Submission to consultation on the ACSQHC Draft Medication Management at Transitions of Care Stewardship Framework

October 2024

Introduction

Advanced Pharmacy Australia (AdPha) (formerly known as the Society of Hospital Pharmacists of Australia (SHPA)) is the progressive voice of Australian pharmacists and technicians, built on 80 years of hospital innovation that puts people and patients first. AdPha supports all practitioners across hospitals, transitions of care, aged care and general practice clinics to realise their full potential. We are the peak body committed to forging stronger connections in health care by extending advanced pharmacy expertise from hospitals to everywhere medicines are used.

AdPha welcomes and congratulates the Australian Commission on Safety and Quality in Health Care (ACSQHC) on the development of the Medication Management at Transitions of Care Stewardship Framework, which will be important in addressing Australia's Tenth National Health Priority Area, Quality Use of Medicines and Medicines Safety.

AdPha members, who lead pharmacy practice in hospitals, are stewards of medicines management at the transitions of care, ensuring patients have a safe transition and reduce their readmission risk and achieve post-discharge recovery and health outcomes.

AdPha convenes various Specialty Practice Groups who we have consulted with in responding to this submission, including:

- Transitions of care and primary care
- Geriatric medicine
- Leadership and management
- Medication safety
- Dispensing and distribution

Medicines are the most common health intervention; up to 90% of people may experience

Advanced Pharmacy Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 • adpha.au • info@adpha.au

medication changes during their hospital stay.[1,2] As highlighted in Chapter 6 of AdPha's *Standards of Practice for Clinical Pharmacy Services*, 50% of medication errors and up to 20% of adverse drug events result from poor communication of medical information at transitions of care.[3] Omitting one or more medications from the discharge summary exposes patients to twice the risk of re-admission to hospital.[4]

Medicine use throughout transitions of care is complex with involvement of multiple clinicians at any given time as patients transition between community and healthcare services, with the need for multidisciplinary collaboration, shared responsibility and accountability as further highlighted in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) Principle of safe and high-quality transitions of care resources.

Medication reconciliation by pharmacists remains the most important means of reducing errors in medication use. Pharmacists have demonstrated they possess the skills to obtain the most accurate medication histories compared to other health professionals and are highly valued by doctors as this ensures patients do not unintentionally skip doses of vital medicines when unexpectedly admitted to hospital. Upon discharge, hospital pharmacists are integral to ensuring continuity of care through providing updated medicines lists for patients.

Increasingly, hospital pharmacists are responsible for the medication summary section of patients discharge summaries and integral in providing information to community-based care providers ensuring safe transition back into care. The ACSQHC in their report on Safety Issues at Transitions of Care, recognised transitions of care as a substantial risk of harm to patients including harms directly caused by medication errors. The report identified six areas of prioritisation all of which hospital pharmacists are integral to achieving, including better responsibility and accountability for communication at transitions of care.

AdPha therefore recognises the value of comprehensive medication management measures at transitions of care and welcomes the opportunity to provide feedback to this vital Framework.

If you have any queries or would like to discuss our submission further, please contact Jerry Yik, Head of Policy and Advocacy at jyik@adpha.au.

Response to submission questions

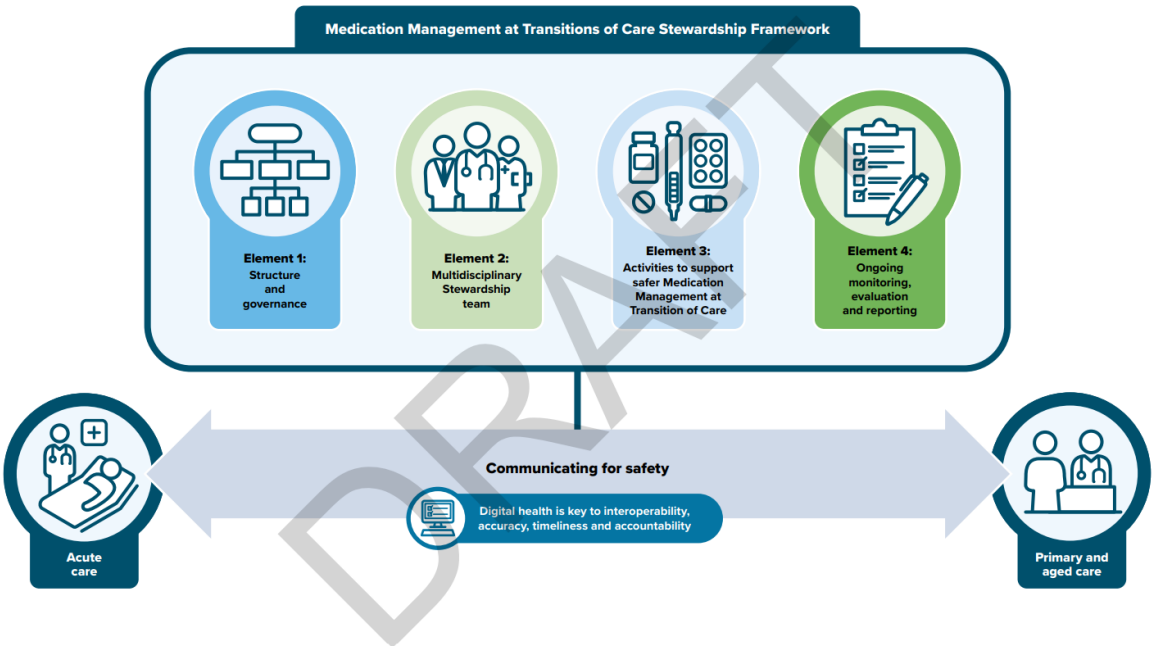

Figure 3: Elements for inclusion in a Medication Management at Transitions of Care Stewardship Framework. ACSQHC's Draft Medication Management at Transitions of Care Stewardship Framework Consultation Paper, 2024.

Question 1: Please indicate if you agree or disagree with the following statement about the Framework.

'The four elements above summarise the most important elements for inclusion in a Medication Management at Transitions of Care Stewardship Framework.'

AdPha agrees in principle with the above Framework statement and believes that the four elements described facilitate medication management at transitions of care to be embedded into hospital and primary care governance structures.

The multidisciplinary approach to stewardship is vital in ensuring the framework is implemented into clinical practice, without the responsibility falling on one clinician alone. AdPha believes this approach is effectively laid out in the governance structure described in figure 6 of the consultation document.

AdPha suggests that the text on the grey arrow in figure 3 and 4, that extends between 'Acute care' to 'Primary and aged care' needs to be reconsidered. It is currently labelled 'communicating for safety', however, the Framework could highlight that high-quality medication management at transitions of care is not based on communication alone. The Australian Medical Association (AMA)'s General Practice/Hospitals Transfer of Care

Arrangements position statement[5], highlights that appropriate and effective transfer of care arrangements involves "more than just transfer of information"; for example, it also includes "providing adequate supplies of medication and arranging timely follow up." AdPha instead suggests that the arrow could capture the three core elements of high-quality medication management at Transitions of Care:

- Communicating for safety
- Ensuring continuous access to medicines
- Timely pre-discharge planning and post-discharge follow-up

Similarly, the preamble to Figure 4 is focused on communication rather than incorporating the above elements. Figure 1 also focuses on communication; however, a box in Figure 1 could be incorporated that highlights other medication management issues including access to medicines, missed doses and medication administration errors following a Transition of Care.

As funding challenges and capacity of clinical staff alongside their ever-increasing responsibilities continues, AdPha supports the suggested Stewardship team arrangements, in particular the suggestion of organisations to allocate time for senior pharmacists to be able to perform the role of a Clinical Champion.

AdPha welcomes the inclusion of the Stewardship activities outlined as per *AdPha's Standards of Practice for Clinical Pharmacy Services*[6] into this framework. AdPha's *Standards of Practice for Clinical Pharmacy Services*, the *Standard of practice in general medicine for pharmacy services*[7], and the *Standard of practice in dispensing and distribution for pharmacy services*[8] describe hospital pharmacist requirements for patients transitioning into acute care settings.

AdPha has long championed for Partnered Pharmacist Medication Charting (PPMC) to be utilised as Medication Management at transitions of care activity as a tool to lower errors and reduce hospital length of stay and welcomes its inclusion in this Framework.

Question 2: The Framework highlights that digital health can facilitate better communication between acute and primary care clinicians. The Framework recognises that digital health maturity varies across health sectors and settings, especially the ability to exchange health information electronically.

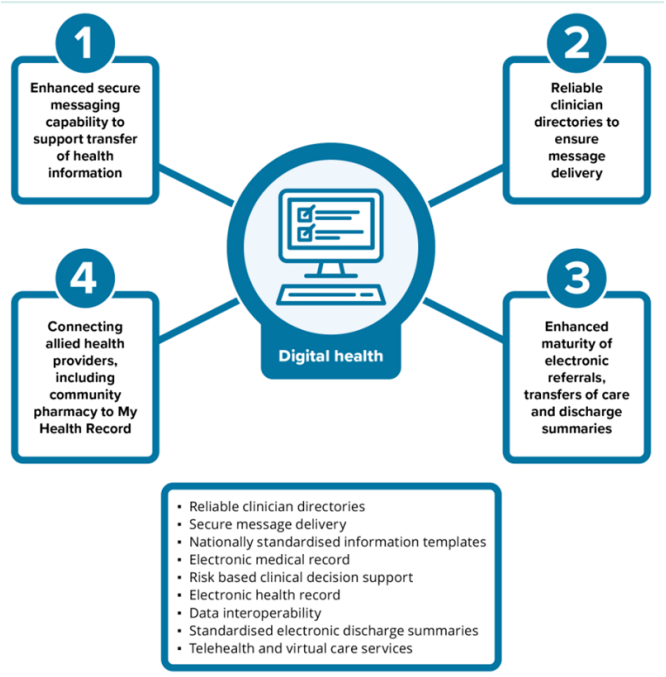

Figure 5: Digital Health Enablers. ACSQHC's Draft Medication Management at Transitions of Care Stewardship Framework Consultation Paper, 2024.

In addition to the digital heath enablers shown in the figure above, what other digital health enablers would support the Framework's implementation in your organisation?

Standardised systems

Much of the transitions of care in relation to digital health technologies currently differs greatly between hospitals. This can be dependent on the level of hospital pharmacy resourcing available, the time of discharge (i.e. weekends) and what local arrangements exist between the hospital and community pharmacies.

Many hospitals have been implementing Electronic Medical Management (EMM) systems in a fragmented approach, without integrating clinical decision-making software, pathology and laboratory data systems, medication administration charts, prescribing and dispensing systems or covering all areas of the hospital which provide medicines. This prevents the implementation of best practice closed loop medication management and necessitates transcription and parallel systems (i.e. paper-based, and electronic medical records), ultimately limiting the benefits an integrated system intended to improve efficiency and reduce prescribing and dispensing errors.

EMM systems, which have been implemented in public hospitals operated by state governments, sit alongside the My Health Record's implementation at a federal level without strong awareness of one another. These dual systems still have varying levels of interoperability which require significant investment from hospitals to connect their EMM

system to a patient's My Health Record. For example, hospital pharmacists routinely provide updated medication lists/charts and medication management plans to patients and primary care providers upon discharge, but currently have no mechanism to upload these important documents to a patient's My Health Record to ensure a safer transition of care.

Although National Guidelines for On-Screen Presentation of Discharge Summaries for discharge summaries[9] exist (currently under review), the different EMM systems cannot produce documents that are in similar recommended formats. This is particularly an issue in states, like Victoria, where great variability and multiple EMM vendors exist between hospitals and their interoperability with Residential Aged Care Home (RACH) EMM systems.

Transfers from ward-based care to a home-based or RACH-based care@home programs are associated with risk. There can be issues with granting prescribing access if hospital clinicians are temporarily taking over care (i.e. Residential In Reach settings or community inpatient programs) leading to delays in medication administration.

Residential Aged Care Homes

Figure 4 and 5 mention 'data interoperability', however, AdPha feel that this could be more specific by providing examples, to make it clearer and more practical. For example, interoperability of medication orders/charts (e.g. to enable electronic interim medication administration charts) is vital, as highlighted in a recent Australian Prescriber editorial: Achieving safe medication management during transitions of care from hospital: time for a stewardship approach[10], the use of EMM in aged care, and lack of interoperability between hospital and aged care EMM systems, is a becoming a barrier to RACHs using hospital-provided paper hospital-supplied interim residential care medication administration charts (IRCMACs) when facilities have a policy that precludes short-term use of a paper-IRCMAC. Up to 23% of these patients experience delays or errors in medication administration after discharge from hospital to a RACH.[11] This can result in patients missing administration of key medications while they wait for a GP to prepare the RACH's electronic medication orders.

Unplanned hospital readmissions have been reported as a result of failure to receive prescribed medications after transfer to an RACH.[12] One of the key recommendations outlined AdPha's Geriatric Medicine and Aged Care Clinical Pharmacy Services Position Statement[13] is the universal use of use of IRCMACs for all transitions of care between hospitals and aged care settings. The IRCMAC 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 RACH. This enables medications to be safely administered immediately after arrival at the RACH, 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 is therefore a key digital health enabler and has been demonstrated to reduce missed or delayed doses of prescribed medicines by 85.2%, with 83.6% of RACH staff reporting improved continuity of care.[14]

Referring to pages 6-8 (Digital Health), electronic transmission of medication chart orders for residential/aged care homes should be mentioned, so it is clear that stewardship pertains to more than transmission of discharge summaries, medication histories, medication management plans and letters.

Primary Care

As per RACGP's General Practice: Health of the Nation 2024 report[15], 31% of GP's rarely or never use My Health Record. AdPha recognises this issue is out of scope for this Framework as it relates to health organisations, however, supports ongoing financial incentives for primary care providers to upload the necessary documents to MHR.

AdPha has collaborated with the RACGP to produce a medicines management at transitions of care resource toolkit for consumers and health care professionals (*an embargoed copy of this toolkit has been provided with this submission, not for circulation*), which provides health practitioners with guidance on medication management services at key transitions of care. The purpose of this document is to clearly define the role of the hospital pharmacist, general practice pharmacist (GPP), and the general practitioner (GP) in delivering safe and quality medication management services to their patients transitioning between acute and primary care.

Question 3: Do you **agree** or **disagree** with the statement: The Framework suggests that a General Practitioner (GP) liaison and/or a Primary Health Network (PHN) representative should be a member of their local MM at TOC Stewardship committee.

Please list any other representatives from primary care you think should be a member of the MM at TOC Stewardship committee.

AdPha agrees that there should be a GP liaison or PHN representative at a primary care level. For example, some organisations include a GP liaison on their Discharge Summary Working Group, which sits under the Standard 6 governance committee.

Due to the variability, complexities and high risk of patients at RACHs and aged care, AdPha strongly recommends that medication management at transition of care stewardship committees also include a nurse representative from a residential aged care home.

We feel that representation by consumers should be considered in the committee to provide a broader perspective, possibly a consumer with community medication

management experience and/or someone with experience supporting a person in residential aged care or disability care.

Question 4: Most applicable setting of organisation providing feedback

The majority of AdPha's members consulted for this submission work in a hospital setting.

Question 5: How do you engage external primary care stakeholders and would this facilitate MM at TOC?

Engagement at a committee level could be established by employing a General Practice Liaison Officer (GPLO) on a discharge summary working group. In particular, General Practice Pharmacists would be ideally placed to provide a bridge between transitions of care.

Most recently, in response to the Strengthening Medicare Taskforce Report, Unleashing the Potential of our Health Workforce (Scope of Practice) Review has aimed to explore the reforms needed to support health professionals such as pharmacists, to work to their full scope of practice, optimising the use of resources across the primary care sector. In this way, further engagement in stewardship activities could be generated through pharmacists working to their full scope of practice.

Engagement would be further enhanced through representation from other primary care groups such as community pharmacy and residential care and would ultimately improve transitions of care governance and planning.

At a day-to-day practice level, frequent communication to plan individual discharges and maintaining good relationships with local RACHs and community pharmacies is essential. Some organisations maintain a list of all local RACHs within their catchment and which pharmacy(s) service them.

Consumers must be represented on stewardship committees to ensure end users and their requirements between transitions of care are appropriately catered to. To identify those at higher risk, consideration should also be given to representatives from Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHO) to join medication management at transitions of care stewardship committees.

Element 3: Activities to support safer MM at TOC

Element 3 describes evidence-based, person-centred stewardship activities across an individual's hospital journey (e.g. on and during admission, discharge planning, transitioning out of hospital).

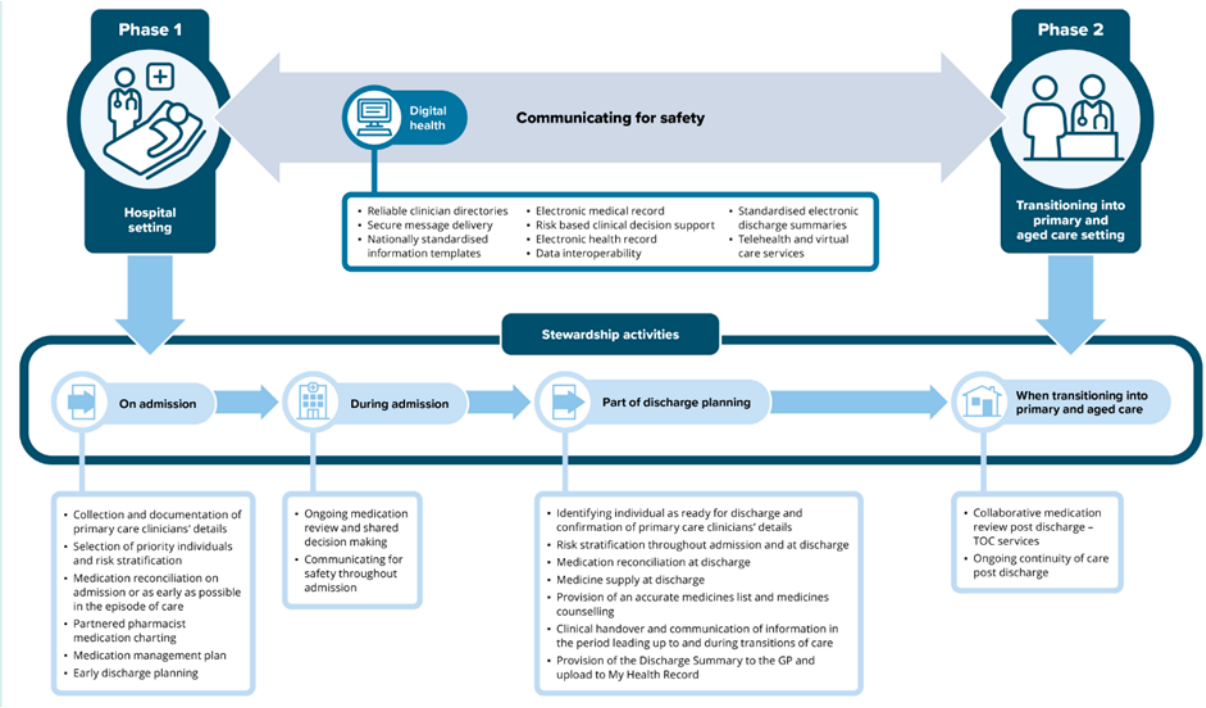

Figure 8: Stewardship activities to support safer medication management at transitions of care, ACSQHC's Draft Medication Management at Transitions of Care Stewardship Framework Consultation Paper, 2024.

Question 6: In addition to the listed Stewardship activities in the figure above, are there other activities that would support MM at TOC?

Collaborative medication review post discharge should include pharmacist-led medicines reconciliation when transitioning into aged care. This should be conducted by an aged care pharmacist and in a primary care setting, conducted by a community pharmacist or general practice pharmacist

Referring to figure 8, 'part of discharge planning' box, the IRCMACs for transfers to residential care homes should be included here. As mentioned previously, IRCMACs are an important evidence-based transitions of care strategy, included in the existing Guiding principles for medication management in residential aged care facilities.[16] However, IRCMACs are not mentioned in the Framework document until page 31, where we feel that it is incorrectly covered under the heading 'medication supply'.

In relation to "Provision of an accurate medicines list and medicines counselling", clarification is required to state this refers "to the individual" and that it should be a "patient-friendly medicines list".

The figure would also benefit from clarification that 'primary care clinicians' include those working in community pharmacies and RACHs.

Figure 8, When transitioning into primary and aged care, we would recommend the addition of medication reconciliation post-discharge. Ideally this should occur at the RACH when the RACF medication chart is prepared, at GP follow-up and at post-discharge HOMR/HMR/MedsCheck services.

For post-discharge medication reviews, AdPha recommends the addition of 'within 7 days for high-risk individuals' as well as inclusion of a multidisciplinary case conference as a further strategy, where appropriate.

Please refer to the attached copy of AdPha and RACGP's medicines management at transitions of care resource toolkit for further suggested roles and activities (embargoed copy provided, not for circulation).

Question 7: Have you experienced any barriers to undertaking these Stewardship activities? If yes, please provide more detail, including how you overcame these barriers.

Weekend discharges can be challenging due to lack of appropriate staff to follow through on transitions of care activities. This includes relaying information to primary care services which may be closed over weekends. Similarly, short notice discharge also carry a risk of stewardship activities not being undertaken as expected. Updating MHR and providing patients with clear patient friendly medication lists and discharge information is therefore key in these situations.

The Australian Pharmaceutical Advisory Council (APAC) Guiding Principles to Achieve Continuity in Medication Management provides the framework for clinicians on how to provide optimal continuity of care with respect to patient's medicines as they transition between different care settings. However, due to funding challenges, hospital pharmacy departments exacerbated by remuneration inequities, it remains challenging for the vast majority of hospitals to deliver all ten Guiding Principles systematically across their entire health service for every patient. The stewardship framework will act as a benchmark and assist in ensuring that health organisations are aware of the necessary stewardship models and activities required to ensure that this is considered within funding structures.

Question 8: Health services should adopt a prioritisation approach to identify cohorts at risk of medication-related harm during TOC as well as medication related hospital readmission.

Do you agree or disagree with the statement: The Framework prioritises assessing and categorising 'high' risk individuals on and throughout admission, based on local risk stratification approach or tool.

Although AdPha agrees in principle with the Framework prioritising the assessment of high risk individuals, AdPha believes that by only prioritising this group we risk identifying those

who may be at rising risk of medication management errors. In addition to the risk stratification tools, clinical judgment remains key in prioritising individuals.

Question 9: Do you agree or disagree with the statement: The Framework recommends that the responsible clinician from the hospital team should contact a 'high' risk individual's GP, ideally early in their admission, to inform them of their 'high' risk status and discuss with them recommended TOC services as part of discharge planning.

AdPha agrees with early communication to an individual's GP and feel that the Framework should also reflect current programs for reducing risk during transitions of care such as, the Hospital Admission Risk Programs (HARP), Geriatric Evaluation and Management at Home (GEM@Home) services.

Question 10: The Framework outlines communication at TOC, such as verbal and electronic information transfer. For example, the discharge summary is provided to the individual, sent via secure messaging to their GP, and uploaded to their My Health Record (if they have one).

My Health Record does not replace direct communication with an individual's GP or other primary care clinicians.

How have you overcome any challenges to communicating MM at TOC information between acute and primary care teams?

The delay of medication administration for older people being transferred back to RACH is a known challenge. AdPha recommends that upon discharge to a RACH, patients are provided with a short-term transitional medication chart such as an IRCMACs to facilitate the seamless medication administration by patients, carers and community clinicians. The provision of an up-to-date medicines chart or medicines list is embedded into hospital pharmacy discharge processes.

The universal use of IRCMACs for all transitions of care between hospitals and aged care settings is one of the five priorities identified by AdPha in our Geriatric Medicine and Aged Care Clinical Pharmacy Services position statement.[13] As previously discussed, this is an important means for achieving better heath outcomes for older people by mitigating the risks of medication-related harms and inappropriate use of medications.

Question 11: The Framework encourages health services to employ a range of practical TOC initiatives to support individuals' medication management post-discharge. The table below includes examples of TOC services that could inform local MM at TOC Stewardship.

TOC services aim to expand access to medicine management services for individuals

post-discharge, and not replace existing hospital services that provide specialised outreach medication management services or targeted interventions for very high-risk, complex individuals.

Hospital-based TOC services	Primary care based TOC services
▪ Post-discharge follow up care and services (such as via telehealth) ▪ Hospital Outreach Medication Review (HOMRs) services ▪ Outpatient clinic review	▪ Post-discharge GP consultation ▪ Comprehensive Medication Management review such as Home Medicines Review (HMR)/Residential Medication Management Review (RMMR) or Aged care on-site pharmacist review ▪ Review by embedded pharmacist roles within the aged care, primary care (e.g. General practice pharmacist), and disability care settings ▪ Community pharmacists providing MedsCheck or Diabetes MedsCheck. This may result in a recommendation to conduct a HMR

Are there any other post-discharge TOC services that should be included?

A patient friendly discharge summary should be considered under the hospital-based transitions of care services. Many patients don't have a regular GP or are staying with a family member and attend a different GP (than their regular GP) so would benefit from a patient-focused discharge summary with key information about the episode of care, key actions for their GP, and a comprehensive list of medications and any changes that have been verified by a pharmacist, and is in a format that meets the patient's needs.

Question 12: Have you experienced any barriers to implementing these TOC services? If yes, please provide more detail, including how you overcame these barriers.

Your answer:

Funding is one of the greatest barriers reported by AdPha members. Funded hospital-based transitions of care services like HOMR and CONNECT are required across all hospital organisations.

Education and buy in to transitions of care stewardship at a ward level would also ensure discharges are arranged in advance so time is given to complete medication management activities in a timely manner.

Question 13: Once the hospital team determines the post-discharge TOC services, they should document this in the discharge summary.

The Framework recommends verbal notification to the GP. This aims to:

- **Enable hospital clinicians to verbally confirm receipt of the discharge summary**

by the GP

- **Provide GPs the opportunity to 'flag' the priority review of these individuals post-discharge**
- **Assist GPs to promptly refer an individual to the TOC service and coordinate timely follow-up care.**

Do you agree or disagree?

Although AdPha agrees that verbal notification would be ideal in communicating treatment changes, members have reported difficulty liaising directly with the patient's GP at time of discharge, especially if this falls out of hours. Receipt is most often confirmed with the GP receptionist who then relays information back to the GP. A clinic nurse or a general practice pharmacist would be best placed to follow up and assist in any medication management queries and ensure the treatment plan as per the discharge summary is being adhered to. However, it should be noted that these roles may be part time and so alternative means of communication to support verbal, such as digital transfer of information may be required.

Question 14: The Framework states any post-discharge comprehensive Medication Management review services provided should be communicated to the individual's GP and uploaded to their My Health Record.

Do you agree or disagree?

AdPha agrees in the secure transfer of details of medication management review services to My Health Record, to ensure all involved in an individual's care, including the consumer themselves, have access to this vital information.

Element 4: Ongoing Monitoring, Evaluation and Reporting

Element 4 suggests a list of quality indicators that may be used to measure MM at TOC Stewardship and report to a local Stewardship committee.

Question 15: How would your organisation report on results of MM at TOC stewardship to your local Stewardship committee, and does this provide insight into areas of improvement?

Hospital readmission rates can be challenging to quantify, especially to target those caused by medication management errors at transitions of care.

AdPha publishes the Standard of Practice in Geriatric Medicine for Pharmacy Services, [16] which describes the clinical activities a pharmacist in a RACH should undertake, including medication management at transitions of care. These should provide the foundation of quality indicators and reporting to a local Stewardship committee. In addition, some hospitals already collate data on the percentage of medicines reconciliations completed

within 24 hours of admission, percentage of patients with a discharge medication list, discharge counselling or discharge summaries completes.

Other reports regarding consumer or primary care clinician satisfaction of discharge services could be employed to see if stewardship activities are fit for purpose.

General questions about the Framework

Question 16: Are there any current legislative and/or policy challenges that should be considered in the Framework?

Scope of Practice

In response to the Strengthening Medicare Taskforce Report, the Unleashing the Potential of our Health Workforce (Scope of Practice) Review final report has recently been released. The Framework will need to consider to the increasingly vital role of pharmacists in primary care in medication management at transitions of care stewardship activities, further reflecting their full scope of practice.

AdPha are also releasing a competency standard for Pharmacy Technicians to showcase technicians' expanded scope of practice which could include medication management at transitions of care stewardship activities.

Pharmaceutical Reform Agreements

To meet the principle of equity for consumers and in aligning with the key recommendations of the Pharmaceutical Reform Agreement Review Report, AdPha has long recommended that the Commonwealth should make the PRAs a uniform policy in Australia and enter into a PRA with ACT and NSW. AdPha understands that the ACT and NSW Government have previously approached the Commonwealth to enter into a PRA.

This would ensure a consistent standard of care for vulnerable patients who have just had a major health event requiring hospitalisation and reduces the need for individuals to immediately seek an appointment with their general practitioner on discharge from hospital to continue receiving vital medicines.

PRAs in other jurisdictions have supported the continuity of care for patients discharging from hospital back into the community by allowing for patients to be supplied the standard PBS quantity of one-months' supply of discharge medicines and eliminating the need for them to make an urgent appointment to see their local GP for medicines post-discharge.

Access to PBS subsidised quantities of medicines is not afforded to Australians being discharged from public hospitals in ACT and NSW. In contrast to other jurisdictions who are able to supply a months' worth of discharge medicines, patients being discharged from public hospitals in ACT and NSW are currently supplied only 3-7 days' worth of discharge medicines, forcing patients to seek immediate GP appointments to access more medicines prescriptions for vital treatments that will prevent readmission to hospital.

Advanced Pharmacy Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 • adpha.au • info@adpha.au

This expectation is extremely difficult to achieve with the current GP shortages where Australians often have to wait up to three to four weeks to see their GP. This impacts on continuity during transitions of care where patients are most vulnerable and at higher risk of hospital readmission.

The expansion of PBS into public hospitals has also allowed more Hospital Pharmacists to be employed and provide clinical pharmacy activities to patients, as well as allow investment into specialised pharmacy services, such as pharmacists specialising in oncology, paediatrics, emergency medicine and geriatric medicine. These services are necessary to safeguard and maximise the federal government's investment into new PBS medicines that treat complex conditions as well as ensuring pharmacists are able to contribute to safe transitions of care.

Pharmacy programs

There are also commonwealth funded pharmacy programs that are not packaged in the Eighth Community Pharmacy Agreement and subject to further negotiation and consultation, which could have impacts on HMR and hospital referral pathways, and other programs that impact or can support the provision of transitions of care services.

IRCMACs

The Framework suggests on page 31 that IRCMACs can only be used in jurisdictions where it has been legislated. As IRCMACs are medication administration records, they may be prepared by a medical practitioner or a pharmacist.

As mentioned earlier, some RACHs have policies that prevent their nurses from using an IRCMAC when they have no other alternative for safely administering and recording medications. This results in patients missing doses of time-critical medicines and sometimes leads to emergency department re-presentation (usually Fridays and weekends when it is harder to access GPs and pharmacies to prepare RACH medication charts and Dose Administration Aids (DAA) in a timely manner). The Commission could address this by supporting RACHs to develop resident-focused transition of care policies that allow the use of paper IRCMACs for a time-limited period while waiting for the GP to prepare the RACH medication chart.

The same issue arises with medication supply. Some RACHs do not permit their registered nurses to administer hospital-supplied discharge medications when they are not supplied in a DAA. This not only contributes to missed doses, but also medication wastage. Again, a more resident-focused policy is needed to facilitate safe transitions of care, good patient care, and reduce waste of medications.

Question 17: Do you have any general comments regarding the MM at TOC Stewardship Framework?

Feedback regarding wording:

On page 43, it is stated that discharges from emergency departments, short stay units and day surgery units are excluded from the framework due to their short length of stay (LOS). Short LOS does not necessarily equate to low risk and emergency department and short stay unit discharges can be very high risk. The Framework must be hospital-wide with strategies tailored to each clinical area of the health service.

Page 27, last paragraph: In the sentence "*Potential … should be discussed and communicated with … regular GP*", add "and RACH/home care provider."

Page 28, last paragraph: In the sentence commencing "For individuals admitted to hospital from RACHs … ", it should be stated that discharge summaries need to also be sent directly to the RACH, because the patient may be admitted to the RACF or reviewed by a GP who is not their regular GP. In the next sentence, the community pharmacy also needs to be contacted for RACH patients.

'Medicine supply on discharge' section, page 30: This section needs to emphasise the increased risk of poor continuity of access to medicines in vulnerable groups, such as those discharged to residential aged care and disability care, and those with limited mobility and carer support (and thus may not be able to readily visit a pharmacy). These groups need to be managed differently to lower risk groups.

After-hours discharges are not mentioned. This is another vulnerable group if there are time-critical medicines, and especially on Fridays, weekends and public holidays when it might take several days to access a pharmacy.

The section on IRCMACs (page 31) is presented under the "Medication supply at discharge heading". IRCMACs and medication supply are separate strategies and are not always provided together. They need to be presented and discussed as separate strategies.

The medication supply subsection headed "For individuals discharging to residential care or community care" should focus only on medication supply. There are unique challenges around medication supply in this group. For example, when a person is discharged to a new RACH, the contracted community pharmacy can't supply medication until they have patient or next of kin consent to be their pharmacy.

Additionally, some pharmacies are not able to supply or prepare DAA-pack medicines until the GP prepares the RACH med chart, which can be delayed. Furthermore, the pharmacy contracted to the RACH can be a long distance from the RACF, thus making timely supply after discharge extremely challenging. It is for these reasons that hospitals should be enabled to provide an adequate supply of discharge medications.

The IRCMAC strategies warrant its own heading. The statement that providing an IRCMAC "will facilitate ongoing, coordinated, and uninterrupted medicine supply post-discharge" is not correct, because IRCMACs are primarily used to enable medication administration, not to facilitate medication supply.

Regarding 'Provision of an accurate medicines list and medicines counselling' (page 31).

First dot-point: For clarity, it would be helpful to mention here that the patient should receive a 'patient-friendly medicines list', alongside a copy of the discharge summary with an embedded medication list.

Page 33, last paragraph: In the sentence commencing "Efforts should be made ....", this would be an ideal place to mention HOMR/HMR.

Box 5 (p37), Nursing staff in RACHs or respite care, last dot-point: Medication reconciliation should also be conducted by a clinician (e.g. senior nurse and ACOP) when the RACH medication chart is prepared by the GP following transitions of care from a hospital.

Table 5, Quality indicators (page 40): IRCMAC indicator – delete "(if applicable)", as this strategy is the standard of care and is applicable to all RACH discharges (as mentioned earlier, there is no legislative barrier to using IRCMACs). If not deleted, it should be explained when this strategy is not applicable.

Clinical leadership (Box 1, Table 2): There should be flexibility around who is the right person to be the Director of medicines management at transitions of care. Medicines management at transitions of care is not typically a strong day-to-day focus for senior medical staff, and there are many senior pharmacists with deep understanding, expertise and practical experience in this space, who would be well placed to lead such a team.

If the clinical champion is a Junior Medical Officer (JMO), they will be likely to have limited experience and would require suitable training.

Members feel that further clarification is needed that this Framework relates primarily to hospitals as there are references to application to health service organisations and other times applicability is to hospitals, i.e. Element 3 Phase 1 From hospital and Phase 2 transitioning into primary and aged care settings.

Note that the link to CATAG guiding principles for medicines stewardship requires updating.

Box 5: For the GP this should include HMR referral and referral to an Aged Care On-site Pharmacist (**ACOP**), RMMR, especially if recommended by treating team in discharge summary. Nursing staff in home care services or RACH should be on alert to 'trigger' a post discharge medication review (noted that they are unable to according to the program rules but have an important role highlight the need to the GP and either or independent credentialed pharmacist for HMR for home care services client) or contracted RMMR credentialed pharmacist/ACOP. Page 36 should include medication review follow-ups and cycle of care for HMR/RMMR.

SHPA is now known as AdPha

Please note that reference has been made in the Framework to the Society of Hospital Pharmacists of Australia (SHPA), however, references will need to be updated to reflect

our organisation's recent name change to Advanced Pharmacy Australia (AdPha).

Advanced Pharmacy Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 • adpha.au • info@adpha.au

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