LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

Updating National QUM Publications

LASA response to the consultation paper

September 2021

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Submitted via email to Sue.Davies@safetyandquality.gov.au

About LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/seniors housing.

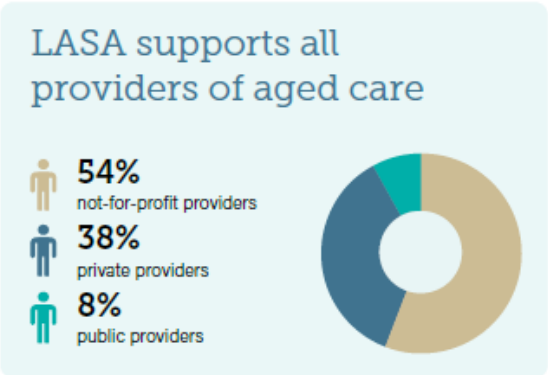
Our Purpose

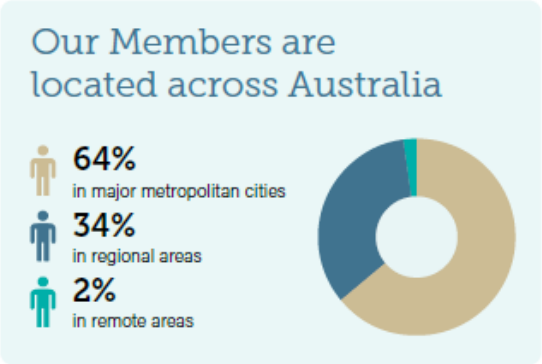
Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing

- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.





Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

Thank you for giving LASA the opportunity to provide input to inform the development of a revised National QUM publications namely the: *Guiding principles for medication management in residential aged care facilities*; and *Guiding principles for medication management in the community.* This review is timely considering that the medication safety landscape and healthcare environment have changed tremendously since the released of the publications in 2012 and 2006, respectively.

While many of our Members would have provided input by completing the surveys, some have provided LASA with feedback and this submission reflects on these comments.

Incorporation of advice and consolidation

LASA is of the view that all of the current principles are still relevant to medication management, whether in aged care facilities or in the community. However, we agree that some of the guiding principles on similar topics could be grouped together as suggested; not only would this avoid any confusion (especially for those who are non-clinicians) but would also reduce the length of the document making it more user friendly. To this end, LASA supports combining:

- GP5 (Nurse initiated non-prescription medicines) and 6 (Standing orders) – as they both relate to administration of medicines by an authorised person.
- GP9 (Continuity of medicines supply) and 10 (Emergency stock) – noting that the transitions of care medication chart is not consistently used across sites, to combine the two would need jurisdictional and legislative alignment and expansion of emergency stock with explicit guidelines on when to use this resource.
- GP11 (Storage of medicines) and 12 (Disposal of medicines) – as storage and disposal are closely related but must ensure alignment with relevant state/territory legislation.
- 13 (Self-administration of medicines), 14 (Administration of medicines by RACF staff), 15 (Dose administration aids) and 16 (Alteration of oral dose forms) be combined into a renamed guiding principle *Administration of medicines within the RACF* – However, this would need to be stepped out for staff for each situation i.e. if incorporated into one GP, they would still need to be addressed individually as there are differing requirements. In addition, self-administration of medicines ability of each resident must be reviewed regularly as this can change as cognitive ability declines (6-monthly at least).

Similarly, we would support combining the guiding principles on similar topics, namely, GP8 (Storage of medicines) and 9 (Disposal of medicines), and GP11 (Nurse-initiated non-prescription medicines) and 12 (Standing orders) of the *Guiding principles for medication management in the community*.

With regard to the areas of importance, these we believe will need new, stand-alone principles. For example, with current greater emphasis on polypharmacy and the use of antipsychotics/restrictive practices to ensure medication safety for older Australians, LASA believes stand-alone principles in these areas incorporating case studies are needed in the updated guiding principles. We also believe the medication management needs of Aboriginal and Torres Strait Islander (ATSI) and CALD people should be given greater focus in the updated guiding principles. Particularly, information provided could be used to adopt appropriate pathways for ATSI people. This will future proof the guidelines as more ATSI people enter RACFs. This community is at greater risk of poor health outcomes than the white Australians.

Additionally, the challenge many providers found in developing policies and processes based on these current guidances is that there are a lot of statements on needing policies, procedures and/or guidelines on particular guiding principles without providing a lot of guidance about what they should contain. Therefore, guidance in this space to support providers in developing policies and

processes would be very useful, though we note that this may be difficult given there are different State/Territory legal requirements.

Format of the National QUM publications

Noting that regulations and practice are likely to experience significant change, it would make sense to have the documents available online, where they can be printed and updated on a regular basis as needed. It would also be useful to have an interactive version of the documents where users can chat and seek real time advice/clarification from experts such as those available in many online services. This service would be very useful for non-clinicians such as care workers with little experience/knowledge in medication management.

The use of Infographics, apps, and links in documents to evidence and tools to support best practice would also be very useful. Consideration should also be given to incorporating the principles into MAC reporting and into in situ clinical management systems for alerts and triggers for HMR/RMMRs.

It has also been noted that the scope is very wide. Suggestion has been made that perhaps different publications should be developed to target different audiences i.e. health professionals, providers and care workers.

Proposed new guiding principles

Person-centred care

LASA is of the view that person-centred care has to be an integral part of any updates to the current Guiding Principles (focus on person-centered care is very important and aligns with the Aged Care Standards and Royal Commission report). To this end, LASA strongly supports the recommendation that a new guiding principle be included in each updated set of guiding principles focused on person-centred care.

Communicating with people receiving care and colleagues

LASA is of the view that communicating with people receiving care and colleagues is essential to the patient centred care approach. We have heard stories that the family didn't know anything about a new medication until they received the pharmacy bill. The new aged care legislation should improve this as there is an expectation that the GP has discussed this with the family or resident prior to prescribing the medication. We believe there should be some comment in the Guiding Principles about the need to ensure that this has happened.

Also, in relation to transitions of care/new admissions/or attendance at specialists' appointments – there needs to be more transparency as to what changes have occurred or been recommended and who is responsible for these. For example, is the GP expected to make the changes and has the resident or family been informed and consented to this?

Comments on specific chapters

Chapter 1: Guiding principles for medication management in residential aged care facilities

Overall, LASA is supportive of the recommendations outlined in the consultation paper. However, and in addition to issues discussed in the 'Incorporation of advice and consolidation' section above, LASA is of the view:

GP1: Medication Advisory Committee

LASA agrees with the recommendations to alter the focus of GP1 to clinical governance of medication management and broaden the commentary and definition of medication management. However, there is a need to ensure that there is an effective process between local facility and organisational MAC. Also, there is no mention of frequency of MACs. We believe it is important to have this in the Guiding Principle as it is another way of ensuring the standards of care are met. As a minimum, we believe MAC should met every three months.

It is also important to note that the contributing professionals proposed for a MAC may be difficult to source in regional, rural and remote Australia. Funding inequities between professional groups makes participation of some professional groups (e.g. pharmacists or nurse practitioners) with specific expertise in medications unviable. Private hospitals have clinical governance regimes to which doctors and other health care professionals sign up because only then can they use the facility to generate an income. Income from visiting residents in RACFs may not provide sufficient financial incentive to persuade doctors to sign up formally to a clinical governance framework and the associated processes and responsibilities.

We also believe that the emphasis should be on appropriateness of the medications and not just deprescribing and the role of medication reviews includes to assess the appropriateness of these medication regimens (part of GP17).

GP2: Information resources

LASA agrees with all recommendations. In addition to what is being recommended, we believe links to relevant legislations, standards (including the new *National Safety and Quality Primary and Community Healthcare Standards* which will be launched on 12 October 2021) and best practice guidelines and other relevant reference materials should also be included in the document. There is a need for a communication strategy to be developed to ensure that users are aware of the changes made to the documents.

With regards to availability of multi-lingual resources, LASA believes there is a need to utilise translation services to ensure resident/family understands what is written. It is not appropriate to just hand over written information. And, it is important to always take account health literacy of resident/family and staff.

GP3: Selection of medicines

LASA agrees with all recommendations. However, we believe something should be said about the role of Advanced Care Directives – maybe a comment that these should be encouraged for all residents as this will guide decisions around medication management.

Additionally, we believe there needs to be a mechanism to hold prescribers to account. There are patently poor prescribing practices in some instances. For example, GPs can ignore RMMR or embedded pharmacist or geriatrician/specialist advice without accountability.

GP4: Complimentary, alternative and self-selected non-prescription medicines

LASA agrees with the recommendation that GP4 be retained and that the resource list be updated to include reference to the NHMRC *Talking with your patients about Complementary Medicine - a Resource for Clinicians* and the PSA *Position statement on Complementary medicines*. We also believe that complementary medications will need to be reviewed regularly and this should be highlighted in the document.

Additionally, we believe there is a need to ensure complementary and alternative medicines (CAMs) are included on medication charts. This can be difficult to achieve for residents who are independent and mobile and can access OTC products (including online). Similarly, residents who visit GPs in their surgeries and/or use non-contract pharmacies, can choose not to share that information.

CAMs should be included in clinical review via RMMR &/or embedded pharmacist. This would imply having access to evidence-based CAM resource. CAMs are currently not covered by standard resources such as Australian Medicines Handbook, MIMs, eTherapeutic Guidelines (NSW health uses Welcome to the Natural Medicines Research Collaboration (therapeuticresearch.com)). Perhaps CAMs clinical oversight could be included in the supply pharmacy contract.

GP5 (Nurse-initiated non-prescription medicines) and 6 (Standing orders)

LASA agrees with recommendations and with combining GP 5&6. However, we believe there would still need to be a distinction between those medications of the nurse-initiated list as they cannot be a prescription only medication, but the homes (depending on legislation) can have an imprest list so nurses can initiate these medications on the prescribers' phone order etc.

Importantly, we believe GPs should be routinely notified by the resident (or where appropriate by the staff) whenever non-prescription medicines is used.

GP7: Medication charts

LASA agrees that GP7 should be retained and updated to highlight the need for future implementation and use of the eNRMC and updated resources include reference to support materials for the implementation of the eNRMC. We also agree with renaming GP 7 to focus on documentation of medication management, which would encompass both hard-copy and use of digital systems. The Royal Commission suggested that there should be a move to having digital medication charts but this needs to come with financial support for some providers to implement infrastructure changes.

With regard eNRMC, it is important that it has effective decision support tools embedded including dosing in elderly (e.g. renal function). Effective communication with prescribers will also be needed for implementation.

Currently GPs are having to document clinical notes twice, once in their prescribing software (e.g., Best Practice and again in Leecare EHR platform). Software systems need to be integrated to avoid unnecessary duplication of tasks.

GP8: Medication review and medication reconciliation

Considering the importance of RMMR, LASA believes GP8 should be split into two discrete guiding principles. Additionally, with the inclusion of medication management in the National Aged Care Mandatory Quality Indicator (QI)program, LASA also believes GP8 should be expanded to include information on polypharmacy and consideration of relevant policies, procedures and guidelines on these topics and the relationship with the QI program, as suggested.

However, as highlighted above, the challenge many providers found in developing policies and processes based on these guides is that there are a lot of statements on needing policies, procedures and/or guidelines on particular guiding principles without providing a lot of guidance about what they should contain, therefore, guidance (regarding what they should contain) in this area would be very useful.

Additionally, since March 2021, active ingredient prescribing is now mandate for prescriptions, but

not for medication charts in RACFs. We believe this needs to be changed to be in line with the prescriptions.

We believe that GPs need more training in deprescribing. In addition, we also believe that facility staff should be encouraged to refer for timely RMMR for:

- new residents (including respite, see (Rec 63 Final Report Aged Care Royal Commission).
- resident with a change in their ability to swallow
- after discharge from hospital
- deterioration in clinical status.

GP9 (Continuity of medicines supply) & 10 (Emergency stock of medicines)

Considering that that GP 8&9 are closely related (given that both have a focus on ensuring medicines are available for administration to people in RACFs), it makes sense that the two principles be combined, as suggested.

However, we believe interim medication charts should be used by all states and territories to mitigate risk when a resident is transferred back to the home until all homes have electronic charts where the treating physicians could make the changes prior to discharge.

With self-administration of medications, we believe this needs to be reviewed regularly, at a minimum every six months.

With regard to GP10, it would be useful to have consistency in naming, noting NSW Health regulation talks about "Urgent use" (See Residential care facilities - Pharmaceutical services (nsw.gov.au)). Consideration could be given to the currency of the NSW Health list of medications approved for stocking by RACFs: it does not include haloperidol for end of life care, or prednisolone for acute flare-up of COPD, asthma, gout; nor frusemide for CHF.

GP11 (Storage of medicines) &12 (Disposal of medicines)

LASA agrees with combining GP 11&12 as suggested but must ensure alignment with relevant state/territory legislation.

With regard to GP12, regulation could be updated to allow destruction of S8 medicines by embedded pharmacist where available. It is often difficult to get supply pharmacists on site, as these sometimes are from out of town. Drug safes can become crowded with medication from deceased residents.

GP13 (Self-administration of medicines), 14 (Administration of medicines by RACF staff), 15 (Dose administration AIDS) & 16 (Alteration of oral dose forms)

All four principles deal with administration of medicines. To this end LASA agrees with combining GP 13,14,15&16 under a single guiding principle entitled *Administration of medicines within RACF* as suggested, and with all recommendations.

Additionally, and as highlighted above, this would need to be stepped out for staff for each situation i.e. if incorporated into one GP, they would still need to be addressed individually as there are differing requirements. Self-administration of medicines ability of each resident must be reviewed regularly as this can change as cognitive ability declines (6-monthly at least).

It is also important that some additional advice for RACF clinicians and nurses is included on when and how to stop and restart medicines during period of acute illness.

GP14 – A sick day policy is recommended for MAC development and oversight. We believe this needs to be individualized and be included in individual medication assessment.

GP15 – Individual unit dose packing should be utilized in DAAs to enable RN to implement dose changes between deliveries. On delivery new DAAs should be checked against Medication chart/s.

GP16 – Consideration should be given for embedded pharmacists to be able to chart alternative medicines from the same class with regard to issues pertaining to swallow (e.g. Lansoprazole wafer for rabeprazole or pantoprazole tablet). Though staff need further education in this area as there is a tendency to crush medications together.

GP17: Evaluation of medication management

On page 31, the consultation paper notes that "Prior to the Australian Government decision to mandate the two above-mentioned national quality aged care indicators, the Department of Health and Human Services in Victoria had implemented a quality indicator program to help public sector aged care services collect and report on five quality indicators including one to monitor the proportion of people using '9 or more different medicines.' Resource materials accompany each indicator. For instance, apart from instructions on how to conduct the audit and collect the data, definitions of the key data elements are included as well as a risk management framework that highlights what action should be taken by the RACF. Whilst developed for public sector aged care services, the resources have also been available for use by all residential aged care providers."

LASA believes this to be an unfair statement, because this comment implies that there was no monitoring of quality if the Victorian indicators were not used. Many aged care providers subscribe to a quality monitoring service to which they supply indicator data which the service analyzes and benchmarks against fellow subscribers.

LASA agrees with recommendation that GP17 be renamed to focus on quality improvement and that the existing evaluation questions be adapted and incorporated as reflective questions where relevant within in each guiding principle.

Additionally. the Royal Commission recommended that a resident be reviewed on admission and this is data that could be collected. LASA believes there need to be some Quality Indicators around this data collection which will support quality improvement.

Importantly, RMMR pharmacists should have access to clinical systems. They need to document in review when is done remotely and whether the resident has been consulted. It would also be useful if the myriad reports on antipsychotics could routinely split into residents with or without a validated psychiatric diagnosis.

Chapter 2: Guiding principles for medication management in the community

General comment

LASA notes that regarding stakeholders to whom the document applies - there are multiple stakeholders referred to throughout the document with different terminology used to refer to the same group of people (and sometimes in the same sentence). This will need to be cleaned up. Additionally, the glossary at the end of the document that is also 'wordy', this should be simplified.

LASA believes a visual map of stakeholders surrounding the care-recipient that reflect the community network for medication management would be helpful upfront with definitions for each

stakeholder group and their relation to the care recipient and each other with regards to enacting the guiding principles. Then consistent use of terminology can be introduced upfront that is aligned to the map. This terminology can be used throughout the guidance materials. Same could probably apply to residential care. Icons for stakeholders could also be used across the document guidance to denote reference to where stakeholder responsibility applies. This will help readers to target content of relevance in team-based approach to responsibility.

LASA is also conscious that the ACSQHC will be developing clinical care standards for aged care (likely by December 2022 to correspond with new introduction of the Aged Care Act). Clear separation of roles/responsibilities across stakeholders in medication management will help in pulling out relevant content for aged care to transfer into the clinical care standards. It will also help aged care providers to navigate how both documents will relate to each other.

GPC1: Information resources

As in Chapter GP2, LASA agrees with all three recommendations to: adapt content within the Medication Safety Standards; ensure information align with all relevant professional board requirements; and that consideration be given to creating web-based lists of medication management information resources. With regards to availability of multi-lingual resources, as highlighted in GP2, LASA believes there is a need to utilise translation services to ensure resident/family understands what is written. It is not appropriate to just hand over written information.

GPC2: Self-Administration

LASA agrees with the recommendation that the language be amended to align with the concept of person-centred care and that additional advice on when and how to stop and restart medicines during periods of acute illness be included in the document, which align with GP13.

GPC3: Dose administration

LASA agrees with the recommendation regarding greater emphasis and more information on the need for medication reconciliation, consent and communication, monitoring and follow-up, and that some additional advice on self-directed medication management during periods of acute illness be included as part of GPC3.

GPC4: Administration of medicines in the community

It is important that all guiding principles align with state/territory legislation, to this end LASA agrees with the recommendation that information and resources relevant to GPC4 be updated/aligned to reflect relevant state/territory legislative requirements and the current practices of care providers and care environments.

GPC5: Medication lists

LASA agrees with recommendation that GPC5 be retained and that the information content and accompanying resources be updated to reflect on recent developments in medication management. Importantly information should be easily accessible to older people in the community, such as via digital support tools including smartphone apps.

GPC6: Medication review

LASA agrees with the recommendation that GPC6 include information on the risks of inappropriate polypharmacy and deprescribing and that other aspects of medication review be considered. Importantly, we believe GPC6 should align with PSA Guidelines for comprehensive medication

management reviews and that effective and collaborative communication especially via case conferencing to facilitate a person's involvement in shared-decision making will ensure safety and quality use of medicines and this should be highlighted in the document.

GPC7: Alteration of oral dose forms

LASA agrees that the guiding principle would benefit from a greater emphasis on a multidisciplinary approach that considers how to manage people with dysphagia (As in GP14, consideration should be given for embedded pharmacists to be able to chart alternative medicines from same class). LASA also agrees that the document should consider how the content of other guiding principles may need to be amended to include self-administration of medicines, administration of medicines in the community and medication review, as suggested.

GPC8 (Storage of medicines) & GPC9 (Disposal of medicines)

As in GP11&12, LASA agrees with combining GP 8&9 as suggested but alignment with relevant state/territory legislation must be ensured.

GPC10 (Nurse-initiated non-prescription medicines & GPC 11 (Standing orders)

As in GP5&6, LASA agrees with the recommendation that GPC 10&11 be combined as suggested but alignment with relevant state/territory legislation must be ensured.

GPC 12: Risk management in the administration and use of medicines in the community

LASA agrees that information and resources relevant to GPC12 be updated or aligned to reflect current tools and practices such as with regard to inappropriate polypharmacy and deprescribing, as well as clinical governance and risk management, as suggested. Importantly, the document must continue to highlight the need for all stakeholders to work together to ensure that there are safe systems for medication management, including systems to monitor quality use of medicines from prescribing through to the administration of medicines, monitoring of their effectiveness and for side-effects.

A Strong voice and a helping hand

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