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**AGREEMENT FOR PROVISION OF MEDICAL SERVICES BY GENERAL PRACTITIONER TO RESIDENTS OF RESIDENTIAL AGED CARE HOMES1**

Dr [insert name] “General Practitioner”

[Insert practice address]

**And**

[Insert name] “Residential Aged Care Home” (Insert ABN)

[Insert address]

**SCHEDULE**

|  |  |  |
| --- | --- | --- |
| **Item 1** | **Commencement date:** | [insert date] |
|  |  |  |
| **Item 2** | **Termination date:** | [insert date] |
|  |  |  |
| **Item 3** | **General Practitioner Details** |
|  | Name: | [insert] |
|  | Registration number: | [insert] |
|  | Name of practice: | [insert] |
|  | Practice phone: | [insert] |
|  | Practice fax: | [insert] |
|  | Practice mobile: | [insert] |
|  | Usual hours of practice | [insert] |
|  | Emergency contact and after hours number/s: | [insert] |
| **Item 4** | **Locum service phone** | [insert] |
| **Item 5** | **Residential Aged Care Facility (RACH) Details** |
|  | Name: | [insert] |
|  | ABN: | [insert] |
|  | Address: | [insert] |
|  | Telephone: | [insert] |
|  | Fax: | [insert] |
| **Item 6** | **RACH Care Manager** |
|  | Name: | [insert] |
|  | Telephone: | [insert] |
|  | Fax: | [insert] |
| **Item 7** | **Nominated Pharmacy** |
|  | Name: | [insert] |
|  | Address: | [insert] |
|  | Telephone: | [insert} |
|  | Fax: | [insert] |

**About this Agreement**

For frail elderly people living in RACHs, having access to quality and responsive General Practitioner (GP) care, is a priority. When access to GP care is inadequate (or fragmented), health outcomes are poorer and there are increased visits to hospital emergency departments.

In the future there is an expectation that, with Government policy geared toward keeping people healthy and in the community for longer, residents of RACHs will largely comprise those with high acuity and complex health care needs. Consequently, the demand for GP care for people living in RACHs will likely increase, placing even greater demands on the time and clinical expertise of GPs that practice in RACHs.

This Agreement acknowledges that there are often barriers experienced by both GPs and RACHs that can put access to appropriate and timely medical care of residents at risk and recognises that access and continuity of GP care will improve when there is a formalised agreement between the GP and RACH to strengthen their partnership.

This Agreement aims to address the gaps and barriers that may exist in each relationship and to ensure that all parties are aware of the conditions and obligations that are required to ensure RACH residents have timely and appropriate arrangements to enable access to ongoing care. It also assists to identify and manage problem before they occur.

**TERMS**

**Introduction**

1. The General Practitioner [insert name] agrees to provide services to residents of the RACH [insert name].
2. This Agreement sets out the terms and conditions on which the General Practitioner [insert name] agrees to provide Services to residents of the RACH [insert name].

**Agreement**

1. Definitions

***RACH*** means [insert name] of [insert address].

***Agreement*** means this Agreement.

***After hours*** means other than the usual hours of practice. According to the Department of Health, After hours periods are:

* before 8am or after 6 pm on weekdays
* before 8am or after 12 noon on Saturdays, and
* all day on Sundays and public holidays

***Advanced Care Directive or Plan*** means resident’s express wishes about his or her future health care.

***Authorised Representative*** means a person who is appointed by the resident to make decisions about his or her future healthcare as outlined in the Advance Care Directive or Plan.

***Business Day*** means a day that is not a Saturday, Sunday or public holiday.

***Care Manager*** means a person engaged or employed by the RACH or a delegate of the Care Manager who is engaged or employed by the RACH.

***Clinic*** means [insert name of the General Practitioner’s Clinic and address].

***Comprehensive Medical Assessment*** means a review of the resident, including assessment of the resident's health and physical and psychological functioning.

***General Practitioner*** means a Medical Practitioner who has an agreement with the RACH to provide Services to Residents.

***Impress Medication*** means Schedule 4 and Schedule 8 poisons as defined by the Drugs Poisons and Controlled Substances Act 1981 (the Act) and Regulations 2006 that are not supplied on prescription for a specific person but which are obtained by an establishment under the authority of a Health Services Permit as referred to in Clause 5.13.

***Non-Attendant Care*** means Services where the General Practitioner does not physically consult with the Resident.

***Periodic Review*** means routine review and monitoring of Resident’s medical condition, prescribing and results.

***Resident*** means a person who reside at the RACH and receives services from the General Practitioner.

***Resident’s Medication Review*** means a review of the Resident’s medication funded under Community Pharmacy Agreement.

***Routine Consultation*** means a consultation by the General Practitioner with the Resident for the provision of Services.

***Services*** means medical services provided by the General Practitioner to the Resident including Periodic Reviews, renewal of medication charts, prescription medications, routine consultations, urgent consultations and non-attendant care.

1. Period of Agreement
	1. This Agreement comes into effect on the date specified in Item 1 of Schedule and terminates on the date specified in Item 2 of Schedule, unless earlier terminated in accordance with this Agreement.
	2. Notwithstanding Clause 2.1, an option to extend the term of the Agreement for a further period may be negotiated by the parties.
2. Services

The General Practitioner (GP) agrees to provide Services to residents of the RACH under the Terms and Conditions of this Agreement.

1. Obligations of the General Practitioner

The GP agrees to:

1. Maintain registration pursuant to the *Health Practitioner Regulation National Act 2009* and professional indemnity insurance appropriate for the provision of services;
2. Provide routine consultations and urgent consultations at a location within the facility which is deemed by the GP to be safe and suitable to provide services to residents;
3. Provide non-attendant care to residents;
4. Ensure that all medical care (including after-hours care) provided by their practice is undertaken by credentialled medical practitioners or an alternative responsible provider/s linked to the same eligible practice under the direction of the patient’s Responsible Provider.
5. Arrange for routine consultations during working hours (at an agreed time) by appointment;
6. Facilitate contact and access to urgent consultations with the nominated residents during working hours and after hours;
7. Respond to calls from the facility on the same working day;
8. Provide a Comprehensive Medical Assessment of residents;
9. Provide medication charts of up to 6 months duration or as deemed suitable by the GP;
10. Follow prescribing best practice to ensure best practice prescribing;
11. Contribute to care planning and case conferencing where arranged by the RACH;
12. Ensure that clear and accurate entries are made in the residents’ medical records and medication charts;
13. Provide clear documentation to the RACH, including computer generated, to enable RACH to carry out care obligations and meet any statutory requirements;
14. Provide After Hours and Locum arrangements and notify the RACH of any changes to After Hours arrangements;
15. Communicate with the family about any changes to health status/medication as requested;
16. Provide timely referral to specialist and allied health services where deemed clinically appropriate by the GP;
17. Commit to reading and acknowledging RMMR recommendations and documenting if the GP will action; and
18. Respect the rights of residents to obtain health care and opinions from another Medical Practitioners or aged care providers of their choosing or transfer of care if requested.
19. Obligations of the RACH

5.1 *Appropriate facilities to provide services* - The RACH agrees to provide supportive facilities for the General Practitioner including:

* 1. Access to available parking at the RACH;
	2. Ready and physical access to the RACH, including access to security door codes;
	3. Access to the Resident’s clinical records and medication charts and other relevant documentation are available at the time of the consultation;
	4. A private area, with appropriate examination lighting, examination couch, hand washing and drying facilities, as agreed;
	5. A cleared desk, chair, telephone and RACH stationary including new drug charts, pathology and radiology forms;
	6. Contact details of allied health providers accredited at the ACF; and
	7. Access to an electrical power point for the General Practitioner’s personal computer.

5.2 *Routine communication* - The RACH agrees to nominate a Care Manager as outlined in Item 6 of the Schedule to communicate with the General Practitioner. The Care Manager or other staff with suitable knowledge and expertise must:

* 1. Be available when the GP provides Services to the Resident at a defined times;
	2. Be aware of care needs of the Resident;
	3. Discuss with the GP the implementation and management plan documented by the GP;
	4. Ensure any RACH requirements are complied with; and
	5. If the Care Manager is unavailable at any time, provide the General Practitioner with appropriate details of an appropriate contact person at the RACH.
	6. *Periodic Reviews* - The RACH agrees to:
1. Maintain a reminder system to ensure that residents receive Periodic Reviews, pathology tests, medical recalls and medical appointments;
2. Arrange and coordinate transport (if necessary) and supervision of residents to receive services from the GP at the clinic;
3. Provide appropriately trained RACH staff to manage the care recommended by the General Practitioner;
4. Be responsible for coordinating and arranging care recommended or referred by the General Practitioner with other care health service providers such as specialists, pathology or allied health services, including booking appointments and arranging transport if required;
5. Ensure that requests for care are agreed and consented to by the resident or the resident’s authorised representative; and
6. Arrange discussions between the resident, the resident’s family GP and RACH staff to ensure Advance Care Directives and Care Plans are updated.
	1. *Urgent consultations* – The RACH on behalf of residents, will:
		1. Obtain, document and provide sufficient information for triage of medical deterioration or new medical conditions using ISBAR (Introduction/Identify, Situation, Background Assessment, Recommendation) form, if available. As a minimum, the Standard Triage Protocol must contain the following information:

 Resident name and time of event:

 Symptoms:

Observed signs, including blood pressure, heart rate, respiratory rate and temperature, state of orientation and consciousness, skin color and feel

 Location of signs and symptoms:

 Pain and severity:

 Actions taken:

 Degree of urgency:

* + 1. Send a facsimile of the Standard Triage Protocol to the General Practitioner; and
		2. Telephone the General Practitioner to ensure appropriate care and/or advice is sought and implemented for the resident.
	1. *Emergency care* – if requested by the resident or where immediate medical attention is deemed necessary by the Care Manager and/or Medical Practitioner at the RACH, the RACH will obtain emergency care for the resident by:
		1. Calling 000;
		2. Calling a Medical Practitioner already in attendance at the RACH; and
		3. Contacting the General Practitioner.
	2. *Transfer to hospital* – When the resident is unexpectedly transferred to hospital, on behalf of the resident, the RACH will:
		1. Contact the in-reach team at the hospital (if available) for advice and triaging;
		2. Complete the Standard Triage Protocol;
		3. Provide a copy of the Standard Triage Protocol to the ambulance officer and/or hospital together with the most recent medical record summary and contact details of the General Practitioner; and
		4. On the same day the resident is transferred to hospital, notify the General Practitioner of the resident’s transfer to hospital; and
		5. Provide the General Practitioner with a copy of the completed Standard Triage Protocol and the outcome by facsimile the following day.
	3. *Resident’s death* – When a resident dies, the RACH agrees to:
		1. Obtain confirmation of the death from a Medical Practitioner as soon as practicable;
		2. Document the circumstances prior to the death and actions already taken by the RACH; and
		3. Notify the General Practitioner as soon as practicable of the death by telephone and facsimile/email to enable follow up by the General Practitioner including issuing of death certificate.
	4. *Hospital discharge* – When a resident is discharged from hospital, on behalf of the resident, the RACH agrees to:
		1. Notify the General Practitioner when the RACH becomes aware the resident is being discharged from hospital;
		2. Obtain from the hospital, a completed hospital discharge summary including a list of discharge medications; and
		3. Provide a copy of the hospital discharge summary and list of discharge medications to the General Practitioner.
	5. *Documentation* – The RACH agrees to:
		1. Provide required access to computerised systems with individual login details.
		2. Ensure all documentation is available to the General Practitioner when services are provided to the resident;
		3. Ensure the General Practitioner’s communication book is maintained at the RACH and provided to the General Practitioner;
		4. Give the General Practitioner access to progress notes, medication charts, incident and triage reports and where relevant copies of clinical observations such as temperature and blood pressure; and
		5. Ensure email/facsimile sent to the General Practitioner include the sender’s contact details and the number of pages sent.
	6. *Medication charts and prescriptions* – To ensure the resident is appropriately prescribed medication, the RACH agrees to:
		1. Enter into arrangement with a nominated pharmacy , as outlined in Item 7 of schedule, to obtain medications for the resident;
		2. Coordinate prescription requirements for the resident by arranging prescribing during routine or urgent consultations;
		3. Notify the resident that requests to the General Practitioner to prescribe outside routine and urgent consultations may incur fees (if not bulk-billed) for the resident;
		4. In order to support dispensing by the nominated pharmacy to the resident, the RACH agrees to:
			1. Arrange medication chart renewal at least 2 weeks prior to the date of expiry;
			2. Where the RACH has not obtained a medication chart from the General Practitioner before the date of expiry, arrange and obtain a short term medication chart of no more than one month’s duration from the Locum or alternative Medical Practitioner;
			3. Where the RACH arranges for the Locum or alternative Medical Practitioner to prescribe medication, the RACH will be responsible for obtaining this medications on prescription from the Locum or alternative Medical Practitioner;
			4. Unless otherwise advised by the General Practitioner, the expiry of the resident’s medication chart or prescription is an appropriate time to review the effectiveness and ongoing need for the medication;
			5. Give the GP a timely reminder about the need to review any psychotropic medication in accordance with clinical standards;
			6. All prescription medication and particularly all Schedule 8 Drugs and PBS Authority Medications, require advance arrangements to obtain prescriptions before the prescription expires;
			7. Maintain a robust system to ensure the resident is reviewed, by the General Practitioner, Locum or alternative Medical Practitioner, prior to expiry of the resident’s prescribed medication; and
			8. Requests from the Nominated Pharmacy for post-dated and back-dated prescription is not permitted.
		5. Advise and arrange review of the resident by the GP if:
			1. The resident’s condition has changed that may indicate a change in medication or withholding of medication;
			2. A medication chart has been changed by another Medical Practitioner that requires review or prescription by the General Practitioner; and
			3. The resident’s medication is withheld or ceased due to the resident’s possible allergy.
	7. *Residential Medication Management Review (RMMR)* – To ensure the resident obtains an annual RMMR, the RACH agrees:
		1. To arrange the RMMR to take place 6 to 8 weeks prior to renewal of the resident’s Medication Chart;
		2. To advise the General Practitioner of the scheduled RMMR and coordinate communications between the Nominated Pharmacy/pharmacist and the General Practitioner;
		3. To ensure appropriate blood tests, such as renal and liver function tests, are arrange prior to the RMMR ; and
		4. Not to take action on recommendations made by the Nominated Pharmacy/pharmacist, without arranging a consultation or Non-Attendant Care with the General Practitioner;
	8. *Impress medication* – Where provided for by the resident’s Advance Care Directive or Plan, the General Practitioner may prescribe and the RACH agrees to make available to the resident, Impress Medication for palliative care and where appropriate as determined by the Facility’s Advisory Committee.
	9. *Risks communication* – The RACH agrees to advise the General Practitioner by telephone and in writing of any infection or incident that may generally expose the resident to health risks such as influenza, gastroenteritis and scabies.
1. Dispute resolution
	1. Both parties will in the first instance attempt to resolve any disputes under this Agreement including disputes about performance, and compliance obligations with individual Parties. If agreements are not reached, then refer matters to senior management of each Party.
	2. Should there be a dispute involving the Agreement a meeting of both parties is to occur to discuss the issue raised to ascertain an amicable outcome.
	3. Notwithstanding the existence of a dispute, each Party will continue to comply with this Agreement except as otherwise expressly provided by this Agreement.
2. Termination

7.1 This Agreement may be terminated by:

1. Mutual consent of the parties in writing; or
2. By one party providing 6 weeks written notice of termination.
3. Governing law and jurisdiction
	1. This Agreement is governed by the laws of the State of [insert name of state].
	2. Each part irrevocably submits to the non-exclusive jurisdiction of the courts of
	[insert name of state].
4. **Confidentiality**
	1. A party may not disclose anything in respect of this Agreement, unless such disclosure is required:
		1. By applicable law; or
		2. Unless prior written consent of the other party is obtained.
	2. A party may disclose anything in respect of this Agreement to the officers, employees and professional advisers of that party but it must use its best endeavours to ensure all matters disclosed are kept confidential.
5. **Consents and approvals**
	1. Where this Agreement gives any party a right or power to consent or approve in relation to a matter under this Agreement, that party may withhold any consent or approval or give consent or approval conditionally or unconditionally. The party seeking consent or approval must comply with any conditions the other party imposes on its consent or approval.

***Signing page***

Executed as an Agreement

**SIGNED SEALED & DELIVERED by**

[Insert name of General Practitioner]

In the presence of:

Signature of Witness Signature

Name of Witness

**SIGNED SEALED & DELIVERED by**

[Insert name of RACH]

In the presence of:

Signature of Witness Signature

Name of Witness

1 This document was reviewed and adapted by the PHN Cooperative with permission from ACCPA, July 2024 and originally adapted from Barossa aged care services MOU and from Dr Dennis Gration’s submission to Senate Community Affairs Committee inquiry into effectiveness of aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised, Nov 2018.

