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AMA submission to the Australian Commission on Safety and Quality in Health Care – updating national Quality Use of Medicines publications

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Introduction

The AMA thanks the Australian Commission on Safety and Quality in Health Care (The Commission) for the opportunity to provide feedback on updating the national Quality Use of Medicines guiding principles for medication management in the community and residential aged care facilities (RACFs).

The AMA notes that the updating of quality use of medicines publications should happen within the context of the existing National Medicines Policy and the National Strategy for Quality Use of Medicines[1], but the AMA believes that there is need for broader reform in this space. It will be important for the QUM publications to include any insights from the National Medicines Policy Review. The AMA will be lodging a submission to the NMP Review which should be considered by the Commission's Project Advisory Group.

The AMA considers the format of the current publications suitable to the needs of the stakeholders. It will be important that the updated publications are written in plain English so that they are accessible to a broad range of users. It will also be important that the publications are translated and available in several languages to be easily accessible to culturally and linguistically diverse groups, particularly those in aged care.

The documents use the terms 'clinicians', 'health care practitioners' and 'health care professionals' interchangeably. The AMA suggests using consistent terminology and include a definition to avoid confusion.

Guiding principles for medication management in RACFs

Many of the harrowing stories unveiled during the Royal Commission into Aged Care Quality and Safety (Royal Commission) hearings pertained to the inappropriate use of medicines. Medication

[1] Department of Health (2002) *National Strategy for the Quality Use of Medicines.*

management continues to be among the top two complaint issues in residential aged care[2]. It is therefore important that this work of the Commission is done in coordination and alignment with any changes to the Aged Care Quality Standards emanating from the recommendations of the Royal Commission.

The Royal Commission proposed that the Aged Care Quality Standards be urgently reviewed and amended to ensure "best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved" and "implementing new governance standard" (recommendation 19)[3].

Crucial to this will be the link between clinical governance in aged care and medication management. The current Aged Care Quality Standards – Standard 8 Organisational Governance[4] does not include medication management as a requirement for RACFs to prove they implement effective clinical governance standards. This needs to change.

The Royal Commission recommended that by 1 July 2022 every aged care provider "uses a digital care management system (including an electronic medication management system) meeting a standard set by the Australian Digital Health Agency and interoperable with My Health Record"[5]. The Government responded in support of this recommendation "The Government is supporting residential aged care facilities to implement an electronic National Residential Medication Chart (eNRMC) and support the adoption of the My Health Record by June 2023"[6]. As noted in the Commission's consultation paper, it will be important that all these ongoing reforms are coordinated with the new Guidance issued on medication management.

Of relevance will be the communication occurring at transition points – when older people are transiting from RACFs to hospitals and from hospitals to RACFs. The current Guidelines include some reference to the Interim Residential Care Medication Administration Charts to be used by hospitals where available. The AMA has received enquiries from hospitals where there is confusion around the use of those charts, who fills the charts and who bears the responsibility for any mistakes made by RACFs in the use of interim charts. The AMA suggests further education is needed in this space.

Consultation questions

Guiding Principle 1: Medication Advisory Committee

The AMA supports renaming of this principle to Clinical Governance of Medication Management. Medication management in aged care should be linked to clinical governance in aged care. The

[2] Aged Care Quality and Safety Commission (2021) *Sector performance report January – March 2021*
[3] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*
[4] Aged Care Quality and Safety Commission (2021) *Standard 8: organisational governance.*
[5] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*
[6] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*

AMA considers it important that this work of the Commission is done in coordination and alignment with any changes to the Aged Care Quality Standards emanating from the recommendations of the Royal Commission, including linking medication management to clinical governance standard, as explained previously. Strategies for this principle should also include that registered health practitioners should be appointed to the clinical governance/medical advisory committee, including medical practitioners, pharmacists, and registered nurses. The resident's usual GP is also a valuable source of advice for medication management and clinical governance.

Guiding Principle 2: Information resources

The AMA supports recommendations under Guiding Principle 2.

Guiding Principle 3: Selection of medicines

Quality use of medicines

The AMA supports the recommendation to strengthen the existing guiding principle regarding the quality use of medicines. Deprescribing and non-pharmacological strategies may be more appropriate, and this should be recognised by the RACF and reflected in the guiding principle. Currently, the standards do not highlight the current context of aged care. The current guidelines state that medication management may be an issue for particular patient groups such as those with dementia. However, medication management is an issue for every patient (particularly due to high polypharmacy rates in older people) and must be prioritised. Medication reviews should be encouraged and should occur annually, and when there is a significant change in the older person's medication and/or medical condition. The National Strategy for the Quality Use of Medicines should be further highlighted in this section.

This section also lacks a patient-centred approach. The importance of informed consent[7] and decision-making capacity should be highlighted here.

The Royal Australian College of General Practitioners *aged care clinical guide (silver book)* is also a useful resource and contains a section on medication management[8]. This should be included as a reference in the guiding principles.

Scope of practice

The AMA partially supports the recommendations under guiding principle 3 pertaining to scope of practice. The AMA supports a separate guiding principle that covers medicines scope of practice in RACF settings. Including clear principles around scope of practice will provide more clarity around who is responsible, and can implement, aspects of the patient's care. It is important however that in writing the scope of practice principle, that current prescribing scopes of practice law under the Australian Health Practitioner Regulation Agency (Ahpra) Boards is carefully considered instead of listing aspirations for some health practitioner groups to expand their scope

[7] Australian Commission on Safety and Quality in Health Care (2020) *Informed consent in health care*
[8] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide: Part A: medication management.*

of practice. Only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. The AMA therefore does not support independent prescribing by non-medical health practitioners outside a collaborative arrangement with a medical practitioner. Prescribing by non-medical practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care. The AMA supports independent prescribing by dentists. Dentists are trained to prescribe medicines for dental conditions and prescribe within their scope of practice.

It is the AMA position that Registered Nurses (RNs) are the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice.

While Personal Care Assistants (PCAs) are an essential part of the aged care workforce, they are not trained to provide clinical health care. The Aged Care Workforce Strategy Taskforce identified significant health-specific training gaps including medication management[9]. Although this work by the Taskforce was completed in 2018, the AMA is not aware that any changes or improvements in this regard to have happened in the meantime. This guiding principle must make clear that PCAs are not appropriate staff members to handle care involving medicines.

The AMA calls for further clarification around the requirement on RACFs to ensure that clinicians 'work within their scope of clinical practice and have the knowledge, skills, competence and delegated regulatory and legal authority to manage, use, and handle and administer medicines'. This requirement should only be relevant to employees of the RACF, and not expanded to visiting medical practitioners.

Medical practitioners are regulated by relevant regulatory bodies (Ahpra, Medical Board of Australia) whose duty is to ensure doctors are capable of performing their duties within their scope of practice. RACFs are not authorised to check the skills, knowledge and competencies of medical practitioners. Doctors spend over a decade training to be able to prescribe. Apart from nurses, it is likely that all clinicians engaging with RACFs will not be employed by RACFs and will only be visiting their patients in RACFs. The AMA is concerned that this requirement will mean that doctors would have to show detailed credentials when they visit a RACF which would cause unnecessary inefficiencies and administrative burden.

The AMA suggests that another appropriate amendment would be to recommend the establishment of written protocols between clinicians (primarily general practitioners) and RACFs that would outline duties and responsibilities of each party involved in the older person's care.

Guiding Principle 4: Complementary, alternative and self-selected non-prescription medicines

This guiding principle should be updated to highlight that there is limited efficacy evidence regarding most complementary medicine and warn, in addition to potential adverse reactions or interactions with conventional medicine, that they pose a risk to patient health either directly through misuse or indirectly if a patient defers seeking medical advice. Consumer investment in

[9] Aged Care Workforce Strategy Taskforce (2018) *A matter of care: Australia's aged care workforce strategy* (page 26)

unproven medicines and therapies also risks patients being unable to afford necessary, evidence-based treatment when there are out-of-pocket costs[10]. Any information being disseminated to residents by health practitioners should highlight these issues so they can make an informed choice.

Residents should speak to their medical practitioner about their use of complementary or alternative medicines. Community pharmacists have a direct conflict of interest as they have the ability to both recommend and sell these products, despite the lack of evidence that they work.

The AMA asks that the Project Advisory Group consider the AMA's position statement on complementary medicines[11].

Guiding Principle 5: Nurse initiated non-prescription medicine

The AMA supports the recommendations under Guiding Principle 5. The AMA reiterates the importance of recording prn and other nurse-initiated medicines and ensuring this information is accessible to the treating medical practitioner. AMA members frequently report difficulties accessing RACF records for their patients which puts their health at risk.

Guiding Principle 6: Standing orders

The AMA supports collapsing Guiding Principle 6 under Guiding Principle 5, with the Principle 5 being renamed to Nurse-initiated medicines to broaden the scope of the Principle.

Question: do AMA members have a view about standing orders in RACF? The ANMF regards them as inappropriate.

Guiding Principle 7: Medication Charts

The AMA supports the recommendations under Guiding Principle 7, in particular the renewed focus on digital health strategies that assist in the documentation of medication management. The AMA has consistently advocated for interoperability between clinical and aged care software systems, My Health Record and My Aged Care, and fully supports the inclusion of this recommendation in the guiding principles.

Guiding Principle 8: Medication review and medication reconciliation

The AMA supports the recommendations under Guiding Principle 8. The AMA acknowledges the importance of regular medication reviews for residents of RACFs. It is the AMA position that medication reviews should occur annually, and when there is a significant change in an older person's medication and/or medical condition[12].

[10] Australian Medical Association (2018) *AMA position statement – complementary medicine – 2018.*
[11] Australian Medical Association (2018) *AMA position statement – complementary medicine – 2018.*
[12] Australian Medical Association (2019) *AMA submission to the Royal Commission into Aged Care Quality and Safety.*

Guiding Principle 9 and 10: Continuity of medicines supply and Emergency stock of medicines

The AMA supports the merging of these two principles, as they are both focusing on ensuring undisturbed medicines supply to people residing in RACFs.

Guiding Principles 11 and 12: Storage and disposal of medicines

The AMA supports retaining and merging principles 11 and 12.

Guiding Principles 13, 14, 15, 16: Administration of medicines within RACFs

The AMA supports merging Principles 13, 14, 15 and 16 into one principle.

Regarding amendment recommendation to Principle 13, the AMA supports additional guidance for periods of acute illness for RACF residents who self-administer medicines. The AMA calls on the guidance to ensure that the period of nurse administration of medicines is based on an assessment from the patient's treating medical practitioner (typically their usual general practitioner) and that it is limited to the acute periods. This will ensure that self-agency is not taken away from older people who are cognitively and physically capable of self-administering medicines.

The AMA supports recommendations pertaining to Principles 14, 15 and 16. See also the section on the AMA's position on scopes of practice (under guiding principle 3) that highlights issues around the administration of medicines. The recommendation for guiding principle 16 should state that both the pharmacist *and* the person's usual general practitioner should be consulted if the person has difficulty swallowing. The person's usual general practitioner must have this information both to determine whether the dose can be altered but also to determine whether other treatments are required to resolve swallowing difficulties.

Guiding Principle 17: Evaluation of medication management

The AMA supports the recommendations regarding the improvement of medication management evaluation, in particular its linkage to the revised Guiding Principle 1 and clinical governance in RACFs.

The AMA also suggests, that along with heightening the focus on the medication management quality indicator, the reflective questions should include those around specific complaints in relation to medication management. Under the Aged Care Quality Standard 6: Feedback and complaints[13], RACFs are expected to receive and review the feedback and complaints from consumers, carers and workforce to improve quality of their care and services. Quarterly Sector performance reports published by the Aged Care Quality and Safety Commission (ACQSC)[14] have consistently shown that between July 2018 to March 2021 medication administration and management have been among the top two complaint issues reported to the ACQSC. These are just the reports filed to ACQSC, and do not include feedback and complaints raised directly with

[13] Aged Care Quality and Safety Commission (2021) *Standard 6: feedback and complaints*
[14] Aged Care Quality and Safety Commission (2021) *Sector performance data.*

RACFs. In the AMA view, one way of helping RACFs improve their performance in relation to medication management will be by including self-reflective questions that link the complaints received and their reduction/increase with implementation of relevant policies stemming from the application of the updated guiding principles for medication management.

Guiding principles for medication management in the community

Guiding principle 1: information resources

Question for MPC/CGP – are there any important information resources missing?

The AMA supports the recommendations for improvement of guiding principle 1. Health literacy is a significant influencer of health outcomes and medication safety and therefore the AMA agrees that access to reliable resources through this guiding principle should be maintained. In addition to NPS MedicineWise, Health Direct should also be listed as an important information source.

Guiding principle 2: self-administration

The AMA supports the recommendations outlined under guiding principle 2. The AMA supports patients being able to maintain independence in taking their medicines as it reflects important principles of dignity of care and empowers the patient to become more involved in their own health care. The AMA supports a person-centred approach to all guiding principles.

The current guiding principle is long and covers several issues. The AMA suggests breaking down different concepts into sub-headings so it is easier to read and more concise.

Guiding principle 3: Dose Administration Aids

The AMA supports the recommendations under guiding principle 3. The AMA notes the common issues around medication errors caused through the Dose Administration Aid process and considers that these risks should be addressed in the guiding principles.

Guiding principle 4: Administration of medicines in the community

The AMA supports the recommendations under guiding principle 4.

Guiding principle 5: Medication lists

The AMA supports the recommendations under guiding principle 5. Digital health technologies that assist in keeping detailed and up to date medicines lists should be referred to in this section, including the NPS MedicineWise app, My Health Record, and Active Script Lists. The AMA reiterates the importance of software interoperability to ensure all platforms can be updated at the same time.

Guiding principle 6: medication review

The AMA supports the recommendations under guiding principle 6. The AMA supports embedding pharmacists into general practice to further improve the quality use of medicines and health outcomes. This model should be recognised in the guiding principle. Currently, it only recognises that community pharmacies participate in Home Medicine Reviews whilst not mentioning pharmacists in other care settings.

Guiding principle 7: alteration of oral formulations

The AMA supports the recommendations under guiding principle 7. Recommendation 1 should state that both the pharmacist *and* the person's usual general practitioner should be consulted if the person has difficulty swallowing. The person's usual general practitioner must have this information both to determine whether the dose can be altered but also to determine whether other treatments are required to resolve swallowing difficulties.

Guiding principle 8: storage of medicines

The AMA supports the recommendations under guiding principle 8.

Guiding principle 9: disposal of medicines

The AMA supports the recommendations under guiding principle 9.

Guiding principle 10: nurse-initiated non-prescription medicines

The AMA supports the recommendations under guiding principle 10. However, it is imperative that this guiding principle indicates that the non-medical practitioner initiating the medicine should make every attempt to contact the prescribing medical practitioner on the grounds of patient safety. Only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Non-medical practitioners do not have the full medical history of the patient to properly assess whether a patient should continue on a medicine. Further, medical practitioners provide patients with a specific quantity of medicine to time with follow up appointments. Any continued dispensing should not interfere with this.

Guiding principle 11: standing orders

The AMA supports the recommendations under guiding principle 11.

Guiding principle 12: risk management in the administration and use of medicines in the community

The AMA supports the recommendations under guiding principle 12. Real Time Prescription Monitoring is an important method for risk management and should be included under this guiding principle.

The AMA supports the introduction and funding by governments of electronic systems, such as real time prescription monitoring (RTPM), to collect and report real-time prescribing and dispensing data relating to high risk medicines as an effective means of addressing problems of forgery, dependency, misuse, abuse and prescription shopping.

While several States and Territories have produced their own RTPM systems, there needs to be as much national consistency as possible for it to work. Any system must be integrated with a national data base to ensure people do not avoid detection by crossing a State or Territory border. RTPM systems require seamless interoperability with clinical software used in hospitals and practices. The AMA understands that the Federal Department of Health has developed a National Data Exchange (NDE) that State and Territory RTPMs feed into[15].

Conclusion

The Quality Use of Medicines is an important policy area for the AMA and the AMA considers it timely that the two sets of guiding principles are updated considering the age of these two documents and how much practice has changed since they were first published. The AMA broadly supports the recommendations outlined in the discussion paper. However, these guiding principles must be considered in the broader context of the National Medicines Policy Review to ensure consistency, and that issues identified through the review are reflected in the guiding principles. It will be important that ongoing reforms are coordinated, particularly when it comes to updating and expanding digital health components such as the eNMRC, Real Time Prescription Monitoring, and My Health Record.

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[15] Department of Health (2021) *National Real Time Prescription Monitoring.*