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**MEMORANDUM OF UNDERSTANDING   
 (Non-Binding)1**

***General Practice & Aged Care Collaboration***

**This Memorandum of Understanding**

**(Hereinafter "Memorandum" or "MOU") is dated this [insert date]**

**BETWEEN:**

[Insert name] “General Practice”   
[insert ABN]

Of the following address:

[Insert address]

**AND**

[Insert name] “RACH’ [Insert ABN]

Of the following address:

[Insert address]

1. **BACKGROUND**
   1. The Royal Commission into Aged Care Quality and Safety recommended the development of a new model of primary care to 'encourage the provision of holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care' (Recommendation 56).
   2. In the future there is an expectation that, with the Government policy geared towards keeping people healthy and living in the community for longer, residents of Residential Aged Care Homes (RACH) will largely comprise those with high acuity and complex care needs.
   3. Consequently, the demand for General Practitioner (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.
   4. It has been noted, access to GP care can be challenging and there are many barriers that impact on the willingness and capacity of GPs to provide services in RACHs.
   5. A formalised agreement between the General Practice and RACH could strengthen their partnership and ensure residents of RACHs have consistent and adequate access to GP care.
2. **PURPOSE**
   1. To support collaborative relationships between RACH [Insert name] and General Practice [Insert name] to ensure residents receive person-centered care that is continuous, safe, timely and effective and delivered in the most appropriate care setting.
   2. To promote a common understanding of the roles, responsibilities, and accountabilities between the Parties in relation to the delivery of consistent quality healthcare for residents within the RACH with a focus on optimising health and well-being in accordance with the resident’s needs, goals and preferences.
   3. This Memorandum is not intended to be legally binding but is intended to document the expectations of each Party.
   4. Each Party respectively is expected to act in good faith in accordance with this Memorandum.
3. **NON-BINDING MEMORANDUM**

The Parties hereby acknowledge and agree that:

3.1 The Terms of this Memorandum are not intended to be legally binding; and

3.2 The Terms of this Memorandum are not exhaustive.

1. **CHANGES TO MEMORANDUM**
   1. This Memorandum may be amended at any time by agreement between the Parties.
   2. Any changes to this Memorandum must be made in writing and signed by the Parties.
2. **GENERAL OBLIGATIONS**
   1. Notwithstanding the non-binding nature of this Memorandum, the Parties will act in good faith and will use their best endeavours to achieve the Purpose and to give effect to the Terms of this Memorandum.
   2. The Parties hereby acknowledge and agree that they will each respectively perform all acts and execute all documents as reasonably required in order to give effect to the terms of this Memorandum.
   3. Each Party agrees to cooperate in the spirit of mutual understanding and goodwill in order to develop the Parties' relationships with one another and in order to pursue the Purpose.
3. **ROLES AND RESPONSIBILITIES**

**General practice [insert name]**

The General practice [Insert name] will have the following obligations:

* 1. To ensure that all clinical 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.
  2. To provide information (and clarity of processes) to the RACH about services provided and after-hours arrangements including, GP attendance times at the RACH, arrangements for medication reviews, comprehensive medical assessments, case conferencing and care planning.
  3. To ensure the designated GP undertakes a comprehensive medical assessment of the resident on admission (preferably within six weeks of admission) and on an annual basis thereafter or whenever a change in the resident’s medical condition suggests that a comprehensive medical evaluation is warranted and provides copy to the RACH.
  4. To designate a practice staff member as a RACH key contact and administrative support person.
  5. To implement a RACH patient register and recall/reminder system for follow-up appointment.
  6. To provide primary care clinical and specialist advice and education, to the enrolled or registered nursing staff of the RACH as necessary.
  7. To provide access to the current after hours On-Call Roster and contact details of the GP.
  8. To provide updated information of GPs and Alternative provider/s visiting the aged care facility.
  9. To provide a high level of customer service to residents and provide feedback about residents’ relevant health care issues to the RACH and carers, family and/or Enduring Power of Attorney (EPOA) via the accepted feedback process.
  10. To ensure the designated GP provides assistance to complete resident assessments and documents to enhance the Aged Care Funding Instrument claiming process.
  11. In circumstances where the designated GP is unable to attend the RACH to organise for an alternative GP to attend, if available, or using telehealth as an alternative to visiting the RACH to assess the resident.
  12. GPs and responsible providers are required to abide by the National Privacy Principles in the Privacy Act (Health Amendment) 2000 when collecting, using, disclosing and storing health information as per the RACH policies and guidelines.

**Residential Aged Care Facility [insert name]**

The RACH [Insert name] will have the following obligations:

* 1. To provide residential aged care services that meets the current aged care quality standards, to ensure that the care and service delivered are safe, high quality, and meet the needs and preferences of residents in their care.
  2. To have the necessary clinical environment, medical stores and clinical equipment (as agreed) available and in good, clean working order.
  3. To have qualified staff on duty and available to assist the GP when they are reviewing the residents at agreed times.
  4. To keep the GP informed of the health and wellbeing of the residents in a systematic and timely fashion.
  5. To facilitate access to clinical and medication software onsite in the RACH and also remotely for the use of the GP.
  6. To ensure all clinical and medication information is current and relevant.
  7. To provide up dated policy and operational information as necessary to the GP.
  8. To participate in ongoing discussions on how to meet continuous improvement processes in agreed situations and provide the opportunity for GPs to contribute to clinical governance and quality improvement.
  9. To agree to provide all GPs with access to the RACH over the 24-hour period including weekends.
  10. To provide cold chain management processes for vaccines and pathology samples as per the National Vaccine Storage guidelines, ‘Strive for 5’.
  11. To notify the GP as soon as possible of a patient death, transfer to or from a hospital to ensure appropriate follow-up.

Importantly, responsible staff should be aware of the following recommended clinical governance standards:

* 1. *Documentation and communication*:
* Documentation is an essential component of effective communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians.
* All health concerns expressed by staff, consultations and services need to be documented and available to the doctor in a common patient file.
* Where necessary this will include instructions for the RACH staff to arrange follow up care arrangements with another provider such as medical specialist, pathology or allied health.
* A system to ensure routine reviews, recalls and appointments needs to be in place.
  1. *Doctor attendances routine or urgent*:
* Medicare requires that a patient be seen for the provision of GP medical services. During a consultation a GP must have access to:
  + Medication chart;
  + Patient file;
  + Documentation of incidents, urgent health deterioration or medical conditions/symptoms reported or noted made available;
  + Staff member attending patient at the time of visit have detailed handover; and
  + Patient is located where they can be afforded privacy and examined.
  1. *Routine medical reviews*:
* The RACH is to arrange routine appointments with the GP:
  + Agreed periodic reviews.
  + Medication chart and Pharmacy Reviews.
  + Specified medical condition reviews e.g. chronic disease, pain management, falls management and mental health.
  + Pathology results monitoring e.g. INR rule 3 exemption.
  + Allied health referral requests.
  + Where staff have concerns about patient care these should be clearly documented and review arranged.
  1. *Patient death or hospital transfer*:
* As above, it is the RACH’s responsibility to notify the GP as soon as possible of a patient death, transfer to or from a hospital to ensure appropriate follow up.
  1. *Prescriptions and Medication Charts*:
* Arrange routine appointment for Medication Chart Renewal 2 weeks in advance.
* Not to permit a locum of usual doctor to prepare a Medication Chart longer than 2 weeks.
* RACH arrange for medical review of patients for all Schedule 8 (S8) or Authority medications before scripts are due.
* Advise usual GP in writing if patient has seen specialist or attended outpatient services and changes have been made on medication or treatment.
* Arrange review if patient has had medication changes requiring ongoing prescribing.
* Notification in writing of non-prescribed medication.
* Not to administer medication without medical agreement.
  1. *Urgent Medical Services*:
* A rapid deterioration in condition should be treated with suspicion. Change in residents’ behaviours may also be an indication of deterioration and should prompt review by a GP. The RN notify the GP and arrange review.
* It will be expected that the RACH provide sufficient information for Triage. A standard triage protocol is recommended and staff calling the GP should be conversant with this. Staff must prepare to discuss with the GP in ISBAR / ISOBAR format.(Introduction/Identify, situation, background assessment, recommendation).
* Protocol should include:
  + Symptoms.
  + Observed full set of vital signs, including response and cognition.
  + Location.
  + Duration/frequency.
  + Pain and severity.
  + Documentation of illness.
  + Recent medication changes.
  + Recent investigation results.
  + Assessment of degree of urgency.
* After hours – ring the GP for direct connection to Locum services/deputising services (if arrangements are in place).
* Inform GP if patient transferred to hospital.
* Where resident lacks capacity or consents, notify next of kin / substitute health decision maker of resident condition and ensure they are involved in care planning.
  1. *Pandemic risk*:
* Advise the GP if the RACH has been advised of infection or incident that may expose residents to health risks including but not limited to COVID-19, influenza, gastroenteritis, or scabies.

1. **TIMING AND DURATION OF PROJECT**
   1. This Memorandum will commence on [Insert date].
   2. This Memorandum will remain in effect unless and until terminated by the Parties.
   3. The Parties may terminate this Memorandum by written agreement.
   4. Any Party may withdraw from this Memorandum by providing one month's written notice to the other Party.
   5. In the event that a Party withdraws from this Memorandum under this clause, then any rights and obligations set out in this Memorandum will cease to apply to the said Party, unless expressly provided otherwise in this Memorandum
2. **CONSEQUENCES OF TERMINATION OR WITHDRAWAL**
   1. In the event that this Memorandum is terminated or in the event that a Party withdraws from this Memorandum:
3. No Party will, under this Memorandum, incur any financial liability to any other Party; and
4. In the event that a Party (First Party) is in possession of any equipment, materials, documents, intellectual property, data or other information (Items) that are the property of other Party (Second Party), then the First Party must promptly return all Items to the Second Party, or destroy any Items if directed to do so by the Second Party.
5. **APPLICABLE LAW**
   1. Notwithstanding that this Memorandum is not legally binding, the Parties agree that in the event that laws need to be applied to it, the laws of [Insert state/territory] will apply.
6. **COMMUNICATION** 
   1. The following nominated personnel from the Parties are the point of contact for the purpose of this MOU:

* [Insert contact name], (Insert RACH name]

Email: [Insert email address]

Phone No. [Insert phone number]

* [Insert contact name], [Insert General Practice’s name].

Email: [Insert email address]

Phone No. [Insert phone number]

* 1. The methods to be used for communication between the Parties are:
* Email or faxes are the preferred methods of communication between Parties when involving resident/patient information.
* Phone calls from the nursing staff to reception of the relevant medical centres when non urgent or as agreed direct to the treating GP.
* Phone calls from the medical centres to the RACH should be directed to the registered nurse on duty.

1. **DISPUTE RESOLUTION STATEMENT**
   1. All Parties will in the first instance attempt to resolve any disputes under this MOU including disputes about performance and compliance obligations. If agreement is not reached, then the matter is referred to senior management of each Party to determine an amicable outcome.
   2. Should there be a dispute involving the MOU document from anyone of the Parties a meeting of all 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 MOU except as otherwise expressly provided by this MOU.

**SIGNED BY THE PARTIES THIS (Insert date]**

*Signed for and on behalf of [Insert General Practice’s name] (Insert ABN] in accordance with section 127(1) of the Corporations Act 2001 (Commonwealth) by being signed by (Insert name} and [Insert name], two of its directors:*

(Insert name], [Insert title]

(Insert name], [Insert title]

*Signed for and on behalf of [Insert RACH’s name], [Insert ABN] in accordance with section 127(1) of the Corporations Act 2001 (Commonwealth) by being signed by [Insert name] and [Insert name], two of its directors:*

(Insert name], [Insert title]

(Insert name], [Insert title]

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.

