

Actions:

1.4.1 Prior to entering into any agreement or care commencing (whichever comes first), the provider gives older people information to enable them to make informed decisions about their care and services.

1.4.2 The provider supports older people to understand information provided to them, including any agreement they will be required to enter into, the terms relating to the older person's rights and responsibilities, the care and services to be provided and the fees and other charges to be paid under the agreement.

1.4.3 The provider allows older people sufficient time to consider and review their options and seek external advice as they wish to.

1.4.4 The provider informs the older person of any changes to previously agreed fees and charges and seeks their consent to implement these changes before they are made.

1.4.5 The provider implements a system to ensure prices, fees and payments are accurate, and transparent for older people.

1.4.6 The provider ensures invoices are accurate, clear and presented in a way the older person understands.

1.4.7 The provider promptly addresses any overcharging and provides refunds to older people.

RACGP response

To support older people making informed decisions about their medical care, RACFs must have a billing policy for all clinical services offered within the RACF (eg general practice, physio, dental). The policy must require RACF staff to inform older people of any potential out-of-pocket costs and support the older person if they wish to discuss with their

carer/guardian/family members. The RACF's billing practices must also be made clear to the older person's carer/guardian/family members. The vulnerability of the older person must also be considered and the RACF must identify how they can support an older person who may decline treatment for financial reasons.

Standard 2: The Organisation

Outcome 2.1: Partnering with older people

Outcome statement:

Meaningful and active partnerships with older people inform organisational priorities and improvements to care and services.

Actions:

2.1.1 The governing body directly engages with older people to set priorities and strategic directions for the way care and services are provided.
2.1.2 The provider supports older people to partner in the governance of the organisation and the design, evaluation and improvement of care and services. The provider engages with older people that reflect the diversity of those who use their services.
2.1.3 The provider understands the diversity of older people who use their services, including those at higher risk of harm, and tailors information, communication and services to meet their needs.
2.1.4 The provider engages with Aboriginal and Torres Strait Islander older people to ensure care and services are accessible to, and culturally safe for, Aboriginal and Torres Strait Islander peoples.

RACGP response

The RACGP supports the inclusion of Outcome 2.1 in the strengthened Quality Standards. However, for any partnership with older people to be meaningful, it must consist of a model where the GP is involved in the co-design of RACF organisational governance, evaluation and improvement of care and services.

GPs are the main source of medical care for older people and play a significant role in supporting their patients as they transition from the community into an RACF. GPs are well placed to understand the older persons/ their patient's needs, particularly for those with complex health and medical needs during their accommodation in an RACF. GP involvement at the outset of setting organisational priorities and improvements to care is crucial as their knowledge and experience in high-quality continued medical care is fundamental to informing the priorities and strategic directions for the way care and services are provided to older people. Further, GP contribution to creating a culture of safety and quality cannot be understated as GPs are in the advantageous position to work with RACF staff and identify improvements to care and services.

Including a GP representative in the governing structure of every RACF will ensure a focus on the health and wellbeing needs of older people and the prioritisation of integrated, comprehensive, coordinated and continuous care. This will drive patient-centred care ensuring that a formal patient voice is represented in the organisation governance. GP involvement in shared clinical governance and clinical oversight will contribute to improved clinical management, greater efficiencies in the care provided and improved engagement of GPs working at RACFs.

GP involvement in the setting of priorities, strategic and business planning not only ensures that the medical and health needs of older people are appropriately met and responded to, but also that the that the care is respectful and culturally appropriate. This is expressly stated in the *Standards for general practices* (5th edition) in *Criterion C2.1 – Respectful and culturally appropriate care.*

The RACGP strongly recommends revising Outcomes in Standard 2 of the Quality Standards to better align with the expectation statement for older people. This includes requiring the governing body of the RACF/aged care provider (including the governing body of the parent organisation) to include a GP representative and for the GP representative to be involved in the strategic and business planning aspects of the quality and safety culture, accountability and quality systems, risk and incident management, and feedback and complaints management.

The RACGP suggests that a definition is provided to who the 'governing body' is in the context of the revised Quality Standards. This submission has taken the governing body to be relevant to individual RACF's and their management and Board arrangements. The document would benefit from a defined term.

Outcome 2.2: Quality and safety culture

Outcome statement:

The governing body leads a culture of quality, safety and inclusion that embraces diversity and prioritises the rights, safety and well-being of older people and the workforce.

Actions:

2.2.1 The governing body leads a positive culture of safety, inclusion and quality improvement, and demonstrates that this culture exists within the organisation.

2.2.2 In strategic and business planning, the governing body:

- **a)** prioritises the rights, safety and quality of life of older people
- **b)** ensures that care and services are accessible to, and appropriate for, people with specific needs and diverse backgrounds, Aboriginal and Torres Strait Islander peoples and people living with dementia
- **c)** considers legislative requirements, organisational and operational risks, workforce needs and the wider organisational environment.

RACGP response

The inclusion of Outcome 2.2 in the strengthened Quality Standards is supported by the RACGP, with relevant changes. As stated in the response in Outcome 2.1, the RACGP strongly recommends the inclusion of a GP representative in RACF governance structures and for various aspects of the governance systems to be at a minimum, developed in consultation with GPs/GP representative.

Outcome 2.3: Accountability and quality systems

Outcome statement:

The governing body is accountable for the delivery of safe and quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system supports continuous improvement.

Actions:

2.3.1 The provider implements a quality system that:

- **a)** sets out accountabilities and responsibilities
- **b)** sets expectations for the organisation's performance, including against the Quality Standards
- **c)** enables the governing body to monitor the organisation's performance, including the safety and quality of services, informed by feedback from older people, carers and workers, analysis of risks, complaints and incidents (and their underlying causes), quality indicator data and contemporary evidence-based practice
- **d)** supports the provider to meet performance expectations and identify opportunities for improvement.

2.3.2 The governing body ensures improvements are made and monitors that investment in priority areas delivers outcomes for older people.

2.3.3 The provider regularly reviews and improves the effectiveness of the quality system.

2.3.4 The provider regularly reports on its quality system and performance to older people and their families and carers.

2.3.5 The provider practices open disclosure, including to communicate with older people and their families and carers when things go wrong.

RACGP response

The RACGP supports the inclusion of Outcome 2.3 in the strengthened Quality Standards, with relevant changes.

As mentioned in a RACGP submission to the ACRC, the RACGP advocates for a model of medical care for older people that integrates with general practice to enables GPs to continue to provide their patients with quality and safe health

care. An integrated model would include GP/general practice involvement and partnership in the implementation of the RACF's quality system. GP contribution supports the need to clarify clinical responsibilities particularly in the areas of communication, clinical handover, health record access and documentation and medication management.

GP involvement at the outset will not only set clear expectations of RACF performance against the Quality Standards, but it will also identify key responsibilities and accountabilities in the delivery of clinical care. As GPs work in the interface between RACF staff and older people, GPs are well placed to identify the medical needs of older people and can provide high-quality primary care services which is critical for assessment, planning and monitoring.

As stated in the response for Outcome 2.1 and 2.3, the RACGP strongly recommends the revision of outcomes and actions in Standard 2 to better enable RACFs to work collaboratively with GPs and general practice to deliver better care and services to older people, and at a minimum for key aspects of the governance system to be developed in consultation with GPs/GP representatives.

Outcome 2.4: Risk management

Outcome statement:

Risks to older people, workers and the organisation are identified, managed and continuously reviewed.

Actions:

2.4.1 The provider implements a risk management system to identify, assess, document, manage and regularly review risks to older people, workers and the organisation.
2.4.2 The provider puts strategies in place and undertakes actions to control, minimise or eliminate identified risks.
2.4.3 The provider collects and analyses data and engages with older people and workers to inform risk assessment and management. This feeds into the provider's quality system to improve the quality of care and services.
2.4.4 The provider regularly reviews and improves the effectiveness of the risk management system.

RACGP response

The RACGP supports the inclusion of Outcome 2.4 into the strengthened Quality Standards, with relevant changes.

Risks to older people in an RACF can arise from poor recordkeeping, errors in performing a procedure, error in the administration of a treatment and from ineffective communication between RACF staff and GPs. A GP representative in the RACF's governing body is critical to ensuring that the RACF's risk management system can identify and prevent circumstances that can put older people at harm. As GPs work at the interface between older people and the RACF, GPs are well placed to identify, assess and manage operational and clinical risks to the patients. The RACGP strongly recommends that RACF governance structures include a GP.

In addition, the RACGP strongly recommends the revision of Outcomes and Actions in Standard 2 to better require RACFs to work collaboratively with GPs and equip them with tools and resources to implement strategies that minimise and manage clinical risks to older people.

Outcome 2.5: Incident management

Outcome statement:

The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.

Actions:

2.5.1 The provider implements an incident management system to record, investigate, respond to and manage incidents that occur in connection with the delivery of care and services and reduces or prevents incidents from recurring.
2.5.2 The provider takes timely action to respond to and manage incidents and practices open disclosure when things go wrong.

2.5.3 The provider encourages older people to report incidents and supports their involvement in identifying ways to reduce incidents from occurring.
2.5.4 The provider supports the workforce to recognise, respond to and report incidents.
2.5.5 The provider collects and analyses incident data. Outcomes are reported to older people and workers and feed into the provider's quality system to improve the quality of care and services.
2.5.6 The provider regularly reviews and improves the effectiveness of the incident management system.

RACGP response

The RACGP supports the inclusion of Outcome 2.5 into the strengthened Quality Standards, with relevant changes. As the above responses for Outcomes 2.1, 2.2, 2.3 and 2.4, the RACGP strongly recommends that a GP representative is included on the RACF governing body.

In addition, the RACGP calls for stronger GP involvement in the RACF's incident management system to ensure that patient safety is protected. GPs manage clinical risks on a daily basis and are well placed to identify methods and contribute to the RACF's incident management system to prevent near misses and adverse events.

To do this, RACFs must establish an incident management system that facilitates GP involvement and enables frank and open discussions between RACF staff and GPs, without fear of recrimination. GPs should also be encouraged to participate in any formal processes to investigate, respond to and manage incidents, in partnership with RACF staff. To further strengthen the RACF's incident management system, the older person's regular GP must be notified in a timely manner in the event of a patient safety incident involving the older person. This is to ensure that the older person receives the appropriate clinical care to minimise any harm to the older person.

As such, the RACGP recommends the inclusion of the following actions to Outcome 2.5:

- GPs are encouraged to participate in the provider's processes to investigate, respond to and manage patient safety incidents.
- The provider notifies an older person's regular GP in the event of a patient safety incident involving the older person.

Outcome 2.6: Feedback and complaints management

Outcome statement:

Older people and others are encouraged and supported to provide feedback and make complaints about care and services. Feedback and complaints made by all parties are acknowledged, managed transparently and contribute to the continuous improvement of care and services. Older people and others can complain without reprisal.

Actions:

2.6.1 The provider implements a complaints management system to receive, record, respond to and report on complaints.
2.6.2 The provider encourages and supports older people, their families and carers, workers and others to provide feedback and make complaints.
2.6.3 Older people are empowered to access advocates, language services and other ways of raising and resolving complaints.
2.6.4 The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong.
2.6.5 The provider collects and analyses feedback and complaints data. Outcomes are reported to the governing body, older people and workers and inform the provider's quality system to improve the quality of care and services.
2.6.6 The provider regularly reviews and improves the effectiveness of the complaints management system.

RACGP response

The RACGP supports the inclusion of Outcome 2.6 in the strengthened Quality Standards as patient feedback is crucial and has been shown to improve clinical effectiveness and patient safety.

The RACGP reiterates the centrality of the GP role to key RACF processes and recommends that an additional action is included in Outcome 2.6 to ensure that GPs are notified where feedback or complaints have been received and is deemed to have an impact on the health and wellbeing of older people. Open discussions between RACF staff and GPs must be encouraged and supported by the RACF to ensure that potential problems and improvements can be identified.

Collecting patient feedback is key to quality and continuous improvement and is a key component of the RACGP *Standard for general practices* (5th edition) More information can be found in *Criterion QI1.2 – Patient feedback*.

Outcome 2.7: Information management

Outcome statement:

Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it. The information of older people is confidential and managed appropriately, in line with their consent. Current policies and procedures guide the way workers undertake their roles.

Actions:

2.7.1 The provider implements an information management system to securely manage records.
2.7.2 The provider's information management system ensures that:
- **a)** workers and older people have access to the right information at the right time to deliver safe and quality care and services
- **b)** the accuracy and completeness of information collected and stored is maintained
- **c)** informed consent is sought to collect, use and store the information of older people or to disclose their information (including assessments) to other parties
- **d)** older people understand their right to access or correct their information or withdraw their consent to share information
- **e)** information from different sources is integrated.

2.7.3 The provider regularly reviews and improves the effectiveness of the information management system.
2.7.4 The provider maintains policies and procedures that are current, regularly reviewed, informed by contemporary evidence-based practices, and are understood and accessible by workers.

RACGP response

The proposed Actions in Outcome 2.7 would not adequately facilitate the sharing of information between RACFs and the GPs to a level appropriate required to ensure the provision of safe and quality medical care to older people. RACGP members have identified that accessing RACF's medical software remains a key barrier to the provision of safe and quality medical care to older people in RACF. This issue is further compounded by the difficulty faced by GPs in locating appropriate information about an older person, as information is often indexed inappropriately rendering some health information to be effectively inaccessible. This has the potential to lead to compromised patient care and adverse outcomes.

Information sharing between RACF, GPs and external care providers is also another area of concern for the RACGP, and a coordinated response is required to minimise the fragmentation of information and care delivered to older people. This would involve improving interoperability between the RACF's systems (ie medical software, electronic prescribing systems) and system integration between RACF and general practice.

The RACGP maintains that a GP-integrated model of care for older people is necessary to ensure older people continually receive quality and safe health care. At a minimum, GPs should be provided with reliable internet connectivity across the RACF and either:

- remote access for the GP to the medical records for their patients in the RACF and/ or
- access to computers with up-to-date software to support the management and sharing of sensitive patient information.

To support this, training should be provided to GPs on the use of RACF's software, ideally at the time of induction/orientation to the RACF. Policies and procedures for GP access to an RACF's medical records must be developed either in consultation with or with consideration to GPs to ensure ease of access for GPs in the future. This will ensure safer care, enable contemporaneous medical records accurate patient information, minimise errors, duplication, and delays in providing quality health care to residents.

The RACGP strongly recommends the inclusion of the following action to Outcome 2.7:

- The provider ensures that:
  - visiting GPs are provided with appropriate access to the provider's information system.
  - training on the use of the provider's information system is provided to the GP.

Outcome 2.8: Workforce planning

Outcome statement:

The provider understands and manages its workforce needs and plans for the future.

Actions:

2.8.1 The provider implements a workforce strategy to:
- **a)** identify the number and mix of workers required to manage and deliver quality care and services
- **b)** identify the skills, qualifications and competencies required for each role
- **c)** engage suitably qualified and competent workers
- **d)** engage workers as employees whenever possible, and minimise the use of independent contractors
- **e)** mitigate the risk of workforce shortages and worker absences or vacancies.

2.8.2 The provider implements strategies for supporting and maintaining a healthy and resilient workforce.

RACGP response

The RACGP supports broadening the workforce planning requirement in the strengthened Quality Standards. However, the RACGP notes that Outcome 2.8 as it currently stands requires review.

Suitably qualified nursing staff in RACFs are essential to the quality of care provided to residents. Concerns about RACF staffing levels and workforce skills are common among GPs and cited as the main reason that GPs find it difficult to provide high-quality care for their patients in RACFs. The RACGP is specifically concerned about the:

- insufficient number, and consistent lack of, nursing and other RACF staff available for residents and to support clinical care
- variable training and use of standard clinical communication tools
- heavy reliance on agency nursing staff
- high staff turnover
- heavy reliance on staff where English is their second language, which can lead to substandard communication skills.

The quality of care delivered to older people is impacted by the lack of consistency in RACF staff delivering care. Permanent RACF staff are critical not only to the provision of continuous and comprehensive care but also to developing relational continuity with older people as they will, by nature, have better knowledge and experience of each older person, their medical history, and individual needs. Permanent staff can develop better relationships with GPs and work in partnership with GPs and general practice to deliver high-quality care. Compared to agency nursing staff, permanent staff will have more clinical time as they will be well-versed in the RACF's administrative processes.

Appropriate clinical governance, especially appropriate clinical staffing at RACFs, has the potential to reduce adverse health outcomes by focusing on prevention and management rather than escalation to acute settings, especially referrals to ambulance and hospital emergency departments at night. This includes having appropriate nursing skills mix in RACFs which can comprise of registered nurses, enrolled nurses and personal care assistants to:

- provide basic nursing care to older people
- collaborate with GPs and other RACF staff
- communicate with patients, GPs and other RACF staff
- undertake assessment and planning
- manage the medication and treatment of older people
- support clinical decision making and clinical handover
- implement treatment plans.

A commitment to ongoing staff training for aged care matters is an essential component for RACFs and should be part of all RACF workforce planning strategies. Training specific to dementia, frailty, nutrition, mobility, palliative care, pain management, use of psychoactive medication, and use of antibiotics would be encouraged by the RACGP.

The RACGP recommends strengthening Outcome 2.8 to require RACFs to undertake regular strategic workforce planning to identify skills gaps and anticipate future issues that may impact care delivery at the RACF.

Outcome 2.9: Human resource management

Outcome statement:

The care and service needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide safe and quality care and services.

Actions:

2.9.1 The provider maintains records of worker pre-employment checks, contact details, qualifications and experience.

2.9.2 The provider deploys the number and mix of workers to enable the delivery and management of safe and quality care and services.

2.9.3 Workers have access to supervision, support and resources.

2.9.4 The provider maintains and implements a training system that:

- **a)** includes training strategies to ensure that workers have the necessary skills, qualifications and competencies to effectively perform their role
- **b)** draws on the experience of older people to inform training strategies
- **c)** is responsive to feedback, complaints, incidents, identified risks and the outcomes of regular worker performance reviews.

2.9.5 The provider regularly reviews and improves the effectiveness of the training system.

2.9.6 All workers are regularly trained in relation to core matters such as:

- **a)** the delivery of person-centred, rights-based care
- **b)** culturally safe, trauma aware and healing informed care
- **c)** caring for people living with dementia
- **d)** responding to medical emergencies
- **e)** the requirements of the Code of Conduct, the Quality Standards and other requirements relevant to the worker's role.

2.9.7 The provider undertakes regular assessment, monitoring and review of the performance of workers.

RACGP response

The RACGP supports the inclusion of Outcome 2.9 in the Quality Standards, with relevant changes.

The RACGP would like to recommend the inclusion of an action that requires RACF staff to:

- actively participate in the Continuing Professional Development relevant to their position and in accordance with the legal and/or professional organisation's requirements
- undertake training in basic life support (BLS) in accordance with the recommendations of their professional organisation, or at least every three years.

This is currently a requirement in the draft *Standards for GPRAC* in *Standard 5 – Qualifications of the RACF care team*.

Outcome 2.10: Emergency and disaster management

Outcome statement:

Emergency and disaster management considers and manages the risks to the health, safety and wellbeing of older people and workers.

Actions:

2.10.1 The provider develops emergency and disaster management plans that describe how the organisation will respond to an emergency or disaster and manage risks to the health, safety and wellbeing of older people and workers.
2.10.2 The provider implements strategies to prepare for, and respond to, an emergency or disaster.
2.10.3 The provider engages with workers, older people and their families and carers about the emergency and disaster management plans.
2.10.4 The provider regularly tests and reviews the emergency and disaster management plans in partnership with workers, older people, their families and carers and other response partners.

RACGP response

While supportive of the inclusion of Outcome 2.10 in the strengthened Quality Standards, the RACGP notes that the provision of care to older people during an emergency or disaster has been overlooked. It is important that older people continue to receive the care they need even during an emergency or disaster.

RACFs must have a communication plan that identifies how the RACF will communicate with all older people's GPs during an emergency or disaster. RACFs must also determine how patient medication and treatment will be managed during this time. In particular, RACFs must have plans in place to ensure that the older people are not without their daily medication in the event of an emergency or disaster.

As such, the RACGP recommend the inclusion of the following actions in Outcome 2.10:

- The provider develops a communication plan in consultation with the GP that describes how the organisation will communicate with GPs and other health professionals to manage the health safety and wellbeing of older people during an emergency or disaster.
- The provider includes in the organisation's emergency and disaster management plans how the organisation will manage the medication and treatment of older people in an emergency or disaster.

Standard 3: The Care and Services

Outcome 3.1 Assessment and planning

Outcome statement:

Older people are actively engaged in developing and reviewing their care and services plans. Care and services plans describe the current needs, goals and preferences of older people, are regularly reviewed and are used by workers to guide the delivery of care and services.

Actions:

3.1.1 The provider implements a system for assessment and planning that:
a) supports the older person to express their needs, goals and preferences
b) identifies risks to the older person's health, safety and well-being (including their physical, mental and emotional wellbeing) and with the older person, identifies strategies for managing these risks
c) informs the delivery of safe and quality care and services.
3.1.2 Assessment and planning are based on ongoing partnership with the older person and others that the older person wishes to involve.
3.1.3 The outcomes of assessment and planning are effectively communicated to:

a) the older person, in a way they understand
b) with the older person's consent, their family and carers and others involved in the older person's care.

3.1.4 Care and services plans are individualised and:
a) describe the older person's needs, goals and preferences
b) are current and reflect the outcomes of assessments
c) include information about the risks associated with care and service delivery and how workers can support older people to manage these risks
d) are able to be accessed by the older person
e) are used and understood by workers to guide the delivery of care and services.

3.1.5 Care and service plans are reviewed regularly, including when:
a) the older person's needs, goals or preferences change
b) the older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes
c) the care that can be provided by an older person's carer changes
d) risks emerge or change or there is an incident that impacts the older person
e) all, or part, of the older person's care is transferred between others involved in the older person's care.

RACGP response

The RACGP supports the inclusion of Outcome 3.1 into the strengthened Quality Standards, with relevant changes. The RACGP notes that the requirements on assessment and planning have been broadened to include a stronger person-centred focus.

However, the RACGP is disappointed to note that the role of the GP in Outcome 3.1 has been overlooked. An older person's regular GPs will typically know the medical and clinical history of the older person, including the older person's whole life experience beyond medical encounters. This knowledge is crucial to the assessment, planning and monitoring of the health and wellbeing of an older person.

GPs must play a central role in the system of assessment and planning implemented by the RACF. In addition, GPs should also be invited to contribute to the preparation and review of an older person's care plan as they are well placed to identify the needs and goals of an older person's clinical care. This is ideally done upon the older person's admission to the RACF.

As such, the following actions are recommended for inclusion by the RACGP:

- Action 3.1.1:
  - Inclusion of d) includes the older person's GP and other health professionals
- Action 3.1.3:
  - inclusion of c) the older person's regular GP

Outcome 3.2: Delivery of care and services

Outcome statement:

Older people get safe and quality care and services that meet their needs, goals and preferences. Care and services are provided in a way that is culturally safe, appropriate for people with specific needs and diverse backgrounds and supports reablement.

Actions:

3.2.1 Older people get care and services that:
a) are provided in accordance with contemporary evidence-based practices
b) meet their current needs, goals and preferences
c) are culturally safe, trauma aware and healing informed
d) support their well-being and quality of life.

3.2.2 The provider delivers care and services in a way that maximises the older person's independence and supports their reablement, where this is consistent with their preference.

3.2.3 The provider ensures older people receive timely and appropriate referrals to other service providers.

3.2.4 The provider implements a system for caring for people living with dementia that:

a) incorporates contemporary evidence—based strategies for the timely recognition of dementia and the delivery of care that best supports people living with dementia
b) enables the identification and regular review of the strengths and skills of people living with dementia and encourages use of these day-to-day
c) enables those who know the older person well to be involved in the planning and delivery of their care and services.

3.2.5 The provider minimises the use of restrictive practices and, where restrictive practices are used, these are:
a) used as a last resort
b) used in the least restrictive form and for the shortest time needed
c) used with the consent of the older person
d) monitored and regularly reviewed.

3.2.6 The provider makes reasonable efforts to involve the older person in selecting their workers (including the preferred gender of, and language spoken by, workers providing care) and maximise worker continuity.

3.2.7 The provider has strategies for supporting workers to:
a) understand the way different older people communicate, including people living with dementia or who otherwise have difficulty communicating
b) communicate effectively with different older people, both verbally and non-verbally.

RACGP response

The RACGP supports the inclusion of Outcome 3.2 in the strengthened Quality Standards, in particular the addition of a system of care for older people living with dementia to address some of the challenges identified in the ACRC as well as the recognition that worker continuity is pivotal to delivery of safe and quality care.

Dementia care training

With the prevalence of dementia among older people living in residential aged care exceeding 60%, RACFs must invest in improving capacity and capability of all RACF staff (clinical and non-clinical staff) in dementia care, regular monitoring and reporting, and management of care plans. This includes specific training on the behavioural and psychological symptoms of dementia. To enable an effective system of care for older people living with dementia, GPs must remain central to achieving this outcome.

The RACGP acknowledges that dementia training is listed as an action under Outcome 2.9 (All workers are regularly trained in relation to core matters *such as*: caring for people living with dementia). However, this suggests that dementia training is merely an option and not a necessity. The RACGP recommends the inclusion of specific actions to require mandatory dementia care training for aged care staff. Adequate training is crucial to effective implementation of care recommended by GPs and other health professionals.

Frailty

To support an older person's independence, RACFs must put measures in place for an annual frailty assessment. The general approach is to have early discussions about end-of-life goals with the older person. This needs to include early involvement of other health professionals including physiotherapist, nutritionist or dietitian, dentist and where appropriate, speech therapist. RACF staff must also be vigilant for the early recognition of complications and acute illness that are common in frailty such as delirium, pressure injuries and falls.

Where an older person has been assessed as frail or pre-frail, this must be communicated to the GP to ensure that relevant referrals to appropriate health professionals can be made and deprescribing can occur to support reablement as indicated in Action 3.2.2.

The *RACGP Aged Care Clinical Guide* (the Silver Book) provides important guidance on *Frailty*.

Partnering with GPs

Continual and coordinated care is key to delivering safe and quality care to older people and reducing and minimising negative health outcomes. To achieve this, RACFs must not only ensure '*older people receive timely and appropriate*

referrals to other service providers' (Action 3.2.3) but that referrals are also appropriately tracked and followed up on. In addition, to provide care to older people that '*are in accordance with contemporary evidence-based practices*' (Action 3.1.1 (a) that '*meet(s) their current needs, goals and preferences*' (Action 3.1.1 (b)), the RACF cannot work in isolation and must recognise the central role played by the GP and general practice in the delivery of consistent, safe and quality care to older people in the residential aged care setting.

The RACGP reiterates the importance of partnering and collaborating with GPs and general practice to achieve this outcome and strongly recommends the inclusion and amendment to the following actions:

- Action 3.2.1:
  - Inclusion of a) are delivered in partnership with their regular/nominated GP
- Action 3.2.3:
  - Amend to: The provider facilitates the timely referrals of older people to other service providers:
    - Inclusion of a) follows up on referrals to ensure that they are appropriately actioned.
    - Inclusion of b) inform the older person's regular GP where a referral has been initiated by other health professionals.

Outcome 3.3: Communicating for safety and quality

Outcome statement:

Critical information relevant to the older person's care and services is communicated effectively with older people, between workers and with others involved in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.

Actions:

3.3.1 The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers and other others involved in the older person's care.

3.3.2 The provider's communication system is used when:

a) the older person commences receiving care and services
b) the older person's needs, goals or preferences change
c) risks emerge or change or there is an incident that impacts the older person
d) handover or transfer occurs between workers or others involved in the older person's care.

3.3.3 The provider has strategies for supporting workers to:

e) recognise risks or concerns related to an older person's health, safety and well-being
f) identify deterioration or changes to an older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition
g) respond to, and escalate, risks in a timely manner.

3.3.3 The provider ensures older people are correctly identified and matched to their care and services.

RACGP response

The RACGP supports the inclusion of Outcome 3.3 into the strengthened Aged Care Quality Standards, with relevant changes.

The RACGP would like to recommend an amendment to the outcome statement:

- Critical information relevant to the older person's care and services is communicated effectively with older people, between workers and with others involved in the older person's care, ***including their GP and other health professionals***. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate ***and in a timely manner.***

This change acknowledges the importance of information sharing between the RACF and GPs/other health professionals. Information must be communicated between the RACF and the GP in a consistent and timely manner, informed by the RACF's communications protocol. The RACF's communications protocol must take into consideration of how the RACF can facilitate communication with older people's regular GP and where possible co-design a system with

GPs to ensure that critical information is communicated in efficiently and in timely manner. This includes managing handover of care with external care providers, escalation plans for when the older person's regular GP is unavailable as well as the follow-up protocol for referrals, urgent and clinically significant pathology or imaging results. This will facilitate the effective use of GP services and also ensure that costs to older people are minimised.

As such, the RACGP would like to recommend the inclusion of the following action:

- Action 3.3.4:
    - Inclusion of e) the follow-up on referrals, urgent pathology and imaging results.

Outcome 3.4: Coordination of care and services

Outcome statement:

Older people receive planned and coordinated care and services, including where multiple health and aged care providers, carers and others are involved in the delivery of care and services.

Actions:

3.4.1 The provider, in partnership with the older person, identifies others involved in the older person's care and ensures coordination.
3.4.2 Carers are recognised as partners in the older person's care and involved in the coordination of care and services.
3.4.3 The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the older person and other providers of care and services, and this is documented, communicated and effectively managed.

RACGP response

Due to the complexity of multidisciplinary care needs of older people, systems of care need to be clearly defined and documented to ensure access to safe and timely comprehensive and quality care for older people. The provision of coordinated care and services to older people is one component of high-quality general practice and it enables the delivery of continuity of care. As such, GPs must remain central to the coordination of care for older people in the aged care setting.

Triage protocols

For provision of coordinated care to be effective, it must be supported by a system that is responsive to older people's needs recognising that as some older people may require more assistance than others. To do this, RACFs must have a triage protocol to determine the urgency of an older person's needs and for this to be communicated this with their regular GP appropriately. The protocol should be developed in consultation with the GP representative (or older person's GP) and must include a triage process where the urgency of an older person's need can be determined, and this process must be undertaken by RACF clinical staff with competent understand how emergency conditions are defined. This will ensure that the older person with the most urgent need is seen first by the GP.

Documentation

The delivery of coordinated care and services is inextricably linked to the RACF's communication systems and the sharing of information between the RACF and the GPs. To ensure that the appropriate information is shared and communicated, RACF staff must ensure that information such as referrals to external care providers (allied health services, other practitioners, specialists) and hospital discharge summaries are documented and stored appropriately. RACFs must facilitate the appropriate and timely transfer of information and documentation where necessary, and during any planned or unplanned transfer of care.

Tracking of referrals

Part of ensuring that the care that older people receive is coordinated is the tracking of referrals. This includes following up on a referral from the time it was requested until the report is available. All referral information must be documented and provided to the older person's regular GP.

The RACGP recommends a review of the proposed actions and suggests the inclusion of the following actions:

- The provider develops a triage protocol in consultation with the GP representative
- The provider ensures all referrals are tracked and followed up in a timely manner
- The provider ensures all referral documentation are stored and index appropriately.

Standard 4: The Environment

Outcome 4.1a: Environment and equipment at home

Outcome statement:

Providers support older people to mitigate environmental risks relevant to their care and services. Where equipment is used in the delivery of care and services or given to the older person by the provider, it is safe and meets their needs.

Actions:

4.1.1 Where care and services are delivered in the older person's home, as relevant to the services being delivered, the provider:
- **a)** undertakes screening to identify any environmental risks to the safety of the older person and workers
- **b)** discusses with the older person, any environmental risks and options to mitigate these.

4.1.2 Equipment provided by the provider is safe, clean, well-maintained and meets the needs of older people.

RACGP response

The RACGP supports the inclusion of Outcome 4.1a into the strengthened Quality Standards.

In addition to the proposed Actions, the RACGP recommends that any equipment provided to the older person is assessed for suitability against their care plan. The older person's regular GP must also be consulted to ensure that the equipment provided will improve quality of life and health outcomes.

Outcome 4.1b Environment and equipment in a service environment

Outcome statement:

Older people access care and services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Equipment used in the delivery of care and services is safe and meets the needs of older people

Actions:

4.1.1 The provider ensures the service environment is:
- **a)** clean and well-maintained
- **b)** safe, welcoming and comfortable
- **c)** fit-for-purpose.

4.1.2 The provider ensures the service environment:
- **a)** promotes movement, engagement and inclusion through design
- **b)** enables older people to move freely both indoors and outdoors
- **c)** unobtrusively reduces safety risks, optimises useful stimulation and is easy to understand.

4.1.3 Equipment used in the delivery of care and services is safe, clean, well-maintained and meets the needs of older people.

RACGP response

The RACGP supports the inclusion of Outcome 4.1b into the strengthened Quality Standards and acknowledges the ongoing consultation on the Accommodation Framework to which RACGP is pleased to participate in. However, as it stands, it is unclear how the Accommodation Framework will intersect with Outcome 4.1b and the Quality Standards as a whole.

While Action 4.1.1 includes provisions for an environment that is fit-for-purpose, there is nothing definitive about what that environment should be. '*Fit-for-purpose'* must include various aspects of building design (ie access to sunlight, fresh air, cross flow ventilation) to ensure that the environment for older people in residential care is appropriate for all aspects of their daily living.

The RACGP also notes that there are no requirements for the provision of appropriate facilities for clinical care in the RACF. The RACGP recommends strengthening the Outcome by including the provision of clinical spaces such as a dedicated consultation and/or treatment room with access to appropriate equipment such as an automated external defibrillator (AED), electrocardiograph (ECG), and vaccine specific refrigerators. Dedicated clinical spaces improves older people's access to care and reduces multiple care transitions to external care providers for simple procedures. Dedicated areas provide assurance that older people are afforded with personal privacy when receiving any form of treatment, whether with their regular GP or any other health professional.

The RACGP strongly recommends that Outcome 4.1b is reviewed and amended to require RACFs to:

- provide dedicated clinical spaces for consultation and treatment
- at a minimum, have access to an AED, ECG and spirometer.

The RACGP also notes that the provision of dedicated clinical spaces is a recommendation for Outcome 1.2 – Dignity, respect and privacy.

Additionally, dedicated clinical spaces along with appropriate clinical equipment is a requirement in the draft *Standards for GPRAC*. More information can be found in *Standard 2: Infrastructure, equipment, consultation spaces and treatment room*.

Outcome 4.2: Infection prevention and control

Outcome statement:

The provider has appropriate infection prevention and control processes. Workers use hygienic practices and take appropriate infection prevention and control precautions when providing care and services.

Actions:

4.2.1 The provider implements a system for infection prevention and control that:
- **a)** identifies an appropriately qualified and trained infection prevention and control lead
- **b)** describes standard and transmission-based precautions appropriate for the setting, including but not limited to cleaning practices, hand hygiene practices, respiratory hygiene, cough etiquette and waste management and disposal
- **c)** is used where care and services are delivered
- **d)** complies with contemporary evidence-based practice
- **e)** includes additional precautions to respond to novel viruses and where older people are suspected or confirmed to be infected with agents transmitted by contact, droplet or airborne routes
- **f)** manages risks to the provider, workers, older people, their carers and family
- **g)** is informed by staff and older person immunisation and infection rates.

4.2.2 The provider implements a system to ensure:
- **a)** that personal protective equipment is available to workers, older people and others who may need it
- **b)** workers and older people are supported to correctly use personal protective equipment.

RACGP response

The RACGP supports the inclusion of Outcome 4.2 into the strengthened Quality Standards. The RACGP notes that infection prevention and control processes and systems is not a requirement in the current Quality Standards.

Infection prevention and control training

As COVID-19 pandemic has demonstrated, the responsibility for preventing and controlling infection in the aged care setting is not limited to just clinical staff. The proposed actions do not require the RACF to provide infection prevention and control training to all RACF staff. The RACGP recommends that all RACF staff, regardless of their role must be educated and competent in infection prevention and control. This is fundamental to reducing the risk of cross-infection and transmission of disease.

RACF staff and resident immunisation

The RACGP notes that the staff immunisation has been overlooked in Outcome 4.2. Staff immunisation is key to infection prevention and control and the RACF must have policies to ensure that all staff are either immunised or have natural immunity against vaccine-preventable diseases that can be transmitted in the residential aged care environment. The policy must also include the assessment, screening and vaccination of all RACF staff to minimise the risk of transmission of vaccine-preventable diseases. RACF staff must be encouraged to obtain immunisations as recommended by the current edition of the Australian Immunisation Handbook.

Personal protective equipment

RACFs must also ensure that personal protective equipment is available to visitors, and not just to RACF staff and older people. Support must be provided to ensure that visitors and older people are applying and removing personal protective equipment in the correct order.

Building design and infection prevention and control

Aspects of the RACF physical environment must consider how it can facilitate infection prevention and control. The RACF must ensure that there is adequate ventilation, whether achieved by natural airflow or air conditioning to reduce the risk of airborne transmission of microbial infections in enclosed indoor environments. RACFs should consult a ventilation engineer or an occupational hygienist for advice on optimal ventilation when designing the space, refitting the space or during an airborne-transmitted outbreak. Other aspects of building design that can influence infection prevention and control are:

- monitoring of entries
- isolation of patients with potentially transmissible infections
- effective cleaning surfaces and fixtures
- appropriate traffic flow of personnel through rooms and corridors, reducing unnecessary contact or proximity between staff, older people and visitors.

As mentioned in Outcome 4.1b, it is unclear how the future Accommodation Framework will feed into the Quality Standards. As such, the RACGP strongly recommends that building design requirements in relation to infection prevention and control are incorporated into the revised Quality Standards.

Based on the response above, the RACGP strongly recommends the inclusion of the following actions into Outcome 4.2:

- All workers are educated and competent in infection prevention and control processes including transmission-based precautions appropriate for the setting, including but not limited to cleaning practices, hand hygiene practices, respiratory hygiene, cough etiquette and waste management and disposal.
- The provider develops and implements an immunisation policy for the assessment, screening and vaccination of all RACF staff.
- The provider ensures that there is adequate ventilation in enclosed indoor areas.

The RACGP also recommends strengthening Action 4.2.2 to include the provision of personal protective equipment to all visitors:

- Action 4.2.2: The provider implements a system to ensure:
  - that personal protective equipment is available to workers, older people and **visitors**
  - workers, older people **and visitors** are supported to correctly use personal protective equipment.

Standard 5: Clinical care

Outcome 5.1: Clinical governance

Outcome statement:

The governing body meets its duty of care to older people and the community, and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care.

Actions:

5.1.1 The governing body:
- **a)** sets priorities and strategic directions for safe and quality clinical care, and ensures that these are communicated effectively to workers and older people
- **b)** endorses the clinical governance framework
- **c)** monitors the safety and quality of clinical systems and performance.

5.1.2 The provider implements a clinical governance framework as part of its corporate governance, that:
- **a)** drives improvements to the safety and quality of clinical care informed by the feedback and experiences of older people, carers and workers, analysis of clinical risk management and quality indicator data
- **b)** includes strategies to ensure clinical care is trauma aware, healing informed and culturally safe
- **c)** supports workers to adopt contemporary, evidence-based practice when providing clinical care to older people.

5.1.3 The provider works towards implementing a digital clinical information system that:
- **a)** enables clinical information to be integrated into nationally agreed electronic health and aged care digital records
- **b)** supports interoperability by the use of national healthcare and aged care unique identifier and standard national terminology.

5.1.4 Where the provider is adding clinical information into the nationally agreed electronic health and aged care digital records, they implement processes for workers and others to access information in compliance with legislative requirements.

5.1.5 The provider implements a system for identifying capacity and obtaining informed consent from the older person prior to clinical care being provided.

5.1.6 The provider implements a system for older people to be partners in their own clinical care.

5.1.7 The provider has processes to ask the older person if they are of Aboriginal and/or Torres Strait Islander origin, record and use this information to optimise the planning and delivery of clinical care.

RACGP response

The RACGP notes the inclusion of a new, clinical care standard in the revised Quality Standards.

Clinical governance

Recommendations from the ACRC final report highlight the importance of general practitioners to the centre of planning for ageing and aged care. All bodies which provide advice on or oversee clinical governance, such as Aged Care Advisory and Workforce Councils, should include a GP representative to ensure a focus on health and wellbeing needs, the value of general practice care and the prioritisation of integrated, comprehensive, coordinated, and continuous care.

GP involvement in the setting of priorities, strategic and business planning not only ensures that the medical and health needs of older people are appropriately met and responded to, but also that clinical risks are appropriately triaged and managed to prevent near misses and adverse events.

As this Outcome stands, it has not addressed this finding nor outlines any solutions to involve GPs in clinical governance.

There is also important cross over with Outcome 2.6: Feedback and complaints, that needs to be addressed in this Outcome. Further, there needs to be requirements for the clinical governance of complaints processes to identify and respond to abuse and neglect of older people.

As such, the RACGP strongly recommends the inclusion of the following actions in Outcome 5.1:

- Action 5.1.2:
    - Inclusion of **d)** GP representation in the clinical governance framework) clinical governance oversight of complaints process to manage and prevent incidents in RACFs
    - Inclusion of **f)** systems/processes to identify and respond to abuse and neglect of older people.

The management of clinical risks and clinical governance is expressly stated in the *Standards for general practices* (5th edition) in *Criterion QI3.1 – Managing clinical risks* and *Criterion C3.1 – Business operations systems*.

Digital clinical information systems

The RACGP commends the ACQSHC on the inclusion of digital clinical information systems and the need to support interoperability between services into the strengthened Quality Standards.

Most patient medical record systems used in RACFs are not compatible with those used in general practice. This impacts information sharing between GPs and RACF which is critical to delivering coordinated care to older people living in residential aged care. The RACGP recommends that any standardised, service-wide system be interoperable with those used in general practice, to create a single source of truth record that seamlessly shares clinical information in real time to all clinicians involve in an older person's care.

At minimum, a clinical information system should:

- facilitate the input of high-quality data by users
- display core clinical information in a way that is easy for users to view and update if required
- support the use of standardised terminology, nationally recognised coding systems and medical vocabularies
- restrict free text to narrative sections of the record
- ensure structured data entry is usable and does not disrupt clinical workflows
- seamlessly populate data from external sources into the record after they are reviewed
- incorporate identity management and access control frameworks that are consistent with industry best practice
- have mechanisms to ensure software currency
- ensure recalls and reminders are clearly visible, easily actioned, can be prioritised based on urgency and clinical importance, and are linked to an audit log that shows what action was taken and who took the action
- support the consistent capture and recording of ethnicity, sex, gender, and Aboriginal and Torres Strait Islander status in all relevant fields.

The RACGP acknowledges that the implementation of new, interoperable digital systems is associated with considerable financial costs and impost to end users (such as time taken to train in the use of those systems). Implementation of these systems will require a significant funding program and transition plan. GPs and RACF staff must be supported with adequate training to transition to new technologies, as well as support to manage the requisite organisational or workforce changes.

It is imperative that GPs are consulted in developing and implementing new digital systems and the RACGP welcomes the opportunity to be involved in this process in consultation with its membership. As iterated in the RACGP response to Outcome 2.7: Information Management, access to digital records should at a minimum include:

- reliable internet connectivity across the RACF
- remote access for the GP to the medical records for their patients in the RACF and/ or
- access to computers with up-to-date software to support the management and sharing of sensitive patient information.

The RACGP would recommend the inclusion of the following actions to Outcome 5.1:

- The provider ensures that training on the use of the provider's digital information system is provided to the GP.
- Action 5.1.3:
    - Inclusion of:
        c) supports interoperability with general practice
        d) ensure recalls and reminders are clearly visible, easily actioned, can be prioritised based on urgency and clinical importance, and are linked to an audit log that shows what action was taken and who took the action
        e) seamlessly populate data from external sources into the record after they are reviewed
        f) incorporate identity management and access control frameworks that are consistent with industry best practice
        g) have mechanisms to ensure software currency
        h) support the consistent capture and recording of ethnicity, sex, gender, and Aboriginal and Torres Strait Islander status in all relevant fields

Outcome 5.2: Preventing and controlling infections in clinical care

Outcome statement:

Infection risks are minimised and, if they occur, are managed effectively. Older people, workers and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

Actions:

5.2.1 The provider implements an antimicrobial stewardship system relevant to the service context and consistent with national guidance.

5.2.2 The provider implements processes to:

a) perform clean procedures and aseptic techniques

b) minimise infection when using and managing invasive devices.

RACGP response

The RACGP notes the inclusion of a new, clinical care standard in the revised Quality Standards and that the requirements on antimicrobial stewardship have expanded from the current Quality Standards.

A successful antimicrobial stewardship program must involve partnership with older people living in residential aged care and their GPs. RACFs facilitate this partnership by sharing decision making with older people about their care and treatment. For example, discussing the likely benefits, harms and risks of the use of antibiotics, as well as advice on why antibiotics may not be appropriate.

GP involvement in quality improvement activities can improve clinical practice in the use of antibiotics. RACFs can facilitate this by inviting GPs to become members of an RACF's medication review committee.

The RACGP is committed to helping GPs to deal with expectations, change management and implementing new initiatives to reduce antibiotic usage where safe to do so.

Outcome 5.3: Medication safety

Outcome statement:

Medicines-related risks to older people are identified and reduced. Medicine-related incidents are analysed and acted on to improve the safe and quality use of medicines.

Note: These actions apply to providers responsible for prescribing and/or administering medicines.

Actions:

5.3.1 The provider implements a system for the safe and quality use of medicines according to evidence-based guidance.

5.3.2 The provider ensures access to medicine reviews, including
- **a)** on commencement and at transitions of care, regularly, and when there is a change in diagnosis, behaviour, cognition or mental or physical condition
- **b)** when there is polypharmacy and the potential to deprescribe
- **c)** when there is a new medicine or change to the medication management plan.

5.3.3 The provider documents existing or known medicine allergies at the commencement of care and when changes occur.

5.3.4 The provider refers adverse drug reactions to the Therapeutic Goods Administration.

5.3.5 The provider implements processes to identify, monitor and mitigate risks to older people associated with the use of high-risk medicines and reduce the inappropriate use of psychotropics.

5.3.6 The provider implements systems for the safe use of medicines that includes:
- **a)** reviewing and improving the effectiveness of medicines review and reconciliation
- **b)** supporting remote access for prescribing
- **c)** ensuring that workers and others caring for an older person have access to the older person's medicines list and other supporting information at transitions of care
- **d)** minimising interruptions to the administration of prescribed medicines and supports access to medicines when an older person is prescribed a new medicine or an urgent change to their medicine
- **e)** ensuring medicines-related information is available to workers and the older person, including on safe, alternative formulations for the older person with swallowing difficulties
- **f)** responding to changes in medication requirements when the older person is acutely unwell.

RACGP response

The RACGP notes the inclusion of a new, clinical care standard in the revised Quality Standards and that the requirements on medication safety have expanded significantly compared to the current Quality Standards.

Medication safety is an important issue in RACFs. Overuse of antipsychotics and benzodiazepines in RACFs is of major concern, particularly when used as a form of chemical restraint. The *RACGP Aged Care Clinical Guide* (the Silver Book) provides important guidance on the prescription of antipsychotics and benzodiazepines as chemical restraint.

It is necessary for GPs to work closely with RACF staff to regularly review and rewrite medication charts and prescriptions to maintain a continuum of medication for residents. There is currently a transition from medication charts to the national standard medication chart, and also to electronic chart prescribing in accordance with mandatory legislative requirements.

Communication and information sharing between GPs, RACF and other external care providers is vital to providing quality care to older people. As discussed in a RACGP submission to the Royal Commission, the draft *Standards for GPRAC* highlights the importance of communication and information sharing in supporting coordinated care and medication management. GP access to electronic health records in RACFs is a crucial element to this.

In the RACF setting, medication orders are written on the RACF medication chart by qualified prescribers, taking into account the needs and views of residents (or representatives), policies of the RACF, legislative requirements and professional standards. The qualified prescriber is usually the resident's GP, but may also be a locum or hospital doctor, Hospital in the Home (HITH) prescriber, geriatrician or palliative care team member. In some situations, registered dental practitioners or registered nurse practitioners may be able to prescribe medications.

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.

The Actions in this Outcome need to reflect the collaborative relationship between the RACF and GPs to manage medications safety and to identity mutually accepted processes to support this management. Feedback from RACGP members who work in RACFs have reported that there is a substantial increase in the amount of administration required for them to complete in order for RACFs to meet the Quality Standards. This additional administration for GPs is unremunerated and puts pressure on an already overworked profession.

The RACGP strongly recommends a review of Outcome 5.3 to ensure that the requirements around medication safety are outcomes focused. It is vital Outcome 5.3 also acknowledges the importance of communication and information sharing between GPs and the RACF in supporting coordinated care and medication management for older people.

Outcome 5.4: Comprehensive care

Outcome statement:

Older people receive safe, quality and person-centred clinical care. Clinical safety risks to older people are identified, managed and minimised

Note: These actions apply to providers according to their service context and the service types being delivered

Actions:

5.4.1 The provider uses its assessment and planning systems to:
- **a)** regularly identify clinical risks and chronic conditions, particularly on commencement, at transitions of care and when there is a change in diagnosis, behaviour, cognition or mental or physical condition
- **b)** develop the clinical assessment and treatment care plan, including for acute exacerbation of chronic conditions.

5.4.2 The provider implements a system for the delivery of evidence-based comprehensive care that responds to clinical safety risks including but not limited to:
- **a)** changed behaviours
- **b)** choking and swallowing
- **c)** cognitive impairment, including dementia and delirium
- **d)** continence
- **e)** falls and mobility
- **f)** malnutrition and dehydration
- **g)** mental health
- **h)** oral health
- **i)** pain
- **j)** pressure injuries and wounds
- **k)** sensory impairment.

5.4.3 The provider uses the comprehensive care system to:
- **a)** deliver comprehensive, coordinated, multidisciplinary and holistic care in accordance with the treatment care plan
- **b)** support workers and others involved in the older person's care to collaborate
- **c)** facilitate access to expert advice and support, and referral when clinical care needs are beyond the service context
- **d)** support older people and their representatives to escalate healthcare concerns when there are changes in an older person's condition
- **e)** use equipment, devices and products to effectively prevent and manage clinical risks.

Technical nursing

5.4.4 The provider implements a system to ensure delivery of technical nursing including but not limited to safe and quality:
- **a)** catheter care
- **b)** stoma care
- **c)** complex wound management
- **d)** oxygen therapy and suctioning of airways
- **e)** enteral feeding
- **f)** tracheostomy care

- **g)** dialysis treatment
- **h)** daily injections
- **i)** tubes including intravenous and nasogastric tubes
- **j)** insertion of suppositories
- **k)** enema administration
- **l)** blood glucose monitoring
- **m)** continuous positive airways pressure (CPAP) management.

Advance care planning

5.4.5 The provider implements advance care planning processes to:
- **a)** support the older person to set goals of care, develop and review advance care planning documents that are consistent with their needs, preferences, cultural practices and traditions
- **b)** ensure that advance care planning documents are stored, managed, used and shared with all relevant parties and at transitions of care; in accordance with relevant law and evidence-based guidance.

Changed behaviours

5.4.6 The provider implements processes to work collaboratively with older people and their representatives to:
- **a)** identify, understand, mitigate and respond to situations that may precipitate changed behaviours
- **b)** identify, understand, and respond to changed behaviours
- **c)** conduct clinical assessment and reassessment and manage the clinical and other identified causes of behavioural change
- **d)** respond to changed behaviours and minimise harm to the older person and others involved in their care.

Choking and swallowing

5.4.7 The provider implements evidence-based processes to manage swallowing and choking risks including when the older person is eating, drinking, or taking oral medicines.

Cognitive impairment, including dementia and delirium

5.4.8 The provider implements processes for:
- **a)** early recognition, referral and management of delirium, dementia and other forms of cognitive impairment
- **b)** identifying deterioration and underlying contributing clinical factors
- **c)** accessing specialist health, allied health and behavioural advisory services.

Continence

5.4.9 The provider implements processes for continence care that:
- **a)** optimises the older person's dignity, functional abilities, mobility and environment
- **b)** provides toileting assistance that is safe, timely and responsive to the older person's needs and preferences.

Falls and mobility

5.4.10 The provider implements processes to:
- **a)** minimise falls and harm from falls
- **b)** clinically assess the reason and consequences of the fall and deliver post-fall management
- **c)** maximises mobility to prevent functional decline.

Malnutrition and dehydration

5.4.11 The provider implements processes to recognise, monitor and manage malnutrition and dehydration, and ensures:
- **a)** timely referral to an appropriate health professional of all older people identified as being malnourished or with unplanned weight loss or gain
- **b)** nutrition and hydration support is provided for older people who cannot meet their nutritional requirements with food and fluid alone
- **c)** food and fluids provided are consistent with evidence-based care of chronic conditions.

Mental health

5.4.12 The provider implements processes to recognise, monitor and respond to changes in an older person's mental health including but not limited to:
- **a)** depressive symptoms or other mental health conditions
- **b)** their distress
- **c)** when thoughts of self-harm or suicide are expressed or present a risk of harm to others
- **d)** self-harming or harming others.

Oral health

5.4.13 The provider implements processes to ensure:
- **a)** timely clinical oral health assessments are conducted

b) referral to oral health professionals when required
c) access and use of products and equipment required for daily oral hygiene.

Pain

5.4.14 The provider implements processes to:
a) recognise an older person's pain, including where the older person experiences challenges communicating
b) monitor, record and manage an older person's pain.

Pressure injury and wounds

5.4.15 The provider implements processes to:
a) prevent pressure injuries and wounds from occurring
b) conduct comprehensive skin inspections
c) manage pressure injuries and wounds when they occur.

Sensory Impairment

5.4.16 The provider implements processes to:
a) recognise, monitor, and respond to hearing loss, vision loss and balance disorders
b) support the use of assistive devices and aids to maximise the older person's independence, function, and wellbeing.

RACGP response

The GPs role in providing comprehensive care to older person's needs to be considered and acknowledged within this Outcome. As it stands, Outcome 5.4 does not recognise the collaborative role that external care providers (eg GPs) perform in the planning and delivery of care older people living in RACFs. The proposed Actions of Outcome 5.4 ignore the recommendations from the ACRC regarding importance of general practitioners to the centre of planning for ageing and aged care.

The Actions within Outcome 5.4 are a mixture of processes and clinical responsibilities that does not reflect the person-centred focus that the Quality Standards has set out to achieve. The RACGP strongly recommends differentiating responsibilities between clinical care and service delivery to clarify expectations on providers (ie RACF) as well as other health professionals. Processes need to be developed collaboratively to account for the agreed roles and responsibilities for the care of older persons at this stage of their life.

The *RACGP Aged Care Clinical Guide* (the Silver Book) provides important guidance on common clinical conditions in aged care (Part A) and general approaches to aged care (Part B) that may be a useful guide to understanding the GP role in providing comprehensive care of older person's in aged care for the above actions.

The RACGP strongly recommends that actions 5.4.1 to 5.4.16 are substantively revisited to include the collaborative role of external care providers (eg GPs) in the planning and delivery of comprehensive care in aged care. Examples of this are detailed in the below actions:

- Action 5.4.1
  - Expansion within **b)** develop the clinical assessment and treatment care plan in collaboration with an older person's regular GP, including for acute exacerbation of chronic conditions.
- Action 5.4.10
  - Inclusion of **d)** timely notification of any falls / incidents to the older person's regular GP.

The RACGP would recommend the inclusion of the following actions to Outcome 5.5:

- Action 5.4.5
  - Inclusion of **c)** coordinates advance care directives according to views of any appointed substitute decision maker, where available, when a resident loses decision-making capacity.
- Action 5.4.11
  - Inclusion of **a)** all patients admitted to a residential aged care facility (RACF) are screened for risk of malnutrition and, if at risk, referred to a dietitian.

Outcome 5.5: Care at the end of life

Outcome statement:

The older person's needs, goals and preferences for care at the end of life are recognised and addressed. The older person's pain and symptoms are actively managed, their dignity is preserved, and their representatives are informed and supported at the end of life and during the last days of life.

Note: These actions apply to providers according to their service context and the services being delivered.

Actions:

5.5.1 The provider has processes to recognise when the older person is approaching the end of life, supports them to prepare for the end of life and responds to their changing needs and preferences.

5.5.2 The provider supports the older person approaching the end of life to develop or review advance care planning documents to align with their needs, goals and preferences, including requesting or declining life-prolonging care or responding to reversible acute conditions

5.5.3 The provider uses its processes from comprehensive care, to plan and deliver end of life care that:

- **a)** prioritises the comfort and dignity of the older person, and supports their spiritual, cultural, and psychosocial needs
- **b)** identifies and manages changes in pain and symptoms in a timely way
- **c)** communicates information about the older person's preferences for end-of-life care and the place where they wish to receive this care with workers, representatives, and others
- **d)** supports access to specialist palliative care
- **e)** provides a suitable environment for end-of-life care, including timely access to specialist equipment
- **f)** provides information about loss and bereavement to others.

5.5.4 The provider implements processes to minimise harm to older people in the last days of life including to:

- **a)** recognise that the older person is in the last days of life and respond to rapidly changing needs
- **b)** provide pressure care, oral care, eye care and bowel and bladder care
- **c)** recognise and respond to delirium
- **d)** minimise unnecessary transfer to hospital, where this is in line with the older person's preferences
- **e)** ensure that medicines to manage pain and symptoms are prescribed, administered and available 24-hours a day.

RACGP response

The RACGP notes the inclusion of a new, clinical care standard in the revised Quality Standards and that the care at the end-of-life care has been expanded from existing requirements in the current Quality Standards.

However, the GP's role in palliative and end of life care has been overlooked in Outcome 5.5. As it stands it does not recognise the collaborative role that external care providers (such as GPs) perform in the planning and delivery of palliative and end of life care. The role of the GP needs to be considered and acknowledged within this space. RACF processes need to be developed collaboratively with GPs to account for the agreed roles and responsibilities for the care of older people at this stage of their life.

GPs have an essential role in advance care planning and are well placed to initiate and implement an advance care plan or advance care directive. They have ongoing and trusting relationships with their patients and can discuss future care at a time when patients have stable health and decision-making capacity. While, RACF staff can initiate initial conversations around advance care planning, a medical professional, usually the patient's GP, must sign off on any advance care planning documents to confirm that the patient has decision making capacity to do so. As it stands, Action 5.5.2 does not reflect the RACF staff responsibilities clearly nor the important role of GP in advance care planning processes. The RACGP strongly recommends differentiating responsibilities between clinical care and service delivery to clarify expectations for RACF as well as other health professionals.

The *RACGP Aged Care Clinical Guide* (the Silver Book) provides important guidance on *Palliative and end of life care*.

As highlighted by the RACGP in a submission to the ACRC, availability of registered nurses and end-of-life medications in RACFs will impact RACF's availability to minimise harm and deliver end-of-life care to older people (Actions 5.5.3 and 5.5.4).

As such, the RACGP recommends the following amendment to Action 5.5.2:

- The provider supports the older person approaching the end of life to:
  - Inclusion of **a)** develop or review advance care planning documents to align with their needs, goals and preferences, including requesting or declining life-prolonging care or responding to reversible acute conditions
  - Inclusion of b) appoint a substitute decision-maker for a later time when they may lose their decision-making capacity.

The RACGP recommends the inclusion of the following action in Action 5.5.4:

- Action 5.5.4
  - Inclusion of f) clear guidelines for GPs and RACF staff around Schedule 8 medication prescription and phone orders.

Standard 6: Food and Nutrition

Outcome 6.1: Partnering with older people on food and nutrition

Outcome statement:

The provider partners with older people to provide a quality food service, which includes appealing and varied food and drinks and an enjoyable dining experience.

Actions:

6.1.1 The provider partners with older people on how to create enjoyable food, drinks and dining experience at the service.

6.1.2 The provider implements a system to monitor and continuously improve the food service in response to:

- **a)** the satisfaction of older people with the food, drink and the dining experience
- **b)** older people's intake of food and drink to ensure it meets their needs (including review of Quality Indicator data on unplanned weight loss)
- **c)** the impact of food and drink on the health outcomes of older people
- **d)** contemporary evidence—based practice regarding food and drink.

RACGP response

The RACGP supports the inclusion of Outcome 6.1 into the strengthened Quality Standards. With limited expertise on this topic, the RACGP defers to the recommendations made by Dietitians Australia on the food and nutrition of older people living in residential aged care.

Outcome 6.2: Assessment of nutritional needs and preferences

Outcome statement:

The provider understands the specific nutritional needs of older people and assesses each older person's current needs, abilities and preferences in relation to what and how they eat and drink.

Actions:

6.2.1 As part of assessment and planning, the provider assesses and regularly re-assesses each older person's nutrition, hydration and dining needs and preferences. The assessment considers:
- **a)** what the older person likes to eat and drink
- **b)** when the older person likes to eat and drink
- **c)** what makes a positive dining experience for the older person
- **d)** the older person's individual and nutritional needs
- **e)** issues that impact the older person's ability to eat and drink.

RACGP response

The RACGP supports the inclusion of Outcome 6.2 into the strengthened Quality Standards. With limited expertise on this topic, the RACGP defers to the recommendations made by Dietitians Australia on the food and nutrition of older people living in residential aged care.

Outcome 6.3: Provision of food and drink

Outcome statement:

Older people have food and drinks that are appetising, flavoursome and nutritious, have variation and choice about what they eat and drink and are able to eat and drink as much as they want.

Actions:

6.3.1 Menus (including for texture modified diets):
- **a)** are designed in partnership with older people
- **b)** are developed and reviewed with the input of chefs/cooks and an Accredited Practising Dietitian, particularly for older people with specialised dietary needs
- **c)** are regularly changed, include variety and enable older people to make choices about what they eat and drink
- **d)** enable older people to meet their nutritional needs.

6.3.2 For each meal, older people can exercise choice about what, when, where and how they eat and drink.

6.3.3 Meals provided to older people:
- **a)** are appealing (including the use of moulds to shape texture modified foods) and flavourful
- **b)** served at the correct temperature and in an appetising way
- **c)** are prepared and served safely
- **d)** are in accordance with each older person's choice and needs, including where older people have specialised diets or need support to eat.

6.3.4 Older people can safely access snacks and drinks (including water) at all times.

RACGP response

The RACGP supports the inclusion of Outcome 6.3 into the strengthened Quality Standards.

Assessment and planning (Outcome 3.1) of older people should be linked to Outcome 6.3, as undernutrition or malnutrition is one of the indicators for frailty in older people. It may also indicate other health problems. An accredited dietitian is best placed to provide advice on the nutrition support required.

The *RACGP Aged Care Clinical Guide* (the Silver Book) provides important guidance on *Frailty*.

Outcome 6.4: Dining experience

Outcome statement:

Older people are supported to eat and drink and enjoy the dining experience.

Actions:

6.4.1 The provider makes sufficient workers available to support older people to eat and drink.

6.4.2 Workers encourage and physically support older people to eat and drink where required and ensure that older people eat and drink as much as they want.
6.4.3 The dining environment supports a sense of belonging, social engagement, reablement and enjoyment.
6.4.4 There are opportunities for older people to share food and drinks with their visitors.

RACGP response

The RACGP supports the inclusion of Outcome 6.2 into the strengthened Quality Standards.

Where RACF staff are supporting and facilitating older people to eat and drink, this must be done in a respectful and culturally appropriate manner. The RACF must ensure that staff receive appropriate cultural competency and cultural safety training with consideration to the cultural diversity of the RACF population.

There is also significant crossover with Action 5.4.11 in Outcome 5.4: Comprehensive care which should also be addressed in this Outcome.

Standard 7: The Residential Community

Outcome 7.1: Daily living

Outcome statement:

Older people get the services and supports for daily living that are important for their health and well-being, consider their specific circumstances and enable them to do the things they want to do. Older people feel safe in their service environment.

Actions:

7.1.1 The provider supports and enables older people to do the things they want to do, including to:
- **a)** participate in activities that promote their emotional, spiritual and psychological well-being
- **b)** minimise boredom and loneliness
- **c)** maintain connections, and participate in activities that occur, outside the residential community
- **d)** have social and personal relationships
- **e)** contribute to their community through participating in meaningful activities that engage the older person in normal life.

7.1.2 The provider implements strategies to protect the physical and psychological safety of older people.
7.1.3 Older people have control over who goes into their room and when this happens.
7.1.4 Older people can entertain their visitors in private.
7.1.5 Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.

RACGP response

The RACGP supports the inclusion of Outcome 7.1 into the strengthened Aged Care Quality Standards, in particular acknowledging older people's right to maintain relationships and engage in sexual activity.

The RACGP reiterates the centrality of GP's role in the older person's health and well-being and maintains that strategies to protect older people physically and psychologically must include input from the older person's regular GP and other health professionals. This must be done in partnership with the older person and their carer/guardian/family members.

The RACGP welcomes the acknowledgement of gender diversity in the Quality Standards and supports the position outlined by the Australian Human Rights Commission on older people who are lesbian, gay, bisexual, trans or gender diverse or intersex.

Outcome 7.2: Planned transitions

Outcome statement:

Older people experience a planned and coordinated transition to or from the provider. There is clear responsibility and accountability for an older person's care and services between workers and across organisations.

Actions:

7.2.1 The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that:
- **a)** there is continuity of care for the older person
- **b)** older people, their families and carers as appropriate, are engaged in decisions regarding transfers
- **c)** receiving individuals or organisations are given timely, current and complete information about the older person as required
- **d)** when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.

7.2.2 The provider facilitates access to services offered by other individuals or organisations when it is unable to meet the older person's needs.

7.2.3 The provider maintains connections with specialist dementia care services and accesses these services as required.

RACGP response

The RACGP supports the inclusion of Outcome 7.2 into the strengthened Quality Standards, in line with Recommendation 66 of the ACRC's findings to improve transition between residential aged care and hospital care.

The RACGP notes however that the Outcome 7.2 only accounts for planned transitions and does not have any requirements for unplanned transitions that older people may experience during their time in residential care. In addition, the RACGP maintains that the role of the GP is central to this process and that GPs must be involved in the older person's transition of care, whether planned or unplanned.

This should preferably include GP input to discharge/management plans, but at a minimum the older person's GP must be provided with timely notice of transfer/discharge and relevant information. This is critical for continuity of care, and to ensure that care plans are adhered to and monitored, and that all relevant information is available to all involved in providing care. The includes ensuring that the older person sufficient medications until their GP, or another appropriate prescriber, can attend the older person.

The draft *Standards for GPRAC* discuss this point in some detail in *Criterion RACF1.1 – Access to care*.

The RACGP recommends an amendment to Outcome 7.2 to include requirements for:

- unplanned transitions
- the RACF to obtain relevant discharge information and ensure that the older person's GP has a copy of the discharge information
- GP input into discharge/management plans.