SHPA Submission to Consultation: Department of Health and Aged Care – Aged care pharmacist in residential aged care, September 2022

List of SHPA Recommendations on the Aged care on-site pharmacist measure

Funding model for employment of on-site pharmacists

Recommendation 1: Primary Health Networks in partnership with pharmacy professional organisations, should be funded to coordinate the aged care on-site pharmacist measure, and working within existing aged care governance structures, deliver quality geriatric medicine pharmacy services in residential aged care homes.

Recommendation 2: Hospital pharmacy departments should be eligible to be service providers for the aged care on-site pharmacist measure.

Theme 1: Developing and defining the role of the on-site pharmacist

Recommendation 3: Clinical services delivered by aged care on-site pharmacists, including their key role requirements and responsibilities, must be required to meet the best-practice geriatric medicine clinical pharmacy services in residential aged care settings as defined by SHPA's *Standard of Practice in Geriatric Medicine for Pharmacy Services*.

Recommendation 4: Aged care on-site pharmacists should be integrated into residential aged care multidisciplinary teams, collaborating with doctors, nurses, allied health professionals and aged care workers, to provide direct patient care.

Recommendation 5: Aged care on-site pharmacists should be responsible for and be supported in providing robust clinical governance of aged care pharmacy services.

Recommendation 6: Career progression and development opportunities, including enrolment in SHPA's *Advanced Training Residency in Geriatric Medicine*, should be offered to support a sustainable aged care pharmacist workforce.

Recommendation 7: **Funding should be provided to peak pharmacy bodies such as SHPA, to develop training, continuing professional development, and support services for pharmacists including mentoring and networking opportunities, to encourage uptake of the aged care on-site pharmacist role.**

Theme 2: Training requirements for pharmacists

Recommendation 8: **Aged care on-site pharmacists should be credentialled to participate in this program, which can recognise a broad range of relevant training and experience in the delivery of geriatric medicine and aged care clinical pharmacy services to expand the aged care workforce and utilise the skillset of all who are equipped to provide a high-quality service.**

Recommendation 9: **SHPA's *Essentials of Residential Aged Care Pharmacy* self-paced online training course, adapted from its highly regarded *Foundation Seminar in Geriatric Medicine*, should be a recognised course that meets training requirements for aged care on-site pharmacists.**

Theme 3: Development of health outcome indicators and associated reporting

Recommendation 10: **Outcomes measured should have a patient safety and satisfaction focus, and data collected reported back to relevant professionals in a meaningful way to drive behaviour change.**

If you have any queries or would like further information about SHPA's submission, please contact Jerry Yik, Head of Policy and Advocacy at jyik@shpa.org.au

Funding model for employment of on-site pharmacists	
Question	**Response**
1. Do you believe funding should be provided directly to residential aged care homes or coordinated through Primary Health Networks (PHNs)? Why is this your recommended funding model?	**Recommendation 1: Primary Health Networks in partnership with pharmacy professional organisations, should be funded to coordinate the aged care on-site pharmacist measure, and working within existing aged care governance structures, deliver quality geriatric medicine pharmacy services in residential aged care homes.** The Society of Hospital Pharmacists of Australia is the national professional organisation for more than 6,100 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is committed to facilitating the safe and effective use of medications, which is the core business of pharmacists, especially in hospitals. Our submission is informed by our Geriatric Medicine, and Transitions of Care and Primary Care Specialty Practice Leadership Committee members who practise in various settings, providing inpatient, outpatient and outreach care to older Australians in hospitals and in residential aged care homes nationally. Between the two options provided, in principle, SHPA supports the funding for an aged care on-site pharmacist to be coordinated through the Primary Health Networks (PHNs). SHPA members believe it is important to have a central body who can coordinate the implementation of the program to ensure greater transparency, consistency, and appropriate governance across all residential aged care homes in their catchment. SHPA also would like to acknowledge that under the Multi-Purpose Services (MPS) Program, several residential aged care homes fall under the governance of state-funded Local Health Networks which address the unique challenges to residential aged care delivery in these areas, whether it be due to geography, workforce maldistribution or other reasons, and flexibility should be facilitated for these arrangements to continue. SHPA strongly believes however, that it is essential to also establish consistency and equity of service delivery to older Australians living in residential aged care homes across the country. To achieve this, SHPA recommends that there is an overarching governance structure to oversee the program implementation across all PHNs. Consideration should also be given to where this work fits in with existing governance

	structures for aged care, such as the Aged Care Quality and Safety Commission (ACQSC), Aged Care Quality Standards, and the expansion of Independent Hospital Pricing Authority (IHPA) to include aged care. Centralising the delivery of the aged care on-site pharmacist measure through the PHNs means that the service provider they contract is likely to engage an appropriate number of suitably trained pharmacists to support a range of residential aged care homes in their local catchment. In this model, the service provider will be able to appropriately distribute resources across multiple residential aged care homes, including those in rural and remote locations, providing equity of health care to older Australians living in those settings. Residential aged care homes in rural and remote locations may otherwise struggle to engage an aged care on-site pharmacist to support their service. SHPA recommends that the service provider contracted by the PHNs endeavors to have a regular aged care on-site pharmacist attend each residential aged care home, to support a robust integration of the pharmacist into the existing care teams. Roster changes may however be required to accommodate pharmacist leave, ensuring all residential aged care homes are being serviced by an on-site pharmacist at all times, even if their regular pharmacist is unavailable. SHPA also recommends a degree of flexibility in the use of virtual/telehealth pharmacy services to support residential aged care facilities in activities that can be conducted remotely. This of course does not replace a face-to-face, on-site service, but assists in delivering a comprehensive service to each residential aged care home. In the proposed model where pharmacists can service up to 250 residents, pharmacists are likely to be practising across multiple sites, thus a virtual service may be needed to support sites the pharmacist is not present at in cases where urgent care is required. This is even more crucial for some regional and remote locations with a handful of aged care beds, pharmacists should still be able to tend to their needs on the days when they are not on-site. SHPA does however wish to highlight that the 1:250 pharmacist-to-resident ratio exceeds that which is recommended in *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1) and we would like to express our concern that the large volume of patients will impact on the pharmacist's ability to provide a comprehensive clinical pharmacy service to each resident. It is also worth noting that many residents now living in residential aged care homes are highly complex patients and their level of care is bordering on sub-acute in terms of their clinical needs. According to *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1), the

	ideal geriatric medicine pharmacy service requires the following evidence-based, full-time equivalent, non-dispensing Geriatric Medicine Pharmacist-to-bed staffing ratios: 1:20 in acute aged care, 1:30 in subacute aged care, 1:200 in long-term residential aged care, 1:40 in residential Transition Care Programs and 1:20 in respite care. Fundamentally, the key factor that will underpin the success of this program, lies with the PHN's choice of service providers. Service providers must have a strong clinical governance framework to ensure residents receive safe and high-quality clinical pharmacy services and must provide adequate support to the pharmacists practising in these homes. Service providers must demonstrate compliance with sector standards including *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1), and the Aged Care Quality Standards, this includes having robust clinical governance structures. **Recommendation 2: Hospital pharmacy departments should be eligible to be service providers for the aged care on-site pharmacist measure.** SHPA strongly advocates for public and private hospital pharmacy departments to be eligible to provide the aged care on-site pharmacist service to residential aged care homes through their respective PHNs, noting that they are currently excluded from the provision of the Residential Medication Management Review (RMMR) and Quality Use of Medicines (QUM) programs funded under the Seventh Community Pharmacy Agreement (7CPA). The inclusion of hospital pharmacy departments will also assist with ensuring there is a sufficient aged care pharmacist workforce, given both community pharmacy and hospital pharmacy sectors are currently experiencing workforce shortages. An additional benefit of enabling hospital pharmacy departments to become service providers is that this would allow aged care on-site pharmacists to work within a team of pharmacists, providing aged care services or geriatric medicine services in their department. This reduces the professional isolation that occurs in various pharmacy sectors, contributing to stress and burnout, and presenting a grave risk to workforce sustainability. On-site aged care pharmacists who are a part of a hospital pharmacy department will also have the greatest number of options for career progression and development compared to other pharmacy sectors, thus again mitigating risks to workforce sustainability.

	Hospital pharmacy departments have strong clinical governance structures in place and are mandatorily accredited to the *National Safety and Quality Health Service (NSQHS) Standards* for services they provide both inside and outside of the hospital, ensuring a high-quality service is being provided. Hospital pharmacy departments also have pharmacists in all roles, working in teams with team leaders and a network of senior pharmacists to support them in their practice. This contrasts with non-mandatory accreditation arrangements for health services in the primary care sector. SHPA sets the standard of pharmacy care in hospitals through its highly regarded *Standards of Practice* series that is widely utilised and well-referenced by pharmacists and health professionals seeking guidance on the delivery of clinical, operational and specialty hospital pharmacy services. SHPA should be funded to provide further guidance on the clinical governance of the aged care on-site pharmacist measure, training to upskill pharmacists moving into these roles, and mentorship opportunities via SHPA's Specialty Practice framework to connect aged care on-site pharmacists with an online community of peers and leaders in the field.
Theme 1: Developing and defining the role of the on-site pharmacist	
Question	**Response**
2. What do you see as the key role and responsibilities for an on-site pharmacist in residential aged care homes? Please consider the role in relation to the Medicines Advisory Committee/residential aged care home clinical governance.	**Recommendation 3: Clinical services delivered by aged care on-site pharmacists, including their key role requirements and responsibilities, must be required to meet the best-practice geriatric medicine clinical pharmacy services in residential aged care settings as defined by SHPA's *Standard of Practice in Geriatric Medicine for Pharmacy Services*.** **Recommendation 4: Aged care on-site pharmacists should be integrated into residential aged care multidisciplinary teams, collaborating with doctors, nurses, allied health professionals and aged care workers, to provide direct patient care.** Aged care on-site pharmacists will work in collaboration with doctors and nurses to provide direct patient care as well as to support high-quality clinical governance. Pharmacists practising in these roles will work with multidisciplinary teams to ensure that treatment is rational, safe, cost-effective, aligned with the person's

healthcare goals and preferences, and manageable without excessive treatment burden.

Hospital pharmacists regularly provide geriatric medicine pharmacy services to optimise medication management and improve medication-related outcomes for older people in hospitals, residential aged care and ambulatory settings, and during transitions of care between settings. Their roles and responsibilities are outlined in Table 1 of *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1), a summary of which is included below.

SHPA strongly recommends that *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1) is adopted by all bodies involved in the regulation and the delivery of the aged care on-site pharmacist measure in residential aged care homes, including ACQSC, PHNs, service providers, and residential aged care homes, and that achieving the Standard is integrated into all clinical governance structures. *SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services*[1] (Attachment 1) remains the only national standard of practice in Australia which describes comprehensively, the best practice pharmacy services patients in residential aged care should be receiving.

The aged care on-site pharmacist roles and responsibilities should also align with the *Guiding principles for medication management in residential aged care facilities* and the *Guiding principles to achieve continuity in medication management,* which promote safe, quality use of medicines and medication management in residential aged care homes and during transitions of care.

Table 1: Best-practice geriatric medicine clinical pharmacy services for residential aged care homes
(Adapted from SHPA's Standard of Practice in Geriatric Medicine for Pharmacy Services[1])

Type of care*	**Frequency****
Patient-focused activities	
Medication history and reconciliation on admission to the facility.	Within 48 hours of admission
Medication chart review	Monthly for stable residents Fortnightly for complex cases Weekly for acute cases

Clinical review of new or changed high risk medication orders	Within 48 hours of changes
Comprehensive interdisciplinary medication review	Within one week of admission and repeated at intervals determined by clinical need (not less than yearly and within one week of returning from an unplanned hospital admission)
Monitoring and review of deprescribing plan and outcomes	Regularly until deprescribing complete. Frequency is dependent on medication being deprescribed.
Multidisciplinary ward round participation	Weekly
Multidisciplinary team meeting/case conference participation	Weekly
Provision of information to patients and/or carers about medication changes	Within 48 hours of changes to high-risk medications and at next review for other medications
Assessment of older persons' ability to self-administer medications	Upon admission if resident wishes to self-administer medications (repeated if there is a significant change in clinical status or medication regimen)
Self-administration of medicines program	Upon admission if resident wishes to self-administer medications
Assessment of older persons' ability to take prescribed medications e.g., ability to swallow, lung power	Upon admission if resident wishes to self-administer medications (repeated if there is a significant change in clinical status or medication regimen)
Medication reconciliation after any care transitions	Within 48 hours of return to residential aged care home
Health service-focused activities	
Provision of medication information to prescribers, nurses and care workers	Whenever necessary or within 24 hours of request
Participation in Medication Advisory	Regularly

Committees	
Quality Use of Medicines activities (e.g. audits, quality improvement activities, stewardship activities, staff education)	Regularly
Contributing to medicines policy and procedure development	Regularly
Participation in team meetings related to medication management e.g., falls meetings, high-risk patient meetings, etc.	Regularly
**These activities are to be conducted per facility.* ***This is a rough guide – frequency is dependent on number of beds, acuity of patients, and aged care home needs.*	

Consideration should be given to how an aged care on-site pharmacist who is likely to be practising across multiple facilities given the 1:250 pharmacist-to-resident ratio, will be 'readily available' to aged care staff and residents as proposed in the consultation paper. A hybrid model of on-site and virtual/telehealth services may need to be considered, along with a more realistic pharmacist to bed ratio in order for the aged care pharmacist to be readily available and able to provide a comprehensive clinical pharmacy service.

Recommendation 5: Aged care on-site pharmacists should be responsible for and be supported in providing robust clinical governance of aged care pharmacy services.

SHPA believes that aged care on-site pharmacists should not only attend Medication Advisory Committees (MACs) but should drive the work of the committee in supporting the safe and effective management of medications and the quality use of medicines in the facility. The aged care on-site pharmacist should seek to reorientate the MAC's focus on the overarching quality and process measures surrounding the use of medications in the facility, rather than simply outputs, and should lead quality use of medicines activities in the facility. These activities include education for other health professionals and residents/carers, audits, a range of stewardship activities (analgesic, antipsychotic, anticholinergic, anticoagulant and antimicrobial),

	development of policies and procedures, and meeting medication management accreditation standards. Aged care on-site pharmacists should also play a significant role in educating and supporting the staff at their residential aged care facility to adjust to the use of the electronic National Residential Medication Chart (eNRMC) if this is newly adopted to access funding for an on-site pharmacist. The eNRMC will be a positive step towards improving the timely order and review of medications, and reducing medication transcription errors especially during transitions of care.
3. How could residential aged care homes or Primary Health Networks be supported in engagement of pharmacists to work in aged care homes? Do you have a suggested approach to engaging pharmacists in rural and more remote locations to work on-site in residential aged care homes under this measure?	**Recommendation 2: Hospital pharmacy departments should be eligible to be service providers for the aged care on-site pharmacist measure.** PHNs are likely to commission a service provider to engage pharmacists to work in residential aged care homes. SHPA strongly recommends that a wide range of service providers are eligible to apply for this contract, including public and private hospital pharmacy departments. Broadening the eligibility criteria for service providers increases the competition, which in turn improves the quality of services being contracted. It also increases the pool of resources which is essential at a time where there are significant sector workforce shortages. It is highly encouraged that PHNs ensure that service providers engaged to recruit pharmacists to these roles, provide them with appropriate remuneration to attract suitably trained and experienced pharmacists, capable of delivering a high-quality service to older Australians, whose use of medications are often complex. Current service models for the provision of medication management reviews (HMRs or RMMRs) have discouraged accredited pharmacists from participating due to insufficient remuneration. Public and private hospital pharmacy departments are well placed to support PHNs in the delivery of this measure and should not be excluded from the eligibility criteria on the basis of them being state and territory funded entities. The MPS Program combining funding of aged care services from the Australian Government with state and territory health services, sets a precedent for the transfer of funds between the Commonwealth and States and Territories. Therefore, hospital pharmacy departments should be eligible to tender as a service provider for the aged care on-site pharmacist measure. In particular, this model is beneficial in rural and remote locations where the public or private hospital may be the sole health service in the area or may be servicing the co-located aged care beds as is the case in MPS

	program. Nursing staff employed by the hospital are shared between the acute and aged care beds, eliminating the need to source additional nursing staff to attend to the aged care residents. Similarly, the hospital pharmacy departments could provide clinical services to the residential aged care home in the region without placing an unnecessary burden on an already stretched workforce. However, even in metropolitan areas, hospital pharmacy departments are best placed to provide clinical pharmacy services to residential aged care homes. Hospital pharmacy departments are accredited to the *National Safety and Quality Health Service (NSQHS) Standards* for services they provide both inside and outside of the hospital. This guarantees that a high level of quality care and clinical governance is expected and provided at all times. Hospital pharmacy departments also have a hierarchical structure in place to support less experienced pharmacists, equivalent to grade two as suggested in the consultation paper. Professional isolation when working with complex patients such as in aged care, can be challenging. Hospital pharmacists have team leaders and a network of senior pharmacists to support them in their practice. They also have access to pharmacy department resources and professional development opportunities. Integration between hospital pharmacy departments and residential aged care homes means pharmacists can easily move between the two settings, either in a formal rotational manner or on an adhoc basis, creating more career growth opportunities and an expanded aged care workforce. Many major metropolitan hospital pharmacy departments have pre-existing frameworks and structures in place to provide dedicated geriatric medicine pharmacy services in acute and sub-acute care settings (i.e. Austin Health, Alfred Health, Sir Charles Gairdner Hospital, Gosford Hospital). Some examples of these services are listed below: *Queensland Residential Aged Care Facility Support Services (RaSS)* The Queensland Health funded RaSS are a partnership between GPs, residential aged care homes, hospital and health services, and community service providers. RaSS health professionals, including the RaSS Pharmacist, provide acute care services to residents of residential aged care homes, in the most appropriate location.[2] *Hospital outreach medication review (HOMR) services* Hospital-led outreach medication review services are currently provided by some major metropolitan public

	hospitals in Victoria (i.e. Monash Health, Austin Health, Alfred Health and Western Health through the Community Outreach component of their Immediate Response Service). Certain hospitals in Western Australia also run a HOMR program known as Complex Needs Coordination Team (CoNeCT) Pharmacy, which provides a metropolitan-wide post-discharge service on referral for complex patients considered at high-risk of medication misadventure and who are unable to access timely community pharmacy services.[3] *Better at Home* Better at Home[4] is a home-based rehabilitation program delivered at Alfred Health in Victoria, modelled on an inpatient subacute ward. It offers an alternative approach to delivering inpatient care and treatment to people within their own homes. A wide range of clinical services are provided through this program including medication reviews and management. *Geriatric Evaluation and Management at home (GEM@Home) services* GEM@Home services aim to provide care for older people who would otherwise be admitted to hospital and to people who are transitioning home after a hospital presentation. The GEM@Home program is delivered by an interdisciplinary team, including a clinical pharmacist, and is led by a consultant geriatrician.[5] *Mobile Assessment and Treatment Service (MATS) geriatric care team model* At Alfred Health in Victoria, MATS operates within the Hospital Admission Risk Program and provides care for frail, elderly people living in nursing homes and in the community. Clinical pharmacists are embedded into the MATS team structure to reduce the polypharmacy burden on older people in their care and optimise medication safety, particularly on transitions of care.
4. How could this relatively new role be promoted to pharmacists to encourage uptake?	**Recommendation 6: Career progression and development opportunities, including enrolment in SHPA's *Advanced Training Residency in Geriatric Medicine*, should be offered to support a sustainable aged care pharmacist workforce.** Career progression is an essential element when promoting the aged care on-site pharmacist position. The equivalent of a grade two hospital pharmacist, as described in the consultation paper, may be interested in a position like this if it was promoted with a clear career pathway. This may include enrolment into *SHPA's Advanced Training Residency in Geriatric Medicine*, a two-year structured workplace training program

	supporting pharmacists in advancing their professional practice towards Advancing – Stage II (Consolidation Level) performance of the *National Competency Standards Framework for Pharmacists in Australia 2016*. It may also include upskilling to a 'team leader' or 'equivalent grade three' role. Please see attached the *Practice Area Framework and Knowledge Guide – Geriatric Medicine Advanced Training Residency* (Attachment 2) for more information on *SHPA's Advanced Training Residency in Geriatric Medicine*. Offering attractive remuneration is also essential when promoting the aged care on-site pharmacist role. Specialised pharmacists whom we hope to attract to these positions, expect to be well remunerated for their expertise. It is therefore essential that PHNs ensure that service providers engaged to recruit pharmacists to these roles, provide them with appropriate remuneration to attract suitably trained and experienced pharmacists capable of delivering a high-quality service to older Australians. SHPA would like to note that the remuneration for a grade 2 pharmacist is varied across different states therefore, the remuneration of an aged care on-site pharmacist needs to be redefined to ensure standardisation across the country. In addition to remuneration, an allowance should be offered to pharmacists servicing residential aged care homes in rural and remote locations. Promoting the aged care on-site pharmacist as part of a team of pharmacists is another way to encourage uptake. An equivalent of a grade two pharmacist in hospital should not be practising in isolation, especially with highly complex patient groups such as those in residential aged care homes. Professional isolation in these instances can be quite stressful, causing burnout and resulting in pharmacists exiting the workforce. Grade two pharmacists must be supported by a team of pharmacists working in a similar environment, and supervised by a more senior team leader. More and more, pharmacists are now seeking roles that offer flexibility in hours and hybrid models of work to support a more balanced work and family lifestyle. Roles such as the aged care on-site pharmacist are well suited to offer this flexibility given the more administrative components of the role can be done from home and do not necessarily need to be completed during traditional working hours. This does not detract from the need for there to be an on-site clinical pharmacy service, it simply complements this, supporting a more comprehensive service delivery. Professional bodies such as SHPA, can support the uptake of the aged care on-site pharmacist role by providing specialised Government funded training packages, and ongoing professional development courses. SHPA's Specialty Practice framework could also be utilised to promote these roles to members in

	our Geriatric Medicine, and Transitions of Care and Primary Care streams who have already expressed interest in this area of practice. SHPA also has the structure in place to provide support to members practising in residential aged care homes by creating a stream where they can form a network to support practice on the ground. Finally, pharmacy schools should be encouraged to incorporate core knowledge and skills necessary to delivering an aged care on-site clinical pharmacy service, in their courses. This includes placements in residential aged care homes to raise awareness of this new career pathway for pharmacists and spark the interest of students. Ideally, all pharmacy graduates in the future will be equipped to deliver high-quality geriatric medicine clinical pharmacy services, which will in turn increase the capacity of the workforce to support this measure.
5. How can on-site pharmacists best collaborate with the aged care health care teams (including residents and their families, other staff, the local general practitioner and pharmacy) in regard to transitioning between health care settings?	In the first instance, it is essential that the aged care on-site pharmacist builds rapport with the aged care healthcare teams. This will be more achievable when working on-site and integrating into daily residential aged care home activities. The pharmacist will need to adopt a proactive approach to ensure a robust integration. Establishing structured protocols for admissions, transitions of care, and discharges will be an essential part of the aged care on-site pharmacist role. It will also be imperative to educate aged care healthcare teams on these protocols, so they are aware of the expected communication methods and timeframes. As discussed in SHPA's position statement on *Geriatric Medicine and Aged Care Clinical Pharmacy Services*[6], the universal use of Interim Medication Administration Charts (IMACs) is required to support safe transitions of care between residential aged care and hospital settings, and the aged care on-site pharmacist is well placed to support the use of IMACs in residential aged care homes during transitions of care. An IMAC is a document that is populated with the patient's details and discharge medication information, usually completed and signed by the hospital pharmacist, and sent with the patient to the residential aged care home. This enables medications to be safely administered immediately after arrival at the facility, while waiting for a general practitioner to prepare a long-term care medication chart, which can sometimes be delayed by up to seven days. The IMAC is particularly important given patients undergo numerous changes to their medicines during an inpatient stay, and must continue their new medication regimen after discharge into a residential aged care setting.

	The aged care on-site pharmacist's role will be to directly liaise with the hospital pharmacist who created the IMAC to ensure a smooth transition of care and ensure the resident transitioning back to the aged care facility will be able to take their new or changed medicines, and overall facilitate the uptake of IMACs and support aged care workers involved in medicines administration to use IMACs. The handover of care using the IMAC will also prompt discussions between the aged care on-site pharmacist and hospital pharmacist to facilitate appropriate, timely and efficient medication supply. This will also assist to reduce medication-related out-of-pocket costs for aged care residents and minimise medication wastage, which currently frequently occurs at the transitions of care with medicines supplied by hospitals discarded in pharmaceutical waste bins, only to be resupplied by the community pharmacy. Hospital pharmacists are well versed in collaborating with patients, family, aged care staff, community pharmacists, and local general practitioners when patients are transitioned between health care settings, ensuring all necessary information in handed over in an accurate and timely manner. The aged care on-site pharmacist should aim to support the transition of care process by reviewing the patient's medications, ensuring they are correctly and safely taking or receiving their medications as per hospital discharge medication information, and that the intended weaning or cessation of medications post-discharge occurs in a safe and timely manner.
6. How should continuing professional development, mentoring and networking for on-site pharmacists be supported and maintained?	**Recommendation 7: Funding should be provided to peak pharmacy bodies such as SHPA, to develop training, continued professional development, and support services for pharmacists including mentoring and networking opportunities, to encourage uptake of the aged care on-site pharmacist role.** SHPA is renowned for its high quality, current clinical education offering with diverse content and delivery modes including, online professional development, seminars, webinars, symposiums, and its Journal of Pharmacy Practice and Research (JPPR). SHPA hosts the largest scientific pharmacy conference in Australia each year, *Medicines Management, the annual SHPA National Conference,* bringing together over 1,000 leading pharmacists each day from all areas of practice to shape the future of medicines management and patient care. SHPA also offers a Foundation Residency Program, and Advanced Training Residencies, which are formal, structured experiential learning program for pharmacists, consolidating initial education

	and training whilst progressing the early career practitioner towards advanced practice. SHPA Residencies are available to pharmacists practicing in all settings. As mentioned above, SHPA's well established Specialty Practice framework with 31 specialties, provides a supportive networking environment, connecting members practising in similar specialties around the country. Belonging to an online community of peers and leaders in the field, who share their knowledge through discussion forums and online resources, pharmacists and their practice are supported by reliable and timely information. SHPA's Specialty Practice continues to grow to accommodate new and advancing areas of practice and support pharmacists in these settings.
Theme 2: Training requirements for pharmacists	
Question	**Response**
7. What training currently exists that could be adapted to meet training requirements? Can existing training be upscaled if required?	**Recommendation 8: Aged care on-site pharmacists should be credentialled to participate in this program, which can recognise a broad range of relevant training and experience in the delivery of geriatric medicine and aged care clinical pharmacy services to expand the aged care workforce and utilise the skillset of all who are equipped to provide a high-quality service.** SHPA believes it is essential to credential aged care on-site pharmacists to ensure adequately trained and experienced pharmacists to work in residential aged care homes, with older Australians who are often on complex medication regimens. SHPA is one of two accreditation bodies who are able to accredit pharmacists to undertake Home Medicines Reviews and Residential Medication Management Reviews and is well placed to credential aged care on-site pharmacists. Criteria which aged care on-site pharmacists could satisfy to achieve credentialling, which also offers pathways for recognition of prior learning and professional experience, are: ▪ Be an accredited pharmacist; or ▪ Complete SHPA's Foundation Residency with an aged care rotation; or ▪ Complete an SHPA's Advanced Training Residency in Geriatric Medicine; or ▪ Have minimum three years' post-registration experience in a hospital pharmacy department primarily providing clinical pharmacy services to geriatric patients; or

	▪ Have minimum three years' post-registration experience primarily providing pharmacy care to geriatric patients in the community; or ▪ Complete SHPA's *Essentials of Residential Aged Care Pharmacy* self-paced online training course and have practised as a pharmacist for minimum two years post-registration. Limiting the training to the Accredited Pharmacist course will severely impact the number of pharmacists ready to step into these roles, and will eliminate many hospital pharmacists, a significant portion of the workforce who are highly skilled and some even specialised in geriatric medicine. Older Australians in residential aged care homes deserve to be provided quality clinical pharmacy care by those who are best placed to do so, this may mean a variety of training and experience should be recognised when recruiting to these roles. **Recommendation 9: SHPA's *Essential of Residential Aged Care Pharmacy* self-paced online training course, adapted from its highly regarded *Foundation Seminar in Geriatric Medicine*, should be a recognised course that meets training requirements for aged care on-site pharmacists.** SHPA's *Essentials of Residential Aged Care Pharmacy* self-paced online training course, adapted from its highly regarded *Foundation Seminar in Geriatric Medicine*, meets training requirements for aged care on-site pharmacists and includes content on fundamentals of aged care pharmacy, clinical fundamentals, and clinical governance and quality use of medicine principles.
8. What should be the model/provider of national oversight of the training to ensure the ongoing quality of the training, consistency of training across all training providers and maintenance of	Current arrangements regarding the accreditation of pharmacist training and continuing professional development via the Australian Pharmacy Council's (APC) *Accreditation Standards for Continuing Professional Development Activities* should be maintained for continuing professional development for aged care pharmacists. SHPA is one of four Accredited CPD accrediting organisations in Australia. With respect to SHPA's Advanced Training Residency in Geriatric Medicine, SHPA is the accreditor of health services and sites that are able to provide this program, and should be funded to do so alongside the implementation and offering of Advanced Training Residency in Geriatric Medicine to on-site aged care pharmacists. Maintenance of currency of knowledge once training is completed is suitably achieved by current Pharmacy

currency of knowledge once training is completed?	Board of Australia requirements on CPD, where a pharmacist's CPD activities need to be within scope of their practice.
9. How would accredited pharmacists make the transition into the role of an on-site pharmacist in a residential aged care home?	Accredited pharmacists with recent hospital pharmacy experience should be able to step into the aged care on-site pharmacist role without further training. However, accredited pharmacists who have not practised in hospital settings should consider completing SHPA's *Essentials of Residential Aged Care Pharmacy* course to ensure they are well equipped with the skills necessary to provide appropriate clinical governance on the use of medications in the facility, and to effectively lead/support MACs.
Theme 3: Development of health outcome indicators and associated reporting	
Question	**Response**
10. What outcome indicators should be included in addition to the Aged Care Quality Indicators for medication management, e.g. specific indicators on inappropriate antimicrobial use, anticholinergic load	Outcome indicators that should be considered in addition to the Aged Care Quality Indicators for medication management, include: ▪ Medication-related emergency department presentations and hospital admissions/readmissions ▪ Medication-related falls ▪ Inclusion of and enforcement of cessation dates for high-risk medicines including but not limited to: antipsychotics, opioid medications, benzodiazepines, short course antibiotics ▪ Clear indications for use for each medicine recorded, especially for high-risk medicines ▪ Polypharmacy ▪ Dose review in relation to renal and hepatic function ▪ Collaboration with aged care teams

reduction?	▪ Input and involvement in MACs ▪ Resident consent where appropriate **Recommendation 10: Outcomes measured should have a patient safety and satisfaction focus, and data collected reported back to relevant professionals in a meaningful way to drive behaviour change.** Fundamentally, outcome indicators measured should give a clear picture as to whether the aged care on-site pharmacist's interventions are reducing harms and increasing quality of care for the individual resident, in line with their needs and satisfaction, and that of their carers. The individual patient must be at the centre of all decisions made and care provided, and outcomes should be framed to measure the patient's safety, satisfaction, and quality of life. The purpose of measuring each outcome indicator, and how the data collected will be used, must be clearly outlined so as not to risk collecting data that will not be useful in impacting on change. Outcome indicators are important in monitoring quality of care however, caution must be exercised to ensure they are not used as blunt instruments, but rather holistically in view of behaviours we want changed. For example, a degree of polypharmacy may be necessary when treating complex patients therefore, medication usage should be monitored in line with best practice guidelines to assess appropriate use rather than overall use. It is also essential that data gathered should be reported back to prescribers in a meaningful way that can be used to drive change in behaviour. Outcome indicators reported should be gathered in a streamlined and automatic manner, where possible, so as not to be too time consuming and burdensome on staff, taking away time best spent on patient care. It is also essential that data is only collected once, i.e., if certain information is already available through other platforms e.g., Pharmaceutical Benefits Scheme usage etc., then there is no need for additional reporting. Finally, it is important to recognise that most pharmacist interventions are only useful if the GP actions the changes suggested therefore, outcomes reported must be viewed with this understanding. Measures must be put in place that support GPs to provide a comprehensive clinical service to residential aged care residents and hold them accountable to review and action pharmacist recommendations where appropriate. Without GPs having the time and willingness to do this, the aged care on-site pharmacist role will be extremely limited in the value it can provide.

11. Are there any barriers to the on-site pharmacist working with the Medicines Advisory Committee, and if so, how can they be addressed?	As mentioned above, aged care on-site pharmacists working across multiple homes may find it difficult to provide a comprehensive service to each facility given the distance between each and competing priorities. These may be barriers to the on-site pharmacist working with the MACs across various homes. A higher pharmacist to bed ratio, along with an element of flexibility to deliver administrative components of the work via virtual/telehealth services, would support aged care pharmacists in better collaborating with MACs across the homes in which they practice.
Theme 4: Transition from services funded under the Seventh Community Pharmacy Agreement Pharmacy Programs	
Question	**Response**
12. What support will residential aged care homes require with this transition, in addition to the on-site pharmacist?	Residential aged care homes may need support in implementing the eNRMC to be eligible to access funding for an aged care on-site pharmacist.
13. What is the optimum period of time required for this transition, i.e. how long do you think the Residential Medication Management Review and Quality Use of Medicines Program services funded under the 7CPA Pharmacy Programs should continue at residential	Once an aged care on-site pharmacist is engaged, approximately four weeks might be required to allow time for the completion or suitable handing over of any outstanding RMMRs and medication management plans, and to allow time for orientation and integration of the on-site pharmacist with the current residential aged care home teams.

aged care facilities that have engaged an on-site pharmacist?	
Do you have any other comments or feedback?	

Attachments

1. *Standard of Practice in Geriatric Medicine for Pharmacy Services*
2. *Practice Area Framework and Knowledge Guide – Geriatric Medicine Advanced Training Residency*

References

[1] Elliott RA, Chan A, Godbole G, Hendrix I, Pont LG, Sfetcopoulos D, et al. Standard of Practice in Geriatric Medicine for Pharmacy Services. Journal of Pharmacy Practice and Research. 2020;50(1):82-97.
[2] Burkett E, Bandiera D, Donovan R, Cranitch E, Nash T, Ward T. Implementation tool-kit for \ Residential Aged Care Support Services (RaSS). CARE-PACT and Healthcare Improvement Unit, Queensland Health, Brisbane, 2019.
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