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AMA submission to the Australian Commission on Safety and Quality in Healthcare – Baseline report on Quality Use of Medicines and Medicines Safety

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Introduction

The AMA thanks the Australian Commission on Safety and Quality in Healthcare (ACSQHC) for the opportunity to provide a submission to phase one of the Baseline Report on the Quality Use of Medicines (QuM) and Medicines Safety consultation regarding the aged care sector. The AMA considers QuM in aged care an important issue in overall improvement and reform of the aged care sector.

As the Royal Commission into Aged Care Quality and Safety (the Royal Commission) has revealed, Australia's aged care system is in crisis. The provided discussion paper lists several programs, tools and trials that aim to improve QuM and medicine safety. However, the reality is that to improve QuM and medicines safety in aged care, aged care systemic issues must be resolved. The AMA urges the ACSQHC to read the AMA's submission to the Royal Commission[1].

There are several systemic improvements that must be made to the health and aged care sectors that will subsequently improve all three issues: polypharmacy, the inappropriate use of antipsychotics, and transitions of care. This consists mainly of improving workforce capability, capacity, and connectedness through:

- Minimum mandatory staff to resident ratios in residential aged care facilities (RACFs),
- Mandatory minimum qualifications for personal care attendants,
- Maintaining continuity of care through a regular GP,
- Increased access to medication management reviews,
- Recognising health and aged care systems as one system, including interoperability between clinical information systems, My Aged Care and the My Health Record.

[1] Australian Medical Association (2019) *AMA submission to the Royal Commission into Aged Care Quality and Safety.*

Minimum mandatory staff to resident ratios in residential aged care facilities

The AMA believes that the main issue influencing the safety and quality of care in aged care is the capacity, capability, and connectedness of the aged care workforce. It is extremely difficult to provide safe and quality care without enough staff to carry out the work. There is substantial evidence that links staffing numbers to the quality of care received[2,3,4].

The lack of focus on maintaining staffing levels has resulted in an increase in the proportion of inadequately trained personal care attendants, and a decrease in the proportion of registered nurses (RNs)[5]. This is despite the increasingly complex and severe medical conditions of older people living in RACFs, which will continue to increase over time due to the focus on keeping older people at home for as long as possible.

The declining proportion of registered nurses (RNs) in aged care is an important systemic issue that will need to be addressed if the aged care system is to achieve an increased standard of care regarding QuM and medicine safety. On most occasions, RNs are the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice. Doctors rely on RNs to carry out their clinical directions when they leave the RACF. Older people in RACFs need RNs to safely administer medicines and help prevent medical issues that could potentially lead to prescribing medication.

On many occasions, RNs are not available or cannot be found for an appropriate clinical handover with the doctor. AMA members have reported that sometimes there is no RN on site to administer medication at night. AMA members who work in aged care consistently, and overwhelmingly, raise inadequate staff numbers and staff training as the most urgent issue for safety and quality in aged care. Mandatory minimum staff to resident ratios and availability of registered nurses 24/7 in RACFs is essential for QuM and medicines safety.

Mandatory minimum qualifications for personal care attendants

Personal care attendants (PCAs) spend proportionally more time caring for older people than any other staff type[6]. This makes them a crucial component to the aged care workforce and a crucial component in influencing medicine safety and quality issues.

However, PCAs are not equipped to provide basic health care. The *Aged Care Workforce Strategy Taskforce* identified significant health-specific training gaps such as basic care skills (nutrition and hydration), oral health, mental health, dementia, palliative care and end-of-life care, and

[2] Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study* Collegian
[3] Dellefield, M et al (2015) *The relationship between registered nurses and nursing home quality: an integrative review (2008-2014)* Nursing Economics. 33:2, Pages 95-108
[4] Castle, N and Engberg, J (2005) *Staff turnover and quality of care in nursing homes* Medical Care. 43:6
[5] Mavromaras et al (2016) *The aged care workforce*. Department of Health
[6] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 28

medication management[7]. There is no requirement for aged care providers to ensure that their PCA employees receive training or professional development for the above, or any, care skills[8].

Other professions that have the responsibility to care for people have mandatory minimum qualifications and are regulated[9], and the AMA believes that this should be no different for PCAs.

The AMA calls for a mandatory minimum qualification for PCAs. Older people should be appropriately cared for in a way that prevents the use of medications in the first place, as much as is clinically appropriate. For example, appropriate training in dementia management and reducing responsive behaviours for all aged care staff is crucial. This may contribute to the reduction of chemical and physical restraint use in aged care. Another important aspect of dementia care will be appropriate environmental design suited to the needs of dementia patients.

Maintaining continuity of care through a regular GP

Despite the older population's increasing need for medical attention, doctors are not well supported to provide their services to older people in aged care settings. This lack of support comes from both the health and aged care systems. AMA members report that a focus on continuity of care (receiving care from a usual doctor) in aged care settings is generally not recognised, despite the evidence that continuity of care is linked with improved health outcomes[10]. The role of GPs and other medical professionals in caring for elderly patients needs to be acknowledged, adequately supported and remunerated.

An additional systemic issue is education and training for doctors in caring for older people. The AMA believes this should be increased and it must begin at medical school, by introducing young doctors and medical students to RACFs. The comparatively smaller and more stable population compared to the patient population of large teaching hospitals would offer medical students and trainees a different experience. Being trained in a RACF environment would also provide young doctors with practical experiences around other interventions available for older people that do not necessarily include use of medication. For example, physiotherapy, diet and physical exercise, and psychotherapy.

Additional training should be based on (currently lacking) clinical research that specifically looks at medication management in older people. As the Canadian Study outlined on page 11 of the discussion paper highlights, current guidelines deal with medications for a specific disease type and are typically based on young and healthy individuals.

[7] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 26
[8] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 40
[9] Australian Health Practitioner Regulation Agency (2017) *Who we are*
[10] Barker, I Steventon, A, and Deeny, S (2017) *Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data* BMJ. 356:j84

Medication management and general practice pharmacists

Medication reviews are important safety mechanisms to reduce the use of unnecessary medications. The AMA supports increased access to Residential Medication Management Reviews and Home Medicine Reviews (HMRs) and is pleased to see their access has been extended under the Seventh Community Pharmacy Agreement. However, while accredited pharmacists are able to provide up to 30 HMRs a month, the AMA believes that medication reviews should occur annually, and then on an as-needed basis to ensure medications are appropriate for older people.

The Department of Health's MBS Review into GP rebates has proposed a reduced rebate for medication reviews. The AMA does not support a reduction into any medication management review items for GPs. These items support proactive care, better medication management, and reduce potentially avoidable hospitalisations by reducing the risk of an adverse drug event.

Pharmacists who work with doctors have an important role in assisting with medication adherence, improving medication management and providing education about medication safety. The AMA supports integrating non-dispensing pharmacists with general practice as a method to reduce the costs to the health system that comes with medication misuse. This has a range of benefits including ensuring continuity of care for patients in RACFs, as the GP and the pharmacist work closely together when prescribing and reviewing medications.

In 2015[11] the AMA proposed that non-dispensing pharmacists in general practice would focus on medication management, in particular:

- medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a RACF,
- patient medication advice to facilitate increased medication compliance and medication optimisation;
- supporting GP prescribing;
- liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital;
- updating GPs on new drugs;
- quality or medication safety audits; and
- developing and managing drug safety monitoring systems.

Supplementary activities, depending on the needs of individual practices, could include activities such as patient education sessions, mentoring new prescribers and teaching GP registrars on pharmacy issues.

In the 2018-19 Budget the Government supported the engagement of pharmacists within general practice as part of its funding announcement for the Practice Stream of the Workforce Incentive Program (WIP). This came into effect on 1 February 2020. Under the WIP subsidy support was extended to assist general practices to employ other health professionals, including non-dispensing pharmacists.

[11] Australian Medical Association (2015) *General practice pharmacists – improving patient care.*

Research[12] has demonstrated that pharmacists working within general practice have a valuable role to play in identifying and resolving drug related issues. Further work[13] has been undertaken to assess whether a model of structured pharmacist and GP care reduces hospital readmissions with results expected to be published soon.

Recognising health and aged care systems as one system – interoperability in digital health

To improve QuM and medicines safety in aged care, Australia should acknowledge that health and aged care are two parts of the same system that should be geared towards optimising the health and wellbeing of older people. The artificial separation between the two systems needs to be removed to achieve optimal safety and quality of care for older people.

One of the biggest gaps along the intersection of aged care and health care systems is the lack of interface and coordination of clinical information systems, that can result in loss of important information that may hinder medication prescribing, dispensing and management.

Digital health and clinical informatics provide significant opportunities to develop systems to maintain accurate and up to date medicine records for older people, at the same time enabling evidence-based research into QuM[14].

The application of digital health and clinical informatics to medication management can bring improvements to how medication is prescribed, dispensed and information shared between health care, aged care, and pharmacies, reduce mismanagement of medication and avoid polypharmacy in aged care. The AMA believes that digital health application should enable full replacement of handwritten scripts by electronic medication charts.

My Health Record (MHR) provides an opportunity to improve the communication and sharing of information, including information on medication, between different care providers. The AMA has called for interoperability between clinical information systems, My Aged Care and MHR as a way of reducing fragmentation between the health and aged care systems. While the AMA recognises that MHR is not designed to replace traditional communication channels between multiple clinicians and healthcare providers involved in the care of a patient, if it is used by the majority of healthcare providers across all sectors of the health system, MHR will be a vital repository of a patient's clinical history. Access to MHR from the RACF will mean all healthcare providers who treat an older person within the RACF have access to their clinical history. Similarly, if an older person is treated in hospital, especially when arriving through an emergency department, the treating clinicians would be able to access the vital information for that patient, in particular the medications they are using.

[12] Benson H, Lucas C, Kmet W, Benrimoj SI, Williams K. (2018) *Pharmacists in general practice: a focus on drug-related problems*. Int J Clin Pharm.

[13] Foot H, Freeman C, Hemming K*, et al* (2017) *Reducing Medical Admissions into Hospital through Optimising Medicines (REMAIN HOME) Study: protocol for a stepped-wedge, cluster-randomised trial*. BMJ Open.

[14] Australian Medical Association (2019) *Innovation in aged care.*

The AMA recognises that the aged care system has a long way to go in terms of improving their digital health literacy and capacity. However, a plan must be put in place to improve this.

Specific issues

Polypharmacy

As outlined in the Consultation Paper, polypharmacy remains a significant issue in aged care.

One of the significant challenges of the current system is the lack of a national coherent approach to polypharmacy. In our submission to the Royal Commission into Aged Care Quality and Safety[15] the AMA called for a national strategy on polypharmacy to be developed, along with evidence-based guidelines for prescribing to the elderly. In the AMA view, having a strategy and guidelines may reduce adverse events, hospitalisation and Pharmaceutical Benefits Scheme costs.

As evidenced by the Consultation Paper, the Department of Health is currently developing a new quality indicator on medication management in RACFs. The AMA is included in the consultative process on its development. In the AMA view, introduction of this new quality indicator is positive as it will provide an overall picture of the medication management by the aged care sector. However, the AMA believes that there should be broader coordination between the Quality Indicator performance measurements and the Aged Care Quality Standards audits and accreditation. In our submission to the Royal Commission, the AMA recommended that Quality Indicator data should be made an integral part of the accreditation/audit reports conducted by the Aged Care Quality and Safety Commission. Medication management data that is published individually for every RACF could help older people and their families make informed choices when selecting their providers of aged care services.

Inappropriate use of antipsychotics

There are several ways Behavioural and Psychological Symptoms of Dementia (BPSD) can be managed before antipsychotics are prescribed. This includes ensuring the environment is dementia-friendly and ensuring there are activities and programs available that assist in managing symptoms.

Ensuring adequately trained staff are available to implement these interventions is essential to preventing the inappropriate use of antipsychotics. The interventions trialled in the RedUse[16] study cited by the Consultation Paper, that lead to reduction of prescriptions and use of antipsychotic medication, included staff education about the use of these medications, as well as applying non-pharmacological strategies for managing behavioural and psychological symptoms of dementia, insomnia, and anxiety.

[15] Australian Medical Association (2019) *AMA submission to the Royal Commission into Aged Care Quality and Safety.*

[16] Westbury et al (2018) *RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities* Medical Journal of Australia MJA 20B (9)

A systemic approach to utilising allied health services for non-pharmacological based interventions, such as exercise, massage, dentistry, etc will also be crucial.

Transitions of care

One of the biggest systemic challenges during transitions of care is inadequate communication between the aged care provider, hospitals, and the older person's GP. Communication between providers of health and aged care services has a direct impact on health outcomes for the older person. GPs are central to the care of older people in RACFs, yet AMA GP members often report that they are not contacted when their patient is transferred to hospital.

The AMA's position on communication standards is outlined in our position statement on *General Practice/Hospitals Transfer of Care Arrangements – 2018*[17]. This document outlines the necessary communication that is required for transfer of care arrangements between GPs and hospitals. These principles can also be applied to aged care settings.

The AMA has previously called for communication between GPs, hospitals and aged care providers to be improved through the introduction of minimum standards and guidelines. Developing and mandating these standards together with indicators/benchmarks to facilitate monitoring, would be one way of scrutinising the progress towards medication safety information exchange at transitions of care. Uptake of MHR by aged care and healthcare sectors could be another way of monitoring the exchange of information, provided that older person's privacy and security is protected in an interoperable MHR/My Aged Care environment.

Conclusion

The AMA believes that resolving QuM and medicine safety issues in aged care goes beyond solely implementing specific programs. There are several systemic issues that must be resolved before QuM and medication safety can be achieved, particularly in RACFs. QuM and medicine safety can be improved by improving the capability, capacity, and connectedness of the health and aged care workforce.

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[17] Australian Medical Association (2018) *General Practice/Hospitals Transfer of Care Arrangements – 2018*