The Society of Hospital Pharmacists of Australia (SHPA) response to Improving medication management in residential aged care (VIC) via survey, August 2022

1. **Please select the most applicable group you are representing when responding to this survey.**

   Aged Care Stakeholder – Professional Organisation

2. **Where do you obtain information and knowledge of residential aged care facilities (RACF) including workforce, medication management, and/or resident care?**

   Information regarding the RACF workforce is obtained through Australian Institute of Health and Welfare reports. Practices regarding medication management knowledge is gained through perspectives of SHPA members in our Geriatric Medicine and Transitions of Care and Primary Care Speciality Practice Groups.

3. **From your perspective, what are the current constraints and challenges within the current medication legislation that impacts residential aged care facilities?**

   Medication administration delays and errors are common when patients transition between healthcare services. Patients discharged to RACFs are prescribed an average of 11 medications of which 7 are new or were modified during hospitalisation.[1] Up to 23% of these patients experience delays or errors in medication administration after discharge from hospital to a RACF.[1] Unplanned hospital readmissions have been reported as a result of failure to receive prescribed medications after transfer to an RACF.[2]

   One of the key recommendations outlined in the Society of Hospital Pharmacists of Australia's (SHPA) Geriatric Medicine and Aged Care Clinical Pharmacy Services Position Statement[3], is the universal use of use of Interim Medication Administration Charts for all transitions of care between hospitals and aged care setting.

   An Interim Medication Administration Chart is a document that is populated with the patient's details and discharge medication information, usually completed and signed by the hospital pharmacist at the discharging hospital and sent with the patient to the RACF. This enables medications to be safely administered immediately after arrival at the RACF, while waiting for a general practitioner (GP) to prepare a long-term care medication chart, which can sometimes be delayed.

   The use of Interim Medication Administration Charts has been demonstrated to reduce missed or delayed doses of prescribed medicines by 85.2%, with 83.6% of RACF staff reporting improved continuity of care.[4]

   'Section 36E of the DPCS Act requires that the approved provider of an aged care service must ensure a registered nurse (RN) is in place to manage the administration of prescribed (and dispensed) medications, Schedule 4, Schedule 8 and Schedule 9 drugs to residents receiving high-level residential care.'

   The current medication legislation stipulates that only *prescribed* medication may be administered which limits the widespread use of IRCMACs as they are *charted* by a pharmacist, not prescribed. SHPA proposes that wording in legislation is changed from 'prescribed' to 'charted' to allow IRCMACs to be utilised across Victoria and better support transition of residents across aged care settings.

In addition, guidance should also include the support of utilising hospital supplied medications once transferred to a RACF. This will ensure continuity of care and medication safety during transitions of care.

4. **Please rank from 1 to 8 the current constraints and challenges, with 1 being the highest priority challenge and 8 being the lowest priority challenge. To rank the current constraints and challenges, please drag and drop each constraint to the appropriate rank.**

    1. Workforce Challenges (including availability, skills, and competencies)
    2. Administration of medications
    3. Quality and safety pertaining to medication management
    4. Lack of medication management Education and Upskilling
    5. Lack of measures and precautions on Schedule 4, 8 and 9 Medications
    6. Lack of clarity of the medication management requirements
    7. Lack of guidance required about current obligations/legislation
    8. Other, please describe below

5. **Should the requirement in the *Drugs, Poisons and Controlled Substances Act* for residential aged care facilities to have a Registered Nurse in place to manage the administration of Schedule 4, 8 and 9 medications apply regardless of the level of care a resident receives?**

    Yes. A lower level of care does not necessarily indicate that a residents medication regime does not contain high risk medications.

6. **How should requirements of the Act apply to a resident who is determined to be able to self-administer their medications, with or without support?**

    As outlined in SHPA's Standard of Practice in Geriatric Medicine[5], SHPA recommends that once capacity has been assessed, residents in RACFs should be able to self-administer medicines if they wish to, through the Self-Administration of Medicines Program (SAMP).

    In residential care, when a resident wants to self-administer medicines an assessment of their capacity must be conducted. Various performance-based instruments exist to assess a person's capacity to manage their medicines. The content of these tools is variable, but most include the ability to read and explain a dispensing label, open packaging and remove a dose, orientation to time and memory recall.

    Some tools use the person's own medicines for the assessment, whereas others use a mock medicines regimen. The former may be best suited to settings in which the person's own medicines are available such as in their home. The latter may be more feasible in the hospital setting. Supervised self-administration of medicines can also be used to assess a person's ability to manage medicines.

    Self-administration of medicines programs (SAMP) involve supervised medicine self-administration to assess a person's ability to safely manage their medicines, encourage participation in their care, provide education and training in medicine-taking and identify supports required for ongoing medication management.

    People who complete a SAMP may demonstrate better medicines knowledge, better adherence and

fewer medication errors.[6] People most suitable for SAMP are medically stable with a relatively stable medicines regimen. A pharmacist should be involved in identifying and assessing patients or aged care residents for the program, organising medicine supply in the required format, providing education and monitoring outcomes.

In residential or community aged care, a SAMP should be conducted when a person wants to self-administer their medicines. A SAMP commences with an assessment to determine the suitability of the person for the program and format of medicine supply which could be in original packs or dosage administration aids and to obtain consent. Medicines are dispensed with full directions, in the format that the person will use. The person administers their medicines with direct nurse supervision. If they demonstrate correct administration over several days, the program may allow for greater independence with regular monitoring.

7. **Should the role of Registered Nurses (RN) supervising Enrolled Nurses (EN) and Personal Care Workers (PCW) supporting residents with self-administration of medication be clarified?**

   Yes. The roles should be clearly outlined and in which circumstances PCWs and ENs can administer medications.

8. **If a limitation is to remain for only residents receiving high-level care, how should high-level care be defined in residential aged care facilities?**

   No comment.

9. **Should the *Drugs, Poisons and Controlled Substances Act* require a Registered Nurse (RN) to be onsite at the residential aged care facility to manage the administration of medications at all times?**

   Yes. Oversight is required by a RN if they are to appropriately delegate medicine administration tasks to ENs or PCWs.

10. **Do you have other suggestions for how management of medication administration could be strengthened? What are the implications of your suggested changes?**

    Pharmacists annotating medication administration guidance on medication charts or educating staff about alerts on Electronic Medication Management systems could assist in strengthening the safety aspects of medication administration.

11. **What type of educational guidance would better support the management of the administration of prescribed medications in residential aged care facilities?**

    Specifying the minimum training requirements for all staff involved in medication administration would better support this.

    Pharmacists embedded in to RACFs can assist in educating staff on the appropriate medication administration requirements as well as medication handling.

12. **Should legislation require a minimum level of training and qualification for Personal Care Workers (PCW) administering medications?**

Yes. The administration of medication requires understanding of medication storage, formulation, dosage measurements as well as knowledge about medication handling. Although PCWs are not a regulated workforce, a minimum level of training and qualification should be required by legislation if RNs are to confidently delegate administration duties to PCWs.

13. Should the legislation require that medication must be administered by a Registered Nurses or Enrolled Nurse in any of the following circumstances?

Administration by RN or EN	**Yes**	**No**
All Schedule 4, 8 and 9 medications for residents who do not control or administer their own medications?	**X**	
Medications used for chemical restraint?	**X**	
Medications not in dose administration aid?		**X**
Medication that is administered on a 'as needs' basis (PRN)	**X**	
Medications considered high risk? If yes, how should this be determined?	**X** Through education and training (e.g. APINCHS medicines) as well as embedding pharmacists into RACFs who can educate and alert staff, prompts on Electronic Medication Management (EMM) systems.	
For certain residents? If yes, how should this be determined?	**X**	
Other?		

14. What would be the benefits of restricting the administration of medication?

Increasing medication safety by ensuring that only suitability trained healthcare professionals are able to administer medications.

15. What would be the implications of restricting the administration of medication?

Increased burden on nursing staff by not utilising the existing workforce, that with appropriate training, could assist in some aspects of medication administration. Restricting some administration to RNs only could also put excess pressure on RN workload and lead to medication errors.

16. Do you have any other comments, suggestions, or concerns about potential changes to the legislation?

With any change in this legislation, appropriate oversight is required to ensure that PCW and ENs receive adequate training in order to be able to administer medication to residents. Competency for medication administration, storage and handling should be re-assessed at regular intervals.

Education for all staff around the quality use of medicines can be supported by the integration of pharmacists in RACFs. In addition, they can be a valuable resource to trouble shoot medication related queries. Regular medication reviews by pharmacists can also support reducing polypharmacy and simplifying medication regimens, reducing nursing time spent administering medications.

The overuse of Dosage Administration Aids (DAA) in aged care may be due to the convenience of the RACF to allow PCWs to administer medication, rather than for the benefit of the residents. DAAs can contribute to significant medication wastage when there are medication changes as well as increasing the risk of errors due to discrepancies between DAAs and the medication charts. If only RNs and ENs can administer medication, this may reduce the use of DAAs and associated complexities.

References

[1]. Elliott R.A., Tran T., Taylor S.E., Harvey P.A., Belfrage M.K., Jennings R.J., Marriott J.L.(2012). Gaps in continuity of medication management during the transition from hospital to residential care: an obervational study (MedGap Study). Australas J Ageing 31(4): 247-54

[2] Elliott R.A., Taylor S.E., Harvey P.A., Tran T., Belfrage M.K.. (2009).Unplanned Medication-Related Hospital Readmission following transfer to a Residential Care Facility. J Pharm Pract Res); 39(3): 216-18.

[3] The Society of Hospital Pharmacists of Australia. (2021). Geriatric Medicine and Aged Care Clinical Pharmacy Services Position Statement.

[4] Elliott R.A., Taylor S.E., Harvey P.A., Belfrage M.K., Jennings R.J., Marriott J.L.(2012). Impact of a pharmacist-prepared interim residential care medication administration chart on gaps in continuity of medication management after discharge from hospital to residential care: a prospective pre- and post-intervention study (MedGap Study). BMJ Open; 2(3): e000918.

[5] Elliott, R.A., Chan, A., Godbole, G., Hendrix, I., Pont, L.G., Sfetcopoulos, D., Woodward, J. and Munro, C. (2020), Standard of practice in geriatric medicine for pharmacy services. Journal of Pharmacy Practice and Research, 50: 82-97. https://doi.org/10.1002/jppr.1636

[6] Richardson S.J., Brooks H.L., Bramley G., Coleman J.J. Evaluating the effectiveness of self-administration of medication (SAM) schemes in the hospital setting: a systematic review of the literature. PLoS ONE 2014; 9: e113912.