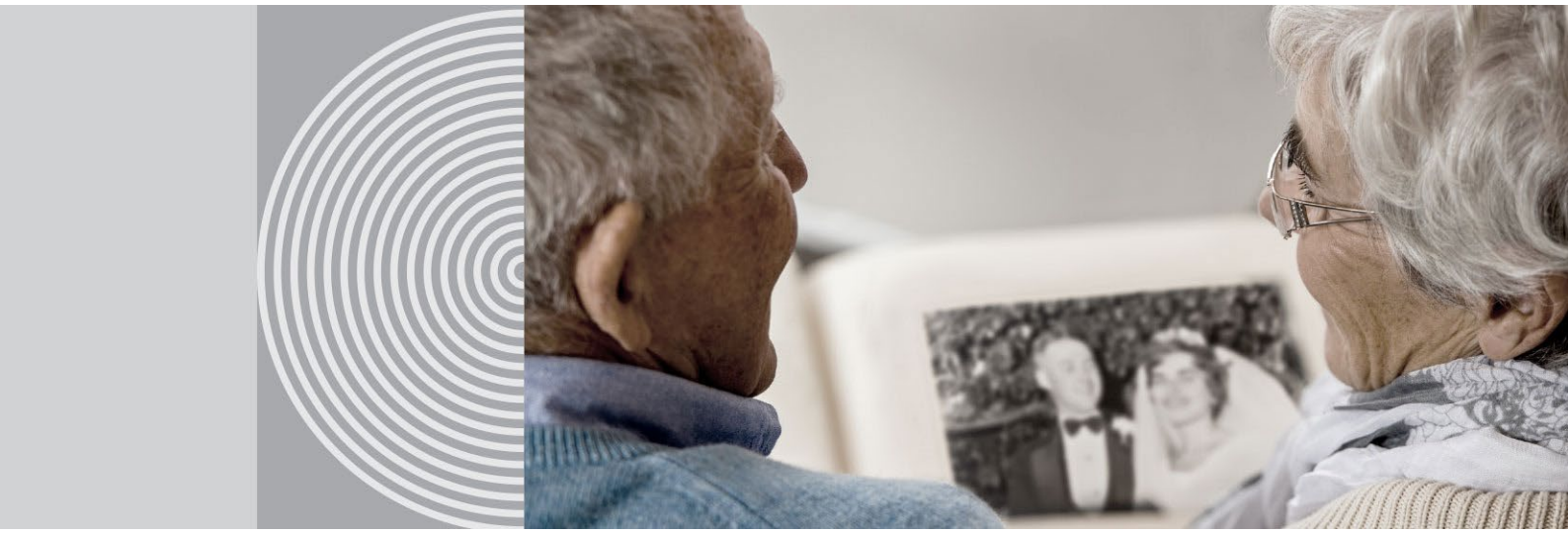
RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part B. Provision of after-hours aged care services



General principles

- Access to a regular general practitioner (GP) after hours is valued by patients and reduces emergency department visits.
- Appropriate care procedures for residential aged care facility (RACF) residents must be determined and agreed upon when the patient's regular GP is unavailable and/or emergency care is required. Collaborative agreements are vital for preventing fragmented care and compromised quality of healthcare services.
- Coordinated resident care should include the documentation of GP preferences for care, including processes for GP follow-up, in appropriate circumstances, prior to arranging an ambulance transfer.
- Collaborative care models between nurse practitioners and GPs increase the former's ability and availability, allowing them to provide more primary care services to RACF residents.
- RACFs need to ensure GPs providing care in the after-hours period have access to staff and clinical handover material that supports continuous care to all residents. Lack of, or inadequate, transfer of care is a major risk to resident safety.
- GPs and other members of the RACF care team need to have timely access to advice around the management of all RACF residents, especially in the after-hours period when key personnel may not be available in person.
- A lack of appropriate nursing or other support staff affects the capacity of GPs to provide care to patients. Access to a registered nurse needs to be available at all times in order to assist with patient care.
- An accredited practice must either provide after-hours aged care services or have arrangements in place so other services can manage its patients' needs after hours.

Introduction

There is a variety of ways that residents in residential aged care facilities (RACFs) can access a general practitioner (GP) after hours. Some general practices provide after-hours care to patients using a rotating on-call roster of GPs in their practice to provide care to RACFs outside regular operating hours (the after-hours period). Other general practices will engage a medical deputising service to provide after-hours care for patients in RACFs. Deputising service GPs attend and treat residents, and provide feedback to their regular GP.

General practice staff can facilitate administration of patient records and immunisations, Medicare Benefits Schedule (MBS) items, case conferencing arrangements and reminder systems for review appointments.

Common after-hours general practice services for RACF patients may include:

- symptomatic infection (eg urinary tract infection, cellulitis, chest infection)
- behavioural problems
- significant change in wellbeing
- lacerations
- catheter replacement
- medical assessment of acute incidents (eg unwell, fall, injury).

After-hours aged care services in the community

As patients sometimes require medical care outside the normal opening hours of their regular general practice, they value an ongoing relationship with a practice or GP who provides medical care on a 24-hour basis. Research indicates that patients who have better access to their general practice after hours have significantly fewer emergency department visits than patients who are unable to access their regular practice.[1]

Processes set in place to provide services to older people in the community should be no different to the provision of services to any other patient.

If an accredited practice is unable to provide after-hours aged care services, it needs to have arrangements in place so other services can manage its patients' needs after hours. An accredited practice must inform its patients of its normal opening hours and the arrangements for care outside of those normal opening hours.[2] Non-accredited practices also should have after-hours arrangements in place for their patients.

To deliver aged care services after hours, a practice could deliver care directly, either during the sociable after-hours period or for the full after-hours period. The sociable after-hours period includes any time in the full after-hours period outside 11.00 pm to 7.00 am.

If a practice does not directly deliver care, it could participate in a cooperative arrangement with other practices to deliver after-hours care during sociable or unsociable hours. After-hours care may also be performed on behalf of a practice; however, for the purpose of accessing the Practice Incentives Program (PIP), there must be a direct and continuing relationship between the practice and the clinicians who perform the after-hours care on their behalf.

Regardless of what system is in place, older people in the community should be well informed by their regular general practice on how to access after-hours care.

After-hours aged care services in RACFs

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

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

When determining what care is required (including hospital transfer), the general condition of the patient, family preferences and any existing advanced care plan need to be taken into consideration. To prevent inappropriate transfers to acute facilities, it is preferable that the treating GP, their delegate and RACF staff, nurses and/or care manager consult each other prior to transfers occurring. Efficient protocols for information gathering and communication facilitate more effective use of GP services. In addition to the benefits this has for patient care, it ensures that patient costs for these services are minimised.

Collaborative agreements between RACFs, GPs, other specialist medical practitioners and allied health professionals who service RACFs' residents are vital for preventing fragmented care and compromised quality of healthcare services.

Residents used medical deputising services more frequently than patients in the community, with an increase in use from 2008 to 2012 to nearly double that of older people in the community.[3] This increasing use highlights a need to better integrate RACF care with existing services and to implement oversight to ensure appropriate use of after-hours services.

Hospital avoidance

RACF residents have disproportionately high demands for acute medical services, frequently presenting to emergency departments, with many requiring hospital admission.[4,5] Unnecessary admissions to emergency departments and hospitals, owing to relatively minor and repeated health problems, or lack of appropriate end-of-life care plans,[6] can be prevented with timely provision of primary care. This is particularly important given unnecessary hospital attendances can expose residents to potential complications (eg hospital-acquired infections, falls, disorientation).[7]

To succeed in this way in the after-hours period, resident care must be coordinated between RACF staff and GPs or other medical practitioners providing care (refer to Part B. Collaboration and multidisciplinary team-based care). This coordination should include the documentation of GP preferences for resident care, including processes to follow up with the GP, in appropriate circumstances, prior to arranging an ambulance transfer (which may in fact be unnecessary).

Collaborative care models between nurse practitioners and GPs increase the former's ability and availability, allowing them to provide more primary care services in RACFs.[8] Under the guidance of a GP, with initial training and ongoing support and collaboration, nurse practitioners are able to provide comprehensive assessment, communicate acute care needs to the GP and facilitate care within the RACF.

In turn, increased primary care within the RACF addresses many of the factors that lead to unnecessary emergency department and hospital admissions. In order to succeed in such a collaborative care model, there needs to be buy-in from all stakeholders, including key clinical staff and health service management/executive. Greater buy-in for GPs may require encouragement; for example, funding to support the provision of after-hours care.

Collaborative and coordinated care

Because of the complexity of multidisciplinary care needs and multiple care providers, systems of care and collaborative arrangements need to be clearly defined and documented to ensure access to safe and timely comprehensive and high-quality care. Collaborative arrangements between the RACF and GP:

- strengthen the relationship between RACFs and GPs [9,10,11,12]
- ensure residents can access appropriate care 24 hours a day
- help maintain continuity of care for residents[13,14]
- potentially prevent avoidable hospital presentations and admissions.[8,15]

Care coordination between the RACF, primary care and acute health services influences the quality of care in RACFs. Communication and information sharing between services are seen as vital to providing high-quality care to

residents.[16] Coordination needs to extend into the after-hours period in order to maintain continuous and comprehensive care.

Effective clinical handover of care of RACF residents is critical in the after-hours period. This includes access to current health information and qualified RACF staff involved in the ongoing care of residents. Clinical handover of resident care to other members of the RACF and external care providers occurs frequently (refer to Part B. Medical records at residential aged care facilities). Lack of, or inadequate, transfer of care is a major risk to resident safety. It can result in serious adverse patient outcomes, including:

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

As such, RACFs need to ensure GPs providing after-hours care have access to staff and clinical handover material that supports continuous care to all residents. This may come in the form of, or combination of:

- GP and staff briefings
- handover notes
- access to facilities and equipment
- on-call and emergency contact details.

GPs working in the after-hours period must have access to appropriate handover contacts and can request to have access to the RACF's information technology systems, software (including residents' shared health summary/record or event summary) and secure messaging used by other RACF staff. Wherever possible, GPs could also take part in face-to-face handover.

Supportive infrastructure

Effective infrastructure and supports can help to ensure the same level of care can be provided to RACF residents in the after-hours period as during usual consulting hours.

GPs and other members of the RACF care teams need to have timely access to advice around the management of all RACF residents. This is a particular concern in the after-hours period when key personnel may not be available in person. For some residents, such as difficult psychogeriatric patients, advice may need to be immediate. Investment in online technologies and telehealth will give care teams at rural and remote RACFs greater access to timely specialist advice (refer to Part B. Older people in rural and remote communities). It also provides GPs working in these facilities with a peer-to-peer education and collaboration platform.

RACFs, particularly in rural areas, need increased investment across a broad range of infrastructure and supports (eg built infrastructure and bed capacity). Built infrastructure in the form of a treatment room in RACFs would ensure a more cost-effective service solution by avoiding unnecessary transfer to hospitals and other facilities.

Concerns

Registered nurses play a vital role in RACFs, not only in supporting patients, but also in supporting GPs. GPs working in RACFs believe access to a registered nurse needs to be available at all times in order to assist with patient care.[17] Agency nursing staff (or after-hours providers) do not have the required background knowledge on patients to support continuity of care. A lack of appropriate nursing or other support staff affects the capacity of GPs to provide care to patients. Such a barrier can be overcome with better staffing ratios and more effective handover between staff. There is currently no recommended nurse-to-patient ratio in RACFs. This means RACFs determine their own needs, which may or may not be reflective of the staffing levels required to ensure high-quality care.

Appropriate clinical governance, especially appropriately clinically staffed RACFs, has the potential to reduce negative health outcomes by focusing on prevention and management rather than escalation to acute settings, especially referrals to ambulance and hospital emergency departments after hours.

Funding to support aged care services

With regard to funding for services in RACFs in the after-hours period:

- GP after-hours attendances (MBS item numbers 5010, 5028, 5049 and 5067) are still subject to the rebate diminishing per patient seen
- the $55 flag-fall payment for GPs attending RACFs is not applicable to RACF after-hours items
- there is no funding for a GP's non–patient facing time associated with an after-hours RACF service (eg writing reports, liaising with other members of the care team).

In addition to RACF item numbers, GPs have access to MBS item numbers for after-hours attendances to aged patients at an institution or home (other than hospital; MBS item numbers 5003, 5023, 5043 and 5063). As per the equivalent RACF items, these are still subject to the rebate diminishing per patient seen and do not attract the $55 flag-fall payment.

The PIP General Practitioner Aged Care Access Incentive (ACAI) aims to encourage GPs to provide increased and continuing services in RACFs. This incentive is paid to a general practice once its GPs provide a specific number of services in a financial year, and its value is not increased for providing services in the after-hours period.

References

1. O'Malley AS. After-hours access to primary care practices linked with lower emergency department use and less unmet medical need. Health Aff 2013;32(1):175–83.
2. The Royal Australian College of General Practitioners. Standards for general practices. 5th edn. East Melbourne, Vic: RACGP, 2017.
3. Joe A, Lowthian J, Shearer M, et al. After-hours medical deputising services: Patterns of use by older people. Med J Aust 2016;205(9):397–402.
4. Arendts G, Quine S, Howard K. Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research. Geriatr Gerontol Int. 2013;13(4):825–33.
5. Arendts G, Etherton-Beer C, Howard K, et al. Nurse led care coordination: Trial protocol and development of a best practice resource guide for a cluster controlled clinical trial in Australian aged care facilities. Arch Gerontol Geriatr 2014;58(1):15–19.
6. Fan L, Hou X-Y, Zhao J, et al. Hospital in the Nursing Home program reduces emergency department presentations and hospital admissions from residential aged care facilities in Queensland, Australia: A quasi-experimental study. BMC Health Services Research. 2016;16(1):46.
7. Jones JS, Dwyer PR, White LJ, Firman R. Patient transfer from nursing home to emergency department: outcomes and policy implications. Acad Emerg Med 1997;4(9):908–15.
8. Marsden E, Craswell A, Taylor A, et al. Nurse-led multidisciplinary initiatives to improve outcomes and reduce hospital admissions for older adults: The Care coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration project. Australas J Ageing 2018;37(2):135–39. doi: 10.1111/ajag.12526.
9. Fleischmann NG, Geister C, Hoell A, Hummers-Pradier E, Mueller CA. Interprofessional collaboration in nursing homes (interprof): A grounded theory study of nurse experiences of general practitioner visits. Appl Nurs Res 2017;35:118–25.
10. Boscart VM, Heckman GA, Huson K, et al. Implementation of an interprofessional communication and collaboration intervention to improve care capacity for heart failure management in long-term care. J Interprof Care 2017;31(5):583–92.
11. Panayiotou A, Batchelor F, Yates P, Tehan J. Is increased carer knowledge of the health care system associated with decreased preventable hospitalisations for people in the community diagnosed with dementia? A systematic review. Syst Rev 2018;7(1):209. doi: 10.1186/s13643-018-0875-6.
12. Mueller CA, Fleischmann N, Cavazzini C, et al. Interprofessional collaboration in nursing homes (interprof): Development and piloting of measures to improve interprofessional collaboration and communication: A qualitative multicentre study. BMC Fam Pract 2018;19(14):1–12. doi: 10.1186/s12875-017-0678-1.
13. Tammes P, Purdy S, Salisbury C, MacKichan F, Lasserson DS, Morris R. Continuity of primary care and emergency hospital admissions among older patients in England. Ann Fam Med 2017;15(6):515–22. doi: 10.1370/afm.2136.
14. Brinkman-Stoppelenburg A, Rietjens JAC, van der Heide A. The effects of advance care planning on end-of-life care: A systematic review. Palliat Med 2014;28(8):1000–25. doi: 10.1177/0269216314526272.

15. Arendts G, Howard K. The interface between residential aged care and the emergency department: a systematic review. Age Ageing 2010;39(3):306–12. doi: 10.1093/ageing/afq008.

16. Stocker R, Bamford C, Brittain K, et al. Care home services at the vanguard: A qualitative study exploring stakeholder views on the development and evaluation of novel, integrated approaches to enhancing healthcare in care homes. BMJ Open 2018;8(3):e017419. doi: 10.1136/bmjopen-2017-017419.

17. The Royal Australian College of General Practitioners. Submission to the aged care workforce strategy taskforce. East Melbourne, Vic: RACGP, 2018.