Checklist for contact of GP or RaSS

STEP	ACTION	DONE?
1	Collect **resident's medical record** and **medication chart** including: • Results of recent tests • Recent changes to medications • Substitute health decision maker contact details e.g. enduring power of attorney (EPOA) contact details • Contact details for treating GP	☐
2	Have a copy of the relevant RACF decision support tool in front of you	☐
3	Check the resident's Advance Health Directive (AHD) / Acute Resuscitation Plan (ARP) / Advance Care Plan (ACP) for documented wishes	☐
4	Undertake a full set of **vital signs** including: • Response and cognition • Airway and breathing assessment (respiratory rate and effort; oxygen saturations) • Circulation assessment (pulse and blood pressure) • Disability assessment (including blood glucose) • Temperature and pain assessment (use cognition appropriate tool)	☐
5	Pen and paper available to document any instructions	☐
6	**P**repare to discuss with GP or a RaSS in the ISBAR format **I**dentify yourself, your role and where you are calling from **S**ituation or the reason for your call and the current problem e.g. Chest pain **B**ackground including past medical history of resident and usual level of function **A**ssessment including • Vital signs • Other relevant clinical findings including any recent behavioural changes • Confirmation of resident choices • Recent medication changes • Recent investigation results **R**ecommendations arrived at in collaboration with GP or a RaSS	☐
7	If resident is to be reviewed in facility by GP or a RaSS or to be transferred to hospital – prepare documentation including copies of: • Facility name and 24 hour contact details for RN or clinical manager • Summary of reason for transfer and recent vital signs • Past medical history and baseline level of function • Recent medical notes, results of investigations • Recent changes to medications • Current (regular, prn and short-course) medication AND sign-off charts • Advance Health Directive or Acute Resuscitation Plan or Advance Care Plan • Contact details for next of kin and substitute health decision makers	☐
8	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	☐