Care Provider Connect

GP-RACH Partnership Resource Kit

Part 2

Embedding Systems

A compendium of resources for partnerships that are well established and are ready to embed systems to improve their ways of working

phn BRISBANE NORTH

An Australian Government Initiative

This Resource Kit is a collection of tools designed to provide a framework and begin conversations. It is not a manual that needs to be completed, but care providers are encouraged to use whichever forms and templates will benefit their unique partnership

Acknowledgement

This Resource Kit has been developed by Brisbane North PHN with input from our General Practice in Aged Care Incentive (GPACI) Expert Advisory Group, and the PHN MyMedicare Cooperative. We acknowledge that some resources used or referenced herein are from other organisations, and that these organisations retain copyright over their original work. Referencing of material is provided throughout for clarity. We thank the Expert Advisory Group for their co-design and the Cooperative for their contributions, as well as the rest of our Residential Aged Care community for their generously given time to help us better understand the reality and needs of the sector.

Brisbane North PHN would also like to take this opportunity to acknowledge the Traditional Custodians of the land on which this work was developed and will be implemented. We acknowledge their continued connection to country, their complex and holistic health and care provision structures, and the ongoing challenges their communities face in accessing equitable aged care. We commit to working alongside First Nations communities in our region and learning from their wisdom in caring for their elders.

Disclaimer

Contents

Introduction

As part of the General Practice in Aged Care Incentive (GPACI) implementation support program, Brisbane North PHN undertook a series of workshops, consultations and in-person conversations with Residential Aged Care Homes (RACHs), General Practitioners (GPs), Practice Managers, Nurse Practitioners and Metro North Health staff. As a result, we have developed this co-designed resource to translate this implementation plan into a guide for operational practice.

This Resource Kit is a collection of tools that have been highlighted as useful for RACH-GP partnerships. It is not a manual that needs to be followed, rather a guide to provide an optional framework and begin conversations.

Care providers are not obliged to complete every resource but are encouraged to make use of any templates or forms that will benefit their circumstances and partnership.

Purpose of Resource Kit

The aim of the GP – RACH Partnership Resource Kit is to provide tools and tips for improving coordination between RACHs and GPs. Through collaborative effort, stronger partnerships between RACHs and GPs will support improved planning and delivery of primary care services in the RACH setting for residents (National PHN Cooperative, 2025).

It recognises that in residential aged care, collaboration across the care team has benefits for patients, the team and its members, and the organisations. Many different care providers can make up a resident's care team, and not all are co-located within the RACH. Through a series of steps, all members of the care team can improve their experience in delivering care, leading to improved outcomes for the resident (National PHN Cooperative, 2025).

This kit acknowledges that both RACHs and GPs are required to uphold their own strenuous professional standards, that do not completely overlap, and that a better understanding of each other's requirements will result in an improved working relationship. For GPs these are the RACGP – Standards for general practices (6th edition) and the General Practice in Aged Care Incentive. For RACHS these are the Aged Care Act (2024) and the Quality Standards | Aged Care Quality and Safety Commission.

The Resource Kit is divided into three sections, with the first focused on Establishing a Partnership, the second focused on Embedding Systems, and the third on Providing Quality Care. It is designed to provide additional support at any stage of a RACH-GP partnership and is not required to be completed in a linear fashion. We envisage care providers to take and apply whatever is useful from the Resource Kit for their unique circumstances.

How to give feedback

The PHN is constantly striving to improve and include the latest best practice evidence into all the work we do; therefore, we acknowledge this Resource Kit may change and iterate over time. Please contact the PHN at agedcareprojects@brisbanenorthphn.org.au if you have any feedback regarding the content of this document or would like to contribute to its improvement in later versions.

Word documents templates

Word document versions of each form or template are available to download.

They can be accessed by clicking this icon: 

A Strong Foundation

Improving coordination between RACH and general practice enables both parties to understand and respond to the health care and other needs of residents and improves access to quality primary care.

Well understood arrangements facilitate better experiences for providers and residents. They can also support regular engagement and communication between health care professionals which can reduce errors and incidents that can lead to the need for urgent and/or after-hours care (National PHN Cooperative, 2025).

Possible Actions at the RACH to Improve Collaboration

- Allocation of RACH staff that are responsible for coordinating visits with the General Practice, enable a staff member to be on hand on the GP's arrival as an onsite contact point to assist with logistics such as finding records and patients.
- Does the RACH have - or is it possible to create - a dedicated, safe and private environment such as a consultation room for the GP? This protects residents' privacy and supports the delivery of quality care.
- Utilise the ISBAR clinical handover tool as a standardised approach to support best practice clinical handover – this will assist to improve communication between care staff.
- Access to an onsite pharmacist is beneficial for GPs, RACH staff and residents. Speak to your PHN about accessing an Aged Care On-site Pharmacists (ACOP).
- Telehealth also provides an opportunity for collaboration or coordination conversations if face to face is a challenge. The PHN Cooperative has developed a national online training for RACH to enhance telehealth capabilities, for both routine and afterhours telehealth use. See here: https://resiagedcaretelehealth.training/
- The Aged Care Transfer Summary is a digital solution using My Health Record. It provides crucial health information about residents, supporting the transition of the resident from an aged care setting to acute hospital care when needed (National PHN Cooperative, 2025).

Possible Actions at the General Practice to Improve Collaboration

- Utilise GPACI MBS items such as the Care Coordination items that assist in supporting planned and coordinated care with the multi-disciplinary team included.
- Utilise the ISBAR clinical handover tool as a standardised approach to support best practice clinical handover – this will assist to improve communication between care staff.
- Agree on a triage framework with the RACH to enable all parties to be on the same page when incidents such as a patient fall occur. It is important that RACHs and General Practice know how to manage these instances both in-hours and after-hours.
- Discuss immunisation plans with the RACH – including plans for vaccine storage and access.
- Utilise My Health Record (MHR) - Aged Care Support Plans are now integrated into MHR providing the care team with more comprehensive information. This enables quicker and better-informed decisions regarding their treatment (National PHN Cooperative, 2025).

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Partnership Meeting Schedule

Regular check-in meetings provide both parties an opportunity to identify what is working and what can be improved, and develop a plan for these improvements.

The following table establishes the partnership meeting schedule, roles and responsibilities.

Agreed meeting format	
Meeting schedule and frequency of meetings	
Coordinator/Lead	
Representatives and role	
Partnership vision	

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Partnership Improvement Action Plan

Processes to identify and document issues arising, and actions that the GP and RACH will undertake to resolve them are encouraged. The Partnership Improvement Action Plan aims to strengthen communication, clarify roles and improve collaborative outcomes.

It can be used as an agenda for your partnership meetings.

Area	Issue	Solution	Dates	Progress
Administration (includes clinical documentation)			**RACH Actions** / / **GP Actions** / / **Date Agreed** / /	
Care access			**RACH Actions** / / **GP Actions** / / **Date Agreed** / /	
Medication charts			**RACH Actions** / / **GP Actions** / / **Date Agreed** / /	
GP/Practice/ RACH communication			**RACH Actions** / / **GP Actions** / / **Date Agreed** / /	

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Care planning activities			**RACH Actions / /** **GP Actions / /** **Date Agreed / /**	
After hour care			**RACH Actions / /** **GP Actions / /** **Date Agreed / /**	
Post hospital follow-up			**RACH Actions / /** **GP Actions / /** **Date Agreed / /**	
Advance Care Planning			**RACH Actions / /** **GP Actions / /** **Date Agreed / /**	
Other			**RACH Actions / /** **GP Actions / /** **Date Agreed / /**	

Ways of Working Improvements

Below is a list of the most common areas for improvement in ways-of-working between GPs and RACHs. These can be discussed during partnership meetings, or any other collaboration spaces to consider together:

- What is our structure for safe effective care (clear accountable roles)?
- How do we provide feedback to one another?
- How will we escalate care processes?
- What are our Incident Management procedures?
- How do we manage transitions to and from hospital or the community effectively?
- How do we handle conflict between staff?
- How do we make collective decisions?
- How are we ensuring person centred care?
- How are dignity and respect for residents, staff and visitors embedded in culture?
- How are we ensuring continuity of care?
- How are we managing End of Life care?
- How do we share specific clinical preferences?
- How do we prioritise work and resident need?
- Do we have a Nurse Practioner collaborative arrangement plan?
- How can we work together on continuous quality improvement?
- Do we have regular timepoints to reflect together on what's working and what's not?
- How are emergent health issues communicated?
- Are there any gaps and/or growth opportunities for our partnership?

Handover Improvement

The Implementation Toolkit for Clinical Handover Improvement, developed by the Australian Commission on Safety and Quality in Healthcare, is a 'how to' guide for managers and clinicians reviewing their local clinical handover processes. It was released by the Commission in 2010 and can be used as a supporting resource for health services meeting the National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care, 2011).

The Commission has also published the Medication Management at Transitions of Care Stewardship Framework which is designed to strengthen existing organisational systems, processes and clinical practice, and aims to support coordinated governance of medication management at transitions of care, reduce medication-related harm and hospital readmission rates and improve communication across clinical settings to enable timely discharge planning and post-discharge medication review (Australian Commission on Safety and Quality in Health Care, 2025).

Handover Incidences

The following list includes timepoints in a resident's Primary Care experience that would benefit from a handover protocol.

- On admission to the RACH.
- Pre and post GP visit to the RACH (RACH could consider nominating a designated staff member to act as the primary communication point for each GP).
- Transferring to hospital/ED (Yellow envelope used?).
- Returning from hospital (Yellow envelope returned, scanned and shared with the GP?).
- Pre and post specialist involvement.
- Pre and post allied health involvement.
- Pre and post pharmacist involvement.
- Pre and post RADAR involvement.
- Between clinical staff shifts after a GP/RADAR visit.
- Between afterhours services and RACH staff/GP.

Some GP-RACH partnerships have found it useful to develop a flow chart mapping the current handover processes, identifying; where and how they occur and who is involved, points in the patient journey where handover would be helpful but is not currently in place, and (based on this) identifying any risks and gaps to prioritise for improvement.

Incident Management

It is recommended that RACHs ensure that regular General Practitioners and other primary care team staff are aware of incident management processes that are in place at the RACH. This is to support prevention of incidents and to enable documentation of incidents should they occur when GPs and primary care staff are onsite.

Best Practice Guidance for incident management (2021) in a RACH from the Aged Care Quality and Safety Commission can be found here: https://www.agedcarequality.gov.au/sites/default/files/media/effective-ims-guidance-august-2021.pdf

The Aged Care Quality and Safety Commission Preventing Incidents Framework (2025) can be found here: https://www.agedcarequality.gov.au/for-providers/serious-incident-response-scheme/incident-management-systems/preventing-incidents#residential-care-incident-example

Download Word Template

Incident Reporting

If your RACH does not currently have an incident reporting documentation process, you will need to address this urgently. However, if a significant incident has occurred, RACHs and GPs may wish to use this basic incident reporting template to communicate issues in the interim, while official protocols are developed. Debriefing procedures are also highly recommended.

Significant Incident (eg. abuse, neglect, clinical errors)	Response from RACH	Response from GP	Follow-up actions	Timeline	Notes

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Leave Arrangements

This document is a duplication of the template provided in the first section of the Resource Kit "Establishing a Partnership" under GP Led Documentation, due to its importance. If no leave arrangement plans were made at the beginning of the GP-RACH partnership it is highly recommended this be addressed together when exploring systems to improve joint ways of working, to avoid resident's care suffering during periods of GP absence or increasing the burden on hospital based supports who are not equipped to cope with GP leave cover.

GP Name

GP Planned Leave					
Date(s)	**When was RACH Informed of Leave**	**Covering GP**	**Covering GP Contact Details**	**What Cover Provided (as usual, as needs or Telehealth)**	**After-hours Arrangements**

GP Unplanned Leave	
Task	**Process**
Inform RACH	
Inform Patient	
Arrange Cover	
Handover	

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