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Chair
RACGP Expert Committee – Standards for General Practices
RACGP
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Via email: standards@racgp.org.au

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Dear Expert Committee Chair

Alzheimer's Australia comments on the 2nd draft of the RACGP Standards for General Practices (5th edition)

Alzheimer's Australia welcomes the opportunity to comment on the second draft of the RACGP Standards for General Practices (5th edition).

Alzheimer's Australia is the peak body providing support and advocacy for people with dementia and their families and carers in Australia. Dementia is the second leading cause of death in Australia, and there is no cure.[1]

Alzheimer's Australia represents and supports the more than 353,800 Australians living with dementia, and the more than one million family members and others involved in their care[2]. Our organisation advocates for the needs of people living with all types of dementia, and for their families and carers; and provides support services, education, and information. We are committed to achieving a dementia-friendly Australia where people with dementia are respected, supported, empowered, and engaged in community life.

Our comments relate to the role of general practice in providing care for people with dementia, and we offer some overarching comments followed by comments on several specific standards and criteria.

Overarching comments

The standards need to take into account the following facts:

[1] Australian Bureau of Statistics (2015) *Causes of Death, Australia, 2013:* Cat no. 3303.0
[2] Australian Institute of Health and Welfare (2012) *Dementia in Australia.*

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- There are estimated to be over 353,800 people with dementia in Australia and the number is increasing dramatically in line with population ageing. 70% of these people live in the community – that is nearly 250,000 Australians with dementia in the community who need to access general practices. As dementia is correlated with age, most of these people will also have other health conditions and will have a high need for primary health care services. **Providing appropriate care for people with dementia who live in the community, including through home visits, should be core business for every general practice.**

- The remaining 30% of people with dementia – more than 100,000 people – live in some form of institutional care, mostly residential aged care facilities. In fact more than half of all people living in residential aged care have dementia. **General practices need to provide an appropriate service through visits to the increasing number of Australians living in residential aged care, including those with dementia, as part of their core business.**

It is noted that the RACGP requires a two-person survey team, one of whom must be an appropriately trained GP surveyor, the other of whom can be an appropriately trained nurse, practice manager, allied health practitioner, or Aboriginal health worker with experience in general practice. **Alzheimer's Australia urges the RACGP along with general practice accreditation agencies to consider the involvement of consumers in monitoring quality in general practice, including the inclusion of appropriately trained and approved consumers in survey teams.**

Module 1 Standard 1: Communication with patients

The standards need to include the basics for communicating effectively with people with dementia. The special needs of certain groups of patients (e.g. those with a disability, those who are hearing impaired, those for whom English is not their first language, Aboriginal and Torres Strait Islander people) are taken into account under Standard 1, but the particular communication needs of people with dementia are not discussed. More information can be found at: https://fightdementia.org.au/national/support-and-services/carers/managing-changes-in-communication .

Alzheimer's Australia Dementia Advisory Committee has also developed a guide setting out good communication tips for talking to people with dementia. This can be found at: https://www.fightdementia.org.au/research-and-publications/papers-and-evaluations/talk-to-me

In the section discussing informed decision-making, **the standards need to refer to the role of carers, substitute decision makers, and advance care plans in ensuring people with cognitive impairment including those with dementia can be engaged supported decision making when appropriate.** More information can be found at: https://fightdementia.org.au/sites/default/files/NATIONAL/documents/Dementia-and-your-legal-rights.pdf

Module 2 Standard 2 Criterion QI2.2: Safe and quality use of medicines

Many older people with mild cognitive impairment and dementia will also have other health conditions, often several chronic conditions, and multiple medications may be prescribed. The standards are inadequate in relation to the role of the GP in supporting medication adherence by patients: they simply suggest (not require) that practitioners include evidence in patient records that clinical team members have informed patients of their own responsibility to comply with treatment plans; and that practitioners explain the diagnosis and treatment plan in an understandable, unrushed manner. **The standards should require practitioners to demonstrate that they have taken appropriate measures to support medication adherence particularly in the case of older patients with mild cognitive impairment and dementia who are prescribed multiple medications.**

It is noted that the standards refer to the need for practitioners to "regularly review the list of a patient's current medications to ensure that the list is up-to-date and that errors are not made when prescribing or referring". This is strongly supported, as regular medication review is particularly important for patients who are prescribed multiple medications, including those with dementia, to avoid unwanted drug interactions and to ensure that patients using medications such as antipsychotics are well monitored. We also recommend that the Standards encourage the documentation and review of both pharmacological and non-pharmacological interventions, especially for people with a diagnosis of dementia.

Module 3 Standard 1: Comprehensive care

The preamble to this Standard notes that the scope of general practice spans prevention and health promotion, as well as early intervention and management, with a whole of practice population approach taken. However, there is no reference to health promotion and preventive activities in the criteria and indicators that follow. As with other chronic diseases, risk factor reduction is critical in the case of dementia in the context of both prevention and early intervention. Research over the last decade has shown that addressing behavioural and related clinical risk factors can help to reduce a person's risk of dementia. Up to a third of cases of Alzheimer's disease are potentially attributable to preventable risk factors. It is estimated that a 10-25% reduction in type 2 diabetes, hypertension, obesity, depression, physical inactivity, smoking and cognitive inactivity could prevent as many as 1.1-3.0 million cases of Alzheimer's disease worldwide[3].

The standards should include criteria and indicators relating to health promotion and disease prevention, and early intervention in general practice.

Module 3 Standard 1 Criterion GP1.2: Home and other visits

[3] Barnes DE Yaffe K (2011). *The projected effect of risk factor reduction on Alzheimer's disease prevalence*

It is stated under this criterion that: “Your regular patients who are in residential aged care facilities, residential care facilities, or hospitals also need to be able to access care from your practice.” The Indicator for this criterion is: “Our patients can access home and other visits, both within and outside normal opening hours, when safe and reasonable.” Yet in terms of a practice demonstrating that they meet this criterion, there are no mandatory measures, and even full application of the optional measures would not adequately demonstrate that a practice was actually delivering home and other visits in accordance with need. **The standards should require practices to demonstrate meaningful efforts to meet the needs of their practice populations for home and residential aged care visits**.

Module 3 Standard 1 Criterion GP1.6: Engaging with other services

The explanatory text for this criterion acknowledges the importance of the practice engaging and working with other healthcare providers, and other services (including social, disability, and other services). Alzheimer’s Australia notes that for people diagnosed with dementia and their carers, referral to appropriate support services is critical. Yet Indicator A states only: “Our practice coordinates comprehensive care with other health services”; and the only mandatory measure against this Indicator is: “Demonstrate that practice staff are aware of local healthcare providers”. Both the Indicator and the measure need to be broadened to **ensure general practices routinely refer people to, and aim to coordinate the person’s care with, other non-health services (e.g. social services and other forms of support) as appropriate, in addition to other healthcare services.**

Module 3 Standard 3 Criterion GP3.1: Practice facilities

This standard should include an Indicator relating to **the importance of the general practice being accessible for people with special needs – for example those with cognitive impairment.** This goes beyond having an accessible toilet. The general practice will be more accessible for people with dementia if dementia-friendly design principles are adopted – for example, use of simple visual signage, shallow seats with arms in the waiting area, and quiet area for those who may find noise and visual stimuli disturbing. More information can be found at: http://www.enablingenvironments.com.au/.

Thank you again for the opportunity to comment, and I trust these comments are helpful in the finalisation of the draft Standards.

Yours sincerely

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